

OFFICE OF  
INSPECTOR GENERAL

# Semiannual Report

October 1, 1984 — March 31, 1985

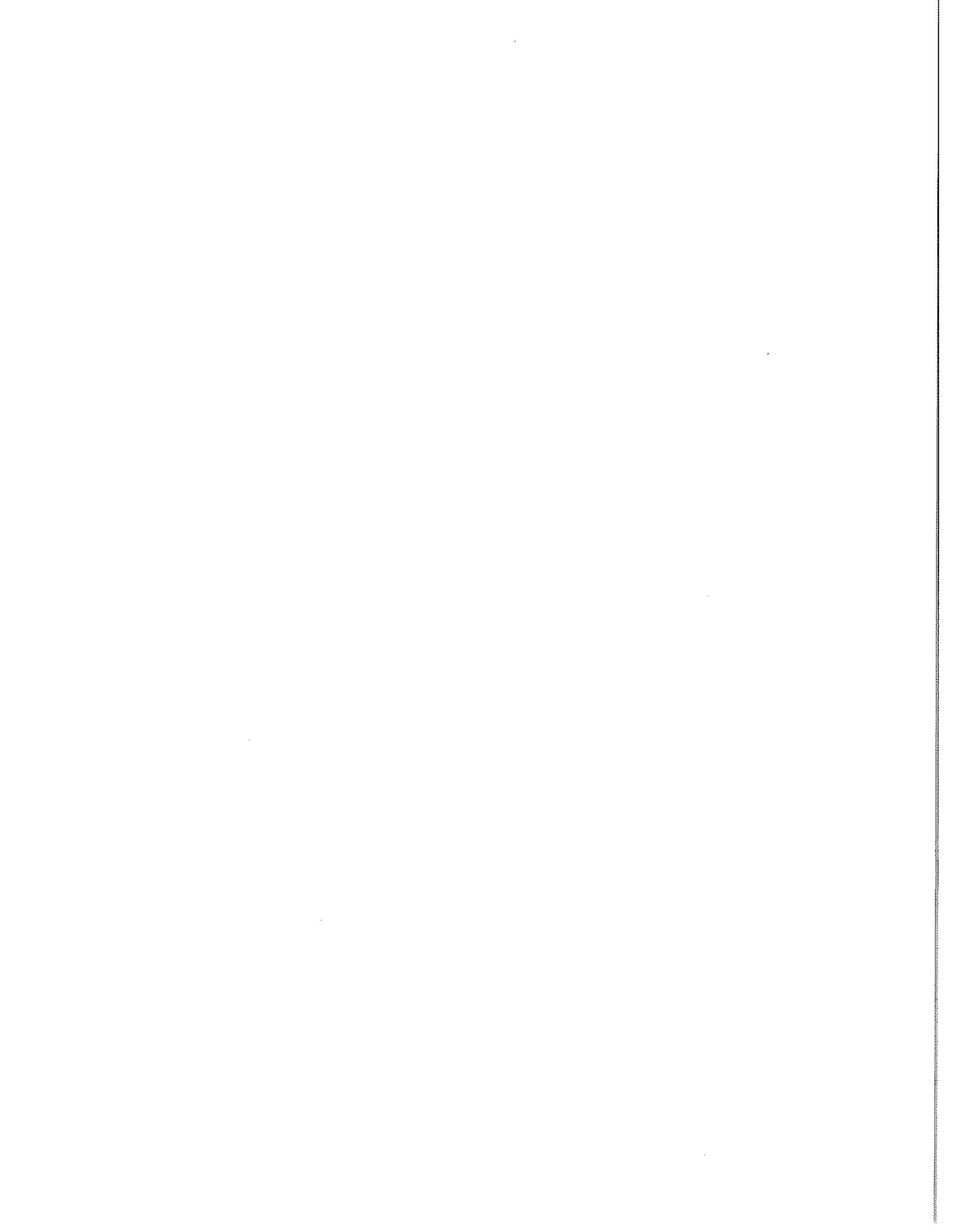


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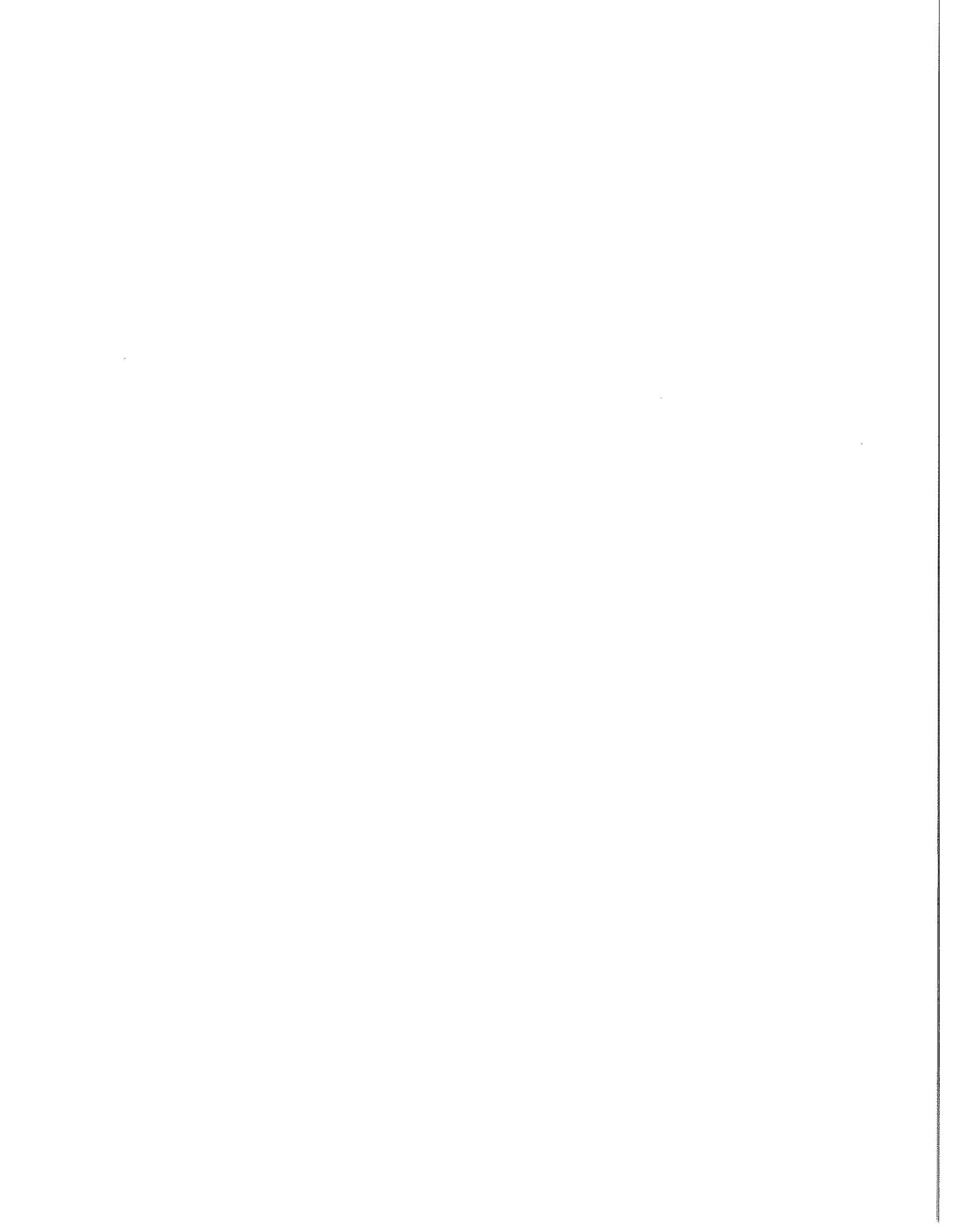


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# OIG OPERATING HIGHLIGHTS



## CHAPTER I

### OIG OPERATING HIGHLIGHTS

The Department of Health and Human Services' Office of Inspector General (OIG) was established in 1976 to reduce the occurrence of fraud, abuse and waste in HHS programs and to promote economy and efficiency in the Department's operations. During fiscal year 1985, the OIG will be monitoring programs with a total projected budget of \$318.5 billion, the largest budget of any Federal department.

This current OIG Semiannual Report to the Secretary and Congress describes OIG activities and accomplishments from October 1, 1984 to March 31, 1985. Items are organized according to the individual program areas within HHS:

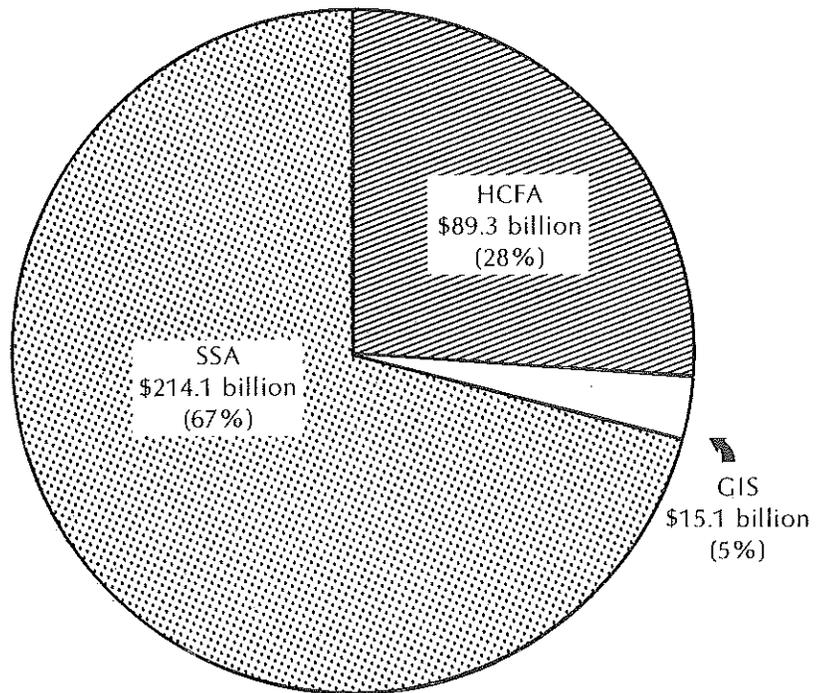
- The Health Care Financing Administration (HCFA), with an FY 1985 budget of \$89.3 billion, includes the Medicare and Medicaid programs.
- The Social Security Administration (SSA), with an FY 1985 budget of \$214.1 billion, represents the largest piece of the HHS budget. SSA administers the Old Age and Survivors Insurance, Disability Insurance, and Supplemental Security Income programs, and manages at a national level the State-administered Aid to Families with Dependent Children, Low Income Home Energy Assistance, and Refugee Resettlement programs.
- Grants and Internal Systems (GIS) encompasses the Public Health Service, the Office of Human Development Services which administers a variety of programs including Head Start, and overall departmental management. All of these combined have a FY 1985 budget of \$15.1 billion. Although GIS programs have a comparatively small budget, they represent 83 percent of the Department's discretionary funds.

Chart 1 shows the FY 1985 breakout of HHS funds by these major departmental programs.

The goal of the OIG is to promote economy and efficiency and to reduce the incidence of fraud, waste and abuse in HHS programs and

### DHHS EXPENDITURES BY PROGRAM

FY 1985



**PROJECTED OUTLAYS: \$318.5 BILLION**

Chart 1

operations. To do this, we target our resources on the areas of greatest vulnerability and highest possible return. The increasing success of this strategy is evidenced by the fact that total savings for this period amount to over \$3.0 billion, and the number of successful prosecutions is at a record high of 532. An analysis of individual cost savings is contained in Appendix C of this report. (See page 81.)

Brief statements of major OIG accomplishments are highlighted below under the headings of "OIG Accomplishments for This Reporting Period" and "Significant OIG Findings That Could Result in Savings." Detailed descriptions of OIG activities are included in following chapters, entitled Health Care Financing Administration, Social Security Administration, Grants and Internal Systems, Legislative and Regulatory Review, and President's Council on Integrity and Efficiency.

### **OIG Accomplishments for This Reporting Period**

- Administrative sanctions by the OIG resulted in 110 health care providers being "kicked out" of the Medicaid and Medicare programs for health care-related fraud and for providing poor quality of services. (See page 24.)
- Investigations of Medicaid/Medicare fraud resulted in 245 convictions, and financial recoveries and savings of \$11.6 million with an additional \$3.0 million in Civil Monetary Penalties settlements. (See page 19.)
- Investigations of Social Security fraud resulted in 468 successful prosecutions and over \$10.5 million in recoveries and savings. (See page 34.)
- Congress recently enacted an OIG-proposed legislative change making Medicare benefits secondary to benefits available to beneficiaries with working spouses under age 65. The Congressional Budget Office estimates that this will result in \$2.1 billion in Medicare savings over the 5-year budget cycle. (See page 10.)
- Implementation of the OIG's recommendation to use front-end controls to identify Medicare beneficiaries who are also covered by employer-sponsored health plans will prevent the payment of \$390 million in erroneous benefits. (See page 13.)

- OIG found that the Department of Treasury waited only 2 days before drawing down Social Security Trust Fund monies to cover Social Security checks. The “float period” has been extended to the standard 4.4 business days, with expected savings of \$122 million. (See page 83.)
- The elimination of overstated and unallowed costs in approximately 150 Peer Review Organization cost proposals netted \$46.2 million in savings. (See page 19.)
- Improved controls over SSA’s stop payment process for checks issued after death in the SSI program resulted in the recovery of \$24 million in erroneous payments. (See page 30.)

### **Significant OIG Findings That Could Result in Savings**

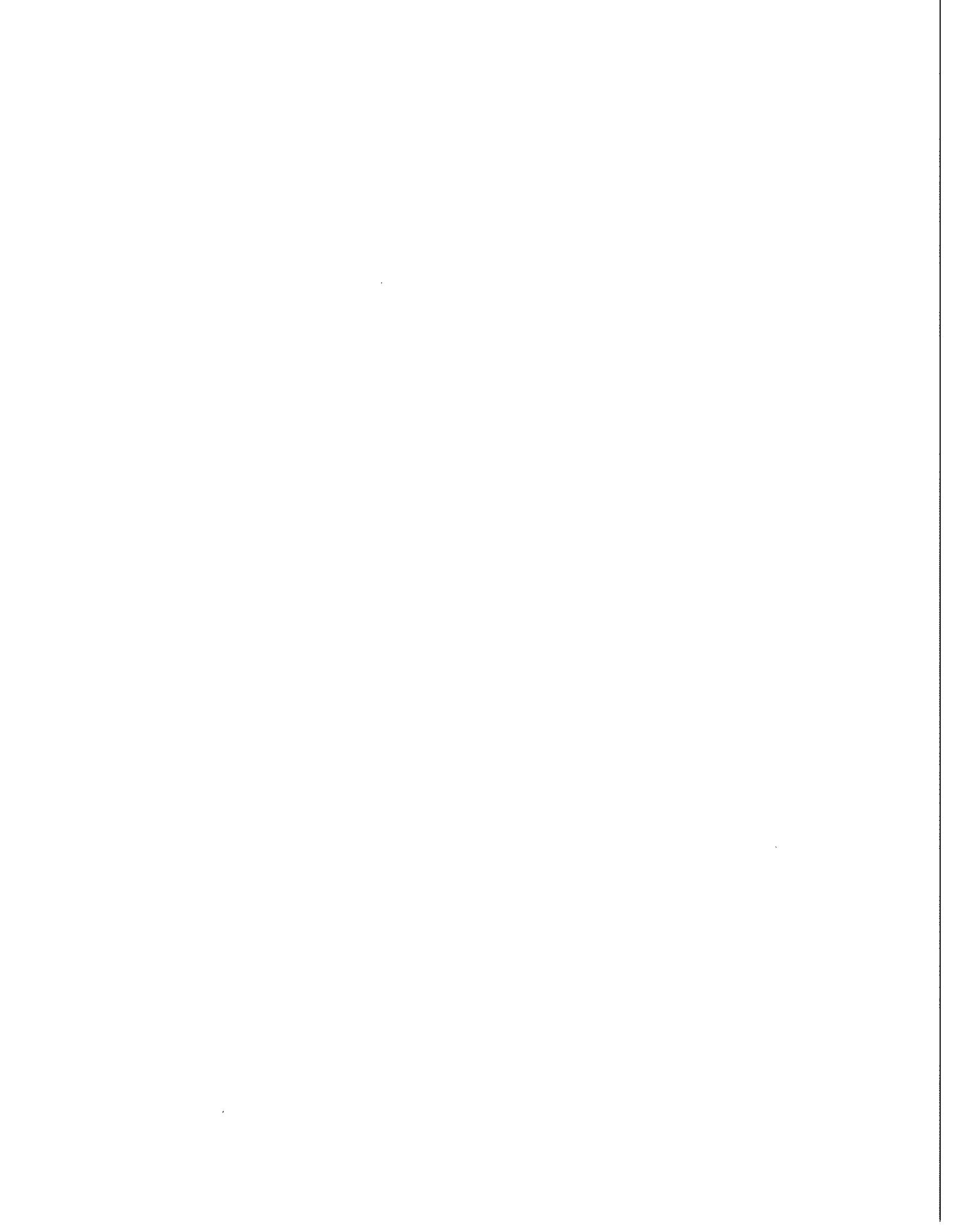
The following savings can be realized upon enactment of new legislation:

- \$695 million in FY 1986 and about \$6.6 billion through FY 1990 could be saved by reducing the excessive indirect medical education cost factor added to Medicare prospective payment rates. (See page 11.)
- Raising the Medicare Part B deductible to \$100 and indexing it could save Medicare \$2.3 billion over the next 5 years. (See page 12.)
- Eliminating Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare (Buy-In program) could save \$2.4 billion over a 5-year period. (See page 10.)

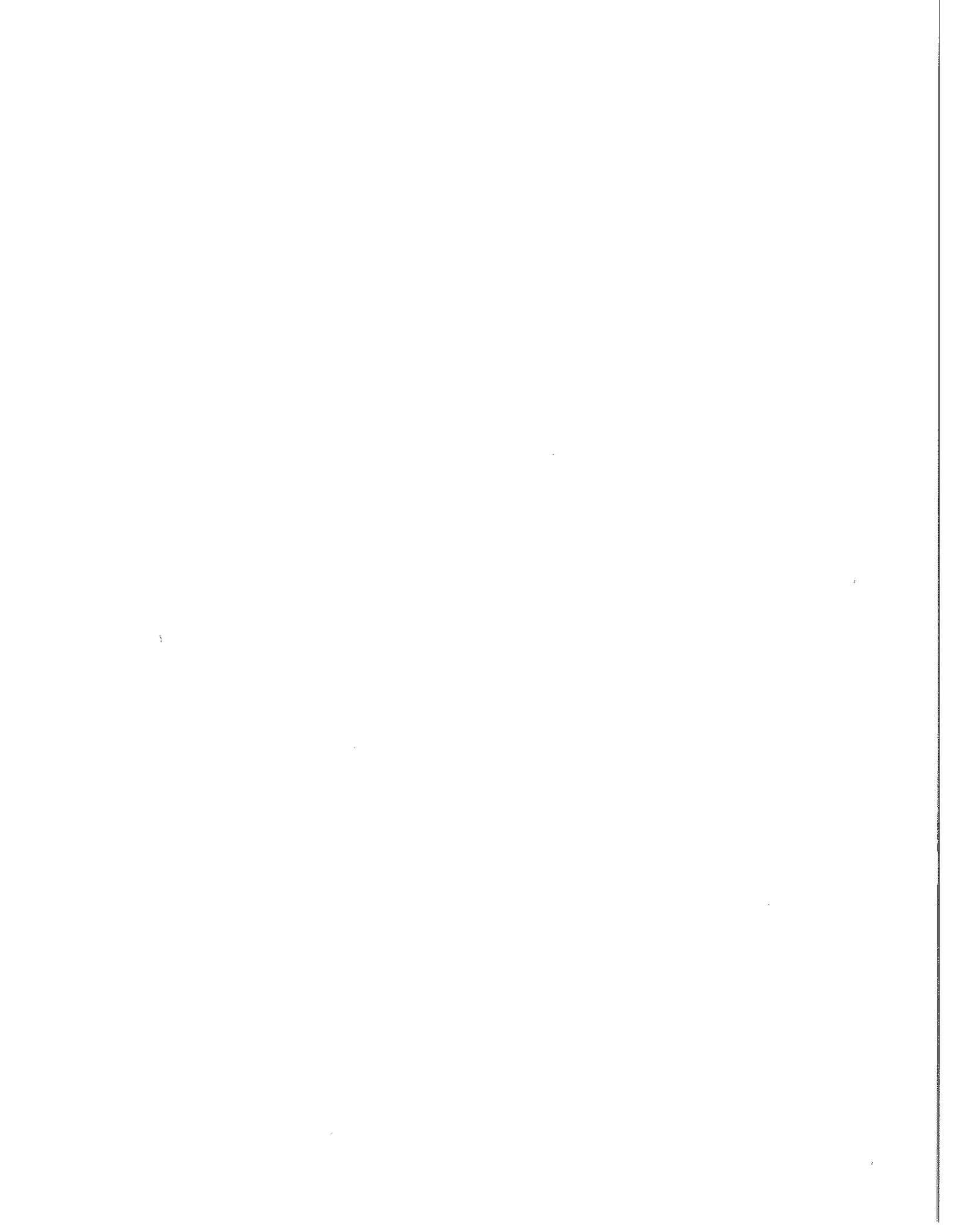
The following savings can be realized upon departmental action:

- Excluding from Medicare coverage assistant surgeon services on routine cataract surgeries could save Medicare \$30 million annually. (See page 14.)
- Requiring States to consider shared living arrangements in determining refugee cash assistance could save \$16.7 million annually. (See page 31.)

- Optimizing States' use of Centers for Disease Control and State supply contracts to purchase vaccines for Medicaid's Early Periodic Screening, Diagnosis and Treatment immunization program could save Medicaid \$14 million annually. (See page 14.)
- Improving procedures to detect unreported marriages under Title II (OASDI) programs could save \$38 million over a 5-year period. (See page 31.)
- Improving accounting procedures over Title II payments could avoid the risk of millions of dollars in Trust Fund losses resulting from payments made after the death of beneficiaries. (See page 29.)



