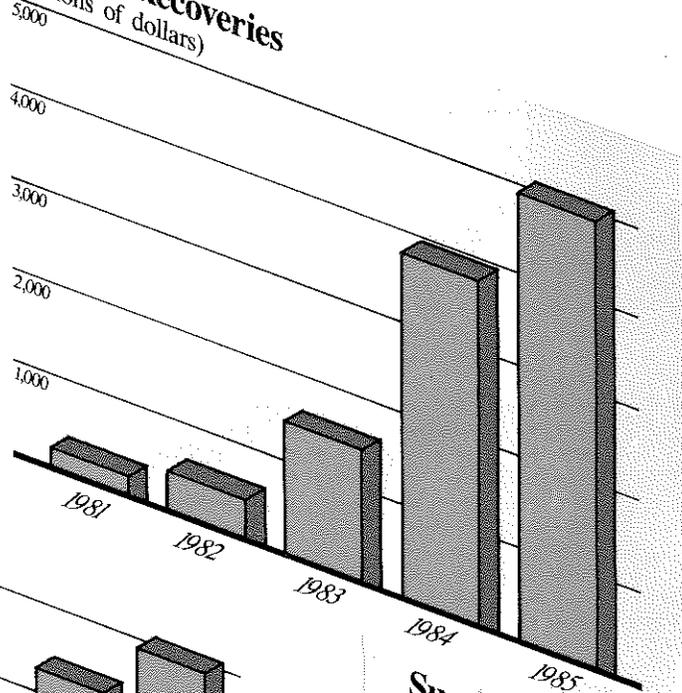




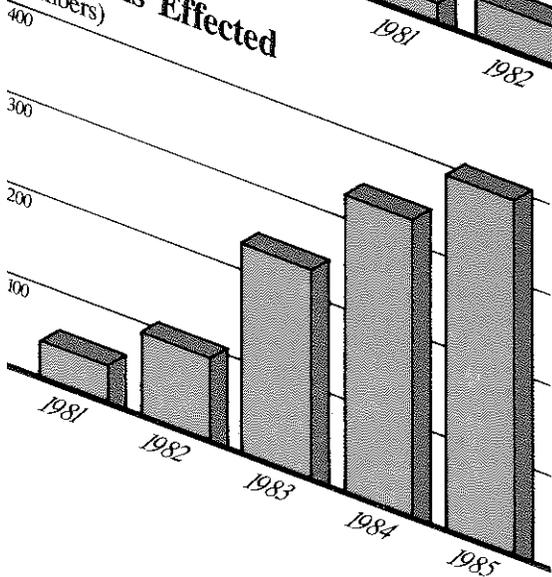
Department of Health and Human Services
Richard P. Kusserow
Inspector General

OFFICE OF INSPECTOR GENERAL

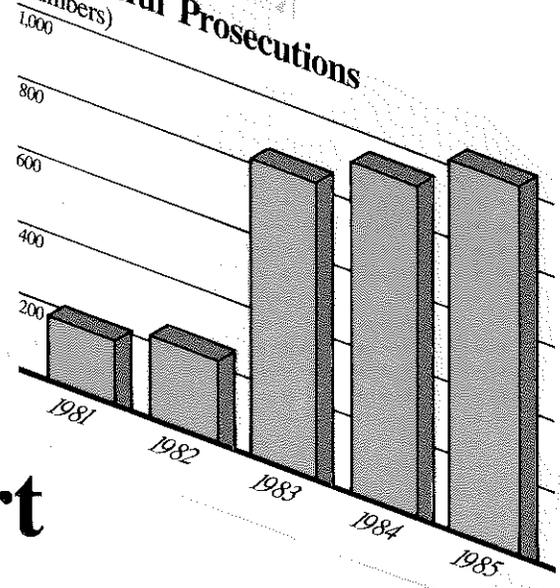
Savings/Recoveries
(millions of dollars)



Sanctions Effected
(numbers)



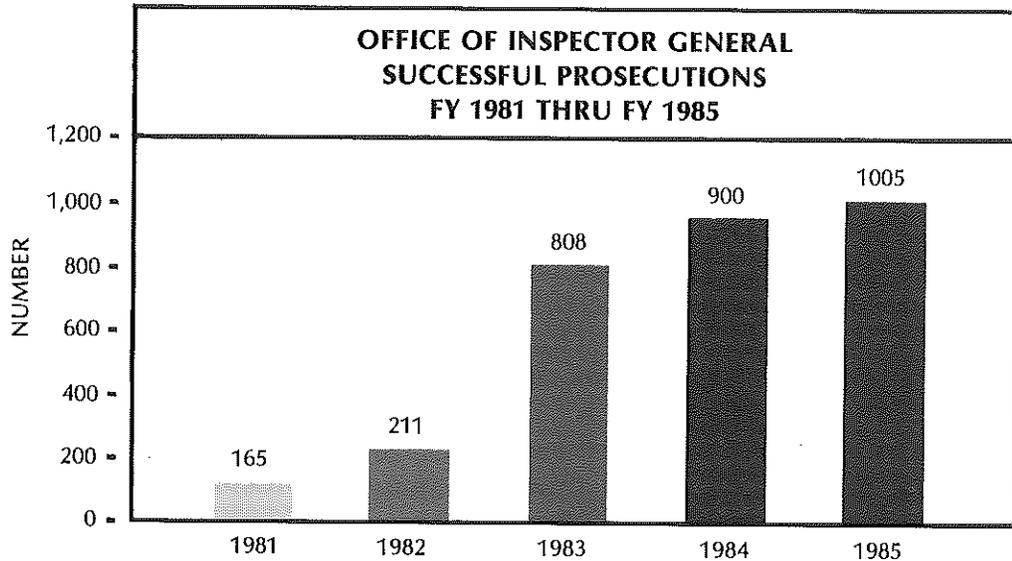
Successful Prosecutions
(numbers)



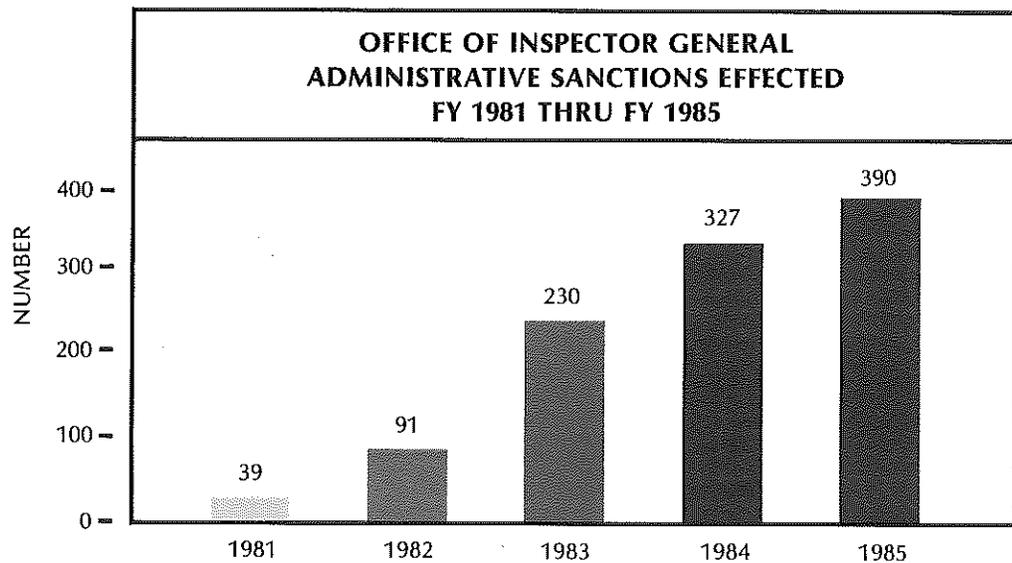
Semiannual Report to the Congress

April 1, 1985 – September 30, 1985

- An all-time high of 1,005 successful prosecutions (over a 500 percent increase since 1981), of which 75 were health care convictions, with an additional 405 obtained by the State Medicaid Fraud Control Units.



- Administrative sanctions taken against 390 health providers and suppliers "kicked out" of the Medicare and Medicaid programs, a 900 percent increase since 1981.



While the above charts show OIG savings, successful prosecutions and sanctions figures for the entire fiscal year 1985 and illustrate success trends over the past 5 years, this report deals specifically with the last 6 months of the fiscal year (April 1985 through September 1985).

Of the total fiscal year results, those attributable for this reporting period (April 1985 through September 1985) were:

- nearly \$2 billion in settlements, fines, restitutions, recoveries and savings;
- 473 successful prosecutions of wrongdoers obtained federally and another 200 obtained through State Medicaid Fraud Control Units; and
- 280 health providers and suppliers sanctioned from the Medicare and/or Medicaid programs for fraudulent or abusive practices.

Detailed descriptions regarding activities during this 6-month period will be found in the remaining chapters.

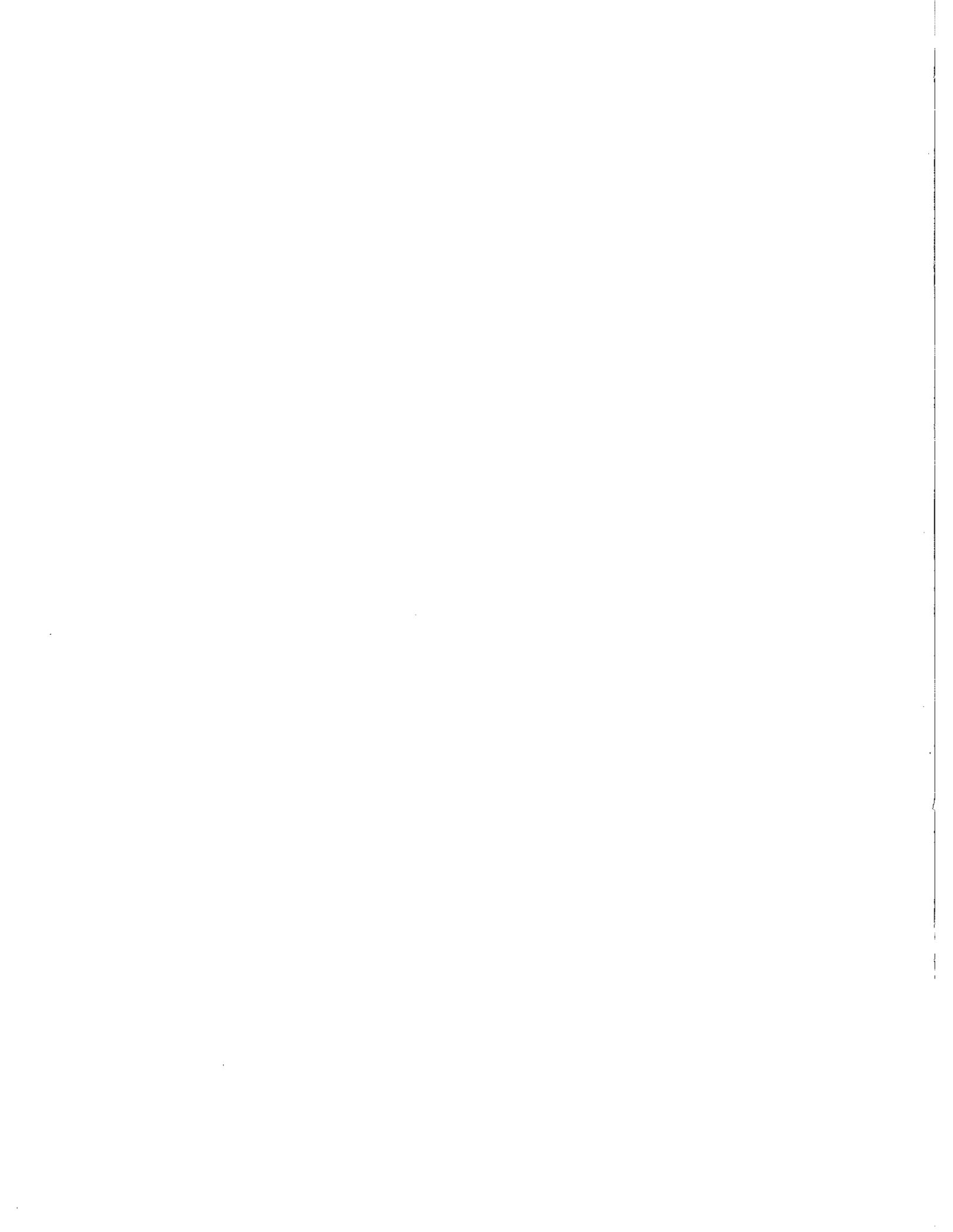
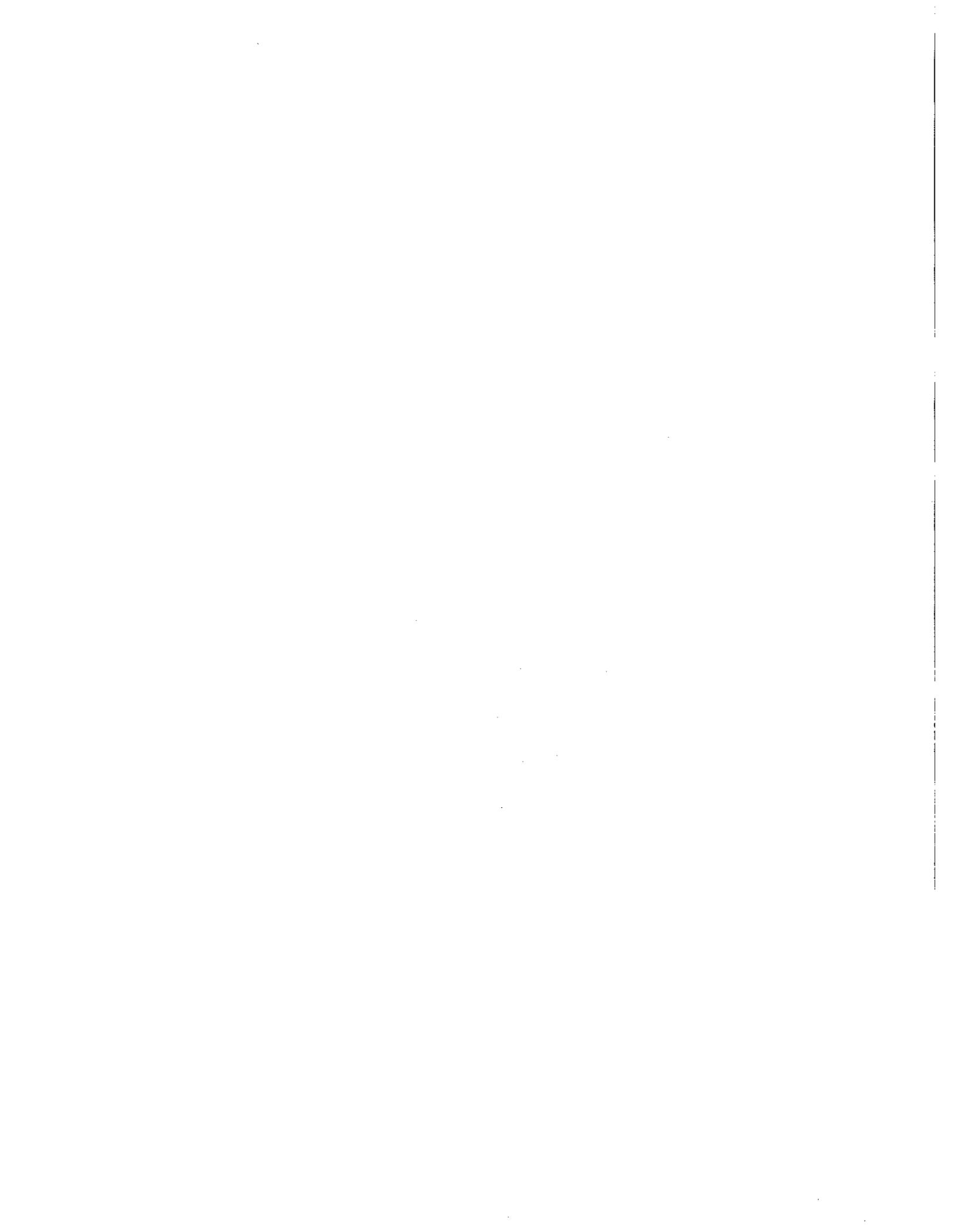
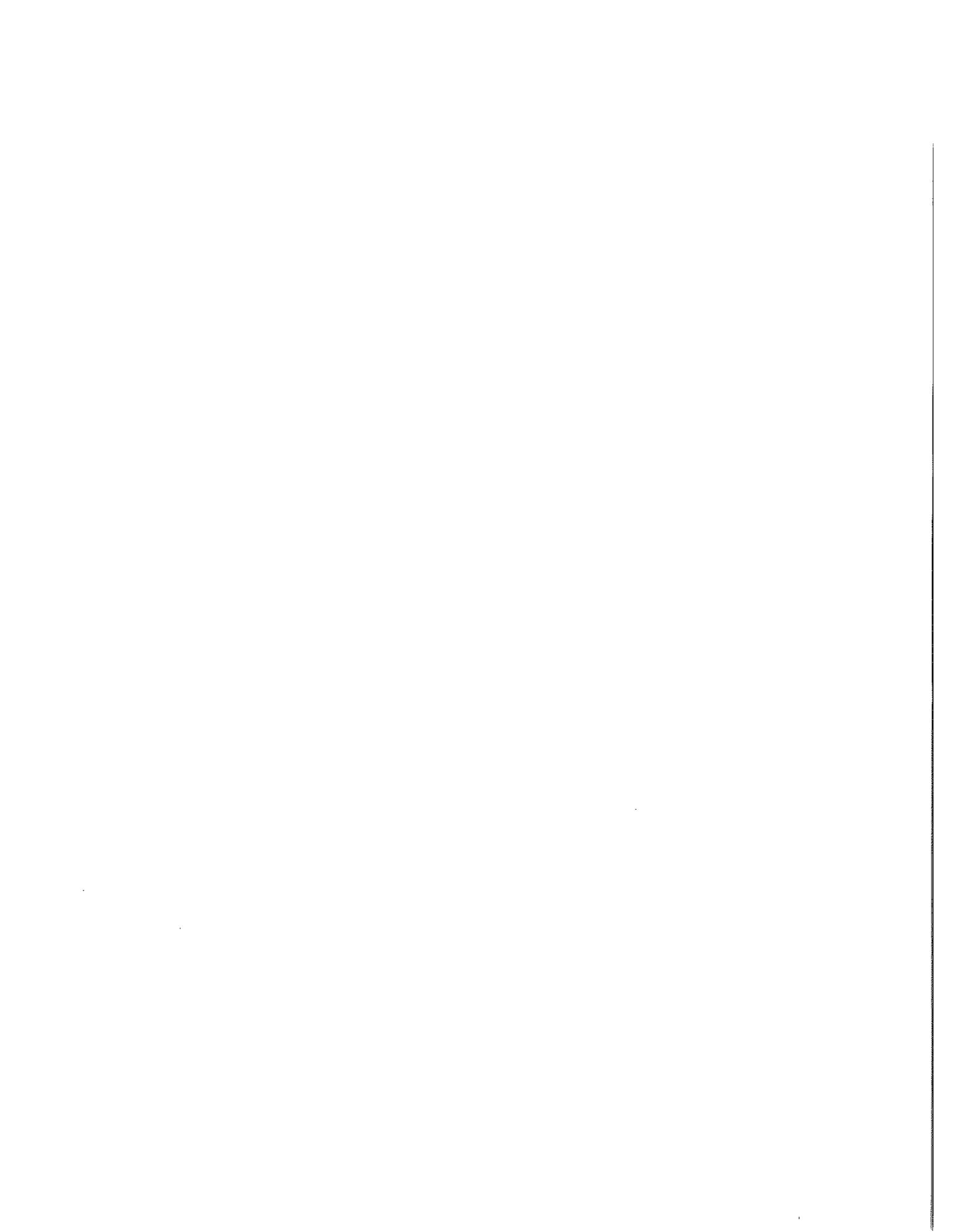


TABLE OF CONTENTS

	Page
Chapter I OIG Operating Highlights	1
Chapter II Health Care Financing Administration	7
Chapter III Social Security Administration	31
Chapter IV Grants and Internal Systems	47
Chapter V Legislative and Regulatory Review	63
Chapter VI President's Council on Integrity and Efficiency	69
Appendix A Unenacted Legislative Recommendations	75
Appendix B Unenacted Program Recommendations	83
Appendix C Analysis of Cost Savings	87
Appendix D Summary of Cost Savings	93
Glossary of Terms and Acronyms	97



OIG OPERATING HIGHLIGHTS



CHAPTER I

OIG OPERATING HIGHLIGHTS

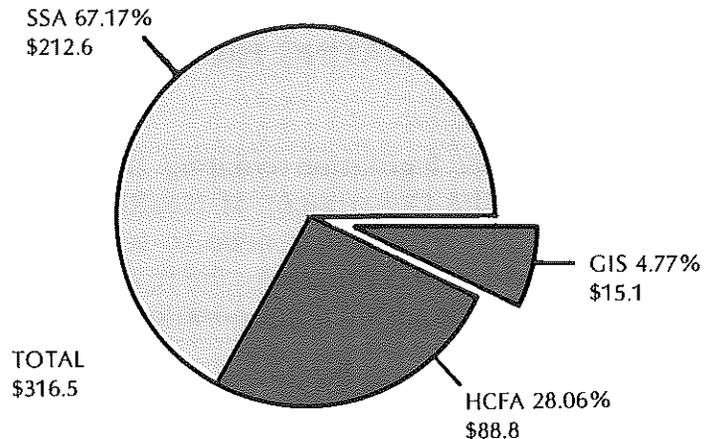
Since the enactment of legislation creating the Office of Inspector General (OIG) within the Department of Health and Human Services (HHS) in 1976, the OIG mission has been to ferret out and eliminate fraud, waste and abuse in HHS programs and to promote the overall efficiency and economy in departmental operations.

