

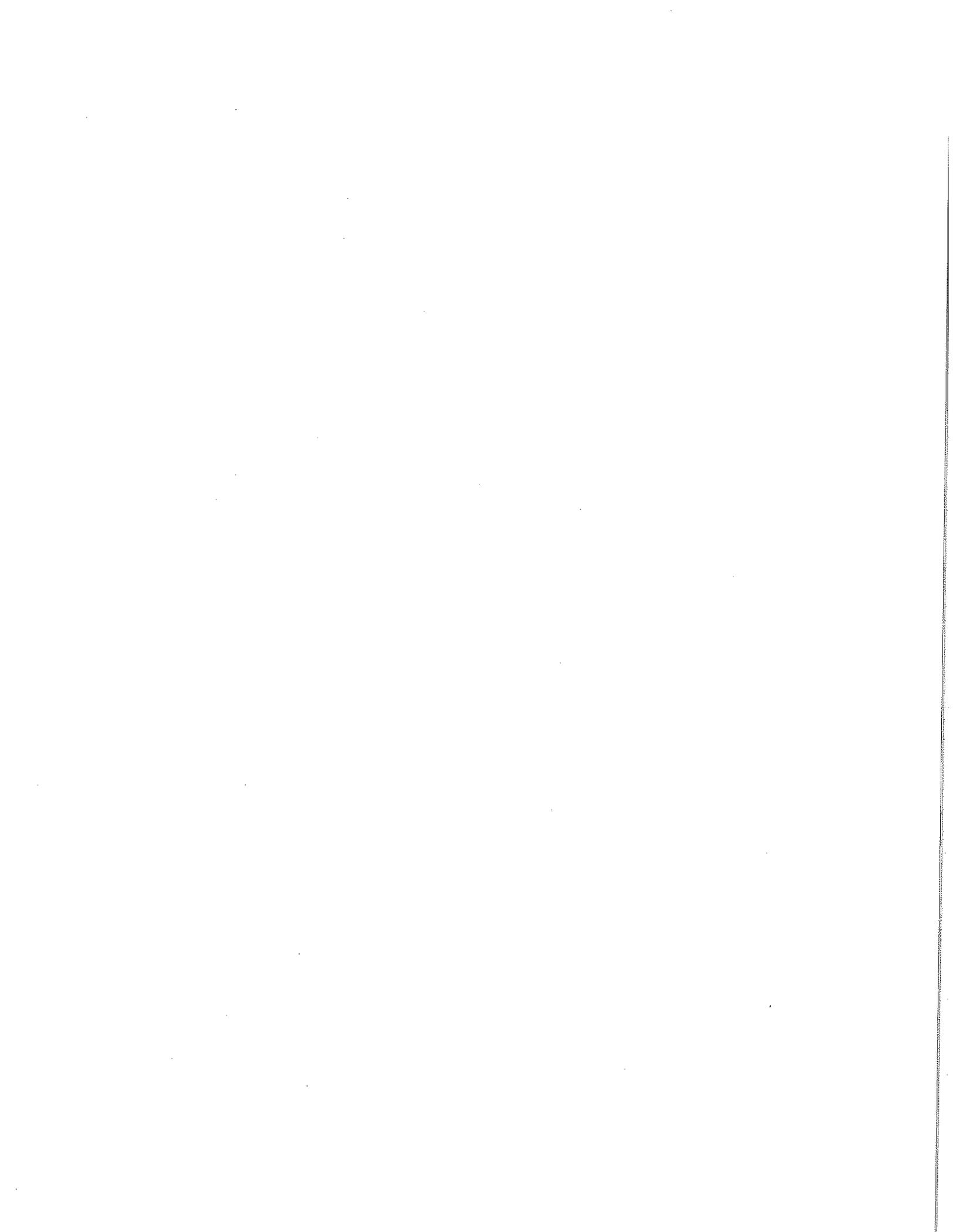
OFFICE OF
INSPECTOR GENERAL

Semiannual Report

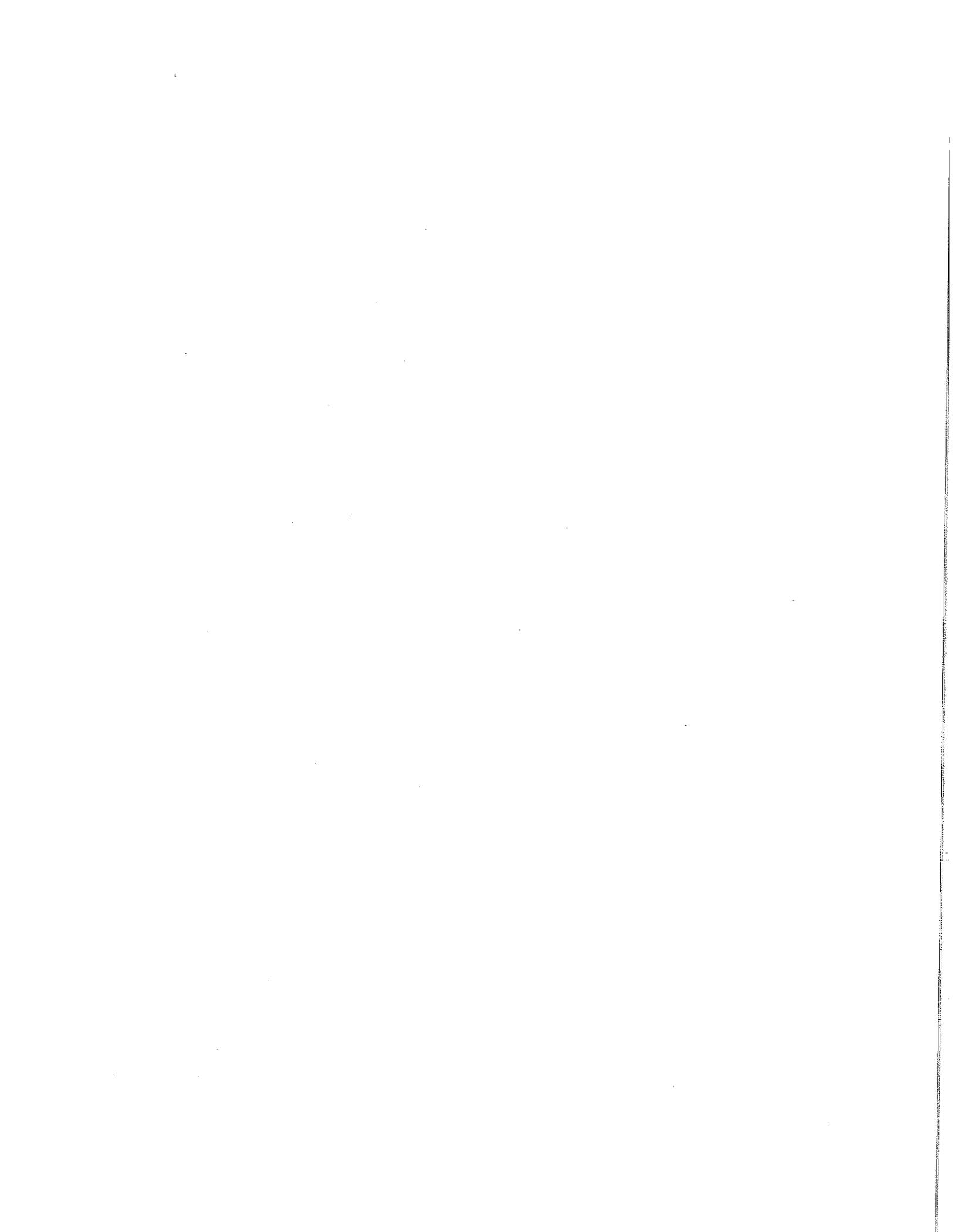
October 1, 1985 — March 31, 1986



Richard P. Kusserow
Inspector General



- Expanding use of excess hospital beds to provide long-term nursing care has the potential of significantly cutting construction costs and providing more patients access to long-term care. (See Page 3)
- The OIG found that State medical boards are coping with two major vulnerabilities concerning the licensing of physicians: (1) insufficient information about the adequacy of education being received by foreign medical graduates and (2) insufficient reporting by teaching hospitals on the performance and conduct of resident physicians. (See Page 8)
- Promoting transfers of automated Aid to Families with Dependent Children (AFDC) claims processing and information retrieval systems between States could save public assistance programs about \$449.8 million within the next 3 years. (See Page 22)
- Reducing Medicaid's administrative matching rate for skilled medical staff from 75 to 50 percent could save \$63 million annually. (See Page 3)