# HEALTH CARE FINANCING ADMINISTRATION



## CHAPTER II

### HEALTH CARE FINANCING ADMINISTRATION

Some 50 million Americans, including the nation's elderly, poor and disabled, will have their health care needs served by Medicare and Medicaid during FY 1985. Spending for these two programs, administered by the Health Care Financing Administration (HCFA), is estimated for the current fiscal year at \$66.2 billion and \$23 billion respectively. This represents about 28 percent of the HHS budget and about 9 percent of the total Federal budget.

While health care costs have grown at thrice the inflation rate, the rate of increase has actually dropped from 16 percent in 1980 to 5.9 percent in FY 1984. For Medicare this is due in part to the prospective payment system (PPS) for hospital reimbursement, now in its second year of phase-in. Under PPS, hospitals are paid fixed amounts which are determined by type of illness.

Considerable OIG effort has been devoted to front-end reviews of the PPS mechanism with the objective of effecting systemic improvement in areas considered vulnerable to fraud, waste and abuse. Prevention activities, focusing on emerging reimbursement issues such as area wage indices, recalibration of Diagnosis Related Group (DRG) weights/case mixes, the impending freeze on Medicare payments to hospitals, and hospitals' capital costs and their impending inclusion in PPS, all should result in additional savings.

In Medicaid, OIG reviews continue to identify innovative features used by States to control program costs so that the most efficient and cost effective methods can be modeled for use in other States. Special OIG initiatives in long term care focus on whether Federal funds are being appropriately spent and whether patients are receiving the care that is being paid for.

During the first 6 months of FY 1985, we identified a number of areas where, with legislative change, regulatory reform, or tightened program administration savings of \$13.6 billion over a 5-year period are possible. Similarly, OIG reviews identified questionable program expenditures of

some \$33.8 million. Recommendations made call for appropriate financial adjustment and procedural change.

To highlight each aspect of OIG activity, this chapter is divided into: (1) legislative change/regulatory reform; (2) program administration; (3) program payments; (4) ongoing reviews in health; and (5) legal and administrative sanctions of wrongdoers.

### **Legislative Change/Regulatory Reform**

OIG reviews during this reporting period identified four areas where, with legislative action or regulatory change, some \$13.4 billion will or could be saved over a 5-year period.

#### **WORKING AGED: COVERED SPOUSES**

Under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, Medicare benefits became secondary to benefits under an employer group health plan for employed individuals age 65 through 69. This exception applied only when either the beneficiary or his/her spouse was employed and covered by an employer group health plan, and both individuals were age 65 through 69. The OIG recommended a legislative change which was enacted extending this provision to beneficiaries with working spouses under age 65. As a result of this legislative change, Medicare has now become the secondary payment source for over 300,000 additional beneficiaries. The Congressional Budget Office estimates that this action, coupled with efforts to identify beneficiaries who are also covered by employer-sponsored health plans, will save Medicare an estimated \$2.1 billion over the next 5-year budget cycle.

#### **MEDICARE/ MEDICAID BUY-IN**

When Congress established Medicare Part B in 1966, it also enacted legislation creating the Medicare Buy-In program, making it possible for States to enroll eligible Medicaid recipients in the Medicare Part B program. The intent of Congress was to shift some of the financial burden of providing health care to the nation's elderly poor from States to the Federal Government.

To encourage participation, Congress offered States several financial incentives. For instance, by paying monthly premiums for dually eligible recipients, States could shift the cost of health care (except for the

deductible and coinsurance) from Medicaid, which they partially funded, to Medicare which is totally federally funded. Congress also permitted States to claim Federal financial participation (FFP) in the cost of monthly premiums paid on behalf of Medicaid recipients receiving cash assistance.

The intervening years have shown the Buy-In program to be extremely costly and complex. For example, Part B reimbursement for dually eligible enrollees was higher than the norm because a greater percentage of these enrollees were users of Medicare services. The average Part B reimbursement for dually eligible recipients totalled \$369 in 1978 as compared to the norm of \$257. In 1980, average Medicare Part B reimbursement for dually eligibles rose to \$552. To help reduce these costs and eliminate many of the complexities surrounding the program, OIG is recommending that HCFA seek legislation calling for the elimination of FFP in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare. This could save the Federal Government almost \$2.4 billion within a 5-year period if States continue their current rate of participation in the Buy-In program.

In the unlikely event that some States discontinue program participation, savings to the Federal Government could increase because health care is less expensive under Medicaid than Medicare. Dually eligible recipients would not be detrimentally affected as they could obtain free medical care under Medicaid or self-enroll in Medicare Part B.

HCFA disagreed with the need for this legislative recommendation at this time because of the Administration's broader proposal to limit overall Federal spending in Medicaid.

Under PPS, hospital reimbursement is based on standard rates for specified services. These payments covering most patient costs do not recognize the added costs for patient care incidental to teaching hospitals. To compensate these hospitals for their added costs of training interns and residents, Congress authorized an add-on 11.59 percent adjustment factor to the Federal portion of the DRG rate.

## **INDIRECT MEDICAL EDUCATION COSTS**

An OIG review to evaluate the reasonableness of the adjustment factor showed that Medicare payments to teaching hospitals for indirect medical education (IME) costs under PPS are excessive. Analysis of Medicare payments to 131 hospitals participating in PPS showed wide variances in the amount of annual IME payments at full implementation levels. Some examples are:

- Total IME payments to hospitals have ranged from \$101,000 to \$26.2 million annually. Twenty-six hospitals received IME payments of more than \$10 million.
- IME payments per intern/resident ranged from \$1,800 to \$153,000 annually.
- IME payments per Medicare discharge ranged from \$59 to \$8,600 annually.

Excessive IME payments will total about \$695 million in FY 1986 and about \$6.6 billion through FY 1990 unless needed changes are made. The underlying cause of the excessive IME payments is that the teaching hospital adjustment factor authorized by 1983 Social Security amendments doubled from 5.795 percent of operating costs to the present 11.59 percent. No empirical data was available that supports this doubling of the IME factor. We recommended that Congress return the IME factor to the original 5.795 percent. The Administration's FY 1986 legislative proposals include this recommendation.

#### **MEDICARE PART B DEDUCTIBLE**

An OIG survey showed that most private health plans require participants to pay deductibles ranging from \$100 to \$250. Most of these plans are raising deductibles to sensitize the insured to unnecessary medical usage and to increase cost sharing. A major exception has been Medicare Part B.

Our review showed that while Medicare Part A (hospital coverage) has kept pace with health care costs, Part B has not. Part A began with a \$40 deductible in 1966 and Part B with a \$50 deductible in 1967. The Part A deductible has now risen to \$400 effective January 1, 1985. Part B, on the other hand, has only been increased by \$25 in the last 18 years. A major reason for this disparity is that the Part A deductible is indexed to keep pace with rising health care costs, while the Part B deductible is not.

We recommend that HCFA seek necessary legislation to index the Part B deductible. Additionally, in order to compensate for inadequate past increases, we are recommending that HCFA also propose legislation to raise the deductible now to at least \$100. The effect of these proposals, if enacted into law, would be to reduce net Federal Medicare outlays by about \$2.3 billion over the next 5 years.

HCFA agreed that the Medicare deductible should be indexed. The

Administration's FY 1986 budget included such a proposal. However, HCFA did not agree the deductible should be increased to \$100 at this time, because the Administration decided to use the Medical Economic Index as a basis for increasing the deductible.

### **Program Administration**

During this reporting period OIG reviews identified a number of program areas where more efficient management and tightened internal and fiscal controls could result in annual savings of over \$45.4 million. In addition, another \$27.8 million in program expenditures were questioned as to their allowability under regulations, law or cost principles. In these instances, recommendations called for financial adjustment and appropriate procedural change.

In 1982, Congress required most employers to make their health plans available to employees who are 65 through 69 and to their spouses. If such coverage was chosen, the health plan rather than Medicare would have primary liability (i.e., would be first payer) for services provided under the plan.

Our previously reported review of six intermediaries and three carriers found little evidence that these provisions were producing anticipated savings. Eleven months after implementation, contracts reviewed had not identified a single claim that was fully paid under an employer health plan and only 15 claims partially paid. We believe this poor showing was due in part to the heavy reliance placed on providers to initially identify beneficiaries covered by employer health plans. Past studies have shown that millions of dollars in third party resources are lost to the Medicare program every year, much of it due to providers failing to identify third party medical insurance resources.

To maximize cost savings to Medicare, we had recommended specific ways for HCFA to increase its existing efforts to see that intermediaries and carriers rely on front-end controls to identify those beneficiaries who are also covered by employer-sponsored health plans. Implementation of these recommendations are reflected in HCFA's FY 1986 budget savings estimate of about \$390 million.

**WORKING AGED:  
IDENTIFYING  
PRIMARY PAYERS**

**ASSISTANT  
SURGEON SERVICES**

OIG reviewed carriers' coverage policies and national coverage guidelines to determine whether Medicare should continue to pay for the services of an assistant surgeon during routine cataract surgery. Our review showed that although the primary ophthalmic surgeon requires assistance, this assistance can be and is often provided by a surgical technician and/or operating room nurse. An assistant surgeon is not medically necessary during routine cataract surgery as evidenced by the practices of many primary ophthalmic surgeons who do not use them. We also found that carriers in nine States limit or deny Medicare reimbursement for these services on routine cataract surgery.

We are recommending that HCFA exclude from Medicare coverage the services of an assistant surgeon on routine cataract surgery. However, Medicare policy should provide that in certain instances where other medical conditions exist (as specified by HCFA), the primary ophthalmic surgeon could request prior approval for use of an assistant surgeon. Eliminating these unnecessary physician services could save between \$30 and \$40 million annually. We also plan to recommend that HCFA look at other similar surgical procedures to determine whether the services of an assistant surgeon should be reimbursed.

HCFA agreed to eliminate Medicare payment for unnecessary assistant surgeon services by promoting uniform carrier handling of claims for such services and proposing routine disallowance of such claims if adequate justification is not submitted.

**EPSDT: VACCINE  
PURCHASES**

The State-operated Early Periodic Screening, Diagnosis and Treatment (EPSDT) program provides medical examinations and treatment for Medicaid-eligible children. States establish their own procedures for providing the necessary vaccines to physicians. However, low-cost, federally contracted vaccines are available if purchases are made with Federal funds. Relatively low-cost State supply contracts are also an option. OIG's survey of 30 States—which provided 70 percent of EPSDT immunizations—found that 22 were not taking advantage of low-cost Federal or State supply contracts for the purchase of vaccines. States were generally allowing physicians to purchase vaccines for EPSDT immunizations from expensive open market sources. Based on our review, we estimate that Federal Medicaid savings nationwide could amount to \$10 million annually. Another \$4 million in annual savings are possible if Federal contracting arrangements were made for additional vaccines.

HCFA agreed with our recommendation and has taken steps to effect implementation.

Congress has long been concerned with improving Medicare home health agency (HHA) reimbursement methodology and applying cost limits by type of service provided rather than to an HHA's aggregate or total cost. In July of 1984, HCFA issued regulations to update the schedule of limits. The regulations—while reducing the amount paid per visit—require continued application of cost limits in the aggregate.

## **HOME HEALTH AGENCIES**

To determine if savings could be realized by applying the HHA cost limits by type of service, OIG had performed a computer analysis of pertinent cost/reimbursement data submitted by 374 HHAs. We found that savings of \$2.9 million would be realized for periods covered by these reports if HCFA had applied the cost limits by type of service. Nationally, the savings could amount to \$35 million annually.

In our previous Semiannual Report, we had recommended that HCFA, in accordance with congressional intent, revise the regulations to require application of the HHA cost limits by type of service rather than in the aggregate. HCFA will be applying per service limits in its upcoming HHA cost limits notice.

Pharmacies often dispense pre-packaged 30-day supplies of unit doses for Medicaid nursing home patients. If for some reason the prescription is discontinued, there will be unused drugs remaining. In many cases, these sealed unused drugs can be returned to the pharmacy.

## **UNUSED DRUGS**

Although Federal regulations do not require that unused drugs be returned to pharmacies for redispensing, we found that some States permit such returns but do not require appropriate credits to Medicaid. We estimate that for the seven States reviewed, Medicaid drug expenditures could be cut by \$1.4 million annually if HCFA revised the Medicaid regulations to require appropriate credits for returned unused drugs.

HCFA plans to advise the States reviewed of the need to assure that Medicaid is properly credited for returned drugs.

Reviews in four States disclosed that per diem rates used to reimburse Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) were incorrectly established and resulted in overcharges to the Medicaid program totaling \$3.7 million. In one State about \$2.9 million was claimed for patients' home and hospital leave that had been previously reimbursed. In the other three States discrepancies involved calculation errors (\$685,321) and unsupported or unallowable costs (\$115,000).

## **ICF/MRs**

**MEDICAID  
OVERPAYMENTS**

A previous review in one State found that contrary to Federal policy, a State failed to credit the Federal account for its share of Medicaid overpayments at the time the overpayments were identified. Our follow-up review disclosed that despite HCFA's efforts, the State continued to under-credit the Federal Government with its share of Medicaid overpayments by \$7.7 million. Recommendations call for appropriate financial adjustments and monitoring by HCFA to assure that this problem does not recur.

**ADMINISTRATIVE  
COSTS**

OIG assessed the allowability of administrative costs incurred by four Medicare intermediaries, carriers and other Medicare contractors and recommended disallowances of approximately \$1.3 million in costs considered unallowable for reimbursement. Unallowable costs included: expenses which did not benefit the Medicare program, claims in excess of approved budgets, incorrect computation of return on investment, unallowable bad debts and costs unrelated to contract scope.

Additionally, OIG assessed administrative costs claimed by States for certifying health care facilities for participation in Medicare and Medicaid. Sections 1864 and 1902 of the Social Security Act authorize States to be reimbursed for the costs of providing this service. Our review of costs claimed by two States disclosed unallowable costs of \$1.4 million, the bulk of which (\$1 million) pertained to salary costs which were claimed twice.

### **Program Payments**

The OIG reviews specific types of program payments and numbers of individual providers reimbursed under Medicare and Medicaid. Around \$110.8 million in overpayments and cost avoidance were identified by these reviews in this 6-month period. Following are some of our more significant findings.

**INAPPROPRIATE  
PATIENT  
DISCHARGES**

We found evidence of Medicare program and beneficiary abuse through medically inappropriate discharges, transfers and readmissions by hospitals under the prospective payment system (PPS). This resulted in as much as \$3.2 million in inappropriate payments being made to date. HCFA agreed with our findings and will direct the Peer Review Organiza-

tions (PROs) to issue denials or undertake other actions, such as sanctions, when such practices are found. Also, any potential adverse patient outcomes of such practices will be promptly identified and corrected.

The Omnibus Budget Reconciliation Act of 1981 makes Medicare the secondary payer for certain end-stage renal disease (ESRD) beneficiaries. Specifically, the law requires that a person with renal failure cannot be placed on the Medicare rolls until 1 year after onset if the person has health insurance through employment. In such instances, the private health insurance would pay for the individual's health care expenses to the extent of the policy coverage for the 1 year. We conducted reviews in two States to determine if Medicare was being billed properly. These reviews disclosed that Medicare was being billed inappropriately as the primary payer. An estimated \$2.5 million annually can be saved in those two States alone by implementing tighter payment controls. These reviews will be expanded to other States.

#### **SECONDARY PAYER FOR ESRD**

As part of our study of PPS, we reviewed the Diagnosis Related Group (DRG) for Percutaneous Transmittal Coronary Angioplasty (PTCA). PTCA is an alternative to coronary bypass surgery which is generally performed in the catheterization laboratory as opposed to the operating room. This procedure is currently included in a DRG that represents major open-heart procedures which require significantly more resources than PTCA. The current payment methodology results in inflated amounts being paid for PTCA. HCFA agreed, and will incorporate the change in a PPS regulation. Overall annual savings resulting from this change are estimated to exceed \$60 million a year.

#### **DRG MISCLASSIFICATION**

A review of psychiatric services rendered in 1 State by 36 physicians to beneficiaries in hospitals found that services billed were not supported by documentation in the medical records, consultation services were not correctly billed and psychiatrists were consistently misusing a code which provided for a higher payment. Through these improper billings, the physicians were found to have been overpaid more than \$57,000. Tighter controls on this type of billing are estimated to save an additional \$187,000 based on the post-billing practices of these 36 physicians.

#### **PSYCHIATRIC SERVICES**

Examples of the more significant individual provider reviews were:

- A supplier of dialysis equipment furnished dialysis supplies in excess of the amounts allowed by regulations. As a result, the OIG found that the company had been overpaid more than \$411,000.

#### **PROVIDER REVIEWS**

- A physical therapy group was overpaid in excess of \$180,000 due to its billing for services which were not medically justified.

### Ongoing Reviews in Health

Our ongoing prevention activities are focusing on emerging PPS reimbursement issues such as area wage indices and recalibration of DRG weights. As in the past, priority is being given to review of Medicare reimbursement of hospital capital costs which are soon to be included in PPS.

#### **PROSPECTIVE PAYMENT SYSTEM**

The 1983 Social Security Amendments significantly changed the way hospitals are reimbursed under Medicare. Starting in FY 1984 hospitals are now reimbursed prospectively on the basis of a flat rate established for each Medicare case. The rate paid generally depends on which DRG the case falls under (e.g., kidney transplant or coronary bypass) and where the hospital is located.

Not all hospital costs are currently included in PPS. Capital costs such as interest and depreciation continue to be reimbursed on a reasonable cost basis and will be until at least October 1, 1986. After that date, capital expenses will no longer be excluded from PPS if a method acceptable to Congress for including these costs is found.

The OIG has pointed out several areas dealing with PPS in general and capital costs in particular where management attention is needed.

#### **COMPUTING DRG RATES**

Under PPS, the Federal DRG rates used to reimburse hospitals for medical care provided Medicare patients were calculated based on primarily unaudited 1981 cost report data submitted by providers. Certain pass-through costs, such as capital costs, were to be excluded from the DRG rates, as these costs were to be paid on a retroactive basis. From our review of 1981 hospital cost report data we determined that approximately \$1 billion of capital costs had not been excluded, thus overstating the Medicare costs used to calculate the DRG rates. We estimate that over a 5-year period beginning with FY 1986, these unexcluded capital costs will result in Medicare overcharges approximating \$2.8 billion.

In FY 1986, HCFA is required to recalibrate the DRG weights. Based on our review of capital costs, we pointed out to HCFA that rebasing the DRG rates would not only correct deficiencies in the present data base, but would also adjust the capital cost exclusion to its proper amount.

HCFA indicated that it knew there was capital in the base year costs but that adjusting the rates for budget neutrality under the Tax Equity and Fiscal Responsibility Act largely eliminated any potential for over-payments. OIG does not agree with HCFA's position.

Under PPS, Medicare provider decisions will be subjected to peer review evaluation as to the quality of care and necessity of admissions. These reviews will be made by Peer Review Organizations (PROs) in each of the 50 States, the District of Columbia, and three Territories. The vast majority of the PROs (53 of 54) operate under fixed price contracts with HHS.

OIG performed preaward audits of approximately 150 cost proposals valued at \$435 million. As a result of our reviews, during ensuing negotiations HCFA was able to reduce amounts originally proposed by about \$46.2 million.

## **PEER REVIEW COST PROPOSALS**

### **Legal and Administrative Sanctions of Wrongdoers**

Concerned about the escalating cost of health care and indications of fraud and patient abuse, the OIG has targeted major investigative resources on health care cases over the past 4 years. During the past 6 months, our health care investigations resulted in 31 convictions and \$6.8 million in investigative recoveries and savings. The State Medicaid Fraud Control Units obtained another 214 convictions and \$4.8 million in recoveries and savings. In addition, \$3 million more in settlements was obtained under the Civil Monetary Penalties Law.

The need for reducing costs without impairing the quality of medical care is clear. By punishing health care providers who defraud Medicare and Medicaid, we can stop their criminal activity and recoup some of the losses. In doing this, we are also preventing the criminals from

## **CRIMINAL FRAUD AND PATIENT ABUSE**

endangering patients. Sometimes blatant disregard for human life has been apparent, as in the case of a Virginia man who was convicted of selling false transcripts to people which showed they had fulfilled requirements of medical schools which they never attended. The OIG assisted in the follow-up investigation of persons buying the transcripts, which led to the January 1985 indictment of two New York "doctors" who had submitted their bogus credentials to obtain licenses to practice. A fraud in which medical professionals administer placebos or dangerous substances, or in which the "professionals" are medically incompetent and unqualified, clearly constitutes patient abuse.

**CLAIMING  
SERVICES NOT  
RENDERED**

Just as insidious is the more common fraud of claiming payment for needed services not given; while the cost of the fraud may be determined, the extent of patient suffering is incalculable. Following are two examples of this kind of fraud.

- A Georgia doctor was sentenced to 5 years in jail and fined \$5,000 for submitting false Medicare claims for office visits of elderly and disabled patients.
- An Ohio doctor was convicted of billing Medicare for laboratory tests never performed and injections never given.

**IMPROVED  
INVESTIGATIVE  
EXPERTISE**

Three things are necessary to stop ongoing health care fraud and patient abuse: uncovering information about suspicious circumstances, competent and thorough investigation, and prompt prosecutive action by U.S. Attorneys. The elimination of future wrongdoing depends upon identification of program or system weaknesses which permit fraudulent activities. The OIG has made major strides toward doing a better investigative job on both fronts. We have developed the expertise for better detection, better identification of systemic flaws, and better preparation of health care cases for prosecutive action. For example, we selected seasoned investigators to design and conduct a rigorous program in which our agents learn specific techniques for successful pursuit of fraud in the various segments of the health care industry. We also reward agents who identify significant flaws in program regulations and procedures.

**CITIZEN  
PARTICIPATION IN  
DETECTING FRAUD**

Traditionally we have had to rely largely on alert recipients of health care benefits, such as senior citizens receiving Medicare, and on program carriers and intermediaries, for leads on possible fraud in these programs. Thus, Medicare patients who carefully scrutinize their Explanations of Benefits (EOBs) are an important part of our fraud detection efforts.

nation of Medicare Benefits (EOMB) forms and who report discrepancies to us are important allies in the fight against fraud.

