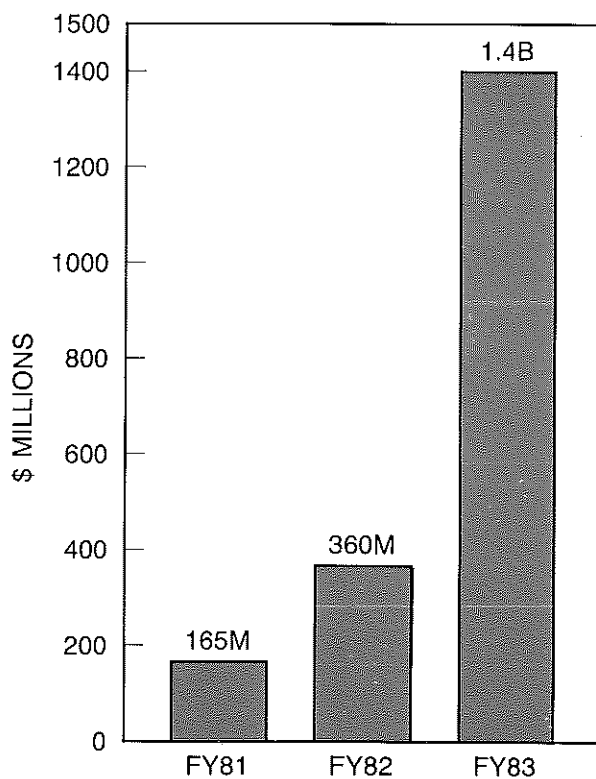


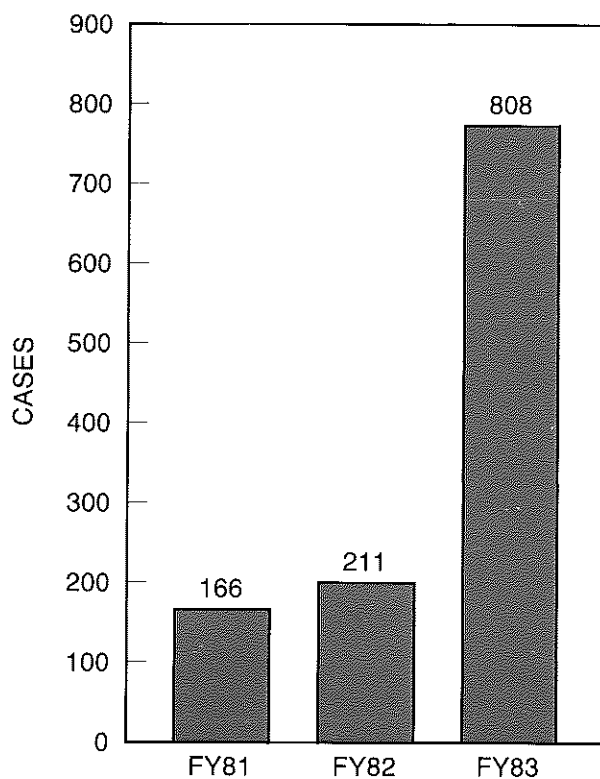
OFFICE OF INSPECTOR GENERAL



Overall Savings



Convictions



SEMI-ANNUAL REPORT

April 1983-
Sept. 1983

OVERVIEW OF MAJOR ACCOMPLISHMENTS OF THE OFFICE OF INSPECTOR GENERAL FISCAL YEAR 1983

- The Office of Inspector General identified \$1.4 billion in savings which could be made in HHS programs: *A 288% INCREASE OVER THE PREVIOUS YEAR.*
 - In health care programs, an additional \$99 million could be saved in six major problem areas by adopting OIG recommendations.
 - In Social Security programs, an additional \$220 million could be saved in five major problem areas by adopting OIG recommendations.
- Inspector General investigations resulted in 808 convictions for criminal acts against Department programs: *A 280% INCREASE OVER LAST YEAR.*
 - Record penalties were meted out including a 20 year fraud sentence to the president of a large hospital.
 - Regulations were published implementing the Civil Money Penalties Law and more than \$1.4 million was collected in just 45 days.
- The Inspector General's office removed 230 problem health providers from participation in the Medicare program through the use of administrative sanctions: *A 253% INCREASE OVER THE PREVIOUS YEAR.*
 - Administrative sanctions for periods ranging up to 30 years were imposed.
 - The first hospital was excluded from Medicare through the use of the Professional Review Organization provisions of law.
- As a result of the Inspector General's special review, several important changes were proposed to strengthen the authority to exclude problem health providers.
- The Inspector General's office was in the forefront of interagency projects in connection with the President's Council on Integrity and Efficiency.



OFFICE OF INSPECTOR GENERAL
RICHARD P. KUSSEROW
INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND
HUMAN SERVICES

ATTACKING FRAUD
ABUSE AND WASTE
IN HEALTH AND
HUMAN SERVICES

**SEMI-ANNUAL
REPORT OF
INSPECTOR
GENERAL
ACTIVITIES**

TABLE OF CONTENTS

	Page
Chapter I OIG Operations and Highlights	1
Chapter II Health Care Financing Administration	9
Chapter III Social Security Administration	31
Chapter IV Grants and Internal Systems	51
Chapter V Legislative and Regulatory Oversight	71
Chapter VI President's Council on Integrity and Efficiency	77
Appendix I OIG Component Missions and Functions	89
Appendix II Graphics	109

OIG OPERATIONS AND HIGHLIGHTS

CHAPTER I

OIG Operations and Highlights

The Department of Health and Human Services (HHS), Inspector General's office, which was created in October 1976, was the first Inspector General's office established by statute in the Federal Government. While a number of factors undoubtedly contributed to this priority, the magnitude of HHS program expenditures clearly was of crucial concern to the Congress.

The size of DHHS programs still maintains a priority among Federal expenditures. In fiscal year 1983 the Department spent \$276.3 billion — an amount greater than the budget of the Department of Defense (218B) and also greater than the budgets of all the remaining departments combined (208B). During this time, nearly one out of every two Americans were directly served by HHS programs. Given such a magnitude of operation and a staff of 142,000 employees, the possibilities for fraud, abuse and waste are altogether evident.

SIZE OF DHHS PROGRAMS

During this period, the Inspector General fielded a force of 1280 auditors, investigators, program analysts and support staff to attack departmental fraud, abuse and waste. This means there was one OIG person for every 280 million dollars of program expenditures, the lowest ratio of staff to expenditures of any Inspector General's office in the entire Federal Government.

OIG RESOURCES AVAILABLE

Given such a disparity of resources to tasks, it was necessary to deploy the resources available in conformance to a strategy carefully planned to maximize the chances of success in the attack on fraud, abuse and waste. One of the major elements of this strategy was a concentration of available forces in the two major program expenditure areas in the Department: Social Security (191B) and Health Care Financing (72B). This re-deployment also involved a massing of resources at points where the risk of loss was highest and an expansion of the use of civil and administrative remedies to deal with fraud and abuse. As a result of this concentration, a major portion of the accomplishments contained in this report relate to these program areas.

ATTACK STRATEGY

Another element of this strategy was, as far as possible, to perform individual audits and investigations with a view to identifying the underlying systemic weaknesses which made the individual losses possible. The weaknesses thus uncovered then became the subject of special studies, audits and inspections

AGENTS FOR CHANGE

designed to determine the extensiveness of the loss and to recommend remedial measures to responsible program officials. The Inspector General's office in effect has acted as an agent for systemic change, thereby producing a multiplier effect in the application of resources to problems.

To accomplish this important mission the OIG is organized into four major components (Office of Audit, Office of Investigations, Office of Health Financing Integrity, and Office of Program Inspections). The mission and functions of these offices are described in Appendix I of this report.

OIG OPERATING HIGHLIGHTS

Health Care Financing Administration

- Requiring parents to contribute to the cost of Medicaid services provided their children residing in Intermediate Care Facilities for the Mentally Retarded (ICFMR), could save \$20 million (see page 11)
- Medicare could save an estimated \$45 million by rounding Part B payments to the next lower whole dollar (see page 11)
- Lowering the rate paid skilled nursing facilities and other providers for return on equity capital could save Medicare \$5 million annually (see page 11)
- Price controls on urological/enteral therapy supplies provided nursing home patients could save Medicare \$17 million annually (see page 12)
- Tightened regulations covering reimbursement for treatment of mycotic (infected) toenails could save Medicare \$10 million annually (see page 12)
- Charges for portable x-ray set-up fees are unwarranted and should be eliminated, annual savings are estimated at \$2 million (see page 13)
- Prompt OIG action stops use of hazardous veterinary x-ray equipment on Medicare nursing home residents (see page 13)

- Despite years of highlighting, three IG reports with cost saving recommendations totaling \$85 million have not been implemented (see page 13)
- Continuing problems found in establishing Medicaid payment rates to Intermediate Care Facilities for the Mentally Retarded—\$23 million questioned this time (see page 15)
- \$4.1 million could be saved in the area of transportation charges for portable x-ray services (see page 16)
- Improving Medicaid edit screen could detect \$2 million in outpatient claims that duplicate all inclusive per diem rate (see page 19)
- Concentration on complex health care operations across the nation led to significant convictions (see page 19)
- Implementing regulations for civil money penalties were published and \$1.9 million obtained in settlements (see page 21)
- The first hospital was excluded under Professional Standards Review Organization authority (see page 22)
- Administrative sanctions for up to 30 years were imposed (see page 22)
- \$10 million was identified as a cost avoidance in the review of a single Nevada hospital (see page 26)

Social Security Administration Highlights

- Accelerating State and local deposits of Social Security contributions will increase interest income and contribution receipts by about \$1.4 billion over 5 years (see page 33)
- Correction of Trust Fund reimbursement process for pre-1957 military wage credits results in recovery of \$56 million (see page 34)
- Minimizing the use of SSA's Immediate Payment Critical Case (IMPACC) system could prevent an estimated \$5 million in overpayments annually and another \$13 million from being charged to the wrong Trust Fund (see page 34)

- Lack of legislative action on prior OIG recommendation results in AFDC recipients continuing to receive duplicate shelter allowances—costing the government millions annually. (see page 37)
- Encouraging all States to adopt OIG Computer screens as part of their front-end controls could identify overpayments of about \$25.7 million in the AFDC program (see page 38)
- Recommended legislation to include medical support as part of child support orders will save the Federal Government \$89 million in FY 1984 (see page 38)
- Adjusting SSA's earnings enforcement policy to allow an analysis of those cases with earnings over a stipulated amount could result in about \$2 million in savings annually (see page 39)
- SSA's new computer center lacks an adequate contingency plan in the event of a disaster (see page 41)
- A special project was entered into with the FBI to investigate benefit and assistance fraud in New York (see page 45)
- Mass indictments in the area of SSA beneficiary fraud has been found to be one of the keys to successful prosecutions (see page 45)
- Project Sacramento, a computer assistance program developed in California to enhance the detection and prosecution of fraud, is being expanded nationally (see page 46)

Grants and Internal Systems Highlights

- Computer match using Federal employment records helped locate delinquent Health Professions and Nursing Student Loan program recipients (see page 52)
- \$20 million could be saved if all PHS construction and renovation projects properly reviewed (see page 52)
- Audits of Foster Care base year costs continue to surface problems—\$8.6 million questioned (see page 55)

- Title XX wrap-up audits found \$12 million in unallowable/questioned costs (see page 56)
- The Indian and Migrant Head Start program can serve an additional 4,500 clients with no increase in program costs (see page 57)
- More children with developmental disabilities can be served with no increase in program costs (see page 58)
- Child welfare training can be improved by more efforts toward teaching grants and less toward traineeship grants (see page 58)

President's Council on Integrity and Efficiency Highlights

- The OIG is heavily involved in the multiple activities of the recently established PCIE standing Committee on Prevention (see page 77)
- A survey and analysis was completed of known cases of computer related fraud. The results were presented to the President's Council on Integrity and Efficiency (see page 79)
- A draft guidance document for use of States in computer matching was completed and circulated to Federal and State officials (see page 80)
- Four standardized extraction formats to enhance efficient extraction of data for computer matching were readied for field testing (see page 81)
- The OIG completed a project to identify possible Medicare and VA duplicate hospital billings. Potential duplicate payments nationally are estimated at \$11,300,000 (see page 82)
- A data source document to capture information for a problem provider clearinghouse was developed and is now in clearance (see page 83)
- A vulnerability assessment questionnaire was developed in connection with the PCIE computer detection screen project and is slated to be sent to Federal, State and private health-related organizations in the near future (see page 83)

HEALTH CARE FINANCING

CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration (HCFA), under its Medicare and Medicaid programs, spent about \$76 billion in FY 1983 on medical care for some 50 million Americans. This is an increase of approximately \$8 billion over FY 1982. With this double-digit growth rate, the Medicare and Medicaid budget is expected to more than double to \$171 billion by 1990. The largest share of the anticipated increase is for Medicare, with program expenditures currently three times that of Medicaid.

In an effort to curb the rising Federal health care bill, the OIG has devoted considerable resources to HCFA review—concentrating on systemic problems in the Medicare and Medicaid programs that not only drive health care costs up but also make the programs susceptible to fraud, waste and abuse. During the second 6 months of FY 1983, there were \$32.1 million in recommended financial adjustments in the HCFA area. An additional \$99 million in savings could be achieved if legislation or in some cases regulations are changed to correct identified problems.

OIG ACCOMPLISH- MENTS

Effort has also been devoted to front-end review of the newly established Medicare prospective payment system for hospital services. Here, OIG is carefully reviewing each of HCFA's proposed implementing regulations—as they are developed—to assure that needed controls are in place from the system's start.

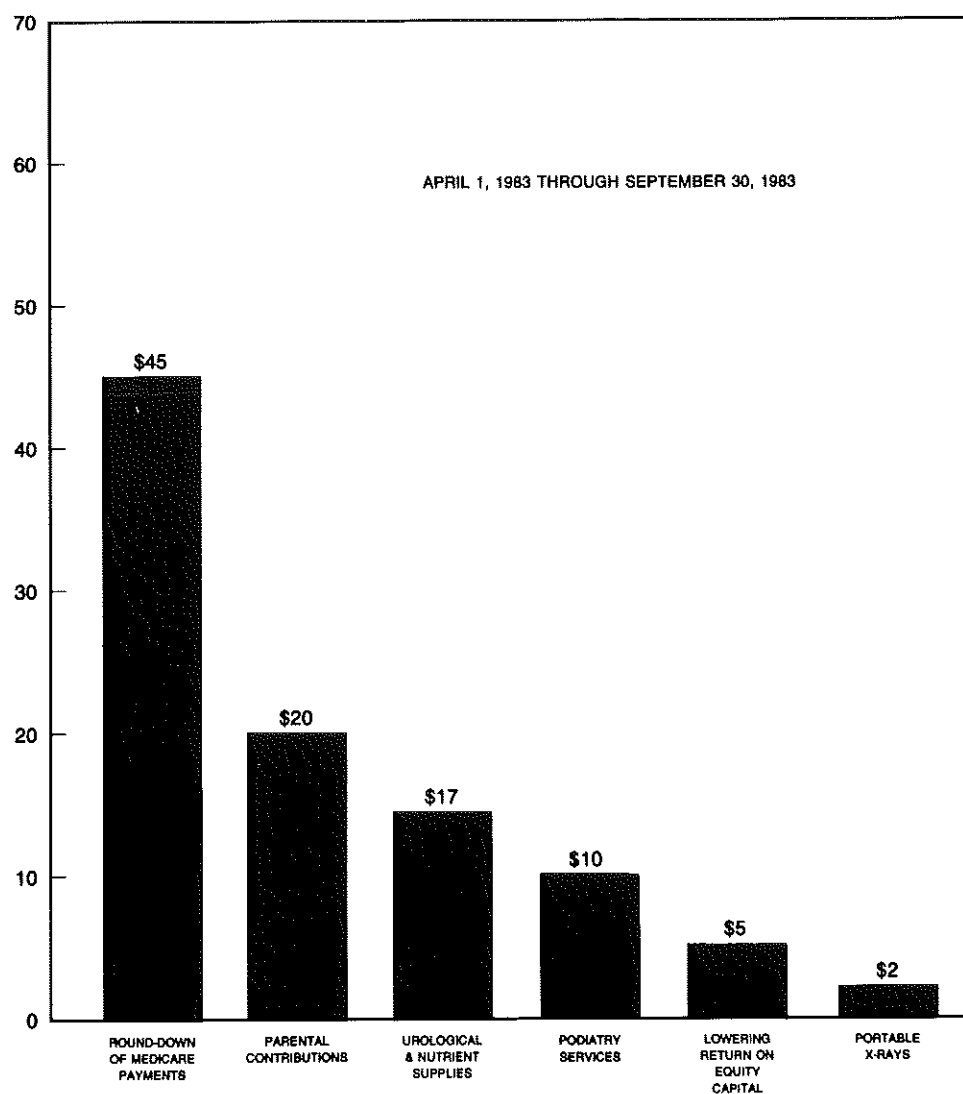
This chapter is divided into (1) legislative/regulatory reform, (2) failure to implement IG recommendations, (3) program administration, (4) computer applications, (5) Medicare fraud, (6) sanctioning activities, (7) ongoing reviews, (8) case development and (9) other significant activities. Additional information on these materials is available from this office.

Legislative/Regulatory Reform

We identified six areas (indicated on the chart which follows) where over \$99 million could be saved if legislative or regulatory changes were made in specific program areas:

— \$99 MILLION —
COST SAVINGS IF INSPECTOR GENERAL
HEALTH RECOMMENDATIONS ARE IMPLEMENTED

\$ MILLIONS



The first area relates to the fact that parents are not currently required to contribute to the cost of Medicaid services for children in Intermediate Care Facilities for the Mentally Retarded (ICF/MRs). A review in three States showed that annual savings of \$623,000 would be possible in these States if financially able parents contributed just \$50 per month until their child reached age 18.

PARENTAL CONTRIBUTIONS TO ICF/MRs

Nationwide, the savings would be about \$20 million. We plan to recommend legislative changes to require financially able parents to contribute to the cost of care of their minor children residing in ICF/MRs. While HCFA agrees this recommendation has potential for further investigation, they gave no indication they would support such a legislative change.

The second area is based on the fact that the Omnibus Reconciliation Act of 1981 authorized the Department to round to the next lower whole dollar payments made in Social Security Income programs. Medicare, however, still pays to the penny.

ROUND DOWN OF MEDICARE PAYMENTS

We estimate that Medicare could save about \$45 million annually if payments for odd-penny claims were rounded to the next lower whole dollar. The effect on individuals would be minimal - about 30 cents per paid claim. HCFA is considering this proposal.

A major area discussed in our last Semiannual Report involved amounts paid Medicare providers for their Return on Equity Capital (REC) — generally the amount invested by owners. These payments were found to far exceed the average return to private companies. Details on our work in this area were furnished on request to a Congressional Committee during hearings on the Social Security Amendments of 1983. The Amendments were subsequently passed by the Congress and enacted into law. The law reduced the REC payment for hospital inpatient services from 150 to 100 percent of the average of the Trust Fund investment rates. This is expected to reduce Medicare outlays for this "cost" by about \$100 million per year.

RETURN ON EQUITY CAPITAL (REC)

However, payments at 150 percent are still being made for hospital outpatient services, skilled nursing facilities (SNFs) and other proprietary providers (e.g., Home Health Agencies). We have recommended that HCFA apply the reduced payment rate to hospital outpatient services and SNFs as well. This should save about \$1.5 million annually.

Concerning REC payments to proprietary providers, other than SNFs and hospitals, both the law and Congressional Conference reports are silent on the allowability of these payments. If HCFA terminates REC payments to other proprietary providers, an estimated \$3.5 million annually could be saved. We recommend that HCFA take immediate action to eliminate such payments.

Overall, HCFA agreed that the REC payment level should be reduced or eliminated if feasible, but they felt the matter should be studied further before taking any specific action.

PODIATRY SERVICES

The fourth area relates to the cutting of nursing home patients infected toe nails which calls for a professional service and is covered by Medicare (routine cutting of non-infected nails is not.) The medical necessity of much of this most common of all podiatry services is questionable—and indicators are of a growing trend of fraudulent and abusive practices by podiatrists.

If HCFA regulations required carriers to restrict frequency of treatment to once every 60 days (a rate considered reasonable by the American Podiatry Association), as much as \$10 million could be saved annually. In addition, if this procedure is the norm rather than the exception, the cutting becomes routine (a conclusion reached by several studies) and should be reclassified as such, with resulting additional savings. HCFA is currently using our preliminary report in the development of new payment screens for podiatry services.

UROLOGICAL AND NUTRIENT SUPPLIES

The fifth area requiring regulatory change relates to the purchase of urological and nutrient supplies. Before 1980, nursing homes purchased supplies on the open market and included the related cost of these items in their Medicare cost reports. Starting in 1980, medical supply firms agreed to provide urological and nutrient supplies to some nursing homes at no cost (on consignment) and to bill Medicare directly for such items.

We compared prices now being paid for these items by Medicare Carriers in nine states to prices paid by other nursing homes in open market purchases. We found amounts allowed by some Carriers range from two to four times greater than market prices. We estimate annual savings to the Medicare program of about \$17 million if Carriers' pricing practices for these types of supplies are improved.

Our recommendations call for regulatory change as well as interim controls now to stop these excessive charges. HCFA agrees that there is a problem in this area and is currently considering ways to revise carrier instructions.

The final area relates to the fact that "set-up" charges for portable x-ray equipment may be an unwarranted expense to the Medicare program. Portable x-ray equipment arrives at a nursing home essentially intact and set-up requires only two minor assembly steps which take about 2 minutes and no tools. Minimum savings from eliminating Medicare reimbursement for set-up charges in just three States are estimated at \$2 million annually.

PORTABLE X-RAY EQUIPMENT

Our recommendations call for HCFA to revise its regulations to exclude Medicare reimbursement for equipment set-up fees. In commenting on our draft report, HCFA agreed that the moving of portable x-ray equipment from one patient's room to another, does not usually involve sufficient time to warrant separate reimbursement. However, they disagreed that such payments should be eliminated. They said that the set-up is an integral part of the activities for a supplier to furnish for covered services and should be included in the overall cost.

As an offshoot to this review, OIG found two providers of x-ray services to nursing home residents using portable x-ray equipment designed for "animal use." The typical veterinary x-ray unit provides minimal means to restrict the x-ray beam size to the area of diagnostic interest...permits close distances between patients and x-ray source...and does not require that the beam be filtered. Patients may be exposed to unnecessary/excessive x-ray from this equipment.

We have expanded our review of such use of veterinary x-ray equipment and have alerted HCFA and FDA to look into this matter. Both offices are actively doing so.