Departmental outlays have increased from \$230.3 billion in FY 1981 to almost \$316.5 billion in FY 1985. They are projected to grow to \$330.4 billion in FY 1986.

- The Social Security Administration (SSA), with a FY 1985 budget of \$212.6 billion, represents the largest portion of the HHS budget. The SSA administers the Old Age, Survivors and Disability Insurance (OASDI); Supplemental Security Income (SSI); the State-administered Aid to Families with Dependent Children (AFDC); Low Income Home Energy Assistance (LIHEA); Refugee Resettlement (RR); and Child Support Enforcement (CSE) programs.
- The Health Care Financing Administration (HCFA), with a FY 1985 budget of \$88.8 billion, includes the Medicare and Medicaid programs and represents the second largest portion of the HHS budget.
- Grants and Internal Systems (GIS), with its combined FY 1985 budget of \$15.1 billion, encompasses two operational divisions in HHS—the Public Health Service (PHS) and the Office of Human Development Services (OHDS)—as well as overall departmental management. Although GIS represents the smallest segment of departmental outlays, it includes 83 percent of the Department's discretionary expenditures.

The following chart shows the FY 1985 distribution of HHS funds by major departmental programs.

**DHHS OUTLAYS FOR FY 1985
(DOLLARS IN BILLIONS)**



This OIG Semiannual Report to the Secretary and to the Congress describes major OIG accomplishments from April 1, 1985 through September 30, 1985. Major OIG accomplishments for the period were:

- Administrative sanctions imposed by the OIG resulted in 280 health care providers being "kicked out" of the Medicare and/or Medicaid programs for health care related fraud and for providing poor quality of services bringing it to a record total of 390 for the year. (See page 25.)
- Investigations of Medicare/Medicaid fraud by the OIG and federally supported State Medicaid Fraud Control Units resulted in 245 convictions, and financial recoveries and savings of \$11.1 million. This included \$6.7 million in civil monetary penalty settlements. Total fiscal year results were 480 Medicare/Medicaid convictions; and financial recoveries, settlements and savings of \$20.9 million. (See page 22.)
- Investigations of Social Security fraud resulted in 386 successful prosecutions and \$25 million in recoveries and savings, for a record year-end total of 854 successful prosecutions and \$35.5 million recoveries and savings. (See page 37.)
- Accepted OIG recommendations for legislative, regulatory or operating policy changes, and HHS management commitments to recoup overpayments which have an aggregate dollar value of nearly \$2 billion for the 6-month period and a total of \$4.9 billion for the fiscal year.

Descriptions of OIG activities which contributed to these accomplishments are presented in subsequent chapters of this report.

Significant OIG Findings:

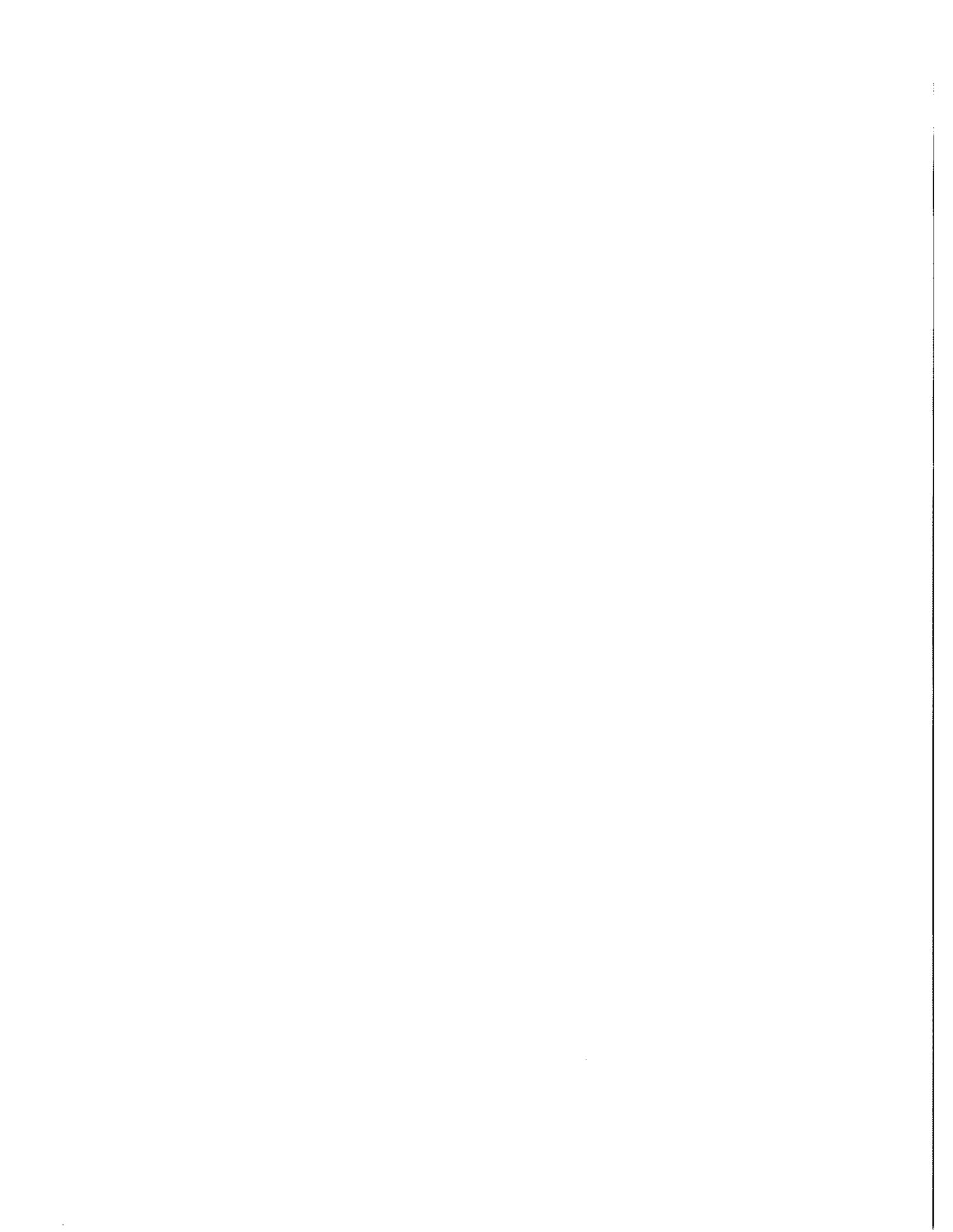
Additional savings could be realized upon enactment of legislation, regulatory change or departmental action as described below:

- Excluding costs improperly included in the cost base for the current DRG rates could prevent annual overcharges to the Medicare program of \$813 million (\$739 million capital and \$74 million medical education costs). (See pages 8 and 10.)
- Eliminating unnecessary Medicare expenditures for intraocular lens, hospital outpatient facility fees, and professional fees related to cataract surgery could save up to \$5.6 billion over a 5-year period. (See page 8.)
- Containing indirect costs of federally sponsored research would make available \$315 million annually for support of thousands of research projects approved on technical merit but unfunded because of budgetary restraints. (See page 52.)
- Eliminating payment of hospital bad debts could save the Medicare program approximately \$92 million annually. (See page 9.)
- Prohibiting Social Security benefits to aliens who worked illegally could reduce trust fund outlays by \$17.1 million in FY 1986 and by billions in future years when those now working illegally reach retirement age. (See page 43.)
- Requiring SSI recipients' income to be considered when determining a family's AFDC grant would eliminate the "favored household" treatment now being given joint AFDC/SSI families and could result in Federal savings of \$73 million annually. (See page 37.)
- Discontinuing payment of certain capital cost items identified by OIG could result in Medicare savings of at least \$899 million annually. (See page 9.)
- Limiting payments for the Part B deductible and coinsurance to the Medicaid fee schedule (under the Medicare Buy-In program), could

result in annual Federal and State Medicaid savings totaling \$220 million (\$120 million Federal share). (See page 12.)

- Requiring community health centers to maximize the use of revenues could reduce their dependency on Federal funds by \$8.8 million annually. (See page 48.)

HEALTH CARE FINANCING ADMINISTRATION



CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

The Medicare and Medicaid programs, administered by the Health Care Financing Administration (HCFA), provide health care for approximately 50 million Americans; nearly one out of every five citizens.

Fiscal year 1985 Federal spending for the Medicare and Medicaid programs is estimated at \$66 billion and \$22.8 billion, respectively. Total funding for these programs represents about 28 percent of the Department's budget and 9 percent of the total Federal budget. The continued rise in health care costs (FY 1984 outlays were \$78 billion for both Medicare and Medicaid) was slowed by cost containment measures such as Medicare's prospective payment system (PPS) for hospital reimbursement now approaching its third year of phase-in. Under PPS, hospitals are paid according to preset rates based on diagnosis, referred to as Diagnosis Related Group (DRG) rates.

For the fiscal year, OIG recommendations adopted by HCFA and legislation resulting from OIG findings and recommendations resulted in \$3.0 billion in savings. During the last 6 months of FY 1985, OIG staff continued to identify areas where, with legislative and regulatory reform as well as tightened program administration, savings to HCFA's health programs of \$4.0 billion annually are possible. Similarly, OIG reviews questioned program expenditures of \$346.5 million. In these instances, our recommendations call for appropriate financial adjustments and procedural changes.

To highlight each aspect of OIG activity, this chapter is divided into: (1) legislative change/regulatory reform, (2) program administration, (3) ongoing reviews in health, and (4) legal and administrative sanctions of wrongdoers.

Legislative Change/Regulatory Reform

OIG reviews during this reporting period identified a number of areas where, with legislative action or regulatory change, approximately \$18.2 billion could be saved over a 5-year period.

**MEDICAL
EDUCATION
COSTS INCLUDED
IN DRGs**

Medical education costs are reimbursed on a reasonable cost basis and, accordingly, are to be excluded from the DRG rates. However, a recent OIG report found that not all medical education costs were excluded from the cost data used in calculating the FY 1984 DRG rates. As a result, Medicare payments for these costs will be duplicated—once as part of the medical education pass-through costs and again through the DRG rates.

Specifically, our review of 133 hospitals' audited 1982 or 1983 base year cost reports showed that some \$1.2 million in nursing school costs for ancillary services and intensive care, as well as costs for paraprofessional medical education, had been included in calculating the Federal portion of the DRG rates. These additional costs represented about 0.2 percent of total Medicare inpatient operating costs for the hospitals under review. Projecting our findings to hospitals nationwide, we estimate that over a 5-year period beginning FY 1986, Medicare will be paying added costs of some \$370 million.

We recommended that HCFA rebase the Federal portion of the DRG rates using audited hospital cost report data from a more current year. Our report is currently with HCFA for comment.

**CATARACT
SURGERY**

A national review on Medicare payments for cataract surgery found that Medicare is paying over \$500 million each year in unnecessary costs including: mark-ups of 200 percent and more for intraocular lens, excessive costs and inconsistencies in payment based on where the surgery is performed (i.e., hospital inpatient, hospital outpatient, ambulatory surgical center, or physician's office), and wide variances in payment for professional service fees.

We recommended that HCFA seek necessary legislation to:

- establish a national cap for lens payment;
- create an independent commission to assess periodically the changes in surgical procedures and technology, and mandate adjustments to Medicare reimbursement;
- limit hospital outpatient facility fees and beneficiary charges to approximate Medicare payments and charges now authorized for ambulatory surgical centers; and

- pay a single professional fee to cover all professional staff associated with cataract surgery.

Five-year Medicare savings of up to \$5.6 billion could be realized if Congress enacts legislation to eliminate unnecessary Medicare expenditures related to cataract surgery. The Inspector General has testified before three congressional bodies—The House Ways and Means, and Energy and Commerce Committees and the Senate Finance Committee—on the findings of the study. HCFA is now reviewing our report.

Under Medicare reimbursement principles, hospitals are paid for bad debts attributable to beneficiary nonpayment of deductible and coinsurance amounts once a reasonable attempt is made to collect the debts.

BENEFICIARY BAD DEBTS

Under PPS, bad debts continue to be reimbursed under reasonable cost principles. However, because hospitals under PPS are allowed to retain profits (or absorb losses) based on their operational efficiencies, the original intent of paying bad debts is no longer appropriate. In fact, there is a trend toward waiver of the coinsurance and deductible amounts by hospitals to induce Medicare beneficiaries to utilize inpatient services because of the profit potential inherent in the PPS reimbursement.

HCFA's elimination of the payment of hospital bad debts, as recommended, would save the Medicare program approximately \$92 million annually. HCFA does not agree with our recommendation at this time but rather believes it should be considered once all costs of inpatient care are included in the DRG rates.

Not all hospital inpatient costs are currently included in PPS. Capital costs as well as those for medical education and bad debts are still paid on a reasonable cost basis and are referred to as pass-through costs. However, hospitals' capital costs including interest, depreciation, and return on equity are being studied within the Department for incorporation in PPS after October 1, 1986. Accordingly, OIG focused on ways not only to improve current Medicare policies for paying capital costs but to establish an appropriate base for incorporating such costs in PPS.

CAPITAL COST ISSUES

An OIG study identified six capital cost elements now being paid and recommended that the advisability of their payment be examined in establishing the base costs to be paid through PPS. Two of the more substantive reviews include:

- *Waiver of interest income offset.* Medicare reimbursement of interest expense is usually reduced or offset by interest income. An exception is interest earned on money saved for future capital needs (funded depreciation). This exception was created to encourage providers to set aside funds for future capital needs. However, given the current hospital bed surplus and that no bed shortages are predicted, this loophole—estimated to cost Medicare \$464 million in FY 1984—may no longer be appropriate.
- *Return on equity capital to proprietary hospitals.* Medicare pays proprietary (for-profit) hospitals a return on shareholders' capital investment in the hospital. However, under PPS, hospitals can realize a "profit" whenever they keep operating costs below the preset Medicare rate. Considering this and the fact that proprietary hospitals have historically had lower than average operating costs, continuing under PPS the \$200 million annual equity return paid these hospitals could well result in windfall profits. The Inspector General testified before the House Energy and Commerce Committee in May on our findings and recommendations.

Eliminating costs identified by OIG, when computing the proposed PPS add-on percentage for capital, would slice about 2 percentage points off the 7 percent historical average now being considered; thereby saving the Medicare program an estimated \$899 million annually.

CAPITAL IN DRGs

OIG reviews disclosed that the cost base used in calculating the current DRG rates included capital costs. This resulted in Medicare paying twice for capital, once as a pass-through and again through the DRG rates. This situation occurred because HCFA, in developing the DRG rates, primarily used unaudited 1981 provider cost report data as its cost base.

We found that the procedures used by HCFA to remove capital costs from hospitals' total inpatient costs prior to computing the Federal portion of the DRG rates did not properly exclude all capital costs. Specifically, certain indirect capital costs, allocated through the hospitals' general service cost centers to ancillary services and special care units, were not identified and removed. We also found that many hospitals charged certain capital costs such as home office depreciation and interest, equipment depreciation and lease expenses directly to departmental cost centers and reported the expenses as operating rather than capital costs. We estimated that duplicate Medicare payments for capital costs totaled \$739 million in FY 1984.

We recommended that HCFA rebase the Federal portion of the DRG rates using a more current year's audited costs. By doing so, we believe HCFA would correct deficiencies in the present data base.

Medicare's waiver of liability provisions, authorized by the 1972 amendments to the Social Security Act, provided protection to Medicare beneficiaries and providers against the intricacies and complexities of the then relatively new health insurance program. Under these provisions, beneficiaries would not have to pay for services denied Medicare reimbursement as long as they did not know that Medicare would deny payment. Providers were protected against absorbing the costs of non-reimbursable services on the same basis.

WAIVER OF LIABILITY

In 1982, HCFA reevaluated the provisions and concluded that the provisions were no longer appropriate for providers in view of the 15 years experience gained. Initially, HCFA attempted a legislative change to curb waivers of provider liability. It then moved to the rulemaking process when realizing the same objective could be achieved by regulation. In February 1985, HCFA published a Notice of Proposed Rulemaking (NPRM).

The February NPRM has not been finalized and, given comments in opposition, there appears to be some question whether it will be. As a result, HCFA's projected savings of \$56 million for FY 1986 may not be realized. We find HCFA's position as valid today as when first presented. A reversal now could be a costly mistake. We, therefore, recommend that the proposed regulation be implemented immediately so that the full amount of savings projected for FY 1986 can be realized. Our report is currently with HCFA for comment.

Family planning services rendered to Medicaid recipients are eligible for a special Federal payment to the State agencies which administer Medicaid. The Federal share of Medicaid payment for medical services, except family planning, ranges by State from 50 percent to 77.6 percent nationally. The Federal share for family planning services is 90 percent.

FAMILY PLANNING

An OIG regional inspection documented administrative and technical problems encountered with the family planning matching policy, and documented misspent matching Federal monies of \$2.8 million in one State alone. Because of the higher matching rate for family planning services, considerable administrative burdens are placed on the States to segregate family planning claims from other medical service claims. We

recommended that the 90 percent match for family planning be eliminated, citing the fact that services are currently mandatory under Medicaid, so special funding is not warranted.

HCFA agreed; and legislation to eliminate the 90 percent family planning match under the Title XX Social Services programs is now under consideration by the Department. We estimate savings of \$500 million could be realized over a 5-year period.

Program Administration

During this reporting period, OIG reviews identified a number of program areas where more efficient management and tightened internal and fiscal controls could result in annual savings of over \$360.9 million. In addition, another \$346.5 million in program expenditures were questioned as to their allowability under regulations, law or cost principles. In these instances, recommendations called for financial adjustments and appropriate procedural changes.