To enhance this participation, we have begun conducting programs to teach the public about health care fraud and to solicit their help. Recently an OIG agent joined a local SSA field representative in meetings with senior citizens to ask their help in uncovering the fraud which drains their benefits. The citizens were asked to review their EOMB forms carefully to identify providers whom they did not recognize and services which they did not receive. This direct contact approach appears encouraging: from eight meetings, the OIG agent received five promising leads.

A major source of our health care cases is the Medicare carriers. In processing claims, carriers are in a position to notice excessive or otherwise aberrant billings by health care providers, which may indicate fraudulent practices. Toward this end the OIG is working with the carriers to develop computer screens to identify possible fraud. About 200 cases of our workload during this reporting period originally emanated from carriers. The following are examples of these cases:

- The Medicare carrier in Texas notified the OIG about suspicious claims originating from a man serving a 1-year term in jail for Medicare fraud. The man had conspired with his sister, his ex-girlfriend and a former cellmate to file claims for fictitious ailments.
- A carrier noticed that an Ohio physician was submitting bills on pre-printed Medicare forms on which the beneficiary information and service dates were filled in by hand. Investigation showed that he was charging the same amount no matter how a patient was treated, and that he billed for laboratory tests and injections never performed.

Providers can be one of our most valuable sources for leads on fraudulent activities of fellow professionals. For example, in New York a psychiatrist reported that the directors of psychiatric and inpatient services at his hospital were billing Medicare for services which were never delivered. The physicians were charged with paying an unwitting billing clerk to prepare Medicare claims for each day certain patients were in the hospital, regardless of whether they were treated. Investigation showed that false claims amounting to more than \$100,000 had been submitted in this manner.

#### **CARRIER ASSISTANCE IN FIGHTING FRAUD**

#### **PROVIDER IDENTIFICATION OF PEER FRAUD**

**PROACTIVE  
PROJECTS**

We believe that health care providers could give us more valuable leads on fraud within their profession. Unfortunately, we have not yet received the response desired. We are seizing every opportunity to meet with and address meetings of health care professionals to encourage their reporting evidence of fraudulent behavior.

To supplement leads from citizens, carriers and providers, we undertake proactive initiatives. We identify similar fraudulent behavior in specific medical fields. Rather than concentrating on the specific cases, we develop efficient detection techniques and identify systemic problems which permit fraud. For example, such work in anesthesiology projects had the following results during this period:

- The former chief of anesthesiology in a Missouri medical center was convicted of obtaining nearly \$18,000 in fraudulent Medicare payments.
- A Colorado anesthesiologist was found guilty of having billed for services not performed and obtaining \$50,000 in overpayments.
- A third anesthesiologist, also in Colorado, was convicted of submitting fraudulent Medicare claims for which he received \$50,000 in overpayments.

Proactive experience in chiropractics resulted in the conviction of two Iowa chiropractors, one for filing 139 false Medicare claims for treatments he never gave patients, and the other for billing Medicare for more than \$16,000 in services not performed.

**GEOGRAPHIC TASK  
FORCES**

Recognizing that HHS shares an interest with others in the programs being defrauded, we have continued pursuing a task force approach in relevant situations. This approach continued to be productive during this period. At present we have three active task forces centered in the geographic areas of Pennsylvania, New Jersey and South Florida. The task forces are generally made up of FBI, OIG and State investigators who combine resources to find and eliminate fraud.

The Pennsylvania Medicare/Medicaid Task Force, which was our first venture in this approach, obtained three convictions against individuals during this period. Since its inception in 1982 it has accumulated a total of 15 convictions. Specific cases include:

- Two physicians who owned a clinic/laboratory and two medical centers in Philadelphia were sentenced for operating a widespread kickback scheme and for submitting false claims to the Medicare program.
- A Philadelphia heart specialist, chief of cardiovascular disease and internal medicine at a local hospital, was sentenced for Medicare fraud and kickbacks.
- The owner of another Philadelphia medical center was convicted of accepting \$15,000 in kickbacks for referring specimens to a diagnostic laboratory.

The successes of the Pennsylvania task force led to the creation of a New Jersey task force which has been specializing in ambulance cases. This task force arranged for the Medicare carrier to provide computer printouts profiling claims submitted by the highest billing ambulance companies in the State. After receiving those printouts, some 2,000 questionnaires were sent to beneficiaries to verify services claimed by these companies. As a result, 23 facilities were identified for further review. During this period the New Jersey task force obtained two convictions and an indictment. Specific cases include:

- The owner of an ambulance company was found guilty of obtaining more than \$150,000 for services misrepresented or not performed.
- The owner of another ambulance company was convicted of submitting fraudulent claims of more than \$100,000 for ambulance services. He altered the records of his company to disguise the type of service actually provided. In addition, he was charged with perjury for telling a Federal grand jury that he had not directed his employees to add incorrect illness diagnoses to bills being submitted to Medicare.

A third task force which has been operating in South Florida for 2 years obtained 12 indictments and 5 health care convictions during this reporting period, of which the following are examples:

- A dentist was convicted of filing Medicare claims while his license was suspended.
- A psychologist who had earlier been declared unqualified to receive

Medicare payments was convicted for fraudulently obtaining such payments by using someone else's identification number.

- A beneficiary and a Medicare carrier employee were found guilty of conspiring to submit fictitious Medicare claims.

#### **STATE MEDICAID FRAUD CONTROL UNITS**

In this period, three more Medicaid Fraud Control Units (MFCUs) were certified in Arizona, New Hampshire and South Dakota. The 36 States with MFCUs account for more than 95 percent of total Medicaid dollars. During the last 6-month reporting period, the MFCUs obtained 348 indictments, 214 convictions, more than \$4.8 million in fines and restitutions, and more than \$9.6 million in overpayments identified.

#### **ADMINISTRATIVE SANCTIONS**

The OIG exercises the various administrative sanction authorities of the Department to bar providers and practitioners guilty of fraud and patient abuse from participating in Medicare and Medicaid. Not only do sanctions prevent the providers from continuing to provide poor quality of care, but they also have the more effective result of making a dent in their bank accounts by cutting off program payments. The following examples are some of the 110 physicians, practitioners or others who have been convicted of a Medicare- or Medicaid-related crime and consequently barred, or have been barred because they provided poor quality of care:

- A California physician who drew blood unnecessarily from elderly patients and administered treatments utilizing a nonfunctioning machine was barred from Medicare and Medicaid participation for 20 years.
- A nurses' aide in Wisconsin who abused a Medicaid patient was barred from program participation for 10 years.
- A South Dakota physician who furnished unnecessary services and services which failed to meet professionally recognized standards was fined the maximum allowed. This was the first time such a fine had been imposed.
- A physician in Maryland was suspended from Medicare and Medicaid participation for 10 years for filing false claims. He billed the programs for construction and building supplies on his residence as being costs to his nursing home.

- The owner/manager of numerous optical companies in Illinois was suspended for 10 years for billing Medicaid for services and eyeglasses which were never furnished.
- A former maintenance man at a nursing home was precluded from receiving Medicare or Medicaid funds directly or indirectly for 10 years for sexually assaulting a Medicaid recipient.
- An individual in New Jersey was barred from Medicare and Medicaid for 20 years. He was convicted of practicing medicine without a license and submission of false claims.
- A pharmacist in Texas was suspended for 15 years for submitting false claims. As a result of his submission of these false claims, Medicaid recipients were incorrectly thought to have exceeded State-imposed monthly prescription limits.

The Civil Monetary Penalties Law (CMPL) of 1981 gave the OIG another formidable weapon for fighting health care fraud, enabling the assessment of thousands of dollars in fines and penalties for each false item claimed. During this reporting period alone, settlements amounted to \$3 million.

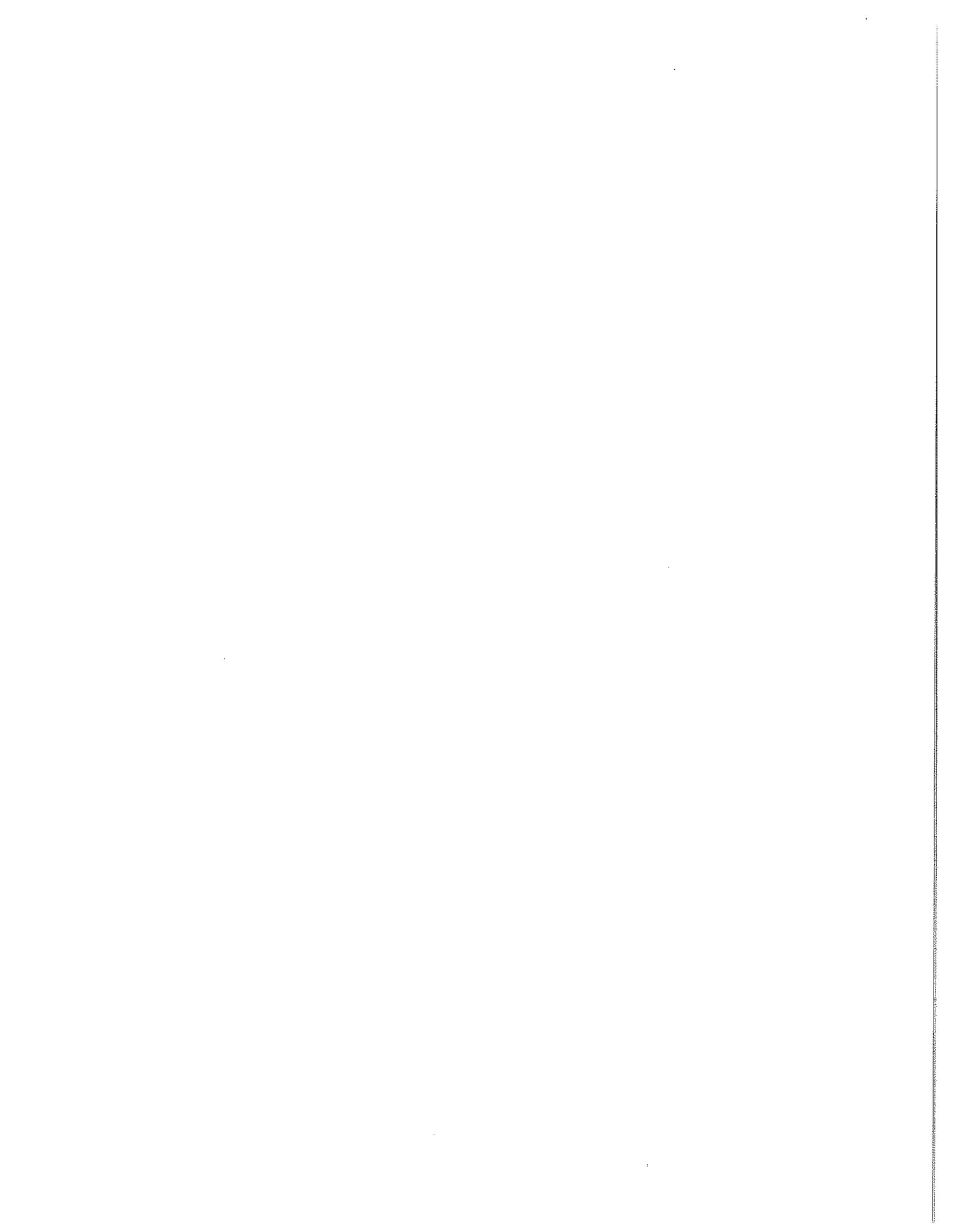
#### **CIVIL MONETARY PENALTIES**

CMPL cases of interest include the following:

- The OIG assessed a nursing home operator convicted of Medicaid fraud \$118,000 in lieu of damages, plus \$2,000 per item or service for 19 false line entries in cost reports. This was our first case to go before an administrative law judge, who upheld the imposition of the full amount of \$156,000 in civil penalties and assessments.
- An Oklahoma physician submitted 112 false consultation claims previously filed as nonassigned anesthesiology claims. The provider agreed to pay \$200,000 in penalties and assessments plus \$47,000 in interest.
- A Connecticut physician submitted claims for 163 podiatrist services which were coded as services which would give him a higher rate of reimbursement from Medicare. He agreed to pay \$81,000 in penalties and assessments plus \$9,000 in interest.

- A Louisiana physician submitted 91 false claims to Medicare over a 2-year period, for which he agreed to pay \$311,500 in penalties, assessments and restitution.

**SOCIAL SECURITY ADMINISTRATION**



## CHAPTER III

### SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) is responsible for the federally administered programs of Old Age and Survivors Insurance (OASI), Disability Insurance (DI), Supplemental Security Income (SSI), and the State-administered programs of Aid to Families with Dependent Children (AFDC), Refugee Resettlement (RR), and Low Income Home Energy Assistance (LIHEA). SSA also administers Part B black lung benefits for claims filed generally before 1974.

Over 51 million Americans will receive \$214 billion in benefits from income maintenance programs administered by SSA. Virtually every payment made by SSA is triggered by a computer transaction. With 16 large scale computers, over 900 tape and disk drives, 3,800 telecommunication terminals and 6,500 programs, SSA operates one of the largest computer complexes in the country.

During this period, OIG focused a significant portion of its resources on reviewing the efficiency and effectiveness of SSA's payment process, overall program administration, and adequacy of internal controls. Primary attention was focused on SSA's Title II programs (Retirement, Survivors, and Disability Insurance) because of the large amount of Federal dollars expended. The OIG is also reviewing, on a continuing basis, SSA's system development projects including their Systems/Claims Modernization Project.

OIG reviews during this 6-month period identified \$22.5 million that could be saved by full implementation of procedural recommendations. In addition, we have recommended financial adjustments totaling \$35.9 million.

#### Program Administration

As a result of accounting, timing and notification problems, monthly payments to Title II beneficiaries are sometimes made after death. We estimated that SSA made \$1.1 billion in such payments during the 2-year period ending December 31, 1982.

#### ACCOUNTING FOR PAYMENTS AFTER DEATH

OIG evaluated SSA's accounting for payments after death from termination to recovery of payment. We found that although SSA recovered \$841 million of the \$1.1 billion paid after death, accountability was lost for the remaining \$284 million. Significantly, \$133 million of this amount had not been restored at the time of our review. Although a portion of the \$284 million may have been or may be returned to the trust funds in the future, such amounts could not be determined or validated from our audit.

These problems were due, in large part, to ineffective accounting controls for payments after death and delays in terminating payments. In this connection, automated systems have not been designed to centrally identify or systematically control these payments. Delays in terminating payments, on the other hand, are caused by inadequacies in manual or automated processes and improperly coded returned benefit checks or electronic fund transfers. Additionally, failure to utilize available sources of death reports and untimely placement of death notification documents in beneficiary case folders contribute to this problem.

We recommended that SSA make the necessary improvements in its financial management systems to provide effective control over and accountability for payments made after death. If our recommended improvements are not made, SSA Trust Funds are at risk of losing over \$1 billion in the next 5 years. SSA agreed, and has begun to take action to improve accounting controls and their processing of death notices.

**SSI STOP PAYMENT  
PROCESS**

The Office of Inspector General recently completed a program inspection on the Social Security Administration's processing of SF-1184s for payments issued after death in the Title XVI program. The SF-1184 (stop payment) process is the vehicle used to notify the Department of Treasury of the need to recover an erroneous payment. The SF-1184 process relies primarily on manual action and, while the system provides some controls, the current process is subject to a high degree of error.

Our analysis of data from the Supplemental Security Record showed that SSA failed to recover \$24 million in erroneous payments for the period 1978 through 1983. In addition, we expect an annual loss of \$4.5 million.

SSA has agreed to automate the issuance of SF-1184s and will develop the needed systems controls to insure the recovery of the future incorrect payments. Additionally, SSA is taking action to recover the \$24 million in incorrect payments identified by this program inspection.

Social Security beneficiaries are required to report personal events to SSA, including marriages, which might affect continued eligibility. Marriage terminates survivor benefit payments for widows/widowers under age 60 with dependent children and for children when they marry.

## **UNREPORTED MARRIAGES**

A computerized match of SSA survivor beneficiary files and marriage files in one State identified unreported marriages involving some \$3.5 million in benefits. If the results of our review are representative of the nation as a whole, we estimate that from February 1970 through December 1981 SSA made improper payments amounting to \$40 million. Additionally, if this problem is not corrected, we estimate that over the next 5 years improper payments will total \$38 million.

Our recommendations will call for SSA to utilize their earnings reference and Numident files to detect unreported marriages nationwide, and perform computer matches of survivor beneficiary files against State marriage files (similar to our State match).

The State-administered Refugee Cash Assistance (RCA) program provides cash and medical assistance to needy refugee adults and children who are not eligible for AFDC. The cost of RCA is reimbursed 100 percent by SSA's Office of Refugee Resettlement (ORR). Our review in one State disclosed that 81 percent of the RCA families lived in households shared with other adults. However, because these arrangements were not considered in determining grant amounts, recipients received a much higher payment than AFDC recipients with similar living arrangements.

## **SHARED LIVING ARRANGEMENTS**

If ORR required States to adjust RCA payments to reflect shared living arrangements, as is currently done in several other assistance programs, we estimate nationwide annual savings of \$16.7 million or about \$83.5 million over the next 5 years. OIG recommendations call for ORR to study alternative methods for adjusting grants for shared living arrangements and issuing regulations to implement the method selected. SSA agrees and is developing a regulation requiring consideration of shared living arrangements in determining refugee cash assistance.

SSA enters into a number of agreements where it provides information to other Federal agencies on earnings records, benefits, employer and related data, and services such as data processing and statistical analyses. This work is normally done on a cost reimbursement basis and is commonly referred to as "reimbursable work." During fiscal year

## **REIMBURSABLE WORK**

1984, SSA authorized \$9 million in reimbursable work to outside organizations.

We found that SSA's procedures for accepting, accumulating and billing for these non-program services were not always followed. Specifically, project coordinators were not fully aware of the duties and responsibilities of their position; internal controls were inadequate to safeguard against unauthorized reimbursable work; accounting and billing procedures were inadequate to ensure the recovery of actual cost; and fiscal and administrative controls were inadequate. The result: unauthorized work was performed and SSA did not recover its actual cost for reimbursable work. Recommendations call for strengthening internal controls over billings for reimbursable work.

### **Electronic Data Processing**

We are reviewing, on a continuing basis, SSA's Electronic Data Processing (EDP) systems development projects, including its Systems Modernization Plan (SMP).

#### **SYSTEMS MODERNIZATION PLAN**

In February 1982, SSA unveiled the SMP to overhaul its computer hardware and software systems. The SMP addressed a general crisis in SSA systems caused by outmoded equipment and old and poorly documented software.

During the first 3 years of the SMP, SSA took major steps to resolve many of its hardware-related computer problems. This has resulted in better service to the public and greater SSA control of major workloads, and has greatly lessened the possibility that SSA computer systems will fail.

The improvement of SSA software, however, has proven to be a more difficult task. Embedded in SSA systems are about 12 million lines of undocumented code in need of improvement. What exists today is software that is largely a product of unplanned patchwork with no regard given to its determining condition nor to the efficiencies available from technical advancements. In the past, we reported on several technical deficiencies in SSA's redesign of their claims processing system and in

their systems planning and standards development. SSA has since taken steps to correct the deficiencies disclosed.

SSA awarded three computer software contracts to assist in its systems modernization effort. Our review disclosed that despite expenditures of over \$1 million and 10 work years of scarce in-house systems personnel time (or about \$407,000 in salary costs) in attempts to improve delivered products, only minimal improvements resulted. Much of the software delivered by contractors was either of no use to SSA or usable only after considerable modifications.

## **SOFTWARE CONTRACTING**

We found that the underlying causes for the generally poor results were that: (1) software improvement, in itself, is extremely difficult to accomplish and is made even more so when done under contract; (2) SSA has little experience in planning, writing, and monitoring software improvement contracts; and (3) there was a sense of urgency by SSA to make quick software improvements which resulted in unrealistically short deadlines for completing work.

We recommended that SSA implement the necessary procedures and controls to ensure that useful products result from contracts for software improvements.

## **Current Legislative Reform**

Currently, SSA requires State and local employers to make consolidated semimonthly deposits for Social Security contributions on the wages of their employees. The Inspector General's Semiannual Report for the period ended September 30, 1984 noted that acceleration of this deposit schedule to the private sector schedule would increase Trust Fund interest income and contribution receipts over 5 years by \$480 million and \$988 million, respectively. The combined savings updated from our prior report are estimated to be \$2.2 billion for the 5-year budget cycle.

## **SOCIAL SECURITY DEPOSITS**

To encourage compliance with accelerated deposit requirements, we 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.

We are pleased to note that the Administration's FY 1986 budget does include a proposal requiring States and localities to deposit on the private sector schedule.

### **Legal and Administrative Sanctions of Wrongdoers**

Diversion of Social Security benefits from their intended purposes is of particular concern because the wrongdoers, sometimes in collusion with Department employees, are stealing funds desperately needed by the very young, widowed, disabled and geriatric beneficiaries these programs were designed to help. Investigations of Social Security cases during the first half of the year resulted in 468 convictions, \$5.9 million in investigative recoveries, and savings of \$4.6 million.

**DEATH MATCHES** Over the past few years we have had remarkable success with major death matches in which SSA's beneficiary rolls were compared by computer with Medicare and other death records. As a result, in 1983 Congress amended the Social Security Act, mandating that SSA compile death data from the 50 States and match it against the beneficiary rolls.

Thus, screening and following up on SSA "hits" is becoming part of our routine investigative work. The following items are examples of the cases resulting from these matches:

- A 68-year-old man in Rhode Island was found guilty of converting his deceased wife's Social Security checks to his own use for 26 months. He had actually been converting the checks for 5½ years, but the statute of limitations had run out on much of that time.
- After the mother of an insurance agency owner died in October 1976, the man began to convert her benefits to his own use. He was found guilty of illegally obtaining \$34,000.
- In the second phase of a death match, a Federal grand jury in Boston recently indicted 12 persons for stealing a total of nearly \$200,000 in Social Security benefits. During the first phase, 17 people were convicted for failing to disclose the deaths of relatives and friends and appropriating for themselves a total of nearly \$800,000 in benefits.

