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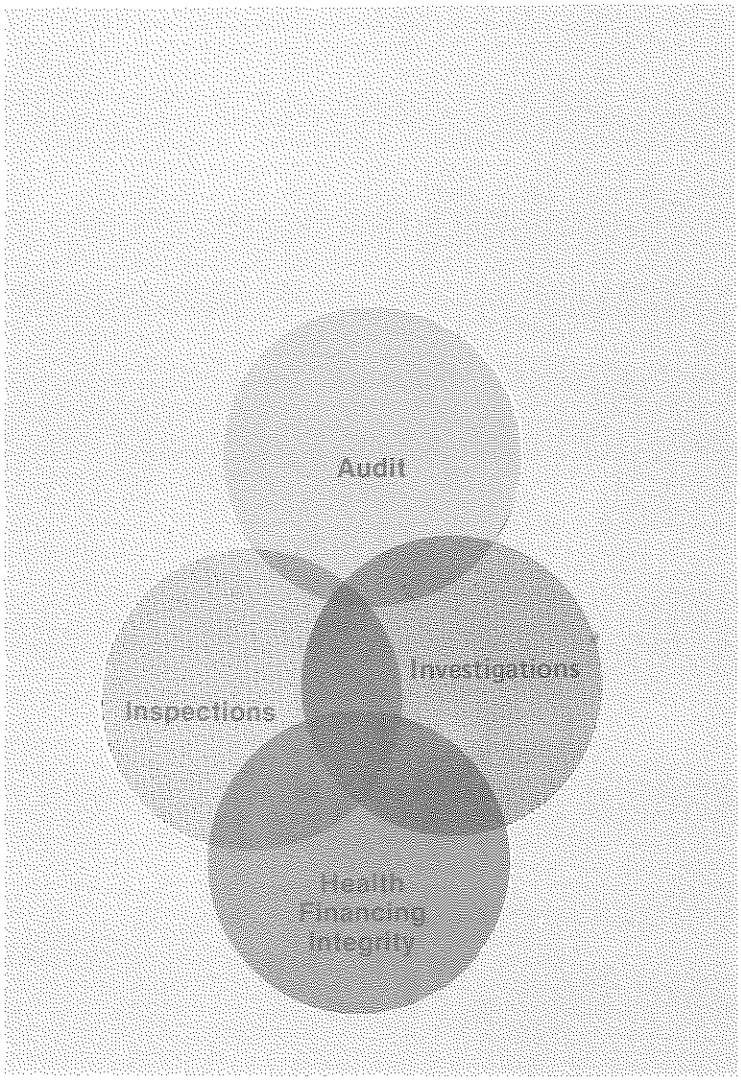
Department of Health and Human Services
Richard P. Kusserow
Inspector General

OFFICE OF INSPECTOR GENERAL



Semiannual Report

October 1, 1982 - March 31, 1983

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

FINANCIAL FINDINGS

OCTOBER 1, 1982 - MARCH 31, 1983*

OIG Component	Cost Avoidances/ Savings	Recoveries	Totals
AUDIT	$501.5	$167.0	$668.5
PROGRAM INSPECTIONS	97.0	-	97.0
INVESTIGATIONS	5.5	34.0	39.5
HEALTH FINANCING INTEGRITY	24.0	7.0	31.0
TOTALS	$628.0	$208.0	$836.0

*In Millions.

Overview and Highlights

This Semi-Annual Report for the first half of the fiscal year, October 1, 1982 - March 31, 1983, marks a change in the reporting requirements for the Office of Inspector General (OIG) in the Department of Health and Human Services (HHS). Previous reporting requirements were on an annual, calendar year basis. A revision in the law by Congress now makes the HHS/OIG semi-annual reporting requirements congruent with those of other Federal Inspectors General.

The first Semi-Annual Report features a number of accomplishments by the Office of Inspector General, which are highlighted below. Activities involved with the President's Council on Integrity and Efficiency (PCIE) and with the Federal Inspectors General committee to promote efforts for the prevention of fraud, waste and abuse formed a major focus of activity for the Inspector General's Office for the period covered by the report. Because of substantially increased emphasis on the prevention facets of our activity and the resources devoted to PCIE projects, there has been a large increase in the savings resulting from management commitments to more efficiently use resources. Similarly, the number of successful case actions and consequent monetary recoveries has also increased dramatically.

The use of administrative subpoenas has also proved an effective tool in obtaining information necessary for the proper conduct of investigations and audits. During the time period October 1, 1982 through March 31, 1983, a total of eight subpoenas were issued. Of those eight, none was contested. It should be noted that the OIG anticipates a sizeable increase in the number of subpoenas to be issued in the future. This is attributable to the increase in staff within OIG, the new OIG responsibilities for suspending providers from Medicare and imposing civil money penalties for the filing of false health claims, and the planned streamlining of procedures for securing an administrative subpoena.

Highlights of the Semi-Annual Report:

- OIG has been working with five other Federal agencies on Government-wide cash management problems. Recommendations already made, if implemented, could save hundreds of millions of dollars annually.

- A study of computer-related fraud and abuse is being headed for the President's Council on Integrity and Efficiency. It is designed to heighten awareness of the vulnerabilities of computerized systems.

- An inventory of State Computer Matching Technology was developed and "Standardized Data Extraction Formats" were prepared as part of the long-term computer matching project.

- Two computer programs called "Project Clean Data" have been designed to assist State and Federal agencies in identifying incorrect or fraudulent Social Security Numbers.

- A major study of the technological options to address the problem of false identification documents was conducted and disseminated to states.

- Based on a Service Delivery Assessment, the Secretary instructed the Health Care Financing Administration to completely redesign the Explanation of Benefits Form sent to beneficiaries.

- An examination of the Child Support Enforcement Program led the Secretary to decide to change the financing of the program.

- A review of convicted providers in Medicare and Medicaid resulted in findings being used to develop profiles of convicted providers.

- Eliminating payments for attorneys fees from SSA's manual disability claims processing system will save $7 million annually.

- Improving procedures to validate data submitted by States in converting cases from AFDC to SSI can save $2.5 million annually.

- Extending the "administrative finality" to more than the present two-year period could save SSA $13.6 million, if action is taken immediately.

- Increasing the frequency of Social Security contributions (FICA) will increase trust fund income by $1.1 billion.

- Requiring mandatory second surgical opinions for selected types of elective surgery could save Medicare and Medicaid $157 million annually.

- Arranging for a more favorable price for cardiac pacemakers similar to prices available under GSA schedule contracts could save the Medicare program an estimated $64 million annually.

- Using sophisticated computer applications, auditors identified millions in potentially unallowable charges to Medicare and Medicaid.

- Eliminating unnecessary and costly periodic level of care recertifications for recipients in Intermediate Care Facilities could save HCFA an estimated $60 million annually.

- Extending Medicare's "lowest charge provision" to additional non-physician services could save Medicare $80 million annually.

- Lowering the rate that Medicare pays certain proprietary health care facilities for their return on equity capital--generally the amount invested by owners--could save an estimated $100 million annually.

- Continuing problems still found in States' claims for services provided by Intermediate Care Facilities.

- Monitoring is still needed over the disposition of assets associated with PHS close down of hospitals and clinics.

- Better monitoring by PHS of the Nursing Student Loan program could reduce excess Federal cash totaling $76 million on medical student loans resulting in savings of $12 million in unnecessary interest expense.

- Concerted efforts have resulted in a 47% reduction in the backlog of cases to be investigated and a 52% increase in the number of positive judicial actions over those for the same period last year.

- Computer matches of SSA beneficiary rolls against HCFA decendent records resulted in 81 convictions and more than $1.3 million in fines, restitutions and recoveries during the past six months.

- The 31 State Medicaid Fraud Control Units reported a total of 513 indictments, 390 convictions and $18,201,987 in fines, restitutions and overpayments in 1982.

- Installation of a toll-free telephone number for the OIG Hotline has tripled the number of incoming calls.

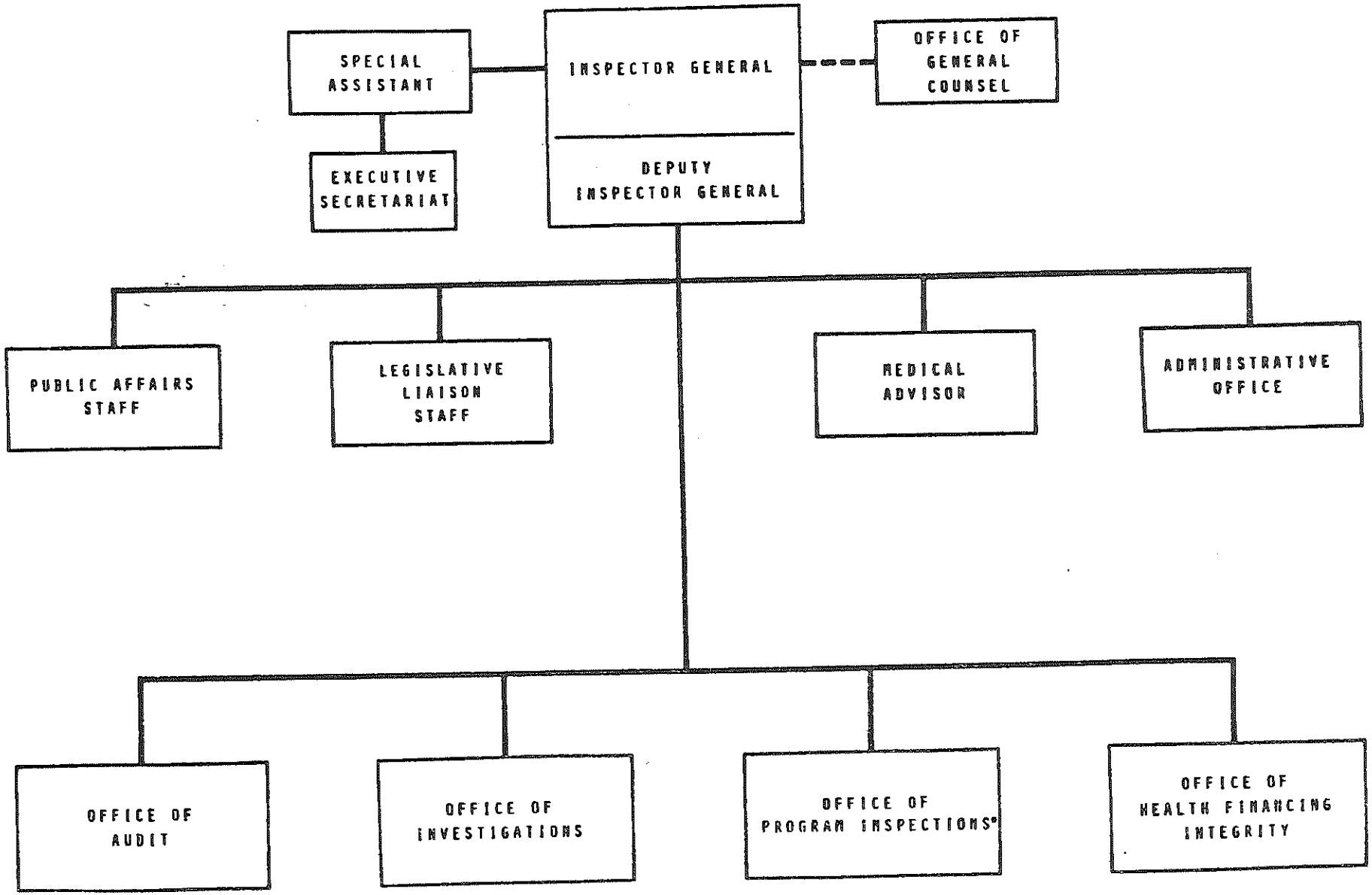
- A program inspection of the policies relating to reimbursement for prosthetic lenses resulted in a recommendation to the Health Care Financing Administration that reimbursement for contact lenses and cataract spectacles be restricted to cost plus a separate amount for lens fitting. It was demonstrated by the inspection that in 1979 program savings of $3,153,415 in the States of Florida and Georgia alone would have been achieved by this change in Medicare policy.

- A program inspection of bills for oxygen concentrators in the New York Region found that 83 percent of the beneficiaries did not use sufficient amount of oxygen to justify the cost of the concentrator rental. The Health Care Financing Administration has taken the necessary steps to insure the least costly medically appropriate system is the basis for reimbursement in the future. This action will result in a cost savings of $2.18 million to the Medicare program.

- A program inspection review was conducted of rehabilitation agencies in Michigan. This review showed the physical therapy modalities utilized by the providers in this review were not reasonable and necessary for the patients' conditions. The intermediary has now developed guidelines specific to diagnosis, type of modalities and duration of treatment for processing and payment of claims. Cost avoidance savings of $3,000,000 in the Medicare program are attributable to development of these guidelines for payment of claims. These preceding three reviews were conducted by HCFA's program validation staff, some of who are now assigned to the Office of Health ~~Care~~ Financing Integrity of the OIG.

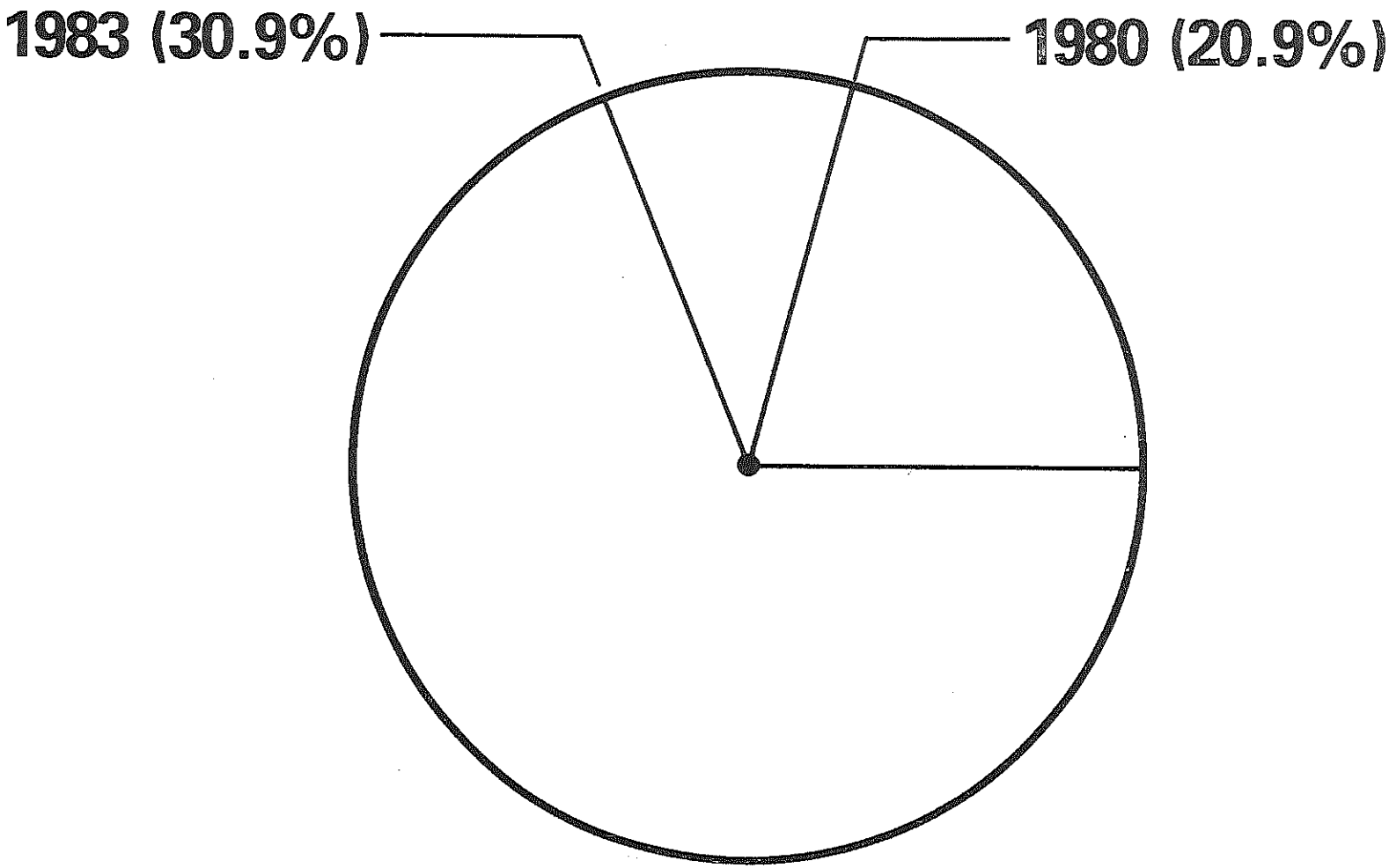
  Staff increases and a reorganization contributed to an increase in the number of women and minorities employed in the Office of Inspector General. Charts illustrating this trend follow.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

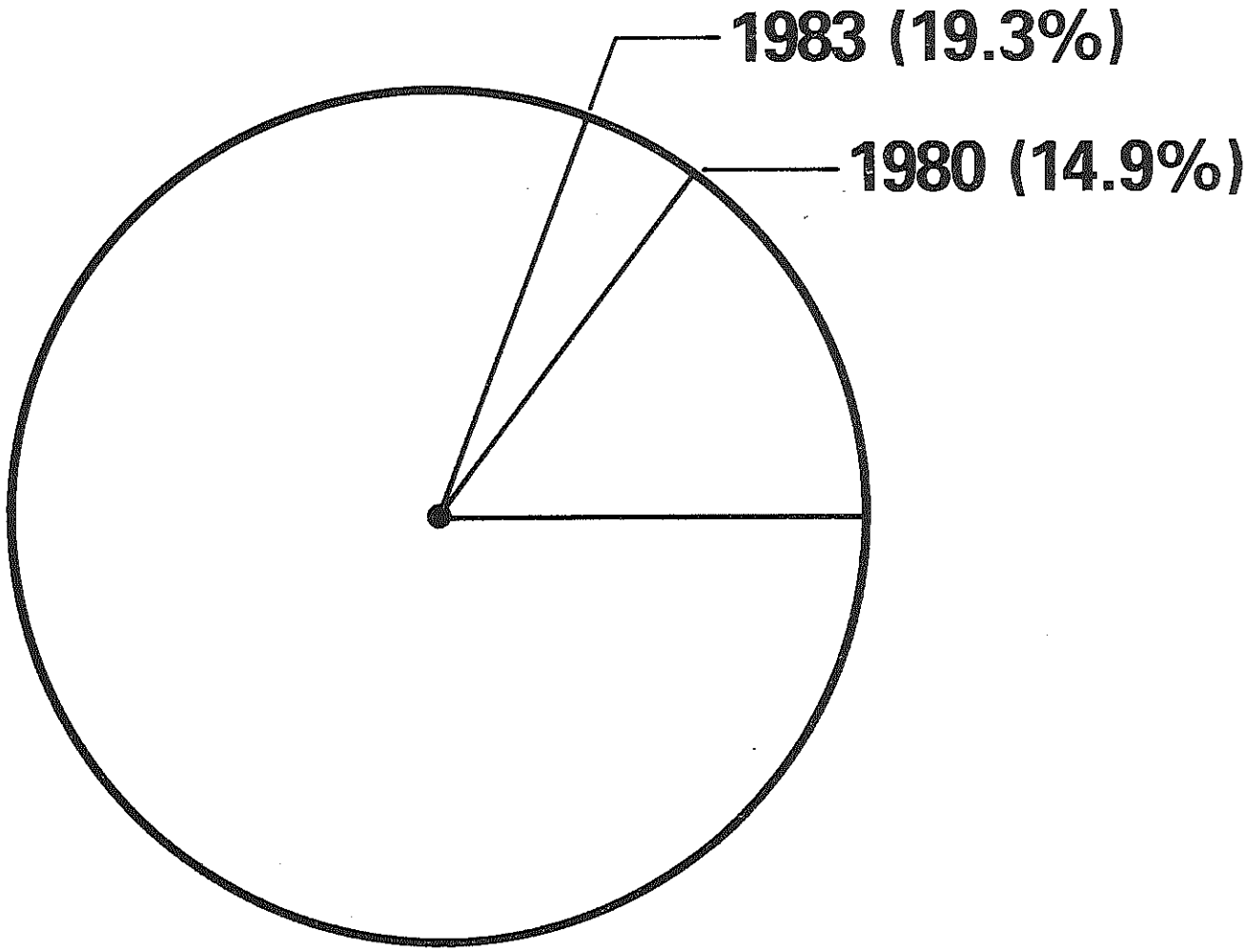


PENDING PUBLICATION IN THE FEDERAL REGISTER

INCREASE OF FEMALES IN THE OIG WORKFORCE, 1980-1983



INCREASE OF MINORITIES IN THE OIG WORKFORCE, 1980-1983



PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

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The President's Council on Integrity and Efficiency (PCIE) is composed of eighteen Inspectors General and representatives of other agencies of the Federal government. The HHS Office of Inspector General conducted several PCIE projects:

o The Department has been working with five other Federal agencies in looking into Government-wide cash management problems. — CASH MANAGEMENT

Preliminary survey work on this project involved evaluating the Department's systems for management and administration of various cash advance funding techniques. Auditors concluded millions of dollars could be saved by consolidating six existing cash advancing systems into one and accelerating implementation and use of improved cash advancing techniques to insure better matching of funds with grantee needs. Appropriate recommendations will be made.

Field work will begin in June 1983 with final summary reports on this audit scheduled to be issued in December 1983.

We have already recommended to Treasury's IG that he coordinate a nationwide study under the auspices of Reform '88 to determine the feasibility of consolidating all Federal cash advancing systems into one. Such a consolidation could conservatively save hundreds of millions of dollars annually.

o The Department has about 142,000 employees with $1.6 billion in annual salary costs. As part of a PCIE project to look into areas of payroll operation most susceptible to fraud, abuse and waste, we examined the propriety of payroll deductions for health insurance and retirement benefits. Auditors found the Department was generally administering these areas properly. — PAYROLL OPERATIONS

We also scheduled reviews to determine whether manual adjustments to employees pay are properly authorized, adequately calculated at authorized rates, and adequately supported and reviewed by supervisory personnel. In addition, we will look at whether special pay benefits for physicians are administered economically and in accordance with Federal regulations.

GOVERNMENT-FURNISHED MATERIAL AND PROPERTY

o The Department provides or funds the purchase of material and property used by grantees and contractors for Federal projects. About $47 million in property furnished or funded by the Department is now in the hands of grantees and contractors.

This PCIE project looked into whether the management and administrative systems applicable to government-furnished property provide adequate safeguards for its care, use and final disposition or return. Survey work to date has not disclosed any problems. We have also provided staff for special review teams headed by the Defense Audit Service in four regions. The PCIE plans to publish the results of this review later this spring.

COMPUTER-RELATED FRAUD AND ABUSE

o The HHS-IG is leading a study of computer-related fraud and abuse for the President's Council on Integrity and Efficiency (PCIE). The task force which he chairs includes experts in computer auditing and computer security from the Departments of Agriculture, Commerce, Defense, and Treasury; the National Aeronautics and Space Administration; and the General Accounting Office.

The study, which is the first systematic survey of computer-related fraud and abuse in Government, is designed to heighten awareness of the vulnerabilities of computerized systems and to assess the need for increased computer security expertise in the Inspector General community. The study is being conducted in a two-phase approach: a survey stage and a follow-up interview stage. The survey stage is now complete and an interim report will be issued to PCIE shortly.

The study will feed into the PCIE initiative on prevention, as well as the President's Reform '88 effort to improve government management. The findings and recommendations will also be coordinated with the PCIE Computer Audit Council to integrate with their work on training curricula for the audit and investigative staffs in OIG. Within HHS, the finding of the study on computer-related fraud and abuse will be used by the EDP Audit Division for reviews of computer-based systems and by the investigative staff for refinement of investigative techniques.

The Senate Governmental Affairs Committee has recently indicated interest in holding hearings on computer crime later this year. In the House of Representatives, Congressman Bill Nelson (Florida) reintroduced the Federal Computer Systems Protection Act (H.R. 1092) on January 31, 1983.

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. Among the significant accomplishments of the project are the development of an "Inventory of State Computer Matching Technology".

  The inventory contains a description of States' matching activities, the computer language, the type of hardware used, the Federal Assistance Programs affected, and the savings resulted from the matches. Copies of the inventory have been disseminated to other Federal agencies, all States, the Congress, and others.

  The project is now pursuing a number of tasks in the third phase of computer matching initiatives, including (1) documentation of cost-effectiveness and best practices in computer matching, (2) field testing of standardized formats (discussed below), and (3) identification of non-benefit matches. The project's newsletter and clearinghouse activities, which have proven highly successful, will continue during this phase.

STANDARDIZED DATA EXTRACTION FORMATS

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

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 a number of 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 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.

INSPECTIONS

- Forty-seven inspections were completed during the first 6 months of the year. These inspections revealed overpayments of $7,010,295 for Medicare and Medicaid services, as well as cost avoidance savings of $24,261,802.

PROVIDER CLEARINGHOUSE PROJECT

- 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. We are working to computerize this data during Fiscal Year 1983, and have developed a form to be used by contributing entities to provide initial and update information.

COMPUTER DETECTION SCRE PROJECT

- A 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. Information gained by this project will also serve as the basis for designing new computer screens. At the present time a vulnerability assessment questionnaire has been prepared to be sent to other Federal, State, and private sector organizations in the health field. In addition, a clearinghouse newsletter has been designed and the operating procedures for the clearinghouse are near completion.

VA-MEDICARE MATCH

- OIG has begun 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. At the present time a computer program is being developed to select the sample beneficiaries to be used in the project. There are indications of a potential $11 million in overpayment during a 2½-year period.

