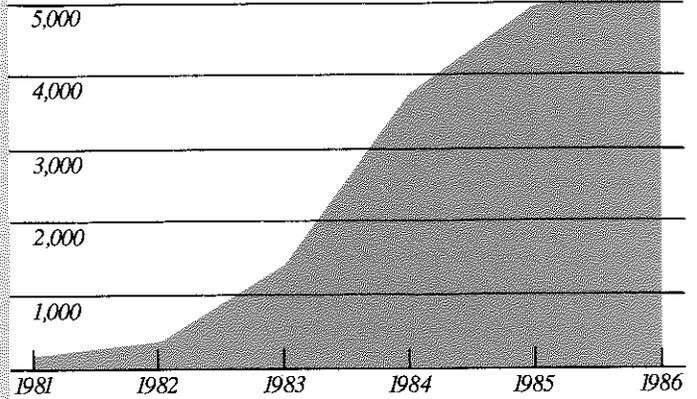




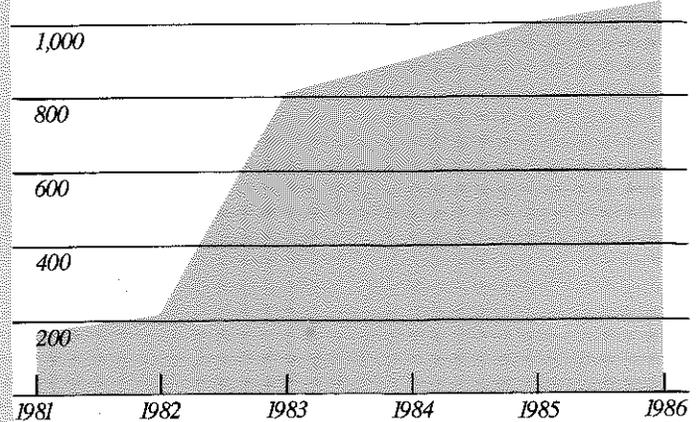
Department of Health and Human Services  
Richard P. Kusserow  
Inspector General

## OFFICE OF INSPECTOR GENERAL

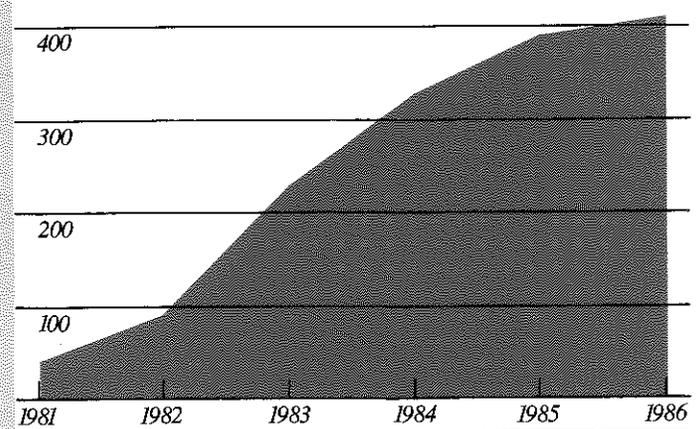
**Savings/Recoveries**  
*(millions of dollars)*



**Successful Judicial Prosecutions**



**Sanctions Effected**

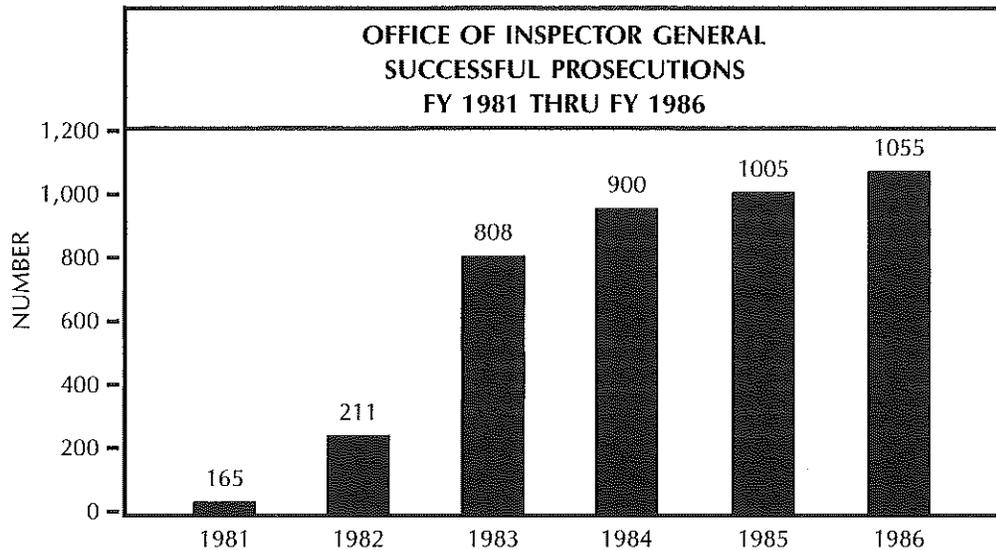


# Semiannual Report to the Congress

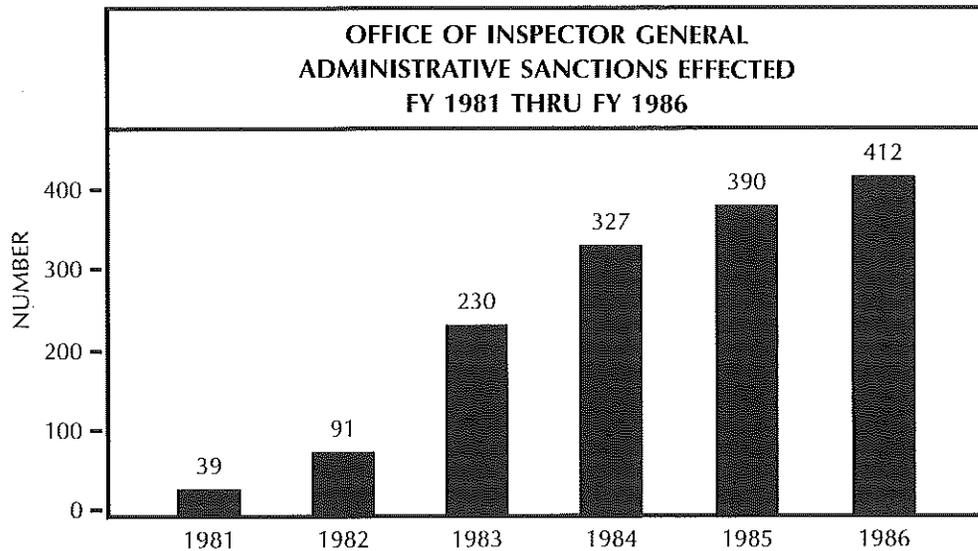
April 1, 1986 —  
September 30, 1986

Dollar results include savings that are attributable to legislative changes predicated on OIG findings. In these instances Congressional Budget Office phase-in estimates are used which are calculated over a full budget cycle. All other savings are annualized savings.

- *Successful Judicial Prosecutions* - Convictions were obtained against 1,055 wrongdoers.



- *Administrative Sanctions* - In addition successful administrative sanctions were imposed against 412 health providers and suppliers who were found to have abused or defrauded the Medicare and Medicaid programs or their beneficiaries and recipients. All sanctioned individuals were either barred from participation and/or financially penalized for their conduct.



For the second 6 months of the fiscal year (April-September), the following is a summary of some of the results including legal and administrative actions, weaknesses identified and actions recommended.

- Successful prosecutions were obtained against 498 wrongdoers with \$29.7 million obtained in related fines, recoveries, settlements and savings.
- Successful criminal and civil prosecutions were obtained against 729 health care providers by OIG and the Medicaid Fraud Control Units under OIG supervision.
- There were 253 HHS regulatory and legislative change proposals reviewed. This included 114 from the Health Care Financing Administration, 56 from the Social Security Administration and 83 from the Public Health Service, Human Development Services and other agencies.
- Medicare could save hundreds of millions over the next budget cycle by further reducing the add-on percentage to the PPS rates paid. Teaching hospitals would still be left with substantial profits from Medicare.
- The \$863 million annual AFDC payments to ineligible could be substantially reduced through new management initiatives and the continued use of disallowances for States which exceed targeted error rates. (See page 39.)
- Social Security trust funds losses could be reduced by millions through implementing adequate internal controls in the National Debt Management System. (See page 19.)

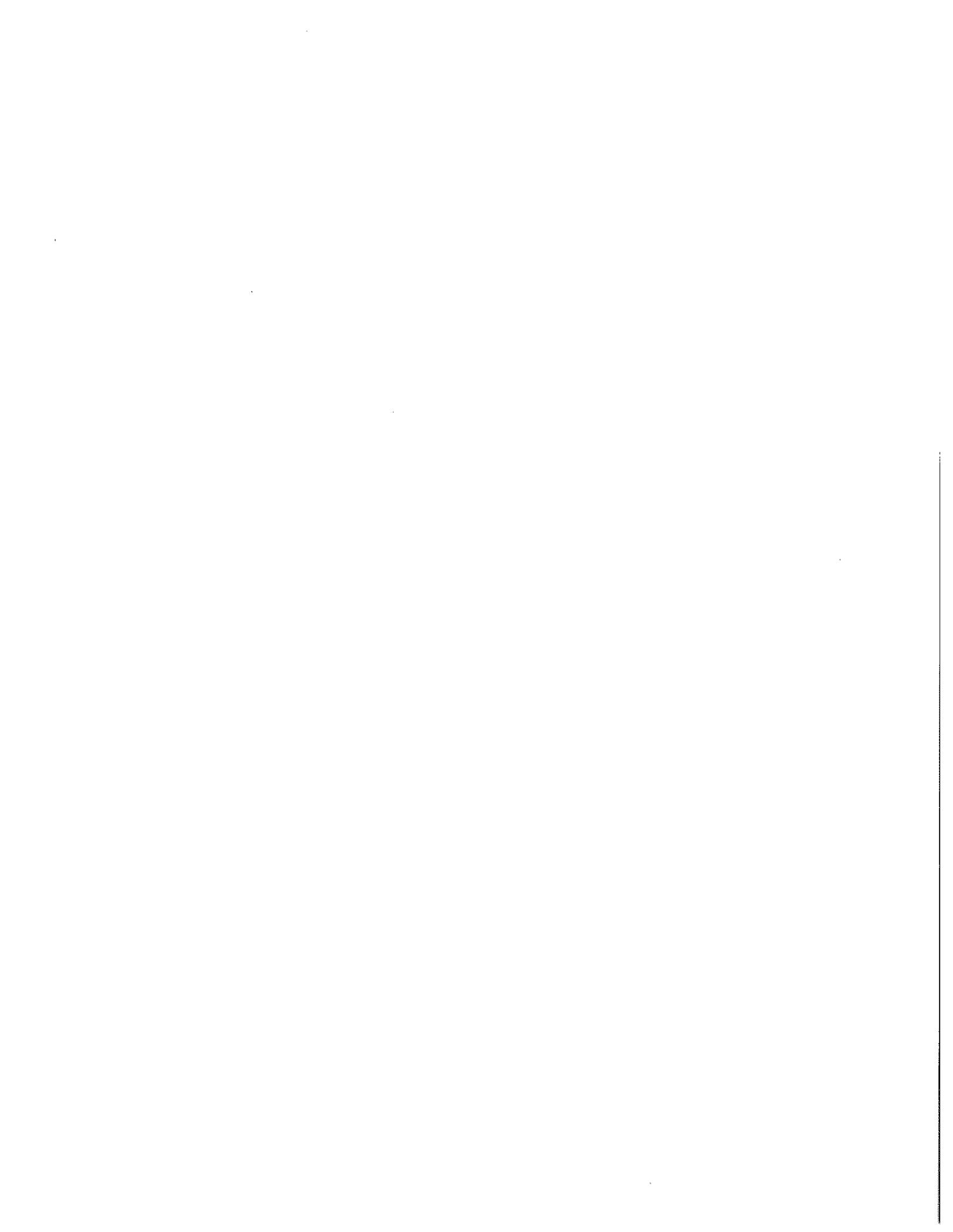
- Over \$700 million could be saved, over a budget cycle, through recovery of unpaid beneficiary coinsurance and deductible amounts by offsetting against Social Security benefits. (See page 2.)
- The Medicaid program could save \$50 million annually by restricting reimbursement to "actual allowable costs" for State-owned/ operated intermediate care facilities for the mentally retarded (ICF/MR). (See page 13.)
- Up to 500 additional Medicare recipients could receive kidney transplants each year and \$37.5 million in Medicare costs could be saved over the budget cycle by tightening the current practices governing the access of foreign nationals to U.S. cadaver kidneys. (See page 4.)
- Twenty-three million dollars in excessive SSA claimant charges could be avoided annually by improving administrative law judge reviews of attorney fees. (See page 21.)
- First year PPS hospitals' profits of \$5.5 billion substantiate the need to rebase PPS rates using more accurate, audited cost data. (See page 2.)
- Increased use of existing AFDC pre-eligibility checks could reduce inappropriate payments by over \$800 million annually. (See page 40.)
- Sixty-nine million dollars could be saved annually if Medicare carriers were required to use their "inherent reasonableness" authority to limit excessive charges for ambulance services. (See page 6.)
- Annual State and Federal savings of \$485 million could be realized by eliminating duplicate AFDC shelter benefits which would lead to more uniform and equitable assistance payments to all AFDC recipients. (See page 38.)
- Nearly \$16.4 million could be saved annually by requiring physical therapy services to be billed through SNF providers when rendered by outside physical therapists. (See page 4.)
- Appropriations to cover FY 1988 health education loan defaults could be reduced by \$20.5 million through tightened management controls over borrowing. (See page 34.)
- The SSN application process can be improved by terminating agreements with State welfare agencies to process requests for SSNs and increasing controls to identify questionable SSN applications. (See page 22.)

- Head Start grantee noncompliance with the statutory limit on administrative costs could be curtailed by strengthening controls over grantees. (See page 36.)

The following three chapters provide detail on the aforementioned highlights and other OIG accomplishments by operating program sequence:

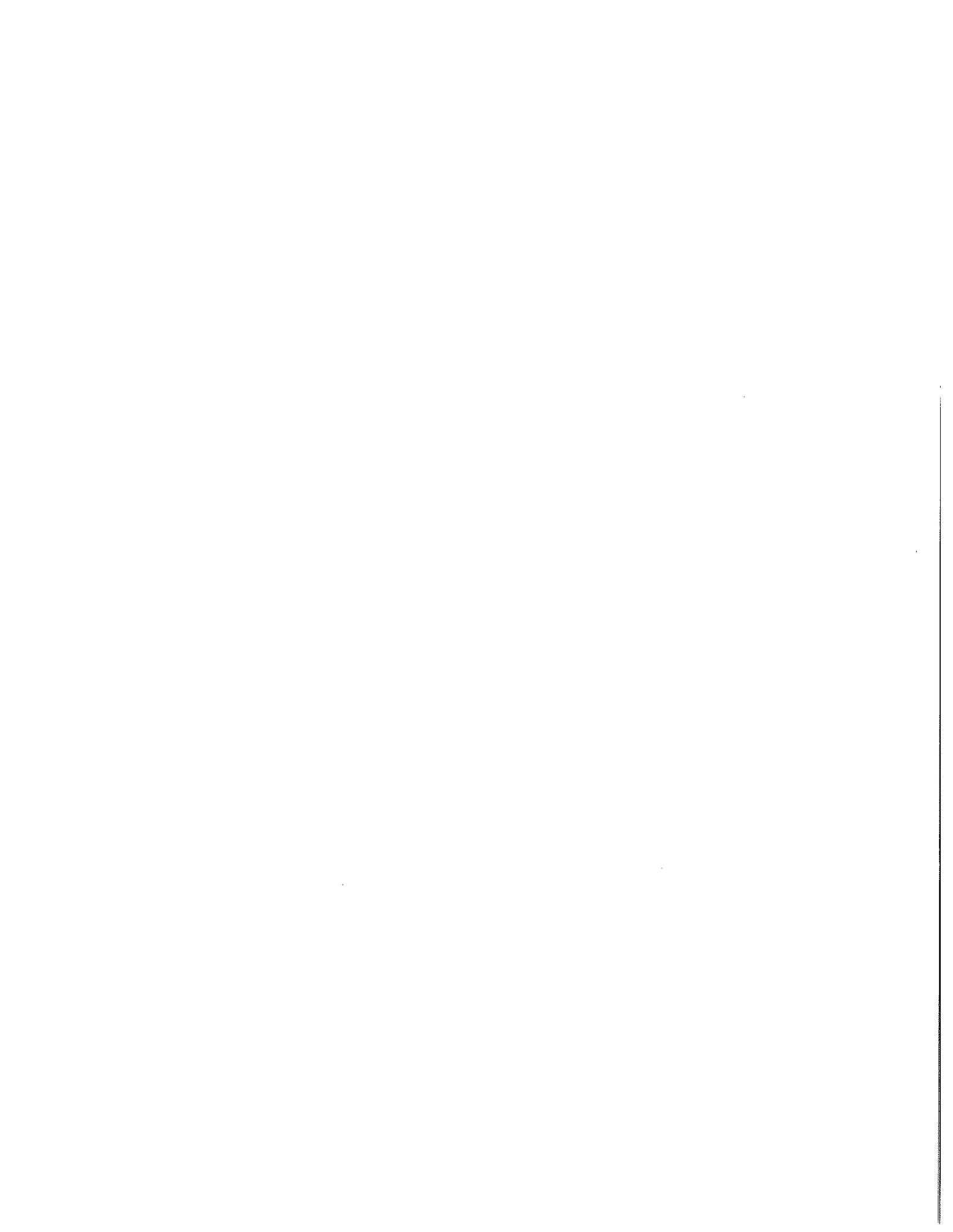
- The Health Care Financing Administration (HCFA), with a fiscal year 1986 budget of \$94.3 billion, administers the Medicare and Medicaid programs.
- The Social Security Administration (SSA), with a fiscal year budget of \$211.2 billion, administers the Old Age, Survivors and Disability Insurance (OASDI); Supplemental Security Income (SSI); and Black Lung programs.
- Grants and Internal Systems (GIS), with its combined fiscal year budget of \$28.5 billion, includes the Public Health Service (PHS), the Office of Human Development Services (OHDS) and the Family Support Administration (FSA),\* as well as overall departmental management.