Failure to Implement IG Recommendations

In the following areas IG recommendations included in previous Annual Reports and involving significant dollar savings have still not been implemented.

At a number of health facilities, we found psychiatric services were not limited to traditional treatment, but included a broad spectrum of services usually provided at an off-site location. Many of these services seemed of a social, recreational or educational nature and thus suspect for reimbursement under

PSYCHIATRIC SERVICES

Medicaid. The lack of clarity as to what constitutes "medically justifiable" services, coupled with the failure to define "billable encounters," in our opinion, results in significant abuses. At \$54 authorized per patient visit, some \$10 to \$20 million annually could be involved nationwide. Though HCFA initially agreed with us that Medicaid standards for outpatient psychiatric services were needed, they have not taken the necessary implementing action.

LABORATORY SERVICES

The second area in which there has been a lack of responsiveness relates to laboratory charges. Since 1976, numerous cases of fraud and abuse connected with laboratories have been reported to HCFA. In a review in six States focusing on the Medicaid and Medicare payment process for lab services, we found:

- Fees for laboratory services were excessive;
- Labs billed Medicaid on an individual test basis when they were actually made as part of a series on automated equipment;
- Labs billed Medicaid for tests they were not certified to perform; and
- Duplicate payments were made to different providers for the same test.

HCFA has formed a task force on independent laboratory reimbursement to look into this problem. The task force is in the process of developing a final report which will specifically address fees for laboratory services. The focal point of the task force was to ensure that the government be a prudent purchaser of laboratory services, and thus that fees charged for Medicare beneficiaries and Medicaid recipients be the same as the fees for which physicians are able to obtain laboratory services. In addition, HCFA's 1984 legislative package included a proposal for competitive procurement for bulk purchases of laboratory services, DME and other services. However, HCFA has not sought necessary legislation to correct all of these problems.

In our opinion, however, legislation is needed to prevent laboratories from charging Medicaid and Medicare more than what they bill physicians for the same test. We believe that annually about \$45 million in Medicaid and Medicare payments made to clinical laboratories are either fraudulent or unnecessary.

Another area of inactivity relates to our previous finding that one State charged housekeeping services (e.g., shopping, ironing) for recipients to the Medicaid program without requiring that they be medically necessary by being linked to a "physician's plan of treatment." We found that this one State alone claimed \$15 million over a 15-month period for such services. We estimate that nationwide improper claims could run as high as \$30 million annually.

HOUSEKEEPING SERVICES

Although HCFA is currently reviewing this regulation, to date they have not taken any action to correct this problem.

Program Administration

We also surfaced significant problems and questionable program expenditures of \$32.1 million in connection with several facets of Program Administration.

In three States we found a continuing problem: per diem rates used to reimburse ICF/MRs were incorrectly determined and resulted in overcharges to the Medicaid program totaling \$23.6 million. One State agency did not have in place an approved methodology for determining reimbursement rates. In developing their rate the State incorrectly allocated costs, included duplicate and unallowable costs, and understated patient days. As a result, Medicaid was overcharged about \$22 million during a 1-year period. Another State included in the ICF/MR rate charges of \$667,000 for excessive fringe benefit costs. In a different case, a State made unallowable incentive payments to ICF/MRs totaling about \$363,000. We also found claims totaling \$819,000 for care provided patients in non-certified ICF/MR facilities. The improper claims were the result of faulty communications between State personnel conducting certification activities and those preparing Medicaid claims for Federal financial participation.

CONTINUING PROBLEMS WITH REIMBURSEMENTS TO ICF/MRs

We found that the Federal Government incurred unnecessary interest costs in six States of about \$2.3 million because States drew down excessive amounts of Federal funds to finance their Medicaid programs. Moreover, two States used recovered funds to earn interest, but did not credit the Federal Government with the Federal share (\$1.5 million) of such interest.

EXCESSIVE DRAWDOWNS

Current Medicare guidelines allow Medicare beneficiaries to routinely receive oxygen concentrators at a reimbursement rate of \$300 per month when their intake could be satisfied through an oxygen tank which is typically reimbursed

GUIDELINES ON OXYGEN CONCENTRATORS

at about \$70 per month. The OIG recommended that stricter national guidelines be issued to limit the use of oxygen concentrators to those instances where their use is justified by the volume of oxygen prescribed by the physician. It is estimated that Medicare would save \$15 million through the issuance of these stricter guidelines. HCFA is examining this situation.

**PORTABLE X-RAY
SERVICES**

We reviewed transportation charges for portable x-ray services in Idaho, Oregon, and Washington. These States were selected because a comparison with other areas indicated that the transportation charges were extremely high. We found portable x-ray suppliers were being allowed portage payments for each patient x-rayed during a multiple patient visit. We recommended HCFA change carrier guidelines for making payments for transportation of portable x-ray equipment. HCFA agreed and issued national guidelines. These new guidelines should result in a cost avoidance savings of \$4.1 million.

**THIRD PARTY
LIABILITY
PROCEDURES**

Federal law requires State Medicaid agencies take reasonable measures to determine the legal liability of third parties to pay for services covered by Medicaid. To determine one State's compliance with the law, we examined that State's identification of third party resources in the Aid to Families with Dependent Children Program. We found that third party resources available to dependent children through the absent parent's health insurance plan had not been identified in 13 percent of the cases in the sample. It was estimated that a procedural change to better identify third party resources would result in savings to the Federal Government of \$2.8 million.

**EMPLOYER GROUP
HEALTH PLAN
PAYMENTS**

Under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) Medicare benefits become secondary to benefits under an employer group health plan for employed individuals age 65 through 69. This exception applies only when either the beneficiary or his/her spouse is employed and covered by an employer group health plan, and both individuals are age 65 through 69. If these provisions were extended to beneficiaries with working spouses under age 65, Medicare would then become the secondary payment source for over 300,000 more beneficiaries. With this legislative change, Medicare would realize annual savings of \$304 million.

**MEDICARE
CERTIFICATION
COST**

During this 6-month period we assessed the allowability of Medicare administrative and health facility certification costs and found \$4.3 million in unallowable or questionable costs. The bulk of these improper charges were:

- \$0.8 million for improper pension costs claimed;
- \$0.7 million for State overcharge of health facility certification costs;
- \$1.6 million for excessive administrative costs claimed by a Medicare contractor.

New legislation replaces PSROs with Professional Review Organizations (PROs) for the review of medical necessity of Medicare stays. Since many corporations have utilization review systems, we looked at the best private and State utilization review systems with a view toward lessons for Medicare utilization review.

PROFESSIONAL REVIEW ORGANIZATIONS

We contacted some 40 major private sector employers and most of the 50 State Medicaid agencies. We identified and delivered to HCFA numerous examples of excellent utilization review in both corporations and States, which disclosed that both States and the private sector successfully employ among their utilization review techniques more *pre-service* review than does Medicare.

We recommended PRO attention be concentrated on inappropriate admissions, inappropriate and uneconomical care, misdiagnoses or inappropriate coding, and systemic abuses to maximize payment. We also delivered to HCFA a compilation of private sector and State medical procedures which are done on an out-patient basis, and a compilation of private sector health care cost containment activities. Our recommendations have been implemented by HCFA in the proposed PRO regulations.

Medicaid State agencies send explanation of benefits (EOB) on a monthly basis, within 45 days of the payment of claims as is required by Departmental regulations. The projected annual cost of this activity is between \$3-5 million, of which 75 percent is Federally reimbursed.

MEDICAID EXPLANATION OF BENEFITS

We contacted the States and found that most were negative about EOBs. Twenty-six States felt that on a cost-benefit basis, the EOBs were not worth the effort and indicated they would favor their elimination if the Federal requirement were removed. Fourteen felt there was a positive value to them and ten other States were neutral.

Even among those taking a positive view of EOBs, only a few defended them on the basis of the leads they provide for utilization review or fraud and abuse investigations.

Because of the inability of States to identify real benefits to Medicaid EOB procedures and because of the perfunctory nature of compliance uncovered we recommended that HCFA:

- Seek a legislative change to repeal the mandatory EOB requirements now in law, or allow States greater flexibility in providing information to recipients;
- Encourage States to establish voluntary targeted EOB programs for Medicaid; and
- Package information about successful methods as a means of providing easy and inexpensive technical assistance to the States.

HCFA is in agreement with the legislative proposal to repeal the EOB mandatory requirement and has submitted it to Congress in the FY 1984 budget.

**NONURGENT
HOSPITAL
EMERGENCY
DEPARTMENT**

Between fiscal years 1975 and 1983, hospital emergency department costs have grown from comprising 3.1 percent of total hospital outpatient costs in 1975 to 5.6 percent of those costs in 1983. Concerned about these rising costs, the Secretary asked us to study inappropriate use of emergency departments by Medicaid and Medicare beneficiaries. We focused on whether emergency departments are being used for inappropriate care and the costs and consequences of such use.

We found that nonurgent emergency department use is a problem for Medicaid but not Medicare beneficiaries and that this inappropriate health care costs the Medicaid program approximately \$440 million annually. If Medicaid beneficiaries who use emergency departments for nonurgent care diverted to more appropriate providers, approximately \$295 million could be saved. We also found that some reasons Medicaid beneficiaries use the emergency department for nonurgent care is because of a lack of alternate providers, convenience, accessibility, and hospital willingness to serve them.

We recommended that HCFA work to increase the availability of service alternatives to the emergency department, remove legislative and regulatory constraints on State Medicaid programs related to co-payments and revise some

outpatient reimbursement policies. HCFA has included changes in co-payment provisions and prepaid or capitated services in its 1984 legislative proposals.

Auditors developed two computer applications, discussed below, that match inpatient and outpatient files to identify improper claims. Appendix A highlights some of the 38 computer applications that were used during calendar year 1983 to spot potential problem areas in the Medicaid and Medicare programs.

OUTPATIENT SERVICES OVERPAYMENTS

In cases where States use an all-inclusive per diem rate in their Medicaid programs, billings for outpatient services provided within 24 hours of an inpatient admission at the same hospital are not to be included in the billings for hospital services. These outpatient services are covered by the all-inclusive per diem rate.

Auditors found, however, that certain outpatient hospital services were claimed and paid separately in three States, even though such services were covered by an all-inclusive inpatient hospital per diem rate. Resulting overpayments to hospitals totaled about \$359,000 for this reporting period, and occurred primarily because the States' had not established prepayment edits within their claims processing systems to detect and reject such claims. Note: Over the past year we have reported similar Medicaid overpayments totaling over \$2 million. We recently issued a report consolidating our findings in this area—where we recommend HCFA take certain procedural action to prevent this situation from recurring. HCFA has generally agreed.

Medicare/Medicaid Fraud

To obtain full deterrent and monetary value from successful prosecution of cases, the OIG has intensified its emphasis on health care fraud. Case Review Committees were established in each region, where representatives of OIG offices involved in health care investigations now set priorities, determine the best method of pursuit (criminal, civil or administrative) and allocate resources. The decision to concentrate resources on health care cases was affirmed during this period by some of the heaviest sentences and penalties ever obtained by the OIG.

RECORD PENALTIES

- In Puerto Rico, a physician, who was medical director and president of a large hospital, diverted substantial Medicare and HUD funds through a

network of equipment companies he owned or controlled. The hospital had to operate with inadequate equipment to the detriment of patient care. It finally went bankrupt because of diversion, resulting in dislocation of patients.

The president, found guilty of nine counts of fraud, was sentenced to 20 years in prison and ordered to repay \$686,000. The hospital controller, found guilty of 3 counts of Medicare fraud, received a 10 year prison sentence and was fined \$10,000.

- A Kansas psychiatrist who was convicted of billing Medicaid for services not provided was sentenced to 2 years imprisonment (suspended) and fined \$50,000, the maximum allowable on the counts of conviction. The psychiatrist's termination from the Medicaid program by the State was extended to June 1986.
- A podiatrist with a record of substandard medical practices was convicted of Medicare fraud in New Mexico, sentenced to 3 years in prison and fined \$10,000.
- As the result of earlier kickback convictions of the executive director of a home care agency and the owner of three medical equipment leasing companies, Medicare reimbursement to the agency was reduced substantially, resulting in about \$6 million in recoveries.
- The owner of a portable x-ray company convicted of filing false Medicare claims received a suspended 5 year sentence and must pay \$25,000 in fines and donate x-ray services valued at \$10,000 to the local school district.
- A nursing home owner who filed false Medicaid reports was sentenced in New Mexico to 2 years in prison (suspended) was fined \$10,000 and ordered to restore almost \$14,000. A 5 year suspension from the Medicare/Medicaid programs is in process.
- The bookkeeper at a health center in Alabama was sent to prison for 3 years for embezzling funds from the center.
- A Texas woman convicted of forging Medicare, Medicaid, Workman's Compensation and private insurance company checks sent to her physician employer was given four concurrent 5 year sentences and ordered to restore almost \$5,000.

The groundwork laid for implementing the Civil Monetary Penalties Law (CMPL) had an auspicious payoff this period. Close to \$1.9 million was accrued in direct payments, offsets and savings, more than \$1 million of it coming from a single durable medical equipment company. Implementing regulations for the CMPL were published, and guides were issued on investigating, interviewing and statement-taking, statistical sampling and preparing reports for CMPL cases.

CIVIL MONETARY PENALTIES

In targeting health care investigations, cooperative efforts are proving extremely productive. A model Medicaid/Medicare Fraud Task Force in a northeastern State, composed of FBI and OIG agents and State, HCFA and OIG auditors, is proving that this approach is highly efficient in urban areas with a concentration of Medicaid and Medicare activity. Earlier this year the Task Force began to crack a "Medicaid Mill" with the conviction of one of the owners. During this period another owner, a diagnostic lab owner and four physicians were convicted. Plea bargains are revealing still more kickback arrangements which will entail at least 2 years of investigative work. Similarly, investigation of the owners and employees of a Holter cardio-monitoring machine company and several physicians resulted in two indictments and others are pending. In the unraveling of another kickback scheme involving hundreds of thousands of dollars in Medicare funds, the owner of a shoe store in a local economically depressed neighborhood was convicted of altering prescriptions to include leg braces, giving patients cheap ordinary shoes, and overbilling Medicare. These successes have led to pleas for expansion of the Task Force concept to New York and New Jersey.

TASK FORCE ON KICKBACKS AND FALSE BILLINGS

Concentration on geographic hotbeds of fraud led to establishment of on-site management capability in South Florida, where continuing investigation after earlier convictions has become intense. A similar arrangement is being established in California, where large numbers of health care recipients offer the opportunity for wholesale fraud. Plans for similar arrangements are being made for the Chicago area, where more individuals benefit from Departmental programs than in any other area of the Nation.

MANAGEMENT IN HIGH FRAUD AREAS

State Medicaid Fraud Control Units (MFCU's) have become essential allies in combatting local Medicaid fraud. During this period three more units were certified by the OIG, bringing the total to 34. The MFCU's had an estimated 240 indictments, 200 convictions and \$9.3 million recovered in overpayments, fines and restitutions during this period.

STATE MEDICAID FRAUD CONTROL COMMITMENT

**COMPUTER
PROJECTS IMPROVE
EFFICIENCIES**

In addition to task force and geographic concentrations, some 15 projects devoted to specific segments of the health care industry are in various stages of development. More than half involve computer matching or screening to detect specific subjects warranting investigation. These projects are active measures for fraud detection, as opposed to the traditional approach of waiting for tips or complaints to kick off investigations. They represent more economical use of resources in that a large number of leads can be developed and refined with a minimum expenditure of manpower. Areas under review include billings for anesthesiology, radiology, pharmaceuticals, optical prosthetics, podiatry, cardiac pacemakers and ambulance transportation.

Agents filed 14 Management Implications Reports (MIR's) on health care cases, recommending system changes to prevent similar problems. Implementation of one recommendation to restrict the use of average wholesale prices in Medicaid reimbursement would save an estimated \$65 million.

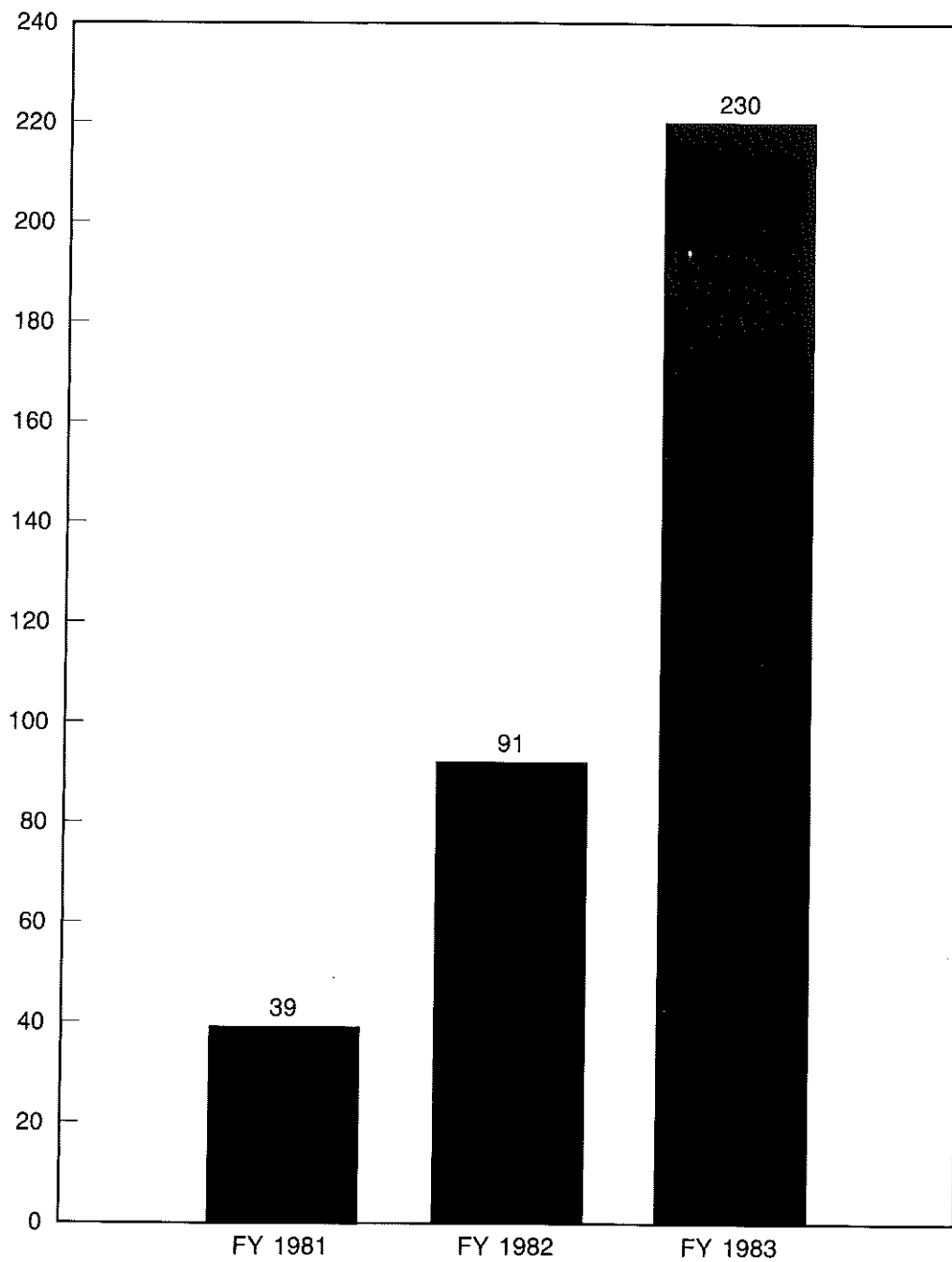
Sanctioning Activities

**SANCTION
ACTIVITIES
INCREASED**

One of the most effective measures the OIG has in the war on fraud and abuse is the sanctioning of providers and practitioners by removing them from the program(s). There were 230 providers and practitioners sanctioned during FY 1983. The increase from previous years is indicated on the chart which follows. Some of the more significant sanctions were:

- The first hospital was excluded from the program under section 1160;
- The owner of a portable x-ray company was suspended from the Medicare program for 30 years as a result of his conviction of crimes in connection with the Medicare and Medicaid programs;
- The owner of an outpatient medical clinic was suspended from the Medicare and Medicaid programs for 20 years. This individual was convicted of fraud, and also demonstrated a complete disregard for the well-being of Medicare patients.
- The owner of a taxi cab services company was suspended from Medicare and Medicaid for 10 years. He fraudulently billed inflated mileages for Medicaid transportation services;

ADMINISTRATIVE SANCTIONS FY 1981 THROUGH FY 1983



- A physician was suspended from the Medicare and Medicaid programs for 10 years because of his conviction for mail fraud and false claims under the Medicaid program;
- A psychologist was suspended from the Medicare and Medicaid programs for 10 years because of his conviction for submitting false Medicaid bills. It was estimated that 96 percent of his Medicaid claims were fictitious;
- A podiatrist was excluded from reimbursement under Medicare for 10 years. This exclusion was based on misrepresentation of facts on Medicare bills to obtain reimbursement for non-covered routine foot care, as well as other charges.

On-going Reviews in Health

We initiated broad-scoped ongoing reviews during this reporting period which will have major impact on the monitoring and control of health care costs.

END STAGE RENAL DISEASE

Medicare's End Stage Renal Disease program (ESRD) provides coverage for persons who require kidney transplants or renal dialysis. Cost of this program rose from \$228 million in 1974 to an estimated \$1.8 billion in 1982.

We are reviewing 22 dialysis facilities and the home office costs of the largest ESRD chain organization in the country. Our focus is on determining whether: (1) cost reports provide accurate and uniform cost data; and (2) the cost report is overly cumbersome and expensive to prepare.

PROSPECTIVE PAYMENTS

As a means of containing health care costs, the Social Security Amendments of 1983 established prospective payments for Medicare inpatient hospital services for cost reporting periods beginning on or after October 1, 1983. During the three year phase-in of the system, the payment amount per discharge will be determined through a blending of each hospital's "cost base," the regional diagnostic related group (DRG) rate and the national DRG rate. During FY 1984 about \$42 billion will be paid for inpatient hospital services - up from \$4.6 billion in 1970.

In an effort to prevent problems before they start, we have been closely monitoring HCFA's development of prospective payment regulations—and have made several recommendations (which were accepted) designed to prevent hospitals from “loading” base year costs and to keep payment levels reasonable.

During 1984 and beyond we will closely monitor implementation of the prospective payment system. Emphasis will be placed on (1) areas vulnerable to abusive payment practices and (2) changes in hospital practices which affect the delivery and cost of health care. Specifically, we will review areas such as hospital admission policies, assignment of DRGs, transfers among hospitals and to nursing homes, premature discharges, capital costs and educational costs (which are now excluded from prospective payment), outliers (patients who have extremely long stays or high costs compared to other patients within the DRG) and intermediary audits of providers' fiscal year 1982 base year cost reports.