CROSSOVER CLAIMS

Under the Buy-In program, States can enroll eligible Medicaid recipients in the Medicare Part B program. Medicaid pays the Part B premium, deductible and coinsurance. Claims for the deductible and coinsurance are submitted to State Medicaid agencies by Medicare carriers after payment of the Medicare-covered amount.

In paying the deductible and coinsurance, if the Medicare payment is greater than the Medicaid fee schedule (and it usually is), the State may limit its payment to the fee schedule. In fact, we noted that 20 States restrict reimbursement to the amount the provider would have been paid under the State's Medicaid program. Savings to the Medicaid program could total as much as \$1.1 billion (about \$600 million Federal share) over a 5-year period if the remaining 30 States and the District of Columbia adopted similar practices. Since all Medicaid agencies may not be aware of this reimbursement option, we have suggested that HCFA point out to these Medicaid agencies the significant savings possible by adopting limited payment practices. Our report is currently with HCFA for comment.

PENSION ACCOUNTING

Results of an OIG review show that HCFA needs to require that intermediaries and carriers treat Medicare as a separate business segment in

determining and charging pension costs to the program. Of the four contractors reviewed, OIG found that Medicare's pension liability was proportionately overfunded by about \$21.9 million.

These over-contributions occurred because the Medicare work force was not segmented but instead was treated as an indistinguishable part of each contractor's overall work force. For example, our review disclosed:

- Generally more Medicare employees left employment without pension rights than non-Medicare employees. However, the resultant gains from reduced pension costs were (inequitably) spread over the entire work force even though the Medicare work force was the primary cause of the gain.
- The same inequitable spread was made again with pension plan enhancements. When pension plans are enhanced, benefits are often increased to individuals already retired. The actuarial methods being used in applying costs associated with such enhancements, however, failed to recognize that proportionately fewer Medicare employees had retired (a factor of Medicare being a relatively new program).

As a result of this lack of segmentation, annual pension costs are treated as an indirect cost and are allocated to the Medicare program. When pension costs are charged indirectly to Medicare, they are higher than when they are charged directly because certain conditions, such as those discussed above, which would lower Medicare's proportionate cost are not being considered.

Based on our findings, we estimate that Medicare may have over-contributed as much as \$200 to \$230 million to pension plans at all Medicare contractors since program inception. Of this amount, about \$140 million will be recovered if contractors implement segment accounting.

HCFA agreed with our recommendation to require segment accounting for pension costs in future contracts with intermediaries and carriers.

Home health care was intended by Congress to be less costly than institutional care because of its intermittent nature. However, results of an OIG study indicate that the cost of intermittent home health care often exceeds the cost of full-time care in a nursing home, and that the extent of home health services may not be needed or suitable for a great

HOME HEALTH CARE UTILIZATION

number of patients. For example, we found that during calendar year 1983:

- in 23,014 cases, monthly home health benefit payments exceeded the cost of full-time monthly care in skilled nursing facilities by about \$17 million; and
- in 2,371 cases, payments were made for individuals receiving 60 or more HHA (home health agency) visits during a month—an average of over two visits per day.

The physician's treatment plan, the primary control over home health services, may not be the best vehicle for controlling overutilization of services. Physicians have little positive incentive to prevent overutilization and are often pressured by patients and HHAs to sign liberal treatment plans. In many instances, these treatment plans are designed by HHAs which have a strong incentive to maximize patient visits.

HCFA has proposed a co-payment provision which would provide an incentive to control utilization. Our analysis of national home health payments shows that this proposed requirement would save the Federal Government at least \$94 million annually. While we strongly support the co-payment provision, data developed during our study indicate that additional steps must be taken to effectively control the utilization of home health services. One such measure that we have recommended calls for HCFA to establish limits on the number of visits normally needed based on the patients' medical diagnoses. Monthly costs of skilled nursing facilities' (SNFs) care should be considered when establishing these limits. Any visits in excess of such limits should be justified by the physician and evaluated by the appropriate intermediary. Such a course of action would not impact on patient needs but would assist in curbing abuse in the provision of excessive services. We estimate that implementation of this additional control will save the Medicare program about \$17 million annually (\$85 million over a 5-year period), exclusive of the co-payment savings.

HCFA has informed us that it is in the process of establishing more detailed home health screens for many diagnoses. It feels the new HCFA guidelines, combined with the use of regional home health intermediaries, should lead to more uniform and sophisticated medical review procedures and to reductions in the amount of noncovered services paid by Medicare.

The Deficit Reduction Act required the Department to develop an appropriate wage index for use in the Medicare PPS. Under the law, the new index was to take into account area differences in the use of part-time workers—a deficiency of the existing index.

HOSPITAL WAGE INDEX

HCFA conducted a wage index survey by obtaining data from hospitals on gross salaries and the related hours paid for a year. New wage indexes for 363 geographical areas were then calculated. HCFA estimated that using the wage indexes (based on unaudited data) to adjust the 1984 and 1985 PPS payments would result in \$17 million of additional payments to hospitals.

OIG questioned HCFA's conclusions on the grounds that the hospital data had not been independently verified. A joint review, made by the OIG and fiscal intermediaries, disclosed a number of instances where wages had been overreported or employee time underreported. Incorporating the results of this review in its calculations, HCFA corrected the wage indexes which, as applied to 1984 and 1985 PPS payments, will result in a net reduction of \$7 million in payments to hospitals.

OIG reviewed Medicaid administration in seven States to determine whether Federal funds were being claimed for payments made for drugs determined to be less-than-effective by the Food and Drug Administration (FDA). Federal regulations prohibit Federal sharing in the costs of these drugs and all identical, related or similar drug products.

LESS-THAN- EFFECTIVE DRUGS

We found that these States had not promptly halted payments for less-than-effective drugs. We also found a general inconsistency among States in identifying similar and related drug products. Among the problems contributing to this situation was States' failure to act on FDA notices of less-than-effective drugs when published in the *Federal Register*. Rather, the States waited for notification from HCFA which generally occurred 2 to 6 months after the FDA notice. With regard to similar or related drug products, two States attributed their failure to identify all related drugs to the lack of a HCFA published list of all drugs that should be denied Medicaid reimbursement.

All told, we identified about \$1.3 million in Federal payments made to seven States for less-than-effective drugs. If the experiences of these States are typical of all States, as much as \$8.6 million in Federal funds may have been misspent over the 10-month period reviewed—clearly a misuse of Federal funds.

More importantly, payments for less-than-effective drugs are an indication that recipients are being denied quality care. We recommended that HCFA move aggressively to correct this situation. HCFA's comments to our report outline a number of corrective actions being taken.

We informed the Veterans Administration (VA) Inspector General and the Department of Defense (DOD) Inspector General of our findings and recommendations for use in a similar review of their programs. We also offered to provide specific technical details of our audit in order to expedite any VA and DOD reviews in this area.

**MEDICAID
OVERCHARGES**

OIG reviews in five States showed that Medicaid was overcharged \$17.6 million. Two States failed to reduce Medicaid claims for amounts received from third parties, such as private insurers, resulting in a \$7.6 million overcharge. A third State incorrectly computed Medicaid per diem rates for several of its intermediate care facilities resulting in a \$2 million overcharge. A fourth State, contrary to Federal policy, failed to credit the Federal share of provider overpayments at the time the overpayments were identified, resulting in a \$6.9 million overcharge. The remaining State misclassified an institution for mental diseases (IMD) as an intermediate care facility and improperly charged Medicaid \$1.1 million for noncovered treatment of IMD patients under age 65.

Appropriate procedural changes and financial adjustments were recommended. HCFA generally concurred with our findings and recommendations.

**MEDICARE
ADMINISTRATIVE
COSTS**

OIG assessed the allowability of administrative costs claimed for reimbursement by Medicare intermediaries and carriers and recommended approximately \$3.2 million for disallowance. Unallowable costs included: excessive charges for claims processing system installation, inequitable cost allocations, and duplicative telecommunications costs.

**DRG
MISCLASSIFICATION**

The 1983 Social Security amendments significantly changed the way hospitals are reimbursed under Medicare. Starting in FY 1984, hospitals are reimbursed prospectively on the basis of a flat rate established for each Medicare case. The rate paid generally depends on which diagnosis related group (DRG) the case falls under (e.g., DRG-88, Chronic Obstructive Pulmonary Disease) and where the hospital is located.

As part of our study of the prospective payment system (PPS), we reviewed a number of DRGs to determine vulnerabilities to incorrect or

manipulative coding, which could cause erroneous DRG assignments. Based on review findings in one specific area, erroneous DRG assignments caused estimated Medicare overpayment of \$41 million. Highlights of this review follow:

- DRG-88, Chronic Obstructive Pulmonary Disease (COPD), is the ninth most frequently billed DRG, and among the top ten in the amount of total reimbursement. OIG reviews at 11 hospitals found that 60 percent of the cases reviewed were erroneously assigned to DRG 88, and an additional 5 percent were unnecessary admissions. This resulted in overpayments of more than \$116,000. Projecting our findings for the nation, as much as \$41 million would be incorrectly paid by Medicare annually for this DRG.

Nail removal was classified as an operating room procedure for as many as 1,100 discharges. Medicare reimbursement was made on the basis of a surgical DRG, when in fact nail removal does not require the use of an operating room. HCFA agreed with our recommendation to reclassify nail removals so that they are not considered operating room procedures, resulting in savings of \$2.4 million annually.

NAIL REMOVAL

An OIG national inspection of Medicare beneficiary hospital accounts found that a total of \$164 million is currently being held as credit balances in hospital accounts of Medicare beneficiaries that should be returned to Medicare. This is money that hospitals received from Medicare for services provided to beneficiaries that were also paid for by private insurers.

CREDIT BALANCES

Although our report is still under review in HCFA, several regional offices have issued instructions to the intermediaries to ensure that hospitals return the money paid to them by Medicare.

The Omnibus Budget Reconciliation Act of 1981 makes Medicare the secondary payer for certain end-stage renal disease (ESRD) beneficiaries. Specifically, the law requires that a person with renal failure is not eligible for Medicare until 1 year after onset, if the person has health insurance through employment. The private health insurance pays for the individual's health care expenses to the extent of the policy coverage for the year.

SECONDARY PAYER FOR ESRD

In four regional studies of this issue, the OIG identified Medicare overpayments of approximately \$11 million that should have been paid by the beneficiary's private insurance.

- SECONDARY PAYER
AUTOMOBILE
ACCIDENTS** Under the 1980 Medicare and Medicaid amendments, payment is excluded for any item or service, to the extent that payment has been or can reasonably be expected to be, made under an automobile or liability insurance policy or under no-fault insurance. Our reviews of Medicare payments involving accident injuries identified \$6.2 million in potential Medicare overpayments.
- OUTPATIENT
PSYCHIATRIC
SERVICES** The Medicare law limits outpatient psychiatric services to a maximum of 62½ percent of the first \$500 billed per patient per year, or a maximum allowable of \$312.50.
- HCFA regulations and directives to carriers with regard to applying this statutory limitation have been inconsistent, resulting in varying carrier controls on outpatient psychiatric service claims. All but four of the Nation's carriers apply the limit to both physician and nonphysician rendered services. These four, in compliance with HCFA's instructions, do not apply the limit to nonphysician care until the supervising physician's claim reaches the limit.
- Based on a computerized analysis of the CY 1983 claims records of these four carriers, we project that as much as \$3.2 million could be saved if the limit were uniformly applied to both physician and nonphysician services. Our study is with HCFA for review.
- ANESTHESIA
SERVICES** The Medicare program spends nearly \$1 billion annually for over three million anesthesia services provided to beneficiaries. In a recent review, we found that anesthesia services provided during cataract removal, hernia repair, and pacemaker implant vary. We found that local anesthesia administered by the surgeon with the patient monitored and evaluated by an anesthesiologist (local standby anesthesia) is provided more frequently than general anesthesia administered by anesthesiologists. Standby anesthesia generally does not require the full range of services associated with general anesthesia. Because of this factor, some carriers pay less for local standby anesthesia. We estimate that program savings of some \$47 million could be achieved annually if HCFA required all carriers to reimburse local standby anesthesia services at a rate lower than general anesthesia services.

Ongoing Reviews in Health

OIG has a number of reviews underway focusing on the appropriateness of Medicare and Medicaid payments for services provided and the quality of care received. Following are highlights of several of these reviews.

To qualify for Federal sharing in the cost of services provided in skilled and intermediate nursing facilities, each State must certify (and recertify annually) through onsite inspections that such facilities meet Federal standards. Such standards are intended to insure that quality care is provided. Preliminary results of OIG reviews in two States disclosed that not all recertification requirements were being met.

FACILITY RECERTIFICATIONS

In one State, we found that due to a misinterpretation of a HCFA instruction, the State did not make annual onsite inspections at 261 of the 352 facilities reviewed. Accordingly, for varying periods between June 1982 and September 1984, these facilities operated without valid provider agreements and lacked positive assurance that serious health and safety violations did not exist. Payments to the 261 facilities during this period totaled about \$67.7 million.

In the second State, many facilities with health and safety deficiencies were recertified without written justification for such action. Under Federal regulations States may recertify facilities with deficiencies provided there is written documentation to assure that patient health and safety are not in immediate jeopardy. As a result, the State Medicaid agency claimed about \$110 million (FFP) for services which may not have been eligible for Federal sharing.

Although our reviews are continuing, we have alerted HCFA to these situations so prompt action can be taken to help ensure that patients' health and safety are not being jeopardized.

Medicare payments for chiropractic services are limited to one procedure, treatment of subluxation (a partial dislocation of the spine) and then, only if the need for treatment has been confirmed by x-rays taken by or under the supervision of a doctor of medicine or an osteopathic physician. In 1984 (the most recent data available), chiropractic treatment of subluxation was the ninth most frequently billed service under Medicare Part B with payments totaling about \$94 million, an average annual increase of 19.2 percent since 1975.

CHIROPRACTIC SERVICES

In an ongoing OIG review, preliminary results indicate that Medicare is being billed for chiropractic services in addition to the one covered procedure (i.e., treatment of subluxation as documented by x-ray). Using computer screening techniques, we targeted a number of cases in one State where services performed by chiropractors were billed to Medicare by physicians. Over 400 patients, involving about 1,000 claims handled by 17 physicians and 38 chiropractors are under review. Some 4,000 procedures have been billed as part of these claims. Preliminary results further indicate that about 99 percent of these procedures involved unallowable costs because the services were performed by the chiropractor and/or by the chiropractor's staff, yet billed as covered physician services. Our review is continuing.

In a related OIG review, we recommended that HCFA seek necessary legislation to place a cap of 12 services per year per beneficiary on chiropractic services, thus estimating savings of about 8.6 percent of Medicare expenditures for chiropractic services or about \$56 million over a 5-year period. We also recommended removal of the x-ray requirement since it is not administratively cost effective and does not have the direct effect of curtailing utilization.

**PRO
ADJUSTMENTS**

Under PPS, inpatient records are to be reviewed by a Peer Review Organization (PRO) to determine the necessity and appropriateness of the admission, the quality of care provided and the validity of diagnostic information furnished the fiscal intermediary. Payments questioned by the PRO are to be adjusted by the fiscal intermediary.

Our review in one State found that PRO-questioned payments (amounting to an estimated \$6.75 million) were not being processed to effect financial adjustments by fiscal intermediaries. HCFA officials indicated that this was a nationwide problem with as much as \$300 million in incorrect payment adjustments that had yet to be processed. During the time of our review, a new electronic procedure for processing adjustments was developed by HCFA. We plan to expand our review to other States to better estimate the magnitude of this problem and determine the effectiveness of the procedures and whether additional corrective action is needed.

EDP REVIEWS

OIG is examining the efficacy and cost effectiveness of computer edits/screens that Medicare carriers have in place to prevent payments for unallowable services. Preliminary results from one such review identified a promising mechanism used by one carrier to detect improper claims for ambulance services.

By regulation, Medicare will pay for ambulance services only if other means of transportation would endanger the beneficiary's health and if the beneficiary is being transported to such destinations as a hospital or nursing home. Currently, almost all carriers use manual processes to determine whether claims for these services meet destination and level of service requirements. We found that one carrier had implemented a place-of-service coding system and corresponding computerized prepayment edits that increased claims processing effectiveness. After the first year of implementation the carrier's identification of improper claims and denial rate increased 19.5 percent.

If such systems are feasible at all carriers, Medicare payments for non-covered ambulance services could be reduced by as much as \$64 million annually. Our review is continuing.

Hospitals' costs for operating psychiatric, rehabilitative or alcoholic units are excluded from PPS if such units are a distinct part of the hospital and meet certain other requirements. Costs for these units continue to be paid on a reasonable cost basis as they were prior to the implementation of PPS.

PPS EXEMPT HOSPITAL UNITS

Our review in two States, however, disclosed that such costs per patient discharge were included in total cost data used to develop the DRG rates, causing the DRG rates to be inflated. This resulted in hospitals in these States receiving excessive reimbursements through the DRGs of approximately \$4 million. We are expanding our review to other States to determine the nationwide impact of this problem.

To qualify for Medicare or Medicaid reimbursement physicians must be licensed by the State in which the services were performed. This licensing requirement is applicable to medical doctors, chiropractors, osteopaths and podiatrists. An OIG review in one State identified 434 providers who received Medicare or Medicaid payments when their licenses were inactive, i.e., authorization to practice had lapsed or been withdrawn. The licenses of 133 of these providers had been inactive at least 3 years.

UNLICENSED PHYSICIANS

To date, almost \$10 million in Medicare payments have been made to these providers during the time their licenses were inactive. Equally significant is the fact that physicians who fail to renew their licenses may not be complying with continuing education requirements. The latter could contribute to Medicare and Medicaid beneficiaries not being fur-

nished quality care. We are planning to expand our review to other States and incorporate other detection methods to determine the nationwide impact of this problem.

Legal and Administrative Sanctions of Wrongdoers

Fraud prevention, along with the prosecution and sanctioning of defrauders, has become one of the more effective methods of reducing health care costs without impairing the quality of care. Financial penalties can compensate for losses incurred through fraud, while administrative sanctions can remove abusive providers from our programs.

Efforts over the past few years to concentrate our scarce resources on health care investigations have been increasingly successful. During the past 6 months, we obtained 44 health care convictions, for a total of 75 for the year compared with 49 in FY 1984, an increase of 53 percent. Investigative recoveries and savings for this period amounted to \$11.1 million, for a total of \$20.9 million for the year in comparison with \$15.4 million in FY 1984, a 36 percent increase. During this period, we obtained \$6.7 million in civil monetary penalty settlements for a total of 70 settlements and \$9.7 million for this year.

In addition, we have worked with and testified before various House and Senate committees on legislation—H.R. 1868—that would tighten up and close the loopholes that presently exist in our sanctioning and civil money penalties authorities.