SUSPENSION AND DEBARMENT

- Office of Investigation staff worked on a task force for studying the feasibility of a government-wide suspension and debarment system. DHHS exclusion mechanisms for grants, contracts and other discretionary funding programs were surveyed, along with those of other Departments. The report recommended that a uniform government-wide system be imposed.

ADMINISTRATIVE SANCTIONS

- OI reviewed and commented on a PCIE proposal for a coordinated approach to imposing sanctions against Federal employees for misconduct, as well as the use of incentive awards for employees who disclose instances of fraud, waste and abuse.

PROPOSED COMPUTER MATCH CLEARINGHOUSE

- Work on the Fraud Prevention Subgroup of the PCIE Working Group on Match Opportunities resulted in a proposal which is under IG review. The proposal calls for creation of a centralized computer matching service center which would give technical assistance and serve as a clearinghouse for Federal and State agencies interested in performing computer matches.

PREVENTION ACTIVITIES

PREVENTION ACTIVITIES

The Federal Inspectors General, working in cooperation with the President's Council on Integrity and Efficiency have formed a committee to promote efforts for the prevention of fraud, waste and abuse. The HHS/OIG has conducted several projects as part of the prevention effort, and undertaken a number of prevention-related activities.

SECRETARIAL BRIEFING PAPERS ON COMPUTER TECHNIQUES AND RECIPIENT FRAUD

o The newly restructured Office of Program Inspections recently completed two exhaustive reports for the Secretary on the OIG's use of computers and on recipient fraud. The former discusses the OIG's progress in using computer technology to speed up our traditional functions of audit and investigation; and, on a proactive basis, to detect and prevent instances of fraud, waste and abuse in HHS programs. It presents a brief historical overview of OIG activities, including a description of why we use computer technology and the safeguards we are taking to protect the individual's rights of privacy. It also highlights the nature and accomplishments of some of our most important efforts (i.e., matches and screens). Finally, the report discusses the current OIG role in the President's Council on Integrity and Efficiency (PCIE) computer-related projects, principally the Long-Term Computer Match Project and the Computer Security Project.

The report on recipient fraud synthesizes the current studies and intiatives by the OIG and the HHS operating divisions addressing the problem. It discusses the fact that the extent of recipient fraud is unknown, although a General Accounting Office study found that 18 percent of the known fraud cases involved recipients. The paper describes the basic methods with which recipients defraud HHS programs and describes many projects and ongoing activities, such as computer matches, technical assistance products (e.g., False Identification Study), system reviews (e.g., Review of SSN Issuance System), and computer screens (e.g, Project Clean Data).

While intended primarily as briefing documents, these pieces also enable the OIG to better understand and focus its own future efforts in these critical areas.

PROJECT CLEAN DATA

- 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.

  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). One program identifies 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 60 agencies in 40 States and to several Federal agencies. Many States reported identifying thousands of incorrect SSNs in their data files. SSNs being used fraudulently also have been identified. The OIG will continue to distribute these programs in an effort to facilitate computer matching.

FALSE IDENTIFICATION

- In June 1982, the OIG/OPI began a review of identification security techniques and alternate issuance systems, in response to the increasing incidence of lost, stolen and forged public assistance checks and food stamp Authorizations-to-Purchase (ATPs), and Congress' growing concern over the use of falsified documents in obtaining welfare benefits. From our earlier review of alternate delivery systems, and our understanding of the rapid technological advances in the areas of electronics and document security, we determined that such a study would be of value to States and other governmental entities seeking ways to reduce fraud and abuse in their benefit programs. The report discusses the following questions:

- what is meant by identification security?

- what is the current state-of-the-art in identification technology? and,

- what electronic measures are available to further tighten security over the benefit issuance process?

The report, to be viewed as a resource/technical assistance piece, makes no specific recommendations concerning secure identification or alterante delivery systems. On-the-contrary, the review led us to believe that no one system would be appropriate and cost-effective for all jurisdictions and programs. The final report has been distributed to all Federal OIGs, State Welfare and Medicaid Agencies, State Fraud Units, and key Congressional Committees, among others.

VULNERABILITY IDENTIFICATION

o Besides catching criminals and recovering Department monies, Office of Investigations has a major fraud prevention objective. Actions to achieve this objective are interwoven with the fabric of day-to-day operations, occasionally emerging as discrete activities. These prevention activities may be generally classified as vulnerability identification, communications and awareness, and elimination of fraudulent activities.

Vulnerability identification takes several forms.

- In their reviews of proposed Department program regulations and policy statements, OI staff identifies weaknesses which might permit or encourage program fraud.

- Allegations brought to OI attention which do not require full field investigations but which could indicate problems are referred to appropriate OIG components for further review or audit.

- Conditions observed in specific cases which could be changed on the spot to prevent fraud are brought to the attention of on-site managers.

- Security and protection specialists survey Department buildings and work areas and advise managers on safeguarding property and preventing physical attacks.

- General program weaknesses or needs for control which are observed during investigations are described in Management Implications Reports (MIRs). The MIRs are examined by OIG program analysts who then recommend system or regulatory changes and other preventive measures to top program management. During this reporting period 20 MIRs were prepared.

COMMUNICATIONS AND AWARENESS

o Arrests, indictments, convictions and sentences of those who defraud Department programs undoubtedly are deterrents to others who might consider similar actions--but only if they know about these penalties. Thus an aggressive public awareness program is essential. OI gives the Public Affairs Officer advanced notices of important events, and works with the media throughout the nation to obtain coverage. The grouping of related cases into major projects, such as the SSA Benefits Project, also encourages fuller news coverage.

TRAINING DEPARTMENT EMPLOYEES

o Communications and awareness as prevention activities are also extended to cover Department employees. For example, SSA employees--particularly new ones--working in areas frequented by persons smuggling illegal aliens are instructed on recognizing and dealing with attempts at bribery or subversion to obtain false social security documents. They are also trained to detect counterfeit or false immigration documents. Similarly, FDA inspectors are being alerted to recognize subtle attempts by regulated business to influence the inspection process. A combined live and video fraud-awareness program for all Department employees, which is nearly completed, will alert them to their responsibilities for preventing and detecting misuse of Federal funds.

o Representatives of Reader's Digest and the Miami Herald have recently interviewed the Assistant Inspector General for Health Financing Integrity. These interviews have served as a mechanism to make more people aware of the work of this Office and the fraud and abuse problems in the Medicare and Medicaid programs. In addition to acting as a deterrant to potential abusers of the programs, they provide individuals who believe fraud and abuse have taken place with a channel to make their complaints.	INTERVIEWS BY NATIONAL PUBLICATIONS
o A speech was given to the Medicare/Medicaid Law Institute. As with the interviews, this speech made the participants aware of the work of the Office, and the measures available to punish fraudulent or abusive acts against the programs.	SPEECH TO MEDICARE/MEDICAID LAW INSTITUTE
o OIG regional offices have met with every Medicare contractor and Medicaid State agency to acquaint them with the operation of the Inspector General's Office. These meetings have ensured the contractors and State agencies have an understanding of the IG's mission.	MEETINGS WITH MEDICARE CONTRACTORS AND MEDICAID STATE AGENCIES
o A member of our Chicago regional staff has served as an advisor to the United Council on Welfare Fraud in designing the 1983 training program. This effort will result in attendees at the training program in Harrisburg, Pennsylvania in June gaining a knowledge of the OIG's Office of Health Financing Integrity and an awareness of our efforts in the fraud and abuse area.	ADVISOR TO UNITED COUNCIL ON WELFARE FRAUD
o In FY 82 Part A Medicare contractors cleared 135 cases of abuse and established overpayments of $1,788,073. In the first three months of this fiscal year, based on available data, Part A Medicare contractors have identified 27 cases and established overpayments of $2,723,321, almost a million dollars more than the entire previous fiscal year.	STATE MEDICAID AGENCIES AND MEDICARE CONTRACTORS EFFORTS

COMMUNITY AWARENESS EFFORTS

o Regional Office prevention activities:

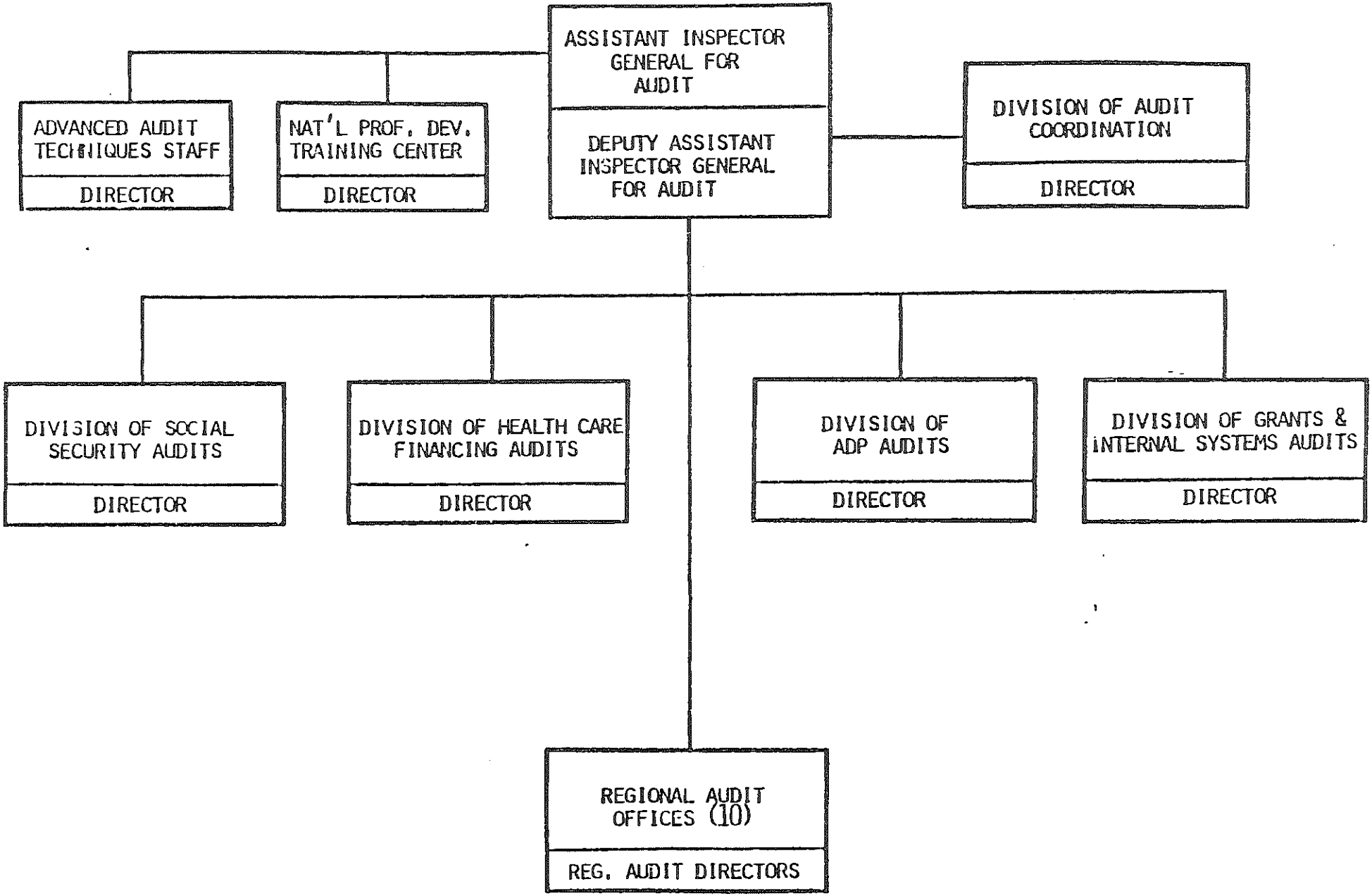
- To restrict increasing costs of health care, Region I staff presented "Corporate Responses to Maintaining Health Care Costs" at a forum of the New England Human Services Coalition. This forum was held in Boston, Massachusetts and involved the Directors of the State Human Services Coalitions of the six New England states.

- To improve the management of mental health services, Region X staff consulted for Kane County Department of Rehabilitation Services on appropriate designs for mental health evaluations.

- To broadcast the Inspector General's efforts against fraud, waste, abuse and inefficiency, Region X staff spoke on a central California radio talk show, both providing information about the OIG and answering questions called in by the listening audience.

OFFICE OF AUDIT

OFFICE OF AUDIT



OFFICE OF AUDIT

REDIRECTION TAKING HOLD

The first six months of FY 1983 showed measurable progress in redirecting audit resources into the Department's largest and most expensive responsibilities--social security and health. The work of the Inspector General (IG) in seeing that the single-audit concept is implemented allowed the Office of Audit to place increased emphasis on programs more susceptible to fraud, waste, and mismanagement (see Exhibit A).

In consonance with this redirection, the scope of many audits took on a new format. Past audits were primarily financial in nature with emphasis on the allowability of charges for selected transactions. The thrust of many of our new audits is going beyond the review of transactions and searching out problem areas from a larger, more systemic perspective. For example, auditors are looking at whether: (1) various procurement and billing practices are efficient and economical, and (2) legislation resulted in the most efficient and economical delivery of health services.

The Office of Audit is in the forefront in use of advanced audit techniques, including the use of computer auditing. More sophisticated computer screens (checks) and analysis techniques are being developed. In addition, our Computer Audit Division is currently involved in a several man-year task of overseeing the overhaul of the Social Security Administration's mammoth computer system.

Statistically, the number of reports issued has declined because of the redirection and start-up time needed on new assignments. The bulk of the drop was due to reduction of contract closing,

university, and State and local government-type audits. However, as auditors moved into new and more complex areas, cost avoidances/savings rose substantially.

Reports Issued This Period By OPDIV and OS				
SSA 23	HCFA 130	PHS 803	OHDS 776	OS 140

Cost savings, as used in this report, refer to areas where Department managers have made a formal commitment to implement audit recommendations. Action taken or planned should: (1) prevent improper expenditures/obligations of agency funds in the future, and/or (2) improve agency systems and operations thereby avoiding unnecessary expenditures.

Cost savings differ substantially from costs questioned in that (1) savings relate to future periods and cost questioned with past periods and (2) savings deal with improvements/refinements or elimination of unnecessary expenditures whereas, questioned cost pertains to: violations of regulations, law, or cost principles.

From October 1982 through March 1983, Department managers agreed to take action on audit recommendations containing cost saving features totaling $669 million (see Exhibits B, C, and J). Some of these items are not discussed in this report since many of the findings were contained in reports issued during prior periods.

This report discusses areas in Health and Social Security Programs where an estimated $484.1 million can be saved if regulatory or legislative changes are made. Some of these items have not yet been agreed upon by responsible officials and are not included in the cost savings figure.

OIG AUDIT REDIRECTION

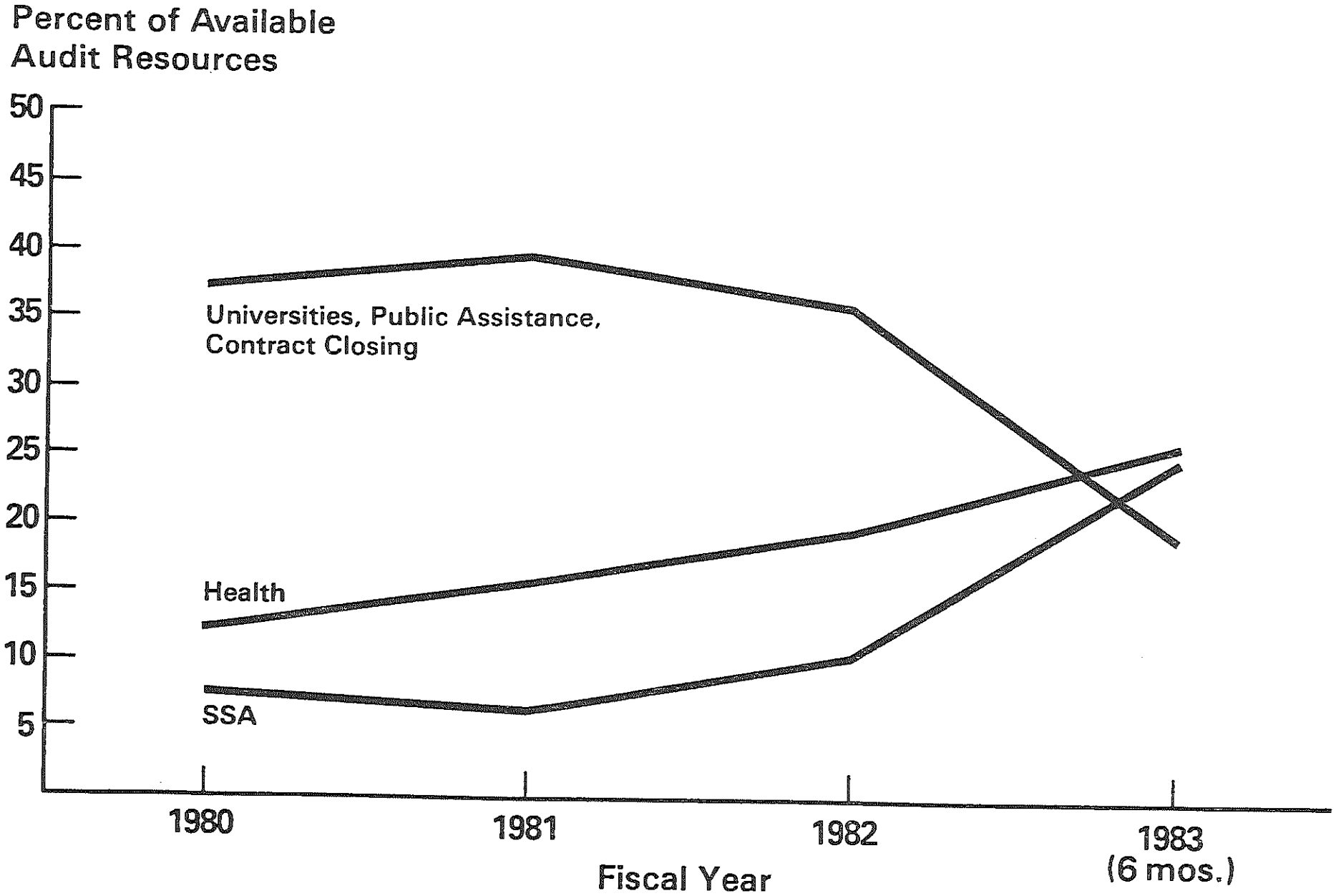
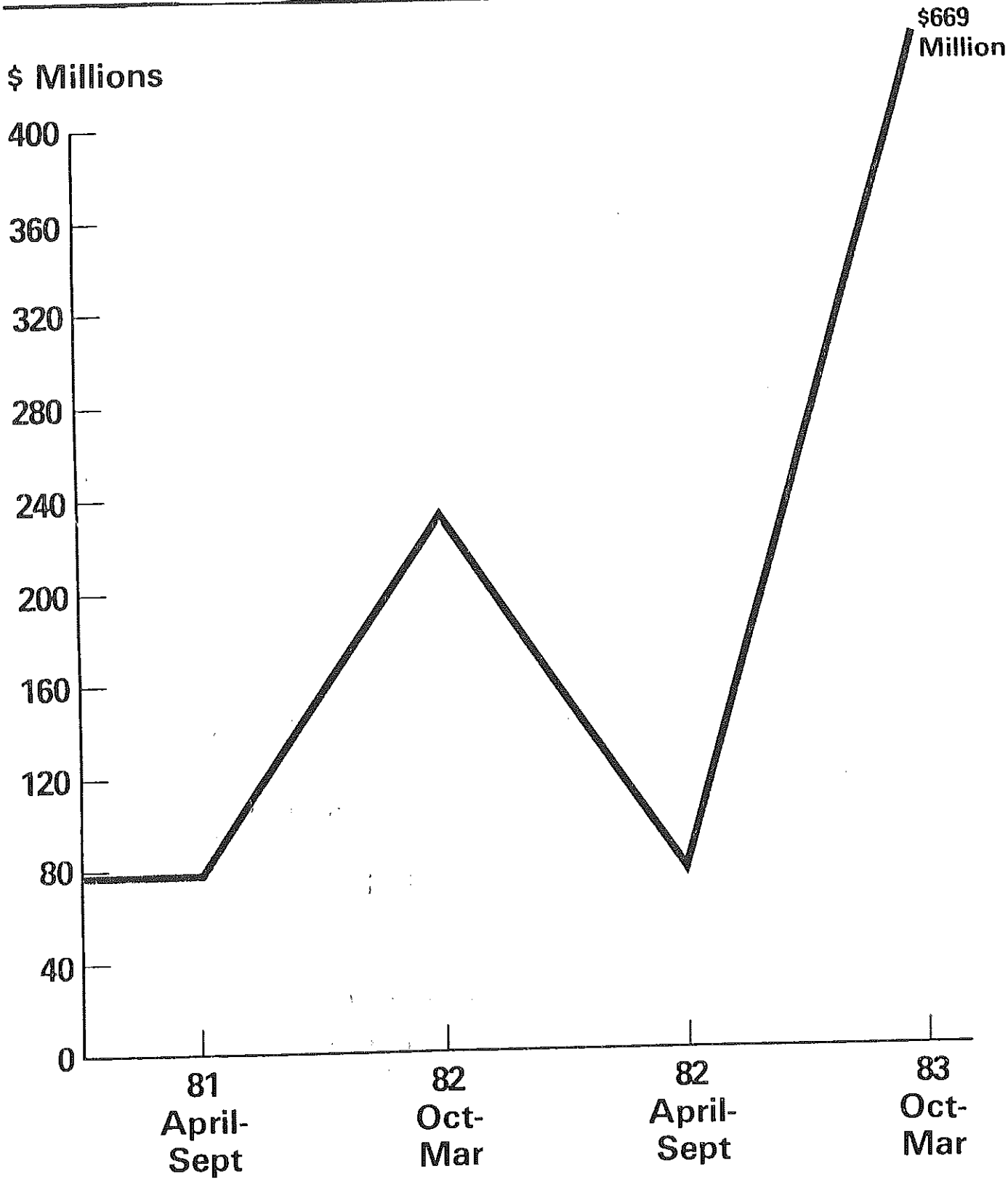


EXHIBIT A

EXHIBIT B

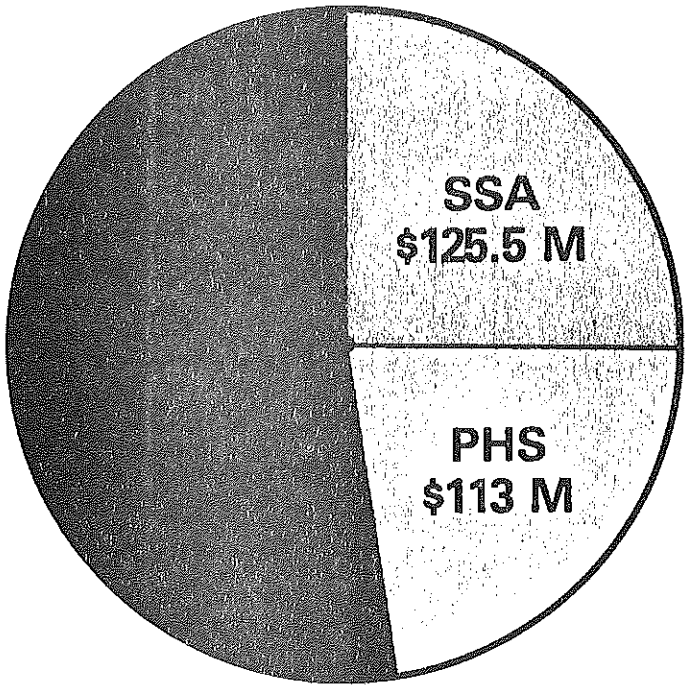
COST SAVINGS/AUDIT CONCURRENCES *
APRIL 1981 - MARCH 1983



*An analysis of Audit cost savings is shown at Exhibit J, 1 through 3.