We will also continue to work closely with HCFA as our reviews progress. As appropriate, when information we develop indicates a need for revisions to the prospective payment system to assure reasonable payment levels and quality care, recommendations will be made to program officials and reported to the Congress.

Individual Provider Reviews

Among the activities the OIG carries out is the review of individual cases. For this period, this review identified over \$72 million in Medicare overpayments and cost avoidance, and over \$32 million in Medicaid cost avoidance and overpayments. Some of the more significant cases were:

- A case which involved a Florida psychiatric hospital where accrued but unpaid lease payments were reported for program reimbursement. This case identified a \$2.7 million overpayment covering four cost report periods.
- A case involving a Massachusetts clinic which claimed physician dialysis services to inpatients of a teaching hospital when most of the services were actually rendered on an outpatient basis. An overpayment of over \$100,000 was made to the clinic. It has also been estimated that a \$1 million abuse overpayment may have been made to this clinic.

- A case of a medical center in Nevada where a medical review of a sample of medical records determined that 27.4 percent of the Medicare days, and 40.7 percent of the Medicaid days were not allowable under the programs and that there were inappropriate admissions of patients. As a result of these findings cost avoidance savings of \$7.1 million in Medicare and \$2.7 million in Medicaid were identified.
- A review of a hospital chain where we found one large hospital was expensing in the year of purchase, capital costs up to \$5,000 instead of depreciating them over the life of the goods, non-allowable contributions were being made to various political campaigns and 41.4 percent of the claims reviewed were partially or totally non-covered. We identified Medicare cost avoidance of \$1.4 million in the medical review area and Medicare overpayments of \$34,000.
- A review of the medical records of a specialty hospital in New York revealed that no approved utilization review plan was in effect. This resulted in a \$21.9 million overpayment to the facility. Of that amount, \$10.9 million was the Federal Government's share.
- A large facility selected for review after a profile of Part B claims for inpatients indicated a high number of direct patient care services. Many of the hospital-based physicians' rationales indicated that physician services were 100 percent administrative (Part A). We identified that non-reimbursable hospital-based physician costs were included in the cost reports for FY 1978 to 1980. This resulted in a \$1.3 million overpayment.

Other Significant Activities

CARRIER CASE CONFERENCE

The Inspector General sponsored two Medicare carrier case conferences in New York and Chicago in September 1983. The conferences were hosted by the Blue Shield of Greater New York and the Blue Cross and Blue Shield Association in Chicago. They were designed to provide a forum for discussion of ideas, approaches, and techniques to enhance the fraud and abuse case development capabilities of carriers, the Health Care Financing Administration, and the Office of the Inspector General, and to coordinate our efforts in the identification and disposition of Medicare fraud and abuse violations. Further, they were intended to provide a management-level setting for addressing those issues which were considered most urgent in addressing our goals.

APPENDIX A

During calendar year 1983, some 38 computer applications have been used to spot problem areas in the Medicare and Medicaid programs. These applications consist mainly of computer matches or screening techniques. Matches involve the comparison of two or more computer files to determine the similarity of data. Screens look for patterns, illogical relationships, and prohibited practices. Details on several significant applications follow.

Payments for prescription drugs represent a sizable portion of Medicaid program outlays. To determine whether drug costs charged the programs were being inflated, we developed three different computer applications to identify:

**PRESCRIPTION
DRUGS**

- pharmacies dispensing generic drugs but charging brand name prices;
- manufacturers that produce comparable drugs which are costed at different unit prices; and
- whether the drug cost claimed and paid by the carrier exceeded the usual or customary charge for that drug.

These applications were run at two locations. In one location, Medicaid payments of \$2.3 million were projected as being over the usual or customary charge. (OIG has begun a nationwide review.) In the other location, 49 pharmacies were tentatively identified as dispensing generic drugs at brand name prices. Cases from this test are now with the U.S. Attorney's Office.

We developed three computer applications to examine procedures at hospitals and skilled nursing facilities (SNFs) to identify unnecessary or premature hospital admissions, unreasonable use of emergency room facilities and the potential savings associated with the adoption of a multiple visit fee structure for hospitals and SNF visits. These applications identified:

**INPATIENT
HOSPITAL
UTILIZATION
ANALYSIS**

- hospital stays for ambulatory disorders;
- number and extent of weekend admissions;
- extent of emergency room use; and
- number of multiple visits in hospitals and SNFs.

**DURABLE MEDICAL
EQUIPMENT**

Applications run in one location identified potential savings of \$2.9 million if hospitals and SNFs adopt the multiple visit fee schedule. Output of other applications is currently being reviewed.

Patients requiring the use of durable medical equipment (DME) ordinarily rent this equipment as an allowable cost for Part B Medicare. However, where the DME rental costs are greatly in excess of the purchase price, considerable savings could result if the equipment were purchased rather than rented for the patient.

We developed a computer application which compares the aggregate of the rental costs for each DME item to the purchase price of that item. Preliminary results of this application—run in 2 locations—indicate that if DME items were purchased rather than rented, savings of approximately \$1.4 million would accrue to the Medicare program.

**ABNORMAL
BILLINGS BY
PHYSICIANS**

We developed ten different computer applications to identify: (1) a pattern of two or more physicians billing the same recipients for similar services on the same day (commonly called concurrent care); (2) a sole physician billing for an all-inclusive surgical procedure and then billing for individual follow-up visits, when the follow-up visits were part of the all-inclusive rate; and (3) different physicians billing the same patient for initial hospital visits on the same day.

These applications have been run in eleven locations. In 3 locations, over \$300,000 in overpayments were identified along with recommended improvements in computer controls which will save \$32,000 annually in one State. The computer output is being analyzed in the other locations.

SOCIAL SECURITY

CHAPTER III

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) has the largest budget (70 percent) of all operating divisions in the Department of Health and Human Services. In part, SSA is responsible for the Federally-administered Old Age and Survivors Insurance (OASI) program, Disability Insurance (DI), Supplemental Security Income (SSI), and the State-administered program of Aid to Families with Dependent Children (AFDC). SSA also administers Part B Black Lung benefits for claims filed generally before 1974.

Expenditures for the major programs administered by SSA are enormous and increasing. Estimated 1983 expenditures of \$181 billion are expected to increase to \$216 billion in 1986. (Further information in graphic form is found on pages 110-111).

Due to these massive budgetary outlays, a significant portion of OIG resources were expended in examining SSA's operations and payment processes. Of major emphasis: targeting opportunities to increase Trust Fund receipts or reduce expenditures through revised procedures or management improvements.

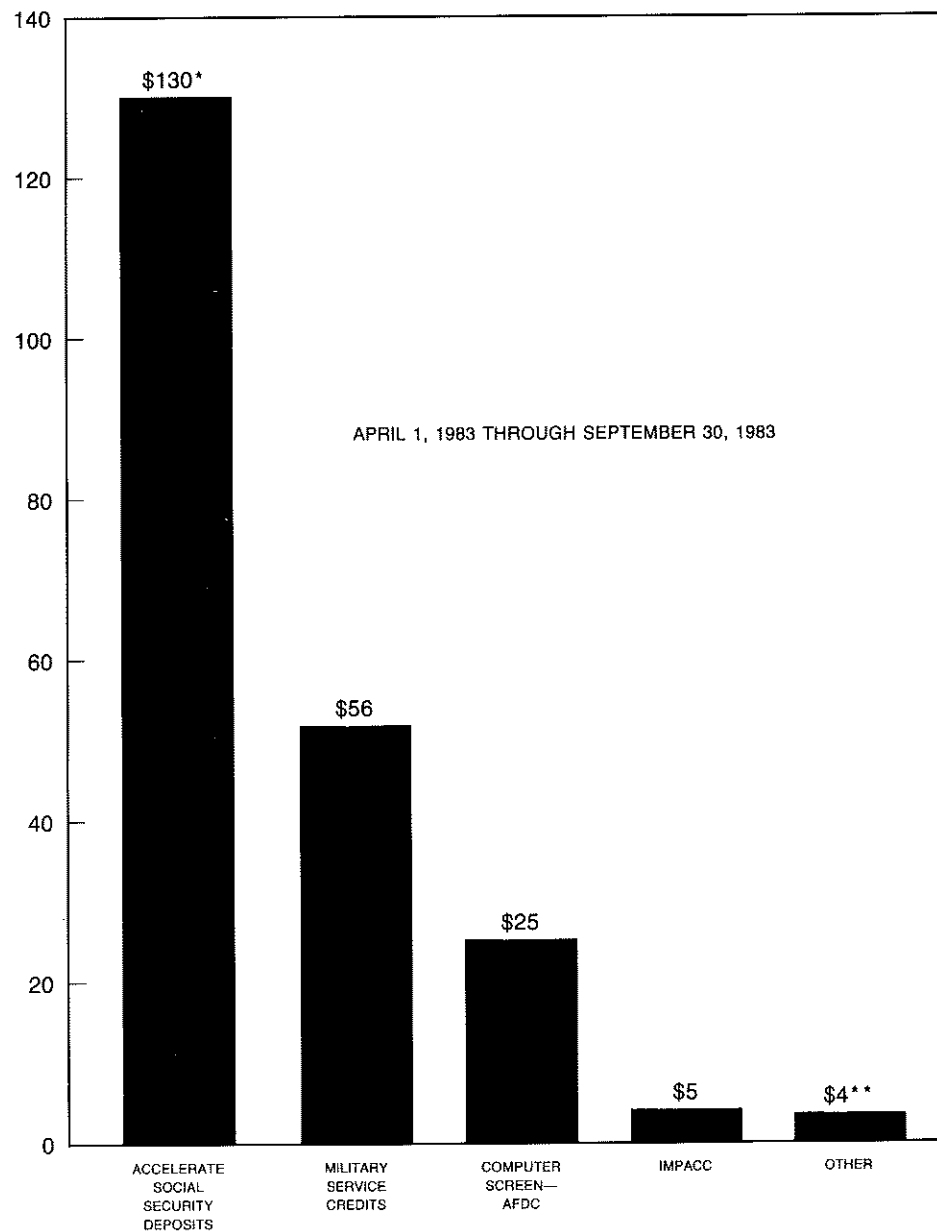
Our primary attention was on SSA's Title II programs, Retirement, Survivors, and Disability Insurance, since these programs account for the largest portion of SSA's outlays. Specific attention was directed to: (1) verifying that the Social Security Trust Funds received proper reimbursement for certain payments due from the general fund of the Treasury, (2) improving cash flow into the Trust Funds by accelerating State deposits of Social Security contributions, (3) detecting and controlling abuse within various benefit programs, with continued heavy reliance on computer applications and (4) improving internal and accounting controls in the benefit payment operations.

Auditors issued 43 reports recommending financial adjustments of \$39 million. More importantly, 6 reports identified improvements in SSA's Trust Fund activities, program administration and EDP operations which could save \$220 million (See following chart) and increase Trust Fund income by \$1.4 billion.

OIG ACCOMPLISH- MENTS

— \$220 MILLION —
COST SAVINGS IF INSPECTOR GENERAL
SSA RECOMMENDATIONS ARE IMPLEMENTED

\$ MILLIONS



* FICA deposits would be accelerated by \$1.3 billion over a 5 year period.
** Earnings Enforcement \$1.8 million; Black Lung \$2.1 million.

This chapter highlights our major audit, investigative, and management review activities. Our findings are presented by: Trust Fund activities, program administration and EDP improvements or implications.

Three audits, some covering a five year period, identified potential savings in excess of \$191 million if OIG recommendations covering specific problem areas were fully implemented.

TRUST FUND ACTIVITIES

The Inspector General's Semiannual Report for the period ended March 31, 1983 noted that Congress had passed legislation mandating a semimonthly deposit schedule of Social Security contributions for State and local employers. Social Security contributions made by the States total about \$19 billion annually. The semimonthly schedule, effective January 1984, will increase Trust Fund interest income and contribution receipts over the next 5 years by \$715 million and \$1.1 billion, respectively.

MORE FREQUENT SOCIAL SECURITY DEPOSITS WILL INCREASE TRUST FUND INCOME BY \$1.4 BILLION

Our recently-issued final report on State deposit schedules, recommends a further legislative change requiring State and local employers to follow the private sector schedule. Requiring individual employers to deposit on the private sector schedule directly with IRS would provide the flexibility in deposit timing which is needed by smaller employers. It would also accelerate the deposits of larger employers who generally can meet tight time deadlines.

The semimonthly schedule would require States to make single consolidated deposits for all covered employers twice each month. To meet this requirement, individual employers would generally be allowed about one week after a bi-weekly payday to get their deposits to the State for consolidation.

Smaller employers, who constitute about 35 percent of those reporting, are generally not capable of meeting such a time frame. Without a flexible deposit schedule that recognizes their processing limitations, noncompliance could be expected to become a significant problem.

Acceleration of State deposits resulting from adoption of the private sector schedule would further increase Trust Fund interest income and contribution receipts over five years by \$130 million and \$1.3 billion, respectively. To encourage compliance with accelerated deposit requirements, our report also recommends that the six percent interest rate charged on late State Social

Security deposits be increased commensurate with the market level rates currently charged on late private sector deposits.

Legislation to implement this proposal is under consideration in the Department.

**OASI TRUST FUND
DUE \$56 MILLION
FOR PRE-1957
MILITARY WAGE
CREDITS**

Until April 1983, Treasury annually transferred from the general fund to the Trust Funds an amount to compensate for Social Security benefits, and any interest lost thereon, paid to veterans on the basis of gratuitous wage credits granted for military service prior to 1957. The amounts transferred to the OASI Trust Funds—\$617 million in 1982—were computed by SSA's Office of the Actuary at five-year intervals. Payments began in 1966 and were to continue for 50 years until September 2015.

Public Law 98-21 changed the method of reimbursement. Instead of annual payments, it required that a lump-sum settlement of future liability for the credits be made 30 days after enactment, with recomputations for adjustment purposes to be made in 1985 and each fifth year thereafter.

Our review examined the latest computed annual transfer amount made in September 1980. We found that:

- SSA's actuarial calculations had understated the general fund liability for pre-1957 military service wage credits. This resulted in a cumulative net under recovery of reimbursements to the Old Age, Survivors and Disability Trust Funds of \$56 million as of September 30, 1980.
- The Office of Actuary used 1975 summary statistics to make the 1980 computations of past and future expenditures for military service credits. The data base supporting the 1975 statistics had been inadvertently discarded, destroying the audit trail.

Recommendations, concurred in by SSA, called for correction of these conditions. In May 1983, the under-reimbursed amount was recovered when SSA's Office of Actuary adopted our recommended changes in computational assumptions when calculating the lump-sum prepayment of future liability for military service credits required by the Social Security Amendments of 1983.

**DI CLAIMS
PROCESSING**

SSA's Immediate Payment Critical Case (IMPACC) system was developed to expedite disability benefit payments in cases where critical conditions exist,

such as undue beneficiary hardship. However, it was designed for expedited claims processing without the internal controls built into SSA's primary claims processing system.

The absence of internal controls causes serious and costly problems. It does not update the Master Beneficiary Record (MBR) to reflect payments made. To update the MBR, SSA has to manually develop data and process it through a different system. IMPACC does not effectively interface with other processing systems, causing an estimated \$5 million in annual overpayments. Payments were made through IMPACC which duplicated payments made through other claims processing systems. Additionally, when disability payments are processed through IMPACC they need to be manually identified as such for proper charge to the Disability Insurance Trust Fund. It was determined, however, that disability payments were not always properly identified, causing an estimated \$13 million in incorrect charges to the Old Age and Survivors Insurance Trust Fund.

Although the IMPACC system is needed to process critical claims, our report recommends that SSA do more to process a claim before it becomes critical. SSA's district offices generally process claims through the Claims Automated Payment System (CAPS), SSA's primary automated payment system. When CAPS is used, payments are made, records are posted and accountability retained automatically. Because of CAPS limitations and SSA imposed restrictions on CAPS usage, the district offices had to forward nearly 600,000 claims in 1982 to SSA's Office of Disability Operations (ODO) or the Program Service Centers for processing. Claims forwarded to these locations were sometimes delayed in processing to such an extent that many became critical. As a result, IMPACC had to be used to expedite payment of the critical claims.

Recommendations in our draft report call for changes in IMPACC and SSA's other processing systems to ensure that interfacing occurs to prevent overpayments and properly account for all payments made. Auditors also recommended internal control improvements and methods to expedite claims processing at ODO and the program service centers, by eliminating identified impediments that now cause claims to be delayed to the point they become critical. SSA is reviewing the draft report and its recommendations and addressing many of these problems as part of their systems modernization plan.

Section 228 of the Social Security Act (Prouty Amendment) authorizes Social Security benefits for uninsured individuals who attained age 72 before 1968 or attained age 72 after 1967 and have received at least three quarters of coverage

**OASI TRUST FUND
ADMINISTRATIVE
EXPENSES**

for each calendar year after 1966. It also provides that funds be appropriated to the OASI Trust Fund to cover the costs of beneficiary payments, lost interest resulting from these payments and associated administrative expenses. SSA's Office of the Actuary computes the reimbursement amounts.

Our review of the 1982 reimbursement of \$138.7 million to the Old Age and Survivors Insurance (OASI) Trust Fund showed that, except for a minor problem relating to administrative costs, the OASI Trust Fund was properly reimbursed for the costs of the age 72 Prouty benefit payments.

Administrative expenses were calculated by determining the percentage of OASI administrative expenses applicable to Prouty beneficiary payments. Each year beginning with FY 1978 the Office of the Actuary computed the administrative cost portion of the reimbursement prior to complete actual benefit data becoming available. This necessitated the use of partially estimated beneficiary payment statistics for the calculations. The estimated beneficiary payment statistics were overstated because they did not reflect consideration for continually decreasing numbers of Prouty beneficiaries—135,000 in FY 1978; 75,000 in FY 1981. As a result, a higher than actual percentage of Prouty payments was applied to total OASI expenses overstating administrative expenses. No adjustments were made after the actual benefit payment data became available.

Based on our audit, the Office of the Actuary decreased the FY 1982 reimbursement estimate by \$199,000 to adjust for overclaimed administrative expenses and related interest. Future computations will reflect the correct population of special age 72 benefit payments.

**IMPLEMENTING IG
RECOMMEN-
DATIONS**

The following items discuss several areas where prior IG recommendations involving significant dollar savings have still not been implemented. These matters were discussed in prior Annual Reports.

**CANCELLED
BENEFIT CHECKS
NOT CREDITED TO
FEDERAL
PROGRAMS**

We reported in the 1980 Annual Report that States were retaining and not crediting Federal programs for their portion of uncashed AFDC benefit checks and other collections. Some \$30 million was identified as due the Federal Government. During 1981, 15 audits identified \$9 million due Federal programs.

We recommended that the Commissioner of Social Security issue regulations requiring the timely return of the Federal portion of uncashed benefit checks

and other credits. However, the proposed new rules were delayed pending a review of all proposed new Federal regulations. SSA now informs us that regulations requiring the return of the Federal portion of these checks within 180 days should be issued shortly.

The issuance of new regulations was initially delayed pending clearance with new Administration policies and to correspond with regulations to be published for the SSI program concerning repayment to States of their portion of unnegotiated SSI checks. Subsequent delay was caused by State opposition and Congressional inquiries.

An estimated one million AFDC recipients in 41 States reside in housing that is subsidized by the Department of Housing and Urban Development or a State agency. These same recipients are also receiving a shelter allowance in their monthly AFDC benefit payment. The result: millions of dollars in duplicative shelter payments are being made each year. Current legislation makes it optional for States to consider subsidies in determining AFDC assistance payments. We recommended that SSA seek a legislative amendment to the Social Security Act requiring all States to consider these allowances in determining AFDC assistance payments.

**DUPLICATE
SHELTER
ALLOWANCE
COSTING THE
GOVERNMENT
MILLIONS
ANNUALLY**

A current House bill (HR 1) prohibits housing assistance from being considered as income for determining eligibility or extent of entitlement to any person living in subsidized housing under any other assistance programs including AFDC. This legislation, if enacted, would give AFDC recipients in subsidized housing an unfair financial advantage over beneficiaries not residing in such housing. Furthermore, this legislation would continue what we believe is a \$300 million annual duplication in assistance payments.

We continue to recommend that the Department seek a legislative amendment to the Social Security Act requiring all States to consider shelter allowances in determining AFDC assistance payments.

Auditors reviewed the adequacy of internal controls, allowability of payments, eligibility of beneficiaries, efficiency of operations and other aspects of various SSA programs including: AFDC, SSI, Railroad Retirement, and Black Lung. In line with the Office of Audit's emphasis on computer auditing and use of advanced techniques, several of these reviews utilized sophisticated computer matches.

**PROGRAM
ADMINISTRATION**

Auditors issued 30 reports recommending financial adjustments of \$39 million and numerous procedural changes on several of SSA's programs. The bulk of

questioned costs related to problems found in the AFDC vendor payment program. Highlights of these matters follow:

**AFDC VENDOR
PAYMENTS OF
\$35.3 MILLION
QUESTIONED**

Normally, AFDC assistance payments are made directly to clients with whom the children are living. However, in certain cases, the State can make payments directly to individuals or agencies furnishing food, living accommodations, or other goods and services to AFDC families called vendor payments. Before the payments can be made, three requirements must be met: (1) the client must have an identified money management problem; (2) the State must attempt to solve the problem by providing social services; and, (3) the client must be able to be removed from the vendor payments program within 2 years.

Auditors found one state made vendor payments of \$31.7 million and another made payments of \$3.6 million from October 1, 1977 through September 30, 1980 which did not meet the restrictions noted above. In one case, this is the second time this matter has been reported. Recommendations call for financial adjustments of \$31.7 million and \$3.6 million respectively.

SSA is now considering these recommendations, particularly in light of legal opinions that error rates disclosed by the AFDC Quality Control process are the exclusive basis for taking disallowances, and expects to resolve them within the statutory 6 month time frame.

**CHILD SUPPORT
ENFORCEMENT**

The Child Support Enforcement assessment highlighted the fact that the liability of the absent parent for the medical care of the child is often not enforced. In many cases these children are eligible for Medicaid which is paying for their care despite this parental liability. Where State Child Support Enforcement agencies and State Medicaid agencies enter into agreements to enforce the liability and therefore reduce the State Medicaid liability, significant Title XIX savings can be realized. Because these agreements have been rare, the assessment recommended that the absent parent be required to provide medical support as part of the court child support orders.

In response to this recommendation, the Secretary directed that regulations be drafted which seek medical support as a part of court child support orders whenever health care is available to the absent parent at a reasonable cost. These regulations have now been published. The estimated savings for FY 84 to the Federal government is \$89 million and to the States is \$70 million.