- Increasing use of specialized computer edits to identify noncovered Medicare ambulance services could result in savings of \$64 million annually. (See Page 4)
- Eliminating unnecessary chest x-rays at nursing homes could save \$15 million annually and reduce beneficiaries' exposure to unnecessary levels of radiation. (See Page 5)
- Youth use of smokeless tobacco is a growing national problem with serious current and future health consequences. Research, public information and youth education could help relieve the problem. (See Page 30)
- Improvements in prospective payment system (PPS) coding requirements and a strengthening of peer review organization (PRO) review responsibilities focused on particular diagnostic related groupings (DRGs) could save nearly \$39.6 million annually. (See Page 10)
- Aliens issued non-work SSNs are obtaining unrestricted replacement SSNs by exploiting a loophole in the enumeration process. (See Page 26)
- Reimbursing local standby anesthesia services at a lesser rate than general anesthesia services could save the Medicare program \$84 million annually. (See Page 8)



The following three chapters elaborate on several of the aforementioned highlights and other OIG accomplishments by the following operating program sequence:

- The Health Care Financing Administration (HCFA), with a fiscal year 1986 budget of \$93.4 billion, includes Medicare and Medicaid programs.
- The Social Security Administration (SSA)*, with a fiscal year budget of \$223.4 billion represents the largest portion of the HHS budget. The SSA administers the Old Age, Survivors and Disability Insurance (OASDI); Supplemental Security Income (SSI); the State-Administered Aid to Families with Dependent Children (AFDC); Low Income Home Energy Assistance (LIHEA); Refugee Resettlement (RR); and Child Support Enforcement (CSE) programs.
- Grants and Internal Systems (GIS)*, with its combined fiscal year budget of \$16.1 billion, encompasses two operational divisions of HHS — the Public Health Service (PHS) and the Office of Human Development Services (OHDS) — as well as overall departmental management.

* Several of the Department's need based entitlement programs formerly administered by SSA or OHDS have been incorporated into a newly formed Family Support Administration through a Department reorganization initiative.