\* Effective April 1, 1986, oversight of 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 formerly administered by SSA, was transferred to the newly formed Family Support Administration (FSA) through a Department reorganization initiative.

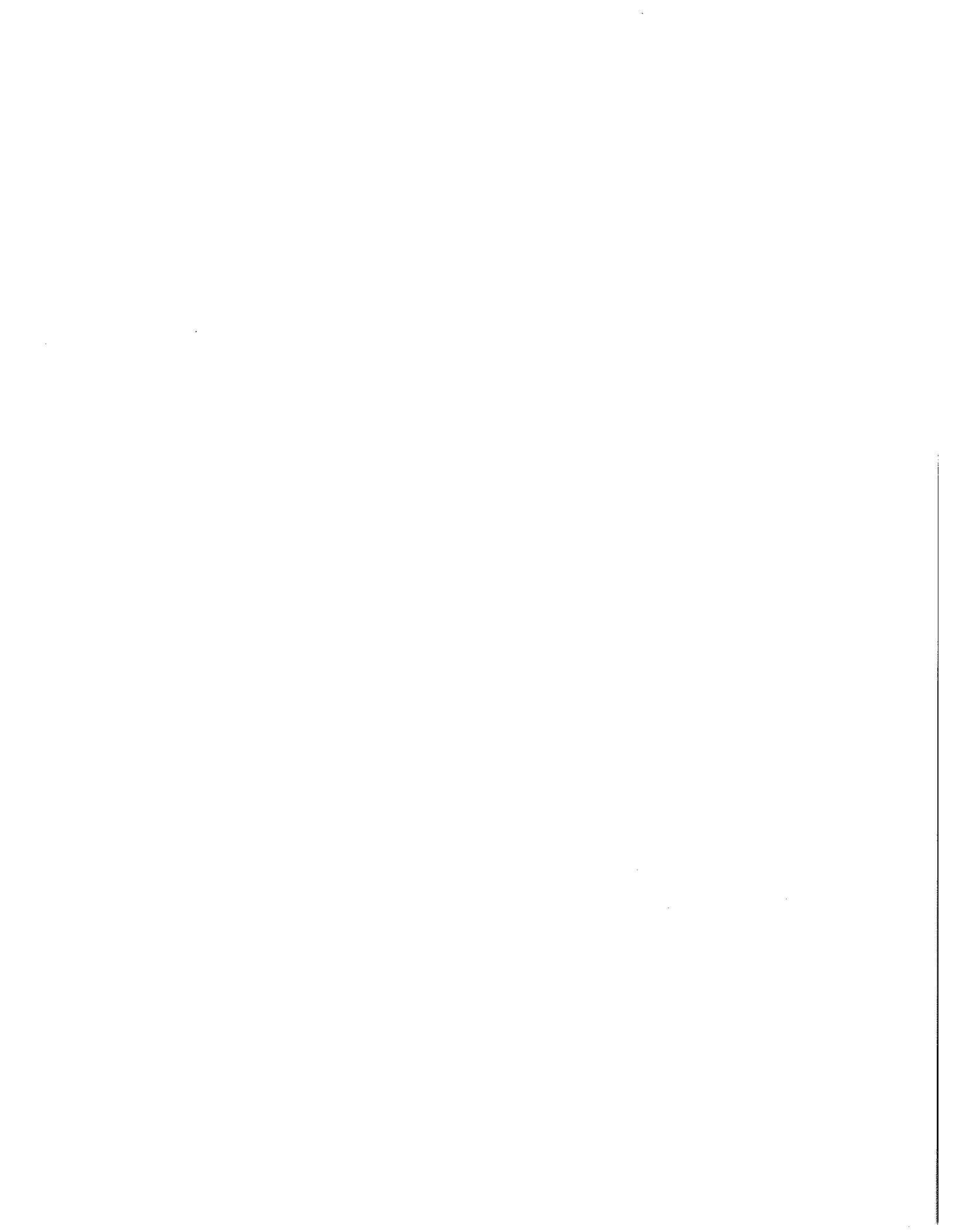


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**HEALTH CARE FINANCING ADMINISTRATION**



## Chapter I

### HEALTH CARE FINANCING ADMINISTRATION

Office of Inspector General (OIG) reviews during the period identified a number of areas where changes in legislation, regulations or program administration could generate some \$1.4 billion in savings over the budget cycle. These reviews also pinpointed areas where improved management and tightened internal and fiscal controls could result in annual savings of more than \$77.3 million. The allowability of another \$49.3 million in program expenditures was questioned, with recommendations calling for procedural improvements and financial adjustments. In areas where investigative evidence indicated fraud and abuse, 729 successful criminal, civil and administrative prosecutions were obtained against health care providers as a result of investigations by OIG and the State Medicaid Fraud Control Units (MFCUs) with oversight by the OIG.

The OIG also reviewed and commented on 114 regulatory and legislative change proposals affecting Medicare and Medicaid, and testified before Congress on the success of the civil monetary penalties legislation.

The Medicare and Medicaid programs, administered by the Health Care Financing Administration (HCFA), provide health care payments for more than 50 million of the Nation's poor, elderly and disabled. FY 1986 Federal spending for the two programs is expected to total \$94.3 billion: \$69.0 billion for Medicare which is financed by the Social Security Title XVIII (Health Insurance) trust funds, and \$25.3 billion for Medicaid which is financed from general revenues.

Considerable OIG effort has been committed to reviewing Medicare's prospective payment system (PPS) for hospital reimbursement and recommending systemic improvements in areas considered vulnerable to fraud, waste and abuse. Health maintenance organizations (HMOs) were also reviewed, and ways were identified to ensure that program requirements were met. The OIG also addressed the implications of foreign nationals' access to cadaver kidney transplants.

The OIG also reviews States' compliance with Federal Medicaid laws. Reviews centered on whether Federal funds were being appropriately spent and whether beneficiaries received medical services being paid for.

**MEDICARE  
HOSPITAL PROFIT**

Since the inception of the Medicare prospective payment system (PPS), concerns have been raised about the financial impact of the system on hospital operations and correspondingly on the sufficiency of resources to provide quality care. Responding to these concerns, OIG analyzed 1984 cost data for 2,099 hospitals to determine their Medicare profits for the first year of operations under PPS. The study showed that:

- Hospitals surveyed earned Medicare profits of almost \$2.2 billion in the first year under PPS. These results indicate that first-year profits for all PPS hospitals could amount to \$5.5 billion.
- Eighty-two percent of the hospitals sampled earned profits averaging \$1.3 million per facility. Those experiencing losses generally had a low volume of Medicare revenues.
- Average Medicare profits were eight times the amount of average losses.
- The average Medicare profit margin realized by surveyed hospitals was about 15 percent. This exceeded by 7 to 15 times the profit margins reported by the American Hospital Association on patient revenues from all sources.
- Two hundred and four hospitals (9.7 percent of those reviewed) realized the largest profits, averaging \$5.9 million per facility.

The OIG findings indicate that operating costs used to establish PPS rates were originally overstated due to the inclusion of costs in base-year data for capital, direct medical education, exempt units and unallowable costs.

The OIG recommended that HCFA pursue legislative authority as necessary to rebase PPS rates (after full transition to a 100 percent Federal rate), using more accurate, audited cost information. HCFA noted that an overall rebasing of the rates on the basis of later audited cost report data is not the only avenue available for evaluating whether, and how, the PPS rates should be revised.

**MEDICARE  
BENEFICIARY BAD  
DEBTS**

Thousands of Medicare beneficiaries do not pay their deductible and coinsurance amounts for hospital inpatient stays. Over the budget cycle, amounts owed could total \$1.2 billion. Medicare reimburses hospitals for these bad debts once reasonable attempts at collection have been made. This policy, adopted in 1966 and continued under PPS, was originally intended to prevent costs of beneficiary care from being shifted to non-Medicare patients.

Because hospitals under PPS are to retain profits (or absorb losses), the original intent of reimbursing hospitals for bad debts no longer seems appropriate. In fact, because of the profit potential inherent in PPS, there is a trend for hospitals to waive the coinsurance and deductible amounts to induce beneficiaries to use inpatient services.

If Medicare continues to reimburse these bad debts, a way to recoup some of these funds would be to offset amounts owed by the beneficiary against benefit payments due from Social Security. This is in fact what happens when for example, an intermediary incorrectly pays the hospital for a beneficiary's inpatient deductible. The HCFA can refer the overpayment to SSA for recovery by offset against current Title II benefit payments. The SSA deducts the overpayment over a period of time where deducting the entire overpayment in 1 month would cause an undue financial hardship.

The OIG recommended that HCFA either discontinue Medicare payments to PPS hospitals for beneficiary bad debts or, in coordination with SSA, pursue legislative authority to recover payments for beneficiaries' bad debts through benefit payment offsets. The OIG estimates budget cycle savings to the Medicare trust funds in excess of \$700 million. The OIG findings are with HCFA and SSA for review.

Teaching hospitals receive an add-on percentage to the PPS rate for "indirect medical education" (IME) costs associated with their training activities. A 1985 OIG report found IME payments excessive and recommended that the add-on percentage, which was then 11.59 percent, be halved to 5.79 percent for a reduction of \$600 million annually.

## **INDIRECT MEDICAL EDUCATION**

The OIG's recommendation was partially implemented with the passage of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. The COBRA reduced the factor to 8.1 percent for patient discharges through September 30, 1988 and to 8.7 percent thereafter. This change will save at least \$1.7 billion over the next 5 years.

The COBRA is a positive step towards reducing excessive IME payments. However, since most teaching hospitals made large profits under PPS in 1984, the OIG evaluated their financial need for even the COBRA level of IME payment.

The OIG's analysis of 1984 IME payments to 327 teaching hospitals disclosed that their Medicare profit margins averaged about 18 percent. Even without the IME payments, their average profit margin of 15 percent was still significantly

higher than that of "comparable" nonteaching facilities that averaged 12 percent.

This latest analysis confirms the OIG's earlier recommendation that the IME factor should be reduced. As an interim measure, the factor should be reduced to the 5.79 percent which is supported by HCFA's empirical data. However, in view of the 15 percent Medicare profit teaching hospitals averaged without IME, HCFA should consider whether even a 5.79 percent IME factor is warranted. HCFA generally agrees with OIG's findings and recommendations.

**ACCESS OF  
FOREIGN  
NATIONALS TO  
U.S. CADAVER  
KIDNEYS**

The OIG conducted a study of transplant practices in 15 U.S. cities and estimated that, in 1985, 300 foreign nationals received cadaver kidney transplants in the U.S. and another 200 to 250 kidneys were exported from the U.S. to other countries. The study addressed the implications associated with these practices, such as the reduction in the number of kidneys that would otherwise be available to Medicare recipients and the increase in Medicare costs.

The OIG recommended that HCFA ensure that cadaver kidneys are not offered to foreign nationals or exported to other countries unless it has been determined that no suitable U.S. recipient can be found. The recommendation went further to state that HCFA should prohibit Medicare reimbursement for any of the acquisition costs of those kidneys that are sent to other countries. Implementation of this recommendation would allow 500 additional Medicare beneficiaries to receive kidney transplants during 1987, and generate Medicare cost savings of \$37.5 million annually. The HCFA has concurred with the OIG recommendations and is currently developing a regulatory change.

**PHYSICAL THERAPY  
IN SKILLED  
NURSING  
FACILITIES**

Skilled Nursing Facilities (SNFs) can only accept Medicare patients for physical therapy (PT) if such services can be provided directly or arranged for with outside providers. The OIG conducted a survey of 241 SNFs to assess the arrangements used to provide PT. The results of the survey showed that 62, or about 25 percent, of the SNFs did not bill for PT provided to Medicare-eligible patients. Instead, SNFs often made arrangements with outside service providers to provide PT to SNF inpatients and to bill the Medicare program directly. As a result, PT services were often not economically or efficiently provided, program abuse vulnerabilities were created and unnecessary financial burdens were frequently placed on beneficiaries.

The key factor contributing to the vulnerability of such an arrangement was SNF loss of control over billing. When the bill for PT services was split between the SNF and the outside provider, or when the bill was submitted entirely by the outside provider, PT costs were broken out of or "unbundled" from SNF

operating costs. In these situations the potential exists for multiple billings for the same service. The OIG found that payment for PT services to outside providers was running consistently higher than payment to SNFs for the same service. Excessive program and beneficiary payments amounted to an estimated \$16.4 million during FY 1984.

The OIG has recommended that HCFA propose legislation to modify current SNF reimbursement policy to prohibit unbundling practices for Medicare covered nonphysician services, which includes PT services. The report is currently with HCFA for comment.

The OIG review of two risk-based health maintenance organizations (HMOs) disclosed payment duplication and enrollment problems. **HMOs**

- Risk-based HMOs are required to furnish Medicare-covered services in exchange for a fixed capitation payment. Medicare is not liable for payments for services obtained by an enrollee outside of the HMO. Despite this provision, HCFA does not require carriers to correct or recover such duplicate payments when the carriers' cumulative error rate is below a certain tolerance level. If this policy continues, the OIG estimates that as much as \$3 million per year in duplicate payments will go unrecovered. The OIG recommended that HCFA change its policy on tolerance levels and return all duplicate payments involving risk-based HMOs to carriers for correction and recovery. The HCFA has since taken several actions to assure that such duplicate payments are not made. **HMOs/DUPLICATE CLAIMS**

- Regulations for risk-based HMOs also require that Medicare/Medicaid beneficiaries account for no more than 50 percent of total enrollment by attracting substantial membership from the general community, and that HMOs demonstrate that they are providing a standard of care acceptable to the community at large which in turn helps assure quality of care for the Medicare/Medicaid beneficiaries. **HMO ENROLLMENT**

The HCFA waived the 50 percent limitation for one HMO having an excessive Medicare enrollment. Terms of the waiver required that the HMO make reasonable efforts to meet the 50 percent limitation by March 31, 1988. An OIG review found the opposite situation; the HMO was not making reasonable efforts to accomplish this goal. In fact, at the time of the review, the Medicare enrollment had increased to 72 percent, its highest level.

The OIG recommended that HCFA consider withdrawing the HMO's exception to the enrollment standard. Alternatively, if HCFA determined that the

exception ought to be continued, the OIG recommended that a moratorium be placed on enrolling new Medicare beneficiaries and that interim enrollment targets be set to attain compliance with the standard by March 31, 1988. The HCFA agreed with the alternative recommendation and proposed actions to help the HMO achieve compliance with the 50 percent standard.

**MEDICAL  
REIMBURSEMENT  
FOR AMBULANCE  
SERVICES**

Medicare pays for ambulance services only between specified destinations and only if other means of transportation would endanger the beneficiary's health. This includes payment for service to a hospital if there is medical necessity. In reviews of Medicare claims for ambulance services, the OIG found two problem areas. The first involved the "reasonable charge" method of payment, which is based on customary and prevailing rates in an area, and the second involved transportation of end-stage renal disease (ESRD) patients.

**AMBULANCE  
SERVICES  
"REASONABLE  
CHARGE"**

- The use of "reasonable charge" methods for determining costs often results in rates which are not "inherently reasonable." When this occurs, carriers are supposed to consider other factors in determining payments. The OIG found that use of the reasonable charge methodology has resulted in excessive annual increases in ambulance costs. Only one carrier has used its inherent reasonableness authority to limit ambulance reimbursement; this carrier achieved annual savings of 15.8 percent. If all carriers used inherent reasonableness to limit reimbursement, Medicare could save up to \$69 million annually. Further, if legislative action were taken to allow competitive bidding to establish lower payments for ambulance services, \$545 million could be saved over the budget cycle.

**AMBULANCE  
SERVICES/ESRD**

- The other area reviewed involved transporting ESRD patients by ambulance for "routine" dialysis treatment. Under Medicare policy, ambulance services to and from a hospital outpatient facility for "routine" dialysis typically does not qualify as being medically necessary. This review found that certain carriers usually paid for such ambulance transportation. Accordingly, the OIG recommended that HCFA clarify Medicare coverage guidelines by better defining "routine" dialysis treatments and specifically identifying the conditions under which payments are appropriate for ambulance services by ESRD patients to obtain routine dialysis treatments. This action could save as much as \$8.7 million annually.

The HCFA is acting on the OIG recommendation to issue clarifying guidance and reminders to all carriers that ambulance services to and from a free-standing dialysis facility are not covered by Medicare.

**PEER REVIEW  
ORGANIZATIONS**

Peer review organizations (PROs) were established to evaluate the quality of care and the necessity of hospital admissions under Medicare's PPS. The PROs

perform this function under contract with HCFA. The contract requires that the PROs identify providers whose quality of care does not meet professionally recognized standards. If the PROs are unable to convince the providers to improve the quality of care, the PRO is required to recommend to the OIG either a monetary penalty or a period of exclusion from the Medicare program.

- 1986 was the first full year of operation under the implementing regulations of the Peer Review Improvement Act. The Act provided for sanction of providers on the basis of recommendation by PROs for poor quality of care or excessive services. Thus far, the OIG has proceeded on sanction recommendations from 21 PROs. The following exclusions are examples of actions taken as the result of PRO recommendations.

#### **PRO-RATED SANCTIONS**

—A Kansas physician was excluded for 15 years because the PRO found that in seven cases the care provided presented imminent danger to the health and safety of Medicare patients. The physician had failed to diagnose an acute myocardial infarction prior to discharging the patient to an alcohol rehabilitation program, mismanaged a patient's diabetes condition, and treated a patient with gastro-intestinal bleeding with medications which produced or worsened the bleeding.