The last example illustrates a prosecution technique which has been found extremely effective. Prosecutors have found that grouping their indictments and releasing them together gets the media attention needed for successful prosecution and deterrent effect. During this reporting period we obtained 7 mass judicial actions involving 153 persons.

#### **MASS JUDICIAL ACTIONS**

Project INTERFACE (International Fraud Analysis and Claims Evaluation) was established to investigate fraud in Social Security programs which occurred outside the jurisdiction of the United States. We take suspicious claims from SSA, make fraud determinations and handle investigations and dispositions. Thus far we have realized recoveries of almost \$600,000 from this project.

#### **INTERNATIONAL SSA FRAUD**

The AFDC program is primarily funded by the Department's Office of Family Assistance but is administered and partially funded by the States. When local agencies suspect that welfare recipients are concealing Social Security benefits, we obtain and authenticate records such as canceled checks and other original documentation necessary for prosecution. We also provide witnesses and other assistance in the prosecution of these cases. During this period the AFDC Benefits Project accounted for 104 convictions and almost \$1.2 million in fines, restitution and civil recoveries.

#### **AFDC BENEFITS PROJECT**

In Project Payback we work with SSA to identify and screen instances of incorrect payments to beneficiaries to determine those involved in suspected fraud but who do not meet prosecutive criteria. We then send letters demanding return of the incorrect payment in language to motivate a refund, identifying the office to which the refund should be sent. During this period we reported savings and recoveries of almost \$1.4 million from this project.

#### **PROJECT PAYBACK**

Project SSAMAN (Social Security Administration Multiple Account Numbers), begun in FY 1983, involves the identification and investigation of community-based organizations which may be using multiple SSNs to defraud Federal, State and local benefit programs. Thousands of records are screened for SSNs which are suspect, either because they are nonexistent, duplicative or otherwise questionable. Those which appear fraudulent are shared with State and local agencies for matching against their beneficiary rolls.

#### **PROJECT SSAMAN**

Two judicial actions occurring during this period indicate the extent of efforts to obtain illegal SSNs and cards and the uses to which they can be put:

#### **FRAUDULENT SSA CARDS**

- In New Jersey a joint investigation by OIG and Secret Service agents led to seven persons being convicted of counterfeiting more than \$7 million in Federal Reserve notes, Social Security cards and 50-peso notes on the Central Bank of the Dominican Republic. The investigation is continuing, with other indictments expected.
- Two women were indicted by a Federal grand jury in Ohio under the False Identification Act of 1982 on various counts of SSN misuse. Both are known members of a terrorist group, three others of which were arrested at the same time. The leader of the group, who has been linked to 16 bombings and 2 attempted bombings, was one of those arrested. OIG agents assisted the FBI and Federal prosecutors in the case.

#### **FALSE BIRTH CERTIFICATES**

Puerto Rican birth certificates are widely used by Spanish-speaking aliens to obtain U.S. documents and benefits. The birth certificates are issued by each Puerto Rican municipality and signed by appropriate local officials. Recently the OIG put together a book which shows the proper certificate numbers issued and the signatures that should appear for various periods of time. Using this book, in one summer the Massachusetts Department of Welfare was able to identify and cause to be arrested more than 30 people who were using false Puerto Rican birth records. We are automating the list and producing it in a format useful to Federal, State and local officials in areas having high numbers of Spanish-speaking aliens. We will also be compiling a similar list for Virgin Islands birth certificates, since these are often used by foreign nationals to obtain welfare and student assistance.

#### **CALIFORNIA KICKBACK CASE**

One case involving SSNs, which was described in our last Semiannual Report, has grown so large it has assumed project proportions. In California, Alameda County officials discovered that a county welfare supervisor had developed a scam which may ultimately have involved more than 150 persons.

Former AFDC recipients agreed to allow their SSNs to be used to reactivate welfare payments. The scam is believed to have cost Federal and State agencies more than \$1.2 million. To date 50 persons have been found guilty. Most were given prison sentences. Restitutions stemming from this case during this period amounted to more than \$300,000, for a total of more than \$500,000 thus far.

#### **ILLEGAL ALIENS**

Also related to SSN misuse are projects and cases involving illegal

aliens. The first project, begun in Baltimore in 1982, used specially developed computer programs to target fraudulent use of SSNs by illegal/nonimmigrant aliens. We now work routinely with the U.S. Immigration and Naturalization Service (INS), following up leads uncovered by these projects.

Project SSNAPBACK is an ongoing, nationwide investigative effort worked in conjunction with INS. It was designed to detect fraud perpetrated by illegal aliens against Federal, State and local benefit programs. SSNs used by illegal aliens who are picked up by INS are transmitted to our field offices. We compile listings of those numbers and transmit them to the State agencies to be matched against State and local benefit rolls. The numbers are also used for comparison at the time of application for benefits. In addition, offices and employees which issue an unusually high number of SSNs and cards are targeted for further inquiry.

The following actions are examples of some of our other cases involving illegal aliens during this reporting period:

- In Rhode Island, six Latin American nationals were caught after using fictitious SSNs to apply for unemployment benefits after being laid off from jobs they had obtained with the false SSNs.
- A Nigerian student was convicted of false representation of SSNs on credit card applications. The student established a number of fictitious companies and used SSNs to obtain credit card accounts for nonexistent officers. Using the cards, he obtained valuable goods and cash advances. At the time of his arrest, he had goods valued at \$50,000 at his residence and over \$30,000 in cash.

Occasionally an SSA employee finds access to the system too tempting an opportunity to resist. Some of our employee fraud cases follow:

#### **EMPLOYEE FRAUD**

- An SSA claims clerk, two county investigators and an unemployed man were convicted in Ohio for conspiracy and theft of returned Social Security benefit checks.
- A former employee in Nevada was convicted of embezzling more than \$20,000 from SSA, largely to support a gambling habit.
- A New York SSA employee was found guilty of diverting \$67,000 in benefits being paid to deceased persons.

**MANAGEMENT  
IMPLICATION  
REPORTS**

During this period, as a result of six Management Implication Reports (MIRs), two program vulnerability notices were issued to SSA. These notices were based on evidence of program weaknesses observed by agents in the course of their investigations, and each resulted in corrective actions taken by SSA. One made recommendations on ways to prevent SSA employees from manipulating the SSI payment process. As a result, SSA will require a district office to make direct contact with a beneficiary before making a systems input on the basis of a redetermination form mailed in by another SSA office. SSA also agreed that better monitoring of the automated payment process is needed and will set up an "umbrella review" whereby each office manager must check a systems-generated sample of all systems transactions transmitted from his or her office.

**DISABILITY  
BENEFITS FRAUD**

Disability benefits fraud cases are becoming an increasing part of our investigative workload, often involving widely disparate and seemingly unlikely persons:

- A California man was charged with using the birth records of two deceased infants to obtain SSNs and apply for and receive \$14,000 in disability payments.
- A woman who had been receiving disability payments since 1974 was found to have worked for at least eight different companies between 1974 and 1983.
- An employee of the California Department of Social Services pled guilty to obtaining disability payments since 1976.
- A Rhode Island man was found guilty of illegally obtaining nearly \$30,000 in SSA disability payments. For the past 5 years, he concealed his return to work as Chief of Security at the Rhode Island Adult Correctional Institution.

**VERIFYING  
RECERTIFICATION**

SSA pays more than 2,500 Title II disability beneficiaries annually as a result of civil court summary judgments. Typically, several years elapse from the date the applications for disability benefits are filed until benefits are awarded, resulting in significant retroactive payments being made.

OIG discovered that SSA does not re-verify any eligibility factors in these cases, even though several years elapse between the date of the

application and the date of the court judgment. As a result, the court judgments are made without benefit of information, such as recent employment, which could affect the decision.

OIG recommended, and SSA agreed, that records of earnings should be examined *prior* to court judgments. SSA has begun a study to determine the most appropriate time and manner to get current information on work activity before the courts which might affect their decision.

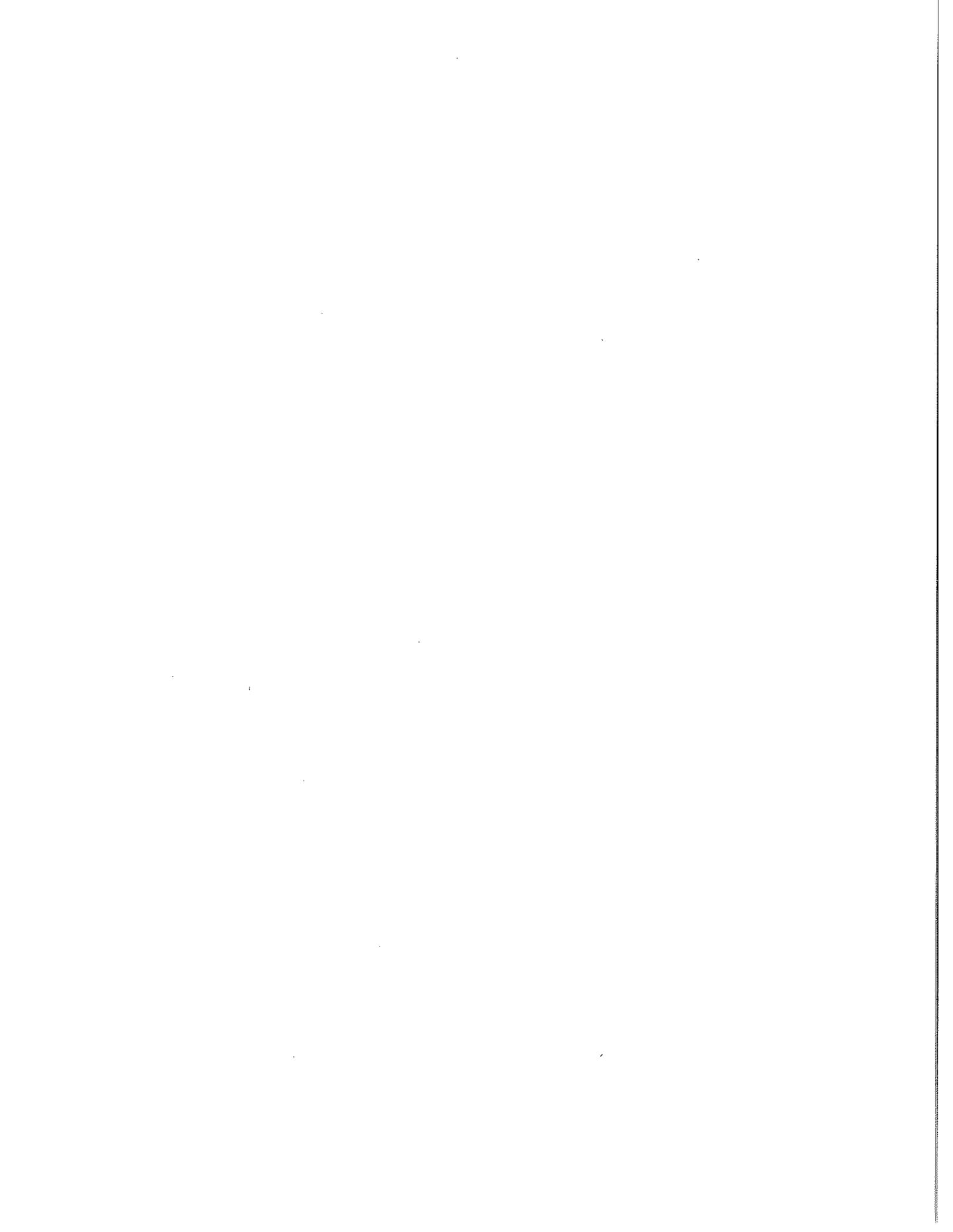
Investigations have revealed that employment and earnings by disability beneficiaries often remain undetected until significant overpayments have occurred. Excepting voluntary report, work activity comes to SSA's attention either through periodic reviews to determine continuing eligibility or through the annual earnings enforcement program.

Both of these enforcement tools have a weakness: time delay. The identification of work activity generally does not occur until one or more years after the disabled individual's return to work.

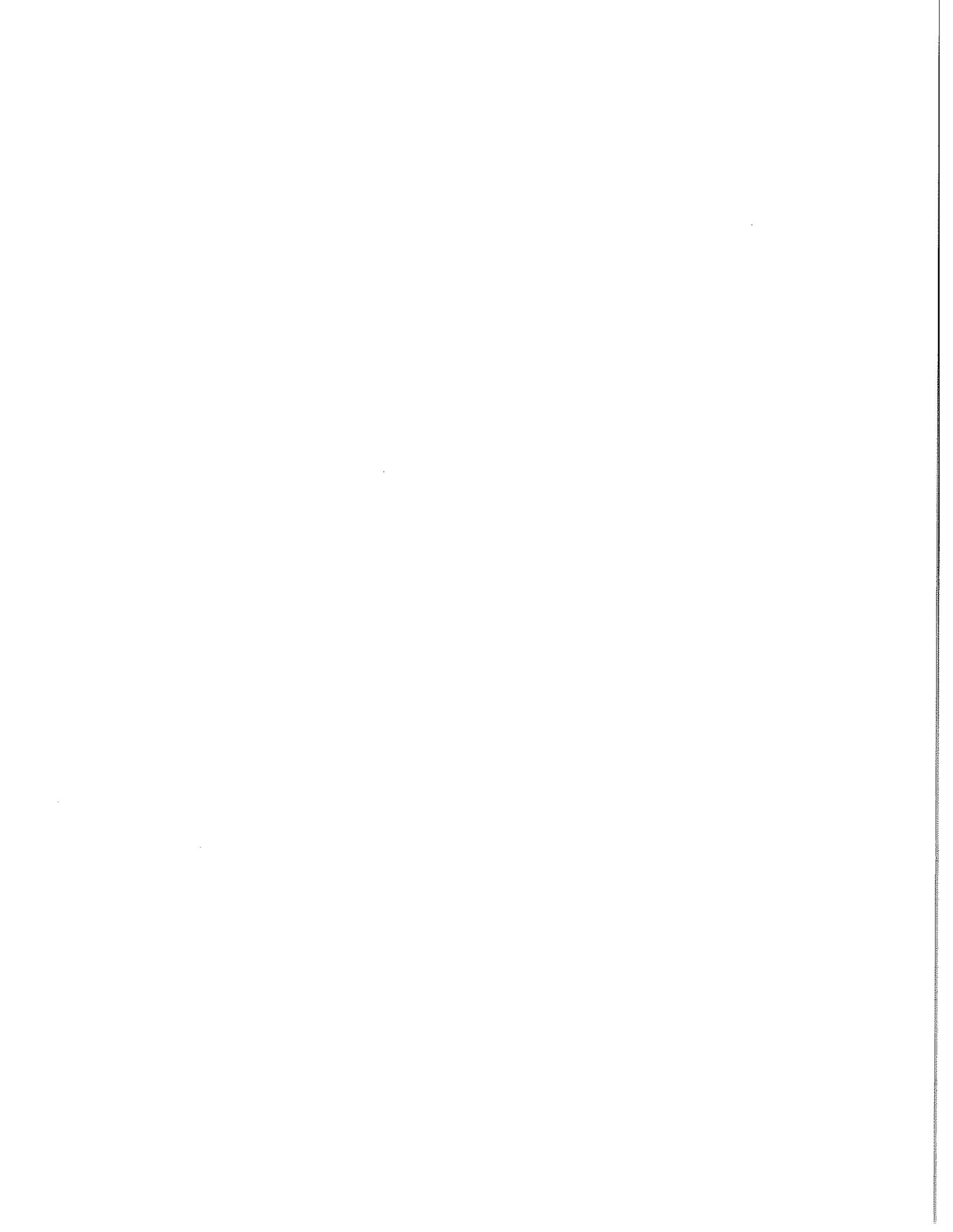
In order to provide for earlier discovery of a return to work, we recommended that SSA institute annual mail contacts with all Title II disability beneficiaries, except those with extreme disability. The beneficiary's signature should be required to establish intent should a question of fraud exist.

SSA agreed with this proposal and is developing a profile of persons who fail to report work activity. Annual mail contacts will be focused on beneficiaries meeting that profile.

**IDENTIFYING  
DISABILITY  
BENEFICIARIES'  
RETURN TO WORK**



# GRANTS AND INTERNAL SYSTEMS



## CHAPTER IV

### GRANTS AND INTERNAL SYSTEMS

This chapter focuses on grants and internal system activities of two operating divisions, the Public Health Service (PHS) and the Office of Human Development Services (OHDS), as well as the financial management activities applicable to the Department as a whole.

In FY 1985 the Department estimates budget outlays of \$8.9 billion for PHS, \$6.0 billion for OHDS and \$224 million for departmental management. Together these areas comprise 5 percent of the Department's budget and 83 percent of the Department's discretionary expenditures.

PHS operates approximately five major agencies, including the National Institutes of Health, the Food and Drug Administration and the Centers for Disease Control. OHDS administers programs that assist the elderly, the disadvantaged and handicapped children, such as the Work Incentive program and Head Start. The wide variety and large number of programs, the enormous number of grantees and contractors, the varied funding methods and the complexity and extensiveness of the Department's administrative structures amplify vulnerability to fraud, waste, abuse and management inefficiencies.

The principal thrust of our effort in this area was toward determining (1) the adequacy of internal controls and other preventive mechanisms, (2) whether funds were utilized efficiently and effectively, and (3) whether selected programs were being administered in an efficient and effective manner.

From October 1, 1984 through March 31, 1985, we identified opportunities for cost savings of \$43.6 million through increased efficiency of program operations and management. Recommended financial adjustments for this same period amounted to \$40.1 million.

Effective systems of internal controls provide strong mechanisms to prevent as well as detect fraud, abuse and waste. OIG is continually monitoring the Department's efforts to establish and maintain effective internal administrative and accounting controls as required by the Federal Manager's Financial Integrity Act and OMB Circular A-123.

**INTERNAL  
CONTROL**

OIG's review of the Department's second-year effort to evaluate its systems of internal control focused on (1) determining whether appropriate actions were taken to correct material weaknesses reported in 1983 and (2) assessing the adequacy of internal control and accounting system reviews performed in 1984. We found that:

- Actions taken to correct 200 previously reported material weaknesses in internal controls were generally adequate. In some cases corrective action could not be fully implemented during 1984.
- More attention is needed to further upgrade the overall internal control process to improve the reliability of the results of internal control reviews (ICRs). We found that problems reported last year for completing ICRs on schedule and documenting and testing the results persisted. Further, the scope of many SSA reviews was limited and many deficiencies identified were not reported to SSA headquarters. The success of the Department's 1985 program depends, in large measure, on correcting these problems.
- In 1984, the Department's evaluation of accounting systems was characterized by a continued lack of adequate documentation of reviews conducted as well as lack of adequate testing for adherence to prescribed procedures. The Department began to revise its methodology for conducting these reviews during 1985. The revision is to incorporate OMB's draft guidelines for evaluating, improving and reporting on financial management/accounting systems. However, the revised methodology is not scheduled for issuance until Spring 1985. This will considerably compress the time available for completion of reviews.

Our observations along with appropriate recommendations have been reported to the involved operating divisions as well as to the Assistant Secretary for Management and Budget. The Secretary cited our concerns in the Department's annual report to Congress and the President on the adequacy of internal controls in the Department.

#### **CASH MANAGEMENT**

Our review of cash management practices used by five States funded under the letter-of-credit system disclosed:

- Federal funds were often drawn down too far in advance of actual need. In two States the cost of interest to the Federal treasury was computed at \$4.6 million over 5 years because of premature draws of cash.

- Accounting controls were not adequate to account for expenditures by grant award.
- Various adjustments, such as child support collections and adjustments for correction of errors, were not given proper consideration in determining the amount of subsequent drawdowns.

Various factors were found to have contributed to these deficiencies. Cash advances were based on estimates that were often unrealistic and did not always reflect adjustments for prior periods. Cash balances frequently could not be reconciled with HHS financial records. This often contributed to the receipt of Federal funds in excess of immediate needs.

Separate reports recommending procedural change and financial adjustment as appropriate were issued to the individual States. (Several of these were issued in prior reporting periods.) Overall recommendations to correct the deficiencies discussed were made to the Assistant Secretary for Management and Budget.

In FY 1985, about \$1.1 billion in Federal funds will be spent to provide comprehensive support and early childhood development services for eligible children up to age five. During this reporting period, we evaluated and issued 514 reports by nonfederal auditors (e.g., public accounting firms) concerning Head Start grantee operations. The reports recommended financial adjustments totaling \$2.1 million in costs charged to the program and also cited 576 deficiencies in grant administration such as problems with accounting, internal controls and recordkeeping practices.

#### **HEAD START**

The 1984 Single Audit Act underscored the single audit approach by mandating that all State and local governments receiving Federal funds in excess of \$100,000 have annual audits of Federal monies expended. OIG has long been an advocate of the single audit and has used the approach to provide basic audit coverage to the many grantees receiving Department funds.

#### **NONFEDERAL AUDIT ACTIVITY**

When problems are noted or questions raised as a result of a nonfederal audit report, OIG builds on the work performed to more fully develop the issues or problems. For example, as a result of questions raised, OIG expanded a Head Start review of one grantee to look into certain areas not covered by a public accounting firm. We found:

- The grantee maintained a self-funded health insurance program for its employees. The costs of such a program are allowable grant charges provided they are reasonable. However, the grantee charged Head Start with insurance premiums that exceeded actual costs by \$478,000. We are recommending that these funds be credited to Head Start and that future insurance premiums charged the program be brought in line with actual costs incurred.
- The grantee charged the Head Start program monthly rent on nine buildings it owned, rather than limiting its building costs as required to either a use charge or depreciation. As a result, the Head Start program was overcharged about \$277,000 over a 6-year period. We are recommending that the grantee negotiate a financial adjustment with OHDS for these costs.
- The grantee purchased equipment during 1 year amounting to \$231,000, but did not obtain the required prior approval of OHDS. We are recommending that the grantee seek retroactive approval or, failing that, make an appropriate financial adjustment.

The grantee concurred with our findings and, for the most part, agreed to implement our recommendations as required by OHDS. OHDS has concurred with our findings and recommendations.