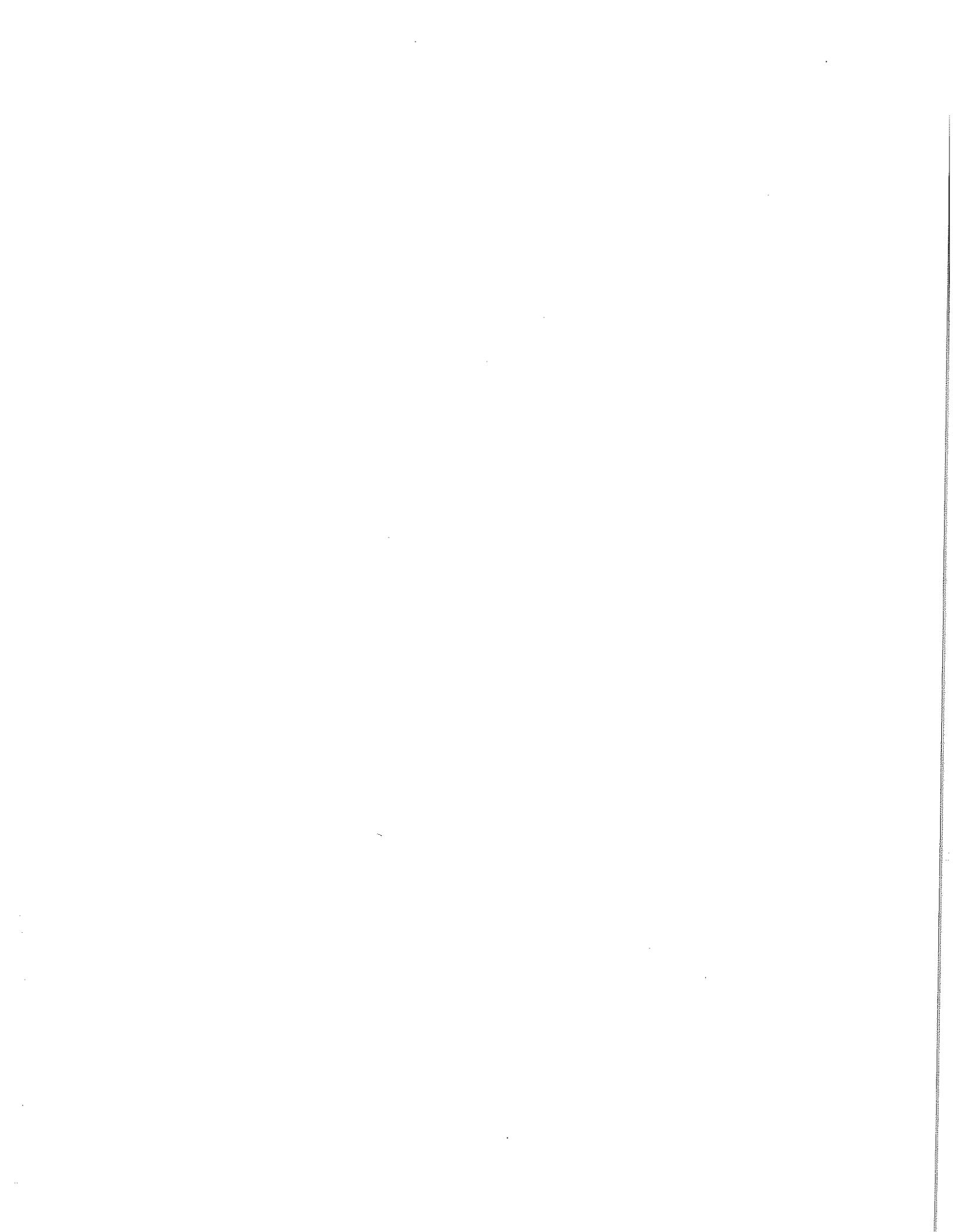


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CHAPTER I

HEALTH CARE FINANCING ADMINISTRATION

The Medicare and Medicaid programs, administered by the Health Care Financing Administration (HCFA), provide health care to more than 50 million of the Nation's poor, elderly and disabled. In FY 1986 Federal spending for the two programs is expected to total \$93 billion. This represents 27.5 percent of the HHS budget and 10 percent of the total Federal budget.

Health care costs continue to rise though not at the same double-digit rate of the past. Medicare benefits in FY 1987 are expected to increase 8.7 percent over FY 1986 as a result of inflation in the health care industry, growth in and the aging of the Medicare population, and changes in the provision and utilization of health care services. Price inflation, especially for institutional care, accounts for the expected 7.3 percent rise in FY 1987 Medicaid expenditures.

OIG reviews center on insuring the high quality and efficiency of our health care programs. We continued our focus on the Medicare PPS mechanism, recommending elimination of wasteful system features, identifying outdated program provisions that not only are unnecessary but lead to program vulnerability and pointing out ways to tighten monitoring of long-term care facilities to ensure that health and safety standards are met. We estimate that some \$788.5 million could be realized with legislative change, regulatory reform or tightened program administration.

Legislative Change/Regulatory Reform

OIG reviews identified a number of areas where, with legislative action or regulatory change, some \$463 million could be saved annually.

OIG surveyed 892 (1984) hospital cost reports to determine first-year profits under the Medicare prospective payment system (PPS). Results of our survey showed that hospitals earned profits in excess of 14 percent under PPS and that:

**LARGE HOSPITAL
PROFITS UNDER
PPS**

- Net profits for the 892 hospitals totalled over \$833 million for a net average profit of 14.12 percent.
- The net average ratio of profits to equity equaled 24.17 percent.
- Overall, 81 percent of the hospitals realized profits and 19 percent incurred losses. Those hospitals experiencing losses generally had a small volume of Medicare revenues.

In October 1985 we notified HCFA of our findings. These results were subsequently reported to Congress in testimony by the Acting Deputy Inspector General before the Finance Subcommittee on Health, U.S. Senate, on February 21, 1986.

We are continuing our review of hospital profits under PPS. We have expanded our initial sample of 892 hospital reports to nearly 50 percent of the hospitals participating under PPS. This was done in order to broaden the geographical distribution of hospitals. We obtained the additional cost reports and are in the process of summarizing and analyzing the data. Preliminary indications from the expanded data sample indicate overall profit margins consistent with those shown in our initial survey.