**SCREENS FOR
AFDC INELIGIBLES**

OIG Auditors designed two computer programs that identified recipients receiving AFDC assistance under more than one case number, either within the

same or from more than one State. This application disclosed overpayments of about \$1.1 million in seven States tested involving 393 pairs of cases.

If the results of our initial reviews are representative of conditions nationwide, we estimate that this computer application could identify overpayments of about \$25.7 million.

Recommendations call for SSA to encourage all States to adopt our computer screens as part of their front-end controls.

SSI provides monthly payments of up to \$304 to about four million aged, blind, or disabled persons. SSI recipients are allowed to earn a minimum of \$65 per month, plus one-half of remaining income earned in a month, before their monthly checks are reduced. Recipients are required to inform SSA of any changes in earnings.

**SSI EXCLUSION
POLICY
OBSTRUCTS
COLLECTION
ACTIONS**

A major cause of overpayments/ineligibility is unrecorded or incorrectly recorded earnings. SSA has a system to detect cheaters or persons who inadvertently fail to notify SSA of earning changes.

The "SSI Earnings Enforcement" program utilizes a computer application to verify reported earnings by matching them with data submitted by employers as part of the Federal Insurance Contributions Act (FICA) tax system.

Under established policy, SSA excluded certain cases from the SSI earnings enforcement process. Cases excluded pertained to recipients with initial or reestablished eligibility dates between February and December of the year of eligibility. SSA presumed that any wages earned by these SSI recipients were for periods prior to the date of their SSI eligibility.

Auditors tested a sample of 220 SSI cases with eligibility dates between February and December 1980 and earnings in excess of \$1,000. Contacts were made with the employers of these recipients and monthly earnings obtained and analyzed. The review determined that 44 persons received earnings after the date of SSI eligibility and had received SSI overpayments ranging from \$25 to \$2,365. The sample results projected to \$1.8 million in annual overpayments nationally.

Recommendations to SSA called for adjustment of the exclusion policy to require analysis of February to December cases with earnings over a stipulated

amount—not to exceed \$1,000. SSA concurred and has revised its policy accordingly.

INELIGIBLE BLACK LUNG RECIPIENTS

A miner or his/her dependents may be eligible to receive both Part B Black Lung and Title II payments if the miner was employed by the coal industry and also paid sufficient FICA tax on earnings. Auditors:

- Matched SSA's black lung payment file against Title II payment records identifying 597 potentially ineligible beneficiaries. Some 453 were found to require termination action, saving the Government \$656,000 annually. Additionally, SSA is taking action to recover overpayments of \$1.5 million made to these ineligible.
- Analyzed the 597 cases determining that often for dual beneficiaries, termination action was entered on the Title II payment file but not the black lung file.
- Followed-up on SSA's termination actions on previous black lung computer matches, finding that SSA terminated benefits in most cases. Some cases, however, still require action.

Appropriate recommendations were made—generally concurred in by SSA—to correct the above deficiencies.

PROBLEMS IN ADMINISTRATION OF ORR PROGRAM

SSA's Office of Refugee Resettlement (ORR) is responsible for planning, developing, and directing a comprehensive domestic assistance program to resettle refugees and entrants. ORR's role is to (1) administer a national program of grants, contracts, and agreements with States, voluntary agencies, and other public and private agencies for the purpose of providing cash, medical assistance, and social services to refugees and entrants; and (2) to monitor the manner in which these grant and contract monies are expended. ORR grants and contracts reimburse the States and participating agencies for the costs of caring for and resettling refugees and entrants.

OIG reviewed selected ORR program operations and contracting procedures. It was found that an organization change could improve operational efficiency, more detailed guidance should be issued to ORR's regional offices and the States, additional data base information is needed and internal control improve-

ments are needed in the contracting area. SSA has developed an action plan to correct these problems.

With 16 large scale computers, over 900 tape and disk drives, 3,800 telecommunication terminals and 6,500 programs, SSA operates one of the largest computer complexes in the country. The Office of Inspector General developed one of the first EDP Audit Divisions in the Federal Government to oversee SSA's operations. In April 1982, SSA unveiled a comprehensive modernization plan—at an estimated \$479 million cost—to update its systems and to create an ongoing program to keep the systems current.

EDP AUDIT EFFORT

OIG is reviewing, on a continuing basis, SSA's implementation of its modernization plan. Special effort was also placed on SSA's contingency plans for its data operations center in case of disaster. Problems found with the contingency plan are discussed below.

Audit's ongoing review of activities in the New Computer Center (NCC) disclosed a most serious problem—lack of an adequate contingency plan in event of disaster. This situation could prove costly to SSA and its beneficiaries.

INADEQUATE CONTINGENCY PLAN

Should one or more of the NCC's key floors be destroyed, SSA could do little more than request Treasury to rerun the prior month's payment tapes until operations recovered. This could be for an extended period depending on the extent of the loss. As payment data changes constantly, the result could well be—based on current SSA estimates—that payments of over \$100 million monthly would be made to ineligible and another one-third million newly entitled beneficiaries would not be receiving payments of some \$90 million.

Inadequacies found in SSA's contingency planning were: (1) lack of detailed risk analyses basic for a workable plan (Auditors noted for example that SSA selected the configuration for a planned backup facility before determining exactly what they would be processing in the event of a disaster) and (2) limited management support given the contingency planning function.

Recommendations will, among other things, call for management involvement in the contingency planning process and SSA-wide risk analyses.

By law, individuals eligible for benefits under both the Railroad Retirement Act and the Social Security Act are issued a check in the total amount due under

RRB MASTER FILE/ SSA PAYMENT FILES

both Acts. SSA furnishes the Railroad Retirement Board with the data updating the amount of the Social Security payments. Using this information, RRB computes the total payment due the beneficiaries under both Acts. Each month RRB provides SSA with an extract of the payment file which was forwarded to Treasury for check issuance. A reconciliation is performed and any exceptions between the payment data provided by SSA and the actual payments are resolved.

RESULTS Auditors have completed a computer match of the RRB death records from 1973 through June 1982 against SSA's Title II Master Beneficiary Record. The match identified 1,046 cases where several million dollars of Social Security benefit payments may have been made after beneficiaries deaths. In a cooperative effort, the RRB's Director of Audit and Investigation is providing confirmation of the deaths for use in our review. We plan to evaluate the RRB/SSA data exchange interface and SSA's action to terminate benefit payments where RRB data received shows a beneficiary is deceased.

DOL/PA WAGE DATA MATCHES Federal regulations require State agencies to use eligibility for Public Assistance (PA). Our review covered two States. The first State compared Department of Labor (DOL) records to PA wage data but did not provide adequate guidance on the use of the match results. Auditors reviewed the files of 46 PA recipients identified by the match. In the second State, auditors found that two counties were not effectively using State wage data to help determine eligibility for public assistance.

RESULTS In the first State, 38 PA recipients had incomes totalling \$286,000 which had not been reported on their PA applications. Thirty-three cases have been referred to the Office of Investigations. Auditors estimate that unallowable AFDC benefits in excess of \$900,000 had been paid over a 15-month period in the second State. As determinations are still being made, actual amounts may well be higher when benefits automatically received under other programs are considered.

ELIGIBILITY/PAYMENT FILES MATCH Most States have adopted an integrated computer system in which program eligibility information and program payment information are combined. Such systems prevent recipients who have been determined ineligible by the State from continuing to receive further payments. The State reviewed has not adopted this form of control. Rather, it maintains two separate systems.

RESULTS For selected periods, auditors ran computer matches of the AFDC eligibility file to the payment file. The matches identified 1,561 cases which were closed on

the eligibility file but were still active on the payment file. Auditors estimate that about \$669,000 was paid to 636 of these recipients during 1982. State agencies have been asked to review these cases and recoup all appropriate overpayments.

A recent match of death records in one State against SSA's Retirement, Survivors, and Disability Insurance payment file disclosed 452 cases where SSA was either unaware of the deaths or had recorded incorrect dates of death. In 359 cases, checks were sent to beneficiaries after their deaths. Overpayments were estimated at \$777,000.

**STATE DEATH TAPE/
TITLE MASTER FILE
MATCH**

At the time of our review, 65 of the overpaid beneficiaries were in current payment status because SSA was unaware of their deaths.

Auditors estimate an annual savings of \$295,000 by terminating just the 65 cases. Data on this match was sent to SSA so that termination action could be taken on these cases. In addition, auditors identified systematic computer programming deficiencies which prevented some reported death information from updating all affected accounts or providing an alert that inconsistent data had been posted to the Master Beneficiary Record. Recommended system changes were made by the auditors and concurred in by SSA to improve the problem areas.

RESULTS

Income maintenance and assistance programs provide benefits to family units. An individual is eligible to participate in benefits as a member of only one family unit. However by using different names, a person can be listed as a member of several family units and participate in benefits as a member of more than one family unit.

**DATE OF BIRTH/
NAME MATCH**

This application matches names and birthdays of AFDC program beneficiaries and identifies situations where two or more members of one family unit have the same names and birthdays as members of another family unit.

Auditors have run this application in four locations. In one State, 28 recipients were identified as fraudulently obtaining \$102,000 in AFDC payments. In the other locations, results have been turned over to the States for review.

RESULTS

To determine whether any individuals received AFDC benefits in more than one State for the same period of time, we matched AFDC files from all 50 States, the District of Columbia, and Puerto Rico.

**AFDC INTER-
JURISDICTIONAL
MATCH**

RESULTS A sample listing 542 recipients shown by the computer files to be eligible in more than one State at a given time has been distributed to the States for termination, adjustment, or recoupment action and cost effectiveness determination.

SCREEN FOR VALID SOCIAL SECURITY NUMBERS Social Security Numbers are frequently used as individual identifiers in AFDC programs. Invalid SSNs could indicate that (1) inaccurate data is being used to determine eligibility or to compute benefits, (2) systems controls need to be strengthened, or (3) the potential for fraud and abuse exists.

Using the range of valid SSNs provided by the SSA, a computer application was developed to determine if SSNs on computer-based files are valid, and to print exceptions.

RESULTS This application was run at three locations with exceptions of 2,382 at two locations. At the other location, 12 percent of the numbers had SSN-related problems which prevented the State from using the SSN to detect fraud.

FEDERAL EMPLOYEES BLACK LUNG MATCH The maximum annual earnings amount a beneficiary under the Black Lung Benefit program may have without reduction in benefits is \$6,600 or \$4,920 if under age 65. Any earnings received above these levels are offset against Black Lung payments at the rate of \$1.00 for each \$2.00 of earnings.

Generally, earned income is included in this determination while income such as Social Security disability insurance benefits, Supplemental Security Income benefits and Federal employee retirement payments is excluded.

This application matched computer files containing the identities of past and present Federal employees against SSA's Black Lung eligibility file. The purpose of the match was to identify Federal employees who also received SSA Black Lung benefits while employed by the Government.

RESULTS We identified 155 Federal employees who received Black Lung benefits. These cases will be reviewed by auditors to determine whether excess Black Lung benefits were paid. Those cases, if any, in which excess payments were made will be provided to the Social Security Administration.

SSA Fraud

COMPUTER APPLICATIONS Social Security investigations continue to account for most of the convictions and pre-trial diversions. Project Spectre, a computerized match of death rec-

ords against benefit rolls, was the source of nearly 20% of these successful actions. Since its inception the project has resulted in 200 convictions and pre-trial diversions and an estimated \$25.2 million in recoveries. During this period there were about 50 convictions and recoveries of an estimated \$1.6 million. The success of this project has also led us to develop other matches underway to find other SSA fraud.

- A match of one State's death records against an SSA payment file yielded about 350 cases for investigation, and more than \$100,000 dollars has already been collected.
- Over 1,000 cases turned up by a match of death information on the Railroad Retirement Board against SSA's Title II payment files are being reviewed to screen cases for in-depth investigation.
- After Project Spectre showed the scale of fraud by relatives collecting deceased beneficiaries' payments, Medicare death tapes were incorporated in SSA's system as an "alert screen". A recent re-match, however, turned up about 14,000 cases where HCFA had a reported date of death but SSA did not. Investigators are reviewing these cases in one large State to determine whether fraud is actually going undetected and the screen is not adequate. Spectre II will be expanded nationwide if this proves to be the case.

A fourth project was entered with the FBI to investigate suspected widespread SSA and other benefits and assistance fraud in New York. Project SSAMANS (SSA Multiple Account Numbers) involves examining thousands of records with Social Security numbers which are suspect, either because they are nonexistent, duplicative or otherwise questionable. Those which appear fraudulent will be shared with State and local agencies for matching against their beneficiary rolls.

Another major project is underway to cope with the problem of illegal aliens capitalizing on benefits programs. In "Project Shepherd" we are investigating a ring of travel agencies in New York City. The agencies smuggle aliens into the country and furnish them with false identification documents. With the documents the aliens gain employment, set up bank accounts, and acquire welfare and other assistance. To date 12 persons have been convicted and others are awaiting trial.

We are finding that one of the keys to successful prosecution of Social Security cases is the increased use of mass actions in which information or indictments

**MASS
INDICTMENTS**

are filed against several individuals at a time. Individually SSA beneficiary fraud cases do not have the prosecutorial appeal or notoriety associated with hard crime cases. Grouping 10 to 50 such cases in a presentation for prosecution within a single jurisdiction clearly increases chances for action. It also draws more public attention, and so has a wider deterrent effect. During this period a total of 150 persons were prosecuted in this fashion, 50 of whom have already been convicted.

**MANAGEMENT
IMPLICATION
REPORTS**

Management Implication Reports (MIRs) are analyses of fraud cases to identify whether problems in the system made the crime possible. OPDIVs are then contacted concerning the results of these analyses to explore possible improvements. One of the 35 MIR's filed this period identified an improvement in the handling of returned SSA checks which could save \$25.6 million in the SSI program alone. After further study SSA implemented controls similar to those by the agent on a pilot basis. The tremendous scope of SSA programs make it imperative to focus scarce resources on areas of greatest impact.

**PRUNING
CASELOADS**

The Social Security caseload transferred previously to the OIG underwent critical pruning and several thousand matters have been discarded as non-productive or reserved for further review and judgment.

**FRAUD DETECTION
ON THE FRONT
LINE**

We are preparing several revised instructions on fraud detection and referral for SSA personnel. Similarly, we began work on technical assistance manuals for major Social Security programs. The manuals are designed to give the investigative community a general understanding of the programs, the ways individuals attempt to defraud them, and investigative techniques which have proved successful.

**PROJECT
SACRAMENTO
GOES
NATIONWIDE**

A more direct assistance project started last year is proving its effectiveness and can now be expanded. The project was begun as a computer assistance program to help California State and local agencies quickly obtain information needed to detect and prosecute fraud against Federal/State income maintenance, medical assistance and other welfare programs. Reporting of results has been sporadic, but at least 150 convictions have been obtained, 20 during this reporting period. Extending this service elsewhere, however, has been hampered by limitations on availability of Social Security and Treasury Department information. These limitations were removed during this period, and any State may now receive this service.

Other Activities

The State of California has started an audit of SSA field office records used for controlling remittances and refunds of money involving State supplemental payments.

CALIFORNIA AUDIT ASSISTANCE

Because of our recently completed review of the Title XVI remittance process, the State requested our assistance to define the universe of cases in which remittances had been received by SSA but for which the State did not receive credit. We assisted by preparing system service requests, providing reference manuals and by interpreting data elements and categories of data.

As a result, the California auditors reported numerous errors and massive potential losses in SSA's processing of remittances. The State's findings, which are currently being reviewed by SSA, emphasized the need for the corrective actions recommended in our review.

We examined the SSA Direct Deposit System from the perspective of five groups: the Social Security Administration (SSA), the Department of Treasury, Social Security payment recipients, the Federal Reserve, and financial institutions.

DIRECT DEPOSIT OF SSA PAYMENTS

Our most significant finding was that processing all Social Security payments by direct deposit rather than using checks would cost the Federal Government at least \$160 million in interest each year. (This would be partially offset by reduced expenditures for postage).

As a result, an interagency task force led by the Department of Treasury revised a direct deposit cost/benefit projection. We also found that direct deposit is being used by some institutions to obtain control of SSA resident recipients' funds by opening a joint/MR account with the recipient and having the recipient sign up for direct deposit.

The Social Security Administration is looking into the problem.

GRANTS/INTERNAL SYSTEMS

CHAPTER IV

GRANTS AND INTERNAL SYSTEMS

This Chapter focuses on the Public Health Service (PHS), Office of Human Development Services (OHDS) and overall Department Administration. Although the dollars involved are substantially less than in the SSA and HCFA programs, the large number of programs and enormous number of grantees and contractors amplify the potential vulnerability to fraud, waste, and abuse. Also, over 84 percent of the Department's discretionary expenditures are made in these activities.

PHS operates approximately 68 major programs ranging from supporting medical research to financing the development of health resources and services. OHDS administers 13 principal programs that assist the elderly, the disadvantaged and handicapped children. Overall, the Department deals with thousands of entities ranging from grantees receiving multiple awards totaling millions of dollars to those receiving a single much smaller award.

A major thrust of the OIG's effort has been on (1) reviewing Departmental internal controls to ensure their on-going effectiveness in preventing or detecting fraud, waste, and abuse; (2) identifying opportunities to cut costs through improved efficiency of Department operations; (3) reviewing Department wide systems such as: debt collection, cash management and employee related issues; (4) providing the Federal leadership for successful implementation of the single audit approach; and (5) monitoring and assessing States' implementation of block grant programs.

OIG ACCOMPLISHMENTS

From April 1, 1983 through September 30, 1983, we recommended financial adjustments of \$29.4 million in these programs. More importantly, we surfaced significant management weaknesses in: grant administration, cash management, and controls over construction costs. The questioned costs by entity were:

	PHS	OHDS	DEPT ADM
(in Millions)	\$14.7	\$12.4	\$2.3

Public Health Service Programs

PHS spent an estimated \$7.8 billion in FY 1983 on health research, preventing disease, and promoting public health in general. During this reporting period

we identified questionable costs of \$14.7 million. Major findings in PHS programs follow.

**COMPUTER
IDENTIFICATION
OF DELINQUENT
BORROWERS**

To assist PHS in locating delinquent Health Professions and Nursing Student Loan borrowers, we used a previously developed computer program to identify delinquent individuals who were also receiving salary from other Federal Agencies or were retired Federal employees. The application matched listings of delinquent borrowers for selected schools with records maintained by the Office of Personnel Management for (1) uniformed personnel of the Department of Defense, (2) personnel from the Tennessee Valley Authority and Coast Guard, and (3) retired Federal employees. We identified 820 doctors and nurses with delinquent loans totaling \$662,000. The Department is seeking authority to institute collection procedures.

**INTEREST EARNED
ON NSL/HPSL
PROGRAM FUNDS**

In a previous annual report, we noted cash management problems related to PHS administration of Nursing Student Loan (NSL) and Health Professional Student Loan (HPSL) programs. While much corrective action is underway, some problems remain.

Under the NSL and HPSL programs large amounts of cash are advanced to educational institutions for use in making loans. We found that at two universities this cash was invested and interest earned amounted to \$695,000. However, this income was not credited to these programs. We estimated that annually \$9 million in interest income may be lost nationwide to the NSL/HPSL programs because excess cash was not invested or investment earnings were not returned to the loan fund. Concurring with our recommendations, PHS has taken actions to identify the schools with unused cash reserves and interest earnings which have not been returned to the program accounts.

**PHS
CONSTRUCTION
CONTROLS
BYPASSED**

We found PHS agencies were awarding renovation and construction contracts without obtaining the required reviews and approvals. Past experience has shown that such internal controls have resulted in substantial sums being trimmed from project budgets. Some of these projects would have been disapproved because they were funded with agency operating funds, apparently violating statutory limitations.

We estimate that future compliance with required review and approval procedures would reduce project costs by \$20 million over a 5-year period. PHS

has begun to implement our recommendations to ensure reviews are properly made.

Since 1961, PHS has used about \$172 million in foreign currencies under a Special Foreign Currency Program to support biomedical research abroad. FY 1982 program obligations totaled \$3 million.

PHS FOREIGN CURRENCY PROGRAM

We found that PHS has little assurance that these program funds were used for authorized purposes or that projects met their goals. Specifically:

- There was no evidence that applications received scientific/technical review.
- Project budgets were either missing, incomplete or not in sufficient detail to indicate the intended use of project funds.
- In one agreement financial control was vested entirely with the Project Director and a checking account was maintained outside the Embassy's normal financial management structure.
- Terms and conditions of project agreements were generally incomplete or vague with regard to standards for expected performance.

During the course of our survey, PHS instituted procedures designed to correct most of these conditions.

Our examination of various non-profit organizations disclosed continuing problems with internal/ financial accounting controls over grant funds. Examples of our findings in this area:

NONPROFIT ORGANIZATIONS

- A facility providing comprehensive health services had unallowable costs of \$1.8 million. These amounts consisted of (1) \$689,000 for unapproved alterations/renovations, (2) \$418,000 for prohibited construction, (3) \$320,000 claimed as unliquidated obligations that were not subsequently paid, and (4) \$370,000 in other unallowable costs. (PHS advises us corrective action is underway.)
- Follow-up review of two Indian Health Service (IHS) contracts with an Indian Tribal government confirmed CPA findings that IHS had improperly paid indirect costs of \$232,000 for off reservation contract medical care, equip-

ment, renovations, and liability insurance costs. (Total funding was \$3.4 million.)

- A \$2.5 million award was made to a grantee to operate two community health centers. We found that the grantee's internal safeguards had been circumvented by top officials and that expenditures of \$200,000 were either improper or not adequately supported.
- A hospital claimed \$458,000 for the operation of a clinical center for an aspirin myocardial infarction study. We found that the hospital improperly charged \$133,000 in routine hospital administration costs to this contract.

INSTITUTIONS OF HIGHER EDUCATION

Federal Departments and agencies annually award about \$8.3 billion to institutions of higher education for research, development and training activities. The DHHS OIG is responsible for the auditing of Federal funds awarded to about 98 percent of these institutions.

In accordance with Federal policy we rely on single, non-Federal audits to provide basic coverage of financial and compliance issues at these institutions. However, limited scoped reviews are still performed in areas where special problems have been identified. In this connection our reviews identified unallowable costs of \$3.5 million including:

- At one medical college equipment valued at \$1.3 million purchased with Federal funds could not be accounted for; and, charges for equipment purchased with Federal funds were improperly included in the college's indirect cost rate computation.
- One institution overcharged Federal grants and contracts \$347,000 for (1) indirect costs which were excessive or not based on negotiated rates and (2) interest earned on Federal funds and not credited to Federal programs.