#### **INSTITUTIONS OF HIGHER EDUCATION**

We rely on single, nonfederal audits to provide basic coverage of financial and compliance issues at institutions of higher education. However, separate, limited-scope OIG reviews are still performed in areas where special problems have been identified.

In one such review we examined cost transfers of \$64 million made by a university that expended over \$1 billion in Federal funds during a 3-year period. The OIG's review (using a statistically valid sample) found that contrary to Federal requirements, cost transfers were: (1) used to eliminate cost overruns (i.e., costs were being transferred from projects with overexpended balances); (2) made to use up unexpended funds; (3) charged to projects based on unacceptable allocation methods; and (4) included unallowable costs. We estimate that at least \$1.8 million of this amount was inappropriately charged to Federal projects. Recommendations call for the university to refund this amount and strengthen review procedures at specific campuses.

**DEBT COLLECTION**

For the 6-month period ended December 31, 1984, debt due the Department increased \$39 million, collections decreased \$21 million, and write-offs of accounts receivable decreased \$112 million. (See summary, page 53.)

The OIG monitors the Department's debt collection activities on a cyclical basis. For this period we examined OS and OHDS (whose collection activities are recorded by the Division of Accounting Operations (DAO) in the Office of the Secretary), and HCFA. We also assessed action taken in resolving prior problems in reporting debts in accordance with requirements of OMB, Treasury and the Department.

*OS and OHDS*—In our Semiannual Report for the 6-month period ended March 31, 1984 we reported that DAO did not properly record or charge interest on sustained audit disallowances to be collected by adjustments to subsequent program funding. Our current review of OS and OHDS debt collection activities showed that some improvements were made in controls and procedures used by DAO to record sustained audit disallowances. However, further action is necessary, as demonstrated by the following examples:

- Accounting errors resulted in OHDS audit disallowances of \$1.1 million not being recorded as receivables or reported to Treasury. Interest was not accrued on these disallowances as required.
- Detailed schedules of amounts due from individual grantees or contractors on sustained audit disallowances were not maintained.
- A system for aging audit disallowance receivables still has not been formalized.

*HCFA*—As of June 1984, the Deputy Assistant Secretary for Finance (DASF) suggested that all program disallowances be separately identified and reported as accounts receivable. However, we found that \$112 million in disallowances made by HCFA program offices had not been reported as accounts receivable.

Our review of HCFA debt collection activity also showed that HCFA is not accruing interest on disallowances of \$74.7 million under appeal because accounting officials believed that it was not practical unless done on an estimated rather than actual basis as prescribed by OMB Circular A-50. Interest due on this amount would total approximately \$6.5

million annually. This matter was discussed with the DASF who issued proposed instructions requiring the accrual of interest during the appeal process.

**COST-PLUS-FIXED-FEE CONTRACTS**

PHS, which has the largest procurement activity in the Department, awarded \$41.4 million in cost-plus-fixed-fee contracts for management and professional services in FY 1984. A limited review of fees allowed on such contracts found that contractors generally received a fee of 7 percent above costs without stringent evaluation of contractor effort, risk assumed, investment required, or complexity of work performed as required by Department procurement policies. Instances were also noted where documentation contained in the contract file did not adequately explain the basis for the negotiated fee. About \$314,000 in fees reviewed were not justified. If these results are representative of other contracts awarded during the period, we estimate that PHS could save about \$630,000 annually by more stringently applying Department procurement policy when establishing these fees.

Recommendations call for PHS to better evaluate and document the determination of fees and monitor the preaward process to ensure that proposed fees are justified.

PHS agreed to tighten evaluation and documentation practices, and has initiated action to monitor and assess fee trends. Effective October 1, 1984, fee information was included in the PHS contract information system. This information will enable PHS to identify potential problem areas for follow-up assessments.

**TIME AND ATTENDANCE**

Time and Attendance (T&A) cards are used to prepare pay checks centrally for about 140,000 Department employees. After the payroll has been completed, the T&A cards are collected and microfilmed. HHS contracts with a commercial vendor to sort, microfilm and prepare the T&A cards for storage. Estimated cost is \$110,000 a year.

During a previously reported President's Council on Integrity and Efficiency review of the Department's handling of unemployment compensation cases, we reviewed FY 1982 payroll records and found that a significant number of T&A cards, both originals and microfilmed copies, were missing or unreadable. Because of this, we were unable to fully document supporting evidence for employees who may have received inappropriate unemployment compensation benefits. Prosecutive or administrative sanctions against some individuals, particularly part-timers, may have been impeded as a result.

To determine if the condition of T&A cards had improved since our earlier review, we sampled microfilmed T&A cards for the five quarters ending June 1983. Of the cards examined, 42 percent were unreadable. Our recommendations call for improved procedures to provide effective control over original and microfilmed T&A cards.

P.L. 98-473 appropriates \$25 million in additional FY 1985 funding to States for training child care providers and parents, including training in the prevention of child sexual abuse. However, the law provides that States will lose half of this funding in FY 1986 or FY 1987 if they fail to pass State legislation by September 30, 1985, requiring nationwide criminal record (fingerprint) checks for all current and prospective day care employees in licensed facilities.

### **PREVENTING SEXUAL ABUSE IN DAY CARE PROGRAMS**

An OIG study found that fingerprinting of day care employees is not the whole answer to the growing child sex abuse problem since few child sex abusers have criminal records. Criminal record screens are desirable but should be combined with background checks, employment history checks, and reference checks to provide maximum security against abuse by day care workers. The OIG found a strong consensus among experts nationwide that education of teachers, parents and children is the most effective approach to preventing child sexual abuse in the home and in child care facilities.

The OIG report was accepted by HHS Secretary Margaret Heckler and used by the Department as a guide in several initiatives to combat growing child sex abuse. These initiatives include the publication of new Head Start preschool program hiring regulations calling for more selective and intensive screening of potential employees, an interdepartmental effort to combat violence within the family, and the publication of the "Model Child Care Standards Act—Guidance to States to Prevent Child Abuse in Day Care Facilities."

An OIG study of 62 Head Start agencies in 18 States revealed that employees of approximately 75 percent of all Head Start grantees routinely draw unemployment compensation during the summer while they are between terms. This practice, which is abusive and contrary to the primary intent of the unemployment insurance laws, is causing an unnecessary drain of \$15.6 million on Head Start funds and \$6 million in other HHS funds. This money is being diverted away from the children it was intended to help to support the overhead of the program. By discontinuing this practice, HHS could substantially reduce its unemployment costs in the Head Start program.

### **UNEMPLOYMENT INSURANCE COSTS IN HEAD START**

An additional \$21.4 million can be saved by having Head Start grantees withdraw from State unemployment programs and create their own State-level group trust funds with contributions made at a substantially lower rate. OIG recommendations call for a change in the Department of Labor (DoL) policy which currently allows these between-term unemployment compensation payments to Head Start employees. The OIG also recommended that OHDS conduct an analysis of ongoing unemployment costs and to promote alternatives to contributing to State unemployment insurance (UI) programs where appropriate. OHDS concurs with these findings and recommendations. The OIG is working with OHDS and the OIG of DoL to facilitate the implementation of these recommendations.

### **Investigative Activities**

Allegations of contractor, grantee and employee misconduct are most often referred to the cognizant program administrator for appropriate management resolution because they generally are management problems. Criminal cases, however, are within the purview of our investigative responsibility. During this period we obtained 33 convictions and had recoveries and savings of about \$700,000 in cases ranging from embezzlements perpetrated by individuals to complex conspiracies and manipulation of grant or contract funds, as illustrated in the following cases:

- The director of a health service organization in Illinois was found guilty of misusing about \$500,000 in funds administered by OHDS. His conviction culminated a 3-year investigation by the OIG and the Internal Revenue Service (IRS), which was based on an OIG audit.
- A student being paid on a National Health Service Corps nursing scholarship changed her major to English, which made her ineligible for these PHS funds. She was charged with embezzling \$22,000 from the scholarship funds by stating she was still eligible.
- The former director of a community action council and the owner of a furnace company defrauded the Government of \$13,500 for furnace burners that were never installed. The director was responsible for a

program to increase the efficiency of oil-burning furnaces in the homes of poor people, and the furnace company official took the money but never performed the work.

- The director of a Head Start program used its funds to liquidate personal debts stemming from convictions for driving while intoxicated, financing a Christmas party for employees, and purchasing liquor for himself.
- A payments clerk at a clinic embezzled more than \$3,200 over a 6-month period by altering accounts and ledger cards on 49 patients.
- A Texas woman filed false eligibility forms with a day care center so that her son could receive day care services. Her filing caused the day care center to receive about \$2,000 in benefits to which it was not entitled.

#### **FRAUD ALERTS**

One of the fraud alerts issued by the OIG during this period was related to a contract/grant issue. The Department of Education (ED) recently investigated a contractor for misuse of Federal funds. As a result, the contractor signed a consent order to repay \$25,000 and to refrain permanently from applying for or administering any Federal contract or funds. Within 3 months the contractor had violated the order, by signing an agreement with a State organization to receive funds allocated by HHS. The State organization not only renewed but also increased the contractor's level of funding, to compensate him for the loss of the ED funding. No one apparently made any effort to find out why ED had terminated the funds and taken possession of some of the contractor's records. On the basis of this incident, we issued a fraud alert urging Federal and State agencies to take all reasonable precautions not to award grants to persons or organizations barred by court orders or consent decrees from receiving or disbursing Federal funds.

#### **AUDIT RESOLUTION**

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

### Reports with Questioned Costs

	<u>Total</u>	<u>Over 6- months old</u>
Unresolved audits, September 30, 1984	197	3
Unresolved audits, March 31, 1985	203	6 <sup>1</sup>
	<u>Number</u>	
Reports issued during period	250	
Reports resolved during period	244	
	<u>Amount (in millions)</u>	
Costs questioned during period	\$109.7	
Costs sustained during period	\$ 44.9 <sup>2</sup>	

<sup>1</sup> These reports are with the following operating divisions for resolution:

	<u>PHS</u>	<u>SSA</u>	<u>OS</u>	<u>OCS</u>	<u>Total</u>
Reports	1	1	1	3	6
Monetary Findings (in thousands)	\$551,537	\$177,145	\$5,596	\$122,334	\$856,612

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

## Summary of Receivables, Collections and Write-Offs

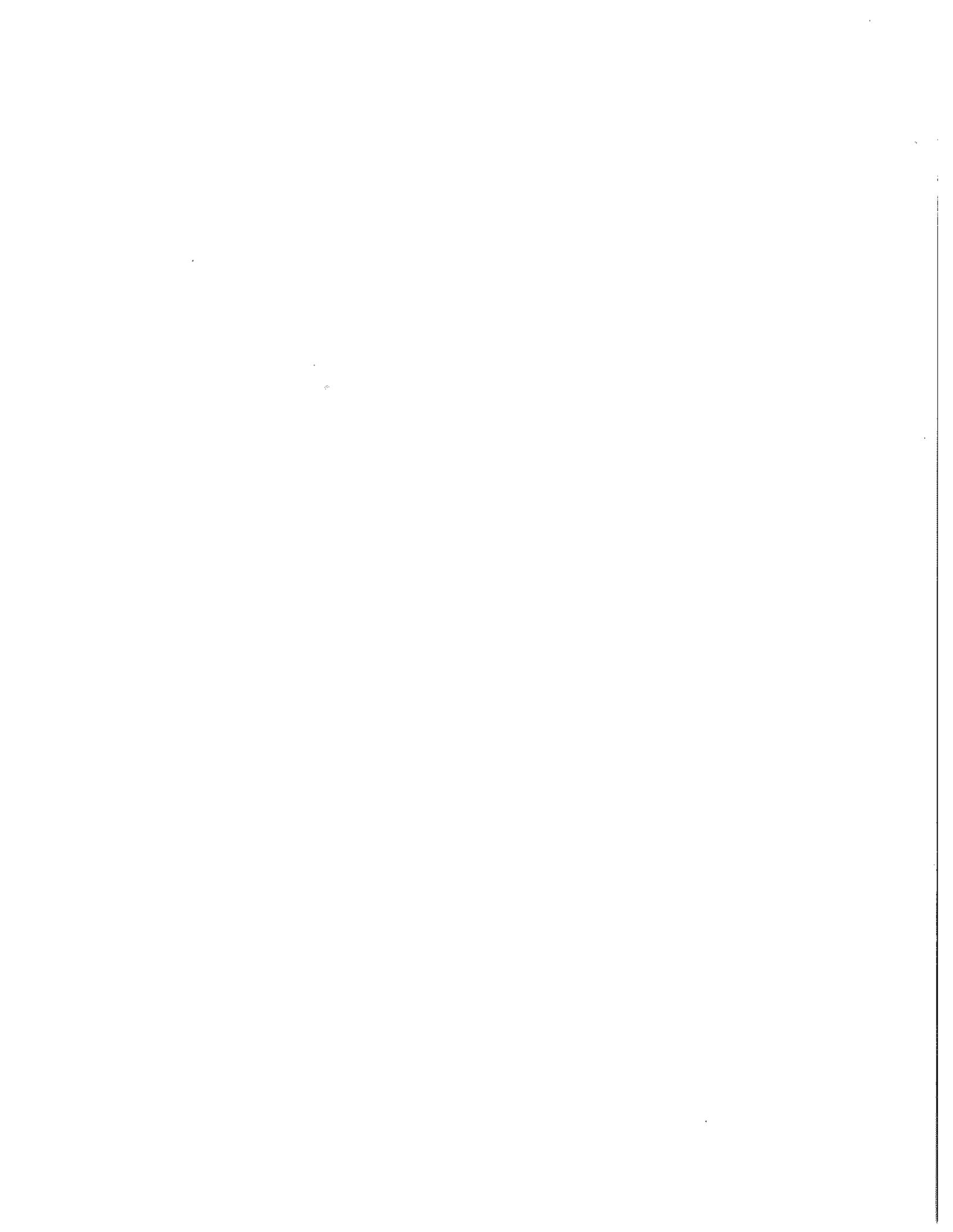
(In Millions)

	Receivables as of		Collections for 6 Months Ended		Write-offs for 6 Months Ended	
	6/30/84	12/31/84	6/30/84	12/31/84	6/30/84	12/31/84
Audit Disallowances	\$ 160 <sup>1</sup>	\$ 206	\$ 24	\$ 34	\$ 2	—
Owed by Public <sup>2</sup>	<u>3,409</u>	<u>3,402</u>	<u>\$670</u>	<u>639</u>	<u>187</u>	<u>77</u>
Total <sup>3</sup>	\$3,569	\$3,608	\$694	\$673	\$189	\$77

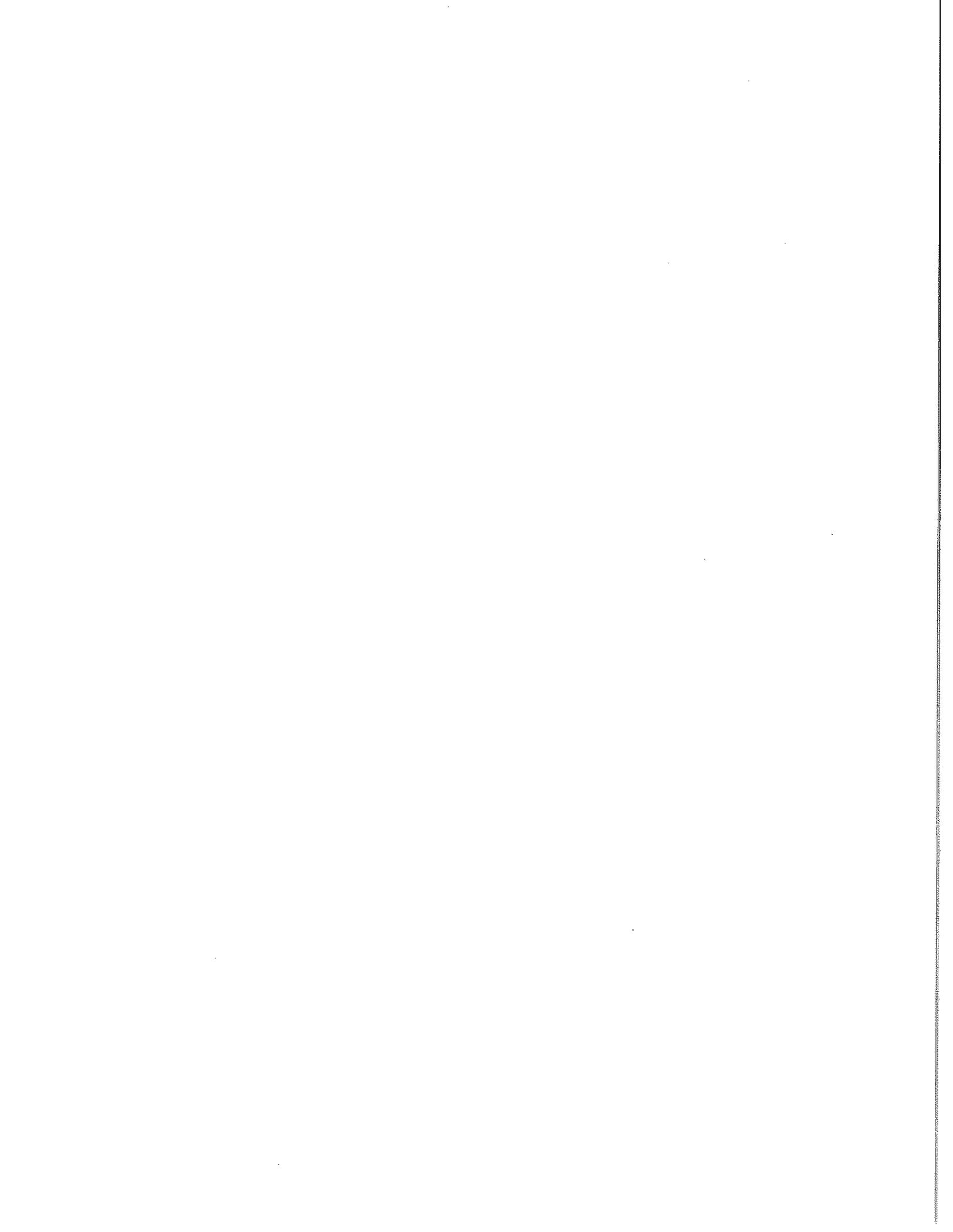
Notes: <sup>1</sup> Debts due to recommended audit disallowances which have been sustained by the program office as of 6/30/84.

<sup>2</sup> Includes amounts other than audit-recommended disallowances. Examples include health professional and nursing student loans, hospital and health maintenance organization facility construction loans, and overpayments to SSA beneficiaries.

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



# LEGISLATIVE AND REGULATORY REVIEW



## CHAPTER V

### LEGISLATIVE AND REGULATORY REVIEW

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

#### PREVENTION

During the period from October 1984 to March 1985, the OIG reviewed 63 HHS regulatory and 183 legislative change proposals. This included 83 from the Health Care Financing Administration, 67 from the Social Security Administration, 78 from the Public Health Service, and 18 from the Office of Human Development Services.

The most important regulations that the OIG reviewed during this period were the four sets of regulations that implement many aspects of the Peer Review Improvement Act of 1982. These regulations govern operation of Peer Review Organizations (PROs) that perform critical reviews of the \$48 billion in Medicare hospital payments. HHS adopted a number of OIG recommendations to help assure that PRO review of the medical necessity, reasonableness and appropriateness of hospital admissions and discharges would be effective. OIG recommendations focused on denial of payments for unnecessary admissions and readmissions, adequacy of reviewer qualifications, and access to PRO records by the Inspector General as necessary to carry out statutory oversight and investigative responsibility.

#### PEER REVIEW ORGANIZATIONS

The Office of Inspector General also developed regulations that were needed to implement the statutorily mandated process for excluding doctors or hospitals from the Medicare program or imposing monetary penalties. These sanctions will result from violations of the obligation to provide medically necessary care that meets professionally recognized quality of care standards. The OIG will monitor the results of the PROs

and will make any recommendations necessary to enhance their effectiveness.

**MEDICARE  
SECONDARY PAYER**

The OIG reviewed draft HCFA regulations which implemented the OIG legislative recommendation recently enacted by Congress making Medicare the secondary payer for beneficiaries whose spouses work for employers that provide family health insurance. The OIG approved of the new regulation, but the review disclosed the need for another legislative change. OIG recommended to HCFA that a legislative change be proposed to amend the Internal Revenue Code to not allow a tax deduction if the employer's health insurance plan differentiated in the benefits it provides between families that have Medicare coverage and other individuals. This type of provision would provide a deterrent against employers who state inappropriately that Medicare is the primary payer. HCFA is considering this additional legislative recommendation.

**ANNUAL  
REGULATORY  
PLANNING**

The OIG reviewed the regulatory plans submitted by each HHS program concerning significant regulations that are anticipated between April 1985 and April 1986. This was the first year that regulatory plans were developed under Executive Order 12498 on the regulatory planning process. Review of agency regulatory plans in the initial phase of development permitted identification of areas where early work can be undertaken to establish fraud, abuse and waste safeguards.