FALSE CLAIMS We continue to pursue successfully individual providers filing false Medicare or Medicaid claims. These providers are usually brought to our attention by carriers, patients and providers' peers. For example, during this period we obtained the following convictions:

- A dermatologist and owner of a Louisiana medical corporation was convicted and sentenced to 3 years imprisonment and fined \$50,000 for submitting 79 false Medicare claims. He was ordered to pay back \$23,000 to Medicare and assessed \$283,000 in civil money penalties.
(6-8300167)
- The former executive director, who was also comptroller of a New Hampshire hospital, was convicted, sentenced and fined \$10,000 for receiving illegal kickbacks. He conspired with a health care supplier

to submit inflated bills for respiratory services to the hospital. The health supplier was sentenced to 2 years in prison and ordered to pay restitution and fines of \$72,000. His company had to pay fines and restitution of \$45,000. (1-8200097)

Reviews

- In conjunction with the Texas Medicaid Fraud Control Unit, we obtained a guilty plea from an ophthalmologist for billing Medicare and Medicaid for nondelivered services and for obstruction of justice. Administratively excluded from the programs in 1979, he used the provider number of a colleague in his billings and tried to get the colleague to lie to a grand jury on his behalf. He was sentenced to 9 years in prison and fined \$55,000.
- The largest Medicaid provider in Florida, a dentist who owned several dental clinics, was found guilty of paying \$5 to \$10 for each Medicaid-eligible child referred to his office. He was also convicted for filing false Medicaid claims, and was sentenced to prison. In 1983, he was also found guilty of defrauding Medicaid and ordered to discontinue practice for 3 years. (14-8300250)
- An Iowa chiropractor was convicted, sentenced and fined \$30,000 for submitting 139 false Medicare claims. He also paid almost \$16,000 in civil penalties. (7-840059)
- A Vermont neurologist pled guilty to billing Medicare for injections never given. He was fined \$15,000 and ordered to pay restitution of \$5,300. (1-8200152)

In addition to following up on complaints from traditional sources, we are finding that our proactive initiatives have enhanced our ability to uncover health care fraud. One type of initiative is our participation on geographic task forces, along with other State and Federal investigative organizations, where there are large numbers of Medicaid and Medicare recipients and providers. Another type of proactive initiative is the development and use of service-specific detection techniques.

PROACTIVE INITIATIVES

To date, we have established the following task forces to attack health care fraud.

TASK FORCES

- The Pennsylvania task force was formed in 1980 and since that time, has been responsible for a number of convictions. Included were the owners of diagnostic laboratories and medical centers, cardiologists,

and the owner of a shoe store who falsified claims for prosthetic devices.

- The South Florida task force was established almost 2 years ago. To date, it has obtained 9 convictions of a wide range of health care providers, including dentists, physicians, optometrists, pharmacies and clinics. Part of the success of this task force is attributed to the accessibility of a Federal prosecutor who is assigned full-time to prosecuting cases developed by the task force.
- The New Jersey task force, now also 2 years old, obtained its first 4 convictions this year. This task force has largely concentrated on ambulance companies.

**SERVICE—
SPECIFIC PROJECTS**

Other proactive projects aimed at specific industry segments have been initiated in one or more regions.

- Ophthalmologists—“Project Eye Doc” was established this past year to identify ophthalmologists having aberrant billing practices. We used computer applications and ophthalmological consultants to identify physicians who (1) may have received kickbacks, (2) submitted bills for surgical procedures that were not performed, or (3) created dummy corporations through which they were able to inflate the costs of intraocular lens, thereby increasing patient and Medicare costs.
- Pharmacies—In several regions we have been looking at inflated Medicaid billings of pharmacies, estimated to be as much as 25 percent of some companies’ billings.
- Hospitals—With the implementation of the new prospective payment system for Medicare, hospitals have initiated incentive plans for physicians. An investigation of three separate proprietary hospital chains was initiated to determine whether their incentive plans violate Federal fraud or kickback statutes.
- Suspended/Revoked Licenses—“Dr. No Ticket” is a two-phase project whereby we (1) identify doctors whose licenses have been suspended or revoked but who continue to bill Medicare for services, and (2) identify physicians who submit claims but who have inactive licenses.

- False credentials—Through “Project Phony Docs” the OIG is striving to reduce HHS expenditures and protect patients who might be victimized by a person practicing medicine without a valid license. Two convictions were obtained this year.

Other projects underway involve laboratories, podiatrists, x-ray services, neurosurgeons and physical therapists.

During this period, the 36 State Medicaid Fraud Control Units (MFCUs) will have obtained an estimated 200 convictions, for a projected total of 405 for the year. Fines and restitutions are expected to exceed \$3 million for the year.

STATE MEDICAID FRAUD CONTROL UNITS

Sanctioning fraudulent health care providers is becoming one of our most powerful weapons. In the past 6 months, we have suspended 280 providers from participation in the Medicare and Medicaid programs, and a total of 390 for the year. The examples following are representative of some of those who have been barred from participation in the programs for fraud or for poor quality of care.

ADMINISTRATIVE SANCTIONS

- A New Jersey nursing home administrator, convicted of filing false cost reports and stealing Medicaid patient funds, was suspended for 25 years. His crimes against the program and the patients resulted in over \$140,000 in improper payments.
- An Indiana ambulance company owner was suspended from the Medicare and Medicaid programs for a period of 20 years after being convicted of submitting false Medicare claims. The scheme involved transporting dialysis patients to treatment centers and claiming that they were bed confined and movable by stretcher only. Approximately \$490,000 in false claims were submitted from January 1980 to December 1982.
- A pharmacist in Illinois, co-owner of a number of medical clinics and pharmacies, was barred from participation in the Medicare and Medicaid programs for 30 years. He was convicted for his part in illegally dispensing controlled substances and for generating massive fraudulent billings.
- A New Jersey pharmacist was suspended for 30 years. He knowingly billed Medicaid for dispensing prescription drugs using false prescriptions. He also had been convicted of distribution of controlled

dangerous substances, distribution of narcotic drugs, and possession of a controlled dangerous substance with intent to distribute.

- A 20-year suspension was imposed on a New York orthopedic supplier. He had submitted over 225 false Medicaid claims which resulted in improper payments of approximately \$200,000.
- An Arkansas husband and wife were each suspended for 10 years. They owned a medical supply company and in 118 instances billed Medicaid for medical equipment which was never provided.
- A former aide at a Louisiana school for the retarded was precluded from receiving Medicare and Medicaid funds directly or indirectly for 15 years for sexually assaulting a Medicaid recipient.

CIVIL MONETARY PENALTIES

Over the past 3 years, the ability to levy civil monetary penalties against providers filing false claims has become a significant factor in deterrence and in returning money to the Government. This year, we used our CMP authority to obtain settlements of \$9.7 million, \$6.7 million of it during the past 6 months. The following examples characterize some of the more significant cases.

William & Patricia Mager

- A Florida couple who operated several clinics billed Medicare for standard tests and treatments neither personally rendered nor supervised by the physicians. We obtained a civil monetary penalty and assessment of \$1.8 million and a 25-year suspension from the Medicare/Medicaid programs.

Elias Rand

- A New York physician, principal owner of a diagnostic radiology clinic, was suspended from participation in the Medicare and Medicaid programs in 1981 for 3 years after being convicted of filing false Medicare claims. While under suspension, he submitted more than 750 claims for some 1,400 services through the clinic, for an overpayment of about \$75,600. After lengthy negotiations we reached a settlement agreement for \$1.1 million.

Joslin Clinic

- The largest CMP settlement against an organization was made for \$700,000 with a Boston clinic. Investigation of renal dialysis procedures had disclosed that 66 percent of the services billed were medically unnecessary outpatient services.

- In Louisiana an Administrative Law Judge (ALJ) upheld the imposition of \$44,000 in civil monetary penalties against a pharmacist who had been convicted on 22 counts of Medicaid fraud.

Although we undertook a record number of administrative sanctions and civil monetary penalty actions in the last year, we are concerned that certain costly or abusive practices are beyond our ability to control because of loopholes in our legal authorities. For example:

LEGISLATION TO IMPROVE SANCTION AUTHORITIES

- In 1984, 255 physicians had their licenses to practice medicine revoked, and several hundred others had lesser sanctions imposed by State medical licensing boards. Yet, these physicians are free to cross State lines to another State where they hold a license, to continue to participate in Medicare and Medicaid. We currently lack the authority to prevent this practice.
- We frequently learn of instances of health care providers who are convicted of (1) fraud against private health insurers, (2) abuse of private health insurance patients, and (3) controlled substance violations. Under current authority we are powerless to bar these providers from participating in the Medicare and Medicaid programs.

To address these problems, and others, in the last year we continued our strong support of legislation currently pending before the Congress to close these loopholes. The legislation is outlined in Appendix A.

Management Implications Reports (MIRs) identify systemic problems observed during an investigation and are referred for analysis and corrective action. During this period, we submitted 31 MIRs related to health care. One such MIR pointed out that setting an arbitrary cap on payments for lift chairs and accepting "fill-in-the-blank" medical authorizations permitted fraud and abuse of Medicare payments for the chairs. We recommended that HCFA establish a formula for computing fair mark-up, and require physicians to justify on their own letterhead the medical necessity for a lift chair.

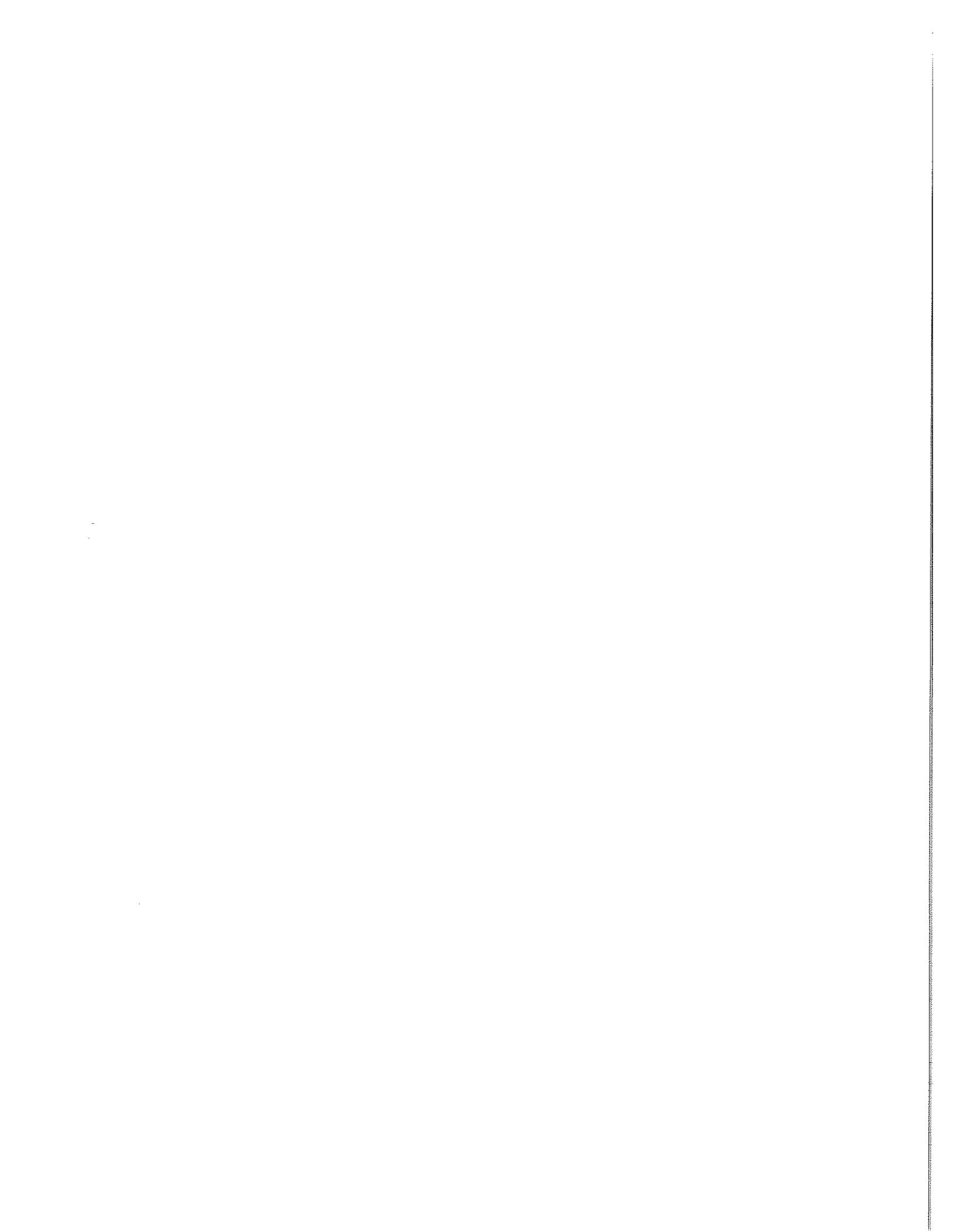
MANAGEMENT IMPLICATIONS REPORTS

Fraud Alerts are another investigative fraud prevention tool used by the OIG. These are distinctive one-page fliers, sent to Federal offices, carriers and intermediaries to warn them of practices or procedures which should be initiated or eliminated to prevent potential fraud. Twenty health care Fraud Alerts were issued during this period. In one case, an OIG Fraud Alert warned HCFA field offices of a multi-state advertising

FRAUD ALERTS

"blitz" being conducted by a Midwestern durable medical equipment company. It described the false-representation characteristics of the campaign and the resulting Medicare program abuse, and warned the field offices to be alert to similar schemes in their own regions.

SOCIAL SECURITY ADMINISTRATION



CHAPTER III

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) administers the Old-Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs. It also has the Federal responsibility for the State-operated Aid to Families with Dependent Children (AFDC), Low-Income Home Energy Assistance (LIHEA), U.S. Repatriate, and Refugee Resettlement (RR) programs. Additionally, Part B of the Black Lung program continues to be administered by SSA.

Currently, some 37 million people are receiving \$188 billion in OASDI benefits. SSI and AFDC payments (Federal share) of about \$16 billion will be paid to approximately 15 million recipients in 1985. This year SSA celebrated its 50th anniversary with OASDI now operating on a sound financial basis. Income to the OASDI trust funds exceeded expenditures by more than \$6 billion in fiscal year 1985. Total FY 1985 outlays for Social Security programs were \$212.6 billion.

To help ensure trust fund integrity, OIG reviews focused on conserving fund resources, minimizing unfavorable fund transfers and maximizing debt collection. SSA continues to respond favorably to OIG reports and recommendations. Specifically, in FY 1985, SSA concurred with OIG recommendations resulting in savings of \$312.1 million. During this reporting period, we identified a number of areas where legislative reforms and tightened fiscal controls could result in trust funds and program savings of \$181.3 million annually. In addition, financial adjustments totaling \$5.8 million were recommended. Investigations of SSA cases resulted in 431 convictions and \$25 million in financial recoveries and savings.

This chapter is divided into: (1) program administration, (2) electronic data processing, (3) legislative reforms, (4) legal and administrative sanctions of wrongdoers, and (5) ongoing reviews.

Program Administration

During this 6-month period, OIG reviews identified several areas where improved accounting practices and adherence to collection procedures could increase trust funds receipts by \$108.2 million.

In addition, another \$5.8 million in program expenditures by State agencies were questioned as to their allowability under law or regulations. In these instances, recommendations called for financial adjustments and appropriate procedural changes designed to prevent their recurrence.

DEBT COLLECTION

As of January 31, 1984, SSA's Recovery of Overpayments, Accounting and Reporting (ROAR) master file listed 505,000 legally defined OASDI (Title II) overpayments valued at \$207 million where collection actions had been terminated. If benefits are subsequently resumed, SSA is required to pursue recovery action, generally through offset of current benefits. We found that SSA recovery procedures were not always followed nor were adequate measures taken to collect \$19.7 million in overpayments:

- About \$13.4 million can be recovered from re-entitled Title II beneficiaries currently receiving benefits but who are liable for past overpayments where collection action had been terminated. Further, we estimate that \$1.3 million annually in additional future recoveries could result if such beneficiaries were identified at the time of re-entitlement to benefits. Such amounts remain uncollected because SSA recovery procedures were not always followed.
- Collection of Title II overpayments is relatively difficult when overpaid individuals are no longer receiving benefits. Therefore, before terminating collection action, SSA is required to redirect its efforts to other persons receiving benefits on the same earnings records, such as survivors of the primary wage earner. Overpayments of about \$6.3 million remain uncollected because SSA did not take adequate measures to collect from these other beneficiaries.

We recommended that SSA enforce compliance with its recovery procedures and take action to collect overpayments in the situations identified.

The Social Security Act requires Title II beneficiaries to report earned income above an exempt amount in order to avoid overpayment of benefits. SSA's earnings enforcement operation identifies unreported or underreported earned income by matching beneficiary earnings reports to the annual W-2 wage data filed by employers. The most recent earnings enforcement operation using 1983 wage data, identified 257,762 potential overpayment cases amounting to an estimated \$150 million.

EARNINGS ENFORCEMENT

A recent OIG review found that overpayments were not being identified and collected as soon as they could be. SSA now waits until virtually all earnings items have been posted to individuals' earnings records before performing the earnings enforcement operation. This procedure takes about 7 months from the time the first cycle of earnings data is posted until the posting of the last cycle. Over a 5-year period SSA could earn an additional \$31.4 million in trust funds interest on overpayment recoveries by performing the enforcement comparison on completion of each posting cycle. In addition, our review disclosed that SSA had not included all wage data in the 1983 enforcement operation, and, as a result, failed to identify as much as \$9.2 million in overpayments.

Our recommendations call for SSA to immediately perform a supplemental enforcement operation on unused 1983 wage data to identify additional overpayments for collection; and perform future earnings enforcement operations several times during the process as employer wage data becomes available.

Under the Refugee Act of 1980, child welfare services are to be provided to unaccompanied refugee/entrant children in accordance with a State's child welfare standards. An OIG review found that one State categorized all refugee children as "special needs" thus providing greater foster care payments. Our review of a representative sample of case files of refugees/entrants receiving foster care showed that none of the children met the State's special needs criteria and that no additional services were provided. Contrary to the State's criteria, SSA's Office of Refugee Resettlement (ORR) officials approved the State's classification. We estimate that \$900,000 was claimed for such cases during FY 1983.

REFUGEE/ ENTRANT PROGRAM

Recommendations call for ORR to stop reimbursing the State for payments made "across the board" to refugee/entrant children.

The Railroad Retirement Act provides for financial interchange between the Social Security system and the Railroad Retirement system. The pur-

RRB/SSA TRANSFERS

pose of the interchange is to place the Social Security trust funds in the same position they would have been if railroad employment had been covered under the Social Security Act.

Further, Public Law 93-445 provides that persons eligible for benefits under both the Railroad Retirement Act and the Social Security Act receive a combined benefit payment from the Railroad Retirement Board (RRB). SSA must transfer funds from the Social Security trust funds to the railroad retirement system to cover the Social Security portion of the combined benefit check. The amount to be transferred is determined by RRB.

OIG has been reviewing several aspects of the RRB and SSA fund transfers. Following are highlights of two of these reviews:

- In reviewing SSA's determination of the rate of return on trust fund investments for transfer purposes, we noted that capital gains and losses were excluded. For example, a capital loss in 1982 of \$319 million on SSA trust fund investments was not considered in the FY 1983 transfer. If the loss had been applied, the amount transferred to RRB would have been reduced by \$26 million. We recommended that SSA reexamine its policies and procedures in this area.
- In the instance of combined benefit payments, RRB is to notify SSA of any adjustments for checks cancelled because of death of the beneficiary or other reasons, and transfer the monies back to SSA's trust funds. However, OIG found that RRB did not transfer about \$6.5 million owed to SSA's trust funds for SSA's share of cancelled checks for the 40-month period ended February 1985. RRB agreed and immediately took action to transfer the funds. By not receiving the funds when due, SSA's trust funds lost almost \$1.5 million in interest. Recommendations call for both SSA and RRB to initiate controls to prevent recurrence.

**ENERGY
ASSISTANCE**

The Home Energy Assistance Act of 1980 authorized grants to States to provide assistance to eligible households to offset rising energy costs that were excessive in relation to household income. Our reviews in three States disclosed unallowable charges totaling \$3.3 million. The bulk of the unallowable charges involved overpayments to eligible households and charges for administrative costs unrelated to the energy assistance program. Financial adjustments totaling \$3.3 million were recommended.

The OIG recently completed a review of a segment of the SSA's Title XVI payments. The purpose of our review was to determine the extent of fraud or other payment errors that might be indicated by the use of recently issued Social Security numbers to obtain SSI payments. The premise for this review was that there would be few legitimate reasons for an adult, U.S. born individual to obtain a Social Security number (SSN) shortly before or concurrent with an application for SSI payments.