—A Missouri physician was excluded for 5 years after the PRO found that he had performed medically unacceptable and unnecessary surgical procedures and had failed to provide services which were medically necessary.

- During 1986 the OIG initiated financial audits of 48 PROs after a survey of HCFA records indicated that many PROs were accumulating excessive cash balances (profits) during the initial 24 months of PRO operations. Audits of the initial round of PRO fixed-price contracts focused on (1) the reasonableness of the negotiated contract amounts; (2) the amount of excess cash balances at PROs and the conditions that caused them; and (3) the extent to which the PROs were experiencing financial difficulties. OIG noted:

#### **PRO CONTRACTS**

—Thirty-seven of the 48 PROs were estimated to earn profits aggregating \$21.7 million, with 6 having estimated profit levels of 20 percent or more. Ten PROs were estimated to lose a total of \$1.15 million, while the one cost-reimbursement PRO would incur neither profit nor loss.

—Cash advances were made to all PROs at the inception of their contracts to cover 2 months of start-up costs. On the average the PROs spent only 48 percent of their advances and invested the balance.

— PRO contracts did not contain adequate property clauses to protect the Government's interest in property purchased with PRO funds.

HCFA generally did not concur with the recommendations calling for changes to contracting procedures to address the issues raised. However, results from both this OIG review and the PRO preaward audits were used by HCFA in negotiating second round PRO contracts.

**PRO COST PROPOSALS**

- At HCFA's request, the OIG audited the reasonableness of costs in 62 PRO fixed-price contract proposals for the second 24-month period. As a result of these audits and the cost findings from the 48 financial audits disclosed in "PRO Contracts" above, HCFA was able to negotiate a cost savings on the second round PRO contracts of more than \$48.6 million.

**FRAUD-RELATED SANCTIONS**

As exemplified by the PRO related sanctions discussed earlier, the PRO Act added new impetus to OIG efforts to rid the health care programs of providers guilty of abusive practices. But the OIG also intensified its efforts to remove providers who have been convicted of fraud as shown in the following examples.

- An Illinois pharmacist was suspended from program participation for 30 years. The pharmacist was the ringleader in an extensive scheme in which drug addicts were given narcotics while Medicaid was billed for prescription drugs.
- A physician in Rhode Island was sanctioned for 25 years for his part in a conspiracy in which he got a kickback each time he implanted one manufacturer's brand of pacemaker.
- A Massachusetts physician, who had been excluded for 5 years in 1981 for filing false Medicare claims, was again sanctioned for 25 years as a result of a conviction for Medicaid fraud.

**MEDICARE AS SECONDARY PAYER**

When enacted in 1965, Medicare was made the first or primary payer for beneficiaries' medical claims, except for services covered by workers' compensation or provided by a Federal hospital. Several times in the early 1980's Congress amended the Medicare provisions, making Medicare the secondary payer for the working aged and end-stage renal disease beneficiaries when these beneficiaries are covered by employer-sponsored group health insurance. The OIG conducted reviews on each of these situations.

- In the first review, two States were tested to determine whether Medicare was reimbursing providers as the primary payer even though the beneficiaries were working and covered by employer group health plans. The inspections revealed that improper payments had been made. Overpayments were projected to be \$5.0 million and \$4.3 million for hospitals in these two States. With implementation of improved controls, annual dollar savings are estimated to be \$5.3 million. The HCFA agreed to recover the overpayments identified and to give guidance to intermediaries and hospitals on identifying beneficiaries covered by an employer group health plan. **MEDICARE AS SECONDARY PAYER—WORKING AGED**
- In the second review, the OIG found \$3.0 million in overpayments for a sample of ESRD beneficiaries in one State where the provider did not identify the existence of employer health insurance. The HCFA agreed to recover the overpayments. **MEDICARE AS SECONDARY PAYER—ESRD**

In addition to reviewing Medicare program operations, the OIG assessed the allowability of costs claimed for reimbursement by Medicare intermediaries and carriers and recommended approximately \$3.9 million for disallowance. Unallowable costs included excessive charges for pension benefits, improperly allocated equipment lease expenses, erroneous charges for employees' personal use of vehicles, excessive charges from providers due to the use of incorrect procedure codes, and inadequately documented costs. **CONTRACTOR COSTS**

The reviews and sanctions discussed highlight some of the areas where the OIG has directed its efforts to reduce costs to conserve the trust funds for future beneficiaries, and to rid the program of fraudulent and incompetent providers. The OIG also performs a major role in ferreting out fraudulent providers and obtaining evidence for criminal and civil prosecution as well as civil monetary penalties.

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

- A medical supplier paid almost \$500,000 in fines, penalties and restitutions for filing Medicare claims for goods never delivered. The agreement included a 10-year suspension from participation in the Medicare and Medicaid programs.

- As a result of an OIG investigation and an audit conducted by the carrier, a hospital signed a \$350,000 agreement after having submitted duplicate claims to the Medicare carrier for diagnostic laboratory tests.
- A cardiologist signed a \$300,000 settlement after a joint OIG/carrier audit found violations involving undocumented services, upgrading of procedure codes and misrepresented diagnoses.
- An anesthesiology group signed a \$273,800 settlement. The group billed for an extra undocumented 30 minutes for every Medicare and Medicaid claim to cover services rendered in a pre-operation holding room. These services were already included in payments for the entire operation.
- An administrative law judge imposed a civil monetary penalty of more than \$240,000 against a physician, and suspended him from the Medicare and Medicaid programs for 10 years. He submitted almost 2,000 false claims for laboratory services.
- As a result of a joint investigation with the State Medicaid Fraud Control Unit, an internist employed by a medical center agreed to a settlement for \$135,000 plus \$8,310 in interest. The internist had billed the Medicare programs for procedures that were not performed.

**CRIMINAL FRAUD** In pursuing health care fraud, the OIG takes a variety of avenues which may involve directing attention to violations of specific statutes or directing its efforts towards specific categories of providers.

**FALSE CLAIMS** ● The basic statute for criminal prosecution of health care providers defrauding the Medicare and Medicaid programs is the False Claims Act. The following are examples of successful criminal prosecution for false claims.

—A Wisconsin physician had to repay \$22,000 to the Medicare program for billing for acupuncture procedures, which are not covered by the program.

—The owner of a South Carolina investment company, and his brother, were convicted for submitting false Medicaid cost reports for three nursing homes. Also convicted were major officers of the nursing homes, who had been convicted earlier, for filing false reports, and receiving kickbacks. All were sentenced to serve time in halfway houses and several years of probation. Total fines and restitutions amounted to \$157,000.

- Persons who have access to the disbursement or receipt of Medicare funds and are convicted of program fraud are most frequently guilty of embezzlement, as illustrated in the following examples. **EMBEZZLEMENT**

—An Ohio administrator was convicted of embezzling \$126,000 over several years from hospital accounts in which Medicare funds were mingled. He was sentenced to 5 years incarceration and ordered to make full restitution.

—A Medicare carrier employee issued Medicare and private insurance checks amounting to \$106,000 to 14 relatives and friends. The employee received part of the profits in return for her part in arranging the scheme. She and another conspirator were ordered to make restitution and sentenced to prison. The others were also convicted, given probation terms and ordered to make full restitution.

- As some of the preceding cases illustrate, the OIG derives economy of effort as well as increased successful prosecutions through working cooperatively with other investigative agencies. Joint investigations benefit from the varied experience and knowledge of agents from both the public or private sectors, and offer the economies of pooled resources. The cases below are examples of other successful prosecutions. These were obtained from OIG work with the Federal Bureau of Investigation. **JOINT INVESTIGATIONS**

—An orthopedic surgeon in New York was convicted for collecting an estimated \$500,000 in Medicare claims for services he did not perform. His fraud took on a myriad of forms, from substituting his name for that of an operating surgeon to billing for multiple services when he only performed one.

—In Ohio an optician had to repay more than \$66,000 to the Medicare program. As head of a nonprofit organization which offered incidental optical services, he was allowed to enter nursing homes where he obtained patients' Medicare numbers. He then prepared false bills for eyeglasses, home visits and fittings at about \$360 per patient.

- In addition to the joint investigations mentioned above, the OIG is also involved in various task forces in geographic areas. This approach is particularly successful in areas with a large Medicare/Medicaid beneficiary population and a correspondingly high number of health care providers. For example, during this fiscal year three convictions resulted from a Houston health care task force consisting of representatives from the OIG, U.S. **GEOGRAPHIC TASK FORCES**

Attorney, FBI and U.S. Postal Service. Since its formation in 1984, the task force has obtained ten successful prosecutions, including those of an ambulance company owner, an optometrist, a podiatrist, the owner of a durable medical equipment company, and a man who devised a scheme to submit false bills while he was in prison.

- SERVICE-SPECIFIC PROJECTS** ● Both singly and in concert with other agencies, the OIG conducts projects aimed at specific types of health care services. For instance, in California the OIG recently had its first conviction from Project Shadow, which concentrates on portable x-ray providers submitting false claims. In this project the methodology used to identify providers who are defrauding the program is to review claims and examine those claims that could not possibly be performed using portable x-ray machines.

**PREPAID HEALTH PLANS** The OIG reviewed two prepaid health plans. One involved Medicare, the other Medicaid.

- PREPAID HEALTH PLANS-MEDICARE** ● The one OIG review covered Medicare claims in a prepaid health plan and disclosed that \$2.5 million of \$3.3 million (75 percent) claimed in 1 year was unallowable: \$1.1 million for nonreimbursable costs inadvertently included in the plan's cost report; \$0.9 million for administrative costs applicable to the plan's non-Medicare activities; and \$0.5 million for administrative costs related to a civil lawsuit settlement. The OIG recommended a financial adjustment for these amounts. No procedural changes were recommended because the plan has since ceased operations.

- PREPAID HEALTH PLANS-MEDICAID** ● The other OIG review covered the Arizona Health Care Cost Containment System (AHCCCS) which is a Medicaid demonstration project providing prepaid health coverage for AFDC, SSI and medically indigent members. The principal objective of AHCCCS is to show that prepaid health plans are more cost-effective than traditional fee-for-service programs. A review of the program showed that the Federal Government incurred duplicate costs totaling \$1.1 million during fiscal year 1983 for medical services provided to 1,200 Native Americans who were obtaining medical care exclusively from Indian Health Service (IHS) facilities. Consequently, IHS was incurring costs to provide the enrollees with medical care for which AHCCCS had already paid non-IHS providers.

In response to OIG recommendations, HCFA, IHS and AHCCCS coordinated their actions to assure that such unnecessary costs are eliminated in the future.

- ICF/MR** Following are highlights of three OIG reviews of reimbursements to intermediate care facilities for the mentally retarded (ICF/MRs) under the State-administered Medicaid program. One review involved an outdated loophole in the

upper payment limits, the second involved unallowable costs and the third involved claims for overpayments.

- The first review was concerned with the regulations that permit States to obtain maximum Federal reimbursement for State-owned and operated ICF/MRs, at the expense of private providers. For example, the OIG and HCFA found that in one State the prospective reimbursement system established for these facilities resulted in the State receiving \$11.1 million (Federal share over 30 months) more than the "actual allowable cost" incurred to provide medical services. Claims submitted for private ICF/MRs on the other hand represented only 97.6 percent of their aggregate costs.

#### **ICF/MR UPPER PAYMENT LIMITS**

The OIG recommended that HCFA move to restrict reimbursement to "actual allowable cost" for State-owned and operated ICF/MRs. Implementation of such a measure would result in estimated savings nationwide of about \$50 million annually to the Federal Government with no lessening in the quality and quantity of services to patients.

- Reviews of the 47 States with sheltered workshop programs for adult residents of ICF/MRs showed that 23 claimed Medicaid reimbursement for the costs of workshop services. The costs of such program services provided ICF/MR adult residents are not to be included in Medicaid reimbursement. These errors in claims resulted in Medicaid overpayments totaling \$27 million during FY 1984. The OIG recommended and HCFA has issued guidelines to clarify coverage of sheltered workshop programs.
- The OIG reviews in three States disclosed overcharges to the Medicaid program as a result of incorrectly computed per diem rates for ICF/MRs and duplicate charges resulting from a computer procedure error. Financial adjustments totaling \$9.1 million and procedural changes were recommended to correct these problems. HCFA concurred with the OIG recommendations.

#### **ICF/MR UNALLOWABLE COSTS**

A similar OIG review involved unallowable cost for institutions for mental disease (IMDs). Medicaid rules prohibit Federal cost sharing for services to persons under 65 years of age in IMDs. Responsibility for caring for these persons rests with State and local governments. An OIG review in one State found that \$4 million was improperly claimed for the cost of services of nine intermediate care facilities which had the overall characteristics of IMDs: (1) a majority of their patients received long-term psychiatric care; (2) the facilities were used by State mental hospitals for alternative care; and (3) a high percentage of the patients had a history of being in mental institutions.

#### **INSTITUTIONS FOR MENTAL DISEASE**

The OIG recommended a financial adjustment and that the State establish procedures for identifying intermediate care facilities which actually are IMDs. The HCFA issued a State Medicaid Manual Transmittal, effective October 1, 1986, which should permit identification of IMDs and facilitate appropriate disallowances. Recent successful litigation in this area should support previous disallowances.

**COMPLIANCE REVIEWS** The OIG also conducted reviews in eight States to determine compliance with other provisions of the Federal laws.

**ABORTIONS UNDER MEDICAID**

- Federal sharing is available to pay claims for abortion services only when a physician has certified that, in his professional judgment, the life of the mother would be endangered if the fetus were carried to term. The State Medicaid agency must have the certification in hand before the physician's claim can be paid.
- Two State Medicaid programs reviewed pay for the costs of medically necessary abortions, but policy in these two States is not to claim Federal sharing for any abortions. Nevertheless, due to administrative error, both State agencies claimed total Federal Medicaid sharing of about \$1.1 million for such costs. The problem was attributed to computer edit problems. Appropriate financial adjustments were recommended.
- In two other States, claims for abortions were supported by the required physician certification. However, follow-up visits to selected providers showed that substantive documentation was not available to support the certifications. In those cases, the OIG recommended financial adjustments totaling about \$610,000 in Federal funds.

**UNALLOWABLE COST-MEDICAID**

- Reviews in four States showed that Medicaid was inappropriately charged \$2.5 million for costs incorrectly allocated to the program, duplicated costs, unallowable interest expense, less-than-effective drugs, payments on behalf of ineligible recipients, and costs claimed at an incorrect Federal sharing rate. Appropriate procedural changes and financial adjustments were recommended. The HCFA generally concurred with the findings and recommendations and is in the process of recovering, or has recovered, inappropriate FFP.

**MEDICAID FRAUD CONTROL UNITS**

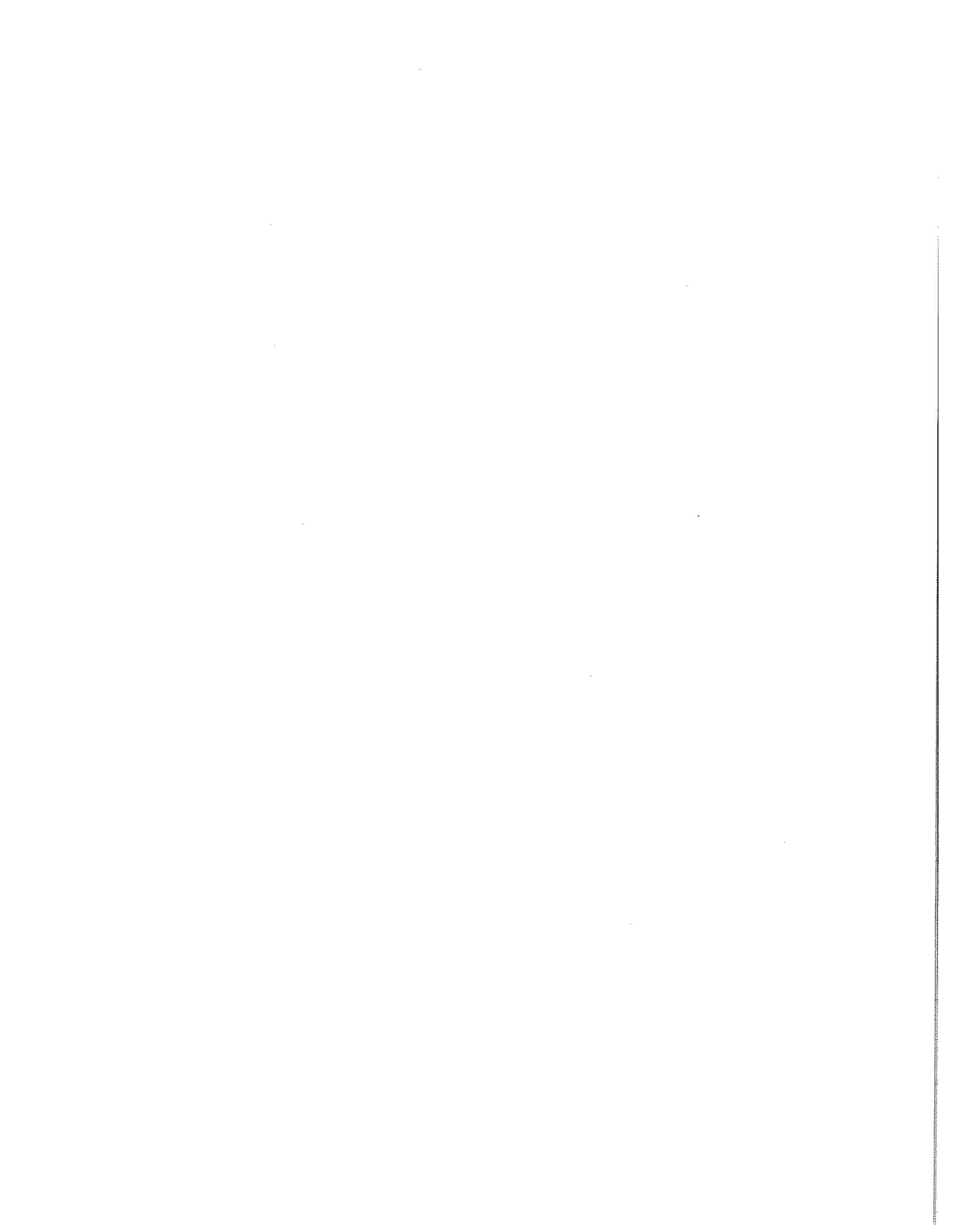
Because the States administer their individual Medicaid programs, the OIG plays a less active investigative role but stronger oversight role in the prosecution of Medicaid providers. Therefore, State Medicaid Fraud Control Units (MFCUs) generally have the lead in investigating fraud in their respective States. The OIG's oversight of the MFCUs, includes certifying them as eligible for Federal

funds for start-up and operating costs, and periodically reviewing them for adherence to standards. The OIG also frequently works cases jointly with them and/or otherwise assists them in their investigations.