At inception of our initial survey of PPS profits made by hospitals, Congress had proposed increasing FY 1986 PPS hospital payment by as much as 1 percent. Subsequently, Congress enacted the Gramm-Rudman-Hollings legislation which caused a 1 percent reduction in 1986 PPS payment rates, effective March 1, 1986. More recently, Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. This legislation limited the increase in hospital PPS payments to 0.5 percent for FY 1986, effective May 1, 1986. We believe our survey of hospital profits and our testimony before the Senate Finance Subcommittee on Health on this matter played a significant role in limiting the increase in hospital PPS payments. This reduction will save some \$400 million for FY 1986.

**SKILLED MEDICAL
PROFESSIONALS
(SMP)**

Medicaid generally matches States' administrative costs at a 50 percent rate. One exception, made at the time the program was created, established the Federal matching rate for skilled professional medical personnel, such as medical doctors, and their support staffs at 75 percent. The higher rate was adopted to encourage States to employ personnel who have the professional medical expertise necessary to develop and administer Medicaid programs that are medically sound as well as administratively efficient.

Since Medicaid is no longer in the developmental stage, continuing this incentive after 20 years no longer appears reasonable or necessary. Moreover, the higher matching rate has led to abuse. Past OIG reviews and internal HCFA studies have shown that State Medicaid agencies have misclassified employees and obtained increased Federal matching. For example, in 1984 OIG reported that one State improperly claimed 75 percent Federal sharing (\$200,000) for staff (1) not specialized in a field of medical care, (2) not performing a job function related to Medicaid administration, and (3) employed by a private employer under contract to the State.

We recommended that HCFA seek legislation to eliminate the 75 percent rate for skilled medical professionals and their support staffs. By using the normal 50 percent rate, Medicaid will save an estimated \$63 million annually. We also recommended that HCFA reexamine the need for enhanced Federal matching in other categories of Medicaid expenditures.

Proposals to this effect are included in the Administration's FY 1987 budget.

Current legislation gives small rural hospitals the option of using excess acute care beds as "swing beds" in providing needed long-term nursing care to Medicare and Medicaid patients. A recent OIG review found this approach beneficial and recommends that it be expanded, on an experimental basis, to larger hospitals including those located in urban areas.

SWING-BED PROVISIONS

Reputable studies have disclosed that the demand for nursing home beds will outstrip supply by more than one-half million beds by 1990. Use of the currently estimated 148,500 excess hospital beds (plus the increased bed surplus expected as a result of PPS) could alleviate new nursing bed construction with resultant savings to the Medicare and Medicaid programs.

Also, conversion of empty hospital beds to swing beds would provide immediate access to long-term care and would avoid a "no care" zone where patients released from hospitals are without prospects of either adequate in-home care or nursing home care.

Because full expansion of this approach could overtax existing control systems, we are recommending that HCFA expand use of swing beds, on an experimental basis, to selected large and urban hospitals. This experiment would be the basis for any subsequent legislation proposed by HCFA to expand the swing-bed provisions to all acute care hospitals. HCFA is awaiting the completion of its contracted evaluation of the rural swing-bed program which it says will enable it to better define the issues and consider other alternatives to this problem.

Program Administration

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 \$325.5 million. In addition, another \$53.3 million in program expenditures were questioned as to their allowability under regulations, law or cost principles. In these instances, recommendations called for financial adjustments and appropriate procedural changes.

AMBULANCE EDITS

Medicare pays for ambulance services only if other means of transportation would endanger the beneficiary's health and if the beneficiary is being transported to specified destinations such as a hospital or nursing home. Currently, almost all carriers use manual processes to determine whether claims for these services meet destination and level-of-service requirements. We found that one carrier had implemented a place-of-service coding system and corresponding computerized prepayment edits that increased its denial rate over 300 percent.

We estimate that implementation of these edit checks at all Medicare carriers having manual systems could identify \$64 million annually in noncovered ambulance services. Our recommendation calls for HCFA to monitor those carriers who are in the process of or planning to implement such edits, and, if their denial rates increase significantly, to require implementation by all Part B carriers. HCFA agreed to contact all regional offices to determine if carrier review of ambulance claims meets legal and manual requirements. If necessary, HCFA will change processing instructions to reflect necessary carrier actions.