ABUSE OF SSNs

It was anticipated that the risk of payment errors in these cases would be high and our study bore out these expectations. We found high incidences of identity problems, ranging from the absence of documentary evidence to the initiation of payments under fictitious identities. Thus, the opportunity for errors resulting from the misidentification of recipients was high.

We recommended that SSA cross-refer multiple SSNs detected in this study, clarify evidence requirements regarding proof of U.S. citizenship, and systematically monitor SSI claims under SSN's issued within 2 years of an SSI application.

SSA has agreed with these recommendations and is taking steps to implement them.

The OIG conducted a review to determine the rate of unverified SSNs contained in the records maintained by States for use in their administration of the AFDC program. The SSN is a critical element in the States' efforts to enforce the income and resource requirements of the AFDC and other needs based programs. However, since the SSN is furnished by the recipient, its reliability as a unique personal identifier is uncertain because it is subject to intentional and accidental misstatements, transpositions and faulty transcriptions.

AFDC RECIPIENTS

More than 23,000 SSNs from AFDC records in the 50 States, the District of Columbia, Puerto Rico and the Virgin Islands Territory were processed through the SSA/SSN verification process. This process indicated that 4,271, or 18 percent of the SSNs could not be verified as belonging to AFDC recipients.

Determining the rate of unverified SSNs in the AFDC program was the first step of a two-part effort. The second part of the study, which will begin in early FY 1986, will focus on determining how many unverified SSNs are invalid and establishing the monetary effect of those invalid SSNs on the AFDC program.

Electronic Data Processing

Virtually every payment made by SSA is triggered by a computer transaction. With 16 large-scale computers, over 900 tape and disk drives, 3,800 telecommunication terminals and 6,500 software programs, SSA operates one of the largest complexes in the country. The OIG is reviewing, on a continuing basis, selected SSA system development projects, included in its Systems Modernization Plan (SMP).

SYSTEMS MODERNIZATION PLAN

We view SSA's software overhaul as the most critical long range system problem. Our systems reviews focus on software improvements with the objective of ensuring that future software will have adequate internal controls and be maintainable, and thus flexible to SSA's changing needs. Our ongoing reviews to date have focused on two critical activities.

First, the SMP called for improvement of software prior to its incorporation into new modernized systems. This effort was delayed, and as a result it is now questionable whether the improvements called for will be completed in time for the new systems being developed.

Secondly, we are reviewing the development of SSA's new Title II claims processing system. This system is one of the two largest, most complex of SSA's systems and is critical to the overall success of the SMP. The first phase of development is the automation of the initial claims input process. SSA plans to put in place, by 1987 a 20,000 terminal network which will allow automated claims-taking in 1,500 offices with concurrent access to major SSA data files. OIG has recently completed a review of SSA's prototype of this system and will be issuing a report in late 1985 focusing on system maintainability, internal controls, and documentation.

PENSION OFFSET

The Social Security Act provides for the offset of some spouse and surviving spouse Social Security benefits for individuals who are also receiving a pension based on employment not covered under Social Security. We performed a computer match to determine if Government pensions are being properly offset against Social Security benefits. In 250 of 861 cases sampled, Social Security beneficiaries were being placed in payment status without their pensions being offset. Applying review results to the universe of Federal pensioners on Social Security rolls as of September 30, 1984, we estimate that recoveries to the trust funds of \$6.1 million could be made in the first year with a possible cost

avoidance of \$40.8 million over the lifetimes of these annuitants.

SSA generally agreed with our recommendations and is taking corrective action.

Legislative Reforms

An OIG review during this reporting period identified an area where legislative changes could result in annual savings of some \$73.1 million.

The AFDC and SSI programs are designed to provide needy individuals with cash assistance to ensure that their basic needs are met. An OIG review noted, however, that where family members residing in the same household receive payments under both AFDC and SSI, neither program considers the economies of shared living arrangements when determining the grant award. As a result, the combined cash assistance provided to a joint AFDC/SSI family can exceed that of two separate AFDC households.

SHARED LIVING ARRANGEMENTS

We used SSA data to determine the savings potential by including SSI beneficiaries in the budget unit for determining the AFDC grant award. This sample data included only households where the SSI recipient was either a parent or child. The results of our review indicate that Federal savings of \$73.1 million would accrue annually if SSI recipients and benefits were considered when determining the AFDC grant amount.

We recommend that SSA seek a legislative change that would recognize the economics of shared living arrangements between SSI and AFDC recipients. We noted that SSA has proposed legislation to include SSI recipients in the AFDC household. This language is similar to our recommended action. The proposal is under consideration within the Department.

Legal and Administrative Sanctions of Wrongdoers

Diversion of Social Security benefits from their intended purposes is of particular concern because the wrongdoers, sometimes in collusion with Department employees, are stealing funds desperately needed by the

very young, widowed, disabled and geriatric beneficiaries these programs were designed to help. Investigations of Social Security cases during the second half of the year resulted in 386 convictions and \$25 million in investigative recoveries and savings. For FY 1985, we obtained 854 convictions as compared with 722 in FY 1984. In FY 1985, we also obtained \$35.5 million in investigative recoveries and savings as compared with \$27.7 million in FY 1984.

DEATH MATCHES Screening and following up on SSA "hits" in matches of beneficiary rolls against death records have become part of our routine investigative work. The following items are examples of the cases resulting from these matches:

- A Massachusetts man was sentenced to 6 months in prison for converting his deceased wife's Social Security checks for 8 years. He forged checks amounting to almost \$31,000.
- A California woman pocketed her grandfather's benefits after he died in 1979. She was found guilty of obtaining \$25,000 illegally and ordered to make full restitution.
- In an ongoing death match in California, four persons were sentenced for violations amounting to more than \$63,000. One woman, a representative payee for her mother, did not report her mother's death to SSA. She had been cashing her mother's checks illegally since 1975.

MASS JUDICIAL ACTIONS Prosecutors have found that grouping their indictments and releasing them together gets the media attention needed for successful prosecution and deterrent effect. During this fiscal year, we obtained 16 mass judicial actions involving 245 persons.

INTERNATIONAL SSA FRAUD Project INTERFACE (International Fraud Analysis and Claims Evaluation) was established to investigate fraud in Social Security programs which occurred outside the jurisdiction of the United States. Under this project, suspicious claims from SSA are evaluated for possible fraud implications, further investigation and potential disposition. Thus far, we have realized recoveries of more than \$1 million from this project.

AFDC STATES BENEFITS PROJECT The AFDC program is primarily funded by the Department's Office of Family Assistance but is administered and partially funded by the States. When local agencies suspect that welfare recipients are concealing Social Security benefits, we obtain and authenticate records such as

cancelled checks and other original documentation necessary for prosecution. We also provide witnesses and other assistance in the prosecution of these cases. During this period, the AFDC States Benefits Project accounted for 148 convictions as compared to 104 in the preceding 6 months, and \$2.8 million in fines, restitutions and civil recoveries. A total of 513 convictions and \$4.9 million have been obtained since 1982.

In Project Payback we work with SSA to identify and screen instances of incorrect payments to beneficiaries to determine those which involve suspected fraud but which do not meet prosecution criteria. We then send letters demanding return of the incorrect payment in language to motivate a refund, identifying the office to which the refund should be sent. During this period, our office issued demand letters for recoveries of about \$5.5 million, for a total of \$6.9 million for the year.

PROJECT PAYBACK

A growing number of investigative cases focus on fraudulent identification schemes, of which the following are examples:

FALSE IDENTIFICATION

- Four members of an Omaha family and a friend pled guilty to obtaining \$23,000 illegally from SSA by cashing checks made payable to a dead man. When the father of the family died in 1983, the family used a fictitious name on a death certificate and did not report his death.
- A California man was convicted for Government theft and mail fraud after assuming the identity of his deceased stepfather. More than \$19,000 was deposited to the deceased stepfather's bank account in Hawaii, which the man converted to his own use.

False identification cases frequently involve Social Security cards and numbers, and require cooperative efforts with other agencies because of the variety of authorities and schemes involved. The following cases indicate the value of Social Security cards, the lengths to which people will go to obtain them and the ease with which they can be sold.

- Two self-styled revolutionaries were each sentenced in New Jersey to 58 years imprisonment on charges that included possession of 10,250 blank counterfeit Social Security cards. They were also charged with possession of identification cards for specific personnel from the FBI, the U.S. Drug Enforcement Administration, the New Jersey State Police, the New York City Police and the Orange County New York Deputy Sheriff's office.

- A Colorado man was sentenced to 4 years in prison for using numerous false Social Security numbers in order to obtain fraudulent credit and financial transactions.
- A Texas woman was convicted of selling counterfeit Social Security cards after it was discovered that she had contracted with a Houston printing company to print 1,000 blank Social Security cards. She intended to sell the cards at a flea market.
- A man in Texas used different identities and SSNs to defraud MasterCard and Visa accounts for amounts in excess of \$16,000. He obtained fraudulent bank loans for an additional \$15,000.

**CALIFORNIA
KICKBACK
PROJECT**

Our California Kickback Project was the result of one case which involved a county welfare supervisor who had developed a scam which may have involved more than 150 persons. Former AFDC recipients agreed to allow their SSNs to be used to reactivate welfare payments. The scam is believed to have cost Federal and State agencies more than \$1.2 million. To date, 112 persons have been found guilty. All have received prison sentences. Restitutions stemming from this case during this period amounted to more than \$87,000, for a total of nearly \$600,000 thus far.

ILLEGAL ALIENS

Also related to SSN misuse are projects and cases involving illegal aliens. The following actions are examples of some of our cases involving illegal aliens during this reporting period:

- A New York couple was indicted for selling bogus documents to illegal aliens. After selling the documents, they accompanied the illegal aliens to Social Security offices and assisted them in obtaining Social Security cards.
- In New Jersey, five illegal aliens were convicted of using false Social Security numbers to gain employment and to obtain unemployment insurance and labor union benefits at Atlantic City casinos.
- A former employee of the Illinois Bureau of Employment Security was sentenced to 4 years in prison for providing false SSNs to illegal aliens who used them to obtain unemployment benefits.

Occasionally an SSA employee finds access to the system too tempting an opportunity to resist. Below are examples of SSA employee fraud cases:

SSA EMPLOYEE FRAUD

- Two long-time Mississippi SSA employees pocketed \$143,000 from the agency through a computer fraud scheme by falsifying numerous documents. They were convicted, fined and ordered to repay the Government through sales of a South Carolina farm, two Florida condominiums and \$21,000 in mutual funds and stocks.
- A former New Hampshire SSA District Manager was found guilty of falsifying his earnings in order to make himself eligible for Title II benefits. He filed applications for benefits knowing that his eligibility was dependent on his false claims of self-employment as an antique dealer.

Disability benefit fraud cases are a significant part of the OIG investigative work load. These cases often involve widely disparate and seemingly unlikely persons:

DISABILITY BENEFIT FRAUD

- A St. Louis public school teacher pled guilty to obtaining disability benefits amounting to \$10,000 at the same time he was teaching aerobic dancing.
- A husband and wife were sentenced to 6 years imprisonment after pleading guilty to obtaining over \$61,000 in disability benefits and food stamps. They concealed ownership of a used-car dealership.
- A self-employed contractor in New York pled guilty to making false statements to SSA about his work activity and income tax evasion. He was sentenced to prison and ordered to make restitution of the \$44,000 received in fraudulent disability payments.

During this period, 35 Management Implication Reports (MIRs) were prepared on SSA cases. Two of them resulted in an SSA Fraud Alert and a Notice of Program Vulnerability issued to SSA. These issuances were based on evidence of similar program weaknesses observed by agents in two different regions in the course of their investigations. Their efforts resulted in corrective actions taken by SSA to prevent employees from circumventing existing HHS and SSA time and attendance procedures.

MIRS AND FRAUD ALERTS

Ongoing Reviews

OIG has a number of reviews underway in the Social Security area focusing on ways to maximize collections of trust funds overpayments and minimize inappropriate trust funds outlays.

Following are highlights of several of these reviews:

SSA OVERPAYMENTS

SSA maintains a computerized system to control the recovery of Title II overpayments from initial identification to final recovery. Overpayment information is entered on this system either automatically through a computerized interface with SSA's Master Beneficiary Record (MBR), or manually through SSA employee intervention. OIG's review showed that this system does not contain and, therefore, control all beneficiary overpayments that are included on the MBR. We identified about 126,000 overpayments totaling \$72 million that were on the MBR but were not on the control system. Our review indicates that about \$57 million of these overpayments are collectible but that aggressive recovery action has not been taken. We provided SSA with a complete listing of the 126,000 overpayments so recovery actions could begin immediately. Our review is continuing.

INCARCERATED FELONS

Public Law 98-21 requires that Title II benefits be suspended to individuals that are incarcerated because of a felony conviction. Ongoing OIG reviews have identified two situations where the requirement—or intent—of the law was not being met.

- We identified instances in six States where incarcerated felons in county jails were receiving Title II benefits. This occurred because county officials were unaware of P.L. 98-21 requirements and SSA had no procedures in place for periodically obtaining data on county felons. OIG has alerted SSA to this situation and will recommend that SSA implement procedures for regularly obtaining felon data from county officials.
- We also found another population of offenders currently receiving Title II benefits. These offenders had been tried in court and determined to have committed a felony, but were declared not guilty by reason of insanity. They are confined to State mental institutions and costs related to confinement are the State's responsibility. However, Title II benefits of over \$10 million annually were paid to these offenders.

- The underlying justification for excluding incarcerated felons from certain Social Security Act benefits is that incarcerated persons who committed felony crimes should not qualify for Federal benefits. Many offenders found not guilty by reason of insanity have committed felonies and are similarly confined. Therefore, it appears that the same justification for denying benefits to incarcerated felons would apply to these offenders as well. OIG is considering recommending that SSA propose a legislative change to suspend Social Security benefits to this category of offenders.

State governments are required to deposit employee Social Security contributions with the Federal Reserve Bank based on prescribed deposit schedules. Generally, contributions not received by the due date are considered delinquent and interest is to be assessed and paid on these contributions.

SOCIAL SECURITY CONTRIBUTIONS

We alerted SSA that about \$5.7 million of interest had not been assessed or collected on delinquent contributions deposited to the trust funds in 1982, 1983 and 1984. In addition, the trust funds could have earned about \$1.1 million of imputed interest if assessments and collections had been made timely.

Recommendations will be made for correction of these problems.

In 1974, SSA began issuing Social Security cards to legal aliens who requested them for non-work purposes. Over 1.2 million nonwork Social Security numbers (SSNs) were issued from 1974 through 1982. According to SSA's records 545,000 of these nonwork SSNs may have been used illegally for work purposes since 1974. Aliens who illegally work, can earn Social Security credits for this illegal employment. The Social Security Act has no provisions to prohibit payment of benefits once insured status is attained even though the alien can be deported for working "illegally."

ALIENS WORKING ILLEGALLY

Our analysis of SSA records disclosed that as of December 1984, an average annual benefit of \$5,688 was paid to aliens in benefit status based on illegal employment. In addition, these aliens deprive employment from some of the most disadvantaged of the American labor force. By 1986, we estimate the trust funds will be paying more than \$17.1 million a year in benefits to an estimated 2,846 aliens who worked illegally. The major impact on the trust funds will be felt later, however, when the large number of aliens now in the 21-40 age group reach retirement age.

By the year 2026, over 155,000 aliens who worked illegally will be eligible for benefits totaling more than \$3 billion annually.

We have alerted SSA that legislation is necessary to stop benefits being paid to persons who worked illegally.

GRANTS AND INTERNAL SYSTEMS



CHAPTER IV

GRANTS AND INTERNAL SYSTEMS

Grants and internal systems (GIS) reviews are made of programs of the Public Health Service (PHS) and the Office of Human Development Services (OHDS) as well as of the Office of the Secretary (OS) which covers overall activities of departmental management. FY 1985 funding in these areas approximated \$8.9 billion for PHS, \$6.0 billion for OHDS and \$224 million for OS. Total GIS outlays for FY 1985 were \$15.1 billion. Each of these departmental entities comprising GIS have consistently cooperated in support of the OIG mission and goals.

OIG continues to identify those program areas where funds could be more efficiently spent as well as pinpointing and recommending correction of system deficiencies that give rise to fraud, waste, and abuse. We have identified several opportunities for eliminating overlapping activities, effecting productivity improvements, tightening controls over cash disbursements and collections, and for effecting other system changes to improve management efficiency and ensure financial integrity. Also, we are assisting in the Department's upgrade of its internal control systems.

Continuing OIG attention is being paid to cash management, debt collection, audit resolution, procurement administration and other activities crosscutting organizational lines. Activities also involve participating in Government-wide projects sponsored by such groups as the President's Council on Integrity and Efficiency (PCIE) and Reform '88.

From April 1, 1985 through September 30, 1985, we identified opportunities for cost savings of \$324.9 million through increased efficiency in program operations and management. In addition, we recommended disallowances of \$31.0 million of costs claimed by grantees. Investigations resulted in 43 convictions and savings and recoveries of about \$100,000.

Public Health Service

In FY 1985, PHS will spend an estimated \$8.9 billion on biomedical research, disease prevention, the safety and efficacy of drugs and other medical products being marketed as well as other activities to generally promote better health for Americans. During the reporting period, our reviews surfaced opportunities to achieve more efficient use of program funds with resultant annual savings of \$8.8 million and identified questionable program expenditures by grantees of \$5.8 million.

COMMUNITY HEALTH CENTERS

Under Section 330 of the Public Health Service Act, grants are awarded to assist in developing and operating both urban and rural Community Health Centers (CHCs) which provide health services to medically underserved populations. These grants are intended to supplement the revenue received from patients, insurance programs, and other assistance programs.

An OIG review of such grants in one region found that patient revenue could have increased an estimated \$648,000 by: (1) eliminating inappropriate fee discounts, (2) ensuring CHC fees are established that more adequately recover actual costs, and (3) requiring all CHCs to bill patients for Medicare deductibles and coinsurance. If these conditions are occurring to the same extent nationwide, PHS supported CHCs could be losing an estimated \$8.8 million per year in patient revenue.

Appropriate recommendations were made to PHS to correct the deficiencies noted. PHS agreed to take the necessary corrective action.

IHS SCHOLARSHIP PROGRAMS

The Indian Health Care Improvement Act authorized the Indian Health Service (IHS) to conduct three interrelated scholarship programs to train the health professions personnel necessary to staff IHS health programs and other health programs serving the Indian people. The three programs provide health professions preparatory scholarships, pre-graduate education assistance, and health professions scholarships, respectively.

One of these programs differs from the others in that recipients must sign an agreement with IHS to serve 1 year of service for each year of scholarship award but not less than 2 years of service. The service would be in either the IHS, an urban Indian organization receiving IHS assistance or certain health manpower shortage areas.

OIG reviewed IHS's internal controls for administering these three scholarship programs. Our review disclosed weaknesses in the administration of all three programs. IHS did not: (1) follow established procedures for processing scholarship applications, (2) establish adequate rating instructions for determining student eligibility, and (3) document key events in the award review and funding process.

With regard to section 104 scholarships, we found that IHS did not institute adequate procedures, controls and reporting requirements to promptly identify and follow up on individuals who breached their scholarship agreements. Accordingly, collection action was delayed in 316 cases involving \$4.9 million where individuals breached their scholarship agreements. Decisions were not made for another 151 cases involving \$2.3 million on whether the Government would waive collection. Some of these requests dated back to as early as 1980.

PHS concurred with our recommendations to implement and tighten internal controls in the several areas of weakness disclosed by our review.