Office of Human Development Services

During FY 1983, the Office of Human Development Services spent an estimated \$5.9 billion to provide a range of social services to the Nation's children, youth, and families, older Americans, the disabled, and Native Americans. The OIG identified questionable costs of \$12.4 million in these programs.

In 1980 Congress provided that Foster Care funding for fiscal year 1981 and later years could be allocated according to a formula using FY 1978 costs as the base. During this 6-month period, we reviewed 1978 base year funding for nine States and recommended financial adjustments of \$8.6 million. The most common problems identified related to (1) children not meeting eligibility requirements; (2) payments made on behalf of children in institutions ineligible for Federal reimbursements; and (3) institutions providing care not being approved or not meeting program eligibility requirements.

FOSTER CARE PROGRAM

At the request of the Assistant Secretary for Human Development Services we conducted another review of the Foster Care program to determine if there is an explanation for the increased costs for foster care overall while the number of children is decreasing, and if there are specific practices that are demonstrably effective in reducing or eliminating the need for foster care. In review of 10 States which contain approximately 63 percent of the children in foster care, we found:

FOSTER CARE COST GROWTH

- Over the 3 year study period (1980-1982), the overall foster care cost increase was 26 percent, the total decrease in number of children in foster care was 5 percent.
- State foster care costs are rising faster than Federal foster care costs and the number of children totally supported by State funds is decreasing faster than the number supported by Federal funds.
- State legislated cost-of-living allowances account for over three-quarters of the Federal foster care cost increases; changes in the foster care population - children are older and more in need of special care - and changes in foster care service delivery systems - greater use of purchased care - have contributed to increased costs also.
- Comprehensive data on many aspects of foster care programs are spotty, difficult to access, and not always comparable among States.
- While many practices designed to reduce or eliminate the need for foster care exist, States could provide little documented evidence of the effectiveness of their efforts.

Program Inspection recommendations were:

- Foster care data collected by OHDS from the States should be compiled in a readily retrievable form and analyzed on an on-going basis to support management decision-making at the national level.
- To enhance sharing among States an inventory of State foster care functions, e.g., rate-setting with contract people, should be developed and disseminated to all States.
- State IV-B plan items found to be effective in managing and evaluating Foster Care programs and for preventing placements should be compiled and shared with all States.

The Inspector General and the Assistant Secretary for Human Development Services were briefed on the inspection findings. HDS has advised us that they are taking actions in accordance with our recommendations.

WRAP-UP AUDITS OF TITLE XX

Effective October 1, 1981 the Title XX Social Service Program was converted to a block grant, with audit responsibility transferred to the States. Federal audits of the prior formula grant program started before the conversion are being completed. These audits concentrated on determining whether States' claims for selected services provided to residents in State operated institutions, and services purchased under contracts by the State were allowable and adequately supported by financial records.

Reports on two States recommended financial adjustments of \$12 million. These costs included:

- \$7.1 million for services that were (1) the responsibility of the State or (2) unallowable charges for services normally provided by facilities in which the individual was living or (3) intrinsic to the purpose of the facility.
- \$2.2 million in overstated indirect costs charges.
- \$2.7 million in refunds due from providers of services at the conclusion of contracts and payments on behalf of recipients whose eligibility was not documented.

CONSULTANT CONTRACTS

In recent years, the Executive and Legislative branches have intensified efforts to improve management controls over use of consultants. The Department is

implementing a plan, approved by OMB, to strengthen controls over consultant service contracts.

P. L. 97-258 require annual OIG reviews of the Department's consultant service activities. Previously we reviewed consultant contracts on a Department-wide basis. We are now selecting one OPDIV on a cyclical basis for detailed review.

During this reporting period we reviewed OHDS management of consultant service contracts. We found some contracts for consultant services were not classified as such; consequently, they were not subject to the special reporting, monitoring and accounting requirements for consultant service contracts. Also, a significant amount of OHDS' contracting activity had not been reported to the Department's Contract Information System.

Our recommendations call for various procedural improvements to correct the noted deficiencies. OHDS concurred with our recommendations and in many cases has already taken corrective action.

In FY 1983, Federal funds of \$912 million were expended primarily to provide Head Start pre-schoolers with educational, health, nutritional and social services. During the final 6 months of FY 1983, financial adjustments of \$3 million were recommended in connection with this program. The most prevalent problems were with accounting, internal controls, and recordkeeping practices of the grantees. The results of these reviews were reported to OHDS.

HEAD START PROGRAM

We reviewed Indian and Migrant Head Start grantees and found that enrollment figures reported by grantees are not matched by actual attendance. These grantees receive about \$65 million annually. When attendance records were matched against HHS-funded slots, approximately one-third of the grantees inspected were below the 85 percent attendance required. Using meal counts as a comparison, half of the grantees were below 85 percent attendance. Two-thirds of the grantees did not do written analyses of their absenteeism as required by regulations.

INDIAN AND MIGRANT HEAD START

We also found that only half of these grantees would receive a 'passing grade' in their documentation of income. Twenty percent of the grantees did not verify income or did so only part of the time.

We recommended that the Office of Human Development Services (OHDS) strengthen the policies, definitions and reporting instructions governing Head

Start enrollment and attendance and improve the on-site monitoring and technical assistance. OHDS has agreed to implement our major recommendations which will result in their serving 1,500 to 4,500 more children at no additional Federal cost; a program capacity enhancement valued from \$3 to \$9.7 million.

**DEVELOPMENTAL
DISABILITY
PROGRAM**

We examined the nature and magnitude of the problem of States not obligating their Federal developmental disabilities formula grant monies. Our major findings included:

- \$11,429,075 was not obligated by the Developmental Disability Basic Grant program from FY 1973 to FY 1982.
- \$826,406 was not obligated by the Protection and Advocacy program from FY 1976 to FY 1982.
- Most States were unaware that their program had failed to obligate its total funds.
- There was no systematic means of gathering information, monitoring or managing the fiscal aspects of the formula DD grant programs.

We recommended the OHDS develop and issue precise monitoring instructions, issue final regulations and manuals implementing 1978 legislation, and implement a control system for tracking the status of audits. OHDS agreed with each of these recommendations and has already begun to implement corrective actions.

**CHILD WELFARE
TRAINING**

We examined the child welfare training program to determine if the investment which OHDS is making is resulting in improved child welfare programs. In addition, we considered whether existing training programs are responsive to the needs of service organizations and States. We found that new program guidelines which had been promulgated by OHDS were more responsive to State government and service providers. They emphasize the greater use of teaching grants rather than student traineeships. This corroboration of OHDS policy has been particularly useful to the Assistant Secretary since these new policy directions have been criticized by various groups with conflicting vested interests.

Our review of the State Auditor's report on one State's administration of a grant awarded under the Older Americans Act showed \$1.2 million in questioned Federal funds. This amount included \$450,000 in sub-grantee expenditures claimed prior to effective date of grant, \$384,000 in unsupported costs, and \$415,000 covering expenditures in excess of sub-grant award and other deficiencies. In addition, the State auditor could not express an opinion on the accuracy or completeness of the State's Department on Aging financial reports submitted to its Federal grantors.

FEDERAL AGING

Departmental Administration

The OIG is responsible for examining the efficiency of Department management. As a major thrust, the OIG continued to assist Department managers in carrying out the mandate of OMB Circular A-123 which required the Department to establish and maintain effective internal administrative and accounting controls. In addition, we reviewed overall Departmental Administration with the special emphasis directed primarily toward assessing the adequacy of: (1) EDP Security, (2) single organization-wide audits, and (3) debt collection activities.

Effective systems of internal control provide strong mechanisms to prevent as well as detect fraud, abuse, and waste. We have assisted the Secretary and the Assistant Secretary for Management and Budget, who has been designated the Department's Internal Control Manager, to carry out the mandate by:

DEPARTMENT INTERNAL CONTROL SYSTEMS

- increasing the number of internal audits we conduct and reemphasizing examination of internal controls as an integral objective of all reviews;
- providing, as a member of the Department's internal control steering committee, technical expertise in development of policies, standards, and methodologies for identifying components responsible for internal control functions, conducting vulnerability assessments, and conducting detailed internal control reviews;
- testing the reliability of selected Department assessments of the vulnerability of component systems; and
- initiating audits of completed Departmental internal control reviews to be used as the basis for the IG's opinion on the effectiveness of the Department's implementation of Circular No. A-123.

**COMPUTER
SECURITY OVER
DFAFS**

Departmental Federal Assistance Financing System (DFAFS) controls and disburses about \$43.4 billion annually in grant funds to Departmental recipients. The Department's Federal Assistance Financing Branch (FAFB) was formed in 1976 to consolidate the Department's grant payment mechanisms under one roof. Initially FAFB used the National Institutes of Health automated grants payment system which it subsequently modified and improved into what is known today as DFAFS. In 1978, the Secretary directed that a new system be designed to replace DFAFS that would rectify negative audit findings and correct system deficiencies. The new system, Payment Management System (PMS) is currently in final design and programming stages and is scheduled to be implemented in January 1984.

Auditors evaluated the adequacy of ADP security for DFAFS and related features of several security problems of which FAFB was aware but had deferred correcting pending implementation of PMS. Specifically, we found that:

- Security features were not adequate to prevent unauthorized access to DFAFS facilities and in particular its computer files.
- A risk analysis had not been conducted since 1978 even though significant system changes have occurred; a risk analysis for PMS is scheduled for FY 1984.
- Formal contingency plans had not been established to provide for continuing operations in case of the loss of computer processing capability.
- Computer programs and program modifications were not being documented.

The Assistant Secretary for Management and Budget has taken or planned steps to correct these weaknesses.

**SINGLE AUDITS AT
INSTITUTIONS OF
HIGHER
EDUCATION AND
NON-PROFIT
ORGANIZATIONS**

In the college and university area and other non-profit organizations, we are continuing under the auspices of OMB to provide Federal leadership to implement the single audit approach called for by Circular A-110. Our efforts to develop a government-wide audit approach will have enormous long-run implications for the way the Federal Government oversees the billions of dollars awarded annually to higher education and non-profit entities.

Pilot audits were performed at 20 colleges and their results are a good example of what can be accomplished through the sincere cooperative efforts of the private and public sectors. The pilot audits have confirmed our belief that uniform audit guidelines are necessary, that institutions of higher education have some weaknesses in their systems of accountability for Federal funds and that the single audit approach can work. Results from these 20 pilot audits have identified system deficiencies in the following areas:

Internal Control Systems	18 institutions
Accounting System	16 institutions
Cash Management	11 institutions
Reporting System	15 institutions
Property Management	16 institutions
Program Compliance Systems	16 institutions

We have revised draft Guidelines for Audits of Federal Awards to Educational Institutions, and have disseminated the revised draft for comment to involved parties.

In order to apply the single audit approach to non-profit organizations, we have developed draft audit guidelines and awarded six contracts to non-profit organizations to have their CPA firms perform pilot audits to test the single audit approach.

Regional audit staff provided technical assistance to non-Federal auditors performing single audits at State and local governments and Indian Tribal organizations. The single audits disclosed some rather significant deficiencies:

- One State auditor reported a number of serious accounting and grant administration problems which resulted in questioning the allowability of \$1.3 million in expenditures and expressed an opinion that the expenditure reports and cash reports submitted to Federal agencies are unreliable. These problems existed due to significant deficiencies in accounting system and internal control procedures.
- Followup work by one of our regional audit offices has disclosed—at the county level—an apparent loophole in Medicare and Medicaid regulations regarding pension expense and a deficiency in one State's sampling procedures for performing AFDC quality control testing in the counties.

SINGLE AUDITS AT GOVERNMENT AND TRIBAL ORGANIZATIONS

- In a draft report, a non-Federal auditor in auditing an Alcohol, Drug Abuse and Mental Health Block Grant could not express an opinion on the allowability of \$2.1 million in expenditures due to inadequate accounting controls over the funds and the lack of documentation to support the charges. (The State's comments have not been received on this report.)
- A non-Federal auditor alerted the State to questioned costs and questionable activities at a sub-recipient participating in the Community Services Block Grant program. The non-Federal auditor found:
 - Sub-recipient of Block Grant funds purchased land for \$97,000 using Community Services Block Grant funds. The land was purchased from a former employee at about \$20,000 above the appraised value. The appraisal was made by a person who later became an employee of the sub-recipient organization.
 - Block Grant regulations specifically forbid funds to be used for purchasing land or businesses. The sub-recipient organization received permission from the Director of State's Division of Community Services to purchase the land. Subsequently, the Director received money from the sub-recipient organization that was related to the land transaction.

The auditee has not commented on this situation.

BLOCK GRANTS Block grants constitute a key element of the Administration's Federalism program. They are changing the way taxpayers' dollars are spent for many health and social services programs and also, the way we do our auditing of program funds.

The Omnibus Budget Reconciliation Act of 1981 consolidated numerous Federal categorical programs into nine block grants and shifted primary administrative responsibility to the States. Within HHS, where previously there had been 32 separate HHS spending programs, there now are seven streamlined block grants totaling over \$6 billion to 57 States and territories and about 200 Indian Tribal Governments. While the \$6 billion represents only 2.5 percent of the total HHS budget, it represents about 50 percent of the Department's discretionary expenditures awarded recipients to carry out the Department's programs. OIG is committed to seeing that sound financial management controls are followed in operations of these programs. Among the statutory responsibilities placed on the States (and tribal governments receiving block funds) is to arrange for independent audits of block grant expenditures, either every year or every two years, depending on the program. The OIG role is to (1) ensure States

are aware of these audit requirements, (2) provide technical assistance in planning and carrying out the audit at the State's request, (3) monitor State audit planning to ensure the requisite audits are conducted, (4) review and process final audit reports, and (5) perform appropriate follow up work, including OIG audits if necessary.

OIG ACTIVITIES

To meet our responsibilities, OIG contacted 53 of the States and territories concerning their audit plans and found that most, through varying approaches (consolidated single audits, audit of block grants only, other approaches), plan to have block grant reviews performed. However, as no time frames are set either by Statute or Departmental regulation, completion dates in some instances of FY 82 audits may well extend into 1984 or later. In addition, we found that six States are not planning full audit coverage at this time on Block Grant expenditures for the October 1981 - June 1982 period—and that another two States are not planning any audit work at all for this time period.

Of the 39 reports we have received to date on block grant programs, our general observations are that, with few exceptions, they are not very informative. Unlike past OIG reports, the State reports received have usually been very brief—some having no more than the standard scope and opinion paragraphs without any discussion of compliance matters, and no major findings reported.

Moreover, Audit follow-up by our staff of the few reports with audit findings, disclosed that some States—despite Federal requirements—have not established centralized State authority to resolve audit findings contained in Block Grant audit reports. In one State the non-Federal audit questioned costs of more than \$200,000 that is still unresolved by the State. This situation could have broad implications with respect to Federal policy to resolve Block Grant audit questions; we plan to closely monitor this area to determine if there is a widespread problem with audit resolution by the States.

Based on experience to date, and to address some of the difficulties mentioned above, we have established an audit subcommittee under a Departmental work group, to focus on audit issues. Some of the issues being addressed are:

- Ensuring State audits of all block grant funds
- Independence of Internal Auditors
- Non-compliance with GAO audit standards

- Frequency of audits
- Due dates for States' submissions of both audit and reports and annual/biennial reports.
- Audit resolution requirements
- Definition of a completed audit report
- Interrelationship of Block Grant audit with A-102P or A-110 audits
- Scope of Block Grant audits

In addition, OIG (in cooperation with the Office of the Assistant Secretary for Planning and Evaluation) is directing preparation of a draft Notice of Proposed Rulemaking that will address the due date question and several of the audit issues discussed above.

**AUDIT
RESOLUTION:
CONTINUED
SUCCESS**

The Department once again has achieved a nearly perfect score for resolving all final reports with monetary findings within the 6-month timeframe mandated by law. The number of open reports dropped from 666 at December 31, 1980 to zero at December 31, 1981—and has stayed at zero for the last 2 years. There was only one unresolved audit during this period. It is with the Health Care Financing Administration for resolution. It involves a report where auditors found that a State claimed reimbursement of \$22.8 million for services provided in Intermediate Care Facilities for the Mentally Retarded operating without valid provider agreements. A financial adjustment of \$22.8 million was recommended. HCFA hopes to have this matter resolved shortly.

Some of the factors accounting for HHS' sustained level of success are:

- a good audit resolution policy which clearly describes the process and provides such important features as the personal (and early) involvement of top level management officials; and
- the reporting and control mechanisms established by both the IG and HHS management to closely oversee the Department's performance in audit resolution.

Public Law 96-304, Section 306, requires the Department to take immediate action to improve collection of overdue debts and reduce the amount of debts written off as uncollectible. For the 6-month period ended June 30, 1983, debt due the Department increased \$153.4 million, collections increased by \$102.3 million, and write off of accounts receivable increased by \$73.1 million.

DEBT COLLECTION

The OIG monitors the Department's debt collection activities on a cyclical basis. For this period we examined SSA and HCFA debt collection activities/procedures. We also assessed action taken by SSA and HCFA in resolving prior problems in reporting debts in accordance with OMB, Treasury and Department requirements.

SSA

Review of SSA's debt collection activities has shown continuing progress. Several new initiatives were being pursued by SSA's Debt Management Executive Team. The first would require the offset of IRS income tax refunds against overpayments. The second would authorize SSA to recover over-payments made to individuals under SSI (Title XVI) by mandatory adjustment of benefits payable to the individuals under Social Security (Title II) and vice versa.

Another significant change involved the location of debt collection units and all remittance processing in the six program service centers. These units would assume overall collection responsibilities for Title II and Title XVI overpayments. The focal point of these debt collection units would be a computer system. The major functions of this system would be to send automated bills to debtors in non-pay status and alert the debt collection units when a telephone follow-up was necessary.

HCFA

Although HCFA has implemented procedures to assess interest on Medicaid and Medicare delinquent debt and has included accrued interest in quarterly reports, we found several problems with their accounting for and reporting of interest during our current review. For example, interest was not being accrued on audit allowances under appeal as mandated under Circular A-50.

We also found that HCFA continues to exclude program disallowances (costs claimed by States and subsequently reviewed and found to be unallowable by regional Medicaid program analysts) from their accounts receivable statistics. HCFA records now show \$227 million in program disallowances. We brought this situation to the attention of the Deputy Assistant Secretary for Finance who stated that formal guidance for handling these receivables will be issued by the end of the calendar year.

Finally, HCFA reported that collection of \$107 million of audit disallowance receivables was contingent on the result of appeals and that another \$32 million was collectible, but not recovered to date. Of the \$32 million uncollected, HCFA reported that \$2 million has been outstanding less than 90 days and \$30 million outstanding in excess of 90 days. Tests of HCFA's accounting records showed amounts reported were accurate.

GIS Fraud

Policing of Departmental funding programs administered as grants is largely the responsibility of the project managers and auditors. Investigation of criminal matters, however, is the responsibility of the OIG. OIG investigations resulted during this period were as follows:

- As the result of bid-rigging by major electrical contractors in North Carolina, the Department of Justice had been probing public projects let for bid in the last few years in several Southeastern States. Recently OI was asked to assist by reviewing the records of an Indian Health Service Hospital in North Carolina. As a result, an electrical company was fined \$75,000 for bid-rigging and its owner was given 90 days in jail. More than \$24,000 in PHS funds were returned.
- Two former health agency officials were convicted for embezzling HHS and CETA funds. They received suspended sentences but were ordered to refrain from holding any position of trust in agencies receiving Federal funds during their periods of probation, and to repay \$9,000.
- A secretary at an IHS hospital in North Carolina was charged with forgery after cashing travel checks intended for other employees. In Oklahoma another employee was charged with maliciously threatening to kill, injure or intimidate hospital employees and patients after making a bomb threat. A third former employee was charged with selling X-ray films from the hospital where he worked to a smelting company. All three were convicted and penalized.

**Summary of Receivables Collections
Write-Offs¹
(In Millions)**

Source	Receivables as of		Collections for Six Months Ended		Write-Offs for Six Months Ended	
	12/31/82	6/30/83	12/31/82	6/30/83	12/31/82	6/30/83
Audit Disallowances ²	\$ 237.0	\$ 197.9	\$ 47.7	\$ 20.7	\$ 0.1	\$ 0.6
Owed by Public ³	3,262.5	3,455.0	635.9	765.2	39.6	112.2
Total ⁴	<u>\$3,499.5</u>	<u>\$3,652.9</u>	<u>\$683.6</u>	<u>\$785.9</u>	<u>\$39.7</u>	<u>\$112.8</u>

Notes: ¹ - The Department changed its debt collection reporting procedures to exclude State reimbursements to SSA under its Supplemental Security Income program. The figures as of December 31, 1982, have been changed to exclude these State supplementations.

² - Debts due to recommended audit disallowances which have been sustained by the program office. As of 12/31/82 this figure included \$184.9 million in amounts under appeal. As of 6/30/83 amounts under appeal totaled \$143.0 million.

³ - Includes amounts other than audit recommended disallowances. Examples include health professional nursing student loans, hospital and health maintenance organization facility construction loans, and overpayments to SSA beneficiaries.

⁴ - HHS has receivables due from other Federal agencies and certain funds from employees. Our comments do not deal with these amounts.

LEGISLATION AND REGULATORY OVERSIGHT

CHAPTER V

LEGISLATIVE AND REGULATORY OVERSIGHT

A special unit in the Inspector General's office has responsibility for review of legislative and regulatory proposals before they are issued to assure that they contain necessary safeguards to prevent fraud and abuse and to promote efficient operation of HHS programs. This front-end review of operational policies avoids costly vulnerabilities that might otherwise remain undetected. The review of regulatory and legislative proposals incorporates the expertise and experience of all OIG components.

FRONT-END REGULATION REVIEW

During the period of April - September 1983, the OIG reviewed 76 regulatory and 184 legislative documents. This included 78 proposals from the Health Care Financing Administration, 59 from the Social Security Administration, and the Office of Child Support Enforcement; 88 from the Public Health Service, and 35 from the Office of Human Development Services. The two most important areas of review during the period from April - September 1983 concerned the regulatory policies that the Health Care Financing Administration (HCFA) established for Medicare Prospective Payment for Inpatient Hospital Service (referred to as PPS) and the Utilization and Quality Control Peer Review Organizations (referred to as PROs.)

The PPS regulation, which implements the Social Security Amendments of 1983, is a fundamental change in the method for paying hospitals that serve Medicare beneficiaries. By rewarding hospitals for delivering care efficiently, this regulation will help control rapidly escalating costs of Medicare inpatient services — which are expected to exceed \$38 billion in FY 1983.