**EXISTING  
LEGISLATION AND  
REGULATIONS**

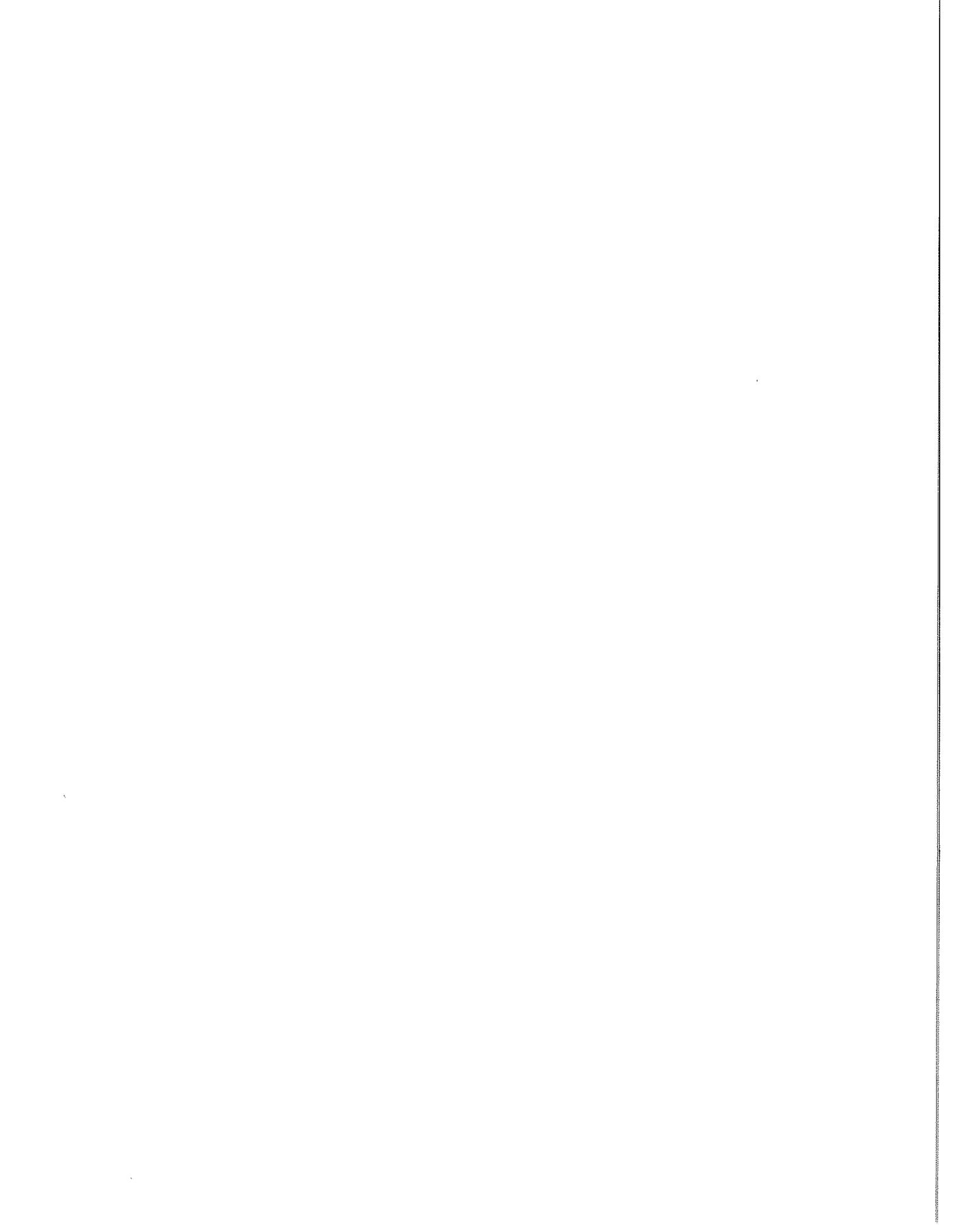
In addition to review of proposed changes in regulations and legislation, the OIG also recommends changes in existing regulations to safeguard HHS programs. These recommendations are transmitted to HHS' operating divisions in audits, inspections and other reports. OIG legislative recommendations of this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

**FRAUD AND ABUSE  
LEGISLATION**

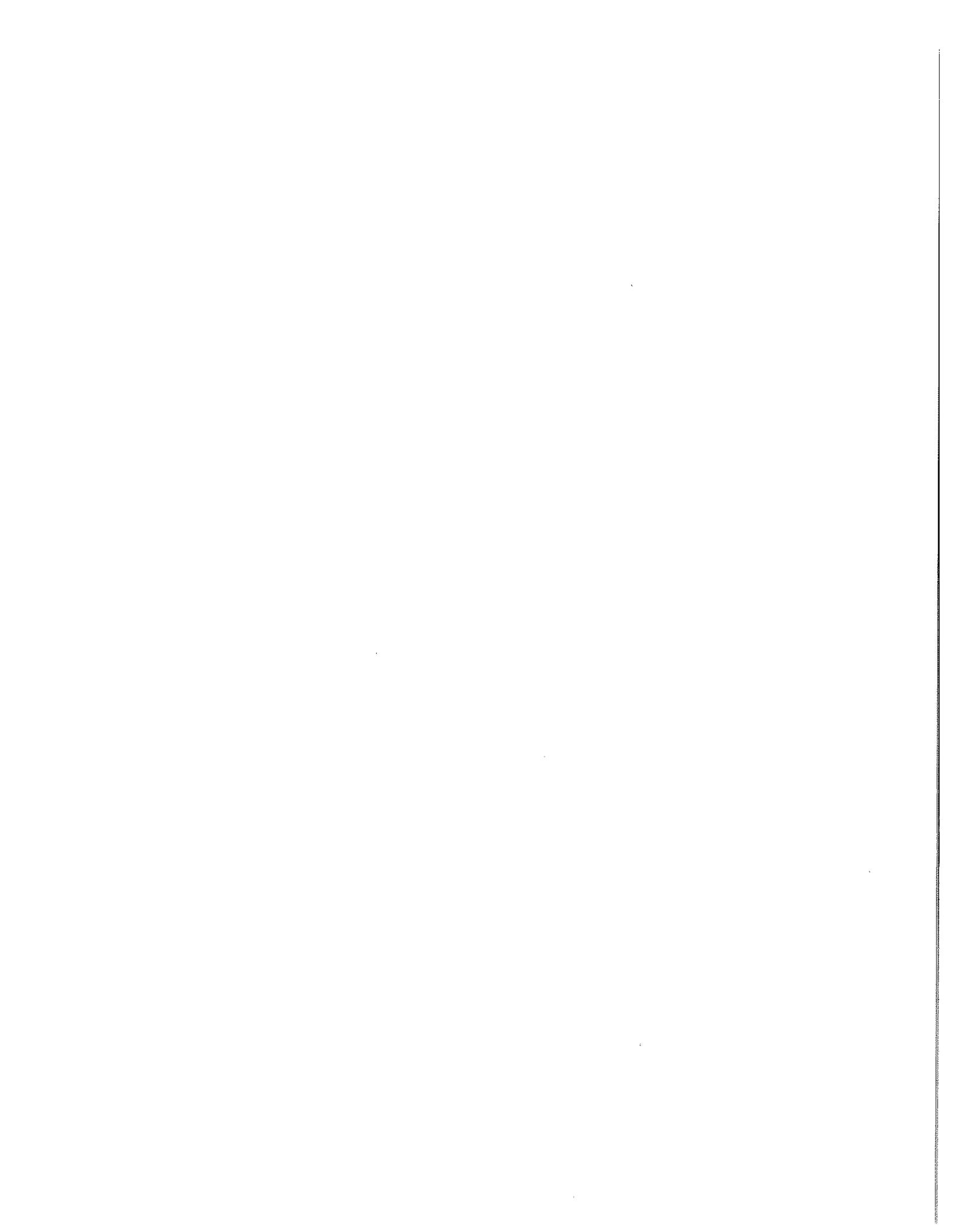
The OIG administers the HHS authority to sanction health care suppliers and providers for defrauding or abusing the Medicare or Medicaid programs. There are two types of sanctions: (1) civil money penalties and (2) exclusion from Medicare and Medicaid. Over the past 2 years, the OIG has developed a number of proposals to strengthen both sanction authorities. These proposals are being included in Medicare and Medicaid fraud and abuse draft legislation in HHS.

Similar legislative changes have been included in H.R. 1868. These proposals are described in Appendix A of this report. The most important change would permit exclusion of practitioners:

- for convictions related to fraud or financial abuse or neglect or abuse of patients in connection with the delivery of health services or other public programs, or drug trafficking; and
- based on action of State licensing boards to revoke or suspend a health care practitioner's license.



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



## CHAPTER VI

### PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

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

In February 1985, we published for the PCIE an inspections report of the relatively new electronic media billing process for health care providers claiming reimbursement under the Medicare, Medicaid or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The inspection focused on the trends and state of the art of the Electronic Media Billing (EMB) process, the incentives and disincentives for its use, and the vulnerabilities of EMB to fraud and abuse. Our inspection found that EMB has significant potential for growth and cost savings, but that major areas of vulnerability were apparent. We recommended that program agencies determine the most cost-effective use of EMB, increase emphasis on EMB use in State agencies, strengthen agreement and certification mechanisms, perform EMB systems risk analyses, and institute audit procedures by program to verify EMB transactions. Subsequent to the release of the report, the Health Care Financing Administration drafted a Medicare Intermediary Manual to provide guidance for insuring increased integrity of electronic media claims.

In March, the PCIE EDP Systems Review and Security Work Group co-sponsored with the National Bureau of Standards, Institute of Computer Science and Technology, a 3-day workshop on "A Work Priority Scheme for the EDP Auditor." Workshop participants included experts in systems development, computer security, and EDP auditing from the Federal and private sectors. The workshop sessions developed a practical risk-based planning methodology for prioritizing audits of EDP systems under development. This methodology will be incorporated into the final product of the work group, a guide for auditing automated information systems throughout their life cycles.

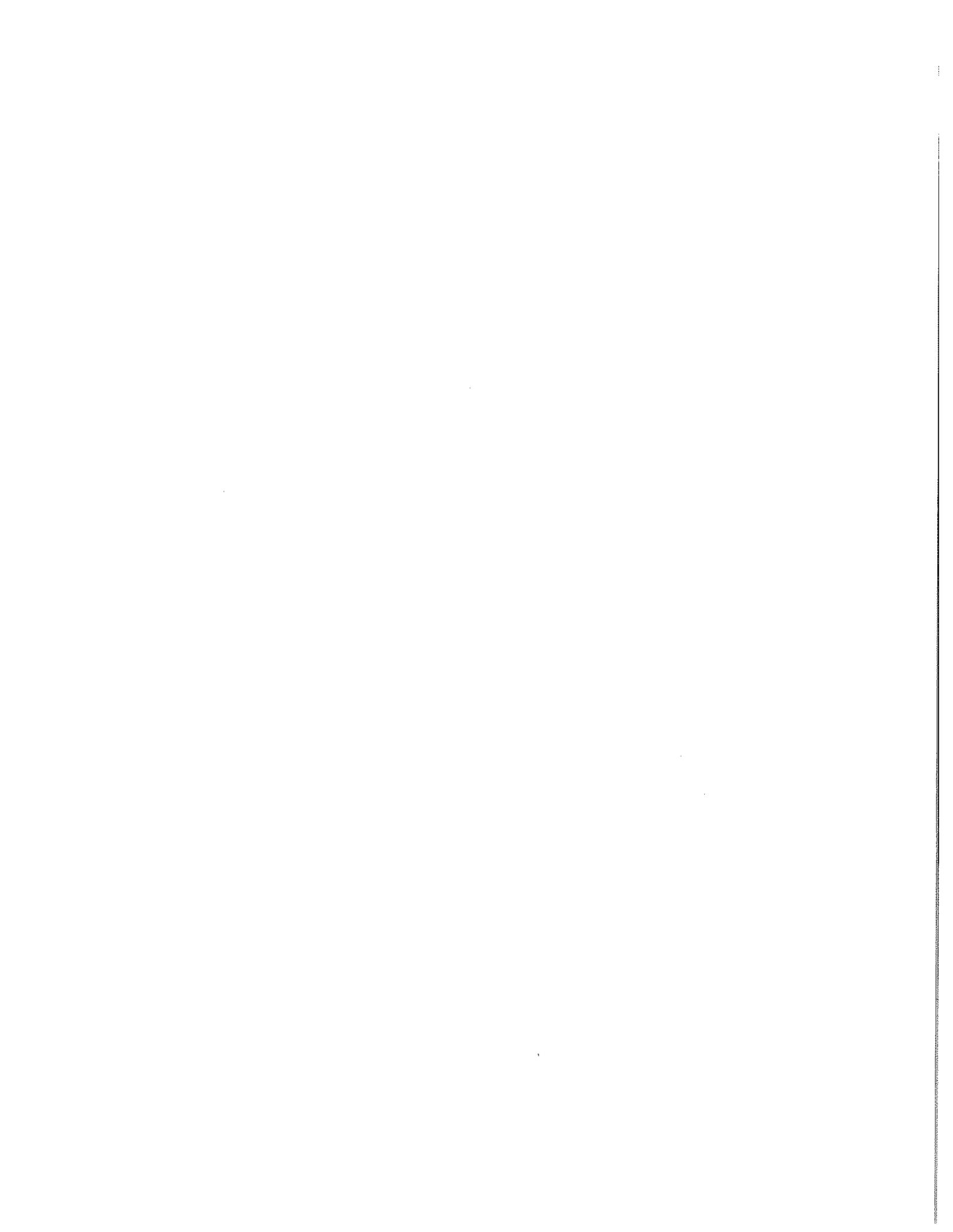
#### **ELECTRONIC MEDIA BILLING BY HEALTH PROVIDERS**

#### **WORKSHOP ON PRIORITY SCHEME FOR AUDITING DEVELOPING SYSTEMS**

**PCIE EXECUTIVE  
DEVELOPMENT  
WORKSHOPS**

In March, the Inspector General hosted a half-day PCIE Executive Development Workshop for the Inspectors General and their top staffs. The topic, "Nonfederal Offices of Inspector General," focused on those State, local or private organizations with missions or activities similar to Federal Offices of Inspectors General. The workshop accomplished the objectives of discovering the extent and types of such organizations and exploring cooperative relationships.

# APPENDIX A



## Appendix A

### UNENACTED LEGISLATIVE RECOMMENDATIONS

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

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>Health Care Financing Administration</b>		
Verification of Medicaid Services: HCFA should allow States greater flexibility in determining methods used to verify services provided to recipients for which payments are claimed.	Draft legislation under consideration in HHS.	\$3-5/year, \$15-25/ 5 years
Second Surgical Opinion: HCFA should seek a legislative change to the Social Security Act requiring Medicaid and Medicare beneficiaries to seek a mandatory second surgical opinion (SSO) for selected surgeries. Studies have consistently shown that mandatory SSO programs reduce surgeries by as much as 29 percent in Medicaid and 18 percent in Medicare. (First discussed in 10/82-3/83 OIG Semiannual Report, ACN 03-30211.)	HCFA is currently evaluating the overall effects and long-term savings of a mandatory SSO program.	\$200/year, \$1,000/ 5 years
Medicare Round-Down: HCFA should seek authority to round down payments on Medicare Part B odd-penny claims to the next lower whole dollar. Individual beneficiaries and physicians/suppliers would pay, on the average, only 30¢ more per claim. (First discussed in 4/83-9/83 OIG Semiannual Report, ACN 03-42006.)	Under consideration by HCFA.	\$45/year, \$225/ 5 years

## UNENACTED LEGISLATIVE RECOMMENDATIONS

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>Health Care Financing Administration, cont.</b>		
<p>Urological and Nutrient Supplies:            HCFA should seek legislative change and revise regulations to prohibit suppliers from billing Medicare directly for urological and nutrient supplies, and require that nursing homes include the cost of such products in their per diem rates. A study showed that it is more cost-efficient for nursing homes to purchase supplies on the open market and bill Medicare for related costs than the current method of medical supply firms billing HCFA directly. (First discussed in 4/83-9/83 OIG Semiannual Report, ACN 06-42002.)</p>	<p>A legislative change is currently under consideration by the Department.</p>	<p>\$17/year,            \$85/            5 years.</p>
<p>Multiple Visits:            HCFA should reduce reimbursement to physicians who see more than one patient at the same nursing home since the doctor incurs lower costs by combining visits. (First discussed in 10/83-3/84 OIG Semiannual Report.)</p>	<p>HCFA plans no action at this time.</p>	<p>\$260/year,            \$1,300/            5 years</p>
<b>Social Security Administration</b>		
<p>Shelter Allowances:            SSA should seek a legislative amendment to require all States to consider receipt of housing subsidy benefits before determining AFDC assistance payments, since AFDC payments often include a monthly shelter allowance. (First discussed in 1981 OIG Annual Report, ACN 01-20250.)</p>	<p>A second report updating OIG findings is in progress. The report will reiterate the recommendation for legislative change.</p>	<p>\$485/year,            \$2,425/            5 years</p>

**UNENACTED LEGISLATIVE RECOMMENDATIONS**

<b>OIG RECOMMENDATIONS</b>	<b>PROGRAM POSITION</b>	<b>PROJECTED SAVINGS IN MILLIONS</b>
<b>Social Security Administration, cont.</b>		
<p>Bank Matches:            SSA should cooperate with HCFA and USDA in seeking legislation to require all States to conduct annual bank matches to detect excess resources belonging to AFDC, Medicaid and Food Stamp recipients where such matches are cost effective. (First discussed in 10/83-3/84 OIG Semi-annual Report.)</p>	<p>SSA plans no action at this time pending results of IRS data used for welfare matching.</p>	<p>\$298 the first year; \$161/year thereafter for a total of \$942 over a 5-year budget cycle</p>
<p>Black Lung Student Benefits:            SSA should request Congress to eliminate student benefits under the Black Lung program since there are a number of other programs which provide educational assistance to students. (First discussed in 1/82-9/82 OIG Abbreviated Annual Report.)</p>	<p>SSA plans no action at this time.</p>	<p>\$10.4/year, \$52/5 years</p>

## UNENACTED LEGISLATIVE RECOMMENDATIONS

### Office of Inspector General

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. Each of these proposals is currently under consideration in HHS, and no projected savings have been determined.

#### Exclusions:

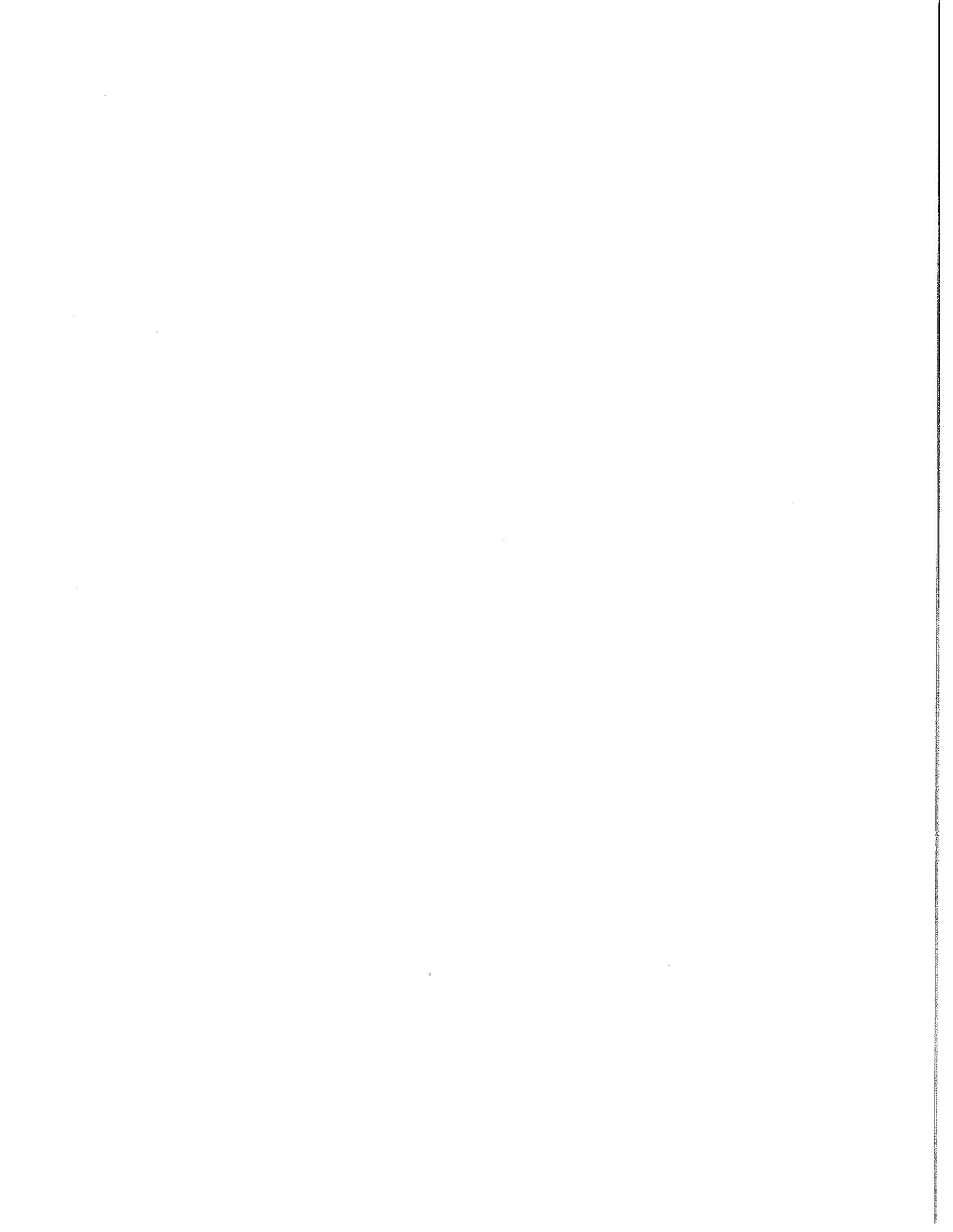
- Exclude from program participation health professionals who are in default on PHS loans and scholarships.
- Establish a minimum suspension period for persons convicted of Medicare/Medicaid crimes.
- Exclude from program participation those guilty of kickbacks in the Medicare/Medicaid programs.
- Exclude 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.
- Sanction those who falsify information on "conditions of participation" applications.
- Exclude based on Peer Review Organization findings of Medicaid violations.
- Exclude from Medicaid/Medicare those who have been sanctioned by other Federal and State health care programs.
- Impose Medicare sanctions on those who have been found to abuse the Medicaid program.