OIG found that the National Institutes of Health (NIH) is unnecessarily holding 47 pounds of pure gold in excess of its immediate or known needs. Although the gold was used in experiments in the 1950's, it was regarded as an expendable element and was not recorded on the property records until August 1980. At that time, the gold was deemed unneeded, but was held on the possibility of future research needs. These needs have yet to arise. The market value of the gold has decreased from \$347,000 in 1980 to approximately \$179,000 in 1983.

UNNECESSARY RETENTION OF GOLD

Our recommendation called for NIH to take immediate action to declare the gold excess and turn it over to the General Services Administration for safeguarding and disposition. NIH concurred with our recommendation.

Under the Health Education Assistance Loan (HEAL) program, the Federal Government currently incurs 100 percent of the financial risk of borrower default. Results of an OIG review indicate that if 10 percent lender risk sharing were implemented, the majority of HEAL lenders would continue their participation in the program. This action would reduce the Federal financial burden by 10 percent in instances of default while maintaining the number of institutions willing to make loans at 70 percent of the 1984 level.

HEAL PROGRAM

HEAL insures loans made by nonfederal lenders to students of eligible health profession schools. Most students may borrow up to \$20,000 per year, up to a maximum of \$80,000 for all years. Interest is computed at the prevailing market rate and accrues while the borrower is in school. Repayment begins 9 months after graduation but may be deferred up to 4 years for students in internship or residency training. If a borrower defaults, the lender is reimbursed the full amount of principal and interest from the Student Loan Insurance Fund (SLIF), which is comprised of insurance premiums deducted from the loan principal at the time the loan is awarded.

HEAL was intended to operate without a Federal subsidy. However, indicators are that the rising default rate could result in a need for Congress to appropriate \$100 million over the next 5 years. This review found that sharing the financial risk of default with lenders, strengthening lenders' authority to deny or reduce the size of loans, requiring counseling of prospective student borrowers, and increasing flexibility in loan collection procedures, could significantly reduce the default rate and contribute to the continued solvency of the SLIF.

Office of Human Development Services

During FY 1985, OHDS will spend an estimated \$6.0 billion to provide a variety of social services to American children, youth and families, older Americans, Native Americans and the Nation's disabled. During this reporting period, OIG identified potential program savings of \$1.1 million and questionable costs of \$5.7 million.

HEAD START The Head Start program provides comprehensive support services and early childhood development services for poor children up to age 5. In FY 1985, up to one-half million children will be provided day care services, nutrition, education, health-related services and other social services costing an estimated \$1 billion.

During this period, we evaluated and issued 531 reports by nonfederal auditors concerning Head Start grantee operations. The reports recommended financial adjustments of \$3.0 million in costs charged to the program. These reports also cited over 576 deficiencies in grants administration such as problems with accounting internal controls and record-keeping practices.

The OIG found that the Single Audit Act of 1984 could significantly reduce the number of individual annual Head Start audits currently required. The Act, which became effective for fiscal years beginning after December 31, 1984, requires that every State or local government obtain—preferably annually but at least every 2 years—independent, organization-wide audits of their operations, including Head Start grantees organized under local governments.

HEAD START SINGLE AUDIT

To determine the potential impact of the Single Audit Act on audit costs of Head Start programs, we surveyed Head Start operations in four regions and identified 146 grantees, about 27 percent, that were organized under local governments and therefore subject to the Act. From a sample of these grantees, we determined that single audit coverage would cut audit costs in half to about \$3,100 per audit. Projecting our results nationally, as many as 1,825 individual Head Start audits could be replaced by lower cost single audits over the next 5 years at a net savings of about \$5.7 million.

We recommended that OHDS formally advise their regional and Headquarters administrators of the change in audit requirements and to be alert to any duplicate audit efforts. OHDS concurred with our recommendation and plans to formally notify regional and Headquarters staff of the change in audit requirements and to develop procedures and policies designed to avoid duplicate single and individual audit efforts and costs.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) was enacted in an attempt to come to grips with the long-standing problem of children entering and remaining in the foster care system. The major thrust of this Act was to strengthen policies and practices in order to reduce both the number of children in foster care and the duration of foster care placements. Data now coming available indicate that P.L. 96-272 objectives are being met: the number of children in foster care and the duration of placement for children has decreased. However, this same data reflects vast differences in the short-term durations of placement among States. Our study looked for discernible differences in State child welfare policies and practices and/or information reporting systems that would explain the differences.

FOSTER CARE CHILD ABUSE

We found that how States respond to investigating reports of abuse has a direct bearing on the foster care entry rates—nationwide the numbers of reports of child abuse and neglect has increased. Differences in State

foster care entry rates are primarily a reflection of differences in State child welfare service policies and practices and are not indicative of differences in quality of foster care programs.

We recommended that OHDS assist States in dealing with the increasing numbers of child abuse and neglect reports that result in unnecessary short-term out of home placements by determining what screening and investigation techniques and practices each State has used successfully and provide this information to all States as a technical assistance document. Also, to enhance the value of foster care data currently collected for national and State users, we recommended that OHDS encourage establishment of some minimal number of data categories where interstate comparability is possible.

FOSTER CARE

Under Foster Care, Federal financial participation (FFP) is available to States for costs incurred in providing care and maintenance to eligible foster care children and for administrative costs. Our reviews of three State Foster Care programs disclosed unallowable costs of \$1.2 million. The bulk of the unallowable costs involved: \$761,000 for improper social services and other costs, \$271,000 in overclaims, and \$212,000 for payments to ineligible facilities and for ineligible children.

In addition to the financial adjustments, we recommended that the State agencies establish necessary controls and procedures to ensure correct financial reporting.

Departmental Management

The Office of the Secretary will spend an estimated \$224 million in FY 1985 to provide overall direction for departmental activities and to provide common services such as accounting to departmental operating divisions. Reviews during this period resulted in recommendations for ways to strengthen debt management activities, audit resolutions, cash management and nonfederal audits.

INDIRECT COSTS— UNIVERSITIES

Indirect costs overhead are those incurred for common or joint objectives and therefore cannot be identified readily with a particular activity. Each year an increasing share of funds appropriated by Congress for research at universities and colleges is being used to finance indirect costs (overhead) rather than being used in laboratories for direct scien-

tific research. We estimate that from 1978 through 1984, annual payments to universities and colleges for indirect costs increased from about \$900 million to \$1.7 billion or to about 46 percent of the \$3.7 billion provided for direct research in 1984.

OIG recently completed a study of indirect costs charged by 13 of the top 100 research universities. We identified opportunities to contain such costs and make at least \$315 million available annually, or about \$1.6 billion over a 5-year period, to meet other budgetary needs of the Government, including the financing of thousands of research projects already approved on technical merit but going unfunded because of budgetary constraints.

While we found that most indirect cost increases were reasonable and appropriate, those relating to "departmental administration" were not. Payments relating to this indirect cost category (which consists of costs for administrative and support services such as salaries and expenses of academic deans, department heads and faculty) increased from \$275 million in FY 1978 to \$575 million in FY 1984—or to an amount equivalent to 15.4 percent of the direct cost of scientific research. Over half of the FY 1984 payments, or \$315 million, for department administration did not appear to benefit Government sponsored research. The payments and related costs benefited, and should have been allocated to, the major university functions of instruction and other institutional activities.

The results of our study are now being evaluated by the Department and the Office of Science Technology Policy.

OIG reviews of indirect costs allocated by State agencies to Federal programs identified that \$11.6 million were unallowable. The bulk of these costs related to inaccurate and unsupported statistical data and classification errors in the States' cost allocation plan. Recommendations call for the elimination of these costs from the States' allocations.

INDIRECT COSTS— STATES

Our review was conducted to determine to what extent the Federal Government is losing money by not mandating maximum use of interest-bearing accounts by nonprofit grantees in PHS and OHDS. The review determined the actual amount of Federal grant funds kept in bank accounts (regardless of draw down frequency), the portion earning interest, and the interest reported and returned.

NONCOLLECTED INTEREST

In a review of a randomly selected sample of 585 grantees, from a total of about 4,000, we found that 80 percent did not earn interest on Federal funds kept in banks, 16 percent earn interest but do not report or return any to the Federal Government; and only 4 percent earn and return interest.

The statistically documented amount of Federal funds lost by these non-profit grantees who fail to collect or return interest is \$4.3 million per year. However, this amount may be significantly higher due to bank deregulation in 1986, when banks may competitively pay more than 5.25 percent interest. About 80 percent of these same nonprofit grantees are also losing an additional \$8 million per year in interest on nonfederal funds kept in non-interest bearing accounts.

We recommended changing departmental regulations (45 CFR 74) and OMB Circular A-110 to require all grantees not statutorially exempt to maintain Federal funds in bank accounts which pay interest. As a result, HHS is sending letters to its grantees encouraging them to place their funds in interest-bearing accounts. In addition, the report of this study has been sent to the President's Council on Integrity and Efficiency suggesting that this issue be reviewed Government-wide.

INTERNAL CONTROLS

The Federal Manager's Financial Integrity Act (FMFIA) (P.L. 97-255) requires Federal agency heads to establish a continuous process for the evaluation and improvement of the internal administrative and accounting control systems and to publicly account for the status of their internal control and accounting systems.

In the 1985 review cycle, the Department's OPDIVs and STAFFDIVs are concentrating their efforts on: (1) refinement of the segmentation of programs and functions into about 9,000 assessable units; (2) training staff in carrying out responsibilities of the FMFIA; (3) conducting vulnerability assessments to determine the degree of risk of waste, loss or unauthorized use of resources, errors in reports and information, and illegal acts or misappropriations. Major goals of the vulnerability process are to identify areas most susceptible to management problems, direct resources to identifying and correcting the most significant problems first and prioritize the scheduling of detailed internal control reviews. Reviews cover such areas as cash management, procurement and purchasing, grants administration, records systems, property management and the budget process.

The OIG is continuing to monitor the Department's progress and provide technical assistance as needed. In this year's cycle, OIG is conducting about 250 reviews to determine the adequacy of the segmentation decisions, vulnerability assessments and internal control reviews performed by Department managers. The results of our work will be sent to the Secretary for use in preparing the required FMFIA annual report to the President and the Congress. In addition, our ongoing reviews of major control systems, such as HCFA's benefits payment system, will supplement the work of the Department in satisfying the requirements of the FMFIA.

In response to congressional requests, OIG performed reviews of:

SPECIAL REVIEWS

- Travel by the Immediate Office of the Secretary (IOS)—We examined 567 travel claims submitted between January 1983 and March 1985 by IOS staff—the Secretary, the Under Secretary and their personal staffs. The claims were generally in compliance with travel regulations except for the absence of specific statements of purpose and justification supporting travel authorized under blanket travel orders. Acceptable justifications were reconstructed from other information.
- Use of Consultants by FDA—We reviewed the hiring of an individual as a special Government employee (SGE) and the subsequent award of three purchase orders to a consulting firm owned by the SGE. We found that FDA officials did not adequately document that (1) the services received from the SGE were commensurate with the expenses claimed and paid, and (2) required contracting procedures were followed when awarding the sole source contracts to the firm owned by the SGE.

For the 6-month period ended June 30, 1985, debt due the Department increased \$152 million, collections increased \$264 million and write-offs of accounts receivables increased \$57 million. Much of the increase in collections is due to payments on receivables HCFA had established, as prompted by debt collection initiatives recommended by OIG. (See summary on page 58.)

DEBT MANAGEMENT

The OIG monitors the Department's debt collection activities on a cyclical basis. During this 6-month period, we examined SSA and PHS collection activities. We also assessed action taken in resolving prior problems in reporting debts in accordance with requirements of OMB, Treasury and the Department.

- SSA: Since our last review, SSA has shown continuing progress in improving debt collection practices and preventing overpayments to beneficiaries. The implementation of their Annual Earnings Test (AET) debt prevention initiative is now complete. AET identifies Title II beneficiaries whose income exceeds a certain exempt amount. SSA estimates the program will prevent \$201 million in overpayments in FY 1985.

SSA has undertaken special studies to identify the various causes of Title II overpayments. These studies are expected to lead to development of cost-effective proposals for preventing the occurrence of large portions of such overpayments.

In addition, our recent reviews identified three areas involving about \$92 million in overpayments where aggressive SSA action is needed. Details of these reviews can be found on pages 32, 33, and 42.

- PHS: Since our last review, PHS has shown continuing progress in improving its debt collection practice. Errors still exist in subsidiary ledger entries for loans receivable for the Health Professions Student Loan and Nursing Student Loan programs. Ledger reconciliation has begun, but a target completion date of September 30, 1985 was delayed because of the moratorium on financial systems development until such time as the Department's new accounting system becomes operational.

We also noted that PHS, because of accounting errors, had overstated accounts receivables for the Health Maintenance Organization program by \$2.6 million. Action has been initiated to correct this problem.

**NONFEDERAL
AUDIT
ACTIVITY**

The single audit approach provides for basic audit coverage through increased emphasis and reliance on independent audits (performed by CPA firms, and State auditors). These audits assist the OIG in carrying out its audit mandate by seeing that HHS program objectives are achieved at thousands of recipient entities and that related expenditures are reasonable. OIG directs, monitors, evaluates and expands (as required) all facets of outside audit reviews. This, in effect, creates an audit network that provides extensive audit coverage at the recipient level.

The contribution of single audits to our work has more than doubled

quantitatively and qualitatively. The number of single audit reports received, evaluated and issued grew from 208 in FY 1983 to 459 through the first 10 months of FY 1985. The number of reports with findings increased over 200 percent. The significance and sophistication of the findings grew even more: questioned costs climbed from \$900,000 in FY 1983 to \$2.6 million through the first 10 months of FY 1985 and the number of opportunities identified to improve the efficiency of grantees' management systems increased from 286 to 656. To a large measure these improvements are attributable to the increasing emphasis OIG has placed on integrating single audits into its operations.

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

AUDIT RESOLUTION

Reports with Questioned Costs

	<u>Total</u>	<u>Over 6- months old</u>
Unresolved audits, March 31, 1985	203	6
Unresolved audits, September 30, 1985	287	5 ¹
	<u>Number</u>	
Reports issued during period	381	
Reports resolved during period	297	
	<u>Amount (in Millions)</u>	
Costs questioned during period	\$202.2	
Costs sustained during period	\$232.7 ²	

¹ These reports are with the following operating divisions for resolution:

	<u>PHS</u>	<u>OHDS</u>	<u>OS</u>	<u>OCS</u>	<u>Total</u>
Reports	2	1	1	1	5 ³
Monetary Finding	\$585,618	\$175,000	\$205,800	\$110,088	\$1,076,506

² Subject to reduction as a result of appeal and/or uncollectibility.

³ Does not include 2 ICF/MR reports which cannot be resolved pending resolution of court case.

Summary of Receivables, Collections and Write-Offs

(In Millions)

	Receivables as of		Collections for Six Months Ended		Write-offs for Six Months Ended	
	12/31/84	6/30/85	12/31/84	6/30/85	12/31/84	6/30/85
Audit Disallowances	\$ 206 ¹	\$ 207	\$ 34	\$ 49	\$—	\$ 1
Owed by Public ²	<u>3,402</u>	<u>3,553</u>	<u>639</u>	<u>888</u>	<u>77</u>	<u>133</u>
Total ³	\$3,608	\$3,760	\$673	\$937	\$77	\$134

Notes: ¹ Debts due to recommended audit disallowances which have been sustained by the program as of 12/31/84.

² Includes amounts other than audit-recommended disallowances such as health professions and nursing student loans, hospital and health maintenance organization facility construction loans, and overpayments to SSA beneficiaries.

³ HHS has receivables due from other Federal agencies and certain funds due from employees. Our comments do not deal with these amounts.

Investigative Activities

Allegations of contractor, grantee and employee misconduct are most often referred to the cognizant program administrator for appropriate management resolution because they generally are management problems. Criminal cases, however, are within the purview of our investigative responsibility. During this reporting period, 43 convictions were obtained, raising the total for the year to 76 convictions and \$800,000 in monetary results. The following cases are examples of investigative activities in this area:

- The former financial director of an Indian Health Service clinic and a friend were charged with embezzling nearly \$113,000 in Federal funds. The friend pled guilty and is cooperating with the Government in the investigation against the former director. (9-84-00293)
- In Texas, the program director of seven day care centers was found guilty of instructing the staff to forge parents' signatures and falsify information on attendance verification forms. The resulting fraudulent claims cost the State Department of Human Resources \$10,000. (6-85-00261)
- Also in Texas, a program director and a contract specialist for the Department of Human Resources, and their wives, were convicted of making false statements and conspiracy. The two couples devised a scheme to sell meat products illegally to day care centers which contracted with the Department for services. (6-85-00260)
- In California, the former executive director of a health education center associated with a university used about \$400,000 in Federal funds to buy land and a collection of 50 1950-model cars. As the center's executive director from 1981 to April 1985, he wrote checks to himself and others to make the illegal purchases. He pled guilty to the charges, but the investigation is continuing to determine whether other persons or additional funds were involved.



LEGISLATIVE AND REGULATORY REVIEW



CHAPTER V

LEGISLATIVE AND REGULATORY REVIEW

The Office of Inspector General places a high priority on preventing fraud, abuse, and waste in HHS programs by reviewing legislative and regulatory changes before they are implemented. These legislative and regulatory changes govern the future operations of HHS programs and have a major impact on whether there is vulnerability to waste or misuse of funds. Our review focuses on changes to promote economic and efficient program operations and controls that prevent and detect fraud and abuse. Without this preventive review, deficiencies in new and revised programs might remain undetected until audits and other studies disclose that funds have been wasted or misspent.

PREVENTION

During the period from April 1985 to September 1985, we reviewed 278 HHS regulatory and legislative change proposals. This included 114 from the Health Care Financing Administration, 67 from the Social Security Administration, 73 from the Public Health Service, and 24 from the Office of Human Development Services and other parts of HHS.

The most significant regulation that we reviewed during this period was the FY 1986 update of the Medicare regulations on prospective reimbursement for inpatient hospital services. This regulation governs \$45 billion in Medicare payments. Our review focused on the need to re-adjust payments to take into account the overstatement of costs that resulted from setting rates on unaudited cost reports and the need to reflect certain other cost escalating factors. OIG recommendations resulted in added safeguards to assure verification of information used for special payments for residents and interns. Other recommended changes were made to clarify actions the Department will take in case of fraud and abuse of Medicare payments. The OIG will continue to review the implementation of the prospective payment system and make recommendations for future regulatory changes based on problems identified by our review.

MEDICARE HOSPITAL PAYMENTS

The OIG prepared proposed regulations to implement the statutory penalties imposed by the Deficit Reduction Act of 1984 on physicians who violate the freeze on physician fees charged to Medicare benefici-

MEDICARE PHYSICIAN FEE FREEZE

aries. The statute requires that sanctions consisting of civil monetary penalties and assessment and/or exclusion from Medicare be imposed on physicians who violate the fee freeze. The regulation proposes to use existing sanction procedures to impose sanctions. The proposed regulations were issued by HHS on September 13, 1985. We will consider public comments prior to developing a final rule.

**HEALTH
EDUCATION
LOANS**

Another major OIG focus was review of regulatory and legislative requirements of student loan programs operated by the Public Health Service (PHS) to assure that loans are made prudently and that lenders use effective methods to collect from defaulters. The PHS has proposed changes to strengthen regulatory requirements in the Health Education Assistance Loan (HEAL), Nursing Student Loan (NSL), and Health Professions Student Loan (HPSL) based on our audit activity. During this semi-annual period we continued to work with PHS to further enhance the requirements for preventing unnecessary borrowing, verifying borrower eligibility and identification, limiting forbearance in loan collection to cases of legitimate financial need, upgrading collection practices in such areas as use of credit reporting agencies and skip tracing, and providing adequate warning of penalties for fraud and clear directions for follow-up on suspected fraud. The OIG has also worked with HHS and PHS to develop proposals to strengthen the statutory requirement for managing debt collection in PHS loan programs. Review on their regulations and legislation continues.