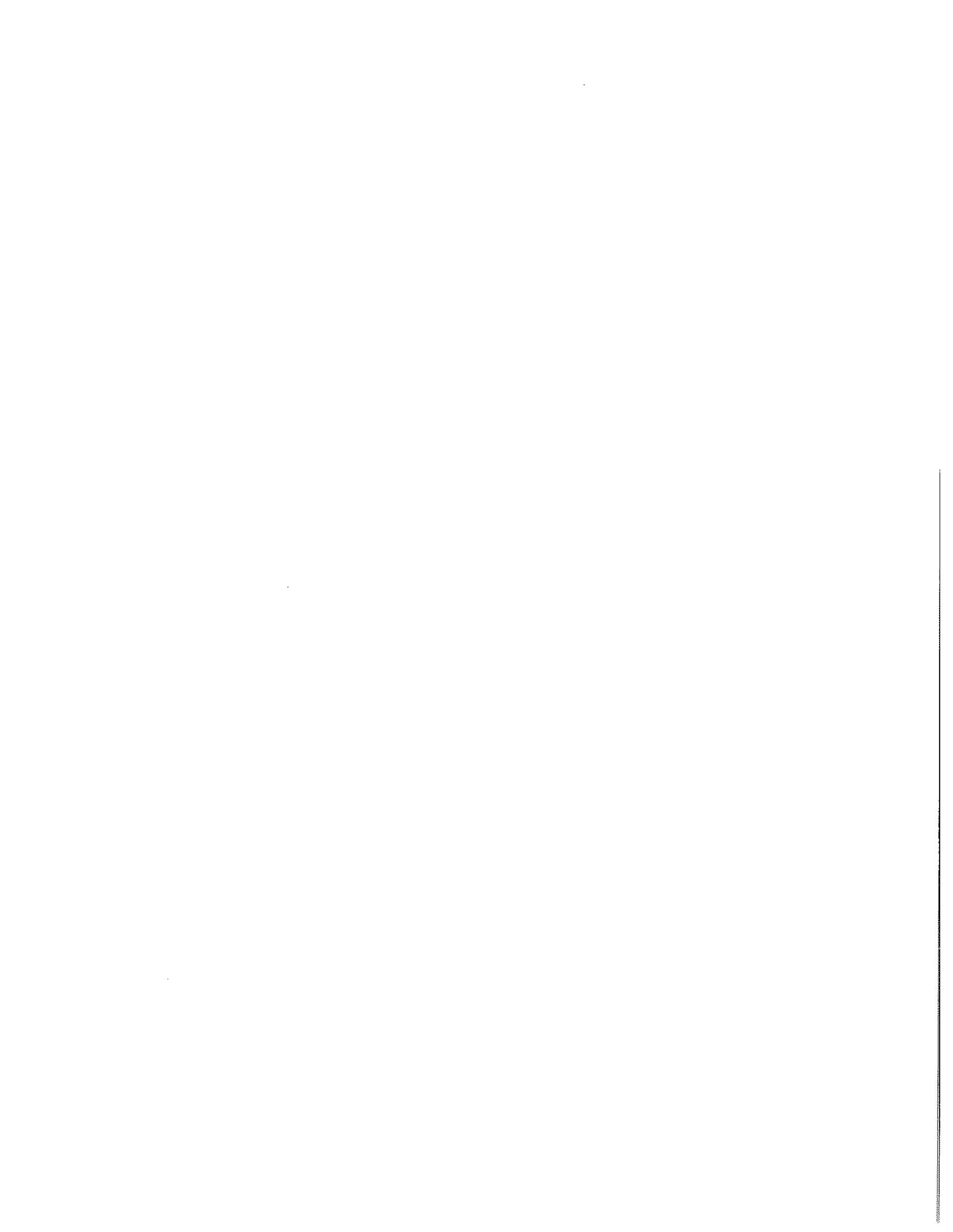
During this period, two new State units were certified, bringing the total to 38. There were 369 MFCU convictions and \$6.0 million in monetary returns reported in this period.

Investigations in one State exposed two cases with exceptionally high amounts in Medicaid fraud. The State had noticed that payments for special prescription footwear for Medicaid recipients had increased from \$2 million in 1982 to \$22 million. In response, the MFCU targeted the industry for special attention.

- In the first case, the owner of three retail shoe stores and two employees were convicted for stealing more than \$1 million from the Medicaid program. Between 1981 and 1985, they had billed for prescription footwear and shoe modifications for nursing home patients, adult home residents and other Medicaid recipients. The special footwear had not been prescribed and, in most cases, had not been delivered.
- In the second case, two corporations which operated four retail shoe stores were found guilty in the theft of \$4.1 million from the Medicaid program. Numerous claims were filed for orthopedic shoes, shoe corrections and shoe modifications when the recipients actually were given nonreimbursable, nonorthopedic footwear such as sneakers and high-heels. The two brothers who owned the corporations are currently fugitives after being indicted for the fraud.



**SOCIAL SECURITY ADMINISTRATION**



## Chapter II

### SOCIAL SECURITY ADMINISTRATION

The OIG reviews during this period focussed heavily on Social Security trust fund losses that could be reduced by millions through implementation of adequate internal controls in its National Debt Management System. An area was identified where regulatory changes could save the trust funds and the beneficiaries millions of dollars in excessive legal fees. The OIG also followed up on implementation of previous recommendations that, if undertaken, could save billions. And the pursuit of defrauders resulted in 371 successful prosecutions with accompanying fines, recoveries and savings of \$18.9 million.

The Social Security Administration administers the Old Age, Survivors and Disability Insurance (OASDI), the Supplemental Security Income (SSI) and the Black Lung programs. Prior to this fiscal year, SSA was also responsible at the Federal level for overseeing many State-administered programs which included, among others, Aid to Families with Dependent Children (AFDC), Low Income Home Energy Assistance (LIHEA), and U.S. Repatriate and Refugee Resettlement (RR) programs. These and other former SSA programs are now the responsibility of the newly established Family Support Administration (FSA). The OIG activities related to FSA programs are reported in the Grants and Internal Systems (GIS) section of this report which begins on page 33.

In FY 1986, about 37 million beneficiaries received an estimated \$195 billion in OASDI benefits. Such benefits are paid from trust funds financed mainly through payroll taxes. Under the needs-based SSI program, over 4 million low-income aged, blind and disabled recipients were paid an estimated \$11.1 billion. Black Lung program benefits paid to disabled coal miners and their dependents approximated \$1 billion. Both the Black Lung and SSI programs are financed from general revenues.

As of February 1986, overpayments to beneficiaries totaled \$3.2 billion. The SSA's collection of these debts has been hampered by its use of three distinct programmatic systems (OASDI, SSI, Black Lung) to control and account for debts. Past OIG reviews noted several internal control deficiencies with these systems, such as lack of formal receivable controls and reporting requirements to manage payments made after a beneficiary's death. To improve its debt management, SSA, in March 1984 contracted for the design, development and

### NATIONAL DEBT MANAGEMENT SYSTEM

implementation of a comprehensive, uniform national debt management system (NDMS).

The OIG found that overall development of NDMS has suffered a number of delays and is now more than 15 months behind SSA's initial implementation date of December 1986. These delays resulted from late delivery and insufficient development of functional requirements as well as changes to the system's scope. The delays also contributed to a failure to incorporate into the NDMS design internal controls previously identified by OIG. Losses to the trust funds caused by the lack of such controls were previously estimated at \$1.2 billion. Although SSA has taken interim measures to reduce the impact of these internal control weaknesses, the trust funds will continue to incur substantial losses until NDMS is fully implemented.

Recommendations call for the establishment of more precise milestones and more accurate reporting of system development activities. The OIG also recommended an analysis of each interface between NDMS and SSA's program payment systems. Such analyses will permit SSA to consider implementation of NDMS along with existing systems. The report is currently with SSA for comment.

**SUPPLEMENTAL  
SECURITY INCOME  
ABBREVIATED  
PROCESS**

In 1979, SSA developed an abbreviated application (ABAP) process in the SSI program so that informal SSI denials would be brought under mainstream systems control. Recently, however, complaints to Congress alleged that scarce SSA resources were being used to take unnecessary applications from individuals who were clearly ineligible for SSI payments. The OIG inspection of the ABAP process found that it had imposed an increased work load on the field offices. Even though that process afforded a high degree of protection to both SSA and the inquirer, it is cost prohibitive when extended to all inquiries. To balance properly the protection of inquirers' rights and the use of scarce resources, the OIG recommended that SSA maintain ABAP's as the primary means of closing out oral inquiries until the oral inquiry policy is reexamined, examine the effectiveness of informal denials in protecting inquirer's rights, and more fully share its rationale for the ABAP process with the operating personnel who work with it on a daily basis. The SSA is evaluating the recommendations.

**DEBT COLLECTION**

The OIG continues to monitor the Department's debt collection activities on a quarterly cyclical basis. For the period ended December 31, 1985, OIG included an examination of SSA's debt collection activities in its monitoring effort. The OIG also assessed action taken to resolve prior problems in meeting debt reporting requirements of the Office of Management and Budget, Treasury and the Department.

The SSA continues to pursue initiatives intended to prevent overpayments from occurring, improve the ability to detect overpayments in a more timely manner, collect debts more efficiently and enhance the capabilities of automated systems to account for the control of debts resulting from overpayments to beneficiaries.

In one initiative, SSA matched over 12.1 million State and Federal death reports against its master beneficiary records and identified about 30,000 cases for further verification. So far, about \$37.1 million in incorrect benefit payments has been identified.

A second SSA initiative is designed to identify, categorize and set target numbers of resolution of backlogged OASDI delinquent debt. In FY 1986, SSA expects to clear \$130 million in backlogged debt.

The OIG studied an issue that is causing an excessive burden on SSA claimants. The Social Security Act provides that administrative law judges (ALJs) are to evaluate the reasonableness of fees attorneys charge claimants for representing them in appeals of SSA decisions. Regulatory criteria has been established for ALJ evaluations. The review found that ALJs generally gave perfunctory approval to fee arrangements instead of following the regulatory criteria. The perfunctory approval resulted in a significant number of claimants paying excessive fees. In one case, a 52-year-old man with severe back pain was awarded past-due benefits of \$10,887. The ALJ authorized the attorney's fee of \$2,772 which was taken from the award. The attorney worked on this case for only 7½ hours. The hourly equivalent of the fee was \$375. In another case, a 57-year-old man with severe back pain was awarded \$14,076. In this instance, the ALJ approved the requested fee of \$3,000 for 6 hours work, an hourly equivalent of \$500.

#### **ATTORNEYS' FEES**

Overall, OIG found that about 45 percent of the fees approved by ALJs in 1984 were above the \$75 per hour limit that the Equal Access to Justice Act generally places on attorney fees the Federal Government will pay successful litigants in suits brought against the Government. Because of the nonadversarial nature of SSA appeals hearings, OIG considers that fees above the \$75 limit are excessive. Of the \$100 million in attorney fees charged successful Social Security claimants in 1984, an estimated \$23.6 million represented excessive charges.

OIG noted that SSA has proposed simplifying the fee approval process by allowing automatic approval of fees under \$3,000 up to a limit of 25 percent of benefits awarded. Implementation of this proposal would exempt 95 percent of

attorney fees now subject to review and would further encourage excessive fees.

The OIG recommendations call for regulatory changes to fee determination criteria that would limit fees and permit easy and consistent application of criteria by ALJs. The SSA agrees with OIG's concerns and is considering courses of action, including OIG's recommendations to correct this situation.

**ILLEGAL SS CARDS  
AND NUMBERS**

Large drains on the Social Security trust funds, as well as commercial fraud throughout the economy, are being perpetrated using counterfeit or illegally obtained Social Security cards and numbers. The OIG took steps towards closing the door on those who obtain Social Security cards illegally. Because many of these illegally obtained cards are used to defraud Government programs, SSA's procedures for handling requests for Social Security numbers were reviewed. The OIG recommended that SSA tighten their control of the issuance process by: (1) building additional automated controls into the system; (2) abrogating agreements with 37 States where welfare agencies take applications for SSNs; and (3) placing employees at selected Immigration and Naturalization Service locations to process SSN requests by newly arrived, legally admitted aliens.

**APPLICATIONS FOR  
SOCIAL SECURITY  
NUMBERS**

Due to the continued use of illicitly obtained Social Security numbers in defrauding Government programs, the OIG reviewed SSA's procedures for handling requests for SSNs. The review found that the SSA employees responsible for reviewing the applications for SSNs were confident that they could identify stolen, forged or counterfeit documents. Moreover, the random review process established by SSA to monitor the applications is lightly regarded by management and is susceptible to manipulation by the reviewer. The review also found that welfare agencies in 37 States processed 1.6 million applications for SSNs in FY 1985, and that SSA receives "second class service" from these agencies in terms of accuracy, duplicate application, and the internal controls. Another finding was that SSA district offices encounter difficulties in determining the validity of Immigration and Naturalization Service documents presented by foreign-born applicants to obtain SSNs.

**FALSE SSNs TO  
OBTAIN BENEFITS**

A significant part of the OIG's investigative activity is generated because of the illegal use of Social Security cards. Through the use of another person's SSN or through the creation of a fictitious SSN, millions of dollars in welfare, disability, unemployment and other benefits are paid each year. Sometimes the fraud is discovered incidental to other crimes. Some examples follow.

- In California, a legally blind man who was caught burglarizing a transit ticket machine in 1981 was serving a 15-year sentence for obtaining disability benefits using SSNs of children killed years before in airplane accidents. He escaped from prison, and was found in Michigan after being involved in an automobile accident. He had already established two new identities and SSA benefit files.
- A Michigan cocaine courier was found to have used 23 SSNs and 2 assumed names to defraud the State and the Federal Government out of more than \$79,000 in unemployment insurance compensation. His scheme was discovered while he was being prosecuted for possession of a large quantity of cocaine.
- In Pennsylvania, a search of a woman's home for evidence of suspected arson and insurance fraud turned up false identification and SSNs. She also had a stock portfolio and bank assets of \$160,000 and \$37,000 in insurance payments from burglary and arson losses on rental properties. Evidence proved that she was part of a conspiracy that included seven other persons—two of them policemen—who were using the fake SSNs to obtain welfare payments. Total losses amounted to about \$30,000 in SSI benefits and \$32,000 in welfare payments. The woman was sentenced to 2 years in prison and had to pay \$38,000 in fines and restitutions. The woman's mother and brother were convicted for aiding her by making false statements. Her boyfriend was sentenced to 3 years in prison for his part, plus he was ordered to make \$25,000 in restitution for his 82-year-old mother's part in the conspiracy.

A persistent problem is the purchase of false SSNs by illegal aliens. Social Security cards and numbers allow them not only to obtain welfare and other benefits but also to work. To meet the need, small industries have sprung up to meet the demand for these identifiers.

## ILLEGAL ALIENS

- In California, a raid on an illegal document ring turned up about 9,000 false Social Security cards, as well as 20,000 counterfeit immigration forms.
- Also in California, four persons—including a former SSA employee—were convicted in a continuing investigation of the sale of valid Social Security cards to illegal aliens. The employee was convicted and sentenced to 3 years imprisonment.

The impact of illegally obtained SSNs to get program benefits and work may be minor in relation to that of other scams based on these identifiers. Social

Security numbers are required for many purposes, such as driver's licenses, credit cards and bank accounts, and can be used to conduct and conceal illegal schemes, as shown in the following examples.

- A Texas man was sentenced to 5 years in jail and ordered to repay \$61,000 for using fictitious names and SSNs to get credit cards and bank accounts.
- In Oklahoma a man who used three different names and SSNs on loan applications must spend 2 years in jail and repay \$41,000 on six bank loans.
- In a series of continuing trials in Washington, D.C., members of a minority religious sect have been convicted of various types of fraud including the use of false SSNs to obtain welfare, fake credit cards and bank accounts. The money obtained through these means was used to support sect members both here and abroad. In addition, the SSNs were used to assist fugitives to escape prosecution.

**REQUIRING  
SOCIAL SECURITY  
NUMBERS**

While SSNs are often used for unscrupulous purposes, they are also used by the Government as a method of checks and balances so that duplicate payments are not made. One of those areas where duplicate payments are made is with auxiliary beneficiaries.

Current law precludes SSA from requiring auxiliary beneficiaries' dependents or survivors of a wage earner to furnish their Social Security numbers (SSNs) as a prerequisite to receiving monthly benefits. Because of this collection of some \$29 million in overpayments from 45,500 auxiliary Social Security beneficiaries may be jeopardized. The OIG conducted a study and found that because SSA does not have SSNs recorded for those beneficiaries, it cannot trace overpayments to them or recover the funds if the beneficiaries subsequently become entitled to benefits under their own SSN or another account number. Without beneficiary SSNs, 1.2 million auxiliary accounts are bypassed by programs designed to detect overpayments. This problem becomes more acute over time because each month about 2,100 auxiliary records are being added without SSNs.