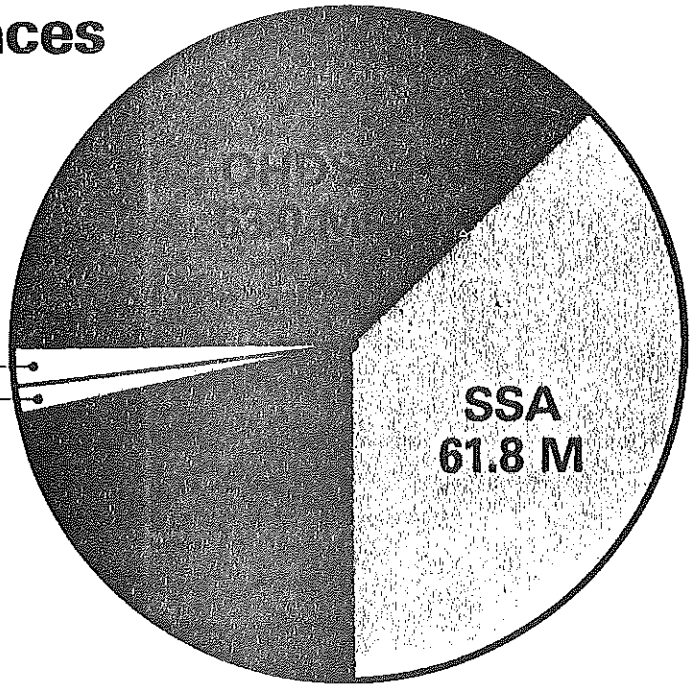
COST SAVINGS AND CONCURRENCES BY OPERATING DIVISION OCTOBER 1, 1982 - MARCH 31, 1983

Savings



$502 MILLION 1/

Concurrences



$167 MILLION

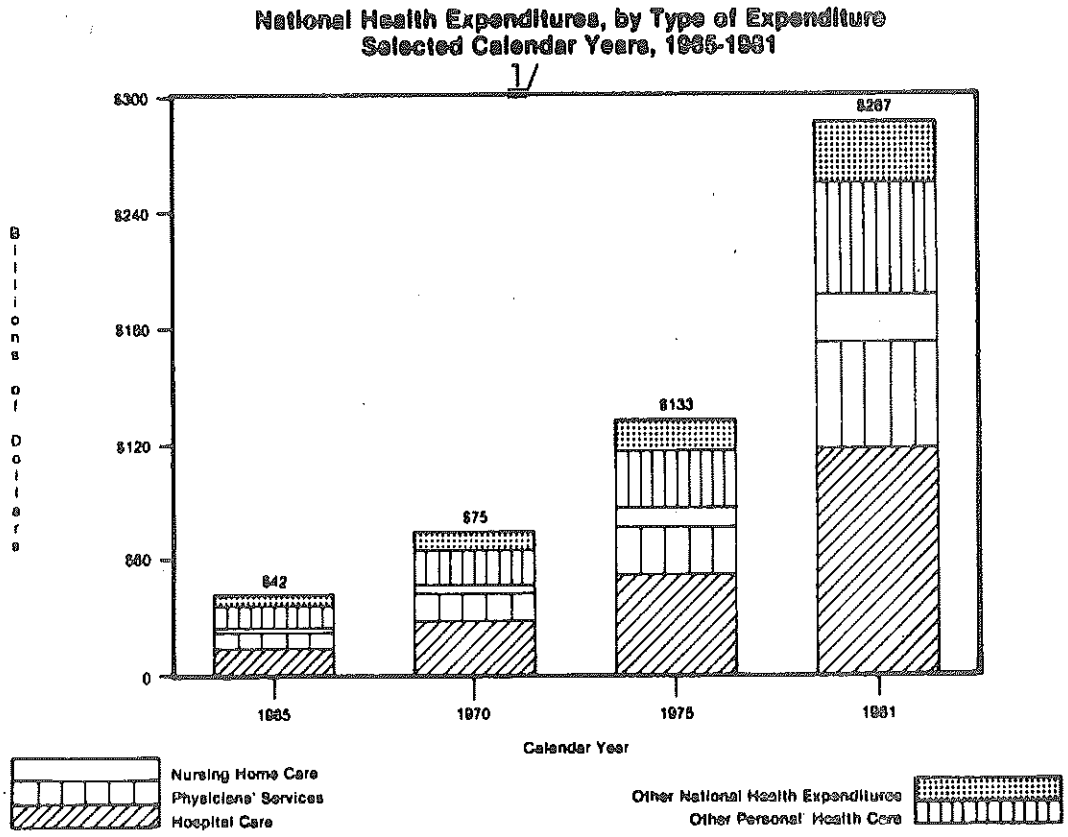
1/ See Exhibit J for further breakout of savings.

OFFICE OF AUDIT

Health Care Financing Administration

HEALTH CARE FINANCING ADMINISTRATION

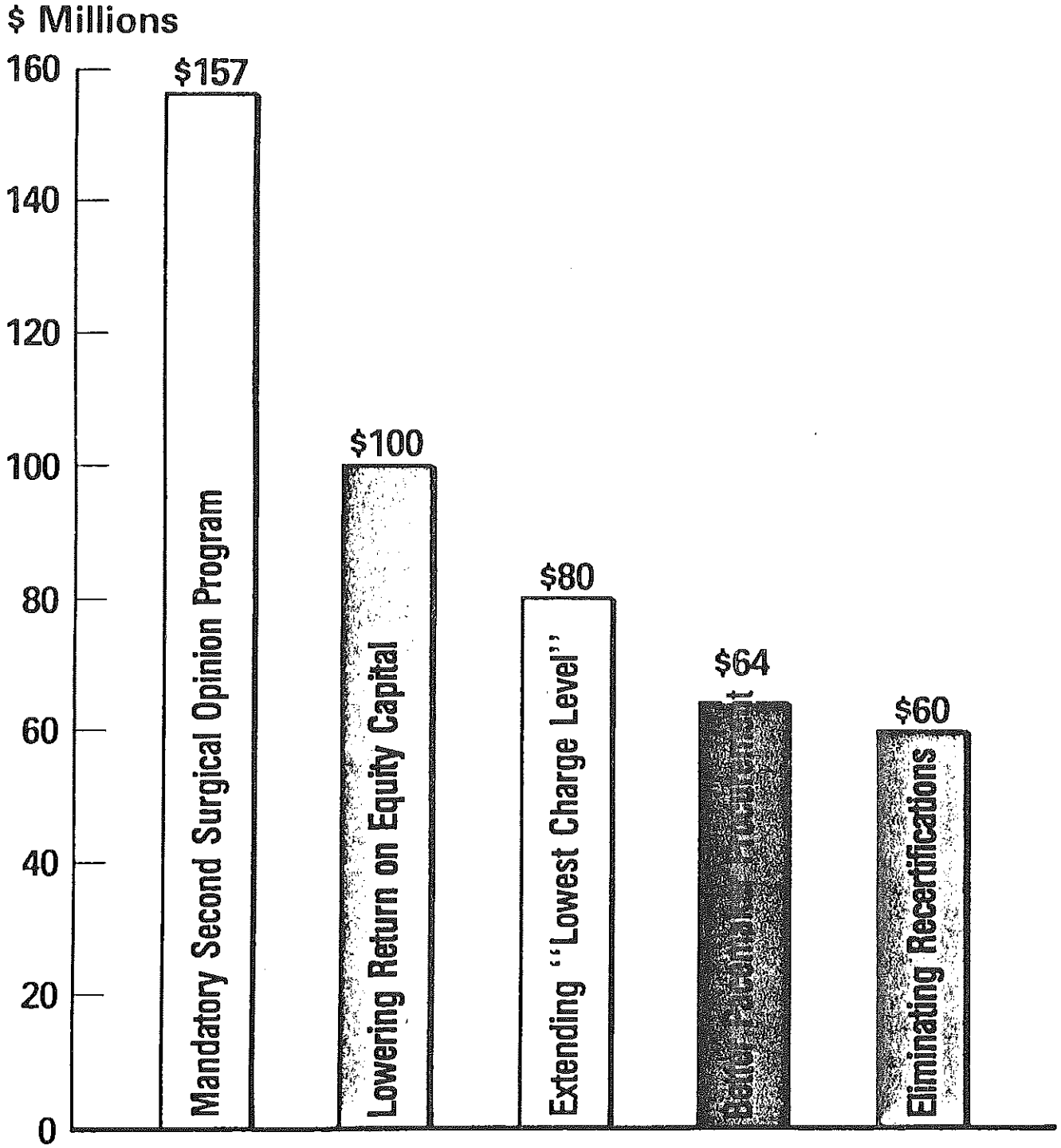
With proposed FY 1983 expenditures of $57 billion and $19 billion, respectively, Medicare and Medicaid together represent the Department's second largest budgetary outlay. A major concern of the Administration and the public is the rising cost of medical care. As shown below, since 1965, health care expenditures have grown at an average annual rate of 12.8 percent. The most alarming increase came in 1980 with 15.8 percent--the highest increase in the last 15 years. These staggering costs are passed on to Government programs, patients, and third parties as shown in the following chart.



1/Source: Health Care Financing Review, Volume 4 September 1982, Page 4.

—— $461 MILLION ——

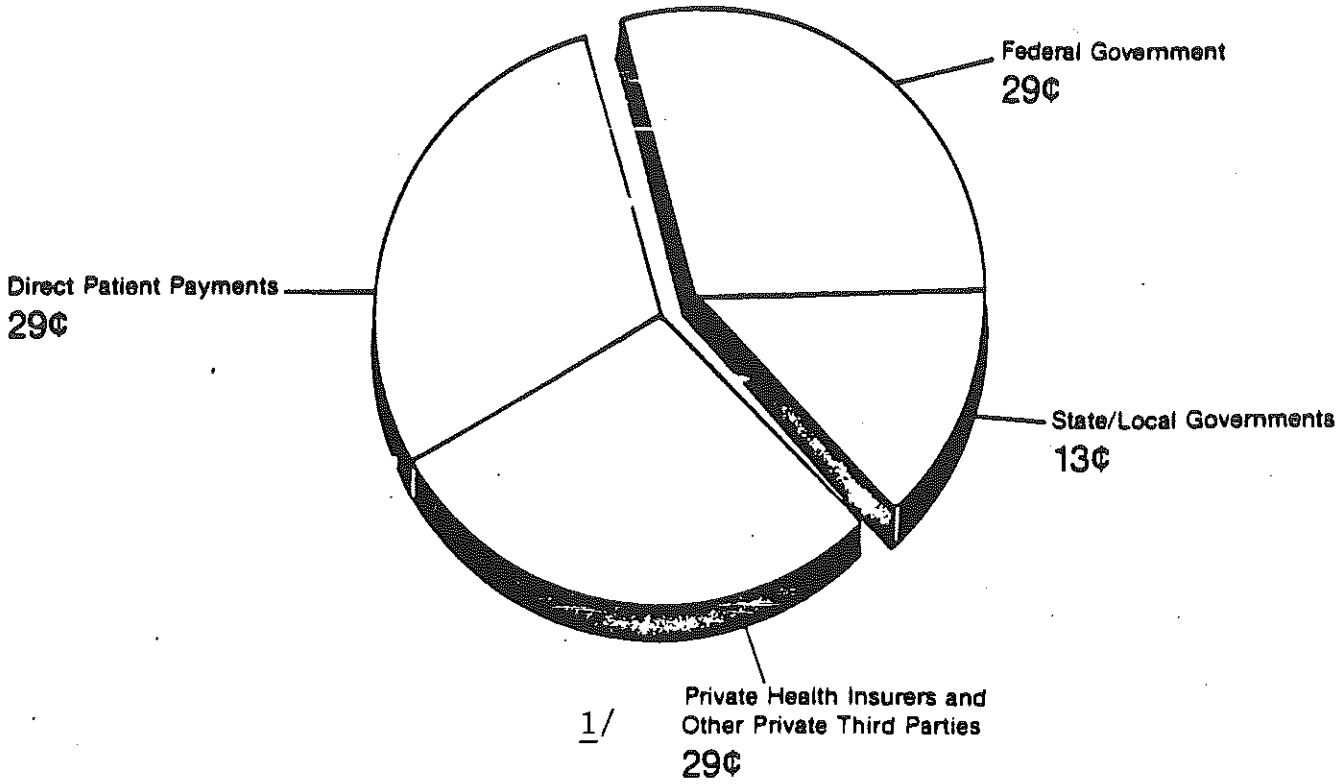
COST SAVINGS IF INSPECTOR GENERAL HEALTH RECOMMENDATIONS ARE IMPLEMENTED



October 1982 through March 30, 1983

The Nation's Health Dollar in 1981

where it comes from...



1/

In line with the Administration's intent to cut health care costs, significant audit resources were redirected into this area. A major audit thrust was to identify areas where, through regulation or legislative changes, programs could be made more efficient and cost effective.

Auditors issued 130 reports on Health Care Financing Administration (HCFA) administered programs recommending financial adjustments totaling $43.7 million. In addition, 5 reports identified savings totaling $461 million.

1/Source: Health Care Financing Review, Volume 4, Dated September 1982, Page 2.

Auditors identified five areas where $461 million could be saved if regulatory or legislative changes were made in specific program areas. Highlights of these items follow:

MEDICARE-MEDICAID LEGISLATIVE/ REGULATORY REFORM

A 1976 House Subcommittee on Interstate and Foreign Commerce Report estimated 2.4 million unnecessary surgeries were performed in one year at a waste of 11,900 lives and $4 billion. The report recommended that HCFA promptly implement a program of independent second opinions for elective surgeries paid under Medicare and Medicaid.

MANDATORY SECOND SURGICAL OPINION PROGRAM CAN SAVE $157 MILLION

Auditors assessed the adequacy of actions taken by HCFA to cut down on this problem and to implement the Congressional mandate. Despite a promising start in sponsoring a voluntary second opinion program during 1977, experience over the last 5 years has shown that neither Medicare nor Medicaid beneficiaries seek second opinions as a general rule.

Studies on second surgical opinion programs consistently point out that voluntary programs have a limited impact; however, the opposite holds true for mandatory programs. For example, based on our study, mandatory programs covering even a limited number of the more common procedures could reduce elective surgeries nationwide by as much as 29 percent in Medicaid and 18 percent in Medicare at an annual cost savings of about $63 million and $94.7 million, respectively. The Office of Inspector General (OIG) recommends that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected types of elective surgery.

Although HCFA agrees that mandatory second surgical opinions appear cost-effective, experience with these programs has been limited. Therefore, they feel it would be premature to seek legislation without further study.

* * * * * *

BETTER PROCUREMENT OF PACEMAKERS CAN SAVE MEDICARE $64 MILLION

On a model-by-model basis, auditors compared prices paid for 2,804 pacemakers bought for Medicare patients by 25 hospitals in 10 States with the prices available to Federal agencies under the General Services Administration's multiple award Federal Supply Schedule (FSS). Most procurements under the Schedule are for Veterans Administration hospitals.

The result: hospitals, and ultimately Medicare, paid an average of $3,424 for each pacemaker identical to those available under the FSS for an average of $2,833--21 percent more.

If arrangements could be made whereby hospitals could obtain a more favorable price for pacemakers, similar to prices available under the Schedule contracts, estimated annual savings to the Medicare program of $64 million would result.

The Department advised that prospective reimbursement will give hospitals incentives to procure pacemakers prudently and that HCFA is studying the effectiveness of recent guidelines for the utilization of pacemakers.

* * * * * *

ELIMINATION OF RECERTIFICATIONS CAN SAVE $60 MILLION

Federal regulations require that Medicaid recipients in Intermediate Care Facilities (ICF) be certified periodically by a physician as requiring the level of care provided in these facilities. Auditors performed reviews in 2 States and obtained information from State Medicaid officials concerning recertification in 24 other States. Auditors concluded that recertifications (1) have no impact on services received by ICF patients, (2) have no material impact on quality of care, and (3) cause waste and increase vulnerability to abuse.

Recommendations call for HCFA to seek a change in legislation in order to eliminate the need for such recertifications. This could result in savings of $60 million annually, without adverse effect on the well-being of patients.

The Department, in its FY 1984 legislative submission proposed a change to eliminate the need for such recertification.

* * * * * *

EXTENDING THE LOWEST CHARGE LEVEL CAN SAVE MEDICARE $80 MILLION

The Social Security Act allows HCFA to pay providers of non-physician services (e.g., laboratory tests, supplies, and durable medical equipment) using a rate called the "Lowest Charge Level" (LCL). LCL is defined as a rate high enough to include the cumulative 25th percentile in the distribution of actual charges submitted during a previous period. The rate applies to items that do not vary in quality from one supplier to another and are widely and consistently available. HCFA identified 12 lab services and 2 items of durable medical equipment subject to the LCL limit.

Auditors report that HCFA could save Medicare and its beneficiaries an estimated $80 million if LCL is applied to 16 additional lab services and selected other items of durable medical equipment and ambulance services.

Tentative recommendations call for HCFA to expand the number of non-physician services subject to LCL. HCFA advised they are working to expand the list of items and services subject to LCL including most of the items mentioned in our report.

* * * * * *

LOWERING "RATE OF RETURN ON EQUITY CAPITAL" WILL SAVE MEDICARE $100 MILLION

Concerned with the possibility of a nursing home bed shortage, Congress, in 1966, enacted legislation allowing a reasonable return on equity capital--generally the amount invested by owners--to proprietary nursing homes providing extended care. This was intended to encourage facility expansion and increase the number of nursing home beds. Congress extended payment of this return also to proprietary hospitals.

HCFA has been paying the maximum rate allowed by law to these providers--1½ times the rates of interest on Federal obligations purchased by the Hospital Insurance Trust Fund (HITF). The rate of return, paid by the program, was about 20 percent in 1981 and 19 percent in 1982.

Audit looked into this area and found, among other things, that amounts paid Medicare providers for their return on equity capital far exceeded the average after-tax returns earned by 950 private companies. They also found that because of the dramatic increase in interest rates in recent years, Medicare's return on equity capital payments increased much faster than industry profits generally. In fact, of $775 million paid to Medicare providers during a recent 31 month period, about $290 million was due solely to increase in the payment rate.

Details on this matter were furnished to a Congressional committee on request. Legislation was subsequently introduced and passed by the Congress, lowering the multiple used to compute the rate of return by one third. The rate was lowered from 1½ to 1 times the interest on Federal Obligations purchased by the HITF.

This reduction alone will save the Medicare program an estimated $100 million annually. There are several other related areas where, in our opinion, further changes are required. These matters will be covered in a subsequent report.

* * * * * *

MEDICAID/ MEDICARE FINANCIAL AND COMPLIANCE AUDITS

Audits completed during this 6-month period focused primarily on: (1) identifying and correcting problems relating to long-term care facility certification, (2) determining the accuracy of facility per diem rates, (3) assessing actions taken by States to credit Medicaid for recoveries from providers, and (4) assessing the allowability of Medicare contractor administrative and health facility certification costs.

Audit reports issued	130
Cost Questioned	$ 43.7 Million

The bulk of unallowable charges/ questioned costs fell in the following areas:

- $22.8 million for services provided by Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) in one State that were not certified or that failed to meet minimum certification standards; — MEDICAID
- $10.8 million for ICF/MR per diem rates that were incorrectly determined in three States;
- $7.2 million for charges by one State for services provided to recipients of a non-Federal Medical Assistance program;
- $1 million for credits/overpayments not returned to Medicaid by one State;
- $.8 million for outpatient hospital services claimed and paid separately to one State although they were covered in an all-inclusive inpatient hospital per diem rate;
- $.3 million for improperly allocated administrative costs claimed by Medicare contractors and State agencies for health facility certification costs. — MEDICARE

OFFICE OF AUDIT

Social Security Administration

SOCIAL SECURITY ADMINISTRATION

INTRODUCTION

The Social Security Administration (SSA) has the largest budget of all operating divisions in the Department of Health and Human Services (HHS). With the population getting older and an upsurge of inflation/unemployment, SSA benefit/entitlement programs have been growing rapidly. Estimated expenditures for 1986 are $222 billion (see Exhibit D).

Due to these enormous budgetary outlays and concerns over the fiscal soundness of trust funds, Audit has undertaken a major task of looking into the payment process controlling these programs.

Audits/surveys during this period were primarily designed to: (1) detect and control fraud and abuse within various benefit programs with heavy reliance on computer applications, (2) improve internal and fiscal controls in the benefit payment operations, and (3) improve the overall economy and efficiency of management operations.

Statistically, the number of reports issued in this area has gone down. There are two reasons--first, audits of State and local benefit programs (primarily public assistance) were substantially cut; secondly, the complexity of many new assignments which involved actuarial assumptions and size of benefit operations, require substantial audit time.

Auditors issued 23 reports recommending financial adjustments of $1 million. More importantly, 5 reports identified improvements in SSA's payment process which could save $23.1 million and increase trust fund income by $1.1 billion.

PROBLEMS IN SSA'S PAYMENT PROCESS

Four audits identified serious internal and fiscal control weaknesses in various phases of SSA's payment process. Highlights of these matters follow:

MANUAL DISABILITY CLAIMS PROCESSING SYSTEM INEFFICIENT AND COSTLY

Most claims for disability insurance benefits are processed through one of SSA's computerized systems. However, a substantial number of claims--95,000 valued at $171 million--are processed annually using a manual system.

Auditors found this system costly... inefficient...and plagued with internal control deficiencies. There was no restriction on the number and types of payments processed; thousands of employees have unrestricted access to the system; controls were inadequate to detect and prevent employee fraud and abuse; and, no controls were in place to detect duplicate/overpayments.

Our report pointed out to SSA that, with proper programming, about 87 percent of the claims could have been processed through one of SSA's automated systems.

Auditors also noted that, on certain disputed claims, beneficiaries frequently obtain legal counsel. If entitlement is eventually granted, legislation requires SSA to withhold up to 25 percent of accrued benefits to pay attorney fees. It costs SSA an estimated $7.0 million annually in administrative costs to act as a paying agent and manually process payments for these attorney fees. Auditors concluded that this cost is unnecessary and should be a matter properly handled by the beneficiary. A statutory change eliminating this requirement is under consideration in the Department.

* * * * * *

SOME SSI RECIPIENTS ALSO RECEIVING AFDC CHECKS TOTALING $2.5 MILLION ANNUALLY

Persons who are eligible for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) may elect to receive either payment, but not both. Since SSI benefits are generally higher than AFDC benefits, most recipients of AFDC convert to SSI as soon as they become aware of the higher benefits. SSA estimates that there are 12,500 persons in this conversion status at any given time.

Based on a sample of 284 cases that converted from AFDC to SSI in one State, auditors found:

- 92 cases receiving both SSI and duplicative AFDC payments of $52,000 (one of every three SSI converted cases continued to receive AFDC payments);
- 71 SSI cases received net overpayments totaling $5,399 because of inaccurate AFDC payment data.

These problems were caused principally by incorrect termination payment dates submitted by the States.

Recommendations, concurred in by SSA, call for improved procedures to validate data submitted by States in order to convert these cases. It is estimated that action taken or promised by SSA will save $2.5 million annually.

* * * * * *

SSI ADMINISTRATIVE FINALITY PROVISION OBSTRUCTS COLLECTION ACTIONS

SSI provides monthly payments of up to $284 to about four million aged, blind, or disabled persons. SSI recipients are allowed to earn about $65 per month before their monthly checks are reduced. Recipients are required to inform SSA of any changes in earnings.

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.

By regulation, SSA has 2 years from date of eligibility or payment decision to correct the SSI payment and to recover overpayments. This is referred to as the "administrative finality" period.

Auditors found that this 2-year period is too short to allow SSA to recover millions in overpayments. The key to SSA's detection system is FICA wage data. However, legislation changed FICA tax reporting from a quarterly to an annual basis. This change has caused SSA many processing difficulties, and resulted in long delays for posting records. Because of these problems, the validation of FICA earnings has been held up.

Delays in the validation procedure coupled with the inadequate 2-year administrative finality period resulted in uncollected overpayments of $147.7 million. In addition, there will be estimated potential losses of $6.8 million for FY 1982 and $6.8 million for FY 1981 unless the 2-year period is quickly extended.

* * * * * *

CONTROLS OVER OVERSEAS BENEFIT PAYMENT PROCESS WEAK

SSA disburses over $1 billion annually in benefits to over 312,000 Social Security beneficiaries living outside the United States. The Department of State is responsible for administering benefit payment operations for most Federal agencies, including SSA, making payments to beneficiaries in foreign countries.

In a joint HHS/Department of State survey, auditors checked on the adequacy of payment operations in three countries: Greece, Italy, and the United Kingdom.

Problems were identified with a lack of (1) segregation of duties among employees processing claims and monthly benefit checks, (2) effective management and supervisory controls, and (3) physical security over benefit checks.

Recommendations have been made to the Department of State to correct these problems. Both the Department of State and SSA have indicated full agreement with findings.

* * * * * *

MORE FREQUENT SOCIAL SECURITY DEPOSITS WILL INCREASE TRUST FUND INCOME BY $1.1 BILLION

The Inspector General's 1981 Annual Report and a recently issued Office of Audit draft report noted that SSA was losing "millions" in trust fund income because the deposit schedule for Social Security contributions on the wages of employees of State and local governments was much more liberal than that for private sector employees. To explain the problem:

Section 218 of the Social Security Act permitted States to deposit Social Security contributions on the wages of State and local employees ($17.9 billion in FY 1982) on a generally more lenient schedule than private sector employers. States were required to deposit Social Security contributions with SSA 30 days after the end of each month without consideration of amount, while private sector employers were required to make deposits with the Internal Revenue Service (IRS) at least quarterly and possibly as often as eight times per month depending on the amount of Federal tax liability.

The State and local deposit schedule of 30 days after the end of the month did not maximize the interest-earning potential of the trust funds. The schedule allowed most State and local employers to deposit less frequently than private sector employers with comparable size payrolls and earn interest on the Social Security contributions of employees pending deposit with SSA.

In a recently issued draft report directed to both SSA and the Department of Treasury, auditors recommended that the private sector deposit schedule be adopted. Congress subsequently passed legislation mandating a semi-monthly schedule. This provision, which will become effective after December 1983, will produce $1.1 billion in additional revenue for the period 1984-1989.

Recommendations will be modified to include alternatives to facilitate State compliance with the new semi-monthly deposit requirement. In addition, the legislative change will be closely evaluated to see how well it resolves this problem.