**Office of Inspector General, cont.**

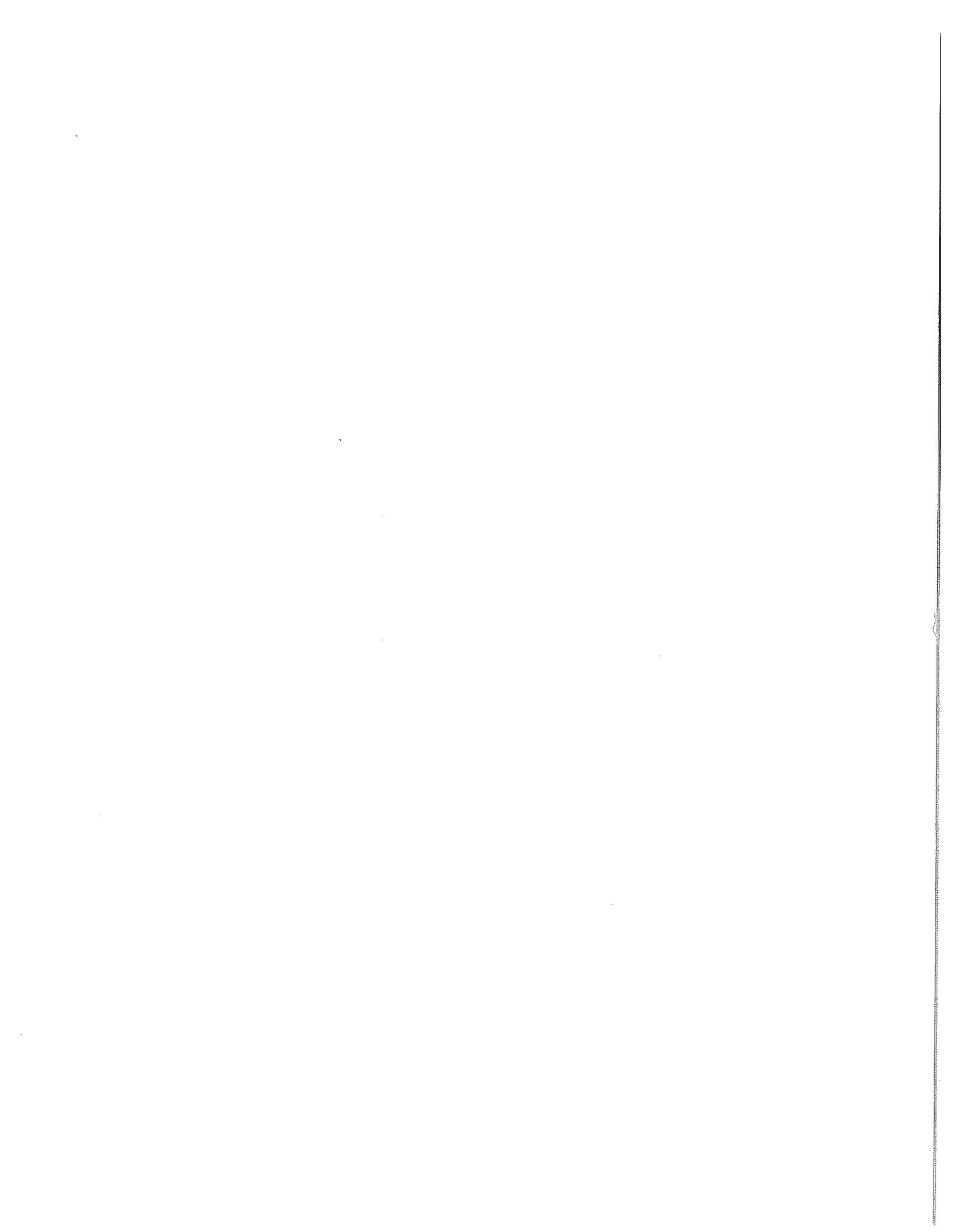
- Exclude from Medicare and Medicaid those convicted of (1) fraud or financial abuse; (2) neglect or abuse of patients; or (3) drug trafficking in connection with the delivery of health care services with a Federal, State or local program.
- Sanction those who do not grant immediate access to the OIG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

**Civil Monetary Penalties:**

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



# APPENDIX B



## Appendix B

### OTHER RECOMMENDATIONS NOT YET ACTED UPON

The items listed in this appendix are recommendations that have been made in various OIG reports and have not yet been implemented. This list does not include preliminary recommendations described in this report which are still under consideration by the OIG.

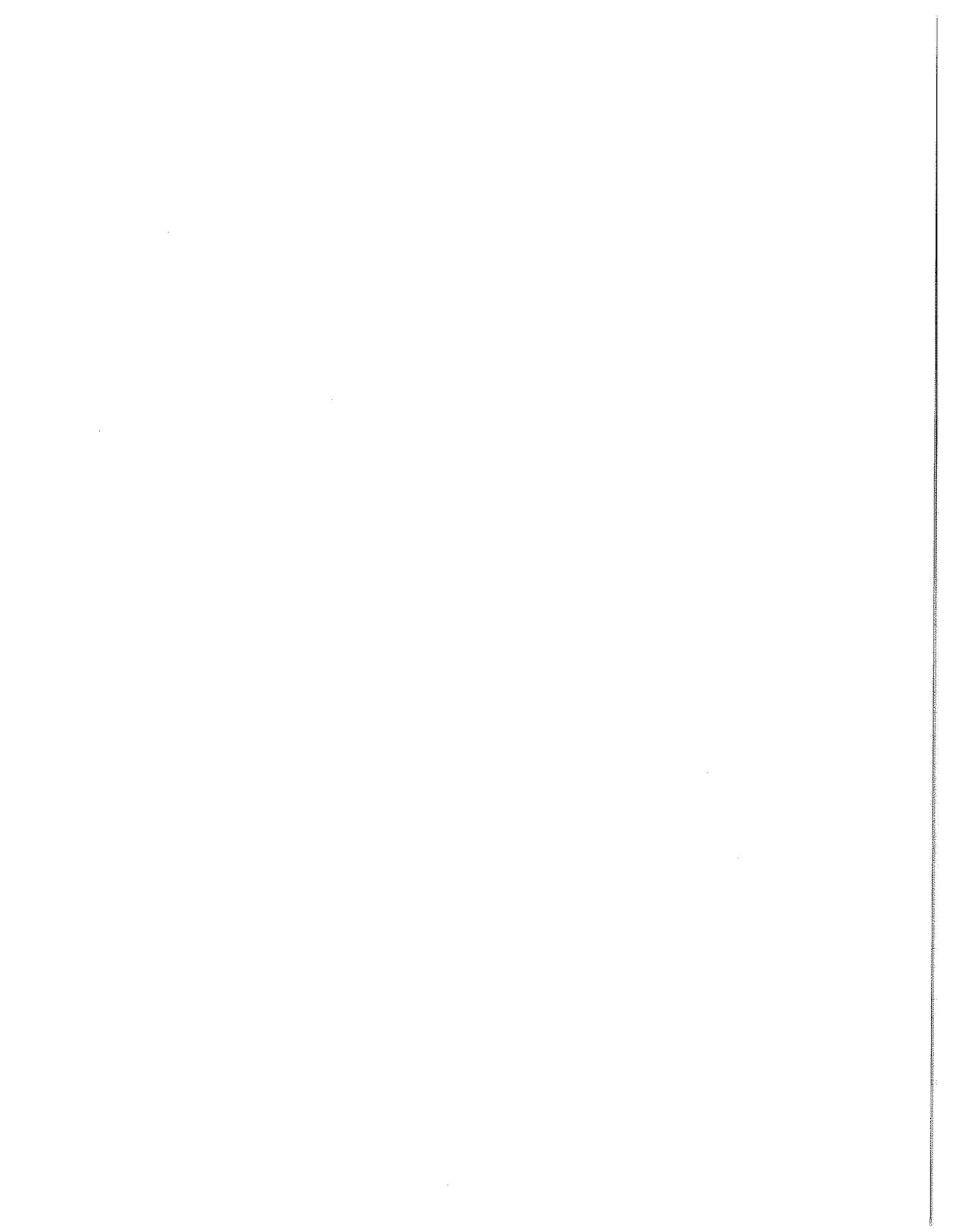
OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>Health Care Financing Administration</b>		
<p>Medicare Payment Cycle:            HCFA should require intermediaries and carriers to slow the Medicare payment cycle to conform to the 30-day payment cycle endorsed by OMB. This would maximize interest earned by the Health Insurance Trust Funds. (First discussed in 4/84-9/84 OIG Semi-annual Report.)</p>	<p>HCFA initially agreed with the recommendation, but has taken no action to date.</p>	<p>\$320-\$423/            year,            \$1,600-            2,115/            5 years</p>
<p>Medicare Premiums:            HCFA should utilize accounting controls to monitor the collection of Medicare's Part A and B insurance premiums billed directly to enrollees. Presently, HCFA cannot account for large amounts of delinquent premium payments. (First discussed in 4/84-9/84 OIG Semiannual Report.)</p>	<p>HCFA has taken no action to date.</p>	<p>Undeter-            mined</p>
<p>Housekeeping Services:            HCFA should take action to strengthen a regulation which permits unallowed billing for housekeeping services not tied to a physician's plan of treatment. (First discussed in OIG 1980 Annual Report.)</p>	<p>HCFA has reviewed the involved regulation, but has not taken action to correct the problem.</p>	<p>\$30/year,            \$150/            5 years</p>

## OTHER RECOMMENDATIONS NOT YET ACTED UPON

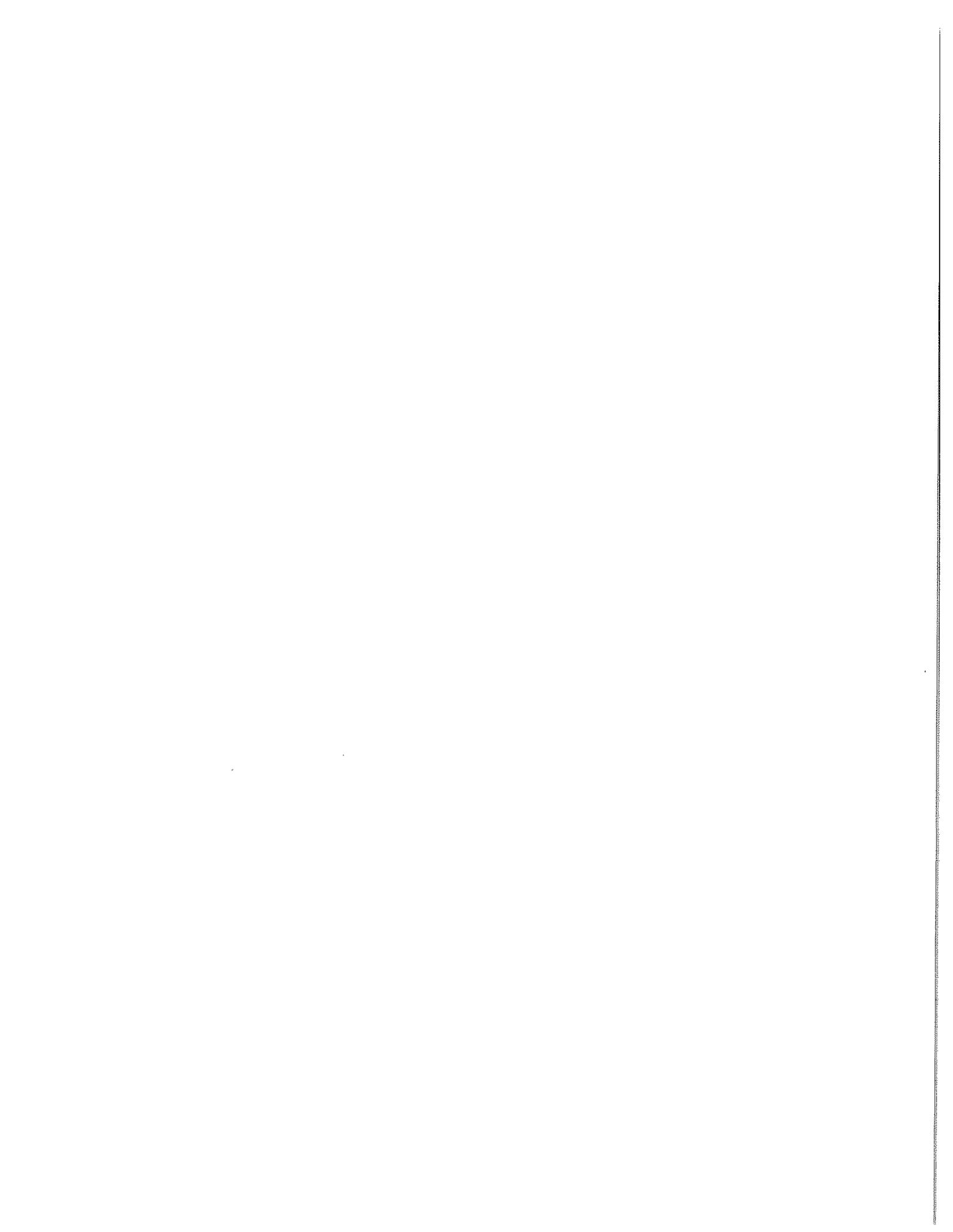
OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>Health Care Financing Administration, cont.</b>		
<p>ESRD Overpayments:            HCFA should collect overpayment from ESRD providers in California who billed Medicare as primary payer when it was the secondary payer.</p>	Submitted to HCFA for collection of overpayment.	\$2.5
<p>Podiatric Services:            As a result of findings in one State, HCFA should issue tighter utilization controls for podiatric services.</p>	Submitted to HCFA.	\$ .2/year, \$1/5 years
<p>Pacemaker Monitoring:            HCFA should reclassify pacemaker monitoring as a lower-paying routine service rather than the current physician-assisted service, and should require less frequent telephone monitoring of pacemakers.</p>	HCFA has limited its guidelines on frequency of phone monitoring, and is still considering the reclassification issue.	\$64/year, \$320/ 5 years
<b>Social Security Administration</b>		
<p>Late Payments to SSA:            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 Semi-annual Report.)</p>	<p>SSA disagreed on grounds that charging interest would greatly strain Federal/State relationships and would not be cost effective. Department of Treasury's cash management staff agrees with the proposal, however, and intends to recommend adoption to departmental management in a forthcoming report.</p>	\$1.3/year, \$6.5/ 5 years

## OTHER RECOMMENDATIONS NOT YET ACTED UPON

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
<b>Social Security Administration, cont.</b>		
<p>Uncashed Checks: SSA should require the prompt return of the Federal portion of uncashed AFDC benefit checks and other credits. (First discussed in OIG 1980 Annual Report.)</p>	<p>SSA agrees with the recommendation; regulations requiring return of Federal portions after 180 days will be issued shortly.</p>	<p>\$13 the first year; \$.5/year thereafter for a total of \$15 over the 5-year budget cycle.</p>
<p>Administrative Finality: 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 timeframe. (First discussed in 10/82-3/83 OIG Semiannual Report.)</p>	<p>This matter is now under consideration by the Department.</p>	<p>\$50/year</p>



# APPENDIX C



## Appendix C

### ANALYSIS OF COST SAVINGS OCTOBER 1984 THROUGH MARCH 1985

This analysis includes savings resulting from management commitments not to expend funds or to more efficiently use resources, thereby avoiding further unnecessary expenditures. Also shown are recoveries which include (1) management commitments to seek recoveries of funds based on OIG recommendations and (2) fines, penalties, recoveries and restitutions from investigations.

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
<b>Health Care Financing Administration</b>		
Change legislation to make Medicare the secondary payer for beneficiaries with working spouses under age 65. (memorandum dated 10/5/83)	Legislation enacted. Implementing instructions issued January 1985.	\$2,100*
Increase existing efforts to ensure that intermediaries and carriers rely on front-end controls to identify beneficiaries who are also covered by employer-sponsored health plans. (ACN 03-42009; report dated 3/7/84)	Recommendation was implemented. Instructions to Medicare contractors were issued in June 1984 for implementation in FY 1985.	\$390
Encourage States to shift elective surgeries from inpatient facilities to less costly outpatient settings, thereby reducing Medicaid costs. (ACN 09-50205; report dated 12/24/84)	HCFA agreed in April 1985 to issue an instruction to all regional offices to encourage States to maximize use of ambulatory delivery systems as a means of reducing Medicaid costs.	\$90
Change the DRG category for Percutaneous Transmittal Coronary Angioplasty from one with a weight of 4.3756 to one with weight of 2.3500. (PIR 84-08; report dated 6/7/84)	HCFA agreed and will change the DRG category as of 10/1/85.	\$60
Eliminate overstated and unallowable costs identified in preaward audits of approximately 150 Peer Review Organization cost proposals. (Various ACNs)	Results of our reviews were used by contracting officers during Oct. and Nov. of 1984 to negotiate more equitable contracts.	\$46.2

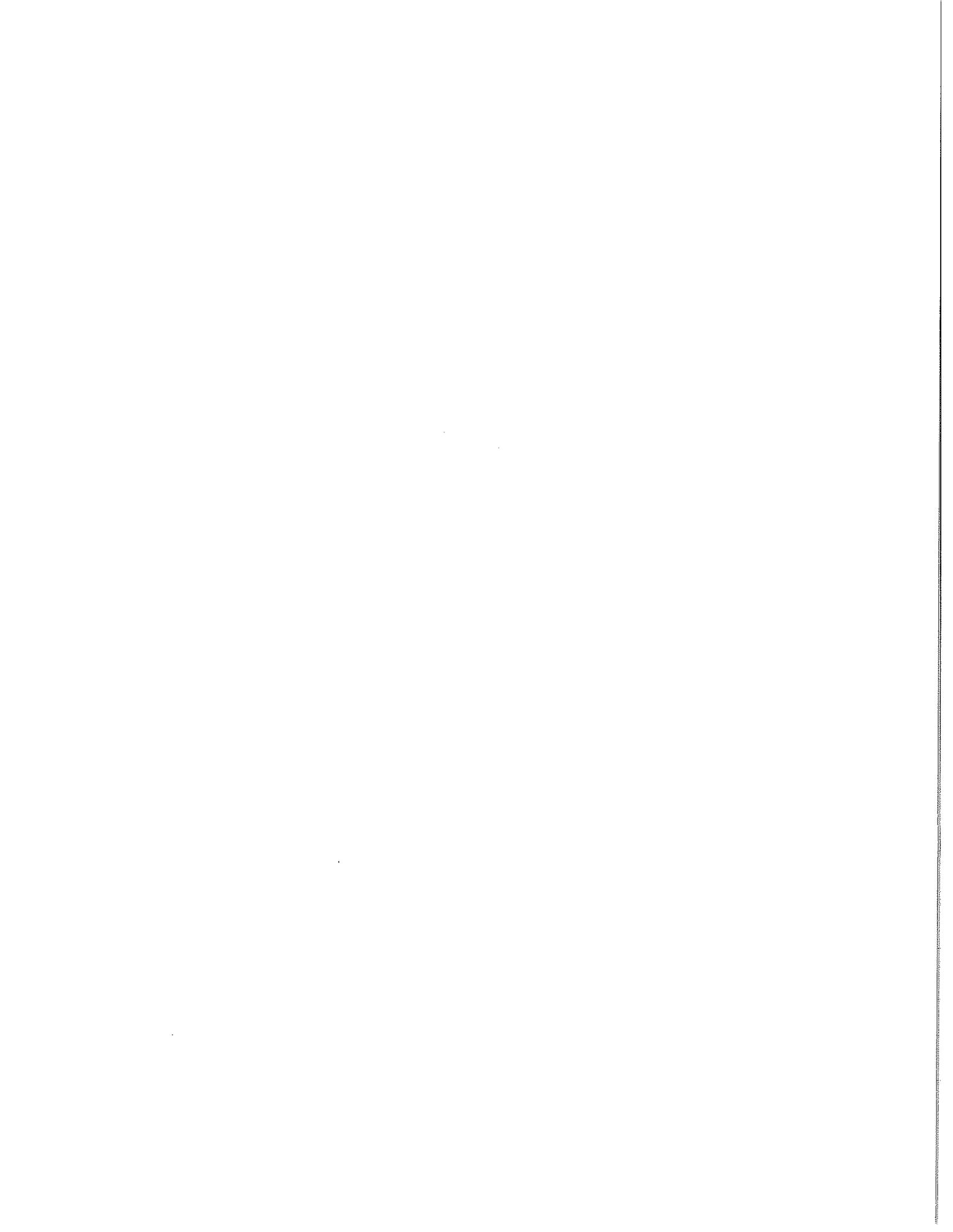
\*Based on Congressional Budget Office estimate for 5-year budget cycle.