The OIG recommended that SSA (1) seek legislative authority to require applicants to furnish an SSN or an application for an SSN as a prerequisite to the payment of monthly benefits and (2) enhance the use of such SSNs in programs that monitor continuing eligibility, payment accuracy and overpayment recovery.

Subsequent to the review, SSA submitted a legislative proposal for departmental review which addressed the issue contained in the recommendation.

Under the Social Security Act, States make disability determinations for Titles II and XVI disability benefits. Administrative costs incurred by States in making these determinations are reimbursable by SSA. Audits of those costs are made by certified public accountant firms under contract with the OIG.

**DISABILITY  
DETERMINATION  
PROGRAM**

In one such audit, unallowable administrative costs claimed by a State over a 3 1/2 year period were \$2.6 million. Most of these costs related to the State's allocation of excessive and unnecessary office rental expense, imputed interest income to the State and inappropriate transfer of personnel to the disability determination program. The SSA concurred with all of the OIG's findings and recommendations.

The OIG also found fraudulent programmatic activities in Social Security disability insurance programs. It is discomfoting to find individuals that conceal information in order to steal from the disability insurance program. The following are just three examples:

- A New York man falsely obtained over \$79,000 in disability benefits even though he earned \$30,000 using a fictitious name as the owner of a flooring company.
- A Chicago man was convicted of receiving disability benefits amounting to \$21,000 while working full time for the Chicago Board of Education.
- A Florida deputy sheriff was convicted for acquiring \$31,000 in disability payments by concealing wages earned from various employers for over 10 years.

Concealing information of this type is not limited to the disability insurance program. The OIG's investigative activities resulted in three convictions of SSI recipients who hid substantial resources to obtain benefits. These cases were identified by matching SSI beneficiary rolls against IRS tax records. These and other examples follow.

**SUPPLEMENTAL  
SECURITY INCOME  
PROGRAM**

- A Federal employee pled guilty to receiving SSI payments amounting to \$20,000 over 8 years while employed by the Justice Department.
- More than \$10,000 was recovered from an SSI recipient who had over \$220,000 in certificates of deposit with a California savings and loan organization.

- A representative payee for an SSI recipient agreed to repay more than \$12,000 after it was discovered that the SSI recipient had resources in excess of \$200,000.

#### **CONCEALING INFORMATION**

Two other income concealment cases highlight examples of individuals who not only stole from the trust funds but also from children.

- A 66-year-old Chicago grandmother stole nearly \$20,000 in Social Security benefits intended for the care and housing of her grandson. Although she allowed the child to be adopted in 1975, she did not tell SSA, continuing to take the monies and spending them for her own use.
- A North Carolina father who served as representative payee for his two minor children was sentenced to 3 years in prison and ordered to pay restitution of \$20,000. He did not disclose that he was not living with his children, and was using their benefits for his own purposes.

#### **REPRESENTATIVE PAYEE ACCOUNTABILITY**

Because of a number of similar problems with representative payees, the OIG reviewed the issue to determine if corrective action could be taken.

The SSA requires representative payees to provide an annual accounting of use of funds on behalf of the beneficiary. Reporting forms, which include a penalty statement and require a signature, are mailed to the payees. The OIG found that if the form is not returned or is incomplete SSA attempts a personal contact. When the personal contact is made an interview is conducted to determine how the funds were used by the payee. It also significantly weakens the possibility of criminal prosecution when it is indicated. Based on the findings, the OIG recommended that SSA revise the interview form to provide for the payee's signature.

The SSA has informally agreed to issue instructions to obtain a signed statement from the payees during these interviews.

#### **INCONSISTENT PROCEDURES FOR HANDLING UNDELIVERABLE RETURNED MAIL**

The OIG found another area of vulnerability in the processing of returned mail. Mail addressed to SSA beneficiaries is frequently returned as undeliverable. The mail could be anything, SSN cards, Medicare cards, benefit increase notices, etc. The SSA has numerous procedures for handling such mail, but there is a disparity concerning the degree of emphasis placed on the importance of post-adjudicative action in the event that delivery cannot be accomplished. An example of a situation where appropriate action was not taken involved the mailing of a Medicare card to a beneficiary. The card was returned to SSA as undeliverable and merely filed in a claim folder. No attempt was made to

determine why the card could not be delivered. Four years later it was discovered that the woman was deceased but SSA had not been notified of the death. To correct this type of problem, the OIG recommended that SSA develop a general guideline which would establish basic procedures to be followed regardless of the type of mail that is returned as undeliverable.

The SSA has informally agreed with the recommendation and will include such guidelines in their operating procedures.

The major problems involving the world's largest computer operation continue uncorrected. In the 1970's, SSA identified inadequate software as a major underlying factor causing chronic systems problems. The SSA Systems Modernization Plan (SMP) emphasized the improvement of software and the creation of an optimal software engineering environment, i.e., the procedures, practices, standards and technological approaches for software production.

## **SYSTEMS MODERNIZATION PLAN**

The OIG previously pointed out problems and delays in the software initiative and made recommendations for improvements. The General Accounting Office (GAO) and General Services Administration (GSA) also expressed concerns about slow progress in SSA's software program.

- Four of the nine current SSA initiatives at the Commissioner's level are dependent upon software engineering for their ultimate success.
- Software improvement has been exaggerated in SSA status reports. The OIG and GAO reports have pointed out that little substantive progress has been made.
- Changing entrenched software practices is difficult. Consequently, only a strong continuous effort by management will eradicate poor programming practices and enforce use of structured coding, adequate software documentation and modern software tools.
- Excessive reliance is being placed on top-down analysis and business system planning. Management fails to recognize that SSA systems problems, and their solutions, lie at the fundamental level of programming practices.
- There is a lack of clear and measurable software engineering milestones which could be monitored by HHS management.
- Progress has been made difficult by frequent shifts in organizational responsibility and staffing for software engineering.

These obstacles warranted an OIG recommendation to elevate the software engineering commitment to the Commissioner's level. The report is currently with SSA for comment.

**SOCIAL SECURITY DEPOSITS**

Currently, SSA requires State and local employers to make consolidated semi-monthly deposits for Social Security contributions on the wages of their employees. Social Security contributions made by the States total about \$19 billion annually.

The semimonthly schedule requires States to make single consolidated deposits for all covered employers twice each month. To meet this requirement, individual employers are generally allowed about 1 week after a biweekly payday to get their deposits to the State for consolidation. Smaller scale employers, who constitute about 35 percent of those reporting, are generally not capable of meeting such a time frame. Without a flexible deposit schedule that recognizes their processing limitation, noncompliance could be expected to become a significant problem.

The Inspector General's previous semiannual report noted that acceleration of the semimonthly deposit schedule to the more frequent and flexible private sector schedule would increase trust fund interest income and contribution receipts by a total of \$1.4 billion over a 5-year budget cycle. Requiring individual employers to deposit on the private sector schedule directly with IRS would provide the flexibility in deposit timing which is needed by smaller employers. It would also accelerate the deposits of larger employers who generally can meet tight deadlines.

To encourage compliance with accelerated deposit requirements, OIG also recommended that the 6 percent interest rate charged on late State Social Security deposits be increased commensurate with the market level rates currently charged on late private sector deposits. These recommendations have still not been implemented.

The OIG is pleased to note that the proposals to require State and local employers to follow the private sector schedule is currently under congressional consideration.

**SSA SYSTEM ISSUES**

The OIG is looking at two other systems issues that when corrected could save millions for the trust funds annually. One issue relates to the starting point from which interest is computed by Treasury when using recovered trust fund payments. The other relates to the calculation of non-resident alien taxes.

- The SSA transfers trust funds to Treasury to cover payment of OASDI benefit checks. Payments subsequently found to be erroneous and recovered by Treasury are restored to the trust funds. Under a 1984 agreement, Treasury pays the trust funds interest on certain of these recoveries for the interval it had use of the funds. While the agreement resulted in \$900,000 in investment income to the trust funds in 1985, an ongoing OIG review estimates that the trust funds could realize another \$5 million in investment income each year if more equitable dates were used in computing interest on recoveries.

### **CREDIT FOR RECOVERED BENEFITS**

Funds are transferred to Treasury based on the issue date of benefit checks plus a 4-day float period (normally required by beneficiaries for cashing such checks). Treasury, however, generally does not provide the trust funds the same treatment for recovered benefits. Instead, Treasury often credits the trust funds as of the date SSA notified Treasury that an erroneous payment had been made. The OIG is planning to recommend that earlier, more equitable dates be used for computing investment income on recovered trust fund payments. For unnegotiated checks this would be the date of check issuance plus the float period. For negotiated checks this would be the date Treasury recovered the funds.

- The 1983 amendments to the Social Security Act provide for the withholding of a tax from OASDI benefits payable to nonresident aliens. Under the provisions of these amendments, which also amended the Internal Revenue Code, half of nonresident aliens' benefits are taxed at a rate of 30 percent. Beneficiaries residing in countries having an approved tax treaty with the United States will be entitled to reduced withholding or exemption from the alien tax.

### **NONRESIDENT ALIEN TAX**

Proceeds from these taxes accrue to the Social Security trust funds. The SSA acts as a withholding agent for IRS, because IRS is the only agency with authority to collect Federal taxes.

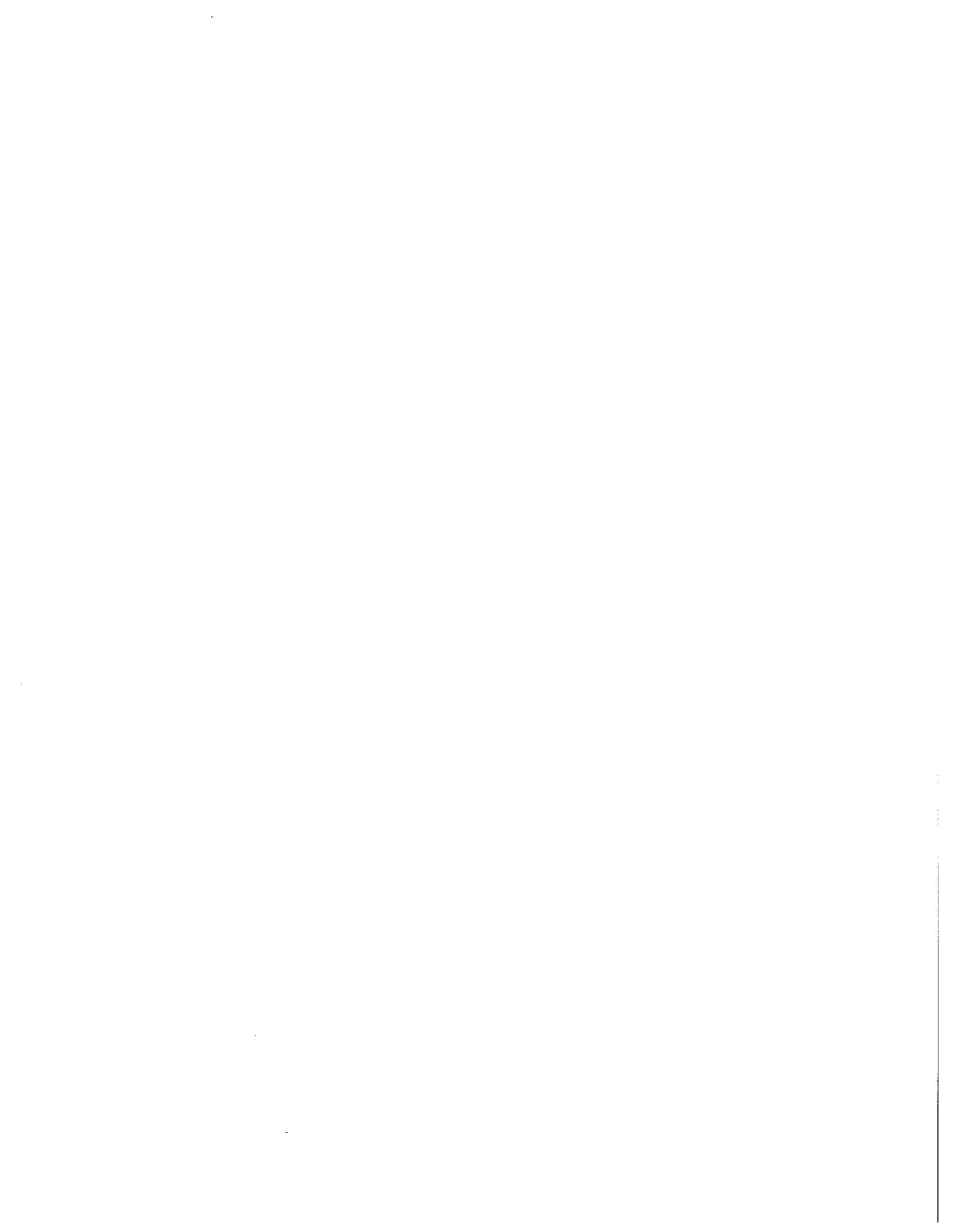
The OIG's ongoing review found that since January 1984, SSA has not fully resolved policy issues which would enable it to calculate and collect overpayments from beneficiaries subject to nonresident alien taxes. Draft policy guidelines were recalled for major revisions. As a result, a backlog of approximately \$10.8 million in overpayments and \$2.3 million in underpayments has not been resolved. As the review continues, recommendations will be developed to remedy this situation.

Occasionally program fraud is committed by SSA employees, as illustrated in an earlier example of selling SSA cards to illegal aliens and in the following cases. (See page 23.)

### **SSA EMPLOYEE FRAUD**

- An SSA contract representative in California became involved in a ring with at least four other persons who were stealing and cashing Social Security checks from various sources. The employee was sentenced to 3 years probation, 100 hours of community service, and ordered to stay away from gambling and to participate in a narcotics addiction treatment program. The others were also sentenced, with the ringleader getting 5 years in prison.
- In Ohio an operations supervisor was convicted of helping her boyfriend cash Social Security checks he had stolen from a postal vehicle. She was fired from her SSA job.

# GRANTS AND INTERNAL SYSTEMS



## Chapter III

### GRANTS AND INTERNAL SYSTEMS

Grants and Internal Systems (GIS) activities cover the programs and operations of the Public Health Service (PHS), the Office of Human Development Services (OHDS), and the new Family Support Administration (FSA), as well as HHS internal management, which includes payroll, personnel, procurement and debt collection.

From April 1 through September 30, 1986, the OIG identified opportunities for cost savings of almost \$1.4 billion through increased efficiency of program operations and management. In addition, disallowances were recommended of \$29.2 million of costs claimed by grantees. The OIG also obtained 63 successful prosecutions and almost \$1 million in related savings and recoveries from defrauders of the programs.

The Department, and specifically the OIG, has audit cognizance responsibility for 945 State and local governments, 2,800 colleges and universities and thousands of other entities receiving funds from any Federal agency. For assistance the OIG relies on nonfederal auditors to provide basic audit coverage of entities' management of Federal funds and compliance with program regulations. To ensure the adequacy of that coverage, OIG reviews and evaluates each nonfederal audit report for adherence to governmental auditing standards and for audit findings or leads requiring OIG action. During this period, 1,408 reports were reviewed and issued and 222 returned for revision or rejected. In all, these reports covered over \$14 billion in Federal funds.

The OIG continues to identify program areas where funds could be more efficiently spent as well as to pinpoint and recommend correction of system deficiencies that give rise to fraud, waste and abuse. The OIG looked at the effectiveness and fiscal efficiency of selected agency programs; collection and cash management activities, both departmentwide and by agency; and adequacy of internal controls and the Department's reviews of these controls.

#### Public Health Service

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

(CDC); Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); and the Health Resources and Services Administration (HRSA). These agencies promote biomedical research, disease prevention, safety and efficacy of marketed food and drugs, as well as other activities that support better health for Americans. Program improvements recommended by OIG are expected to result in annual savings of \$19.8 million. Questionable grantee charges to PHS programs totaled \$6.8 million.

**HEALTH  
EDUCATION  
ASSISTANCE LOANS**

Under the Health Education Assistance Loan (HEAL) program, PHS insures loans made by nonfederal lenders to students in the health professions. In return, PHS charges borrowers a percentage of the loan amount as an insurance fee. These fees are deposited in a revolving fund used to pay lenders for defaulted loans. No appropriated funds are to be used to pay claims. Since the inception of the program in 1978, PHS had guaranteed 54,000 loans totaling \$950 million and paid default claims of \$13.7 million.

The PHS actions to reduce the rapid growth of lenders' claims against the program have not proved fully effective. During FYs 1984, 1985 and the first 6 months of FY 1986, claims have doubled with each succeeding period.

The OIG follow-up review of recommendations made in 1984 showed that PHS had not promptly finalized and implemented regulations to strengthen collection requirements imposed on lenders and to control unnecessary borrowing by medical students. In addition, PHS needs to obtain authority to raise insurance premiums and set higher premiums on loans to students in disciplines having a higher rate of default.

Unless actions are taken to reduce drastically the growth in claims, the loan insurance fund will be exhausted and an estimated \$20.5 million in appropriations will be needed to pay FY 1988 claims. In succeeding years, the need for appropriated funds will increase sharply. The PHS believes the OIG estimates of future claims too high, but generally agreed with most recommendations. However, PHS did not agree with the OIG recommendation to link the premium charged with the experienced claim rate in disciplines with unusually high rates of default.

The OIG's estimates of future growth of defaults rests on past experience adjusted for reductions expected from program reforms. The OIG remains concerned about the solvency of the student loan insurance fund before new program controls are fully effective and believes further action must be taken when three disciplines account for 70 percent of claims.