* * * * * *

FINANCIAL AND COMPLIANCE AUDITS

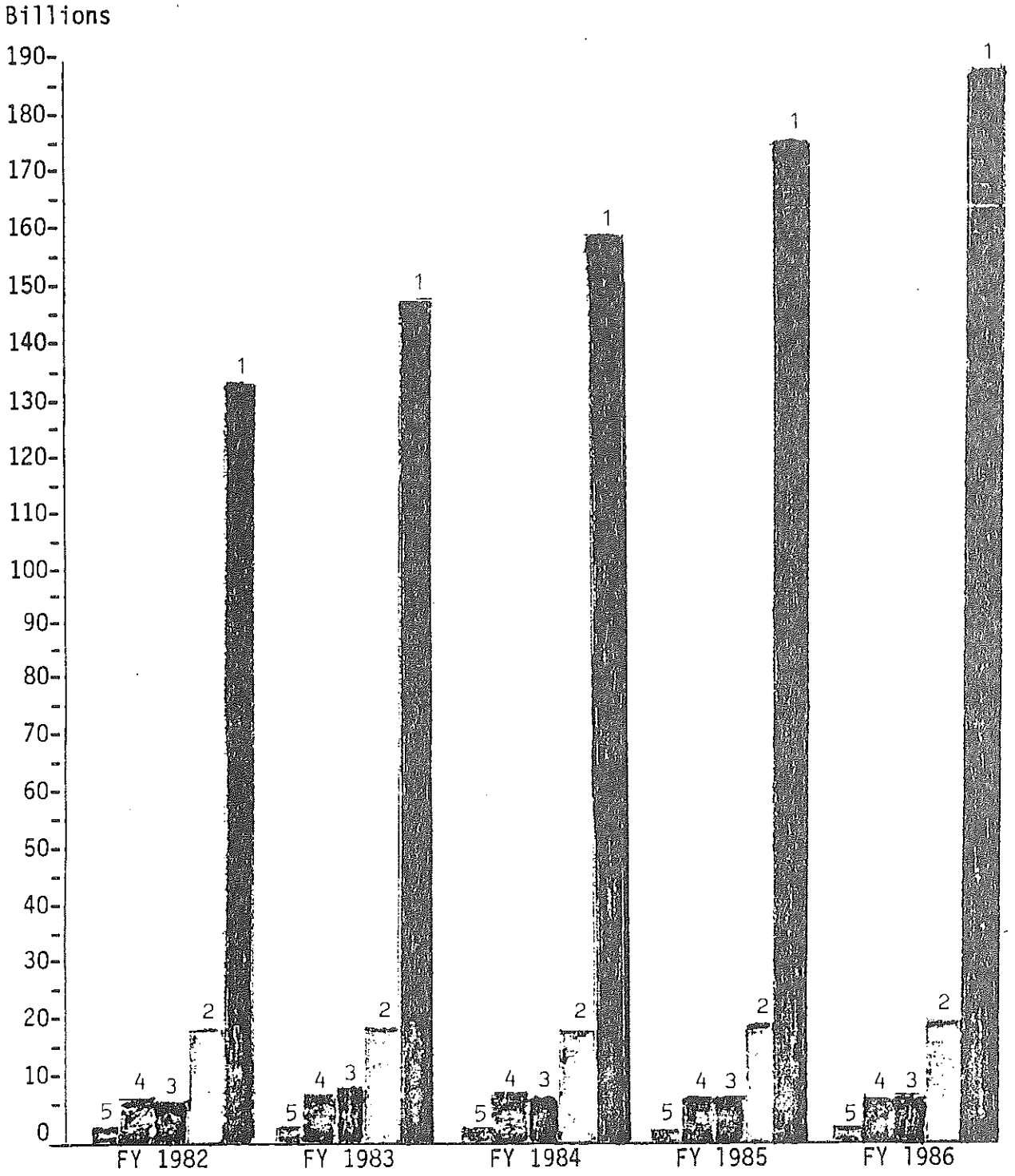
Because of the major audit emphasis on reviewing SSA's payment system and Office of Management and Budget's (OMB) requirement calling for single non-Federal audits of State and local governments, only 13 external type reviews were completed recommending financial adjustments of about $1 million.

The bulk of questioned cost related to problems found in the Low Income Energy Assistance Program. This program was designed to assist low-income recipients in paying for home heating fuels. Audits in two States disclosed that reported program expenditures and administrative costs were overstated.

EXHIBIT D

SSA MAJOR PROGRAMS

EXPENDITURES*
FY 1982 - 1986



1 Old Age Survivors Insurance
2 Disability Insurance
3 Supplemental Security Income
4 Aid to Families with Dependent Children (Federal Share)
5 Black Lung

*Does not include Federal Administrative cost nor the effect of the Social Security Amendments of 1983.

OFFICE OF AUDIT

Computer Auditing/Advanced Techniques

INDEX OF OIG
SOCIAL SECURITY COMPUTER APPLICATIONS

- RAILROAD RETIREMENT BOARD (RRB) DEATH MATCH
- TITLE II DEATH MATCH
- TITLE II TERMINATION
- AFDC BIRTH MATCH
- CLEAN DATA
- SUPPLEMENTAL SECURITY INCOME/FICA WAGE MATCH
- AFDC ELIGIBILITY/PAYMENT MATCH

COMPUTER AUDITING/ADVANCED TECHNIQUES

The Office of Audit is in the forefront in developing and refining advanced audit techniques to attack fraud, waste, and mismanagement in HHS programs. Included in this effort was the development of one of the first Computer Audit Divisions in the Federal Government.

Computers provide a fast, efficient and accurate means of reviewing voluminous data that previously had to be done on a manual basis. Auditors developed and improved computer applications designed to verify data and identify billing practices and utilization patterns that exceeded certain parameters.

Two of the most widely used techniques are matches and sophisticated computer screening techniques. Matches involve the comparison of two or more computer files to determine the similarity or dissimilarity of data. Screens, on the other hand, look for patterns of behavior...illogical relationships..., and prohibited practices.

In addition, the Electronic Data Processing (EDP) Audit Division began a monumental task of reviewing SSA's computer system modernization plan. The plan involves over 100 separate projects to make system changes, integrate various data bases, improve data communication and upgrade equipment capacity. The EDP Audit Division is reviewing the various changes to ensure that adequate controls and safeguards are in place. This Division is also responsible for the actual running of many of the Office of Audit computer applications.

Highlights of computer applications used during this period follow:

RRB MASTER FILE/SSA PAYMENT FILES

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 both Acts. SSA furnishes the RRB 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. In 1980, an OIG report was sent to SSA which identified certain problems connected with the reconciliation process. As a follow-up, this application was developed to determine if any or all of these problems still exist.

This program matches deaths recorded on the RRB master file with the SSA current payment file.

RESULTS

The application has been successfully run. Over 1,100 cases have been identified as deceased on the RRB master file but as being in a current pay status on SSA Records. These will be analyzed in order to develop the amount of overpayment and to determine the causes of all identified problems.

Because SSA must rely on third party reports from relatives, funeral directors, etc., to gather death information, it perennially has difficulty obtaining timely death data concerning beneficiaries of the Old Age, Survivors, and Disability Insurance Program (Title II of the Social Security Act). Payments to deceased beneficiaries could be sizeable and very costly to the program if paid over an extended period of time.

STATE DEATH TAPE/TITLE II MASTER FILE MATCH

This match compared a magnetic tape file of deaths occurring in one State during the years 1979, 1980, and part of 1981 with the SSA Title II master file of beneficiaries receiving monthly payments.

Overpayments of $777,000 and $11,000 in underpayments were identified.

RESULTS

TITLE II TERMINATIONS/ BLACK LUNG PAYMENT FILE MATCH

When the Old Age, Survivors, and Disability Insurance program (Title II) is notified of an event which terminates benefits under both the Title II and Black Lung Programs, this information is to be transferred to the Black Lung program for action to terminate these benefits. If this notification fails to occur, an individual will continue to receive Black Lung payments after Title II payments have been terminated.

This application matched the Black Lung current master payment file against termination actions recorded in the Title II master file.

RESULTS

Black Lung overpayments of $1.5 million were identified resulting from the failure to transfer termination information for 453 cases to the Black Lung program.

DATE OF BIRTH/NAME MATCH

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.

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.

RESULTS

Auditors have run this application in six States. 1,200 raw hits were identified and were refined down to 254 cases where children with identical birthdates were identified in at least two different family units. This occurred both among families in the same State and in matches between the States. The results have been turned over to the States for review.

SCREEN FOR VALID SOCIAL SECURITY NUMBERS

Social Security Numbers are frequently used as individual identifiers in entitlement 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 in an entitlement program.

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 10 locations with the exceptions ranging from a low of 800 at one location to a high of 23,000 at another. At one of the locations, 5,000 numbers were identified as never being issued by SSA. The results have been turned over to individual States for validation and follow-up.

SSI ELIGIBILITY FILE/FICA WAGE FILE MATCH

SSA issues monthly payments to persons eligible for SSI benefits. The SSI payment should be reduced by the amount of a beneficiary's earnings which is above an excludable level. If the recipients do not report their anticipated earnings as required, overpayments occur.

This program matches a State's SSI beneficiary population file with the SSA file of employer-reported FICA wages.

RESULTS

The application has been successfully run. Data is now being analyzed in order to develop the amount of overpayment attributable to the unreported earnings problem.

One significant problem with income maintenance and assistance programs is the possibility of payments to ineligibles. Certain States maintain separate systems for AFDC eligibility and for AFDC payments which may allow recipients to be closed on the "eligibility" file without their payments being terminated by notation on the "payments" file.

AFDC ELIGIBILITY FILE/PAYMENT FILE MATCH

This program matches a State's AFDC "eligibility" file to its AFDC "payment" file and identifies payments to individuals who were either closed on the "eligibility" file or were never eligible for AFDC assistance.

RESULTS

The match in one State identified 1,561 closed cases on the eligibility file but still on the payment file. In addition, 161 cases were found that received payments but were never on the eligibility file. We estimate that about $3.4 million was paid to these recipients during 1982.

INDEX OF OIG
HEALTH CARE FINANCING
COMPUTER APPLICATIONS

- Physician Gang Visits
- Lab Services
- Inpatient/Outpatient Hospital Services
- Durable Medical Equipment
- Ambulance Service
- Abnormal Physician Billings

PHYSICIAN GANG VISITS

Overbilling by a physician for nursing home visits usually occurs when (1) the higher billing rate for a visit to see only one patient is applied to multiple visits at one nursing home on the same day (Gang Visits), or (2) a billing is for a patient not in a nursing home.

This application identifies both situations. It compares physician billings with claims by nursing homes. A comparison by date of service will identify instances where a physician billed for visits when the patient was not in the nursing home. It will also identify when a physician visited more than one patient at the same nursing home on the same day.

RESULTS

This program was run in one State and identified 48 physicians who billed for 30 to 127 visits to nursing home patients in one day--$818,000 was charged for these visits. In addition, 27 podiatrists were identified who billed between 20 and 116 operations to nursing home patients in one day--charging $646,000 for these services. Our review of these findings is continuing.

LABORATORY SERVICE MATCH

Providers of laboratory services perform and bill for a wide range of clinical tests. Physicians may request that the lab perform individual tests or a number of tests done as an automated panel (group). Lab work may be performed by subcontractors. In addition, physicians may perform lab work in their offices.

A computer application consisting of five programs was developed to identify improper billing procedures by laboratories and physicians. Some of the improper billings deal with:

- Lab tests that were not performed;
- Duplicate billings;
- Individual tests that were done as part of a panel at lower costs;
- More expensive tests than those ordered by physicians;
- Profiteering on work performed by subcontractors; and
- Billings by physicians for tests performed in their offices when the work was actually performed at lower costs by independent laboratories.

RESULTS

The output from the various applications is currently being reviewed.

INPATIENT/ OUTPATIENT HOSPITAL SERVICES

In States using an all-inclusive per diem rate, billings for outpatient services provided within 24 hours of an inpatient admission at the same hospital should not be included in the billings for hospital services. These outpatient services are covered by the all-inclusive per diem rate. However, a State Agency claims processing system may fail to include procedures to identify improper claims for outpatient services.

This program matches inpatient and outpatient files to identify improper claims.

RESULTS

At three locations where the all-inclusive per diem rate is utilized, approximately $1.55 million has been identified as outpatient claims paid for services provided during inpatient status.

DURABLE MEDICAL EQUIPMENT

When patients are residing in nursing homes, charges for durable medical equipment should be included as part of the per diem paid to the nursing home. However, in some instances, suppliers are also directly billing the patients for providing this equipment. The potential for overbilling exists because the computerized file does not accurately reflect the "place of services."

This screen identifies the location of the patient when the supplier bills for durable medical equipment. The dates of billing are compared with the dates the patient was in the nursing home.

RESULTS

In one State, potential overpayments of about $1.4 million were identified.

AMBULANCE SERVICE

Claims for certain types of medical services often are followed by other related claims for the same or following day. One example is ambulance service. If a patient requires the services of an ambulance, it is logical that there should be a billing for additional medical services or a hospital admission.

This program identifies billings for ambulance service without a corresponding billing for additional medical services or a hospital admission.

RESULTS

The application developed to detect these situations has been run successfully in one location and the data is being reviewed.

SCREEN FOR ABNORMAL BILLINGS BY PHYSICIANS

Over the years the Medicaid/Medicare programs have been subjected to various abnormal billing practices by physicians.

A computer application was developed to identify various types of abnormal billing practices by physicians, such as (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.

Many claims processing systems do not have effective edits to disclose these types of problems, especially the concurrent care one. The computer process is flexible and has been generalized so that it can be turned over to States, and they can adapt it to their own local problems. This application has been run in five locations.

RESULTS

The program was initially tested against Medicaid records, in cooperation with one State. Computer output showed about $200,000 in potential overpayments. So far, the State has recovered $20,000 and has requested additional computer support. Results from the other four locations are now being reviewed.

OFFICE OF AUDIT

Non-Federal Audit Activity

NON-FEDERAL AUDIT ACTIVITY

The Inspector General's audit redirection of staff into more sensitive and substantive Department programs and OMB policy calling for single type audits at recipients rely heavily on work by non-Federal auditors such as public accountants and State auditors.

Audit effort was devoted toward (1) reviewing and evaluating reports prepared by others, (2) providing technical assistance to various groups on the single audit concept, and (3) providing oversight of block grant programs. Specifically:

EVALUATING REPORTS PREPARED BY OTHERS

The Office of Audit closely monitors and reviews the work of others by evaluating reports and, on a test basis, underlying audit workpapers to make sure that standards for Governmental auditing were followed. For example, from September 1982 through March 1983, some 1,600 reports prepared by others--mostly CPAs and State auditors--were reviewed and evaluated.

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SINGLE AUDIT TECHNICAL ASSISTANCE

To ensure successful implementation of the single audit concept, Headquarters and regional audit staffs have provided orientation and technical briefings to officials of colleges and universities and State and local organizations where such audits are currently underway and to interested State audit groups, CPA firms, and program officials within HHS. In addition, Audit has closely monitored 39 pilot projects to test the implementation of the single audit concept at universities and colleges. The final phase of this initiative will involve (1) reviewing and discussing the results of these audits with all concerned parties and (2) finalizing uniform audit guidelines to be used by non-Federal auditors for these single audits.

In addition, in order to move the single audit approach to the next group of organizations, Audit is taking the Federal agency lead and currently drafting guidelines for use of this concept at non-profit organizations such as community action agencies and social services organizations.

Once the audit guidelines are refined, they will be pilot tested at selected non-profit organizations.

To complement our single audit efforts and also to get audit staff into program areas more susceptible to fraud, waste and mismanagement, contracts are being awarded to State auditors and CPA firms. For example, 62 contracts were awarded to non-Federal auditors to perform reviews of Medicare contractors using audit guidelines developed by the Office of Audit.

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BLOCK GRANT OVERSIGHT

The Omnibus Budget Reconciliation Act of 1981 consolidated 25 separate grant programs into 7 block grants. Authorizations totaled $5.6 billion. Each State and U.S. Territory receiving block grant funds is responsible for administering and carrying out the block grant programs in which it participates. For each such grant, there is a requirement for an independent audit. It may be accomplished by a separate audit of each block grant program, a consolidated audit of all block grants, or a single audit of all funds.

Auditors have been monitoring and tracking State progress in implementing block grant auditing requirements and have been providing technical assistance in the planning and execution of these type audits. Appropriate officials of each State or U.S. Territory have been contacted to determine how they planned to implement block grant audit requirements.

As of December 1982, 33 States had adequate audit plans in effect. However, 6 States had no intention of auditing block grant funds expended in 1981-1982; and 5 States did not have a definite plan developed. (See Exhibits H and I).

Our regional offices are monitoring States having potential auditing problems. Technical assistance will be provided where needed. We are emphasizing the importance of developing a well planned audit system to comply with block grant requirements.

OFFICE OF AUDIT

Grants and Internal Systems

GRANTS AND INTERNAL SYSTEMS

INTRODUCTION

The Grants and Internal Systems Audit Division (GIS) is responsible for assisting managers in improving overall efficiency and effectiveness of internal Departmental management, including the Office of the Secretary, the Public Health Service (PHS), and the Office of Human Development Services (OHDS). Over 75 percent of the Department's discretionary expenditures are made in these areas.

Although expenditures in the Grants and Internal Systems areas are substantially less than outlays for social security and health care (see Exhibit E), the enormous number of grantees and contractors (over 35,000) and the complexity of grant programs combine to amplify potential vulnerability to fraud, waste, and abuse. PHS operates more than 150 major programs ranging from biomedical research support to health resources and services funding. OHDS offers more than 20 programs providing assistance to the elderly, disadvantaged, and handicapped.

Audit emphasis was placed on: grant/contract administration...adequacy of internal controls...debt collection... cash management...student loan programs ...efficient procurement of consultant services, and adequacy of Departmental management information systems such as payroll, accounting, and financial management systems.

Statistically, the number of reports issued and questioned costs by entity:

	PHS	OHDS	DEPT ADM
Reports Issued	803	776	140
Questioned Costs in Millions	$5.2	$25.8	$.2

Highlights of these matters by OPDIV/STAFFDIV follow:

PUBLIC HEALTH SERVICE

Audit focused on the adequacy of internal management controls/procedures over: (1) close-down of PHS hospitals and disposition of assets, (2) collection of delinquent loans under the Nursing and Health Professions Student Loan programs, and (3) propriety of expenditures reported by various grantees. Problems were found in each of these areas.

PHS CLOSES HOSPITALS/CLINICS --SOME ACCOUNTING PROBLEMS REMAIN

The Omnibus Budget Reconciliation Act of 1981 ended free medical care for merchant seamen at PHS facilities and required the closure of these facilities. Auditors evaluated PHS' shut-down procedures and tested controls over the disposition of facility assets. Although facilities were closed by the legislative target date, action in three areas was incomplete or inadequate to protect the Federal interest:

- PHS did not establish a system to track and recover $24.6 million in accounts receivable from closed facilities. At one hospital, efforts to collect $3.6 million in debt have been stalled since 1978.

- Rather than using the Federal Records Center to retain medical records from closed hospitals, PHS chose to open its own facility at a cost of $800,000 annually. In our opinion, this decision was not adequately studied and service at the center has not been effective (some 30,000 unfilled requests for medical information exist).

- There was no systematic effort on the part of PHS to save many research projects through coordination with other agencies engaged in similar activities. Hospitals did not submit final reports on results of various research activities as required. PHS advised that action was underway which should correct these problems.

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WEAK MONITORING OF PHS NURSING STUDENT LOAN PROGRAM

Congress enacted the Nursing Student Loan (NSL) program to establish revolving loan funds--90 percent funded by the Department--at eligible schools to be used for long-term low-interest loans for nursing students. Federal funds of about $260 million have been awarded to approximately 1,145 participating institutions since inception of the NSL program.

Auditors reviewed the NSL program at 45 institutions having 20 percent of the delinquent loans and 26 percent of overdue principal. PHS reported 181,192 loans totaling $152.1 million outstanding. Of these, 47,833 loans valued at $19.1 million were delinquent.

Serious problems were found in PHS administration of the NSL program: overall monitoring/surveillance was weak; schools did not always exercise, nor did PHS enforce due diligence in collection efforts; information provided by schools was unreliable; and legislative measures to aid in collection were not pursued. Consequently, many debtors who are able to repay loans have not done so. Some $12 million in loans may not be collectible because of State Statutes of Limitations.

Schools accumulated $76 million in excess Federal cash on medical student loans to doctors as well as nurses, resulting in the U.S. Treasury incurring $12 million in unnecessary interest expense.

PHS has taken or planned several steps to correct these problems.

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COMPUTER IDENTIFIES LOAN DEBTORS

To assist PHS in locating delinquent Health Professions and Nursing Student Loan borrowers, auditors developed a computer program to identify individuals who were also receiving salary or payments from other Federal programs.

The application matched listings of delinquent borrowers for selected schools with (1) records maintained by the Office of Personnel Management for active Federal civilian employees, and (2) records of principal investigators under grants and contracts awarded by the National Institutes of Health. The comparison provides a screening and identification of individuals who appear on both lists.

The computer match identified 690 doctors and nurses--delinquent $490,000--who were Government employees. In addition, 28 individuals owing $22,000 in total, were coordinating various research projects at institutions. The Department, when results are verified, can then institute collection procedures.

* * * * * *

MANAGEMENT ACCOUNTING PROBLEMS AT NON-PROFIT ORGANIZATIONS

Audits of various non-profit organizations disclosed continuing problems with internal/financial accounting controls over grant funds. PHS needs to continue their monitoring efforts to ensure that grant funds were used for their intended purpose. Examples of our findings in this area follow:

- PHS awarded grant funds of $9.6 million over a 6 year period to a non-profit organization to provide comprehensive health services. Auditors found: $417,000 in charges were made without prior PHS approval as required, $129,000 in unallowable travel costs. Other unallowable costs totaled $205,000.

- An audit of a Maternal and Child health grant disclosed numerous deficiencies in the overall administration of the program. Auditors found (1) $2.5 million in prior year grant funds improperly used to finance operations in the succeeding year; (2) $1.3 million in grants made to ineligible organizations; and (3) $2.2 million in matching expenditures by ineligible organizations.

- A $3.3 million grant was awarded to a non-profit organization to help provide comprehensive, coordinated, and accessible health care. The grant also was to help subsidize a health facility until the facility was certified as a Health Maintenance Organization (HMO). Auditors found that the grantee improperly provided $371,000 to the HMO after it was certified.

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INSTITUTIONS OF HIGHER EDUCATION

Federal audit policy provides for a single, organization wide audit of all financial activities of Federal projects at institutions of higher education. Organization-wide audits that meet prescribed requirements will be accepted by all Federal agencies with awards at the college or university. While a number of institutions have initiated these type reviews, not all are currently participating. Therefore, the Inspector General will provide audit coverage at selected institutions with identified problem areas.

During this reporting period, four audits identified unallowable charges of $1.6 million. Specifically:

- At one institution we recommended an adjustment of $682,000 in personnel service costs charged to Federal awards. Charges were made without evidence that costs were for effort directly related to the Federal grants and contracts.

- Another institution charged $400,000 to Federal grants and contracts in personnel service costs which available records showed were for teaching activities in the university's academic program.

- One medical college constantly maintained large balances of Federal grant funds (an average of $1.6 million in FY 1981) in violation of Federal regulations. Excess cash was used for certain unauthorized purposes and for investments earning interest of about $348,000. The maintenance of these excessive cash balances cost the Federal Government an estimated $687,000 in lost interest.

- An audit of a medical center at another institution disclosed overcharges of $166,000. Claims submitted for patient care costs were in excess of negotiated rates and award provisions.

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OFFICE OF HUMAN DEVELOPMENT SERVICES

Audit activity in the OHDS centered on four areas: (1) allowability of charges by States for Title XX Social Services, (2) adequacy of financial management controls over cash management in the Head Start program, (3) assessment of whether charges for Foster Care payments were for individuals meeting Federal eligibility requirements, and (4) assessment of controls over the award and monitoring of grants. Problem areas were found in these various areas:

WRAP-UP AUDITS FIND SUBSTANTIAL OVERCHARGES TO TITLE XX PROGRAM

Effective October 1, 1981 the Title XX Social Service Program was converted to a block grant, with audit responsibility transferred to the States. Auditors are in the process of completing audits started prior to the block grant conversion. Primary audit coverage was 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.

Audits in four States recommended financial adjustments of $21.7 million. These included:

- $16.0 million for services that were the responsibility of the State...or unallowable charges for services normally provided by facilities in which the individual was living or...intrinsic to the purpose of the facility.

- $2.8 million in charges made for indirect cost using rates which were not approved.

- $1.6 million for a retroactive claim made after the time limitation for such claim expired.

- $1.3 million in charges for ineligible clients...services in two Mental Retardation Centers whose operations were not in accordance with the Federal regulations, and ...other unallowable costs.

* * * * * *

HEAD START CASH MANAGEMENT PROBLEMS CONTINUING

For several years now, HHS auditors, the General Accounting Office, and Non-Federal auditors have reported that Head Start grantees have draw-down cash in excess of need. A recent nationwide OIG review of 253 grantees in 6 regions disclosed the same situation still exists. This time, 168 grantees or about 66 percent of those reviewed, drew-down an estimated $16 million in excess cash under this program.

There are several causes of this situation.

- Grantees were using funding methods which did not provide cash to coincide with their immediate needs;
- OHDS did not have an effective system to track and follow-up to insure the timely receipt of grantee financial reports which are used to monitor and manage cash;
- OHDS permitted grantees to hold unexpended funds at the end of the grant period in some cases for more than a year.

We are recommending that the Assistant Secretary for Management and Budget (ASMB) and OHDS: take immediate actions to eliminate/ collect excess cash...utilize payment methods that result in the best matching of cash with grantee needs...and improve their system of monitoring financial reporting and outstanding cash....

ASMB and OHDS concurred with our recommendations and have taken or planned several steps to correct these problems.

* * * * * *

WEAKNESSES IN GRANT ADMINISTRATION

OHDS awards grants and enters into cooperative agreements to support research, demonstration, service, and training projects intended to improve the quality of life for such populations as the elderly, children, youth, Native Americans, and persons with developmental disabilities. OHDS annually awards almost $100 million in discretionary grants and cooperative agreements.