**ANALYSIS OF COST SAVINGS  
OCTOBER 1984 THROUGH MARCH 1985**

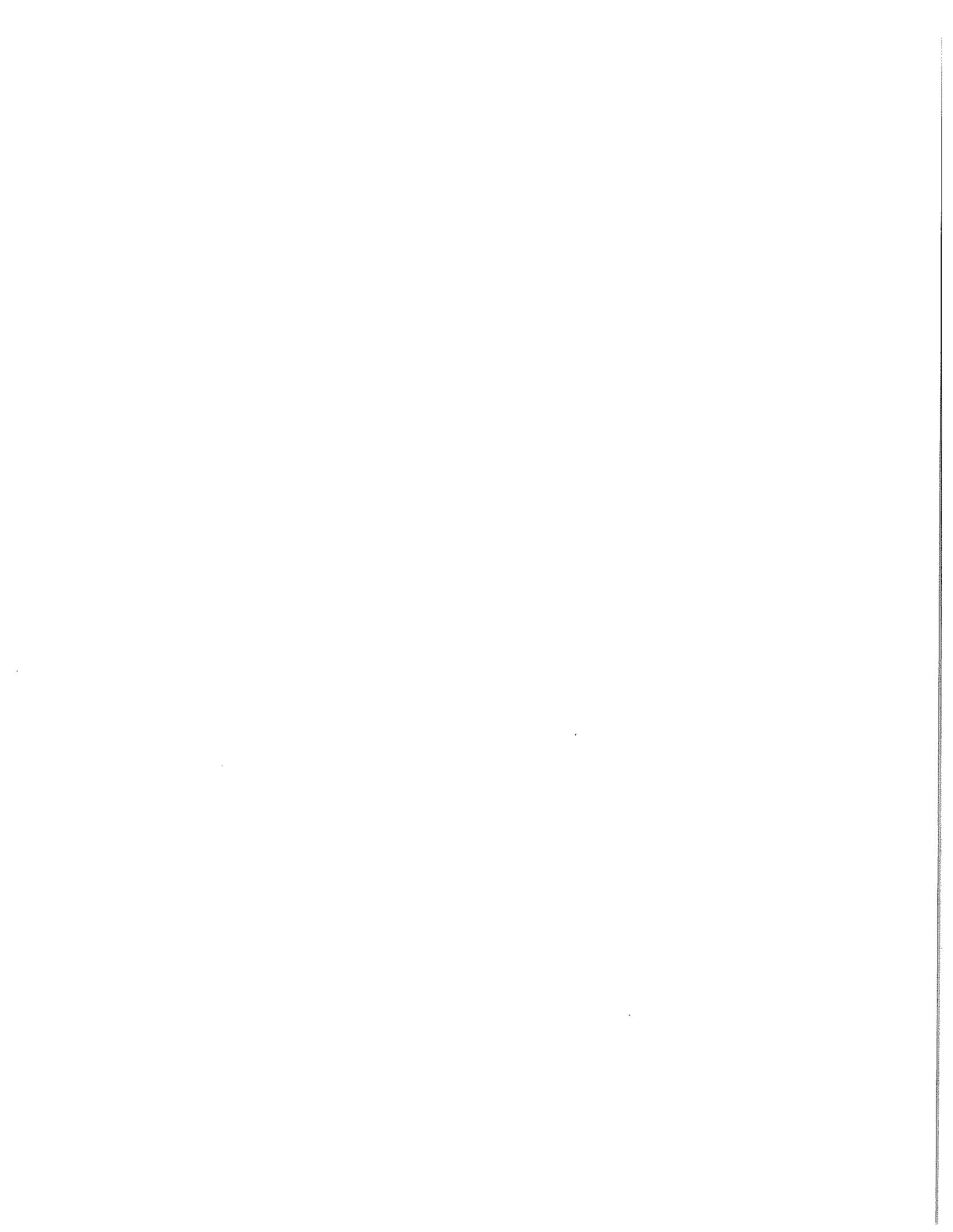
<b>OIG RECOMMENDATIONS</b>	<b>ACTION TAKEN</b>	<b>SAVINGS IN MILLIONS</b>
<b>Health Care Financing Administration, cont.</b>		
Revise Medicare guidelines to reduce frequency of electronic monitoring (over phone lines) of pacemaker patients. (ACN 08-52017; report dated 5/4/84)	New Medicare guidelines on phone monitoring were published to be effective in October 1984.	\$40
Revise proposed regulations to require application of Home Health Agency (HHA) cost limits by type of service rather than in the aggregate. (ACN 06-42010; report dated 6/14/84)	HCFA will be applying per service limits in the final HHA cost limits notice to be published by July 1985.	\$35
Redesign the telecommunications system to replace the more expensive indirect transmission of beneficiary and billing data with direct transmission. (ACN 15-42640; report dated 10/8/84)	HCFA, in a memorandum dated 3/18/85, agreed to implement this recommendation.	\$8.0
Revise instructions to PROs to require denials or corrective actions in transfer and readmission cases involving inappropriate practices. (PIR 84-09; report dated 10/23/84)	HCFA will issue revised instructions to be implemented 7/1/85.	\$3.2
Implement tighter controls in two States to ensure Medicare is secondary payer for end stage renal disease benefits. (1-03-4009-11 and 1-08-4001-14; report dated 11/30/84)	HCFA agreed to this action and implemented the change in April 1985.	\$2.5
Change one State's method for counting patient days when calculating Medicaid reimbursement rates. (ACN 08-50153; report dated 5/21/84)	HCFA agreed to this action and the State changed its method effective 10/1/84.	\$.4
Collect overpayment involving inappropriate billing by psychiatrists in one State. (3-03-4001-01; report dated 11/84)	HCFA agreed to collect overpayment as of 12/84.	\$.2

**ANALYSIS OF COST SAVINGS  
OCTOBER 1984 THROUGH MARCH 1985**

<b>OIG RECOMMENDATIONS</b>	<b>ACTION TAKEN</b>	<b>SAVINGS IN MILLIONS</b>
<b>Social Security Administration</b>		
Treasury should use a more realistic "float period" before drawing down Trust Fund monies to cover Social Security checks. (ACN 13-22684; report dated 7/30/82)	Float was extended from 2 days to the standard 4.4 business day float, thus allowing increased Trust Fund earnings. The change was incorporated into the SSA/Treasury financial management system in June 1984.	\$122
Improve controls over SSA's stop payment process for checks issued after death. (OPI 84-B-003; report dated 9/11/84)	SSA agreed with the recommendation 12/12/84; implementation will occur in the near future.	\$28.5
<b>Public Health Service</b>		
Eliminate overstated and unallowable costs identified in preaward audits of four grantees under the Indian Self-determination Act. (Various ACNs)	Results of our reviews were used by contracting officers during Aug. and Sept. 1984 to negotiate more equitable contracts.	\$1.0
<b>Office of the Secretary</b>		
Eliminate unallowable and overstated costs from indirect cost rate proposal. (ACNs 06-47006, 06-41001, 01-37000; reports dated 1/31/84, 4/19/84 and 8/17/83 respectively)	As a result of our reviews, the Division of Cost Allocation established in Nov. and Dec. 1984 indirect cost rates which were more equitable than those proposed.	\$7.2
Savings resulting from individual provider reviews and miscellaneous reviews.	Actions were taken between 10/84 and 3/85 to implement specific review recommendations.	\$44.8
Savings resulting from investigations.	Actions were taken between 10/84 and 3/85 to implement specific findings of investigations.	\$10.5
Total (in millions)		\$2,989.5



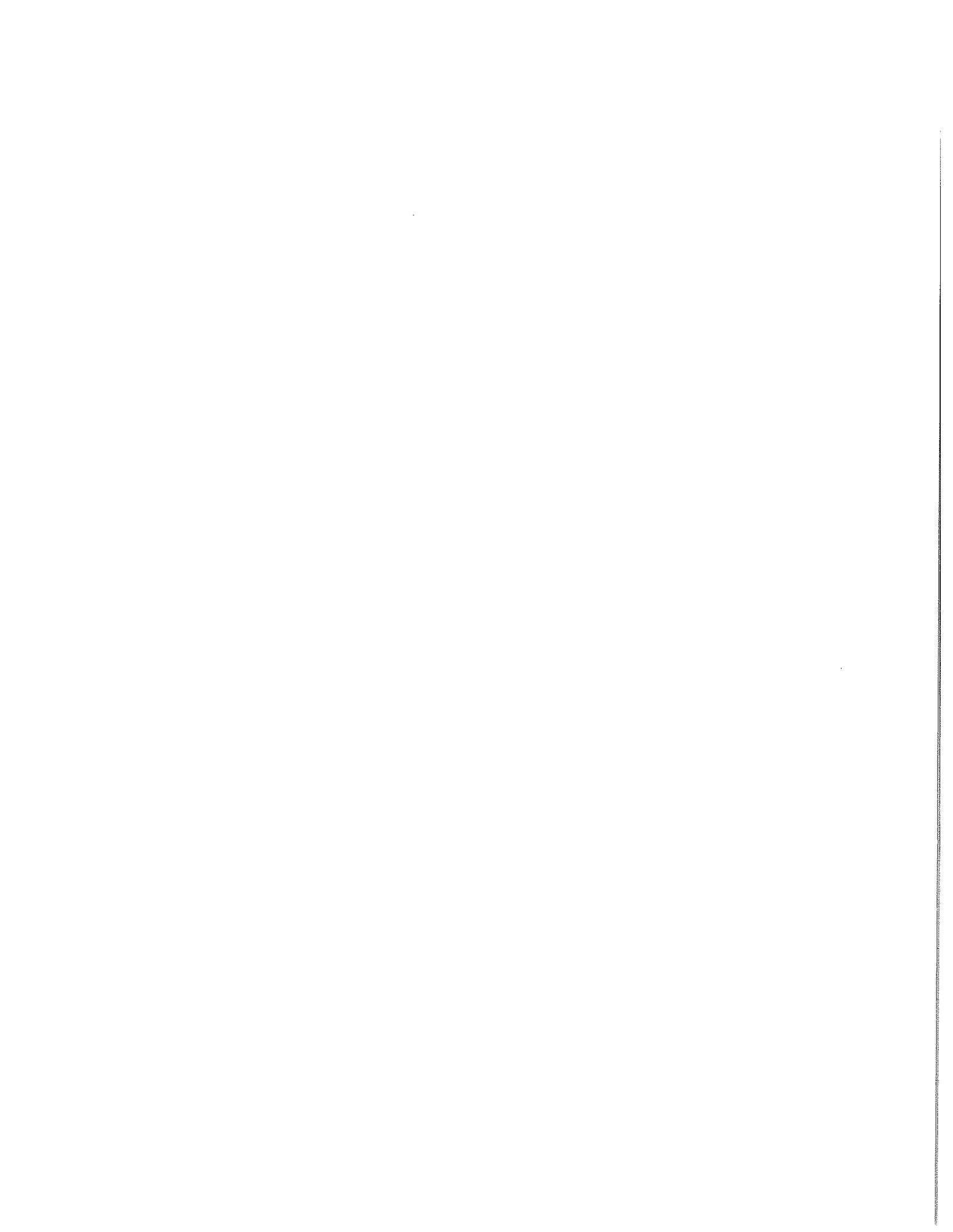
# APPENDIX D



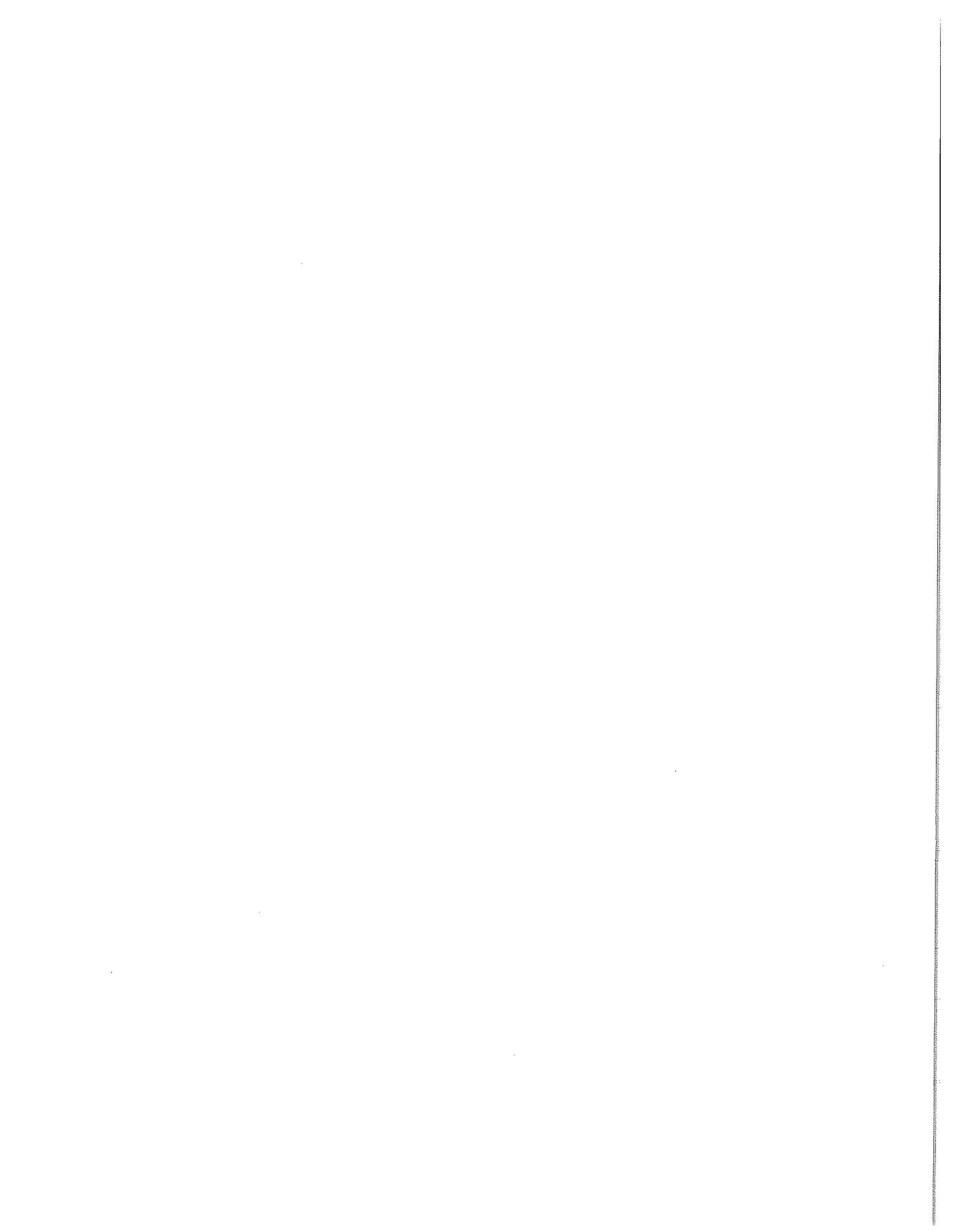
## Appendix D

**SUMMARY OF COST SAVINGS  
OCTOBER 1984 THROUGH MARCH 1985**

	<b>SAVINGS</b> <b><u>\$ MILLIONS</u></b>
Total Cost Savings	\$2,989.5
Total Agreements to Recover	77.7
Recoveries from Investigations	<u>10.6</u>
Total	3,077.8



## **GLOSSARY OF TERMS AND ACRONYMS**



## GLOSSARY OF TERMS AND ACRONYMS

**AFDC—**

Aid to Families with Dependent Children, a federally funded program of assistance payments administered by the States to assist low-income families.

**CMPL—**

Civil Monetary Penalties Law of 1981, which gave the OIG authority to levy fines and penalties against health care providers for each false item claimed under the Medicare, Medicaid, and Maternal and Child Health Services Block Grant programs.

**EDP—**

Electronic data processing

**EOMB—**

Explanation of Medicare Benefits, a form sent to Medicare beneficiaries explaining the services and providers paid by Medicare funds.

**ESRD—**

End stage renal disease

**Individual Provider Reviews—**

The monitoring of Medicare contractor and Medicaid State agency activities specific to individual health care providers identified as potential abusers of the programs.

**INS—**

The U.S. Immigration and Naturalization Service

**MIR—**

Management Implications Report, a report prepared by OIG investigators describing program weaknesses discovered during the investigation of individual cases.

**Practitioner—**

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

**PPS—**

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

**Provider—**

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

**Sanction—**

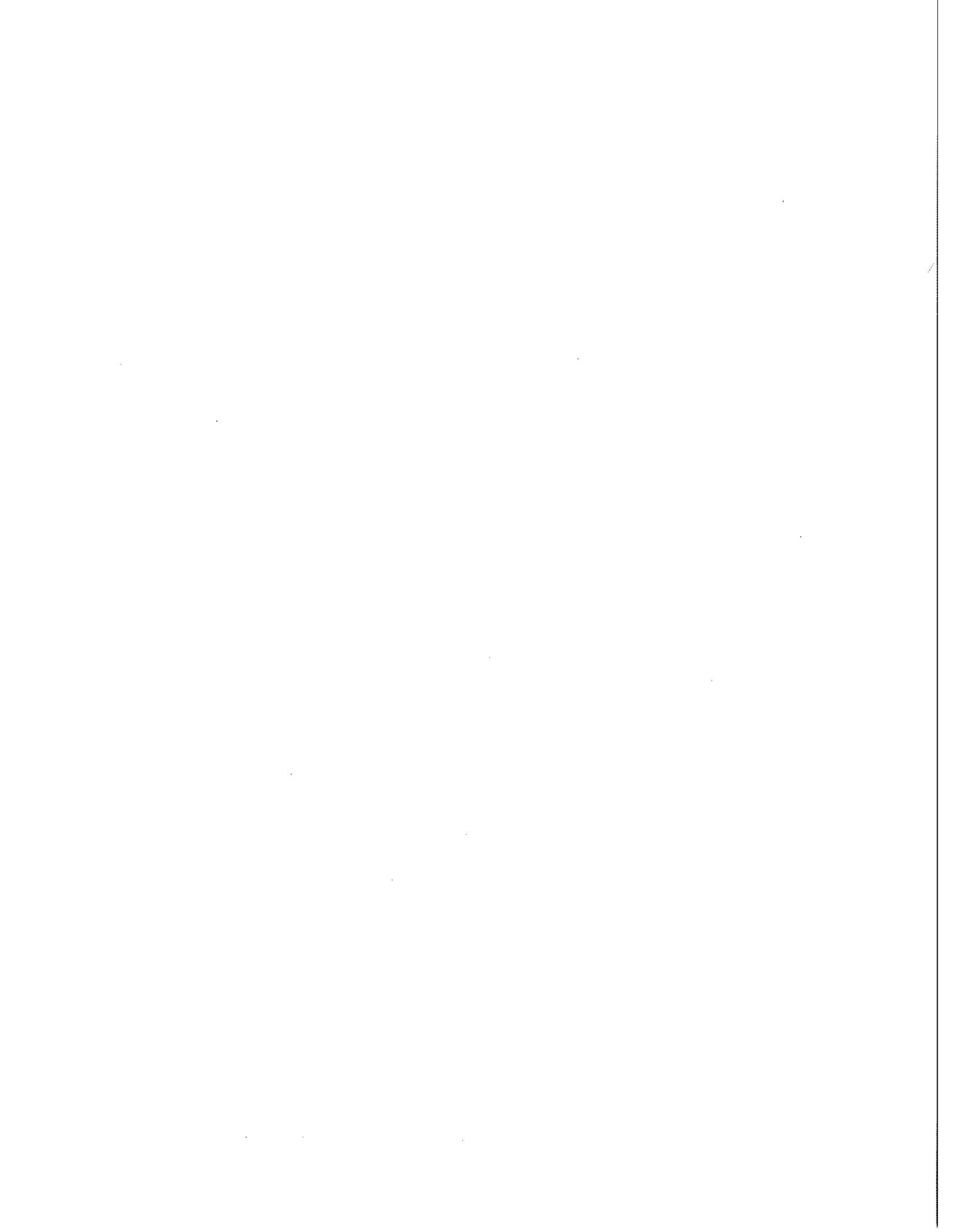
Barring a practitioner, provider, or supplier of services from participation in Medicare and Medicaid, and/or the imposition of a fine.

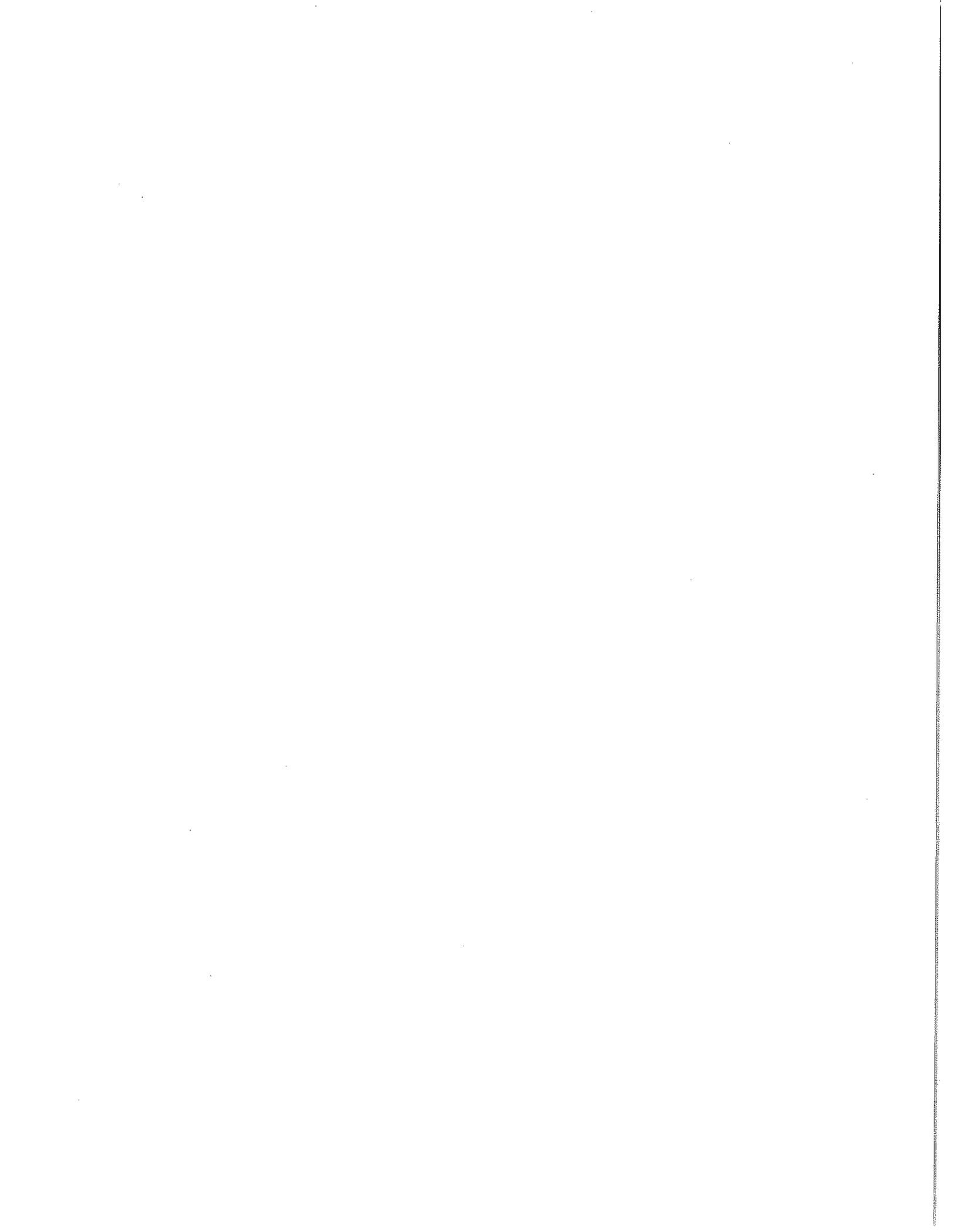
**SMFCU—**

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

**Supplier—**

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





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HEALTH & HUMAN SERVICES

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