The OIG also found that PHS agencies are continuing to contract for new construction and major renovation projects without first obtaining required reviews and approvals—which if obtained would have likely reduced contract costs by \$18.6 million.

## **CONSTRUCTION APPROVALS**

Specifically the review found that:

- The NIH funded three construction contracts by shifting \$4.5 million from appropriations intended for program operations or repairs.
- The PHS's FY 1987 budget submission included \$43 million for NIH and CDC construction projects that had not received required PHS reviews. Historically, such reviews have resulted in reductions in project scope of about 15 percent which in these instances would have reduced budgeted construction costs by \$6.5 million.
- The NIH advertised for the design and construction of an unapproved project having an estimated cost of \$51 million. Had PHS review been received, it is estimated (using the 15 percent factor noted above) that costs would have been reduced by \$7.6 million.

The OIG recommended that controls be implemented to ensure compliance with the established contract review and approval process. The PHS concurred with the report's recommendations and is already taking action to implement them. However, PHS does not believe that data from past savings can be annualized.

An OIG review disclosed that a Hill-Burton construction grant obligated in 1973 had an unliquidated balance of \$1.2 million. These funds could no longer be used for the construction of a health center because the original plans were terminated. However, because the funds were from "no-year" appropriations, they are reprogrammable for other valid purposes or available for reducing future budget authority. The PHS agreed with the OIG's recommendation to deobligate the funds.

## **UNLIQUIDATED CONSTRUCTION OBLIGATION**

The OIG continues to monitor the Department's debt collection activities quarterly. For the quarter ended December 31, 1985, the OIG examined the Public Health Services' debt collection activities. The OIG also assessed action taken to resolve prior problems in meeting debt reporting requirements of the Office of Management and Budget, Treasury and the Department.

## **DEBT MANAGEMENT**

Since the last review, PHS has shown continuing progress in improving its debt collection practices. However, certain problems linger.

Prior reviews identified accounting errors in subsidiary ledger entries for loans receivable for the Health Professions Student Loan and Nursing Student Loan programs, which represent about 60 percent of PHS's debt receivables. The PHS plans to begin the much-needed reconciliation of the loan accounts' balances once the Office of the Secretary moratorium on systems development is lifted and the integrated debt management system is implemented.

### Office of Human Development Services

The Office of Human Development Services (OHDS) provides services to the Nation's children, youths and families, older and disabled Americans. The OIG reviewed OHDS operations and identified questionable grantee charges to OHDS programs of \$7.7 million.

**HEAD START** Audits of Head Start program grants are made by nonfederal auditors. Prior to issuing the reports to OHDS, they are reviewed by OIG for matters requiring immediate action such as possible fraud or abuse, conformance to established Federal guidelines and findings requiring departmental action. During this period, 506 reports were evaluated with recommended adjustments of \$5 million in costs charged to the program. These reports also cited numerous deficiencies in grant administration, such as problems with accounting, internal controls and recordkeeping practices.

**HEAD START ADMINISTRATIVE COSTS** An inspection of Head Start administrative costs found a moderate, but potentially growing, problem with grantees exceeding the statutory limit on administrative and developmental costs. The current limit for those costs is 15 percent of the total grantee budget. Twenty-four percent of grantees reported administrative costs levels of 14 percent or above for a 3-year period; while a yearly average of 8 percent of grantees were at or above the cost ceiling. The inspection found that independent auditors for grantees rarely verify compliance with the statutory limit; policy governing administrative costs was lacking in clarity, specificity, and uniformity of interpretation; and OHDS regional offices were lacking in their analysis of, and controls over, grantee administrative costs. The OIG recommended that there be requirements for more specific identification of administrative costs by grantees, more thorough analysis and documentation of costs by regional offices, and a general strengthening of controls over this

category of Head Start grantee expenditures. The OHDS plans to follow up on OIG recommendations to correct these deficiencies.

Title IV-E Foster Care grants are awarded to States to assist in providing eligible children with routine care and maintenance as well as to assist in the costs of administering the program. Recent OIG reports on two States' claims identified improper charges of \$2.4 million. Unallowable costs included: charges for ineligible children, unallowable social services costs, and administrative costs that did not benefit the program.

#### **FOSTER CARE**

The OIG recommended that the States make financial adjustments totaling \$2.4 million and appropriate procedural changes.

An OIG study of youth suicide found that among the HHS grantees surveyed, runaway programs are most involved in detecting and intervening with youth at risk of suicide. Most family planning programs, community health centers and migrant health centers are only minimally involved in efforts to detect or deter youth suicide.

#### **YOUTH SUICIDE**

The OIG study findings further indicated that the most significant gaps in local service systems include: (a) too few inpatient adolescent psychiatric beds, particularly for public pay patients; (b) limited sub-acute and alternative living arrangements, including residential and day treatment, group homes and foster care; (c) limited outpatient treatment in community mental health centers where demands exceed supply; and (d) too few crises intervention programs and hotlines focusing on youth.

The OIG recommended that the Department educate the public about the seriousness of youth suicide; assure that grantees serving youth receive adequate training and technical assistance on issues related to suicide and other self-destructive behaviors; continue to fund research on youth suicide, including evaluation of the effectiveness of suicide prevention models; and identify a departmental coordinator for youth suicide-related initiatives.

### **Family Support Administration**

Established as a separate agency April 1, 1986, the Family Support Administration (FSA) provides Federal direction and funding for such State-administered

programs as Aid to Families with Dependent Children, Child Support Enforcement, Refugee and Entrant Assistance, Community Service, Work Incentive and Low Income Home Energy Assistance. Each of these programs is designed to promote the stability, economic security, responsibility and self-support of our Nation's families. During this reporting period OIG recommended improvements in FSA programs that could result in annual savings of \$1.3 billion. In addition, OIG reviews identified questionable State charges to the programs of \$14.7 million.

**SHELTER  
ALLOWANCE**

Under current law, States may provide Aid to Families with Dependent Children (AFDC) recipients an allowance for actual shelter costs up to a maximum amount; however, not all States do.

Currently, 41 States pay AFDC recipients a standard amount for basic needs, including shelter. In 33 of these States about 800,000 recipients, who reside in subsidized housing, receive an amount for shelter in their AFDC grant which is greater than the costs they actually pay—thereby duplicating shelter benefits. Eliminating the duplicate portion when computing AFDC benefits would produce significant Federal and State savings (estimated at \$485 million annually) and provide a more uniform and equitable assistance payment to all AFDC recipients, both those who reside in subsidized housing and those who do not.

The OIG recommended that FSA seek a legislative change to require that all States pay actual shelter costs, up to a maximum amount, aside from that portion of the assistance payment designated for other needs. The OIG final report is currently with FSA for review. In commenting on the draft report, the agency disagreed with the recommendations, believing among other things, that such a change would limit State flexibility.

**REFUGEE/ENTRANT  
PROGRAM**

Under the 1980 Refugee Act, States are reimbursed for cash, medical assistance and social services provided refugees and entrants. An OIG follow-up review of one State's practices found that the State had continued to charge the Refugee and Entrant Assistance program for cash assistance payments to ineligible recipients over a 27-month period. Included in the State's claim were payments to refugees and entrants in this country beyond the time limit specified for assistance as well as to persons who were neither refugees nor entrants. Besides specific procedural changes, the OIG recommended that the State make a financial adjustment of \$3.8 million identified as program overcharges.

**ENERGY  
ASSISTANCE**

The 1981 Low Income Energy Assistance Program (LIEAP) provides grants to States to help low income families offset rising energy costs. An OIG review

disclosed that one State improperly charged LIEAP \$6.8 million for a 12-month period.

Included in the State's claim for Federal reimbursement were payments made to ineligible households and overpayments to eligible households. The State also failed to credit LIEAP for cancelled payments. Financial adjustments totaling \$6.8 million were recommended.

The Child Support Enforcement program is a Federal/State effort to obtain child support from absent parents. One of the goals of the program is to reduce assistance costs by collecting child support for AFDC families. The 1984 Deficit Reduction Act amended the Social Security Act to require that the first \$50 of each month's child support collected from the absent parent be paid to the AFDC family. This \$50 payment (referred to as the \$50 disregard) does not affect the family's AFDC grant. The purpose of the amendment is to secure greater cooperation from the custodial parent in locating the absent parent.

#### **AFDC CHILD SUPPORT**

Results in one State of an ongoing OIG review disclosed that the \$50 disregard has not served as a major incentive for AFDC recipients to provide information on absent parents and does not appear to result in additional collections. Although child support collections increased during the first full year of implementation of the \$50 disregard, State officials attributed the increase to new or enhanced collection efforts. The review also found that processing the \$50 payments and recalculating food stamp budgets has been a major administrative expense. (The Food Stamp program does not disregard the \$50 collection.) If reviews in other States show similar findings, a recommendation will follow to eliminate the \$50 disregard provision. Elimination of the provision would result in annual AFDC savings estimated at \$200 million, half of which would be the Federal share.

The national 6 percent quality control error rate in the AFDC program costs State and Federal governments approximately \$863 million annually (based on FY 1984) in payments to ineligibles and overpayments to eligibles. In 1984, only five States had fallen to the legally allowable 3 percent error rate.

#### **AFDC ERROR RATES**

The OIG findings revealed that a number of factors make error rate reduction difficult in the States. The most notable factors were inconsistent interpretation of complex AFDC policies, and failure of States to hold local offices accountable for errors and lower reduction rates in urban areas. On the other hand, many rural States are more successful in error reduction because they have fostered the attitude that every person in the AFDC "network" is important and accountable for assuring the accuracy of benefit payments.

The OIG recommendations included continuing the Federal AFDC disallowances for States exceeding error rate levels and the development of Federal management initiatives and incentives aimed at helping States focus on payment accuracy. The impact of the excessive error rate is that each percentage drop in the national error rate represents \$144 million annually that would not be required to support State and federally financed government programs.

**STATE FRAUD  
DETECTION IN  
AFDC**

Another review looked into the methods used by States to detect, investigate and prosecute fraud in the AFDC program. The study found that AFDC fraud is a serious problem that is not responding to traditional anti-fraud efforts. AFDC fraud detection is a low priority in most States. Data collection techniques are insufficient to determine the scope of fraud in the AFDC program. Also, no fiscal incentives exist for the States to detect fraud more aggressively and no administrative sanction authority exists to deter perpetrators. Inadequate training of eligibility workers and heavy caseloads also inhibit appropriate fraud detection efforts. The OIG found that with improved pre-eligibility techniques States could save approximately \$800 million annually.

**AFDC STATES  
BENEFITS PROJECT**

The AFDC States Benefits Project was established to assist State and local agencies in the detection and prosecution of fraud against income maintenance and benefit programs. With the OIG assistance, State and local agencies can obtain information on the accuracy of SSNs used by applicants for benefits, eligibility for and payment of SSA benefits, and the issuance of benefit checks by the Treasury Department. During this period, 26 convictions and \$841,000 were obtained, for a total of 152 convictions and \$1.4 million in collections for the year.

## **Departmental Management**

The Office of the Secretary provides overall direction for departmental activities and provides common services such as accounting and payroll to departmental operating divisions. The OIG focus during this period was on the Department's internal control systems, debt management practices, audit resolution activities and personnel functions.

**INTERNAL  
CONTROLS**

The 1982 Federal Managers' Financial Integrity Act (FMFIA) requires Federal agencies to establish a continuous process for evaluating and improving internal administrative and accounting control systems and to report annually to the

President and Congress on the status of those systems. The Assistant Secretary for Management and Budget (ASMB) manages the Department's FMFIA effort.

The OIG's interim report on the status of the Department's FY 1986 efforts advised the Assistant Secretary that if all components are to complete their scheduled FY 1986 FMFIA activities in a timely and effective manner, prompt attention must be devoted to:

- *Resolution of weaknesses reported in earlier FMFIA reviews.* The OIG found that as of May 31, 1986 few of the internal control weaknesses previously reported by the Department had been corrected. For example, of 29 reported weaknesses planned for correction in FY 1986, actions on 26 were either not started or not completed.
- *Completion of scheduled internal control reviews.* Meeting scheduled completion dates for internal control reviews continues to be a major concern. The large number of FMFIA reviews that will not be completed until late in the fiscal year (224 planned reviews were off-schedule as of May 31) will prevent OIG and ASMB from effectively evaluating component efforts.
- *Performance of accounting systems reviews.* Corrective action has now been postponed 3 years pending implementation of the departmental Financial Administrative Integrated Management System (FAIMS).

The ASMB has taken prompt action on the OIG's report.

The proportion of Federal audits performed by certified public accountant (CPA) firms and State auditors continues to grow in both numbers and dollar volume. During the 6-month period ending September 30, 1986, 1,408 reports were issued containing recommendations for cost recoveries of over \$45 million. The reports also identified opportunities for improving the efficiency of grantee management systems. Statistical results of reviews this period are:

#### NONFEDERAL AUDITS

Reports issued without modifications	1,090
Reports issued with modifications	318
Returned to auditor	202
Unacceptable reports	<u>20<sup>1</sup></u>
Total audit reports processed	1,630

<sup>1</sup> One of these nonfederal audit reports (relating to the Head Start program) was referred to the appropriate State Board of Accountancy and the cost of the audit was recommended for disallowance.

**HHS WORKERS'  
COMPENSATION  
PROGRAM**

The HHS must continue to pay employees for up to 45 days for time lost due to job-related injury or illness. After 45 days, the Department must pay two-thirds or three-fourths of gross pay depending on the number of dependents. Unless the employee returns to work, these payments continue indefinitely. All injury-related payments are made by the Department of Labor (DOL) and reimbursed by HHS. In 1985, HHS payments to DOL totaled over \$18 million—a 38 percent increase over 1981 when the Department paid about \$13 million.

Weaknesses in departmental guidance and oversight of the injury claims process were disclosed in an OIG report. Lack of adequate guidance has resulted in at least one HHS agency not adequately monitoring the status of injured employees to facilitate their return to work. For example, the Department is only paying for HHS claimants. The Department is implementing the OIG's recommendations to develop appropriate systems and guidance.

**GOVERNMENT-  
WIDE ISSUES**

Much of the OIG's GIS efforts have focused on issues that cut across all HHS programs and in many instances programs of all Federal agencies having contracts and grants with State and local governments, colleges and universities, and nonprofit research organizations. These reviews examine methods used in allocating statewide and grantee indirect costs to Federal programs. Some examples are discussed below.

- *Internal Service Funds* - Internal services (such as telecommunications and printing) are provided by one governmental unit to other units on a cost reimbursement basis. Federally assisted programs are charged a proportionate share of these costs. The OIG reviews of 11 State and local governments have disclosed internal service fund surpluses resulting from overcharges to Federal programs. Recommended adjustments during this 6-month period totaled about \$39 million and improved State/local controls will result in millions in future year savings.

These reviews are an ongoing GIS activity and are being expanded to include examination of various allowable costs charged to the funds.

- *Self-Insurance Funds* - Self-insurance funds absorb casualty and disaster losses internally rather than purchasing protection from insurance companies. Reviews in three States identified about \$3 million in overcharges to Federal programs for self-insurance costs. The States transferred surpluses and earnings on insurance reserves to their general funds without making appropriate adjustments to insurance costs charged to Federal programs. Work will continue in this area because skyrocketing insurance costs are causing more State and local governments to elect the self-insurance route.

- *Cost Transfers at Colleges and Nonprofit Research Centers* - At two medical centers adjustments were recommended totaling \$2.7 million for salary costs inappropriately transferred to Federal programs—primarily PHS/NIH grants. These costs were not adequately supported by employee time records or otherwise documented as proper charges to the grants.
- *Statewide Cost Allocation Plans (SWCAPs)* - In two States, costs allocated to Federal programs were overstated by \$1.4 million. Overstated costs included unallowable interest on installment purchases and costs previously recovered through rentals or user charges.

In accordance with the Senate Appropriations Committee report pertaining to the Supplemental Appropriations and Recessions Act of 1980 (P.L. 96-309), the following information on departmental audit resolution activity is provided.