Weaknesses were noted in certain OHDS grant administrative practices. Specifically:

- Awards were made to applicants rated technically lower than other applicants that were not funded.
- Grant Officers and Project Officers often were not aware of program progress being made by recipients of OHDS grants and cooperative agreements.
- Site visits by OHDS Grants and/or Project Officers were not made annually and in many cases were not made at all, even when problems with grantees had been identified.
- OHDS was not closing out completed grants in a timely manner. We tested 476 grants which had reached their expiration date and found that 439 remained open. About 300 of these had been completed for over a year.
- OHDS used grants, assistance instruments, and cooperative agreements when procurement contracts would have been more appropriate.
- OHDS awarded grants non-competitively without required justifications always being available demonstrating that the projects were of outstanding merit.

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FOSTER CARE PROGRAM

The 1961 amendments to the Social Security Act established the foster care program under Title IV-A to: (1) maintain dependent children in their own homes, (2) assist parents to provide care essential to their children's development, and (3) provide alternative home care when conditions in the child's home would be contrary to the child's well-being. In 1980 Congress passed the Adoption Assistance and Child Welfare Act (Public Law 96-272) which provides that funding to States for fiscal year 1981 and later years may be allocated according to a formula using costs incurred in fiscal year 1978 as the base.

During this 6-month period, auditors completed reviews of the 1978 base year funding for four States and recommended financial adjustments of $120,000. 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.

DEPARTMENTAL ADMINISTRATION

Reviews covering overall Departmental Administration were directed primarily toward assessing the adequacy of controls over: (1) employee benefit programs and withholding deductions, (2) the audit resolution process, (3) debt collection activities, and (4) consultant service awards. In addition, Audit assisted Departmental managers in setting up some of the basic foundation for implementing OMB's Circular A-123 concerning Internal Control Systems.

Detail on these areas follow:

EMPLOYEE BENEFIT PROGRAM

The Office of Personnel Management (OPM) has statutory responsibility for administration of Employee Benefit Programs. These programs--Civil Service Retirement, the Federal Employees' Health Benefit Program, and the Federal Employees Group Life Insurance Program--are contributory benefit programs funded by employee and government contributions. Certain administrative functions are delegated to agency personnel and payroll offices. These responsibilities include determination of employee eligibility for program coverage, collection and remittance of premiums and retirement deductions to OPM, the maintenance of records, and submission of reports.

Auditors found the Department was generally administering various personnel management payroll/accounting functions properly. However, information reported to OPM was not always current because in certain cases payroll deductions were reported late, resulting in an annual loss in interest income to the Civil Service Retirement fund of about $90,000. Also, certain employee separation actions were not always accurate or timely processed.

The Department agreed to take action on recommendations made to correct these weaknesses.

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DEPARTMENT INTERNAL CONTROL SYSTEMS OMB (A-123)

Effective systems of internal control provide strong mechanisms to prevent as well as detect fraud, abuse, and waste. The Federal Managers' Financial Integrity Act of 1982 (P.L. 97-255) and OMB Circular A-123, "Internal Control Systems," required the Department to establish and maintain effective internal administrative and accounting controls. We have assisted the Secretary and the Assistant Secretary for Management and Budget, the Department's internal control officer, to carry out the mandate by:

- 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; and
- testing the reliability of selected Department assessments of the vulnerability of component systems.

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MAJOR PROGRESS IN DEPARTMENT AUDIT RESOLUTION

Over the last 3 years, the Department has made great strides in resolving final audit reports. The number of open reports over 6 months dropped from 666 at December 31, 1980 to zero at December 31, 1981. As noted in Exhibit F, this level has been maintained for the past year and a half. However, there are currently eight unresolved audits--over 6 months old--totaling $6.1 million with the Office of Human Development Services. We are closely monitoring this situation to make sure these audits are cleared-up. As of May 24, 1983, two reports have been resolved and the balance are scheduled for resolution by May 31, 1983.

For the period October 1, 1980 through March 31, 1982, the Department resolved 2,631 reports that questioned $303 million. Auditors reviewed 57 actions on these reports to determine the adequacy of the Department's audit resolution process. Resolution officials sustained 92 percent--$26.1 million of the $28.4 million questioned in these reports. Of the $2.3 million not sustained by Program Managers, the reasons shown for not accepting auditors' recommendations were unsatisfactory for about $466,000. Factors such as auditee's (1) statements that the audit report was in error, (2) proposal for a 50 percent settlement of questioned costs, (3) intent to correct the problem which led to the disallowance, or (4) successful performance of grant tasks were the principal reasons for overturning the audit disallowances.

At the time the reports in our sample were resolved, most of the OPDIVs lacked effective systems for accounting for and managing accounts receivable generated from audit disallowances as well as assessing interest on delinquent disallowances. As a result, 24 percent of disallowances in our sample were not recorded as accounts receivable and $820,000 in interest charges were not assessed and therefore lost.

In 1982 the Department issued and the OPDIVs are currently implementing revised procedures for improving collection of audit disallowances and assessment of interest.

* * * * * *

DEBT COLLECTIONS STILL NEEDS TIGHTENING

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 December 31, 1982, debt due the Department increased $182.6 million, collections increased $59.2 million, and write off of accounts receivable decreased by $21.2 million (see Exhibit G).

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

Although PHS has taken a number of steps to improve debt collection activities, several problems still continue:

- Loans receivable for the Health Professional Student Loan (HPSL) and NSL programs were overstated because the Department's share of cancelled loans was not recorded ($1.6 million for HPSL and and $59.5 million for NSL).

- Various errors in accounting records for both programs resulted in overstatements totaling $8.5 million.

- Health Maintenance Organizations program loans receivable (and accrued interest) were overstated by $40.5 million because PHS did not adjust accounting records for write offs of amounts owed by closed HMOs.

PHS has developed a plan--approved by OMB--for improving debt collection activities which should correct these problems.

* * * * * *

PROCEDURES OVER MANAGEMENT OF CONSULTANT SERVICE AWARDS NEED IMPROVEMENT

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 contract awards. However, accountability is still needed to ensure that operating and staff divisions (1) stop excluding some awards from special review and approval procedures, (2) improve the reliability of contract data in the Department's information systems, and (3) review procurement plans to avoid wasteful contracting.

Recommendations call for various procedural improvements to correct the noted deficiencies.

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EXHIBIT E

GRANTS AND INTERNAL SYSTEMS (GIS)
FY 1983 ESTIMATED EXPENDITURES

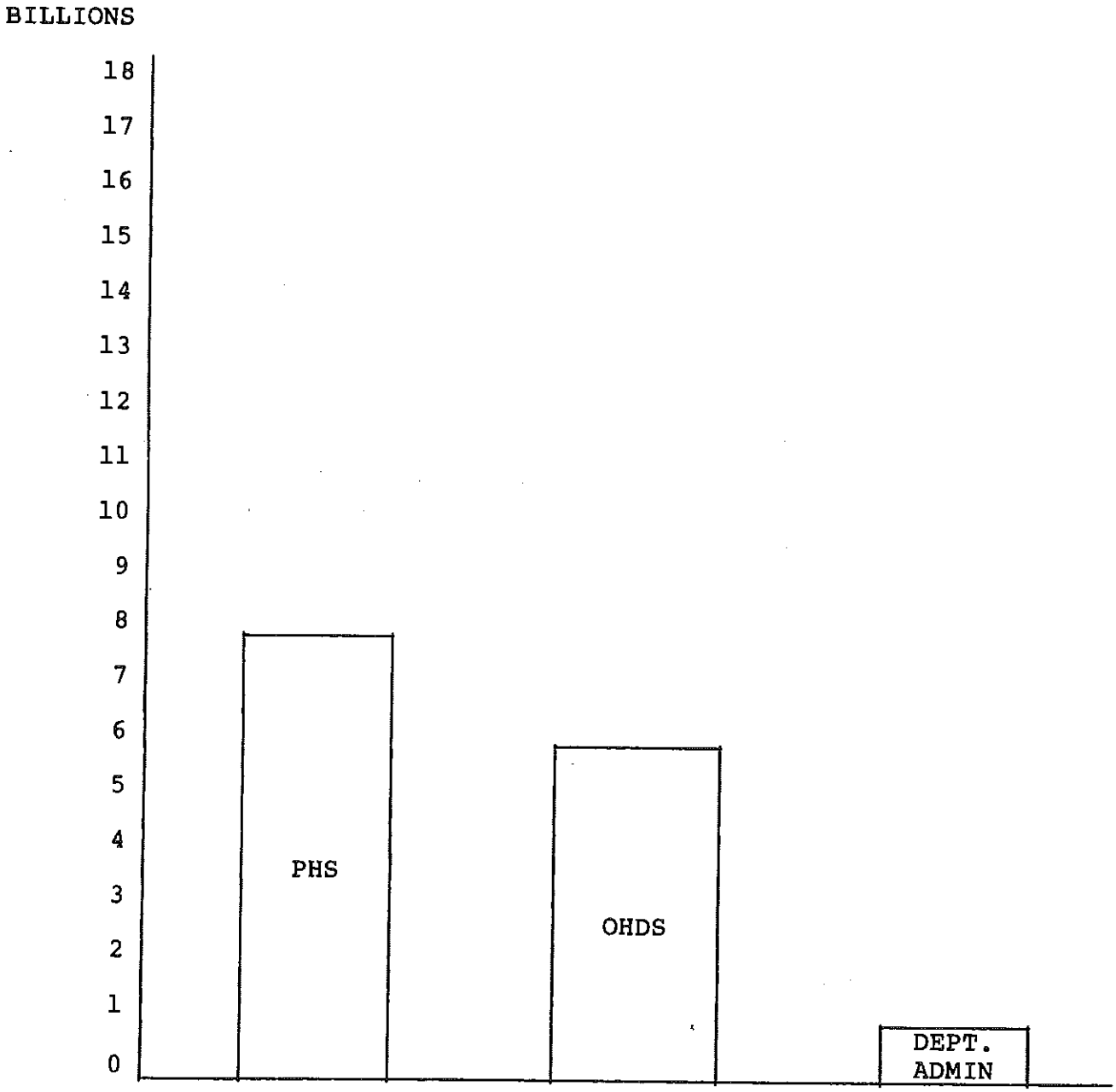
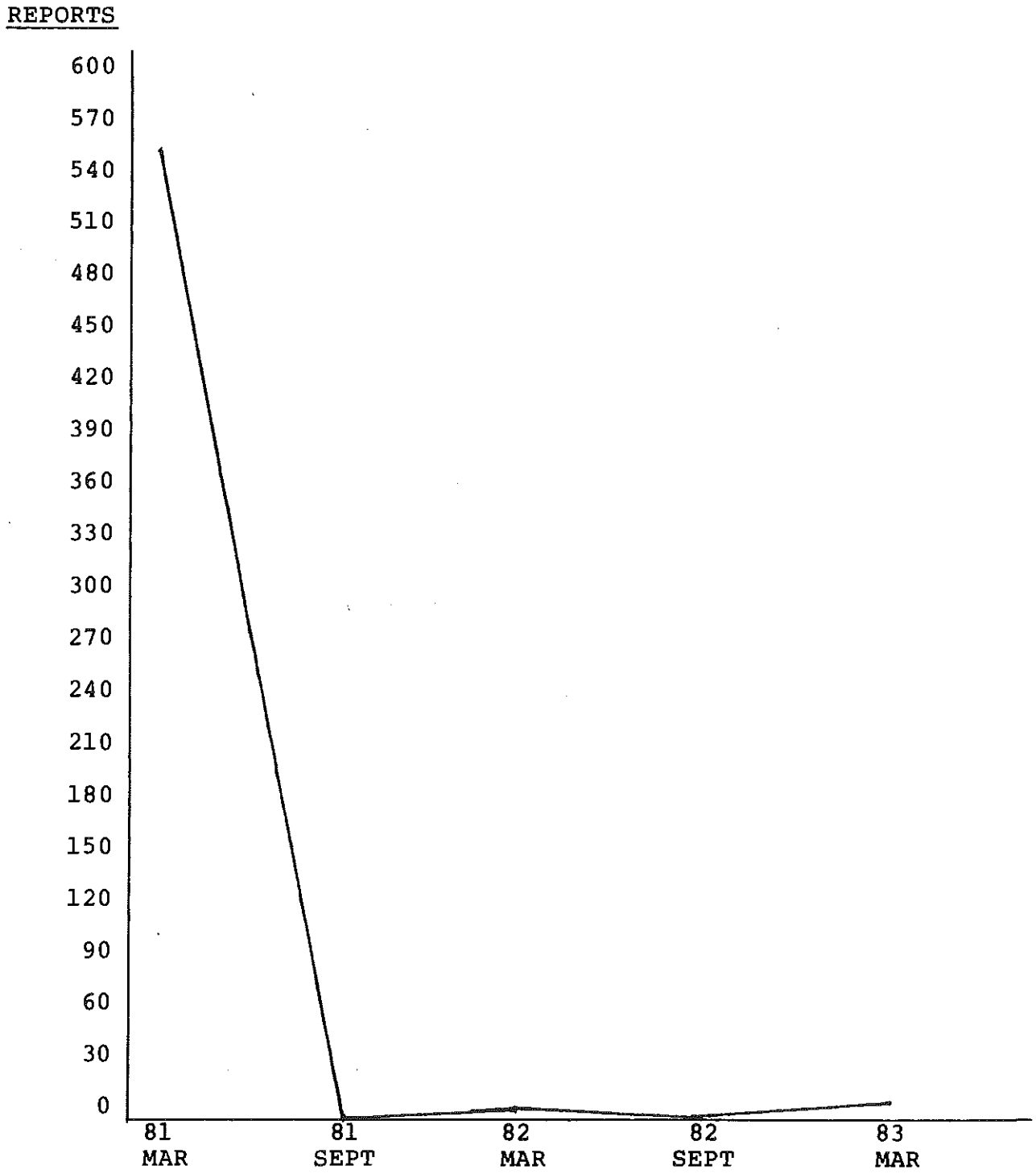


EXHIBIT F

UNRESOLVED AUDITS
MARCH 1981 - MARCH 1983



SUMMARY OF RECEIVABLES, COLLECTIONS WRITE-OFFS (IN MILLIONS)

Source	Receivables		Collections		Write-Offs	
	6/30/82	12/31/82	6/30/82	12/31/82	6/30/82	12/31/82
Audit Disallowances (1)	$ 201.2	$ 237.0	$ 34.0	$ 47.7	$ 1.0	$ 0.1
Owed by Public (2)	3,115.7	3,262.5	1,448.9	1,494.4	59.9	39.6
Total (3)	$3,316.9	$3,499.5	$1,482.9	$1,542.1	$60.9	$39.7

Notes: (1) Debts due to recommended audit disallowances which have been sustained by the program office as of 6/30/82. This figure included $122.1 million in amounts under appeal. As of 12/31/82 amounts under appeal totaled $184.9 million.

(2) Includes amounts other than audit recommended disallowances. Examples include health professional nursing student loans, hospitals, health maintenance organization facility construction loans, and overpayments to SSA/SSI beneficiaries.

(3) HHS also has receivables due from other Federal agencies and certain funds from employees. Our comments do not deal with these amounts. Department-wide procedures applicable to these two types of debt are being developed.

EXHIBIT G

SUMMARY

STATUS REPORT ON STATE PLANS
TO AUDIT FY 1982 BLOCK GRANTS
(as of December 1982

Legend: Numbers represent States not actual audits.

REGION/STATES	STATE CONTACTS		AUDIT STARTS			AUDIT METHODOLOGY USED**					STATES NOT AUDITING FY 1982 FUNDS	REMARKS
	Con-tacted	Not Contacted	In Process	No Starts	Com-pleted	Separate Blocks	Block Pkg. Dept-Wide	Block Pkg. State-Wide	Att P Audits	Un-decided		
I : MA RI* NH VT ME CT	6	0	4	2	1	5 1/	0	0	1	0	RI	Potential problem: RI has no plans to audit '82 blocks.
II : NY NJ PR VI*	4	0	3	1	0	3	0	1	0	0		No problems noted though VI has no starts.
III: PA* VA WV DC* DE MD*	6	0	4	2	0	2 2/	0	0	3	1	MD	Potential problem: DC undecided on audit plan; MD not planning to audit FY 82 Blocks; PA has no starts.
IV : AL* FL GA KY MS NC SC TE	8	0	7	1	0	2	1	0	5 3/	0		No major problems though AL has no starts.
V : IL IN* MI MN* OH* WI*	6	0	2	4	0	1	0	0	4	1	MN	Potential problems: MN has no plans to audit '82 blocks; OH has no audit plan; WI undecided on FY 82 blocks; IN has no starts.

*/ Potential problems in the State.
**/ Separate Blocks: Each Block Grant will be audited and reported on separately.
Block PKG (Dept-Wide): All Block Grants administered by a State Dept will be audited as part of one audit.
Block PKG (State-Wide): All Block Grants administered by a State will be audited as part of one audit.
Att P Audit: Block Grants will be included in States' ATT P audit(s).
Undecided: State has no definite plan for conducting or ensuring audits of Block Grants as required by Legislation.

EXHIBIT H

SUMMARY

STATUS REPORT ON STATE PLANS
TO AUDIT FY 1982 BLOCK GRANTS
(as of December 1982

REGION/STATES	STATE CONTACTS		AUDIT STARTS			AUDIT METHODOLOGY USED**					STATES NOT AUDITING FY 1982 FUNDS	REMARKS
	Con-tacted	Not Contacted	In Process	No Starts	Com-pleted	Separate Blocks	Block Pkg. Dept-Wide	Block Pkg. State-Wide	Att P Audits	Un-decided		
VI : TX NM AR* LA* OK*	5	0	2	3	0	1	0	0	3	1	AR LA	Potential problems: AR & LA not auditing '82 blocks as required; OK undecided on audit plan; AR has no starts.
VII : IA* KS* MO* NE*	4 4/	0	4	0 4/	0	1	1	0	2	0	KS	Potential problems: KS not auditing all FY 82 blocks; info incomplete for IA, KS, MO and NE.
VIII: CO MT ND SD* UT* WY	6	0	4	2	1 5/	1	0	0	4	1		Potential problem: ND not auditing 82 blocks until after June 30, 1983; SD undecided; UT has no starts.
IX : CA HI AZ* NV Pac Is. Guam Am Sa-	4	4	3	1	0	0	0	0	4	0		Potential problem: AZ did not provide specifics on audit plans; NV has no plan for 3 blocks.
X : AK* WA OR ID*	4	0	2	2	0	1	1	0	1	1		Potential problems: AK undecided; ID hs no starts.
TOTALS	53	4 6/	35	18	2	17	3	1	27	5		

1/ Vermont implementing Att P after FY 82.
2/ VA and WV intend to use Att P after FY 82.
3/ KY, NC, FL and SC to use Att P Dept-Wide; TE auditing State-Wide.
4/ MO and NE response to Region VII's letter requesting block grant info was incomplete; Region VII staff will follow-up.
5/ SD Legislative Auditor conducted Dept-Wide audit (not an A-102). Separate report to be issued on Low Income Energy Block; report is in final stage of review as of 1/21/83.
6/ Pacific Islands, Guam, Am Samoa, and Trust Territories not yet contacted. Arrangements need to be worked out with Department of Interior before obtaining block grant audit information.

EXHIBIT I

ANALYSIS OF COST SAVINGS *
OCTOBER 1982 THRU MARCH 1983

AUDIT RECOMMENDATION	ACTION TAKEN	SAVINGS MILLIONS
HEALTH CARE FINANCING ADMINISTRATION		
1. Eliminate excessive nursing differential of 8.5 percent paid to Medicare providers for routine nursing care. (ACN 13-82071)	On September 3, 1982, P.L. 97-248 was signed into law eliminating the nursing differential.	$110.0
2. That action be taken to limit Medicare's participation in the cost of pacemakers to reasonable and necessary amounts using prospective limits and or experiments and demonstration projects. (ACN 08-32608)	HCFA advised that activities were underway concerning coverage and reimbursement of pacemakers.	64.0
3. Eliminate unnecessary periodic recertification of need for services provided Medicaid recipients in Intermediate Care Facilities. (ACN 03-30150)	By memo dated March 2, 1983 HCFA advised that the Department's 1984 legislative proposal included a provision to eliminate this recertification requirement.	60.0
4. That Medicare level of care standards be used for Medicaid when determining the need for skilled nursing care (Problem found in one State). (ACN 03-10153)	The State advised that it would use Medicare level of care standards for its Medicaid program.	20.6

* Cost Savings represent areas where Department managers have made formal commitment to implement audit recommendations. Actions taken or planned should: (1) prevent improper expenditures/obligations in the future and/or, (2) improve agency systems and operations thereby avoiding unnecessary expenditures in the future.

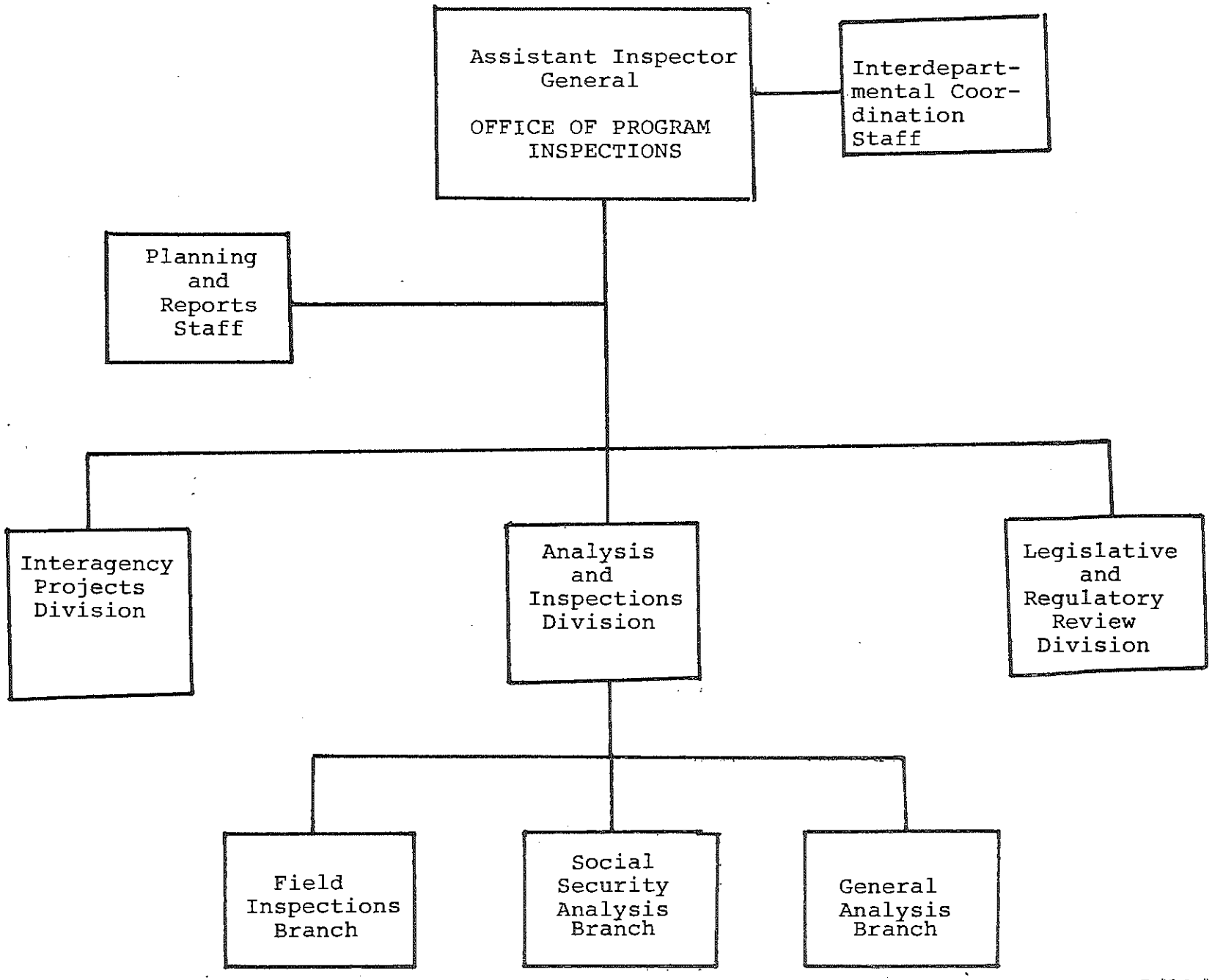
AUDIT RECOMMENDATION	ACTION TAKEN	SAVINGS MILLIONS
5. Reduce Federal payments for laboratory services to reflect prices available on the open market to physicians. (ACN 09-10246)	The California Legislature ordered the State Department of Health to cut prices paid for certain lab tests by 25 percent.	8.4
		263.0
SOCIAL SECURITY ADMINISTRATION		
1. Seek legislation requiring States to consider heating allowances received from other Federal programs in determining AFDC assistance payments. (ACN 01-20252)	SSA advised that the Department has submitted a legislative proposal that would implement our recommendation.	95.0
2. Issue regulations requiring the timely return of the Federal portion of uncashed AFDC benefit checks and other credits. (ACN 15-90250)	SSA advised that final regulations will be issued in June 1983 requiring States to refund the Federal portion of uncashed checks within 180 days.	13.0
3. That New York reduce its Adjusted Payment level by about $10 per case. Note: To determine Federal/State liability of cases transferred from State operated assistance programs to the SSI program, an APL rate is computed. The rate represents what an SSI recipient would have received under the transferred program for January 1972. The rate is used to determine base liability. (ACN 02-12300)	On December 23, 1982, SSA made the final decision that the N.Y. APL rate was incorrect and required adjustment.	12.6
4. Increase the interest charge for late deposits of Social Security contributions. (ACN 13-22690)	SSA concurred and said that a legislative amendment would be prepared for FY 1984 increasing the interest rate.	3.0

AUDIT RECOMMENDATION	ACTION TAKEN	SAVINGS MILLIONS
5. That SSA submit legislation to allow their use of tax return data in verifying earnings of Black Lung recipients. (ACN 13-22701)	The Department's FY 1983 legislative proposal included a provision to incorporate our recommendation.	1.0
6. That SSA make numerous procedural and system changes to improve its processing of the Annual Wage reporting data. (ACN 13-22642)	As part of SSA's System Modernization plan, the Annual Wage reporting process will be redesigned to incorporate the thrust of our recommendations.	.5
7. That Massachusetts credit Federal programs for their share of uncashed benefit checks and other credits. (ACN 01-20601)	The Department concurred with our findings and disallowed an additional $.4 million.	.4
		125.5
PUBLIC HEALTH SERVICE		
1. Improve procedures for determining recoveries due the Federal Government from sale or termination of operations of health facilities provided Hill-Burton Grant funds. (ACN 04-23001)	PHS concurred with our report and has taken action to correct this problem.	80.0
2. Bill third party insurers for health services provided by Indian Health Service facilities. (ACN 12-23133)	The Department's 1984 budget submission notes that a concerted effort would be initiated to collect reimbursements from all sources.	33.0
		113.0
		501.5
		167.1
In addition, managers concurred with audit recommended financial adjustments totaling $167.1 million.		668.6*

* Rounded to $669 Million

OFFICE OF PROGRAM INSPECTIONS

OFFICE OF PROGRAM INSPECTIONS



5/12/83

OFFICE OF PROGRAM INSPECTIONS

FUNCTION

The Office of Program Inspections (OPI) was created in January, 1982 as part of an overall reorganization of the Office of Inspector General. OPI integrates the OIG efforts toward improved management efficiency and effectiveness.