DURABLE MEDICAL EQUIPMENT

In CY 1984 Medicare payments for durable medical equipment (DME) climbed to \$710 million, a 17 percent increase over the previous year. To restrain these costs, HCFA has been developing long-term remedies such as reform of the current charge-based reimbursement system for DME and other Part B services. While OIG supports HCFA's efforts, our evidence suggests that until needed reforms are in place, HCFA must rely on short-term measures such as use of the lowest charge level provision that can be implemented within the existing system.

The 1972 lowest charge level (LCL) amendment gives the Secretary authority to limit Medicare reimbursement for medical services, supplies and equipment to the lowest charge level if, in the judgment of the Secretary, they do not vary

significantly in quality from one supplier to another and are widely and consistently available in a locality. To date only two DME items have been subject to that limitation: standard hospital beds and wheelchairs. We identified an additional seven items of DME that could be subject to the LCL limitation such as oxygen concentrators and walkers. By applying the limitation to these items, HCFA in the short term could save Medicare \$8 million annually.

HCFA is currently acting on our recommendations that it not only apply the LCL limit to the items identified but that it identify other DME items for inclusion under LCL for even more Medicare savings.

OIG found that Medicare may be paying as much as \$15 million annually for medically unnecessary chest x-rays being routinely provided nursing home residents. Our review in three States showed that residents were often receiving chest x-rays mandated by State agency or institutional policy rather than by specific medical need. For example, we found in one State that 43 percent of the x-rays reviewed were scheduled by facility personnel solely to satisfy either the State licensing requirement for a chest x-ray upon admission or the institution's policy for annual x-rays. Our findings suggest that such x-rays do not meet the "medically necessary" criteria for Medicare reimbursement, and subject our beneficiaries to unnecessary levels of radiation. HCFA officials generally concurred with our recommendation. HCFA is developing revised instructions to improve standardized carrier screening for routine tests.

ROUTINE NURSING HOME X-RAYS

Medicare and Medicaid spend over \$14 billion annually to provide services to nearly 2 million patients residing in long-term care facilities. Several reviews this period focused on related aspects of facility certification and HCFA's monitoring to ensure that facilities meet established health and safety standards. Following are highlights of three of these reviews.

LONG-TERM CARE

(1) The Omnibus Budget Reconciliation Act of 1980 allows the Secretary to sanction (deny reimbursement) substandard nursing homes for new admissions. This provision is in lieu of terminating such homes' participation in Medicare or Medicaid. Our review of HCFA's proposed rules implementing this provision disclosed areas that require clarification. Specifically, HCFA should:

ALTERNATIVE DECERTIFICATION RULES

- Better indicate conditions for imposing sanctions.
- Provide specific time frames for each step of the sanction process to ensure either timely correction of deficiencies or imposition of sanctions.

Once this is accomplished, HCFA could then move quickly to identify chronically substandard nursing homes and apply the new fiscal sanction as an incentive for improving conditions under which Medicare and Medicaid patients must live. HCFA plans to include additional clarification in its instructions.

**MONITORING
STATE SURVEYS/
CERTIFICATIONS**

- (2) HCFA's centralized Medicare/Medicaid Automated Certification System (MMACS) contains information gathered by States during their continuing surveys of long-term care facilities. It is designed as a monitoring tool to ensure that facilities meet established health and safety standards. OIG's review in 14 States found MMACS ineffective primarily because it contains stale data. Thus, its output cannot be fully used to monitor State survey and certification activities.

Of the 1,568 facilities sampled, we found that 96 percent had been surveyed within the last 15 months but the results were not entered into MMACS. Moreover we found that HCFA's manual systems used in lieu of MMACS were also unreliable. For example, 5 of 14 States reviewed were not properly surveying all long-term care facilities and thus facilities received \$1.3 million while in noncompliance status.

Recommendations call for HCFA to take steps to (a) ensure that MMACS data is as current as possible; (b) use MMACS to develop a national strategy to ensure that all long-term care facilities are surveyed annually; and (c) identify facilities that, on the basis of past patterns of care, should be selected for HCFA inspections and intermediate sanctions. HCFA has taken steps to improve the accuracy and timeliness of MMACS data.