**AUDIT  
RESOLUTION**

**Reports with Costs Questioned**

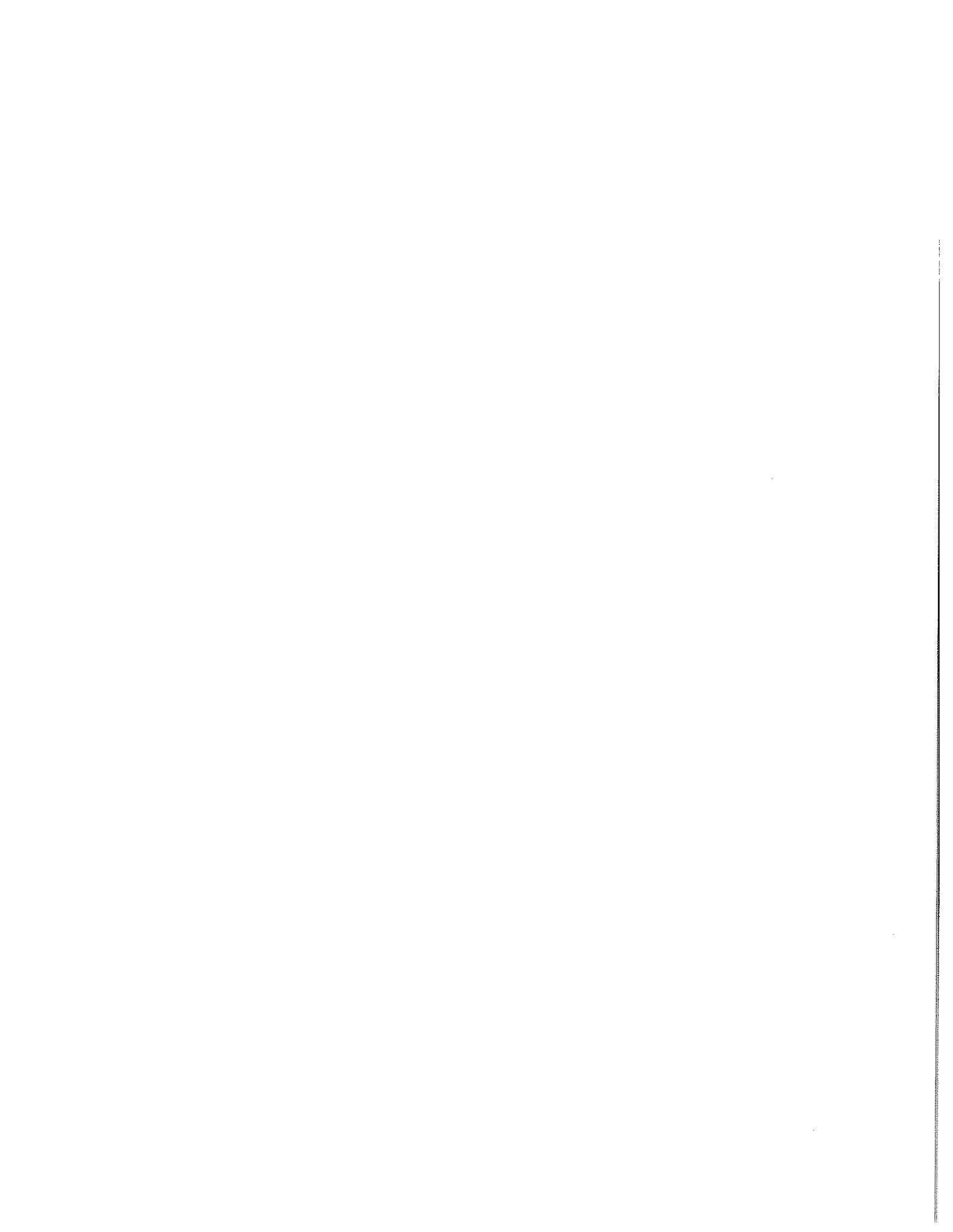
	<u>Total</u>	<u>Over Six- months old</u>
Unresolved audits, March 31, 1986	196	3
Unresolved audits, September 30, 1986	215	5 <sup>1</sup>
	<u>Number</u>	
Reports issued during period	287	
Reports resolved during period	268	
	<u>Amount (in millions)</u>	
Costs questioned during period	\$110.5	
Costs sustained during period	\$ 70.9 <sup>2</sup>	

<sup>1</sup> Includes the following:

<u>OPDIV</u>	<u>Number</u>	<u>Amount</u>
Social Security Administration	1	\$ 8,000,000
Family Support Administration	2	4,527,412
Public Health Service	1	374,537
Office of Human Development Services	1	84,317
TOTALS	5	\$12,986,266*

\* Does not include three ICF/MR reports which cannot be resolved pending resolution of court cases.

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



# APPENDIX A



## APPENDIX A

**UNENACTED LEGISLATIVE RECOMMENDATIONS  
April 1986 through September 1986**

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
<b>HEALTH CARE FINANCING ADMINISTRATION</b>		
<b>Federal Subsidy:</b>		
Trim the Federal subsidy for upper income beneficiaries Medicare Part B. (Position Paper issued June 28, 1985)	This has not been in the Department's legislative program.	\$1,300 per year
<b>Index Medicare Part B:</b>		
Raise the Medicare Part B deductible to \$100 and appropriately index it. (ACN: 09-52043)	Included in the Administration's FY 1987 budget and legislative program.	\$341 per year
<b>Buy-In Program:</b>		
Eliminate Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare. (ACN: 03-50228)	The Administration's FY 1987 legislative program contained an alternative to double the Part B premiums for individuals whose premiums are paid under Medicaid or by employers.	\$216 per year
<b>Part B Premium:</b>		
Round Medicare Part B premiums up to the next higher dollar. (Position Paper issued in January 1985)	This proposal has not been included in the Department's legislative program.	\$175 per year
<b>Medicare Round Down:</b>		
Round down to the next whole dollar Medicare Part B and other payments for Medicare services. (ACNs: 03-42006 and 14-52085)	This proposal has not been included in the Department's legislative program.	\$63 per year

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
<b>HEALTH CARE FINANCING ADMINISTRATION (continued)</b>		
<b>Chiropractor Services:</b>		
Amend the Social Security Act to cap Medicare coverage of chiropractor services at 12 per year per beneficiary. (OAI-055-86-00002)	HCFA is not in agreement with the legislative recommendation. However, HCFA has implemented carrier procedural changes to screen chiropractic services beyond 12 per year.	\$23.9 in CY 1987
<b>Nursing Home Per Diem:</b>		
Revise Medicare regulations to prohibit suppliers from billing directly for urological and enteral therapy supplies and require that nursing homes include the cost of such products in their per diem rates. (ACN: 06-42002)	This proposal has not been included in the Department's legislative program.	\$17 per year
<b>SOCIAL SECURITY ADMINISTRATION</b>		
<b>Deposits of Social Security Contributions:</b>		
Accelerating State and local deposits of Social Security contributions will increase interest income by \$39 million annually and increase trust funds revenues by \$2.6 billion over a 5-year period. (First discussed in 4/83-9/83 OIG Semiannual Report, ACN: 13-32601)	A proposal to require State and local employers to follow the private sector schedule is under congressional consideration.	\$372 the first year; \$546 per year thereafter

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
<b>SOCIAL SECURITY ADMINISTRATION (continued)</b>		
<b>Black Lung Student Benefits:</b>		
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 under consideration.	\$10.4 per year
<b>GRANTS AND INTERNAL SYSTEMS</b>		
Deny between-term unemployment benefits to all Head Start staff. (P-05-86-00008)	Included in pending Head Start reauthorization legislation.	\$21.0 per year

## APPENDIX A-1

### UNENACTED LEGISLATIVE RECOMMENDATIONS FOR WHICH PROJECTED SAVINGS HAVE NOT BEEN DETERMINED April 1, 1986 through September 30, 1986

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 Patient and Program Protection Act (H.R. 1868/S.1323).

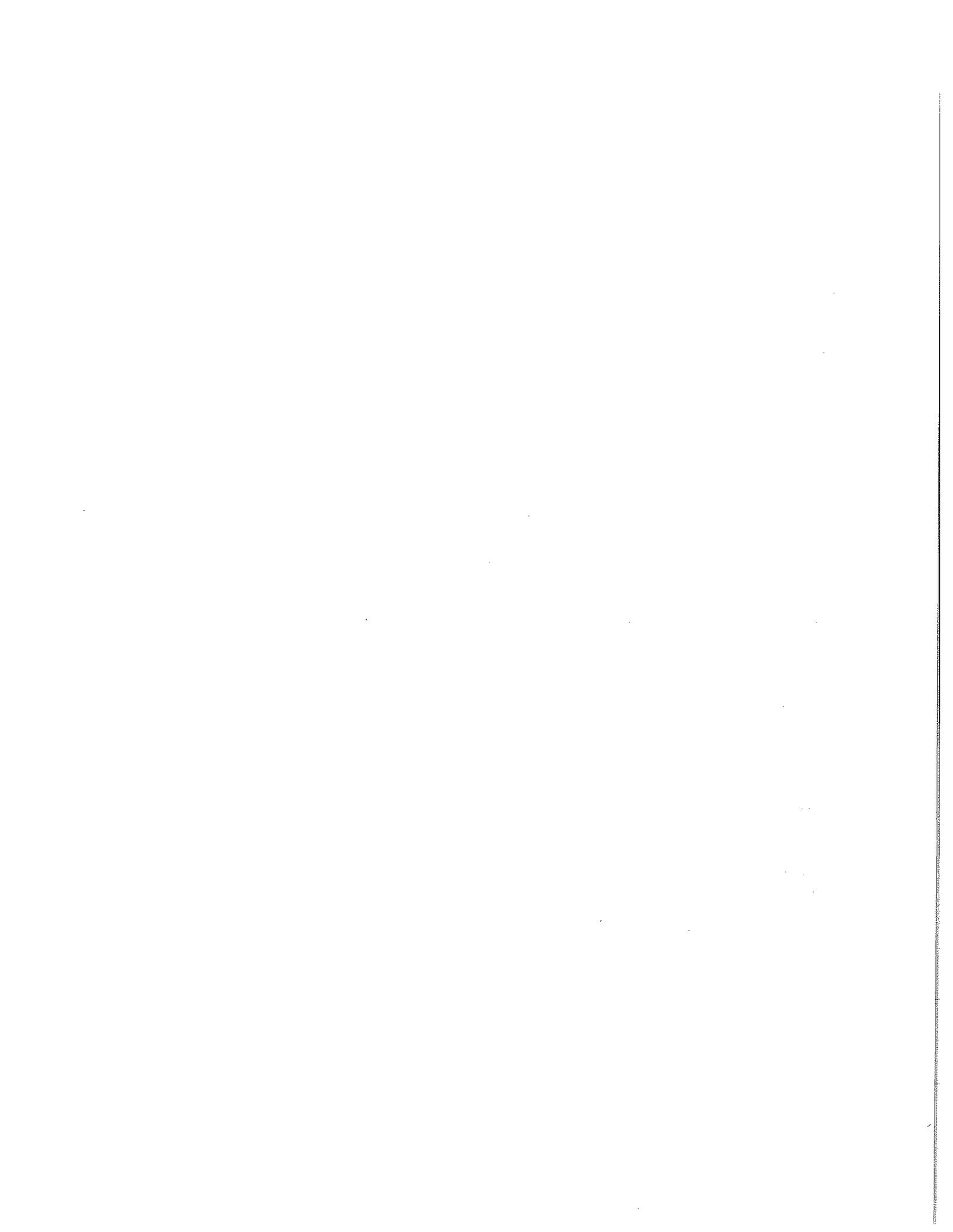
#### Sanctions and Exclusions

- 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.
- Impose sanction penalties on those who falsify information on "conditions of participation" applications.
- Exclude based on peer review organization findings of Medicaid violations.
- Exclude from Medicare/Medicaid those who have been sanctioned by other Federal and State health care programs.

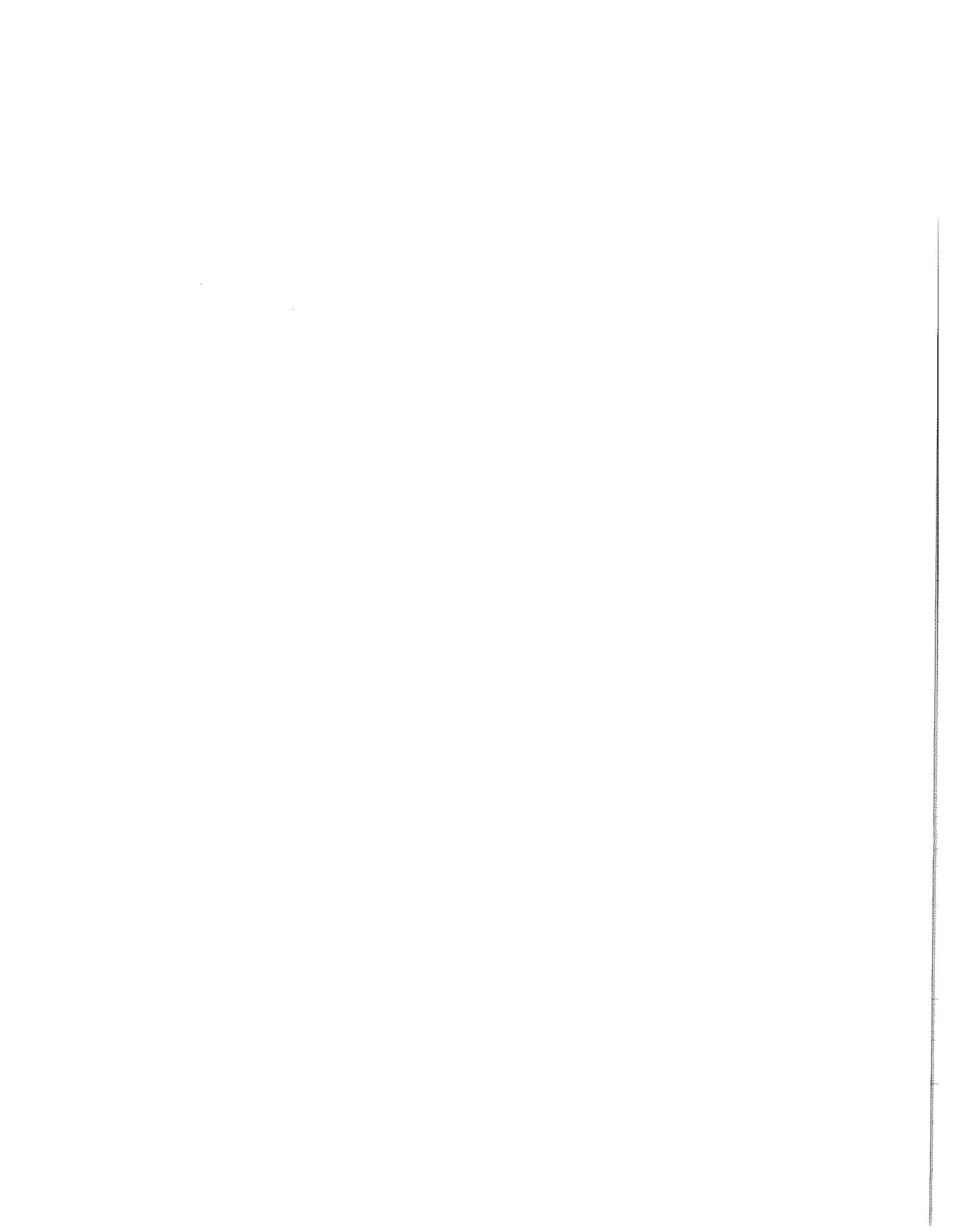
- Impose Medicare sanctions on those who have been found to abuse the Medicaid program.
- Exclude from Medicare and Medicaid those convicted of (1) fraud or financial abuse; (2) neglect or abuse of patients; or (3) drug trafficking in connection with the delivery of health care services or with a Federal, 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 provide information necessary to verify their claims for payment.
- Exclude from participation entities who fail to make required disclosure 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