The legislative authority for OPI derives from P.L. 94-505, Title II, which says that the OIG was created partly ".... to provide leadership and coordinate and recommend policies for activities designed

(A) to promote economy and efficiency in the administration of, and

(B) to prevent and detect fraud and abuse in, such programs and operations...."

This "leadership and coordination" role is the central function that distinguishes OPI from other components in the OIG. OPI also coordinates the various interagency projects of the President's Council on Integrity and Efficiency (PCIE).

Because OPI plays a leadership and coordinating role, OPI staff conduct many different types of activities. These range from short-term examinations of proposed regulations to longer-term assessments of programs and their impacts at the client level. The most common types of activities are:

ACTIVITIES

1. <u>Review of legislative and regulatory proposals</u>

   Proposed changes in legislation, regulation or the administrative practices are analyzed and monitored to determine their effect upon program vulnerability.

2. <u>Corrective Analysis and Follow-up</u>

   OPI has initiated a system to monitor and evaluate follow-up activities of significant findings and recommendations. This system integrates information drawn from OIG audits, investigations, and OPI reviews.

3. Monographs

Monographs are brief written descriptions of OIG's current knowledge of specific fraud, abuse, and waste problems identified in Departmental programs. They may cover a problem in a single program area, but they also may deal with a specific problem endemic to more than one program (such as overclaimed administrative costs). They do not cover the full spectrum of a single program's operations.

4. Service Delivery Assessments (SDAs)

Service Delivery Assessments (SDAs) are short-term examinations of HHS programs and program-related issues. These 3 to 4 month studies provide the Inspector General and the Secretary with timely information about the operations and effects of programs at the local level.

5. Program Inspections

Program Inspections provide analysis of program and management issues within the Department and, like SDA reports, provide the Secretary with specific recommendations. Program Inspections staff also have significant responsibility for projects for the President's Council on Integrity and Efficiency.

6. Management Implication Reports

Management Implication Reports (MIRs) represent a refocusing of the criminal investigative process from an exclusive concern with an individual case to a concurrent consideration of the systemic weakness that permitted the fraudulent or abusive act to occur. Investigators prepare a MIR which describes the systemic weakness identified. OPI staff then analyzes it to determine remedial measures and make recommendations to remedy the problem.

In addition to most of the studies discussed in the PCIE and Prevention sections of this report, following are summaries of reports issued by OPI:

ASSISTANCE TO DEPARTMENT OF EDUCATION

- Over the past year our Service Delivery Assessment (SDA) staff has provided frequent technical assistance to the Department of Education (ED) on ways to obtain timely, policy-relevant information about the operations and impacts of ED programs. This assistance has included critiquing proposed study topics, training ED staff in ways to gather information, and reviewing draft reports.

  This inter-Department cooperation has recently culminated in ED's completion of their first SDA project and the subsequent briefing of top management on the findings.

MEDICARE BENEFICIARY FORMS

- To see whether Medicare beneficiaries are having problems with current Medicare forms, we examined past studies by the OIG and HCFA and interviewed HCFA staff, carrier representatives, and Medicare beneficiaries. We found that (1) Medicare beneficiaries whose physicians take assignment do not have to fill out Medicare forms for reimbursement and thus have few problems with the claims process, (2) some physicians who do not take assignment will, nonetheless, complete the necessary forms as a service to their Medicare patients, and (3) Medicare beneficiaries whose physicians do not take assignment and do not assist patients with Medicare forms often do have problems with the claims process. In addition, all Medicare beneficiaries have major problems with the Explanation of Medicare Benefits (EOMB), which is criticized for its unclear and incomplete explanations, confusing terms, complicated layout, and small print.

  We briefed the Secretary on these problems with current Medicare forms and on improvements which could be made. Based on the briefing, the Secretary instructed HCFA to implement, on a national level, a completely redesigned EOMB which will be much more understandable to Medicare beneficiaries. As a result, HCFA issued a copy of the instructions to the carriers to be made to the EOMB. Many carriers are well along the way to completing the redesign. The balance will have completed the redesign by October 1, 1983.

TEENAGE ALCOHOL ABUSE

- At the request of the Secretary, Region VI SDA staff led a study on teenage alcohol abuse. Key findings presented to the Secretary which were based on visits to 17 sites in 10 States include the following: (1) teen alcohol abuse is a major problem that is growing and has increased during the last ten years; (2) teens

abusing alcohol are at serious risk due to death or injuries resulting from alcohol-related traffic accidents; (3) State officials and providers project that teen alcohol programs and services will decrease as the Alcohol, Drug Abuse and Mental Health Block Grant is implemented; and (4) while they welcome the block grant, most State officials voice a strong desire for a continuing leadership role by HHS and the National Institute on Alcohol Abuse and Alcoholism in the alcohol field.

As a result of the SDA briefing, the Secretary launched a Secretarial initiative on teenage alcohol abuse. Included in the initiative are the following: (1) ten regional meetings began in October 1982 to promote the expansion of prevention and early intervention services for youth across the country; (2) ten regional meetings beginning in Spring 1983 to promote the expansion of treatment services for youth across the country; (3) a Secretarial conference in D.C. sponsored jointly with the Departments of Transportation and Agriculture in Spring 1983 to promote national attention to the cause of teen drunk driving; and (4) a Surgeon General Advisory to the medical community, parents, and teenagers on the medical and developmental consequences of youthful alcohol consumption.

CHILD SUPPORT ENFORCEMENT PROGRAM

o To examine the management and the effectiveness of the Child Support Enforcement (CSE) program, OIG visited 20 sites in 9 states and met with almost 400 AFDC and non-AFDC clients, absent parents, state and local officials, caseworkers, and audit staff. We found that (1) CSE is generally considered to be successful, but greater cooperation is needed between AFDC, Medicaid, and CSE staff, (2) the Federal Parent Locator Service is considered ineffective in locating absent parents, and (3) the current financing of CSE unfairly favors states over the Federal government.

The Secretary instructed the Social Security Administration (SSA) to increase cooperation between Medicaid, AFDC, and CSE staffs and to improve the effectiveness of the Federal Parent Locator Service. Most importantly, he instructed SSA to prepare proposals for altering the financing of the program. As a result, regulations have been published which will become effective October 1, 1983 and which will reduce the Federal matching rate for state administrative costs from 75 to 70

percent and reduce the incentive payments to states from 15 to 12 percent. These two actions alone will save the Federal government $97 million in FY 1984.

CONVICTED PROVIDERS IN MEDICARE AND MEDICAID

- To identify more effective methods to detect and deter provider fraud in the Medicare and Medicaid programs, OIG reviewed documents, met with Federal and state program officials in 4 states, and met face-to-face with convicted providers. We found that (1) most convicted providers have little or no knowledge about how fraud or abuse is detected, (2) thus, fear of sanctions (arrest, conviction, financial penalties, jail, loss of license, suspension from the program) has little impact on their behavior prior to conviction, and (3) what is needed is early intervention by the carriers and the government before abusive practices cross the line into fraud. Providers must have clear guidance on what is and is not permissible and must feel a clear "sense of presence" on the part of government watchdogs.

  These findings are being used by the OIG Office of Investigations and the OIG Office of Health Financing Integrity to develop profiles of convicted providers and to improve systems to detect and deter potential fraud. In addition, we have shared our study methodology and findings with representatives from the Veterans Administration and the Department of Defense CHAMPUS program.

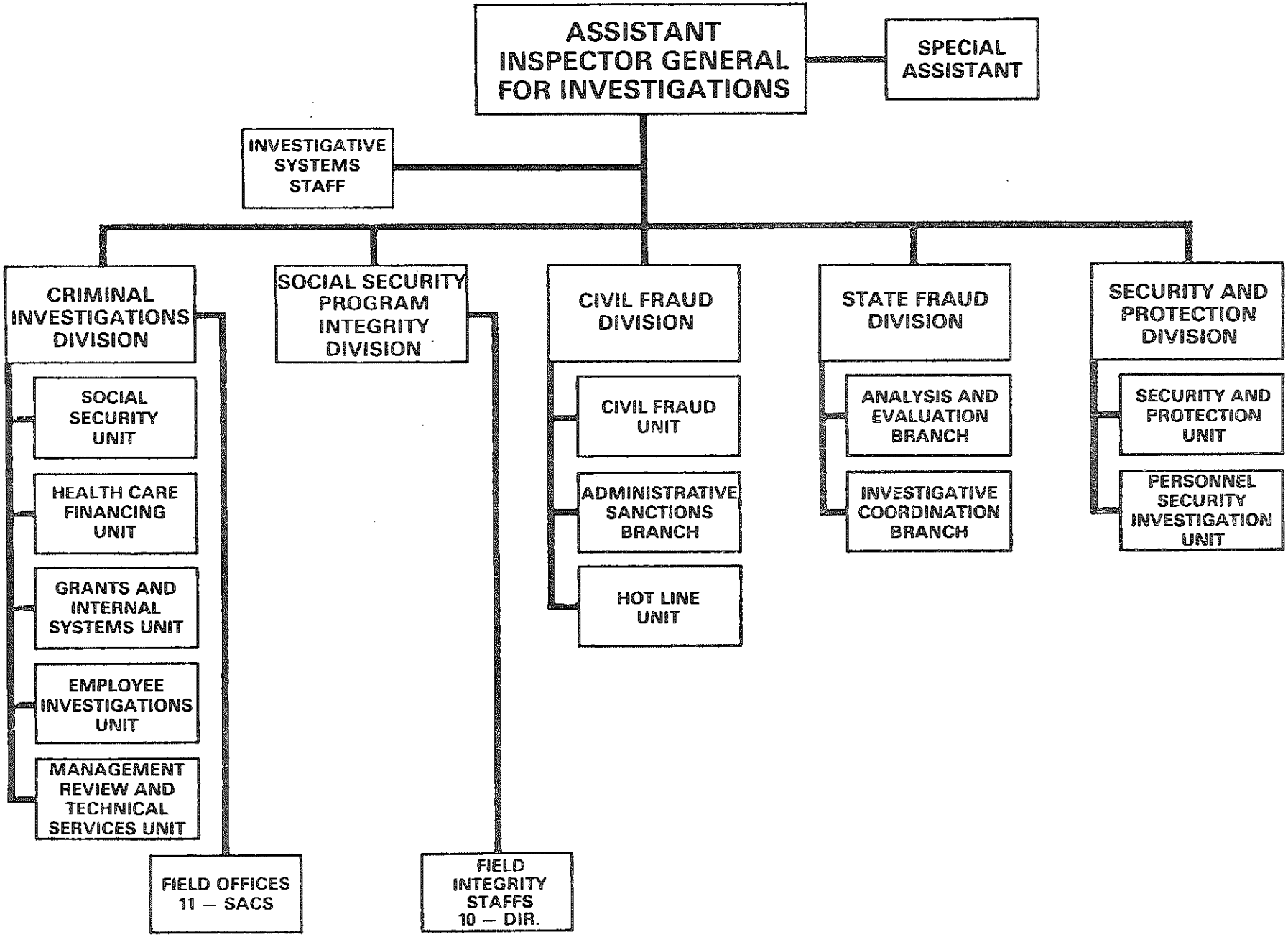
PRESCRIPTION DRUG ABUSE AND DIVERSION IN MEDICAID

- To examine the abuse and diversion of prescription drugs in Medicaid, staff visited 5 states and met with state officials, medical and pharmacy boards, state and Federal Drug Enforcement Administration officials, the FBI, Medicaid Management Information Systems (MMIS) contractors, and local physicians and pharmacists. In addition, we analyzed Federal and state legislation, Congressional and GAO reports, past HHS studies, relevant professional journals, and media articles. The study found that (1) the Medicaid program is a vulnerable source of abusable drugs, either for an individual habit or for profit, (2) the full costs of this abuse and diversion are unknown, but may range from $30 million to $90 million for drugs and drug-related services, (3) few states have been able to control either problem recipients or problem providers, and (4) recent legislation allows more flexibility and thus more opportunities for states and the Federal government to take action.

Based on this study, we are developing ways for the Health Care Financing Administration and the states to take advantage of recent legislation, finalizing plans for OIG use of the Civil Monetary Penalties Act, documenting best practices for distribution to the states, supporting the actions of the American Medical Association's committee on drug misuse, abuse, and diversion, and determining whether authority exists for other actions such as excluding fraudulent entrepeneurs from the program.

OFFICE OF INVESTIGATIONS

OFFICE OF INVESTIGATIONS



MISSION AND STRUCTURE

The mission of the Office of Investigations is to reduce the incidence of fraud, waste and abuse in Department programs and operations by:

- Investigating alleged wrongdoing to determine whether violations of law or regulations exist.
- Furnishing evidence for criminal, civil, and administrative actions.
- Pursuing actions to recover dollars lost through program violations.

The Office also is responsible for providing protection and security for the Secretary, ensuring Department physical security, administering the grant program that funds State Medicaid Fraud Control Units, and operating the Inspector General's Hotline.

OI is structured according to its major functions, with separate divisions responsible for criminal investigations, civil and administrative investigations, State fraud grant administration, and Department security and protection. Investigation of social security beneficiary fraud is handled by a new division, because of the program size and the recent transfer of this function to the Office of the Inspector General.

OI's authorized staff has recently been raised to 385 positions. Transfer of the Social Security program integrity function added about 190 positions to OI's previous staff.

OVERVIEW OF INVESTIGATIVE ACTIVITIES

Within the past year OI moved toward focusing on cases which offered high payoff. To achieve this end, OI investigators began reducing the burdensome backlog of low-priority cases and redoubled efforts to do high-quality investigations on cases which held promise of positive judicial action.

Like any other type of inventory, an excessive backlog of cases is costly to store and manage. Moreover, the inventory looses value with age. As shown in Exhibits A and B, before redirecting its caseload management, OI had opened 1,029 cases and closed 490 during the six-month period ending March 31, 1982. Thus, in that period alone a backlog of 539 cases accrued. Because of the size of the caseload, too much time had to be spent on simply keeping track of a large quantity of cases. The results were poor: during this period 160 cases were presented to prosecutors, of which 69 (43%) were rejected. There were 116 convictions and pre-trial diversions, and 40 conviction assists.

IMPROVED CONVICTION RATE

By comparison, in the six-month period ending March 31, 1983, OI opened 543 cases (52% of the comparable 1982 rate) and closed 506 cases, a 93% closure rate. Through better case management, a backlog of only 37 cases was generated. The declination rate for cases presented to prosecutors was reduced by 50% while the number of cases accepted increased by 70%. Finally, the total number of judicial actions increased by 52%, from 156 to 237.

As shown in Exhibit C, OI's caseload has also reflected the move toward reduction of backlog and high-quality investigation. Convictions increased by 41%, as indicated in Exhibit D. Fines, restitutions, settlements and judgments

resulting from criminal and civil actions amounted to $1,628,650, in comparison with $1,010,699 for the same period last year, for a 61% increase.

The preceding comparisons did not include figures for the Social Security Program Integrity Division because it was not a part of the OIG a year ago and its statistics are kept on a slightly different basis. However, that division carries an impressive workload. Moreover, its conviction rate is also showing marked improvement along with significant increases in recoveries, as indicated in Exhibit E.

The following pages describe, by operating component, OI's investigative activities during this reporting period. Where possible, specific cases are given by way of illustration. They are followed by brief reports on the internal security and Hotline functions.

EXHIBIT A

INVESTIGATION RESULTS (a)
October through March, FY 1982 and 1983

	Number or (Percent) 1983	1982
Investigative Activities		
Cases Opened	543	1,029
Cases Closed	506	490
Backlog Incurred	37	539
U.S. Attorney Actions		
Presentation to Prosecutors	197	160
Declinations	42	69
Percent Declinations	(21%)	(43%)
Judicial Actions		
Convictions and Pre-Trial Diversions	164	116
Conviction Assists	73	40
Total Judicial Actions	237	156
Percent increase in Judicial Actions	(52%)	

(a) Does not include Social Security Program Integrity figures, since this function was not part of the OIG a year ago.

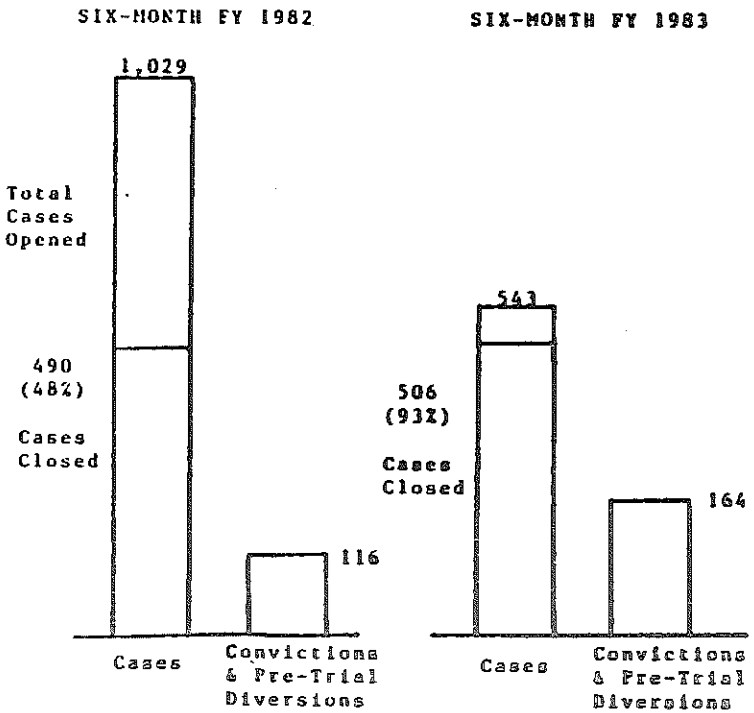
EXHIBIT B

CASE MANAGEMENT

QUALITY OF CASES

October through March, FY 1982 and 1983

Focus on Quality Cases Increases Convictions



Declination Rate Reduced by 50% and Volume of Accepted Cases Increased by 70%

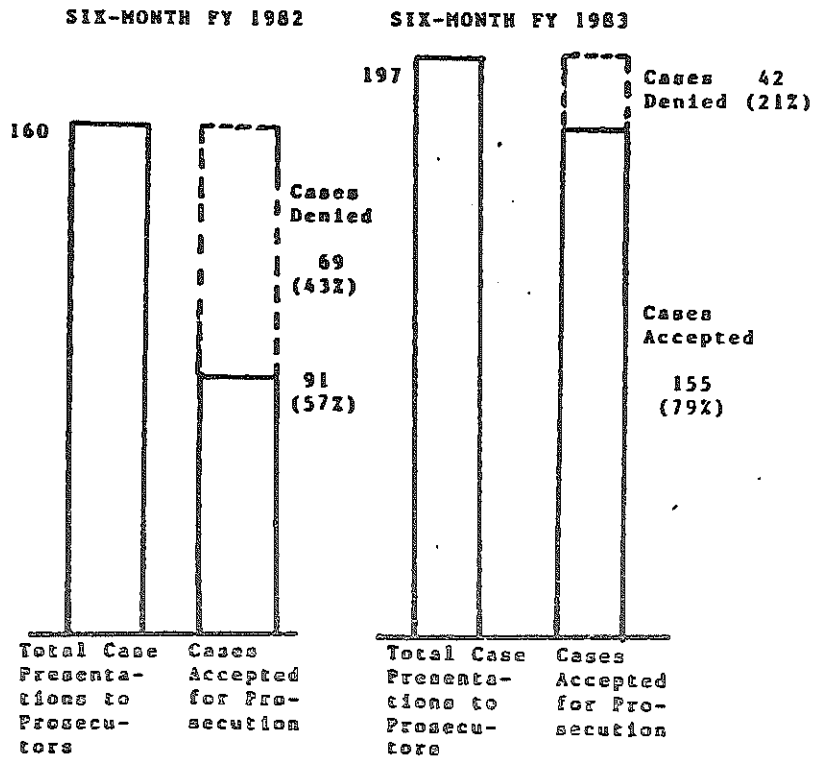


EXHIBIT C

INVESTIGATION CASELOAD BY PROGRAM AREA (a)
October through March, FY 1982 and 1983

Program Area	Number of Cases 1983	1982
PHS	85	105
OHDS	53	66
SSA	295	564
HCFA	523	448
Department Management	35	26
Education	4	4
Total	995	1,213

(a) Does not include Social Security Program Integrity figures, since this function was not part of the OIG a year ago.

EXHIBIT D

CONVICTIONS BY PROGRAM AREA (a)
October through March, FY 1982 and 1983

Program Area	1983	1982
PHS	5	6
OHDS	6	5
SSA (b)	133	65
HCFA	18	38
Department Management	2	0
Education	0	2
Total	164	116
Percent Increase, 1983 over 1982	41%	

(a) Does not include Social Security Program Integrity convictions, since it was not a part of the OIG a year ago.

(b) Includes SSA Benefits Project convictions, 3 in 1982 and 81 in 1983.

EXHIBIT E

SOCIAL SECURITY PROGRAM INTEGRITY DIVISION
INVESTIGATION RESULTS
October through March FY 1982 and 1983

Cases Received	3,975	5,411
Cases Cleared	4,973	4,784
Convictions (a)	182	128
Pre-Trial Diversions	33	36
Recoveries (b)	$4.0 million (c)	$3.7 million

(a) Does not include settlements or judgments in favor of the government.

(b) These figures represent monies actually refunded, fines and restitution ordered by the courts, and amounts suspects agreed to repay under other circumstances.

(c) Does not include $27 million identified in study of unverified remittances, which SSA management is committed to recovering.

OFFICE OF INVESTIGATIONS

Social Security Administration

SOCIAL SECURITY ADMINISTRATION

Historically, the major proportion of OI investigations have revolved around Social Security programs. In view of the tremendous size of these programs, both in dollars of benefits paid and numbers of recipients, the emphasis is logical. Many of the millions of beneficiaries have scrupulously returned overpayments and carefully reported changes in eligibility status. Others have not, and some have deliberately tried to defraud these programs. Over the years major advances have been made in developing computer techniques to identify persons who may have taken unwarranted advantage of the system. Thus the numbers of Social Security program convictions have outweighed those in other program areas. The trend is expected to continue with an entire OI division now devoted to investigation in this area.

Social Security Benefits Project

SSA BENEFITS PROJECT YIELDS 81 CONVICTIONS

One of OI's most successful efforts in fighting benefits fraud has been a computer project known as the SSA Benefits Project. The project involved a computer match of SSA beneficiary rolls with HCFA death notification records. The purpose of this match was to detect individuals suspected of fraudulently obtaining SSA trust fund monies which were mistakenly being paid to deceased beneficiaries. During this six-month period alone this project has resulted in 81 convictions, with fines, restitutions, and recoveries amounting to $1,650,095. In the two years since its inception, a total of 98 convictions have been obtained, along with $9,811,464 in recoveries, fines and restitutions. Savings for the government from the project are estimated to amount to $25.2 million.

Typically, the fraud investigated in these cases was perpetrated by relatives of deceased beneficiaries, who received and converted to their personal use monthly checks that continued to be sent after the beneficiaries' deaths. Over a period of time, the monies illegally converted can amount to a substantial sum. The following cases are typical:

CASHED DECEASED RELATIVES SS BENEFITS CHECKS

- In separate cases in Michigan, a man and a woman were convicted of converting their dead grandmothers' checks to their own use. He was sentenced to six months in prison (plus six months suspended) and ordered to repay $26,000. She was given four years probation and had to repay a similar amount.

- A California woman was arrested for cashing her dead mother's checks. She was suspected of stealing more than $30,000 over an eight-year period. However, because of Statute of Limitations, she could only be charged with thefts after 1977--which amounted to more than $20,000.