PROSPECTIVE REIMBURSEMENT REGULATIONS

The interim final PPS regulation, published on September 1, 1983, incorporated a number of IG recommendations that provide controls against fraud, abuse and inappropriate payments. The most significant IG recommended safeguards include:

- Deduction of fraudulently billed claims from transition rates;
- Deduction of one-time or other costs that distort rates from the transition rates.

- Clear definition of the main criterion for payment, which is the Medicare patient's principal diagnosis.
- Clarification of the role of the Peer Review Organizations.
- Specification that HCFA medical review agents can override a decision of the hospital utilization review committee in order to deny payment for an unnecessary hospital admission.

In addition, the Inspector General's office will monitor implementation of prospective payment and make any necessary legislative or regulatory recommendations for added safeguards.

**PEER REVIEW
STATUTE
IMPLEMENTATION**

The Inspector General has also recommended that the Department take prompt action to implement the Utilization and Quality Control Peer Review Organization statute (Title I, Subtitle C, Tax Equity and Fiscal Relief Act of 1982.) This recommendation was based on a recent IG study of State and private sector utilization review activities which found that such activities are effective in saving health care dollars. (See page for a more detailed description of the study.) In addition, under PPS, hospitals will receive a predetermined payment for each patient treated based on the patient's diagnosis. This could provide financial incentive to hospitals for admitting patients who could be treated more economically as outpatients, reporting more costly diagnoses than the patients actually had, or prematurely discharging patients and readmitting them, thus securing two payments. To deter such practices, we recommended to HCFA that PRO's be required to verify the necessity of admissions, and to validate diagnostic information used for Medicare payment. These recommendations are being implemented in the PRO proposed rules.

Recommendations for New Legislation

In addition to reviewing proposed legislation and regulations, the Office of the Inspector General also makes proposals for new legislation or regulations policies where systemic weaknesses require strengthening of legislative and regulatory safeguards.

**STRENGTHENED
SANCTION
AUTHORITY**

The legislative changes proposed by the Inspector General would provide increased authority to exclude health care practitioners and providers from Medicare and Medicaid to protect the financial integrity of the Medicare and

Medicaid programs, and to protect beneficiaries from harmful or inferior services. The recommended additional sanctions authorities are:

- *Authority to Refuse to Enter Into a Provider Agreement with Convicted Individuals*—The change would enable the Secretary to refuse to allow program participation by providers who are owned, controlled, or operated by an individual who has been convicted of fraud.
- *Authority to exclude from Medicare and Medicaid practitioners convicted of other health care offenses*—Under existing law health care practitioners can be excluded from Medicare and Medicaid only for crimes against these programs. Financial crimes (such as embezzlement, criminal neglect, or controlled substances violations) committed independently of the Medicare and Medicaid programs are not included as a basis for exclusion. This proposal would give the Secretary authority to use information concerning persons who have committed such crimes as a basis for excluding them from Medicare and Medicaid.
- *Authority to impose Medicare Sanctions on those who defraud or abuse the Medicaid Program*—This would allow the Secretary to exclude any person or terminate any provider under Medicare whenever a sanction was imposed by the State Medicaid agency for Medicaid fraud or abuse.
- *Refinements of Civil Monetary Penalties Statute*—These include:
 - A proposal for a single determination, administrative hearing and unified judicial review regarding (a) the imposition of civil monetary penalties and (b) program suspensions.
 - A proposal for subpoena power in civil monetary penalty proceedings.
 - A proposal for civil monetary penalties for acts contrary to Peer Review Organization (PRO) determinations.

The changes listed above are being reviewed by the Administration.

PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

CHAPTER VI

President's Council on Integrity and Efficiency

The President's Council on Integrity and Efficiency (PCIE) is composed of 18 Inspectors General and other representatives of agencies of the Federal Government. Established in 1981 by President Reagan, the Council provides a medium for cooperative interdepartmental efforts to control fraud, abuse, mismanagement and waste. During this reporting period, DHHS was involved in a number of significant PCIE initiatives with various other Federal agencies.

The Offices of the Inspectors General have demonstrated substantial and growing success in the areas of fraud and abuse detection, prosecution and restitution, in the five years since the passage of the Inspector General Act of 1978. Tangible benefits, identified as dollars saved, costs avoided, indictments and convictions have all increased dramatically. One area, however, representing perhaps the greatest potential contribution the IG community can make to governmental management, has largely been neglected. That area is "prevention". It is now the focus of a recently established PCIE standing committee.

PREVENTION

On January 11, 1983, the President's Council on Integrity and Efficiency set up a new committee on prevention activities. Chaired by the IG of the Department of Housing and Urban Development, the committee was charged with increasing the IG's awareness of their responsibility to act as a catalyst in promoting individual and cooperative efforts to implement and maintain sound prevention principles and techniques. The first activity undertaken by the Prevention Committee was a survey of the IG community to obtain information and ideas on current prevention activities. The HHS/OIG had primary responsibility for consolidating and analyzing the results of that initial survey for the PCIE semiannual report. Based on the findings, the Prevention Committee detailed a three pronged agenda for the coming year. Task item #1 was the development of a model prevention plan, which has been reviewed extensively by both the OIGs and the Departments' Assistant Secretaries for Management. Task #2 addresses the ways traditional audits and investigations can be expanded into a more preventive mode. Task #3, which forms the bulk of the committee's agenda, focusses on culling out, developing and disseminating proactive prevention strategies.

The HHS Inspector General, as Chairman of the Front-End and Operational Safeguards Subcommittee, has taken the lead in organizing the workplan and designing the topics to be explored under Task #3. For each topic, current IG practices and success stories will be reviewed, as will other departmental and GAO techniques, and State government and private sector industries surveyed. The common objective will be several compilations of best practices and, where possible, the development of recommended prevention techniques in the areas under review. These “products” will then be shared, not only with the entire IG community but also with the Federal departments and agencies. We also foresee a mechanism, which would make the technical assistance materials available to States, localities and the private sector.

The topics we have established for extensive review are the following:

- Simplified Eligibility/Integrated Eligibility Determination
- Inspection Activities
 - risk analysis
 - program/management inspections
 - service delivery assessments
 - vulnerability assessments (A-123)
 - A-71 reviews
- Front-End EDP Systems Reviews and Security
- Legislation and Regulation Review
- Front-End Controls in the Procurement Review — Grants, Loans and Loan Guarantees
- Front-End Eligibility Verification Systems/Computer Matching and On-Line Systems

The HHS/OIG has the lead on the simplified eligibility EDP systems, review, and eligibility verification work groups. In addition, we will be actively involved in the three remaining areas. While the projected timetables show extensive

work through the middle of CY 1984, with some studies running concurrently, others consecutively, we expect the first of our products to be available for review by the end of December 1983. Status reports will be provided to the PCIE on a regular basis.

For years, Government auditors, Congressional committees, and outside consultants have reported that the Government's computer systems are vulnerable to fraud and abuse. Although most people agree that computer-related fraud and abuse do exist, no one really knows the size of the problem nor the degree of response required of Inspectors General.

COMPUTER SYSTEMS VULNERABILITIES

The President's Council on Integrity and Efficiency (PCIE) directed the Inspector General of HHS to provide a perspective on the nature and scope of computer-related fraud and abuse in Government agencies. He convened an interdepartmental task force which surveyed the agencies about the known cases of computer-related fraud and abuse discovered between January 1, 1978 and March 31, 1982. The survey yielded the following:

- The extent of computer-related fraud and abuse known to Government agencies cannot be determined because agencies did not systematically track these cases. Despite this constraint, 12 agencies did respond with a total of 172 cases (69 fraud and 103 abuse).
- Fraud cases primarily involved theft of cash or diversion of assets, usually through input manipulation of benefit funds disbursement of payroll systems. The majority of abuse cases involved theft of computer time for personal/outside business or entertainment.
- Three-fourths of the cases involved only one perpetrator, usually a Federal, nonsupervisory employee. Perpetrators differed in fraud and abuse cases in the following ways:
 - Four out of five of the fraud perpetrators earned \$20,000/year or less, but almost half of the abuse perpetrators earned over \$20,000/year.
 - Two-thirds of the fraud perpetrators were functional users of the system while three-fifths of the abuse perpetrators were data processing personnel.
- Loss estimates in fraud cases ranged from \$0 to \$177,383, although almost half of the respondents stated that they felt actual losses were higher. Abuse cases had very scant (33%) response on loss.

- Half of the cases were detected by accident, which was twice the incidence of detection through controls. Agency personnel found over half of the frauds and over two-thirds of the abuses. Within agency personnel, co-workers found equal amounts of fraud, but twice as many abuses as managers.

The report recommended that the IG community upgrade its expertise through computer training and awareness programs and that controls in automated systems be given especially close scrutiny.

The HHS/IG presented findings at the July meeting of the PCIE. As a result of this and other concurrent initiatives the PCIE Computer Audit Council is developing computer training curricula for auditors and investigators. OMB will also sponsor training for the Assistant Secretaries for Management on computer-related fraud and abuse. The HHS/IG will also testify at Congressional hearings in October.

LONG TERM COMPUTER MATCHING

The Inspector General co-chairs and the Office of Program Inspections manages the PCIE Long Term Computer Matching Project. In this joint effort, the Department of Health and Human Services and the Department of Labor work with other Federal Departments and State governments to facilitate and improve the use of computer matching and related techniques.

The project is pursuing a number of tasks in the third phase of computer matching initiatives:

- reviewing the Newsletter's content and format, seeking ways to make it more meaningful to the varied audience it reaches, and, determining who should have ongoing responsibility for publishing the newsletter after the Project ends;
- conducting an inventory of Federal Computer Matching efforts, including front-end screens and edits;
- preparing case studies of front-end verification systems, and
- preparing guidance to Federal and State agencies for determining costs/benefits of matching.

MATCHING IN STATE PROGRAMS

In the sphere of public benefit programs, one of the more prominent computer applications which has emerged at State/County levels is computer matching.

This involves the computerized comparison of two or more lists to determine any irregularities that exist among them.

Little analysis as to the extent, type and utility of such matching has been done in this area. This analysis under the auspices of the PCIE showed the need for more focused attention to providing State/local managers at various levels with a written framework to serve as a reference point for a better understanding of management considerations vis-a-vis cost effective computer matching.

Information gathered by site visits to nine States and telephone discussions with seven other States corroborated the need to assist States in setting forth management guidance material in this area, particularly with a focus on three major benefit programs - AFDC, Food Stamps and Medicaid.

More concerted managerial attention to computer matching is crucial to more cost effective computer matching. The need is especially true of managers new to State and local Government who are interested in taking a fresh look at the existing environment, and program managers who feel a need to know more about the applicability of computer matching to their areas of functional responsibility.

A "draft" guidance document was completed September 1983, which sets forth the consensus of input from a variety of sources involved directly or indirectly with computer matching.

This draft, "Manager's Guide to Decision Making," has been widely circulated for review internally within HHS, externally to other Departments, State and local officials and others, including OMB.

Following receipt of comments and further analysis a final product will be issued in November 1983.

The PCIE Long Term Computer Matching Project established four work groups to address special tasks related to computer matching.

STANDARDIZED FORMATS

The HHS/OIG chairs the Working Group on Technology and Programming which was convened to identify technical issues hindering efficient matching activities. The lack of consistent data elements and record formats was identified as a major impediment to efficient and effective matching. To overcome this problem, the Subgroup designed four standardized formats, one for each of the following areas:

- Assistance Programs
- Unemployment Insurance and Other Benefit Programs
- Wage and Earnings
- Medical Programs

Although limited to these four areas, the formats have potential for a wide variety of applications. For example: Agriculture programs vs Wage reports, and Federal Employee Compensation vs Federal Retirement and other benefit programs. The standardized computer formats will enable State and Federal users to:

- eliminate costs associated with the development of new computer software to extract data for matching purposes on a request by request basis;
- achieve significant reduction in turn-around time for requested matches; and
- reduce the amount of follow-up verification necessary to validate raw hits.

The HHS/OIG will field test the formats in 20 States to determine the need for design changes, to estimate costs of implementation, and to identify the full range of benefits resulting from the formats. The pilot test is scheduled to begin October 15, 1983 and will be completed in October 1984.

The Standardized Formats, which will be disseminated to all States and Federal Departments, represent the type of management improvement anticipated by Reform '88. Standardized Formats will facilitate and enhance matching efforts aimed at reducing fraud, waste and abuse and, at the same time, will reduce matching costs by eliminating the need to develop new software for each match request.

VA-MEDICARE MATCH PROJECT

OIG has completed a project to compare hospital billings to Medicare and the Veterans Administration in Florida to determine the extent of providers billing both programs for the same services. Results of the match disclose that potential duplicate payments in the State of Florida were estimated at \$635,000 and the nationwide estimate of potential duplicate payments represent \$11,300,000.

The Office of Health Financing Integrity is forming a problem provider clearinghouse to collect and disseminate information on public and private sanctioned/convicted providers. This information will alert administrators to areas on which to focus their claims reviews, as well as to serve as a possible deterrence. To date, a final notice of the system of records has been prepared, and letters have been sent to various sources to obtain the data needed for the clearinghouse. A new source document to capture the required data from the users has been forwarded to the appropriate components for form clearance.

**PROVIDER
CLEARINGHOUSE
PROJECT**

The computer detection screen project involves utilization of sophisticated computer technology to detect and prevent fraud and abuse in health provider programs. Using computer screening techniques, health care program vulnerabilities will be identified. Effective computer applications currently in use will also be identified. Once effective computer applications have been determined, a clearinghouse will be established to share this information with all members of the health financing community. At the present time a vulnerability assessment questionnaire has been developed, and has been sent to other Federal, State, and private sector organizations in the health field in late October. The Atlanta Training Center of the OIG has also agreed to establish the technology clearinghouse early in FY 1984.

**COMPUTER
DETECTION
SCREEN
CLEARINGHOUSE
PROJECT**

The Social Security Number (SSN) is usually the key identifier in conducting computer matches to detect erroneous and fraudulent payments. However, State and Federal agencies indicate that their files contain numerous incorrect Social Security Numbers, thereby inhibiting computer matching efforts.

**PROJECT CLEAN
DATA**

Two computer programs called "Project Clean Data" have been designed to assist State and Federal agencies identify either incorrect or fraudulent Social Security Numbers (SSNs) that have not been issued; the second program detects SSNs being used fraudulently.

The programs have been distributed to more than 75 agencies in 43 States and to several Federal agencies. Many States reported identifying thousands of incorrect SSNs in their data files. For example, California identified 4,705 incorrect SSNs and Texas identified 5,000 incorrect SSNs. Use of the program in other States identified illegal aliens applying for or receiving benefits.

**CASH
MANAGEMENT**

The OIG has been working with five other Federal agencies in looking into Government-wide cash management systems. Our review had two basic ob-

jectives, namely (1) to evaluate the Department's management and administration of the cash advancing systems' funding techniques and (2) to evaluate the Department's systems for monitoring advance funding to recipients. We will be extending our work in this area to cash balances maintained by grantees.

Auditors surveyed each of the six HHS cash advancing systems and found that internal controls were generally adequate, except that cash drawdowns were not always timely recorded at the Departmental Federal Assistance Financing System (DFAFS) at least partially due to delay in receiving payment vouchers from Treasury. (This process is being replaced by Treasury's Financial Communication System.) In addition, auditors found:

- interest costs of about \$21 million were incurred annually because grantees drew down excess Federal funds under the letter of credit and Treasury check payment methods in advance of their immediate needs;
- cash balances reflected or recipients expenditure reports were not always accurate;
- funds were advanced to recipients without identification of the specific awards for which the cash drawdown related;
- recording of cash drawdowns under one of the letter of credit systems was not always made timely which resulted in reduced control over cash balances; and
- substantial amounts may be lost annually due to delays in closing out grants.

We have suggested that the Department of the Treasury continue to emphasize the use of the three very efficient cash payment systems (Delay-of-Drawdown, Checks Paid, and Checks Issued) and initiate a government-wide study to consider the feasibility of establishing a centralized cash advancing system for all Federal Departments. To the Department we will be recommending that HHS continue efforts—in coordination with OMB and Treasury—for implementing the three above mentioned cash payment system along with other specific procedural recommendations.

GOVERNMENT PROPERTY

It has been estimated that the Federal Government has funded about \$52 billion of property that is in the possession of contractors and grantees. Of this amount about \$223 million was provided by HHS.

This PCIE project looked into whether the management and administrative systems applicable to government-financed property provided adequate safeguards for its care, use and final disposition or return. Our review was conducted at five universities and noted internal control weaknesses over the acquisition, accountability, utilization and disposition of property purchased with Federal funds. Specifically:

- Documentation to demonstrate a need for equipment and to show consideration was given to other available equipment was lacking. Assessment of overall needs was not made before purchase and there was no central place to screen requests before equipment purchase.
- Physical inventories were not taken or taken in a timely manner. Equipment was found off premises in the homes of principal investigators and check out systems were not adequate to determine when it was taken. Further, equipment purchases were not always entered in the accounting records.
- Procedures were inadequate to report surplus equipment to a centralized location so that an effective screening process for proposed purchases could be implemented. As a result, we noted property that had not been reported surplus even though it was not used for years.

OIG COMPONENT MISSIONS AND FUNCTIONS

Appendix I - OIG Component Mission and Functions

OFFICE OF AUDIT

The Office of Audit (OA) has taken record strides in carrying out the Inspector General's redirection of resources into programs most susceptible to fraud, waste, and abuse. During the last six months of FY 1983, OA issued 2,010 reports recommending financial adjustments of \$100.5 million. Audit-recommended financial adjustments of \$81.7 million were accepted by Department managers and entered as accounts receivable. More importantly and consistent with the Inspector General's redirection, 12 reports identified areas where Department managers could save an estimated \$354 million if regulatory or legislative changes are made to correct identified problems. Many of these reports are still undergoing Department review and comment and have not been included in the savings figure discussed below.

Substantial resources have been redirected from audits of colleges, universities, and State administered programs to two of the Department's most vulnerable and costly activities—Social Security and Health (see chart, page 112).

Audit scopes switched from being primarily financial/compliance to a concentrated programmed effort of: (1) seeking ways to improve fiscal controls in the benefit payment process in trust fund financial management and accounting operations, (2) looking for more efficient and economical administration of programs, procurement and delivery of services, and (3) ferreting out fraud, waste, and abuse through the use of sophisticated computer applications.

OA has been a leader in the private as well as the Federal sector in developing and refining sophisticated audit techniques, including advanced statistical sampling and computer applications to combat fraud, waste and abuse. Some 52 computer applications were utilized this period identifying millions of dollars in incorrect or unallowable payments.

One screen alone, if implemented, could save an estimated \$25 million annually in the AFDC program.

Cost savings, as defined by the President's Council on Integrity and Efficiency (PCIE), refer to areas where Department managers have made a formal commitment to implement audit recommendations by preventing improper expendi-

tures or obligations of agency funds in the future and/or improving agency systems and operations. Estimated savings relate to future periods and deal with improvements and refinements or elimination of unnecessary expenditures.

Costs questioned relate to reports where auditors question the allowability of costs claimed in past periods because of violations of law, regulations or Federal cost principles.

Of major significance, Department managers began or completed, during FY 1983, implementation of actions to correct problem areas discussed in prior IG reports. These will save an estimated \$710 million. This, along with audit concurrences, brings our total savings to \$959 million—an increase of over 1000 percent from FY 1980. A list of reports that make up this savings figure is contained in the charts at the end of this Appendix.

Many of these items are not discussed in this report since they were detailed in previously issued reports. Consistent with the Inspector General's new direction to increase internal management reviews, the Office of Audit will be issuing fewer reports with recommended financial adjustments. However, there will be more reports containing cost savings as indicated in the charts on pages 113-115.

Under the auspices of OMB, OA is continuing to provide leadership approach to implementation of the 'single audit' concept at colleges, universities and non-profit organizations. All OA are involved in monitoring and providing technical assistance to implement this concept.

OFFICE OF INVESTIGATIONS

The Office of Investigations has assumed an aggressive proactive role in the detection, investigation and prevention of fraud in Department programs. The limited number of investigators and the large-scale fraud potential in Department programs make reactive investigation of random complaints impractical, if not impossible. Identifying patterns and areas of persistent fraud, as well as systemic weaknesses which leave programs open to fraud, makes for far more productive use of investigative resources. Early efforts have already produced excellent results. OI convictions increased by 280 percent, from 211 in 1982 to 808 in 1983.

In assuming a proactive position, OI first began pruning its excessive caseload. By getting rid of cases which did not offer a high payoff in either prosecution

success or savings and recoveries, OI is improving its success rate and cost efficiency. Reducing the caseload also permits devoting more attention to innovative methods of detection and focusing on areas for which we have oversight responsibilities. Realizing that acquisition of the program integrity function from Social Security would mean a tremendous influx of cases in this major area, OI began to concentrate on shifting to health care cases. As a result, health care cases now comprise more than 60 percent of OI's on-going regular caseload.

The caseload pruning process was not limited to OI's on-going cases. In September OI managers reviewed over 6,000 complaints being carried on the caseload transferred with the SSA Program Integrity function, and reduced that number to 2,655. The Program Integrity Staff's efforts are being redirected to concentrate on fraud perpetrated through the use of false ID cards or misuse of legitimate cards. Current projects involve detection of multi-program fraud, fraud by illegal aliens, and fraud involving fictitious children.

OI has developed some 20 special projects to identify fraudulent activities among special provider or beneficiary groups and in specific geographic areas. Some of these projects take the form of coordinated efforts with other Federal or State investigative agencies. Others are regional pilot projects to determine viability for application nationwide. Many involve some use of advanced computer techniques, such as profiling, matching or screening.

Regional successes with some of the health care projects are leading to projects national in scope. Projects aimed at uncovering kickbacks in the pacemaker and pharmacy industries have proved particularly fruitful. In another instance a State task force approach to combatting Medicare and Medicaid fraud is developing enough convictions and solid leads to warrant expansion of the concept throughout the region.

OI has actively assumed the role of leader, coordinator and technical advisor to State and local agencies for welfare fraud investigations. Experience has shown that routine beneficiary fraud prosecution is most productive when pursued through the State and local channels, where the programs are largely administered. By concentrating on major beneficiary fraud problems and acting as leader and advisor, OI is able to maximize its impact in this area while limiting resource commitment.

The need for automated data management in OI has been recognized for some time. However, there had been no concerted effort to invest the time and resources to this goal. With the impetus and support of the Inspector General's

vision and far-sightedness, OI has completed and implemented a management information capability which in the long run should become one of its most useful tools in targeting areas for fraud vulnerability and successful investigation. Two fully complementary systems were implemented during FY 1983. One collects, stores and retrieves 51 fields of data on every OI case. The other gives field and headquarters management fingertip accessibility to caseload management for tracking current cases.