**VERIFICATION
OF INCOME
AND ELIGIBILITY**

We also continued our efforts to assure that regulations being developed jointly by this Department and the Departments of Agriculture and Labor would effectively implement the income and eligibility verification requirements of the Deficit Reduction Act of 1984. These rules will be a major advance in efficient methods of cross-checking data from several sources to decrease overpayments and payments to ineligible persons in Medicaid, Aid to Families with Dependent Children as well as Food Stamps. It will also assist in pinpointing cases of potential fraud.

DISABILITY

The major SSA regulatory priority during this semiannual period was development of regulations to implement the Disability Reform Amendments of 1984. These rules are intended to assure a fair decision making process for determining eligibility for disability benefits under Social Security. Our recommendations helped to assure that physicians who have lost their medical license or who have been excluded from Medicare or Medicaid for fraud or abuse or poor quality care will not be used as medical consultants in making disability determinations.

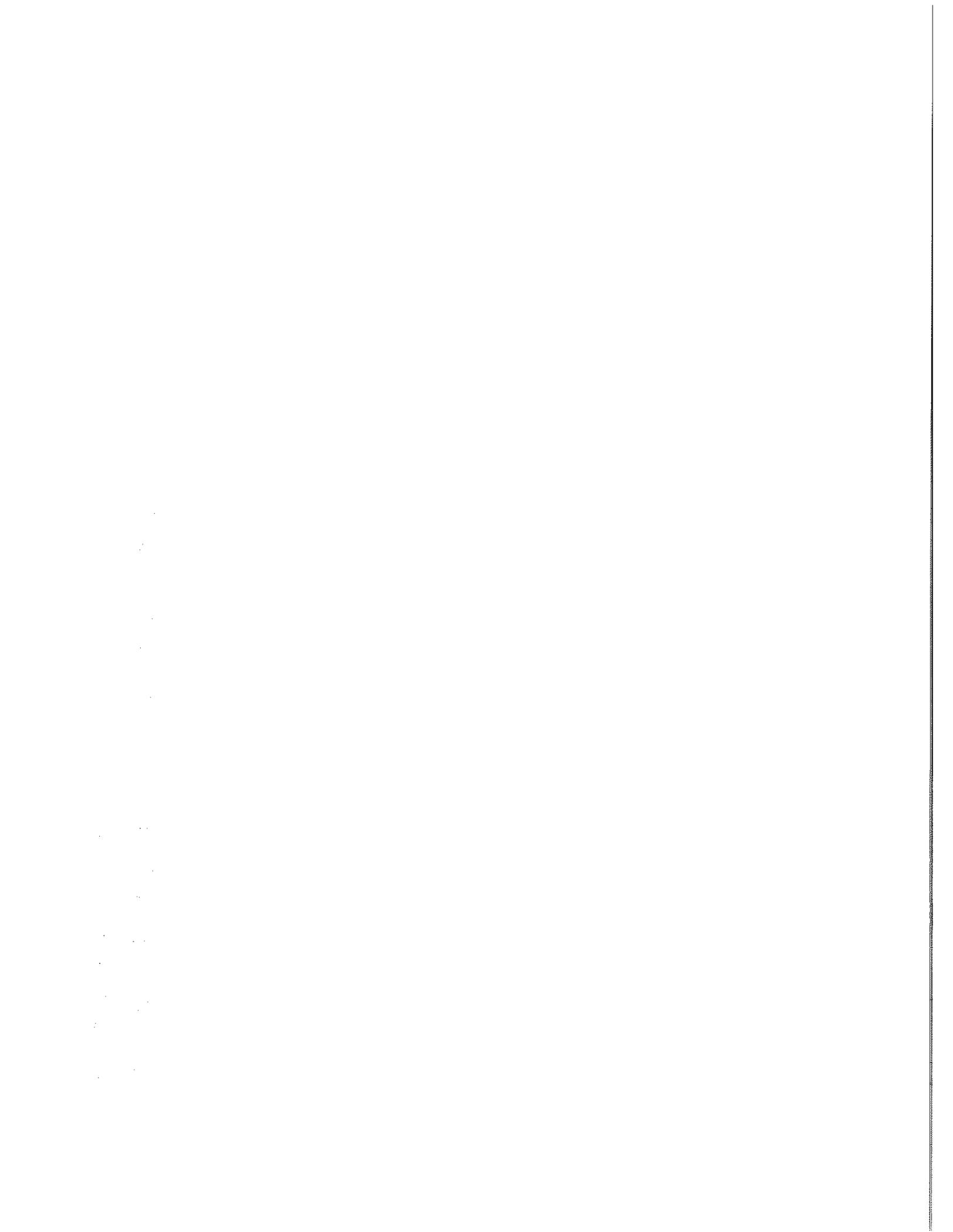
In addition to review of proposed changes in regulations and legislation, we also recommend changes in existing regulations to safeguard HHS programs. These recommendations are transmitted to HHS' operating divisions in audits, inspections and other reports. OIG legislative recommendations of this kind that have not been enacted are summarized in Appendix A of this report.

**EXISTING
REGULATIONS AND
LEGISLATION**

The OIG administers the HHS authority to sanction health care suppliers and providers for defrauding or abusing the Medicare or Medicaid programs. There are two types of sanctions: (1) civil money penalties and (2) exclusion from Medicare and Medicaid. We have developed a number of proposals to strengthen both sanction authorities. These proposals are included in Medicare and Medicaid Fraud and Abuse Amendments introduced recently in the Senate as S. 1323. Similar legislative changes have been included in H.R. 1868 and S. 837. These proposals are described in Appendix A of this report. In addition, the success of our sanctioning and civil monetary penalties programs have become the model for S. 1134, a Government-wide civil monetary penalties program. In June of this year, the Inspector General testified in favor of this legislation before the Senate Governmental Affairs Committee.

**MEDICARE/
MEDICAID
SANCTIONS**

**PRESIDENT'S COUNCIL ON INTEGRITY
AND EFFICIENCY**



CHAPTER VI

PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

President Reagan established the President's Council on Integrity and Efficiency (PCIE) in March 1981 to coordinate Government-wide activities which attack waste and fraud in Government and to improve managerial processes. In addition to strengthening the role of the Inspectors General in performing audits and investigations to identify the sources of waste and fraud, the PCIE has focused on cooperative interagency activities which enhance the Federal Government's overall ability to combat fraud, abuse and waste.

Final rules to implement section 2651 of the Deficit Reduction Act (DEFRA) of 1984 are about to be published by HHS, USDA and DOL. The regulations will implement requirements for State agencies that administer the Unemployment Compensation, Food Stamp, AFDC, Medicaid and Adult Assistance programs to develop an income and eligibility verification system that meets certain statutory requirements. These require States, in their eligibility determinations to:

INCOME AND ELIGIBILITY

- Obtain SSNs on all applicants and recipients and use SSNs to match records.
- Obtain and use wage information. All States must have a wage reporting mechanism in place by September 1986.
- Obtain and use unemployment compensation benefits.
- Obtain and use IRS unearned income data.
- Obtain and use SSA benefit data, e.g., Beneficiary and Earning Data Exchange System (BENDEX) and State data exchange (SDX).
- Use standardized formats and procedures to facilitate data exchanges. The final formats and procedures developed by the HHS/OIG will be used by State agencies.

These income and eligibility verification provisions are based on the work of the PCIE Long Term Computer Matching Project, co-chaired by

the HHS/OIG. The Congressional Budget Office estimates that these provisions will save \$1 billion over 5 years.

**BENDEX EARNING
DATA**

An OIG review of the Beneficiary and Earning Data Exchange System (BENDEX) provided the Social Security Administration with an "early warning" of issues and problems associated with the operation of the system.

This study was particularly appropriate given the recent passage of the Deficit Reduction Act of 1984 (DEFRA) which provides for States' use of BENDEX information (both the benefits and earnings portions) in making more timely eligibility and benefit determination decisions under the Aid to Families with Dependent Children (AFDC), Medicaid and Food Stamp programs.

Our findings showed that although State expectations of BENDEX appear to be increasing, more emphasis is placed on the computer matches. Local eligibility workers are not using the system because information is seldom made available in a timely fashion to be of any use during the application and eligibility determination process. More use of it is made as a post-certification verification tool. A number of operational problems (SSA and State) continue to constrain BENDEX. These usually concern the timeliness, completeness and/or accuracy of BENDEX data.

Our major recommendation centered around the expansion (to five other States) of SSA's current demonstration in one State which provides for automated query capability for obtaining data from the Master Beneficiary Record. A national system of this kind would result in SSA district office administrative savings of at least \$18.9 million the first full year of operation.

**BENDEX
OPERATIONAL
GUIDE**

An operational guide for State public welfare agencies has been produced by the Office of Inspector General and the Social Security Administration to provide State government managers with practical guidance on using the BENDEX system in a cost-effective manner. It is based on the "experiential wisdom" gained by State agencies and incorporates numerous examples of best practices carried out by these agencies.

The guide is meant to provide State government managers of public welfare programs with practical guidance on how to use the BENDEX system in a cost-effective manner. It views BENDEX from a broad,

systematic perspective and addresses design and operational issues likely to be of most relevance to mid to higher level managers, especially in an agency's central office.

OIG staff interviewed 46 perpetrators of computer-related frauds to determine how and why they committed their crimes and to identify generic vulnerabilities in Government computer systems.

PERPETRATOR INTERVIEWS

An analysis of the interviews indicated that the perpetrators were employees of Federal agencies or State, local, and private agencies administering Federal programs. They held a wide variety of positions; but the more common positions were caseworkers, clericals and data entry technicians. None were hackers or outsiders. Just over one-fifth had a prior criminal record. Typically, the perpetrators committed their crime by manipulating input data to cause funds to be illegally issued, and most were aided by coconspirators. The number of illegal transactions per case ranged from 1 to 200 with a median of 8. The reported average loss per case was \$45,000, but about one-fifth of the cases exceeded \$100,000.

Most perpetrators were aware of computer security controls but assessed them as weak. They described ID numbers and passwords as simplistic, edits and screens as known and therefore avoidable, and supervision as lax or naive regarding automated systems. They pointed out that access to or within computer systems was often not restricted.

The HHS/OIG chairs the Working Group on Technology and Programming of the PCIE Long Term Computer Matching Project 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 working group designed three standardized formats, one for each of the following areas:

STANDARDIZED FORMATS

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

We field tested the formats in 18 States. While these tests were underway, Public Law 98-369, the Deficit Reduction Act of 1984 was passed

and included provisions for the use of Standardized Formats and procedures in the data exchanges required for income and eligibility verification in the AFDC, Food Stamp, Medicaid and Unemployment Compensation programs. The Standardized Formats developed and tested by the HHS/OIG have been submitted to the HHS Secretary to implement these DEFRA requirements.

**FRONT-END
ELIGIBILITY**

The PCIE established the Front-End Eligibility Verification Systems work group in order to stimulate technology transfer among the States and to prevent erroneous benefit payments. To accomplish these goals, the work group identified States' front-end use of computer applications to verify eligibility for AFDC, Food Stamp, Medicaid and Unemployment Compensation. State program officials were surveyed about their front-end verification techniques. As a result, a catalog of State activities was compiled and distributed to State program officials in September 1985.

Results of the survey indicate that State use of computerized front-end verification techniques has grown dramatically in the last 2 years. Two years ago, an OIG study disclosed that only 14 States were using 14 front-end computer applications for eligibility verification. The survey responses submitted by the States for this project indicate a tenfold increase. State submissions also show that front-end verification is usually focused on verifying income data or verifying that an applicant does not receive duplicate benefits.

APPENDIX A

Appendix A

UNENACTED LEGISLATIVE RECOMMENDATIONS

April 1985 Through September 1985

The legislative recommendations listed below under HCFA and SSA have been made in specific OIG audits and other reports and have not been enacted by Congress. (Many of these recommendations were mentioned first in other reports; refer to the cited number or report in locating these items.)

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
Health Care Financing Administration		
<u>Second Surgical Opinion:</u>		
HCFA should seek a legislative change to the Social Security Act requiring Medicaid and Medicare beneficiaries to obtain a second surgical opinion on the need for selected elective surgeries. (First discussed in 10/82-3/83 OIG Semi-annual Report, ACN: 03-30211.)	This matter is currently under consideration by the Department.	\$158/year \$790/ 5 years
<u>Medicare Round Down:</u>		
HCFA should seek authority to round down payments on Medicare Part B claims to the next lower whole dollar. Individual beneficiaries and physicians/suppliers would pay, on the average, only 30¢ more per claim. (First discussed in 4/83-9/83 OIG Semiannual Report, ACN: 03-42006.)	Under consideration within the Department.	\$45/year \$225/ 5 years
<u>Urological and Nutrient Suppliers:</u>		
HCFA should seek legislative change and revise regulations to prohibit suppliers from billing Medicare directly for urological and nutrient supplies, and require that nursing homes include the cost of such products in their per diem rates. (First discussed in 4/83-9/83 OIG Semiannual Report, ACN: 06-42002.)	A legislative change is currently under consideration by the Department.	\$17/year \$85/5 years

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
Health Care Financing Administration (Continued)		
<u>Buy-In:</u>		
HCFA should eliminate the Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare Buy-In program. (First discussed in 10/84-3/85 OIG Semiannual Report, ACN 03-50228.)	The Senate Budget Reduction Committee has included this as part of the deficit reduction package.	\$216/year* \$1,080/ 5 years
<u>Verification of Medicaid Services:</u>		
HCFA should allow States greater flexibility in determining methods used to verify services provided to recipients for which payments are claimed. (OPI-B-003-04)	Draft legislation has been sent to Congress for consideration.	\$3-\$5/year \$15-\$25/ 5 years
Social Security Administration		
<u>Shelter Allowances:</u>		
SSA should seek legislation to require all States to pay AFDC recipients their actual shelter costs up to a maximum amount. Under current law, many recipients reside in subsidized housing and also receive a standard allowance for shelter in their AFDC grant. (This recommendation first discussed in the 1981 OIG Annual Report, ACN: 01-20250.)	SSA does not agree.	\$485/year (Federal and State) \$2,425/ 5 years
<u>Bank Matches:</u>		
SSA should cooperate with HCFA and USDA in seeking legislation to require all States to conduct annual bank matches to detect excess resources belonging to AFDC, Medicaid and Food Stamp recipients where such matches are cost effective. (First discussed in 10/83-3/84 OIG Semiannual Report, ACN: 01-40250.)	SSA plans no action at this time pending results of IRS data used for welfare matching.	\$298 the first year; \$161/year thereafter for a total of \$942 over 5-years

*OMB Estimates

**PROJECTED
SAVINGS
IN
MILLIONS**

OIG RECOMMENDATIONS

PROGRAM POSITION

Social Security Administration (Continued)

Black Lung Student Benefits:

SSA should request Congress to eliminate student benefits under the Black Lung program since there are a number of other programs which provide educational assistance to students. (First discussed in 1/82-9/82 OIG Abbreviated Annual Report, ACN: 13-22702.)

This proposal is now under consideration within the Department. We intend to have it reviewed by an ED, HHS, and DOL task force.

\$10.4/year
\$52/5 years

Deposits of Social Security

Contributions:

Accelerating State and local deposits of Social Security contributions will increase interest income by \$113 million annually and increase trust funds revenues by \$2 billion over a 5-year period. (First discussed in 4/83-9/83 OIG Semi-annual Report, ACN: 13-32601.)

A proposal to require State and local employers to follow the private sector schedule is currently under congressional consideration.

\$408 the first year;
\$547/year thereafter for a total of \$2,596 over a 5-year budget cycle

UNENACTED LEGISLATIVE RECOMMENDATIONS

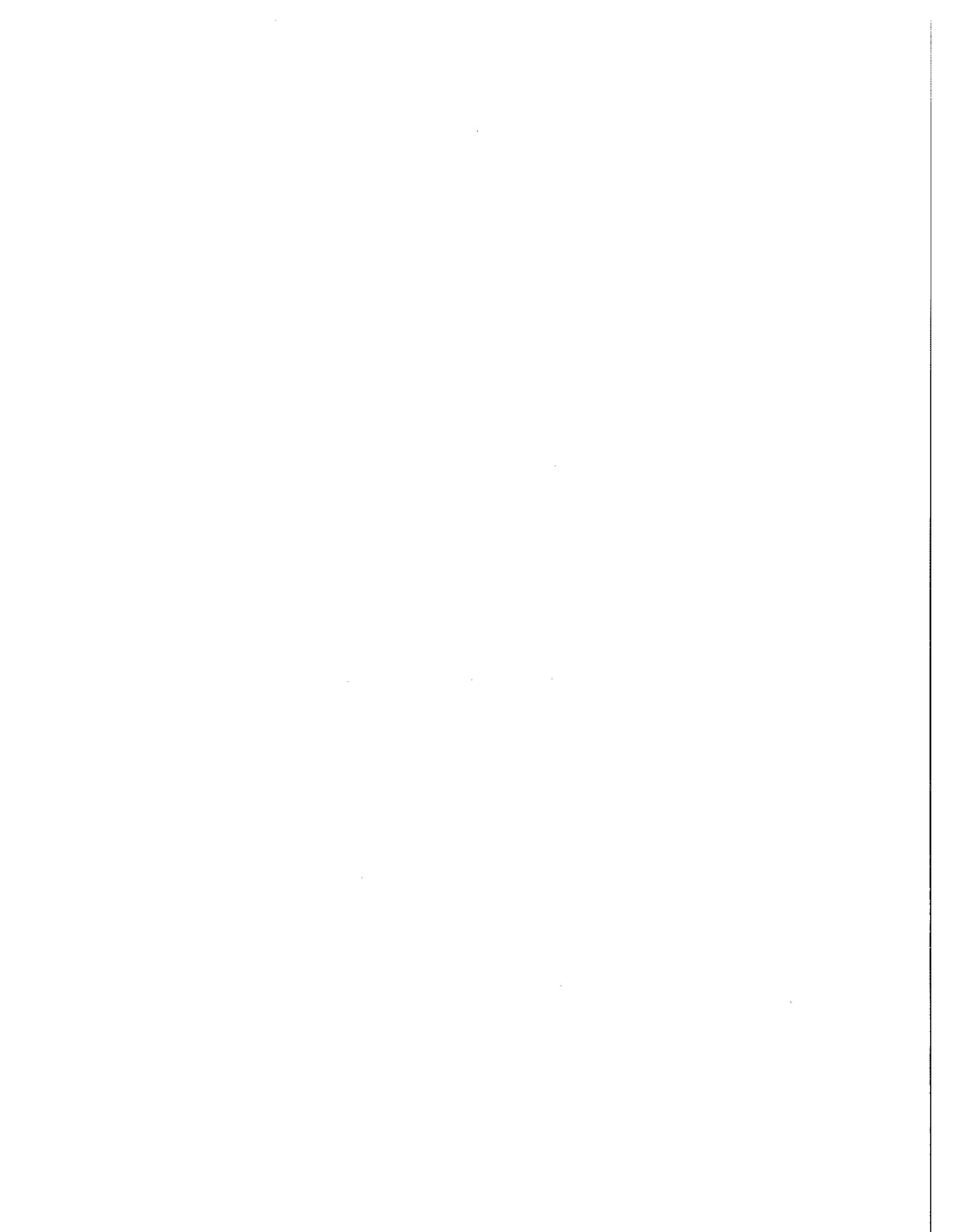
The Office of Inspector General recommendations listed below would strengthen the Inspector General's authority to protect the integrity of the Medicare and Medicaid programs. These proposals are all in the Medicare/Medicaid Fraud and Abuse Amendments (S. 1323). Similar provisions are in H.R. 1868 and S. 837, Medicare/Medicaid Patient and Program Protection Act. No projected savings have been determined.