- A Tennessee man had to repay $26,000 he had stolen in benefits mistakenly sent to his deceased mother. He also was ordered to serve nights and weekends at a Salvation Army facility for six months, plus three years probation.

NURSING DIRECTOR USES DEAD PATIENT'S BENEFITS

Occasionally, the SSA Benefits Project turns up non-relatives using deceased persons' benefits. In Michigan the director of nursing at a nursing home had been made a joint holder of a patient's bank account so she could help him pay bills. After he died, she began cashing checks on the account for her own use. The money in the deceased's account came from direct deposit of Social Security benefits payments. The nursing director was sentenced to three years probation, had to repay $11,600, and had to contribute $200 worth in community service work.

Not everybody identified by the SSA Benefits Project managed to obtain large sums of money. However, the cumulative results are impressive, suggesting advantages to using computer techniques in detecting and investigating other program-related fraud cases.

Other Social Security Benefits Investigations

Aside from major fraud detection projects, most other violators are caught because someone complains. Sometimes these complaints center on public servants who use their positions to obtain illegal personal gains.

PUBLIC SERVANTS USE POSITIONS TO DEFRAUD

- In New York, a district attorney's office reported to the OIG a complaint that a State Veterans Affairs counselor might be getting kickbacks for helping veterans get SSA disability benefits. Investigation showed that the man and two accomplices obtained some $75,000 in kickbacks from veterans the counselor had represented in disability hearings. The counselor was convicted, sentenced to assisting senior citizens one day a week for three years, and ordered to repay almost $70,000 to those from whom had received kickbacks. The other two men each received one year conditional discharge and had to repay $3,000 to those they defrauded.

- A California woman reported to SSA that she had given one of its employees a money order for benefits she had been overpayed, and that he had afterwards wanted more money, ostensibly for further overpayments. Investigation showed that over a two-year period, the employee had fraudulently pocketed nearly $14,000. He did so by cashing monthly benefits checks of four deceased persons, and by converting to his own use overpayments returned by at least two other persons. The employee pled guilty to fraud charges.

Four other SSA employees were prosecuted during this six-month period in Tennessee, California, Illinois, and Ohio for misappropriating deceased persons' benefits checks or overpayments returned to SSA. Apparently, accessibility to the checks and loose accountability within the system sometimes prove too tempting, even though the rewards are usually small and the penalties severe. A draft report issued by OI staff during the period showed that SSA was unable to recover a projected $23 million in overpayments because a large portion of unverified cash refunds had not been properly handled by SSA. Corrective actions proposed could result in another $23 million recovered and avoidance of $4 million in losses in one year alone.

CIVIL SUIT BRINGS IN $300,000

Occasionally individuals engaged in defrauding SSA benefits programs are tripped-up by seemingly minor, unrelated incidents. In February, a 41-year-old legally blind man was ordered to pay the government a total of about $300,000 as a result of a civil suit. The suit followed an earlier criminal conviction for defrauding the SSI program of almost $140,000 over a seven-year period. In this scheme the man had sent for birth certificates of children killed decades before in airplane crashes. With the certificates he acquired Social Security numbers and at least eight identities. He established medical histories under each identity and applied for SSI benefits. The scheme began to unravel when he was stopped by a transit policeman for trying to put a foreign coin in a coin machine. When an SSI check and a bank book in someone else's name were found on him, HHS investigators and the Secret Service were brought in. At the time, he had a quarter of a million dollars scattered about in several different banks.

Aid to Families with Dependent Children

Cooperative efforts with other Federal and State agencies are essential in fraud detection and investigation in the Aid to Families with Dependent Children program (AFDC). This program is administered by the States, and therefore State involvement is fundamental. In addition, eligibility for the program usually determines eligibility for benefits such as food stamps and housing which are under the jurisdiction of other Federal agencies. Thus multilevel cooperative projects have evolved. Computer matches have been used successfully for some time on many of these joint projects.

26 CONVICTIONS FROM AFDC PROJECT

One such project which resulted in a large number of convictions during this reporting period is being conducted jointly with the Departments of Agriculture and Housing and Urban Development and the individual States. Essentially, the project involves matching State employment records with State public assistance recipient files. The purpose of the match is to identify recipients who are working and have not reported earnings to the assistance programs. Such persons thus may be receiving AFDC, SSI, Medicaid, housing subsidies or food stamps illegally. During the reporting period, 26 persons were convicted as a result of this project, a total of $43,293 ordered in restitutions and $ 7,598 collected in fines. These fraud cases typically do not involve extremely large amounts of money. The large numbers of cases identified by this method, however, have resulted in 109 convictions, $92,770 in restitutions and $44,930 in fines since the project's inception.

The success of the AFDC public assistance project led to the development of an AFDC interjurisdictional match involving all 50 States, the District of Columbia and Puerto Rico. AFDC data tapes from the partici-

pating States are compared, to detect individuals who appear on more than one AFDC roll. Preliminary matches have yielded about 20,500 raw "hits" which require further screening and investigation. One particularly interesting case during the last six months involved a conspiracy among a Connecticut woman, a landlord, and a mailman. The woman, who received AFDC checks from three States, transported other Connecticut residents to New Jersey to file for benefits. The scheme involved a bogus address and bribing the mailman and landlord to deliver and receive checks.

PROJECT "MISSING KIDS"

Investigators in Connecticut initiated a project to identify persons who invented fictitious children in order to receive AFDC benefits. AFDC records were compared with Medicaid tapes, school attendance records and vital statistics records. Two cases are still under investigation from this project. A total of eight convictions have resulted, one of them during the last six months.

ILLEGAL ALIENS BENEFITS PROJECT

Another project begun in Connecticut is a spin-off of the OI illegal alien project described in the following section. Illegal aliens using Social Security numbers for work purposes are matched against State welfare rolls. The objective is to identify those who are receiving AFDC and other benefits illegally. Results of this project are not yet in, but 27 cases are currently under investigation.

Social Security Numbers (SSNs) and Cards

FALSE ID'S MAY COST $15 BILLION A YEAR

The General Accounting Office has estimated that crimes based on false identification, including false and misused SSN's, cost the taxpayers more than $15 billion a year. Although not originally intended as such, SSN's have become de facto universal identification numbers in the United States. They are now used in administering tax, welfare, drivers

license and other public programs. They are also one of the factors of eligibility for all HHS benefits programs. Only within the last few years has it become necessary to show evidence of age, identity and citizenship status to obtain an SSN.

Evidence requirements have resulted in illegal aliens and others developing schemes for obtaining SSN's. Illegal aliens need SSN's to work and obtain benefits; others use them for scams based on false identities, as well as to obtain benefits.

Illegal aliens obtain SSN's by purchasing counterfeit cards and numbers, stealing authentic blank cards, and bribing SSA employees. OI and the Immigration and Naturalization Service have been working on a project that focuses on criminal conspiracies to obtain SSN's for illegal aliens. Often the Federal Bureau of Investigation, the Internal Revenue Service and the U.S. Postal Service are involved.

Most of the convictions obtained during this period occurred in areas which have a large illegal alien population: Texas, California, Chicago, and the northeastern seaboard.

ILLEGAL ALIENS AND FALSE SSN'S

- A Texas man was sentenced in November for making and selling counterfeit Social Security cards and birth certificates to OI and INS agents for $500 a set. A search yielded 75 counterfeit cards and the paraphernalia used to create the certificates.

- In December, two other Texas men pled guilty after selling to a government informant and a government undercover agent counterfeit Social Security and alien registration cards for $750 a pair.

- In California, the Los Angeles County Sheriff's Office arrested a man after his former landlord reported that printing equipment and blank Social Security cards had been left on the premises of property he rented out. Charged Federally with counterfeiting Social Security cards, the man fled the country while on bond and is now a fugitive.

- A Chicago man reportedly selling cards to illegal aliens was arrested and convicted after OIG and INS agents monitored a sale to an informant.

- In New York, a citizen of Nigeria who overstayed her visa pled guilty to fraudulently obtaining an SSN and using it to get a Federally subsidized student loan.

OTHER SSN FRAUD CASES

Several convictions were won against individuals other than illegal aliens who used SSN's as the basis for elaborate schemes. The case of the legally blind man in California who painstakingly created at least eight separate identities to obtain SSI benefits, cited earlier, was perhaps the most bizarre. The following illustrate other schemes using fraudulent SSN's.

- In Connecticut a man was convicted for mail fraud, fraudulent use of credit cards, and misuse of social security numbers in a scheme to defraud credit card companies and merchants of goods, services and cash advances totaling more than $50,000.

- A woman arrested by the Chicago police for misrepresenting a social security number was found to have 29 blank counterfeit cards on her person. Investigation disclosed that she also had numerous other false cards and identification used to cash stolen checks.

- An Oregon man pled guilty to using another individual's social security number to obtain tax refunds.

- In New York a man was convicted on 41 counts of criminal possession of forged instruments and one count of grand larceny. The man had represented himself as his father, forged his father's name to U.S. Government bonds, and used his own social security card to negotiate over $43,000 worth of bonds.

- An SSA employee in the State of Washington was sentenced to three years in prison for his part in a fraud scheme to use information from SSA to obtain large-scale tax refunds. The man picked out SSI beneficiaries who were unlikely to file for federal tax refunds and used their SSN's to file fraudulent claims. Over $330,000 in claims had been filed and the first refund check paid before the fraud ring was broken. Two of the other three persons involved were also convicted.

OFFICE OF INVESTIGATIONS

Health Care Financing Administration

HEALTH CARE FINANCING ADMINISTRATION

HEALTH CARE CASES 50 PERCENT OF EFFORT

Burgeoning health care costs have been a cause of deep concern in the Department for several years, with Medicare and Medicaid costs rising from less than $13 billion in 1970 to about $80 billion in 1982. Yet in March 1982, health care cases represented only a little over one-fourth of OI's active caseload. The Inspector General and the Assistant Inspector General for Investigations decided to launch an all-out campaign to devote at least 65% of OI's efforts to health care by 1984. This initiative is working: a year later 50% of the criminal investigation caseload is devoted to health care. Convictions are expected to increase as concentration in this area intensifies.

DIFFICULTIES OF HEALTH CARE INVESTIGATIONS

In terms of dollars, the bulk of health care fraud is committed by institutional and individual providers. Sometimes two or three years elapse between the detection of possible fraud and actual conviction. Pursuit of such offenders is difficult and time-consuming. Complex and often confusing records must be examined and analyzed to establish prosecutable cases. Patterns of violations are often so sophisticated and have so many variables that they seem to defy standardized detection and investigative approaches such as those developed for Social Security programs.

Finally, there is the time lapse generated by the learning process. Historically, health care fraud detection in the Medicare program has depended largely on beneficiaries reporting discrepancies between billings and services actually performed, and on insurance carriers reporting irregularities in the claims they process. Similarly, Medicaid fraud detection has primarily depended on claims processing screens developed by the States over the past few years. The decision made a year ago to emphasize detection and pre-

vention of health care fraud implied the need for creative thought and initiative--which in turn require time to implement.

Provider Fraud

Health care provider fraud usually involves false claims against the Medicare or Medicaid programs, inflated cost reports or kickbacks. Kickbacks take many forms, ranging from cash to expensive travel to free company stock. Historically, substantiation of kickback schemes generally has required time-consuming undercover work. Several large-scale undercover operations are currently underway which should help unravel some of the illegal networks among doctors, institutions and suppliers that exist in the health care industry. Two major kickback schemes were uncovered during this period.

KICKBACKS UNCOVERED

- The president of a Pennsylvania medical laboratory pled guilty to paying a physician and a medical center 15 to 25 percent of Medicaid payments on bills for lab tests they ordered. The investigation was conducted by a combined federal Medicare/Medicaid Task Force consisting of FBI, HHS and Pennsylvania Attorney General agents.

- A drug company president in Oklahoma was convicted for paying kickbacks to a physician for prescribing his company's products. The physician was also convicted and sentenced to six months in jail.

A variety of other schemes are used by providers to sell services and then illegally bill Medicare or Medicaid.

- Operators of a Michigan clinic solicited business in the neighborhood by advertising the availability of jobs and job training. When prospective applicants came in, they were told that physical and psychological examinations were required -- which were then billed to Medicaid. Some services billed were not performed, and some patients were offered kickbacks to refer others to the clinic. The three clinic operators were given jail sentences and fines.

FALSE CLAIMS SCHEMES

- The owner of a medical clinic in South Florida and a doctor associated with the clinic offered free blood pressure tests to elderly residents of mobile home parks. They then told the patients to go to the clinic for an extensive battery of tests, regardless of any medical complaints or history. Medicare was billed for tests amounting to $175,000, many of which were never performed. The owner and physician were sentenced to five years in prison and fined $20,000 each.

- Employees of an optical company which leased spaces in a large department store chain approached elderly customers, offering to clean their glasses. Told that Medicare would pay for their glasses, the customers would sign blank Medicare requests, assigning payment as directed by the salespersons. Because regular corrective lenses are not paid for by Medicare, they were billed as cataract glasses. Claims were made for persons who had never had cataract surgery and for glasses never made. The optical company was fined $120,000 and its owner $40,000. Both the owner and three managers were given substantial prison sentences.

- In New Jersey the owner of a durable medical equipment company and a man suffering from bronchial problems developed a scheme for collecting from both Medicare and a union welfare fund. The DME operator submitted claims to Medicare for oxygen delivered to the patient, and the patient submitted claims to the union. In reality, the patient received only a fraction of the oxygen supposedly delivered. The operator filed false claims amounting to $140,000 to Medicare and $60,000 to the union. The patient defrauded the union fund of $65,000. Both were found guilty, given heavy fines, and must make restitution.

INFLATED NURSING HOME COST REPORTS

Inflated cost reports by nursing homes are usually detected by auditors and subsequently investigated by OI. In a Kentucky nursing home, the owner had inflated costs by about $170,000 by issuing payroll checks for family members who were not actually working there. A variation on the theme was a case in New Mexico, where OIG investigators and auditors were looking into allegations that a nursing home administrator had embezzled patient trust funds. Indeed he had, but another interesting matter turned up. Review of the home's records showed that the owner, who had hastily replaced the $9,000 embezzled by the administrator, had himself profited by some $64,000 from Medicaid by including in the cost report personal expenses unrelated to home operations as if they were expenses related to patient care. The administrator must pay court costs and serve two years probation.

The conviction of two ambulance company owners during this period illustrates some of the tedious work that goes into stopping fraudulent health care providers.

AMBULANCE COMPANY FALSE CLAIMS

- Months of reviewing corporation records finally led to the indictment of a husband and wife who were owners of the largest ambulance service in Arkansas. The wife was charged with more than 200 counts of Medicare and Medicaid fraud. She had instructed employees to bill for transporting patients to and from their homes or nursing homes to doctors' offices rather than hospitals, on dates when no patients were taken to the hospi-tals, and without physician signatures. She pled guilty, was sentenced to prison and fined $5,000. Charges against the husband and the company were dropped in favor of civil action, which is pending.

- After combing through the records of numerous hospitals and nursing homes in North Carolina, investigators found that some of the patients an ambulance company claimed to have transported had died before the time Medicare bills showed they had received the service. The owner was jailed and had to repay. He also had to pay $2,000 to cover the cost of the government's investigations.

JOINT INVESTIGATIONS OF PHYSICIANS

Joint investigations with other Federal and State investigative agencies appear to offer great potential for convicting health care providers. Combining the re-sources and legal authorities of two or more agencies gives a better chance for convictions, particularly for those who indulge in repetitive fraud or who defraud more than one program.

- A patient in Pennsylvania alerted authorities about being treated by a physician's nurse for a bee sting and then finding Medicare billed for physician services never performed. A combined Federal Medicare/Medicaid Task Force took

over the investigation because the physician had previously been convicted for similar violations in the Medicaid program. The physician pled guilty, was sentenced to five months in prison and five years probation, fined $5,000 and ordered to restore $5,000.

- The chief radiologist at a New Jersey medical center was indicted for fraud after an FBI/OI investigation. In question were $22,000 in claims to Medicare and Medicaid. The trial was scheduled to begin on March 24, 1983.

- Agents from the Virginia State Health Department, the Virginia Medicaid Fraud Unit, the U.S. Postal Inspection and OI successfully investigated a physician who illegally obtained at least $30,000 over the past four years. The physician was indicted on 17 counts for billing Medicare for services never performed, billing Medicaid for an ineligible patient, and billing for manual laboratory tests which had actually been performed automatically.

Beneficiary Fraud

FALSE MEDICARE CLAIMS

Medicare beneficiary fraud is relatively rare in comparison with provider fraud. However, fraudulent actions by beneficiaries do occur. An insurance clerk at a South Florida medical clinic submitted Medicare claims for surgery which clinic doctors supposedly had performed on her father, including a mastoidectomy, amputation of a leg, heart surgery and numerous skin grafts. Investigation showed that she had submitted 35 false claims amounting to more than $30,000 for services her father never received. The clerk was sentenced to three years in jail (two and one-half suspended) and three years probation.

MEDICARE CHECK THEFTS

In another case, a Chicago man pled guilty in connection with a scheme to steal and cash Medicare checks. He was sentenced to 30 months felony probation. By successful investigation and prosecution of this case, OI was able to curtail activities of a major theft ring dealing in stolen Medicare checks from a Chicago area hospital.

Medicaid beneficiary fraud primarily involves card abuses. In February a Texas woman was indicted for accepting payment to allow an illegal alien to pose as her daughter and thereby have her baby delivered at Medicaid expense. Investigation is continuing to determine whether the attending physician was involved in what would then be a conspiracy.

Health Care Initiatives

NEW APPROACHES TO DETECTING HEALTH CARE FRAUD

Most of the health care fraud described thus far was detected and investigated without the means of sophisticated technology . As part of the Inspector General's new emphasis, OI is working on several fronts to develop and implement large-scale detection and investigation techniques in various segments of the industry.

- For several months the Denver OI Office has been developing methods to investigate alleged kickbacks in the pacemaker industry. Medicare pays 80% to 90% of all costs associated with pacemaker implants. A single pacemaker costs about $4,000, and some salesmen earn as much as a 25% commission, or about $1,000 for each sale. Kickbacks from salesmen to physicians for ordering their brand of pacemakers are alleged to be widespread. Working with the FBI, the OIG is preparing to launch a national project to detect and investigate such crimes.

- The Dallas OI Office is identifying and cataloging illegal remuneration schemes in the pharmaceutical industry. Patterns of kickbacks to pharmacists by suppliers who relabel generic drugs and sell them under their own labels are being explored industry-wide. Plans are being made to develop an investigative guide as well as identify individual cases for criminal and civil action.

- In South Florida OI has been working on a project to identify individual providers who have fraudulently billed Medicare for prosthetic lenses.

- In Region IX methods are being developed for identifying fraudulent billings of radiological services.

- The success of a combined Federal Medicare/Medicaid Task Force made up of FBI, OIG and State agents in the Philadelphia area has prompted expansion of the concept to several Region II locations. Representatives of the IG's Office of Audit and Office of Health Financing Integrity are being included, as appropriate, as well as the Medicare carrier.

- OI staff is working with the State of South Carolina to develop a nursing home targeting matrix. The matrix will use several different types of data to help select probable program offenders. The project will include analysis to determine whether there is any correlation between patient care deficiencies and fiscal fraud.

IMPROVING PROSECUTION RATES

Another, more direct approach recently taken by OI has already proven highly successful. In areas where U.S. Attorneys' Offices have a particularly heavy load in hard crime cases such as

armed violence and narcotics, health care and other white-collar crimes have difficulty competing for prosecution attention. For example, OI had been unable to get prosecutions in South Florida for over five years. In an attempt to remedy this situation, OI agents from the Atlanta, Miami and Tampa Offices had meetings with the U.S. Attorneys' staffs. The Assistant Inspector General for Investigations traveled to Miami to strengthen relationships with Federal prosecutors. From these meetings, criteria were established for U.S. Attorney prosecution of OI cases. In addition to these efforts, the Department of Justice Criminal Division in Washington, D.C., spent a great deal of time in the prosecution of Medicare and Medicaid cases in the South Florida area.

As a result of these intensive activities, three major prosecutions, described earlier, produced significant convictions:

- The optical company officials who were found guilty of falsely billing Medicare for cataract glasses.

- The clerk who filed $30,000 in false surgery claims against Medicare, using her fathers name.

- The clinic owner and physician who submitted $175,000 in false Medicare claims.

Current OI initiatives are now receiving full support of the U.S. Attorney's Office in South Florida. This success has led to extending such a sustained approach to other locations to improve prosecution and conviction rates.

State Medicaid Fraud Units

STATE FRAUD UNITS CONVICTIONS

The OIG certifies and annually recertifies State Medicaid Fraud Control Units for eligibility for Federal funding. These State investigation and prosecutorial units are funded by the Federal government at a level of 90 percent for the initial three years of their existence and 75 percent thereafter. The main function of the units is to investigate and prosecute health care provider fraud within the Medicaid program. At present there are 31 units. They had a combined total of 513 indictments, 390 convictions and $18,201,187 in fines, restitutions and overpayments in 1982. Exhibit F shows convictions progress over the last few years.

Two new units were certified during 1982, one within the past six months. Of the 29 units eligible for recertification in 1982, on-site reviews were conducted for 18. Some of the recommendations made as a result of these reviews have led to dramatic improvements in the operations of these units. In Arkansas, for example, OIG recommendations resulted in the unit's getting five convictions last year, where there had been none for the previous three years. OIG recommendations for the States of Washington and Illinois prompted major reorganizations and greatly improved productivity.

ESTABLISHMENT OF ADDITIONAL UNITS SOUGHT

OI embarked on a proactive effort to initiate contact with States which do not have units, to inform them of the benefits of the program. In States where interest was high, on-site visits were conducted. So far, visits have been made to Iowa, Minnesota, Oklahoma and New Mexico. Several other States have also expressed a desire for assistance in their application.

To aid both Federal and State investigative agencies, OI is developing a series of manuals. A manual on detecting and investigating fraud committed by pharmacies has been published, and work began on similar manuals for nursing homes, laboratories and patient abuse.

The OIG worked closely with the National Association of State Medicaid Fraud Control Units in conducting a training session on development of financial fraud cases where inspection reports disclose patient care deficiencies. The two organizations are currently developing a national training strategy for health care investigations. They have also drafted, with the assistance of the National Association of Attorneys General, on a model Medicaid Fraud Law for the States which could result in uniform terminology and definitions and clarification of legal issues related to Medicaid fraud. Uniformity should permit decisions handed down in one State to be used in another.

Civil Monetary Penalties Law

MILLIONS AVAILABLE IN POTENTIAL CMPL RECOVERIES

One of the potentially most useful tools for recovering government monies lost to fraud is the Civil Monetary Penalties Law (CMPL). The Law provides for a penalty of up to $2,000 for each false claim submitted and an assessment of up to twice the amount claimed, regardless of other prosecutions, sentences or settlements. Final regulations for implementing CMPL are expected to be issued in June. More than 100 State health care provider convictions have been reviewed, of which at least 20 are ready for processing. Preliminary settlement negotiations are underway on several of these cases, which could lead to several million dollars in recoveries and savings. Cases not settled can be processed under CMPL as soon as regulations are published and an administrative law judge is designated.

As further preparation for implementing CMPL, another 85 cases have been garnered from OI and other OIG sources and reviewed to determine whether to pursue recov-eries through this process. A four-day session is also being planned to train several hundred people on identifying and processing cases subject to CMPL. The number of potential cases and claims appears so large that a computerized information data system has been designed and put into operation, to index and track potential recoveries.

STATISTICAL SAMPLING CONSIDERED

At present cases are reviewed by traditional audit methods or by isolating claims that are clearly fraudulent (e.g., physician claims for hospital visits on days he was known to have been out of town). A comprehensive paper has been prepared on the possible use of statistical sampling and its application to CMPL claims. Suitable cases will be selected for testing the application of this technique, to maximize penalties with a minimum expenditure of time and manpower.