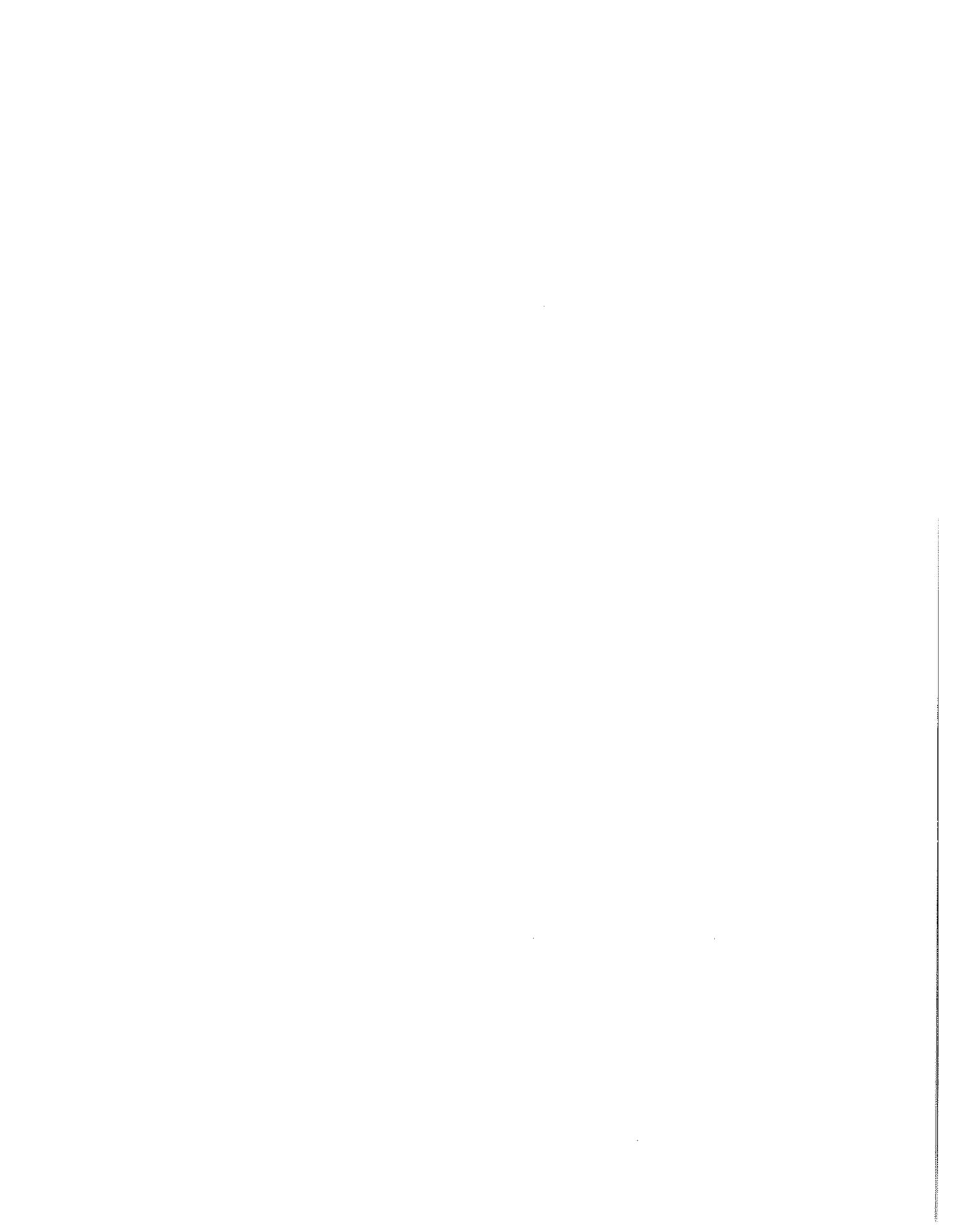
## APPENDIX B

**UNIMPLEMENTED PROGRAM RECOMMENDATIONS**  
**April 1986 through September 1986**

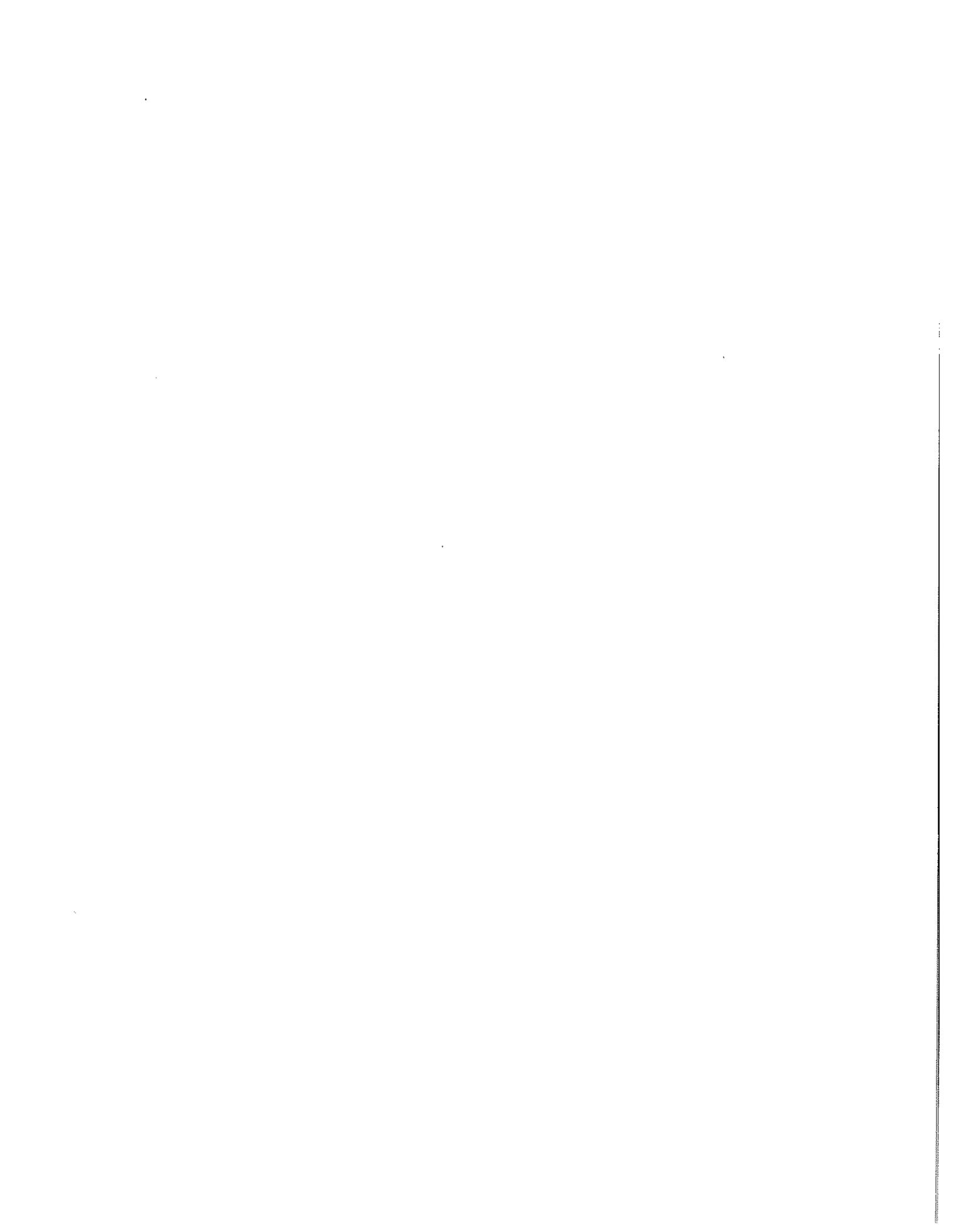
OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>HEALTH CARE FINANCING ADMINISTRATION</b>		
<b>Capital Costs:</b>		
Discontinue Medicare payments for inappropriate capital cost elements. (ACNs: 09-52032, 09-52020, 09-32607, 07-42019 and 07-52004)	No action is being taken on two of the five cost elements that we recommended to be discontinued.	\$941 per year
<b>Multiple Visits in SNFs:</b>		
Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005)	HCFA is looking at alternative reimbursement methods which address the issue raised by the review.	\$268 per year
<b>Mandatory Second Opinion:</b>		
Require Medicare and Medicaid beneficiaries to seek mandatory second surgical opinions for selected surgeries. (ACN: 03-30211)	HFCA issued a proposed regulation on June 17, 1986 to require second opinion under the Medicaid program.  Medicare provisions are included in COBRA.	\$158 per year
<b>Elective Surgeries:</b>		
Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205)	HFCA said that it would soon implement the recommendations.	\$110 per year
<b>Prescription Drugs:</b>		
Better curbs needed on Medicaid prescription drug costs. (ACN: 06-40216)	The Department is considering the recommendations.	\$72 per year

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>HEALTH CARE FINANCING ADMINISTRATION (continued)</b>		
<b>Pacemaker Monitoring:</b>		
Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017)	HCFA has issued guidelines on frequency of phone monitoring, and is still considering the reclassification issue.	\$6 per year
<b>Swing Beds:</b>		
Expand swing bed provisions on demonstration basis to determine feasibility in providing Medicare and Medicaid patients long-term care. (ACN: 03-60221)	HCFA is awaiting the results of its own study.	(To be determined)
<b>MMACS:</b>		
Make improvements to the Medicare and Medicaid Automated Certification System (MMACS) so it can be used as an effective management tool in monitoring nursing home activities. (ACN: 03-60154)	The report is with HCFA for comment.	(To be determined)
<b>SOCIAL SECURITY ADMINISTRATION</b>		
<b>Administrative Finality:</b>		
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)	A Notice of Proposed Rule Making on Administrative Finality was published in the <i>Federal Register</i> in August 1986.	\$50 per year

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>SOCIAL SECURITY ADMINISTRATION (continued)</b>		
Accelerate the Title II earnings enforcement operation (used to identify unreported or underreported beneficiary earnings) to ensure timely identification/collection of overpayments. (ACN: 13-62690)	Although SSA agreed with the OIG recommendation, implementation has been sidelined. Higher priority was given to claims and other system modernization.	\$15.0 per year
<p><b>Late Payments to SSA:</b>            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)</p>	SSA disagreed on ground that charging interest would not be cost-effective.	\$1.3 per year



# APPENDIX C



## APPENDIX C

ANALYSIS OF COST SAVINGS  
April 1986 through September 1986

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
<b>HEALTH CARE FINANCING ADMINISTRATION</b>		
Reduce excessive Medicare payments to teaching hospitals for indirect medical education (IME) costs by halving the PPS adjustment factor to 5.79 percent. (ACN: 09-62003)	Effective May 1, 1986 the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) reduced the IME adjustment factor to 8.1 percent through September 30, 1988 and to 8.7 percent thereafter. Note: Pending the adoption of a departmental proposal to reduce the IME factor to a level supported by HCFA's empirical data, savings reflect only the amount applicable from the effective date of COBRA through FY 1988.	\$1,715.0
Eliminate unneeded payments to proprietary hospitals for return on equity capital. (ACN: 14-62154)	COBRA phases out these payments over a 5-year period FY 1987-FY 1991.	\$980.0*
HCFA should take steps to assure that providers bill third-party payers where Medicare beneficiaries aged 65 through 69 are working and covered by an employer group health plan. (OAI-07-86-00071 and OAI-07-86-00079)	HCFA concurred and is monitoring intermediary and carrier procedures to identify third-party payers.	\$5.3
HCFA should revise regulations and carrier instructions implementing the statutory limitation on psychiatric service to cap physician and nonphysician services and to assure consistent carrier administrative practices. (OAI-09-86-00056)	HCFA concurred.	\$3.4

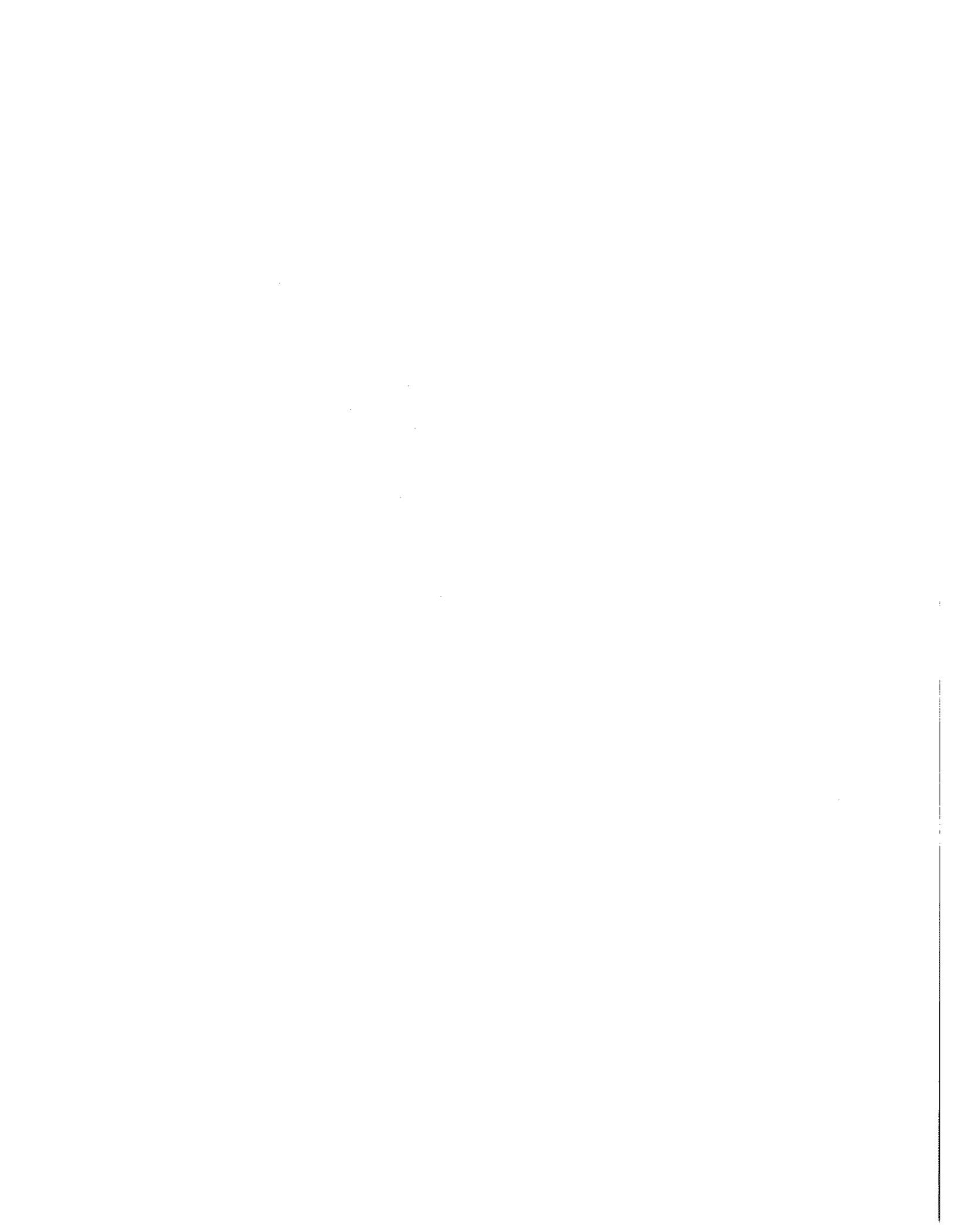
OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
<b>HEALTH CARE FINANCING ADMINISTRATION (continued)</b>		
Management Commitments to Seek Recoveries and Investigative Recoveries:	34 reports	\$76.7
<b>SOCIAL SECURITY ADMINISTRATION</b>		
Restore monies to the trust funds which were incorrectly transferred to the general fund in the annual transfer for refunds of excess FICA taxes. (ACN: 13-62656)	SSA's April 3, 1986 memorandum states that the estimates that caused the incorrect transfer are being revised and that the funds will be restored with the next annual transfer in FY 1987.	\$49.0
Management Commitment to Seek Recoveries and Investigative Recoveries:		\$3.6
<b>GRANTS AND INTERNAL SYSTEMS</b>		
OIG Recommended that the Title IV-E Adoption Assistance Law be modified to create a "medical assistance only" category to avoid unnecessary income maintenance payments. (OAI-02-1984)	The "medical assistance only" category was created with passage of COBRA.	\$1.7*
Implement national standard computer matching formats for State-administered benefit programs to use for income and eligibility verification in keeping with the new DEFRA mandate. (OAI-12-1986)	Final formats have been issued to the States for implementation.	\$1.1

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
<b>GRANTS AND INTERNAL SYSTEMS (continued)</b>		
Promote transfers between States of approved automated Family Assistance Management Information Systems (FAMIS) as an alternative to each State developing its own system. (ACN: 04-60250)	FSA's memorandum of September 15, 1986 notes that the Department: (1) is sponsoring an NPRM to provide funding for in-depth system requirements studies; (2) has issued a final regulation clarifying the requirements for cost benefit analyses; and (3) has increased rejections of States' requests for FAMIS funding when the requests are not adequately supported and justified.	\$449.8
Management Commitment to Seek Recoveries and Investigative Recoveries	171 reports	\$15.4
Savings resulting from investigations.	Actions were taken between 4/86 and 9/86.	\$17.2
Subtotal—Savings	\$3,222.5	
Subtotal—Management Commitment to Seek Recoveries and Investigative Recoveries	95.8	
Total—Second Half FY 1986	\$3,318.2	

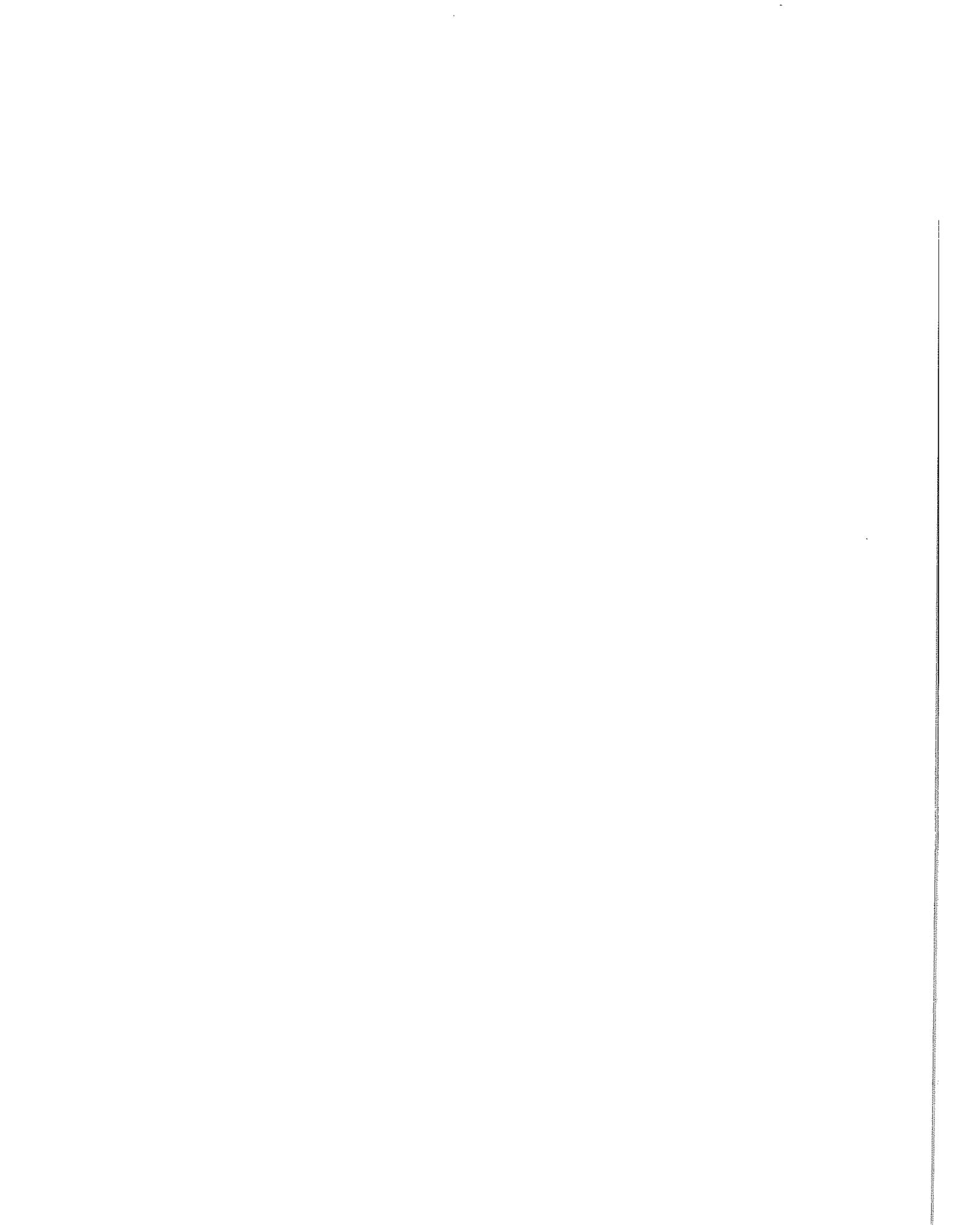
\* Savings based on Congressional Budget Office phase-in estimates over the 5-year budget cycle.

**SUMMARY OF SAVINGS AND RECOVERIES  
FY 1986  
(IN MILLIONS)**

First Half FY 1986	2,053.5
Second Half FY 1986	<u>3,318.2</u>
TOTAL FY 1986	5,371.7







**DEPARTMENT OF  
HEALTH & HUMAN SERVICES**

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