Along with streamlining its caseload, targeting specific industries and areas, and using improved methodology to assure economical resource commitment, OI is aiming at greater monetary recoveries from fraudulent activities. Implementing regulations for the Civil Monetary Penalties Law and aggressive pursuit of recoveries under this law are beginning to pay off. The amounts thus recovered, plus amounts retrieved in large criminal health care cases, amounted to more than \$7 million in this period alone. At this point OI is recovering better than \$2 for every \$1 it expends.

The primary purpose of the OIG's fraud investigation function is to deter would-be offenders and stop those already engaged in this activity. To these ends, OI has increased efforts to improve prosecution action rates, to target cases with high payoff potential, and to impose heavy monetary penalties for health care program violations. OI also gave added emphasis to grouping cases for presentation in mass prosecution actions. These mass actions not only improved the prosecution rates but also had greater public impact. Several mass prosecutions attracted media coverage that would not have occurred on an individual case basis. In addition, OI is enhancing its presence in those geographic areas having high concentrations of Department program activity and funds.

Finally, OI is attempting to get at the heart of fraudulent activity by streamlining its Management Implications Report System (MIRS). In these reports, agents identify program and system weaknesses uncovered during the course of their investigations. The improved system of analyzing, referring and following up MIR recommendations offers the potential for wholesale elimination of opportunities for fraud.

Charts illustrating OI activities and successes are found on pages 116-119.

OFFICE OF HEALTH FINANCING INTEGRITY

The Office of Health Financing Integrity (OHFI) was established within the OIG in January 1983. The some 220 staff within OHFI are devoted to carrying out a

variety of activities intended to detect, investigate (or inspect) and resolve issues of fraud, abuse, waste and mismanagement within Health Care Financing Administration programs.

The majority of staff time is spent investigating instances of suspect health provider fraud and documenting cases so that civil money penalties, sanctions, and/or overpayments can be established. In the process of working cases as instances of criminal fraud are detected, the case matters are referred to the Office of Investigations (OI) to pursue criminal investigations. To assure proper coordination and effective mobilization of resources in conducting investigations, case review committees have been established in each regional office to periodically examine with the Office of Investigation cases identified for investigation, to determine status and review results.

Critical to good case work is a sound system for detecting health providers potentially guilty of some form of program fraud or abuse. In addition to relying on the general public through the establishment of a hotline and complaints received by Social Security Offices and other sources, heavy reliance must be placed on State Medicaid agencies, Medicare contractors and Medical Review Organizations. To assure these operational components recognize the importance of their role in the process and are carrying out their responsibilities in an effective way, OHFI carries out an inspection program. Inspections are conducted in a variety of ways and for a variety of purposes. However, the overall intended purpose of inspections is to ensure that the Medicare and Medicaid programs are operating with maximum efficiency and in such a way to detect willful wrongdoing on the part of the health provider community.

Provisions of 42 U.S.C. 1320a-7a (Civil Monetary Penalties Law) will impact heavily on OHFI's future. These provisions which allow for fines and penalties to be levied administratively for the filing of false claims should considerably improve our capability to control health providers bent on illegally obtaining monies from Medicare and Medicaid.

OHFI must stay on the cutting edge of Medicare and Medicaid program direction and health care practices to constantly evaluate aspects of those directions raising concerns about opportunities for fraud, abuse and waste. Examples of some areas where we anticipate upcoming OHFI inspections activity include:

- prospective payment and particularly prospective payment as the form of reimbursement for inpatient hospital services;

- reimbursement effects of the newly legislated hospice provisions under Medicare;
- medical services rendered to inpatients of nursing homes;
- drug diversion and the practice of controlled substance drugs being abused and reimbursed by Medicaid;
- the effect of reimbursement for end stage renal disease as a result of recently promulgated regulations.

Coordination is key as related to OHFI activities. Not only in developing cases for civil money penalty or other adverse actions against health care providers, but also in examining the systemic effects of various aspects of program reimbursement through our inspection activity. Maintaining a partnership with the Office of Audit in assuring that we are following an in tandem effort of detecting and resolving generic problems is critical for ongoing and future initiatives of OHFI. This function is best carried out through our work planning efforts and through a 'health care coordinating committee' to provide a forum for discussion of critical issues of the day and giving attention to those issues through mobilization of the OIG resources and expertise available.

As we look forward to 1984 and beyond several programmatic and administrative issues come to mind including:

- more effective use of computer techniques to detect potential problems and training of staff on the state of the art through the use of these tools;
- greater time and attention being given to possible abuses by HCFA staff through internal audit type inspections and individual employee investigations;
- more effective deployment of field staff through attrition to provide greater resources in geographical areas where the potential exists for the greatest problems;
- increasing the investigative and inspection skills needed to root out and document the often highly complex schemes engaged in by those illegally benefiting from the programs;

- improving our capacity not only to discover systemic problems but to document and present the results of our findings to be totally persuasive.

As we continue to evolve our critical role in meeting the OHFI Mission, these are some of the general areas where management attention will be focused.

OFFICE OF PROGRAM INSPECTIONS

The Office of Program Inspections (OPI) was established by the Inspector General in order to (1) integrate the OIG efforts toward improved management efficiency and effectiveness and (2) promote fundamental program and management systems integrity. The OPI mission is to identify and document system vulnerabilities and to propose remedial action to problems of fraud, abuse, and waste in all HHS programs, both internally and with the grantees and contractors.

The 51 staff of OPI, located in Washington, Baltimore, and regional offices carry out this mission in a variety of ways. Specifically, we:

- *Conduct Analyses and Inspections*

These short-term studies provide the Secretary, Inspector General and program managers with quick, up-to-date information on the operational efficiency, impact and vulnerability of Departmental programs. Based on the findings of these studies, recommendations for program and management improvements are developed, presented and tracked for agency follow-up activities.

- *Lead and Coordinate Interagency Projects*

OPI leads or coordinates the OIG participation in a number of projects sponsored by the President's Council on Integrity and Efficiency (PCIE) and other interagency efforts to address common problems and opportunities.

- *Review Legislative and Regulatory Proposals*

OPI coordinates the OIG review of proposed legislation and regulations to insure that they are sensible and contain adequate safeguards against fraud, waste, abuse and management inefficiency.

- *Analyze Investigative Reports*

Investigators from the Office of Investigations prepare Management Implications Reports (MIRs) identifying potential system or program vulnerabilities. OPI analyzes those reports to determine if and what kind of corrective action proposals are needed to strengthen internal controls or operating procedures.

- *Promote Deterrence of Fraud, Waste and Abuse*

OPI promotes deterrence by actively promulgating our findings through the provision of technical assistance; participation in governmental briefings, conferences, professional organizations, and public forums; and the preparation of written materials for appropriate publications.

As a response to a quickly changing environment, OPI tries to maintain vision—a sense of what needs to come next. Accordingly, OPI will continue to focus resources on rapid systemic reviews and analysis in order to offer information which is timely and relevant to major issues. In coordination with the efforts of other OIG units, greater emphasis will be placed on prevention activities such as participation and leadership in front-end design of programs and operations; special awareness and training initiatives; legislative and regulatory review; and special deterrence projects.

The Analysis and Inspections Division will continue to ask the basic questions: Are we doing what we should be doing in the most effective and efficient manner? Most importantly, is what we are doing worth doing? Specific changes are underway to (1) produce even more sophisticated analyses which contain, where practical, cost/benefit recommendations for program managers, and (2) expand the inspections process to include analyses of internal review processes within programs. Studies will include:

- A study of whether SSA and Medicare are both reimbursing for the same medical examinations required for continuing disability eligibility.
- A vulnerability study of the early impacts of hospice certification, coverage, and reimbursement policies.
- A study of the magnitude and needs of runaway and homeless youth being served by community-based programs funded partially by HHS.

The Office of Program Inspections will continue to manage for the Inspector General those projects which involve other Federal or State agencies. Projects will include:

- A review of current and potential techniques for using on-line, integrated eligibility verification systems to prevent improper expenditures of funds in Federal and State administered benefit programs.
- Distribution of a comprehensive 'Manager's Guide to Computer Matching' to State officials to help them use computer matching most effectively.
- A study of the potential and pitfalls of electronic billing for claims payment on the part of health care providers.

The Legislative and Regulatory Review Division will enhance the OPI function of preventing opportunities for waste and fraud by reviewing new and revised HHS rules and legislative changes, tracking and analyzing regulatory and legislative trends, and developing new regulatory and legislative strategies to safeguard HHS programs. Specific initiatives include:

- Expand the effort to review more draft rules prior to the formal clearance process in order to give 'early warnings' to OPDIV managers.
- Develop regulatory procedures to meet both OIG needs and HHS and OMB clearance requirements.
- Begin the process of developing the FY 1986 legislative proposals from the OIG.

The efforts of the Office of Program Inspections will continue to focus on improving the efficiency and effectiveness of programs and management systems that are vulnerable to fraud and abuse, and to highlight where costs might be avoided or funds more judiciously spent.

**ANALYSIS OF COST SAVINGS
APRIL 1983 THRU SEPTEMBER 1983**

Health Care Financing Administration

AUDIT RECOMMENDATIONS	ACTION TAKEN	SAVINGS \$MILLIONS
Reduce the Medicare rate paid to proprietary hospital providers for their Return on Equity Capital (REC). (ACN: 09-32607)	The Social Security Amendments of 1983 reduced the REC payment for hospital inpatient services from 150 to 100 percent of the average trust fund investment rate.	100.00
Clearly fix responsibility on intermediaries for review of requests for increases in payment rates submitted by providers of renal dialysis services. (ACNs: 02-92000, 02-92012)	HCFA issued instructions that significantly reduced payment rate increases.	26.00
Improve procedures for establishing per diem rates charged to Medicaid for services provided in State operated Intermediate Care Facilities for the Mentally Retarded. (ACNs: 03-20201, 03-10265)	The State concurred with our findings and revised its instructions for cost apportionment used in computing ICFMR per diem rates.	3.30
Reduce Medicaid beneficiary utilization of: (1) physician services, (2) drugs, and (3) brand-name drugs in lieu of generic equivalents. (ACNs: 03-80232, 03-70217, 03-90604)	As part of a major effort to reduce Medicaid costs, several recommendations to curb unnecessary use of Medicaid services were implemented.	2.60
Improve procedures over hospital cost settlement process. Auditors found deficiencies in almost all aspects of one State's procedures for the settlement process from actually obtaining cost reports to computing settlement amounts. (ACN: 03-20216)	As a result of our audit, the State entered into a contract whereby a national CPA firm would audit 74 cost reports submitted by 14 hospitals.	7.75
Establish procedures to expedite the return of Federal funds recovered from Medicaid providers. (Region X)	Audit results enabled HCFA to initiate action to reduce the State's Medicaid grant award.	1.00
Establish prepayment screens to identify charges that exceed frequency limits. (ACN: 08-20200)	The State concurred and initiated edit controls to preclude this problem.	.028

**ANALYSIS OF COST SAVINGS
APRIL 1983 THRU SEPTEMBER 1983**

Social Security Administration

AUDIT RECOMMENDATIONS	ACTION TAKEN	SAVINGS \$MILLIONS
Eliminate AFDC overpayments disclosed during a computer match of wage records. Overpayment occurred because of nonreporting or underreporting of income.	The involved State either terminated the AFDC benefit payment or made a reduction in the payment.	.250
State should reimburse Federal Low Income Energy Assistance account for improper overclaim of Federal funds. (ACN: 06-20255)	State made cost transfers between the Federal and State LIEA accounts.	1.633
Review computer-generated data and identify AFDC recipients who fraudulently received benefits because of unreported income, or under more than one active AFDC case. (ACNs: 04-10261, 04-30256)	Suspected recipient fraud has been identified and recovery initiated either through court or administrative action.	.576

**ANALYSIS OF COST SAVINGS
APRIL 1983 THRU SEPTEMBER 1983**

Indian Health Service

AUDIT RECOMMENDATIONS	ACTION TAKEN	SAVINGS \$MILLIONS
Proposed costs under a contract to manage and operate a health delivery system should be supported by either current or historical cost data. (ACN: 04-21451)	By using such data the contract was reduced because of unsupportable cost estimates.	.021

**ANALYSIS OF COST SAVINGS
APRIL 1983 THRU SEPTEMBER 1983**

Office of Human Development Services

AUDIT RECOMMENDATIONS	ACTION TAKEN	SAVINGS \$MILLIONS
Reduce excessive amounts of cash on hand. (ACNs: 04-31300, 08-17003, and 12-33156)	Procedures established by auditees to minimize cash balances should save the Federal Government interest of more than \$1.253 million per year.	1.253
Recommended recovery of grant funds and/or fines in assisting U.S. Attorney in Head Start criminal case.	As a result of our audit work, the Court ordered fines amounting to \$412,000.	.412

**ANALYSIS OF COST SAVINGS
APRIL 1983 THRU SEPTEMBER 1983**

Office of the Secretary

AUDIT RECOMMENDATIONS	ACTION TAKEN	SAVINGS \$MILLIONS
Eliminate unallowable costs from indirect cost rate proposals and State-wide cost allocation plans. (ACNs: 03-17019, 03-17013, 03-17011, 03-27014, 03-20450, 04-17013)	The Division of Cost Allocation agreed with our findings and subsequently reduced the involved rates.	5.80
That a State revise its procedures for classifying costs and allocating costs between income assistance (50% FFP) and service functions (75% FFP). (ACN: 03-00288)	The Division of Cost Allocation agreed with our findings and negotiated with the State to bring about the required revisions to the State cost allocation plan.	1.25
Methods used by one State for determining space related costs in preparing indirect cost rate proposals be revised. (ACN: 06-21007)	The Division of Cost Allocation used our audit results to negotiate changes to procedures for establishing space related costs.	6.30
Eliminate unallowable and overstated costs from indirect cost rate proposals. (ACNs: 09-27010, 08-27001, 08-27002)	As a result of these audits, the Division of Cost Allocation was able to establish indirect cost rates which were more equitable than those proposed.	28.30
That a State negotiate a financial settlement with affected Federal departments for incorrect cost allocations made for audited period, and subsequent periods. (ACN: 06-10257)	State negotiated the recommended settlement, which affected HHS and USDA.	.145
Negotiate settlements on delay and extra work claims at NIEHS	The Department negotiated settlements based on our audits which resulted in savings on amounts claimed.	.905

**ANALYSIS OF COST SAVINGS
APRIL 1983 THRU SEPTEMBER 1983**

Department-Wide Administration

AUDIT RECOMMENDATIONS	ACTION TAKEN	SAVINGS \$MILLIONS
Identify dormant unliquidated obligations which if deobligated could result in funds being made available for reprogramming or reductions of future appropriations. (ACNs: 04-31300, 12-23138, 08-23004, and 08-23000)	As a result of audits, unliquidated obligations were reduced by \$21.3 million.	21.3
Promptly report employee payroll deductions to OPM, thus avoiding any unnecessary interest income loss to Civil Service Retirement Fund. (ACN: 12-33139)	Departmental actions taken should avoid \$0.1 million annual income loss caused by late reporting.	0.1
Total Cost Savings April - September 1983		\$208.923
Total Concurrences April - September 1983		81.700
		<u>\$290.623</u>
Saving/Concurrences October 1982 thru March 1983 (See Exhibit J page 3 of 3 Oct - March 1983 Semiannual Report)		668.600
FY 1983 Grand Total		<u>\$959.223</u>

**COST SAVINGS BY
OTHER OIG COMPONENTS (FY 1983)**

	October - March \$ Millions	April - September \$ Millions
<i>Office of Investigations</i> (Recoveries, avoidances, restitutions, fines, etc.)	39.5	23.4
<i>Office of Health Financing Integrity</i> (Integrity inspections, case recoveries, etc.)	37.7	104.2
<i>Office of Program Inspections</i> (Programs Inspections)	97.0	92.0
<u>Overall Total (This page)</u>		\$393.8
<u>Grand Total of Yearly Savings</u>		\$1,353.223

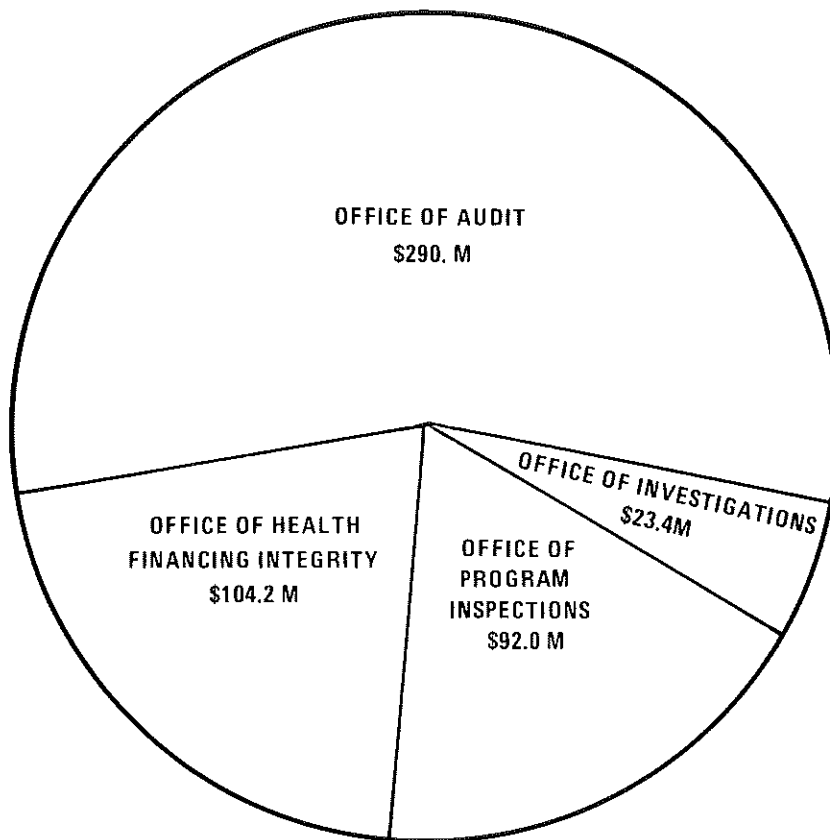
GRAPHICS

OFFICE OF INSPECTOR GENERAL

COST SAVINGS

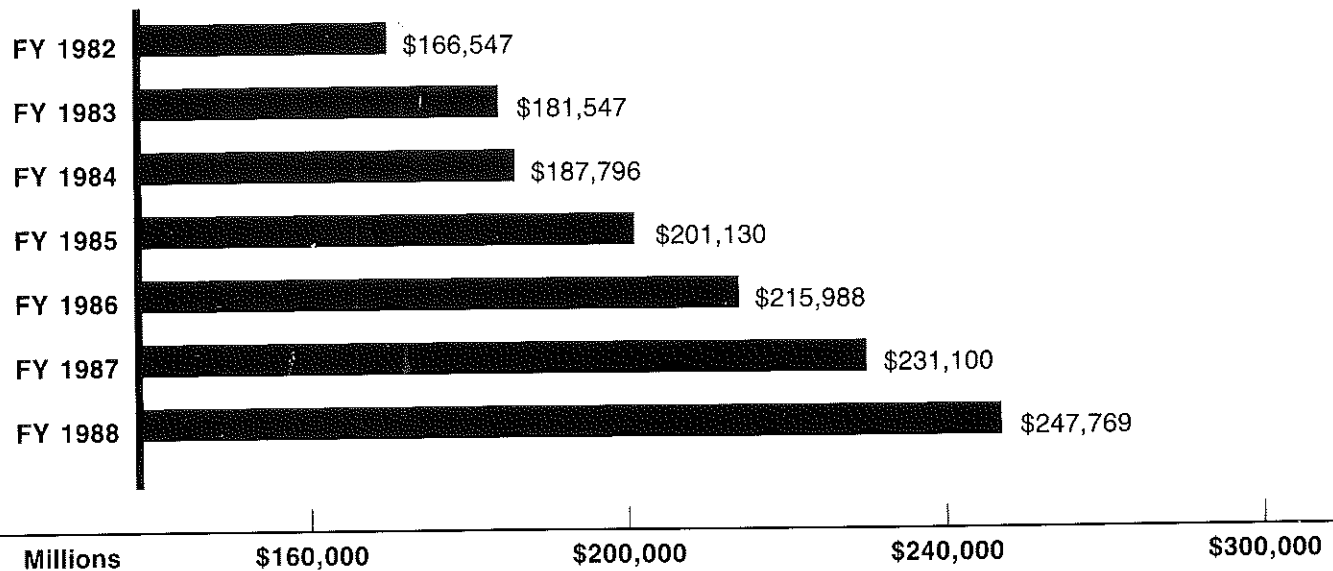
April 1983 — September 1983

By OIG Component



EXPENDITURES AND PROPOSED EXPENDITURES SOCIAL SECURITY ADMINISTRATION

(in \$ millions)



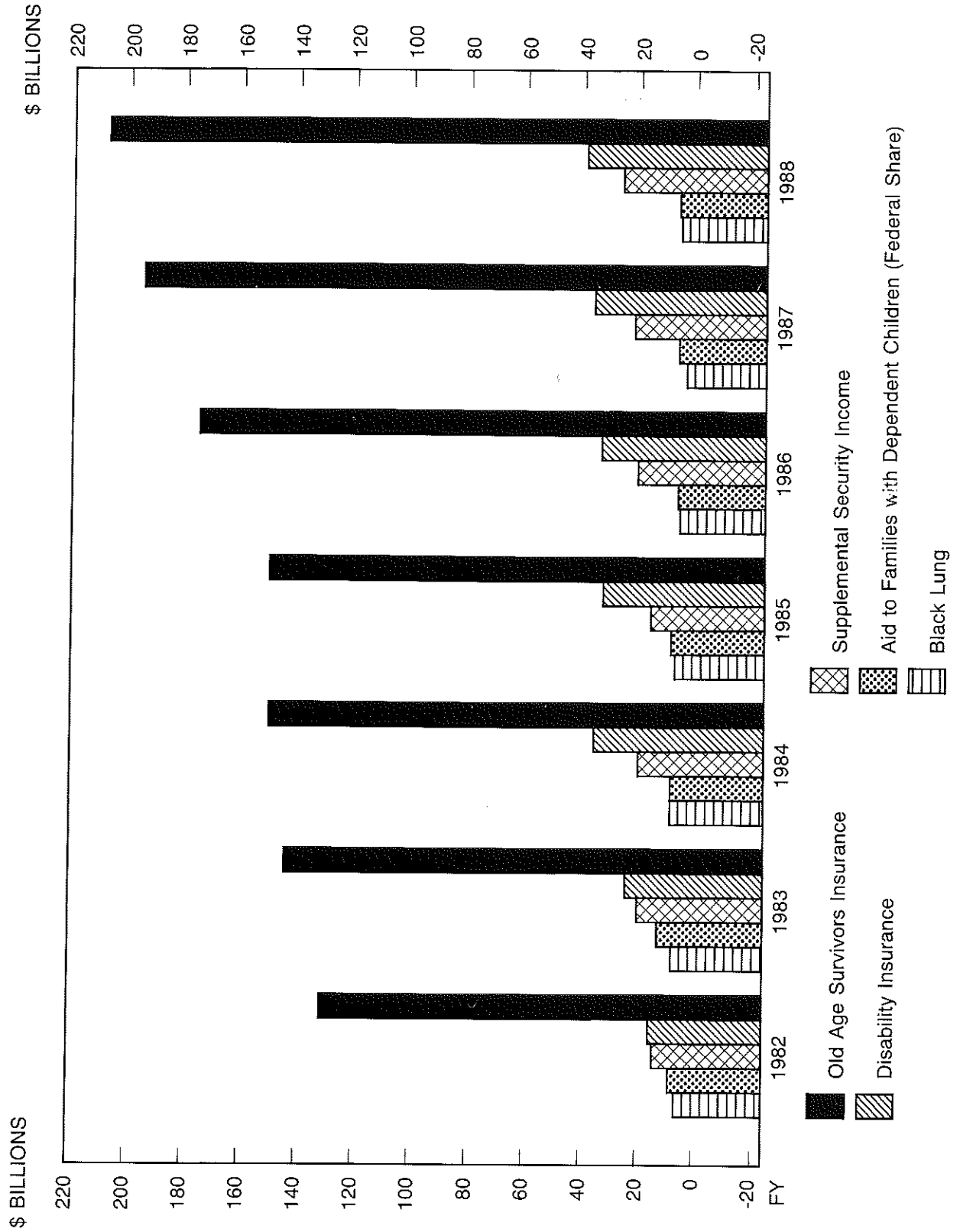
SOCIAL SECURITY BENEFIT OUTLAYS IN MILLIONS BY FISCAL YEAR