HEALTH CARE PROVIDER CONVICTIONS

STATE MEDICAID FRAUD CONTROL UNIT

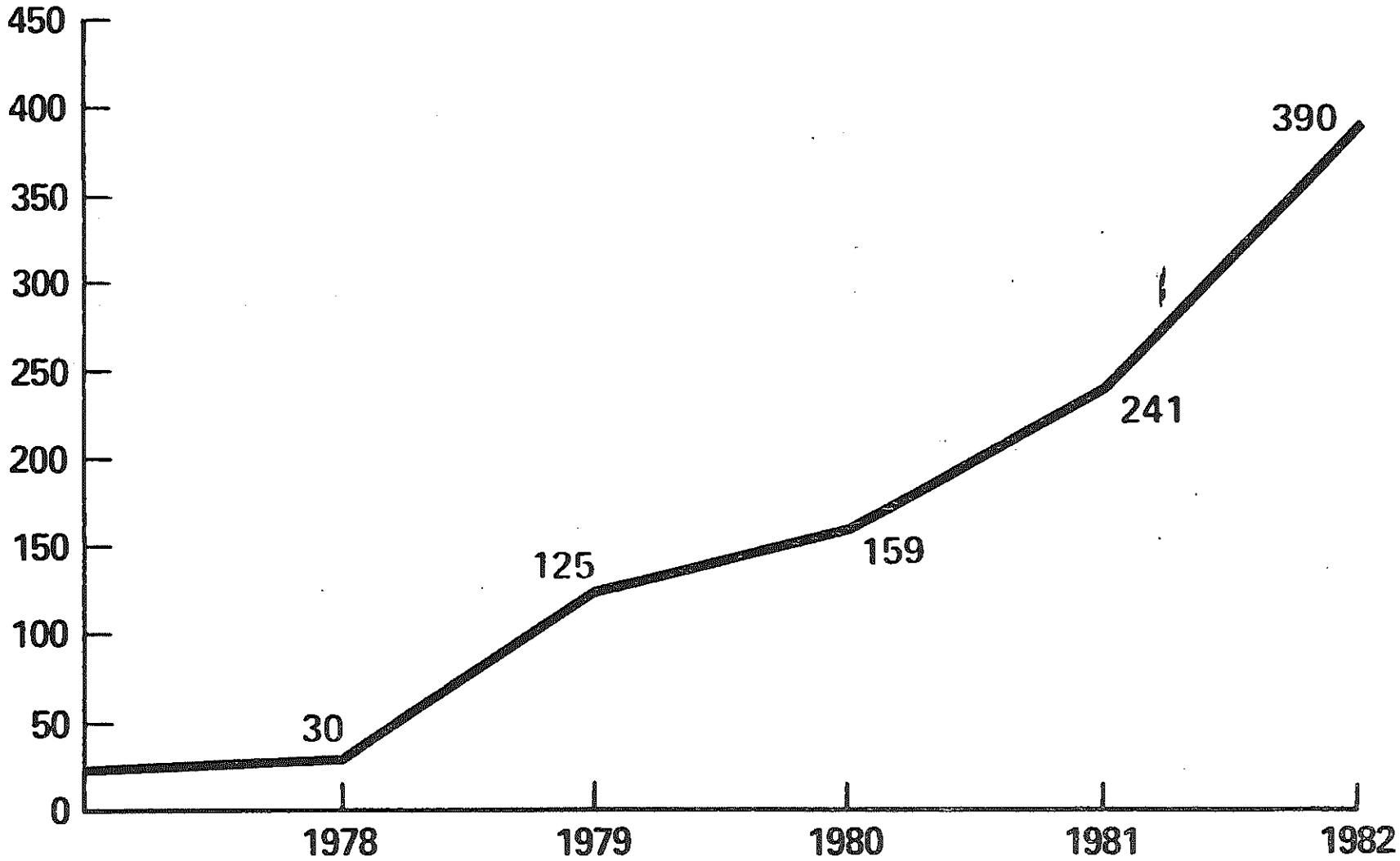


EXHIBIT F

OFFICE OF INVESTIGATIONS

Public Health Service

PUBLIC HEALTH SERVICE

Public Health Service programs are largely administered through contracts and grants. First-line responsibility for monitoring proper performances lies with contract and grant managers, who are expected to deal with apparent irregularities. Detection of fraud depends largely on audit reviews and allegations of persons associated with a contractor or grantee. Successful investigation, in turn, frequently depends on audits as well as personal testimony. The following cases were successfully concluded during the first half of this fiscal year:

TRIBAL LEADERS EMBEZZLE HEALTH FUNDS

- A joint investigation with the FBI resulted in the conviction of three Indian tribal leaders in Washington State for embezzlement and conspiracy. An audit had disclosed that over $600,000 in Federal health money for the tribe had been squandered on personal luxuries. Two of the three received prison terms, were ordered to repay about $30,000 and were fined $43,000. The third jumped bail but was convicted in absentia. He will be sentenced when found.

HEALTH AGENCY EMPLOYEES CONVICTED

- After an administrative assistant at a Nevada health planning agency resigned, he was discovered to have taken $30,000 in agency funds. In a letter to the agency director he expressed his regrets, claiming an uncontrollable gambling habit. He was found guilty, convicted, and sentenced to prison.

- The OIG Office of Audit called in OI after a CPA's audit revealed a discrepancy between a family health center's receipts and bank statements. A joint OI and Arizona Department of Public Safety

investigation resulted in a former bookkeeper's pleading guilty to embezzling $48,700. The bookkeeper received seven years probation and had to restore the embezzled monies.

DEPARTMENT EMPLOYEE CASES

Contract and grant programs are extremely vulnerable to fraud and abuse by Department employees. Opportunities for conflict of interest and theft abound. Detection of such cases depends largely on allegations by fellow employees--which can be hard to come by when the accused holds a position of some power in the agency. The OIG Hotline can be most useful in such cases, as indicated by the conviction of the Indian Health Service official described later in the Hotline section. Other cases resolved during this period show the range of potential fraud.

- In May 1980, investigation was undertaken of an allegation that an FDA medical officer had taken gratuities from a contracting clinical drug monitor. In December 1981, the employee and the contractor were charged with accepting and giving a gratuity, as well as conspiracy and aiding and abetting. The trial ended with a "hung" jury, and a new trial was scheduled. In the interim, the FDA official pled guilty to receiving a supplement to salary. Charges were dropped on the contractor after he read a statement in court acknowledging the inappropriateness of paying money to the official.

- An Indian Health Service employee was told by several Federal officials that removal of x-ray film from the hospital in which he worked was illegal without proper authorization. Nevertheless, the employee allowed an acquaintance to have 43 shelves of the film in exchange for microfilm copies. The

acquaintance sold it to a silver smelting company for several thousand dollars, and the IHS employee went to work for the acquaintance's company soon thereafter. The employee was convicted of embezzlement and theft of government property.

OFFICE OF INVESTIGATIONS

Office of Human Development Services

OFFICE OF HUMAN DEVELOPMENT SERVICES

GRANTEE FRAUD UNCOVERED

OHDS programs largely consist of grants to States agencies for helping children, youth, families and the aged obtain needed services. The grantee agencies in turn sub-grant funds to day care, Headstart, child development, family planning, energy assistance, community action and other service groups. Thus Department employees are usually two steps removed from actual operations, service delivery and the opportunity for fraud. Remoteness from Departmental surveillance, however, gives sub-grantees an excellent opportunity to embezzle monies supposed to be used to operate their programs.

- An HHS/USDA project set up in late 1980 to detect fraud in grantee programs funded by the two Departments is still yielding results. In December the director of an Arkansas day care center was indicted for embezzling $19,860 over a three-month period. The director had deposited federal funds into his personal or business bank accounts.

- In South Carolina a former city councilman was convicted of embezzling $31,000 in Headstart funds. The man had contracted to supply two mini-busses which were never delivered, and the money was not refunded. The man was sentenced to two and one-half years in prison.

- A former Texas school superintendent and operator of a day care center and senior citizens' program was convicted for embezzling Department funds granted to the day care center. Convicted along with him was a member of the school board and operator of a home health care agency. Trial testimony

showed that the two had defrauded about 40% of $490,000 received by the day care center. Both were fined and prohibited from participation in any program financed by Federal or State funds for the duration of their probation.

DIFFICULTY IN TRACING MULTIPLE-SOURCE FUNDS FRAUD

Sometimes grantees receive so many different types of grants from so many different agency programs it is difficult to determine exactly whose funds have been embezzled, and by how much. In Massachusetts, a community action agency received Headstart, family planning, energy assistance, child development and other program funds. It was finally determined that an official of the agency had forged and negotiated checks amounting to $33,800 in HHS child development and energy assistance funds to support a drug habit. In this instance, funding could be traced and the official pled guilty.

INTERNAL SECURITY

In addition to ensuring the security of the Secretary and other top Department officials, OI is responsible for security oversight of 1,600 buildings in which HHS is the principal occupant. The Office is directly responsible for security and protection operations in the headquarters southwest Washington complex, which consists of four buildings housing about 10,000 employees.

SOUTHWEST COMPLEX SECURITY UPGRADED

During the first half of FY-1983, a comprehensive study of the security of the southwest complex was completed and implementation begun. Although all of the improvements have not yet been instituted, they appear to be having a salutary effect, as shown in the following statistics:

THEFT LOSSES DECLINE

Southwest Complex Losses and Incidents	Oct. 1982-Mar. 1983	Apr-Sept 1982
Dollar Losses		
Government Property	$4,871	$16,749
Personal Property	2,710	3,768
Total	$7,581	$20,517
Incidents		
Reported Losses/Thefts	62	71
Other	57	86
Total	119	157

Technical assistance reviews have been scheduled for the major HHS installations in each region, to determine whether their security arrangements also need upgrading.

About 1,463 personnel security clearances were completed and 126 full field investigations initiated, in comparison with 708 and 84 for the preceding six months. In addition, 108 classified document security reviews were completed, and work was begun on a new information security manual.

OFFICE OF INVESTIGATIONS

OIG Hotline

OIG HOTLINE

HOTLINE CALLS TRIPLE

The OIG Hotline, which began its fourth year of operation in February, receives about 100 calls a week. It was originally installed to receive complaints about employee violations of the Department's Standards of Conduct, assuring anonymity if threat of reprisal was feared. It rapidly expanded to become a means for the general public to report fraud and abuse in Department programs. In July 1982 a toll-free number was installed. With no increase in personnel, the volume of calls increased approximately 300%. By the end of the year, the Hotline will have received a total of more than 10,000 calls since its inception. Exhibit G illustrates, by month, the tremendous increase in calls in comparison with the same period in FY 1982.

With the advent of the toll-free number, 99% of the complaints are from private citizens. Program abuse, primarily beneficiary fraud, is the subject of most these complaints.

BENEFICIARY FRAUD LEADS COMPLAINTS

As shown in Exhibit H, complaints about abuse in Social Security programs have increased over 400%. Most allegations are centered around disability fraud, fraudulent use of Social Security numbers by undocumented workers and abuse of survivors' benefits.

Complaints about health care programs, largely Medicare, have increased over 1,000%. Provider double billings and billing for services not rendered are the most common allegations.

Employee calls have substantially decreased over the last year, and steps are being taken to heighten employee awareness and participation in combatting internal fraud and abuse. The first step was to print the Hotline number on payroll slips.

SUBSTANTIATED ALLEGATIONS

Examples of substantiated allegations reported to the Hotline are as follows:

- Allegations were made that a local prosecutor's office which provides child support enforcement services under a cooperation agreement which the county welfare department claimed Federal funding for the salaries and fringe benefits of laid-off employees. The allegations were substantiated and the State was ordered to adjust its claim to HHS by $51,586. 1/

- A high-level Indian Health Service official awarded six contracts totaling over $39,000 to a private management company in which his wife had the majority partnership interest. The official was sentenced to one year in prison.

1/ This case was settled slightly before the reporting period but was not in the previous report.

TOTAL HOTLINE COMPLAINTS BY MONTH FOR OCTOBER 1982 — MARCH 1983

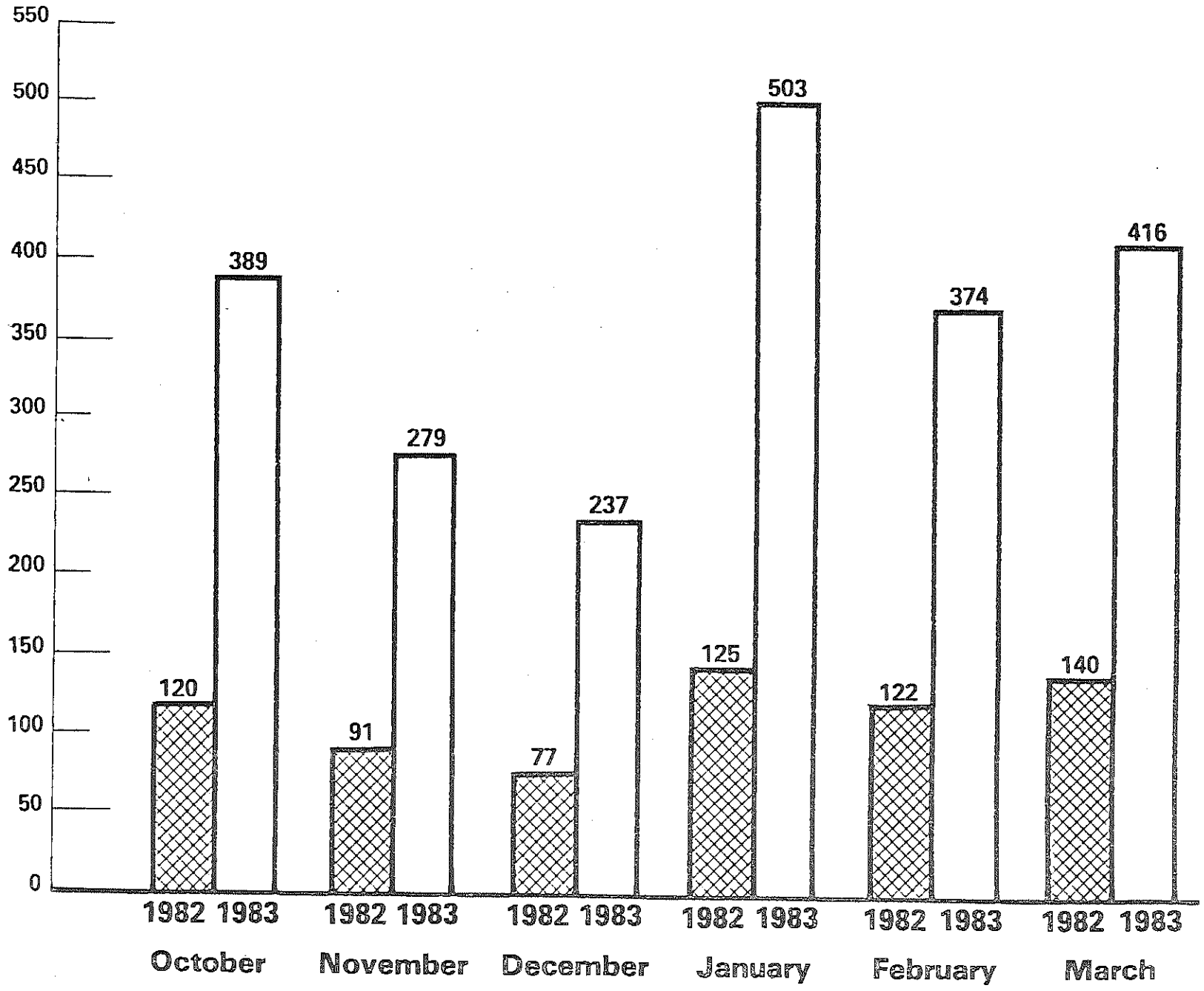


EXHIBIT G

EXHIBIT H

TYPES OF HOTLINE CALLS RECEIVED
October through March, FY 1982 and 1983

Area of Complaint	Number of Calls (a)		Increase or [Decrease] 1983 over 1982	
	1983	1982	Number	Percent
SSA	709	141	568	403%
HCFA	444	40	404	1,010
PHS	69	23	46	200
General Information	301	66	235	356
Wrong Agency	181	57	124	218
Employee Problem	61	65	[4]	[6]
Nuisance or Irrational	78	12	66	550
Other	355	131	224	171
Total	2,198	535	1,663	311%

(a) The 1982 statistics do not reflect the toll-free Hotline telephone number which went in effect on July 18, 1982. The figures for 1983 include toll-free complaints.

OFFICE OF HEALTH FINANCING INTEGRITY

Office of Health Financing Integrity

STRUCTURE/ OVERVIEW

The Office of Health Financing Integrity (OHFI), established as a result of a Reform 88 initiative, has the responsibility for protecting the integrity of the Medicare and Medicaid programs. This activity was previously carried out by personnel of the Health Care Financing Administration. Now this responsibility is carried out by a staff of approximately 185 who are primarily located in ten regional offices, with a small central office staff located in Baltimore and Washington. OHFI is directed by the Assistant Inspector General for Health Financing Integrity and consists of the Division of Policy and Procedures and the Division of Operations.

The Division of Policy and Procedures is responsible for the analysis of program data and other information to assess the Department's efforts to identify and correct policy or organizational problems in Medicare and Medicaid. These efforts are called program inspections. Another type of inspection this Division undertakes is a management inspection. Management inspections are evaluations of Medicare contractors' and Medicaid State agencies' efforts to control fraud and abuse. The Division of Policy and Procedures is also responsible for making recommendations for legislation and/or regulatory changes, and serves as the liaison between OHFI and other entities to ensure coordination in the effort to control fraud, abuse, and waste.

The Division of Operations supervises the sanctions activities authorized under sections 1128, 1156, 1160, 1862, and 1866 of the Social Security Act. It conducts the preliminary investigations of complaints of fraud and abuse and, where warranted, refers cases to the Office of Investigations for criminal or civil fraud investigation. The Division of Operations, in consultation with the Health Care Financing Administration (HCFA) participates in the development of guidelines to State Medicaid agencies and Medicare contractors for control of provider fraud, abuse, and waste. The Division is also responsible for providing general goals for regional operations, and oversees regional efforts to achieve these goals.

Some of the efforts mentioned in the report were initiated by staff of the Health Care Financing Administration.

STATE MEDICAID AGENCIES AND MEDICARE CONTRACTORS EFFORTS

In FY 82 Part A Medicare contractors cleared 135 cases of abuse and established overpayments of $1,788,073. In the first three months of this fiscal year, based on available data, Part A Medicare contractors have identified 27 cases and established overpayments of $2,723,321, almost a million dollars more than the entire previous fiscal year.

Medicare Part B contractors have cleared 562 abuse cases in the first 3 months of the fiscal year. Although this is only 21 percent of the cases cleared in Fiscal Year 1982, the established overpayments of $2,331,073 represent 25 percent of the overpayments identified by Part B contractors in Fiscal Year 1982.

The Medicaid State agencies have reviewed 792 abuse cases in the first 3 months of the fiscal year. These reviews identified overpayments of $10,200,188.

The Part A Medicare contractors have cleared 2665 integrity reviews (i.e., minor problems or potential abuse which when resolved proved to be an honest mistake) in the first 3 months of the year. This represents 35 percent of the number of reviews cleared during fiscal year 1982. The States have reviewed 7,193 cases and identified $2,777,134 in overpayments in the integrity reviews they have completed in the first 3 months of the year. This is 38 percent of the amount of overpayment they identified in FY 1982.

In the area of integrity reviews the Part B Medicare contractors have identified overpayments of $375,258 associated with the 3,953 cases they cleared. Again, this is only 22 percent of the cases they reviewed in Fiscal Year 1982 but represents almost 25 percent of overpayments identified in that fiscal year.

To sum up, in the first 3 months of the fiscal year Medicare contractors and Medicaid State agencies have cleared 13,811 integrity review cases. This is 28 percent of all cases cleared during fiscal year 1982. Overpayments of $3,449,765 have been established for these cases. This amount represents 34 percent of

the overpayments established for integrity reviews for FY 1982. At the same time, they have completed 1,381 abuse cases with associated overpayment of $15,254,582. This amount represents 26 percent of the overpayments established for abuse cases in Fiscal Year 1982.

SANCTION AUTHORITY EXERCISED IN 19 CASES

One of the major responsibilities OHFI has is the imposition of administrative sanctions on physicians, providers or other health providers. To carry out this activity, OHFI has established appropriate policies and procedures to facilitate the case flow. It also has developed an administrative review process to provide the sanctioned individual with a forum for appeals. To date, 19 sanctions have been effectuated.

SANCTION AUTHORITY EXPANDED

In conjunction with its sanction responsibilities OHFI prepared final regulations which were published in the Federal Register on January 27, 1983. These regulations expand the scope of authority to suspend individuals from participating in Medicare and Medicaid if they are convicted of a program related crime. The new provisions provide that operators and administrators of health care facilities, pharmacists, as well as other individuals receiving reimbursement for services, are now subject to suspension. This authority closes one of the loopholes which prevented sanctioning these classes of individuals.

1,746 ALLEGATIONS OF FRAUD PROCESSED

- One of the most important functions of OHFI is to review allegations of fraud and abuse received from beneficiaries to Congress, and others. In the first 6 months of the year, OHFI received 1,953 allegations of fraud and abuse. To date, 1,746 of these allegations have been reviewed and, where the allegations were unsubstantiated, the cases were closed. Where there was sufficient evidence, OHFI appropriately referred the case for disposition by OI, State agencies, contractors, HCFA, etc., after conducting its phase of the development.

o Another activity undertaken by OHFI is the management inspection of Medicare and Medicaid contractors. These inspections are designed to assess the contractors' and State agencies' efforts to ferret out fraud and abuse. Three management inspections have been completed to date, and the weaknesses identified in the States' activities have resulted in reductions in the FFP with a corresponding savings to the Federal government of $108,983.	MANAGEMENT INSPECTION REDUCED FFP BY $108,983
o Program inspections are another of the activities undertaken by OHFI to identify programmatic and procedural weaknesses in the Medicare and/or Medicaid programs. Analysis of data is conducted by both central and regional office staff to identify potential program vulnerabilities. Once a weakness has been identified, decisions are made to conduct either national or regional inspections of the potential problem. In the first 6 months of the year 44 inspections have been completed and $31,308,577 in overpayments or cost avoidance has been identified.	$31,308,577 IN OVERPAYMENTS OR COST AVOIDANCE IDENTIFIED
o Another program inspection of ten independent laboratories was conducted in the State of Massachusetts by the Boston Regional Office. This inspection was conducted because of concerns raised by Massachusetts Blue Shield, the Medicare Part B contractor. The review identified numerous instances where providers were reimbursed for questionable charges such as excessive payments for Electrolyte Panel, medically unnecessary specimen pick up, lab testing at uncertified sites, etc. The recommendations made as a result of the inspection will result in cost avoidance savings of $500,000.	LAB INSPECTION RESULTS IN $500,000 SAVINGS
o A program inspection of bills for oxygen concentrators in the New York Region found that 83 percent of the beneficiaries did not use sufficient amount of oxygen to justify the cost of the concentrator rental. HCFA has taken the necessary steps to insure the least costly medically appropriate system is the basis for reimbursement in the future. This action will result in a cost savings of 2.18 million to the Medicare program.	$2.18 MILLION IN SAVINGS IDENTIFIED

o An inspection was conducted of the University of Chicago Hospitals and Clinics. This study identified inaccuracies in the physician time and effort rationales which resulted in inaccurate allocation of hospital-based physician costs. Bonuses and lecture fees were incorrectly included in cost claimed for Medicare reimbursement. The intermediary audited these areas for the FY 1978 and 1979 cost reports and reopened the FY 1975, 1976, and 1977 periods. Overpayments of $315,480 for Medicare and $401,520 for Medicaid were established by these inspections.	INSPECTION IDENTIFIES $717,000 IN OVERPAYMENTS
o When the PRO legislation was enacted, OHFI was assigned responsibility for preparation of the regulations applicable under section 1156 involving imposition of sanctions. Preparation of these regulations has been completed and the regulations are in the release process. The authority in these regulations will serve as a measure of ensuring the integrity of the health programs.	SANCTION REGULATION UNDER SECTION 1156 PREPARED
o OHFI has the lead in the Health Coordinating Committee of the Inspector General. This Committee has been appointed to ensure there is no duplication in the efforts to eliminate fraud and abuse in the health care community by the different entities of the Inspector General. It also serves as a forum to share information which will be mutually beneficial.	HEALTH COORDINATING COMMITTEE ESTABLISHED
o OHFI has begun to transfer and appropriately modify all regulations currently contained in 42 CFR to 45 CFR. This transfer and modification was necessitated by the reassignment of responsibilities from HCFA to the IG.	REGULATION TRANSFER FROM 42 CFR TO 45 CFR
o A conference was conducted for members of the various regional staffs to bring them up to date on recent developments in the sanctions area to insure cases are properly investigated and documented. This conference also served to acquaint the field personnel with various aspects of the civil monetary penalty (CMP) process, and their responsibilities once the final CMP regulations are published.	TRAINING ON SANCTIONS RESPONSIBILI-TIES

- A program inspection review was conducted of rehabilitation agencies in Michigan. This review showed the physical therapy modalities utilized by the providers in this review were not reasonable and necessary for the patients' conditions. The intermediary has now developed guidelines specific to diagnosis, type of modalities and duration of treatment for processing and payment of claims. Cost avoidance savings of $3,000,000 in the Medicare program are attributable to development of these guidelines for payment of claims.

$3,000,000 SAVED THROUGH CHANGE IN PT REIMBURSEMENT PROCEDURES

- A program inspection was conducted of reimbursement of physicians' services for end stage renal disease patients in the State of Oregon. This inspection revealed incorrect computations of the monthly payment to physicians who have elected the alternative method of reimbursement. The Medicare carrier was only considering the dates of inpatient hospital stay rather than the entire period from the last facility or home dialysis prior to hospitalization to the next routine dialysis after hospitalization. To correct the problem we recommended that HCFA enforce its instructions and consider using a single claim for both monthly and other physician services. Both recommendations were accepted by HCFA and this will result in cost avoidance savings of $879,000 for Medicare.

FINDING OF INCORRECT PHYSICIAN PAYMENTS RESULT IN SAVINGS OF $879,000

- An inspection was conducted of the Massachusetts State Agency reimbursement practices for transportation services under Medicaid. This inspection revealed reimbursement for medically unnecessary, nonemergency ambulance, chair-car, and taxi services. A lack of monitoring procedures for these services as well as in the hospital/taxi and adult day health care programs was also revealed. The State agency has agreed to increase their prepayment and postpayment monitoring activities, redesign their medical necessity form, amend various sections of the transportation regulations and conduct indepth reviews of potentially abusive providers. A cost avoidance saving of $2.5 million to the Medicaid program has been achieved by this inspection.

SAVINGS OF $2.5 MILLION IDENTIFIED IN MASSACHUSETTS MEDICAID PROGRAM

REPORTING GUIDELINES ESTABLISHED

- OHFI has established guidelines for contractors and State agencies used in detecting and investigating fraud and abuse. A system was established for contractors and States to report their efforts in this regard. This system is such that the reports are only delayed a single quarter.

  OHFI monitors contractor/State agency efforts in the fraud and abuse area through the conduct of various analytical studies of workload data, as well as onsite technical assistance visits and formal management inspections.