- Exclude from program participation health professionals who are in default on PHS loans and scholarships.
- Establish a minimum suspension period for persons convicted of Medicare/Medicaid crimes.
- Exclude from program participation those guilty of kickbacks in the Medicare/Medicaid programs.
- Exclude from program participation health professionals who have been sanctioned by State licensing authorities.
- Require the reporting of all final adverse actions made by a State licensing authority.
- Clarify administrative sanctions for circumventing the prospective payment system.
- Sanction those who falsify information on "conditions of participation" applications.
- Exclude based on Peer Review Organization findings of Medicaid violations.
- Exclude from Medicaid/Medicare those who have been sanctioned by other Federal and State health care programs.
- Impose Medicare sanctions on those who have been found to abuse the Medicaid program.

- Exclude from Medicare and Medicaid those convicted of (1) fraud or financial abuse; (2) neglect or abuse of patients; or (3) drug trafficking in connection with the delivery of health care services or with a Federal, State or local program.
- Sanction those who do not grant immediate access to the OIG in the performance of statutory functions.
- Exclude from Medicare/Medicaid those who make false or excessive claims.
- Exclude from Medicare/Medicaid those who furnish excessive or unnecessary services under the Medicaid program.
- Exclude from Medicare/Medicaid those who do not furnish to the Secretary information on subcontractors and wholly-owned suppliers.
- Exclude from Medicare/Medicaid those who do not provide information necessary to verify their claims for payment.
- Exclude from participation entities who fail to make required disclosures that they are owned or controlled by individuals sanctioned under Medicare/Medicaid.
- Exclude providers from participation in Medicaid when a State agency finds good cause.

Civil Monetary Penalties:

- Preserve assets of those suspected of attempting to conceal their assets prior to a Civil Monetary Penalties (CMP) proceeding.
- Increase States' share of CMP awards to encourage State investigation and referral of Medicaid fraud cases.
- Improve the Secretary's authority to impose CMPs through technical amendments.



APPENDIX B

Appendix B

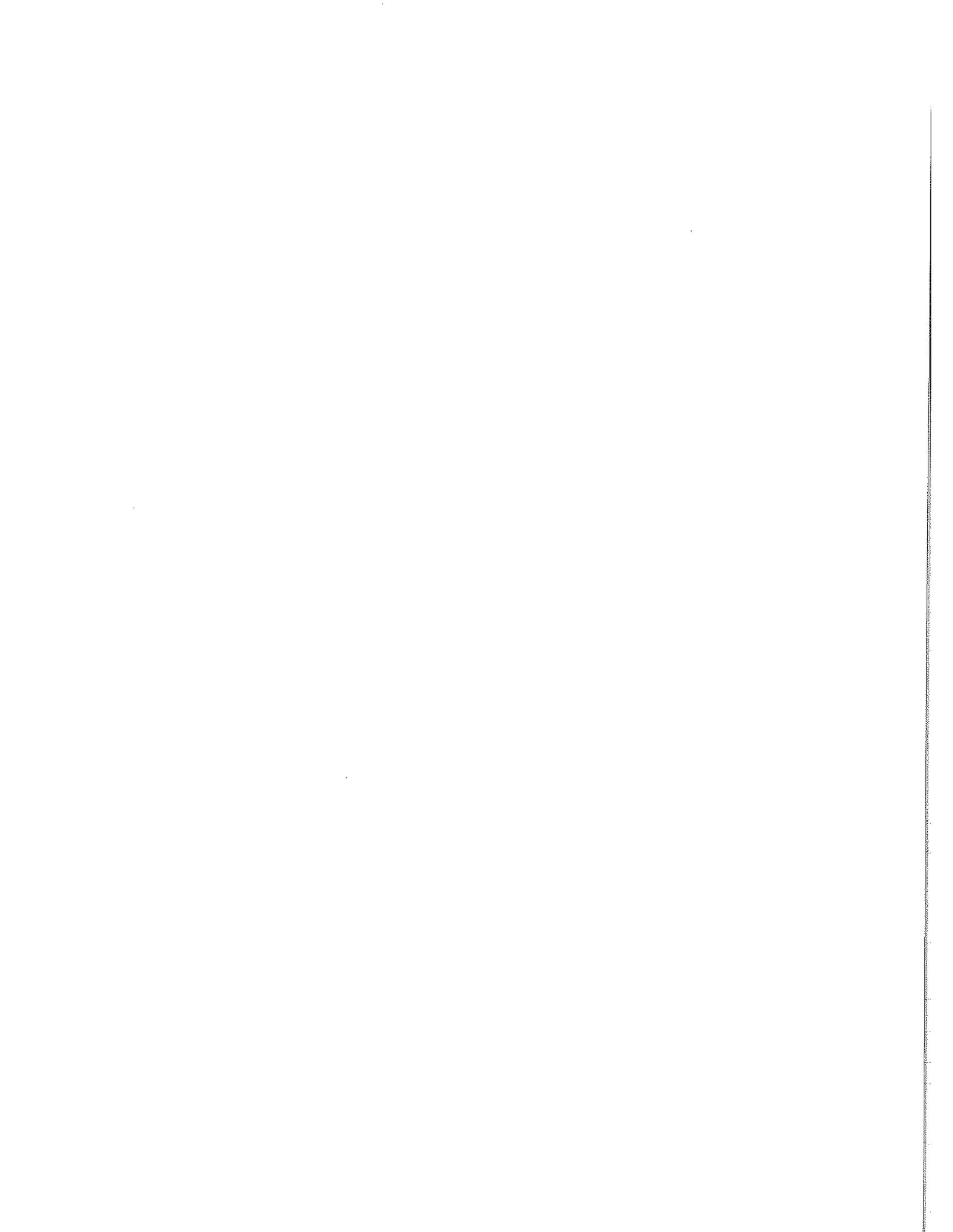
UNENACTED PROGRAM RECOMMENDATIONS

April 1985 Through September 1985

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
Health Care Financing Administration		
<u>Medicare Premiums:</u>		
HCFA should utilize accounting controls to monitor the collection of Medicare's Part A and B insurance premiums billed directly to enrollees. Presently, HCFA cannot account for large amounts of delinquent premium payments. (First discussed in 4/84-9/84 OIG Semiannual Report.)	HCFA agreed with the recommendation and plans to implement it as part of their Reform '88 program.	\$11.8/year \$59/5 years
<u>Housekeeping Services:</u>		
HCFA should take action to strengthen a regulation which permits unallowed billing for housekeeping services not tied to a physician's plan of treatment. (First discussed in OIG 1980 Annual Report.)	HCFA has reviewed the involved regulation, but has not taken action to correct the problem. Alternatives to regulatory revisions are being considered by HCFA.	Undetermined
<u>Pacemaker Monitoring:</u>		
HCFA should reclassify pacemaker monitoring as a lower-paying routine service rather than the current physician-assisted service, and should require less frequent telephone monitoring of pacemakers. (First discussed in OIG 10/83-3/84 Semiannual Report.)	HCFA has issued guidelines on frequency of phone monitoring, and is still considering the reclassification issue.	Undetermined
<u>Multiple Visits:</u>		
HCFA should reduce reimbursement to physicians who see more than one patient at the same nursing home since the doctor incurs lower costs by combining visits. (First discussed in 10/83-3/84 OIG Semiannual Report.)	HCFA is looking into alternative reimbursement methodologies to address this problem.	\$260/year \$1,300/ 5 years

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
Social Security Administration		
<u>Late Payments to SSA:</u>		
SSA should take the necessary regulatory steps to implement procedures for assessing and collecting interest on late State supplementation payments. Currently, SSA incurs all additional expenses for late receipt of State supplementation contributions. (First discussed in 10/83-3/84 Semiannual Report.)	SSA disagreed on grounds that charging interest would not be cost effective. However, Department of Treasury's cash management staff agrees with the proposal and intends to recommend adoption to departmental management in a forthcoming report.	\$1.3/year, \$6.5/ 5 years
<u>Administrative Finality:</u>		
SSA should change regulations to extend from 2 to 4 years the time limit for correcting SSI payments and collecting overpayments, since SSA cannot validate earnings and recover millions in overpayments in the 2-year time frame. (First discussed in 10/82-3/83 OIG Semiannual Report.)	This matter is now under consideration by the Department.	\$50/year

APPENDIX C



OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
Social Security Administration (Continued)		
Using OIG methodology, review an expanded sample of potential Title II overpayment cases generated by the automated earnings reappraisal operation. (ACN: 13-42619)	SSA extended its review as recommended, identifying net collectible overpayments of \$4.9 million.	\$4.9
Eliminate unnecessary subcontracting by grantees in Cuban/Haitian Entrant Impact Aid program and thereby avoid excessive administrative costs. (ACN: 04-50501)	The Office of Refugee Resettlement has acted to eliminate such unnecessary costs and prevent their recurrence.	\$1.7
Total SSA related issues:		6
Total SSA related dollars:		\$283.6
Office of the Secretary		
Establish procedures to record and bill interest on audit disallowance receivables in accordance with established departmental policy and requirements. (ACN: 12-53221)	The Division of Accounting Operations is taking the necessary steps to record and bill interest in a timely manner.	\$4.9
Eliminate unallowable and overstated costs from two educational institutions' indirect cost rate proposals. (ACNs: 08-57001 and 08-57002)	By adopting OIG recommendations, the Division of Cost Allocation was able to establish indirect costs rates which were more equitable than those proposed.	\$1.2
Assure that States' draw downs of Federal cash be made on the basis of immediate disbursing needs and that any interest earned on the excess cash be returned to the Government. (ACN: 12-53004)	The Department agreed with our recommendations and has taken corrective action.	\$.9
Recover duplicative personnel costs included in one State's Statewide Cost Allocation Plan (SWCAP). (ACN: 06-40450)	Our recommended adjustment will be made in the State's next SWCAP.	\$.4
Total Office of the Secretary related issues:		4
Total Office of the Secretary related dollars:		\$7.4

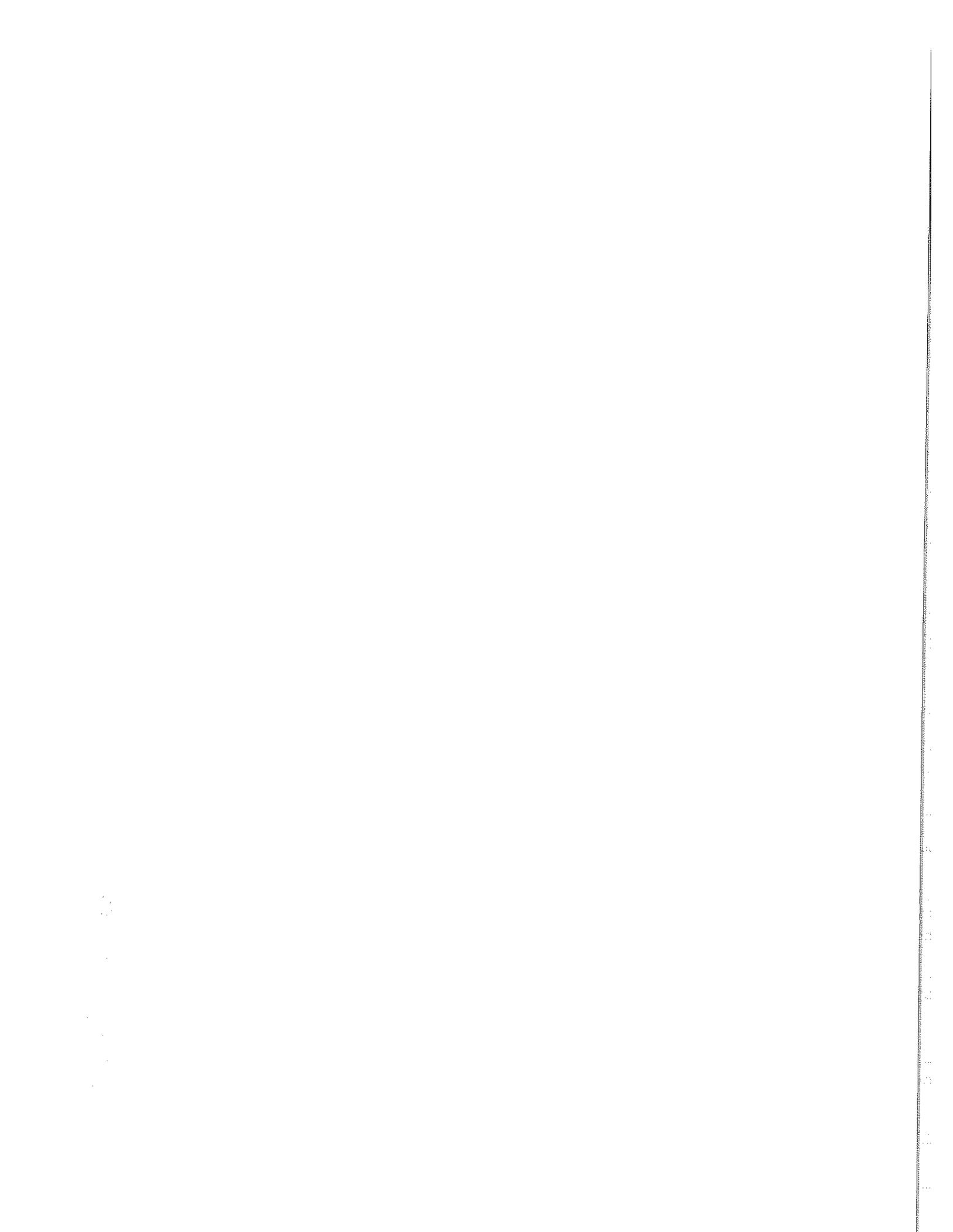
OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
President's Council on Integrity and Efficiency		
The PCIE Computer Matching Project, led by the HHS/OIG recommended specific elements for an income eligibility verification system. Our recommendations are being implemented through Section 2651 of the Deficit Reduction Act of 1984.	Congress adopted our recommendations and included them in Section 2651 of the Deficit Reduction Act of 1984. The dollars shown are derived from Congressional Budget Office estimates for a 5-year budget cycle.	\$1,000.0
Savings resulting from investigations	Actions were taken between 4/85 and 9/85 to implement specific findings of investigations.	\$15.4

**Summary of Savings Related Issues and Dollar Accomplishments
(April 1985 through September 1985)**

Source	Issues	Dollars (in millions)
HCFA	8	\$269.88
SSA	6	283.60
Office of the Secretary	4	7.40
PCIE	1	1,000.00
Savings from Investigations	<u>N/A</u>	<u>15.40</u>
Total Savings	19	\$1,576.28
Agreements to Recover (Including recoveries from investigations)		<u>\$271.30</u>
Appendix C Total	19	\$1,847.58

*NOT
Substantive
in Tables*

APPENDIX D



Appendix D**SUMMARY OF SAVINGS AND RECOVERIES
FY 1985
(IN MILLIONS)**

First Half FY '85	\$3,077.8
Second Half FY '85	<u>1,847.6</u>
Total FY '85	\$4,925.4
Total Cost Savings	\$4,565.8
Total Agreements to Recover (Including recoveries from investigations)	<u>359.6</u>
Total	\$4,925.4

Practitioner—

Individual who possesses a State-issued medical license, e.g., a pharmacist.

PPS—

Prospective payment system, a mechanism whereby hospitals are reimbursed with fixed payments determined in advance according to diagnosis related groups (DRGs).

Provider—

Hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency that has in effect an agreement to participate in Medicare, or a clinic, rehabilitation agency or public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services.

Sanction—

Barring practitioner, provider, or supplier of services from participation in Medicare and Medicaid and/or imposition of a fine.

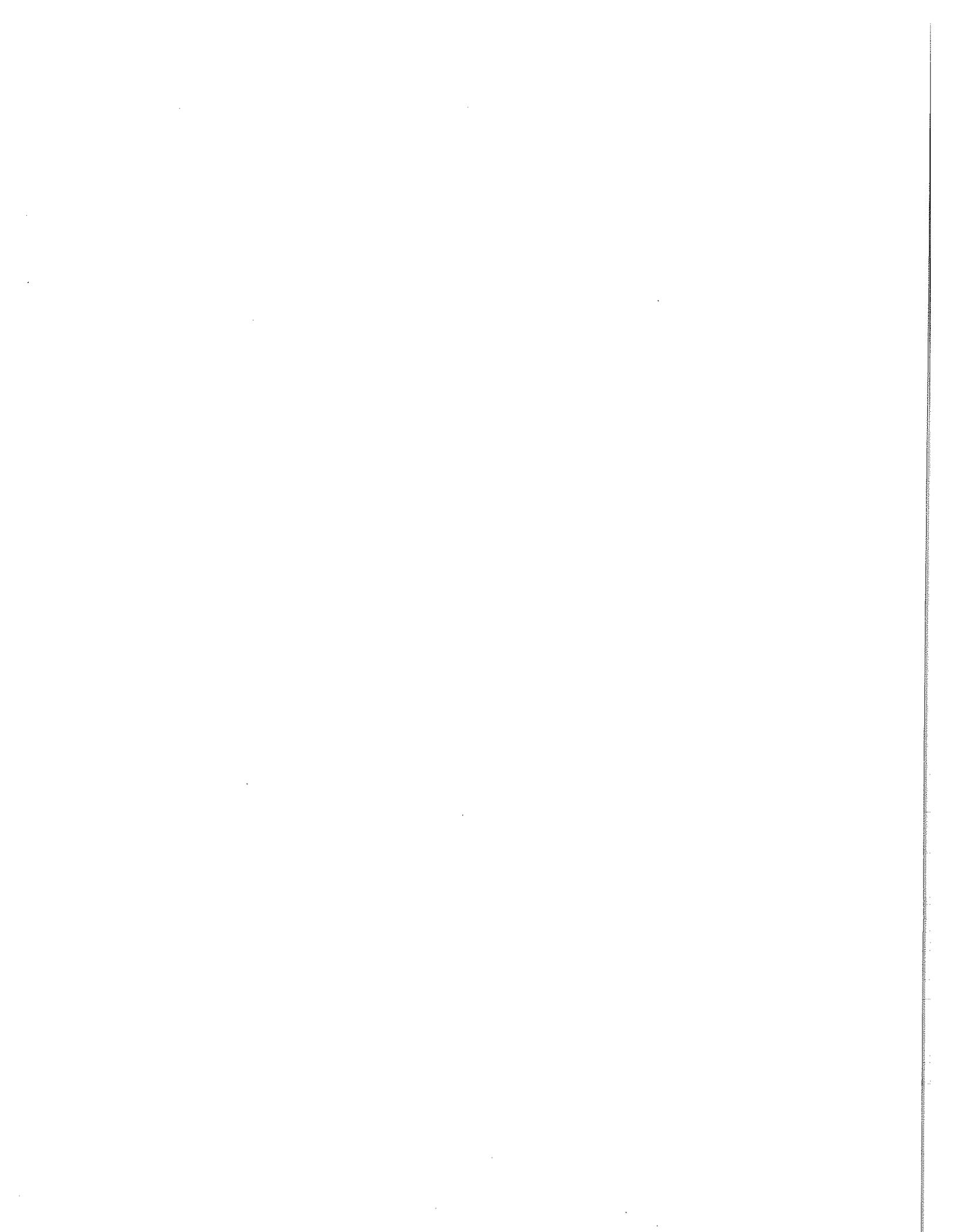
SMFCU—

State Medicaid Fraud Control Units, State-run investigative units for which the OIG has oversight responsibility and which concentrate on Medicaid fraud.

Supplier—

An individual or entity, other than a provider or practitioner, that furnishes health care services and supplies under Medicare, e.g., a durable medical equipment supplier.





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