	FY 1982	FY1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988
OASI	\$134,655	\$148,171	\$155,691	\$167,599	\$181,332	\$195,195	\$209,764
DI	17,399	17,594	17,271	17,795	18,657	19,612	20,782
SSI (Federal)	6,833	7,820	7,236	8,105	8,300	8,530	9,420
Black Lung	1,085	1,077	1,023	1,014	1,013	1,009	1,000
AFDC (Federal Share)	6,575	6,885	6,574	6,617	6,686	6,754	6,803
Total Expenditures	\$166,547	\$181,547	\$187,795	\$201,130	\$215,988	\$231,100	\$247,769

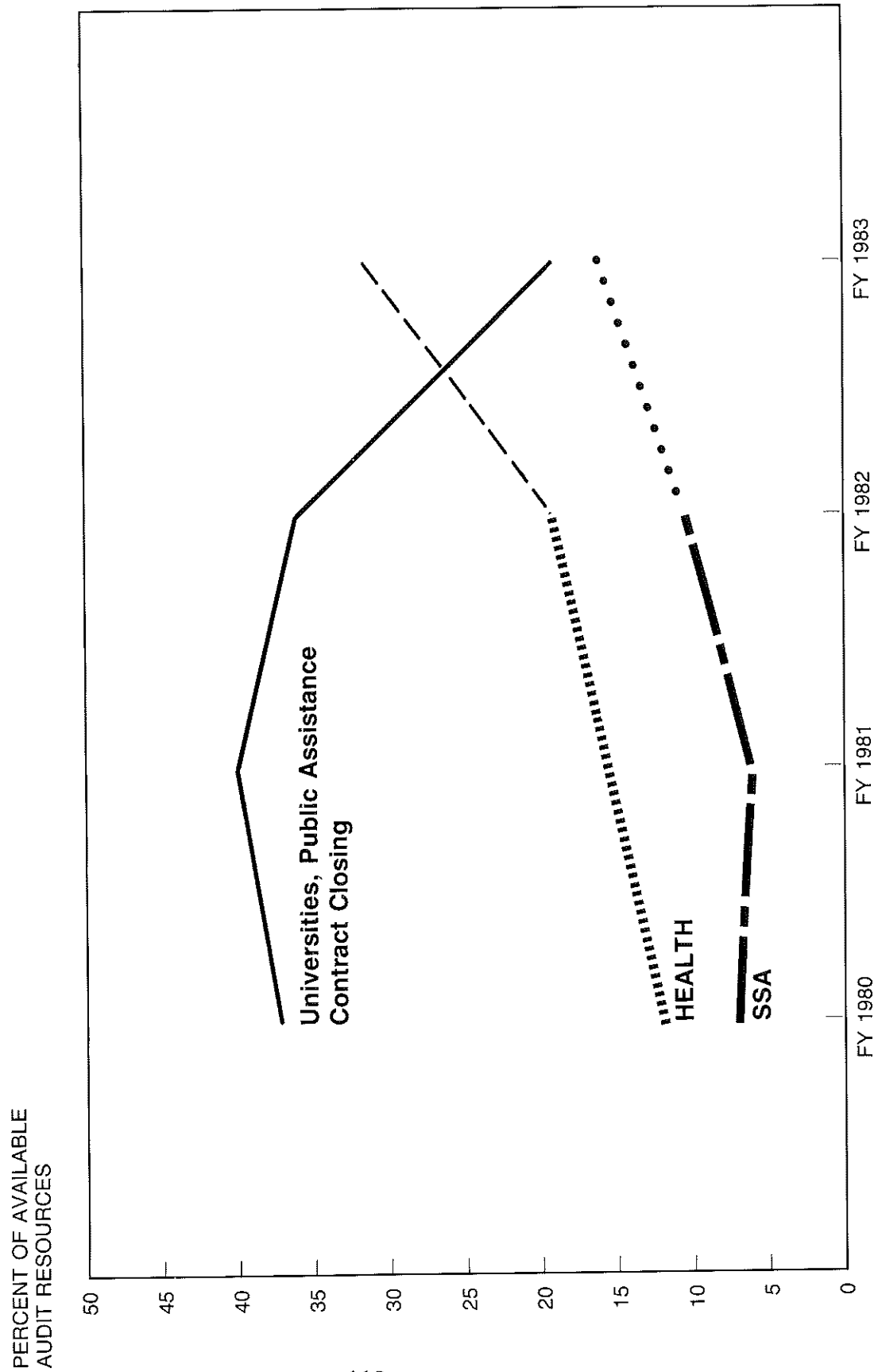
SSA MAJOR PROGRAMS

BENEFIT EXPENDITURES AND PROPOSED EXPENDITURES

FY 1982 - FY 1988

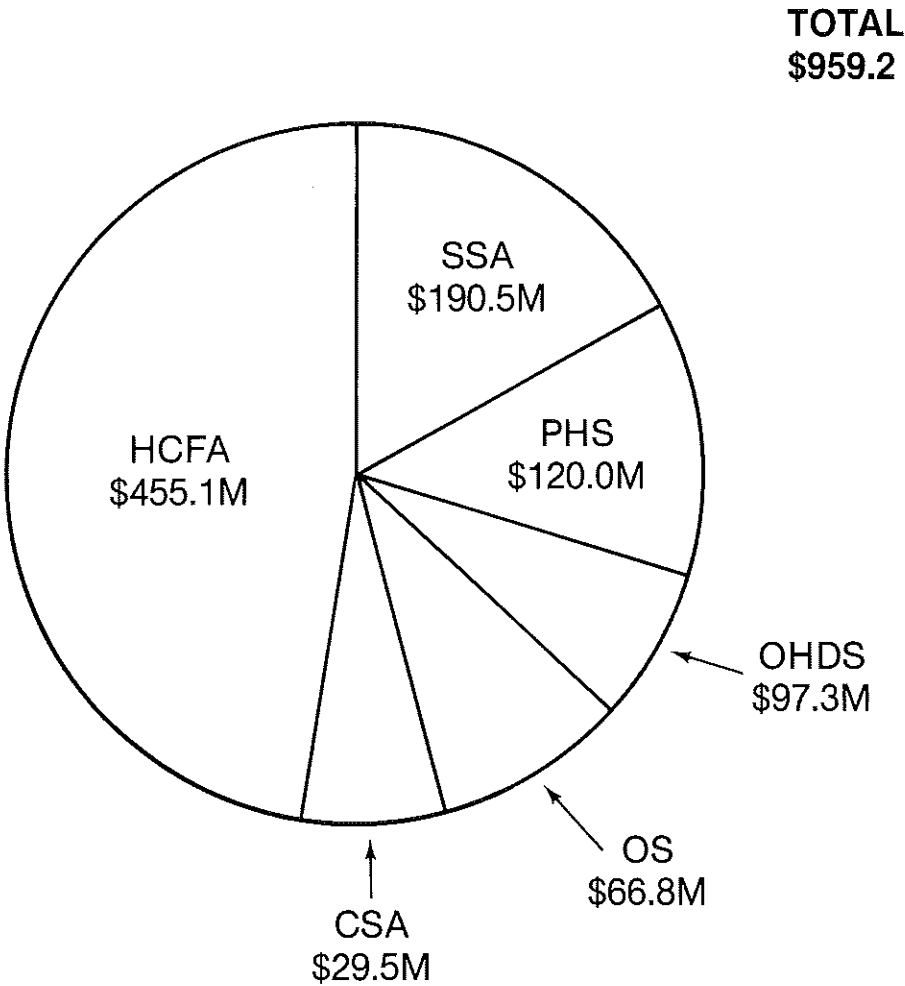


AUDIT REDIRECTION



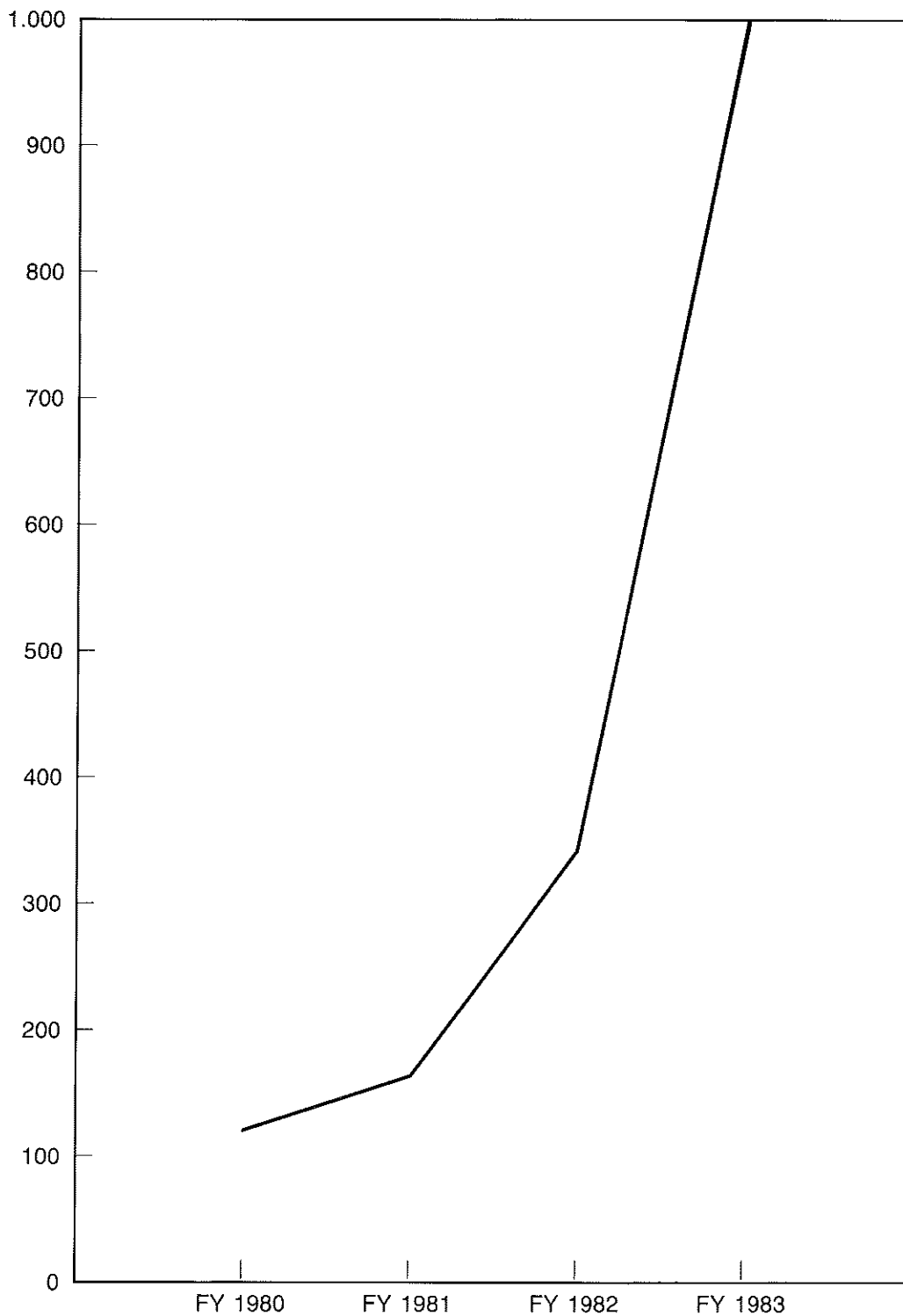
AUDIT COST SAVINGS AND CONCURRENCES BY OPERATING DIVISION

October 1, 1982 - September 30, 1983



COST SAVINGS/AUDIT CONCURRENCES

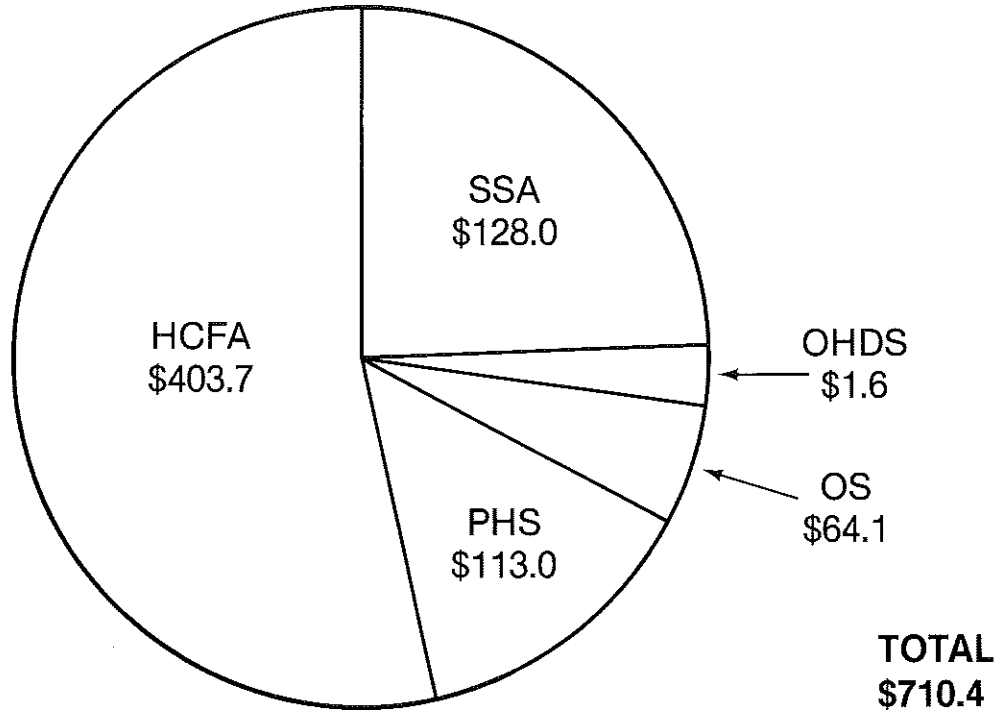
\$ MILLIONS



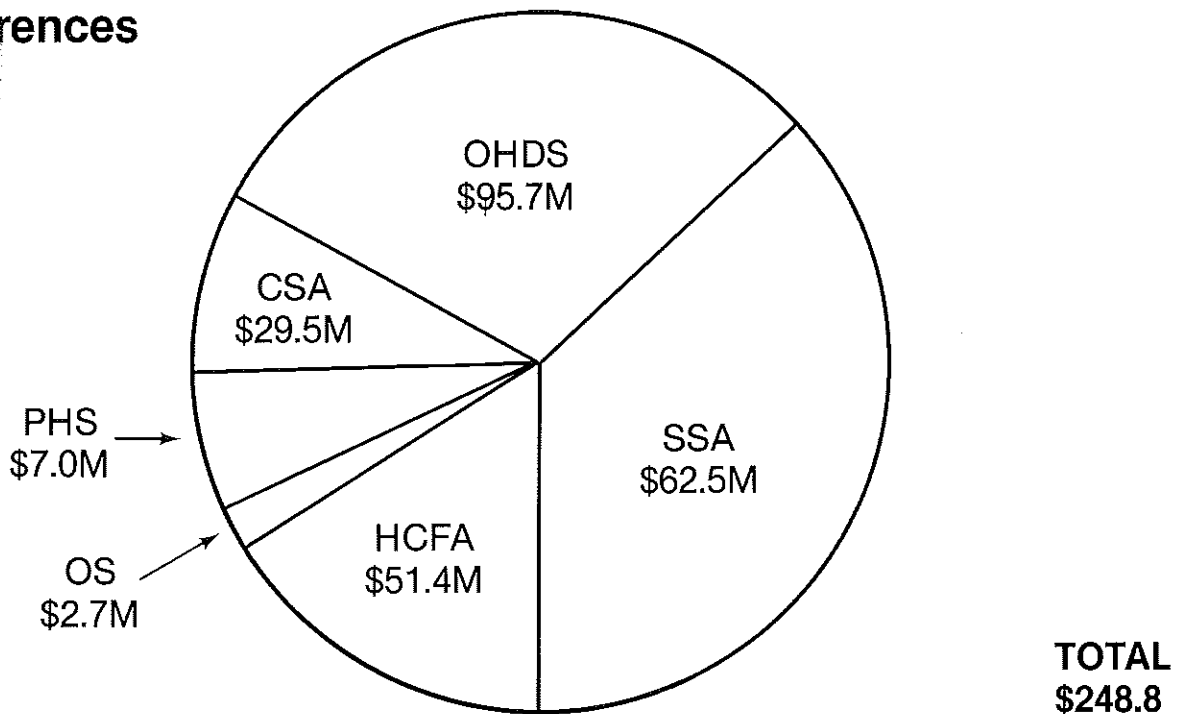
COST SAVINGS AND CONCURRENCES BY OPERATING DIVISION

October 1, 1982 - September 30, 1983

Savings

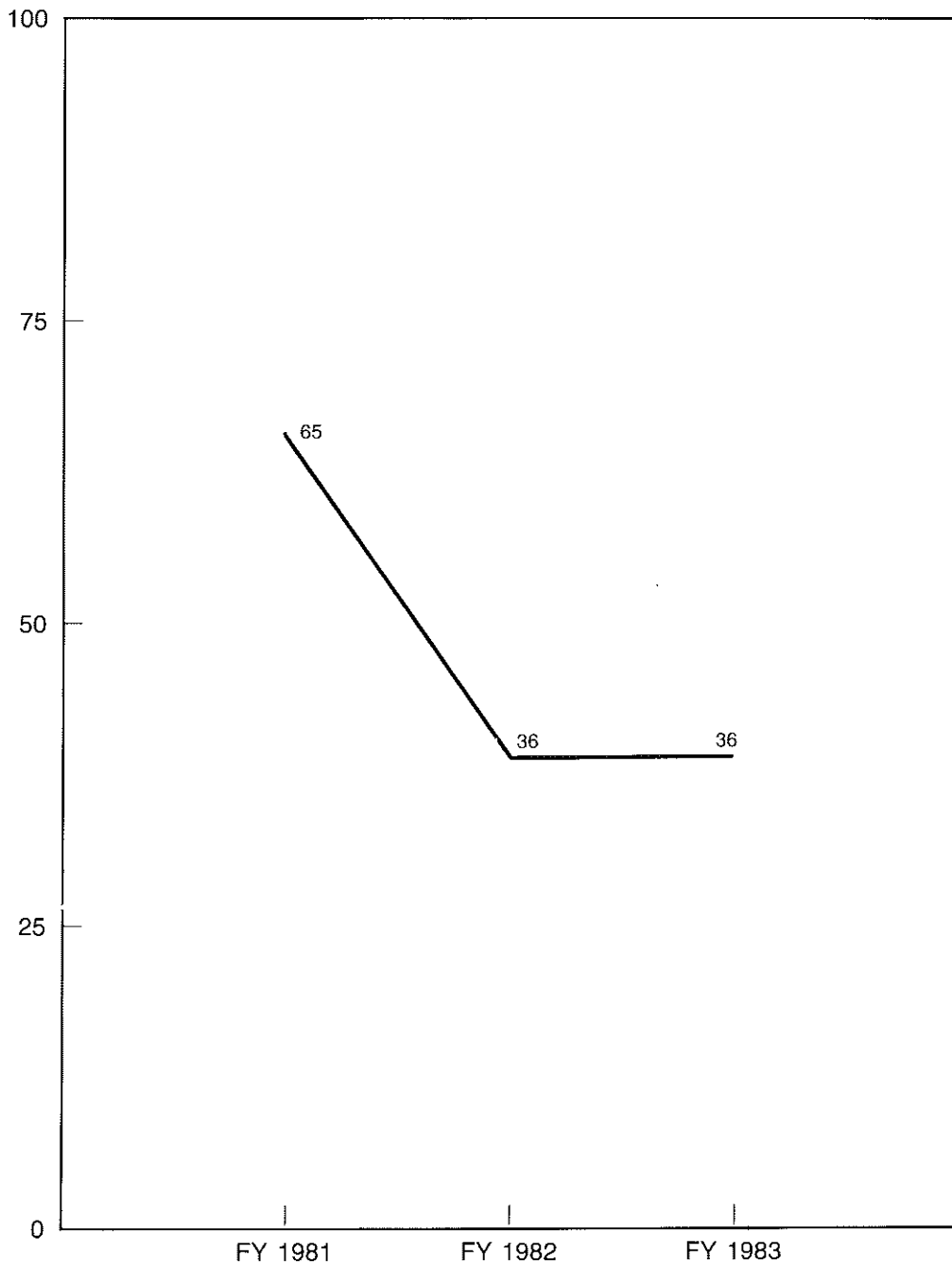


Concurrences



RATE OF DECLINATIONS FOR PROSECUTIONS FY 1981 THROUGH FY 1983

PERCENTAGE
OF DECLINATIONS



MANAGEMENT IMPLICATIONS REPORTS BY PROGRAM AREA First and Second Halves of FY 1983

NUMBER OF
REPORTS