**LOOK BEHIND
INSPECTIONS**

- (3) HCFA has the authority to "look behind" State certification surveys of long-term care facilities. This authority is to be used not only to evaluate the accuracy and thoroughness of State surveys, but more importantly, as the basis for HCFA taking direct action against substandard facilities.

Of 22 inspection reports reviewed, only one was forwarded to the facility in a timely manner. In that case, HCFA within one day of completing the inspection notified the intermediate care facility for the mentally retarded (ICF/MR) of hazardous conditions and initiated termination action. In the other 21, HCFA took from 4 to 20 days—an average of 12.5 days—to notify facilities of hazardous conditions. We attribute these delays to HCFA's not having an established time frame for notifying facilities of inspection results. Because of the likelihood of similar delays, we are recommending a time frame be established for all long-term care facilities, not just ICF/MRs.

OIG found that one State had not adjusted the Federal Medicaid account for overpayments totaling \$44.2 million. The overpayments (covering a 10-year period) were identified by State audits and represent amounts due from county hospital providers. Adjustments had not been made because the State agency deferred crediting the Federal account until overpayments were recovered from providers. The Departmental Grant Appeals Board has ruled in similar cases that the Department has the right to collect the Federal share of these payments, even if recoveries have not been made.

PROVIDER OVERPAYMENTS

In addition to recommending a financial adjustment of \$44.2 million, we recommended that the State establish procedures to prevent this situation from recurring.

An OIG review in one State determined that hospitals often billed at the inpatient rate for Medicaid patients who were discharged on the day of admission. Of 32,724 claims of this nature for the 3-year period ending April 28, 1984, 84 percent were for hospital stays of less than 12 hours. We believe these claims (which included circumcisions, removal or restoration of teeth as well as such non-operative procedures as blood transfusions) should have been billed at the lower outpatient rate. Had this been done, Federal Medicaid savings over the 3-year period could have been as much as \$3.9 million. These findings reinforce our 1984 conclusion that HCFA needs to encourage and provide guidance to States on how to develop ambulatory delivery systems.

OUTPATIENT CARE/ INPATIENT RATE

One State's Medicaid program pays for wider abortion coverage than that permitted under the Hyde amendment, which with few exceptions, prohibits Federal sharing in abortion costs. To ensure that claims for Federal sharing do not include these costs, the State uses claims processing edits to flag them. OIG found, however, that these edits were not always effective and that during a recent 2-year period, \$718,000 in abortion-related costs (hospital per diem charges and related ancillary services) were improperly claimed. Recommendations call for an appropriate financial adjustment as well as procedural improvements to prevent this problem from recurring.

ABORTION- RELATED COSTS

The Omnibus Budget Reconciliation Act of 1980 established Medicare as the secondary payer for items and services that had been or are likely to be paid for under an automobile liability insurance policy or plan, or under no-fault insurance. Private health insurance has primary responsibility for payment of the person's medical expenses which were incurred as part of the accident.

MEDICARE AS SECONDARY PAYER IN AUTOMOBILE ACCIDENTS

A review was completed in the States of Missouri and Colorado to validate whether providers were identifying Medicare Secondary Payer (MSP) auto

accident situations and correctly billing the private insurance plans; and to determine the extent to which Medicare contractors were properly identifying and processing MSP auto accident claims. The studies projected total overpayments of \$4.6 million in these two States and made recommendations for increased efforts by HCFA to establish effective detection programs to identify and correctly process MSP claims. HCFA issued detailed procedures with an effective date of January 1986, and has conducted training sessions to ensure that the secondary payer system is improved. Implementation of our recommendations could reduce trust fund expenditures by over \$7 million annually.

**MEDICAL
LICENSURE AND
DISCIPLINE**

A recent program review of medical licensure and discipline practices was conducted in 24 States. We found that there was considerable concern about (1) the inadequacy of the education being received by many foreign medical graduates, (2) the failure of many teaching hospitals to conduct thorough credential screening of residents and inform boards of resident performance, (3) major backlogs in the handling of disciplinary cases and few disciplinary actions being taken on the basis of malpractice or incompetence, (4) a pattern of inadequate State resources are being used to support State licensing board activities, (5) licensing fees are often not being used to support State licensing boards, and (6) general fear of being sued has a chilling affect on individuals reporting medical incompetence and wrongful conduct. OIG recommendations are under consideration within the Department.

**ANESTHESIA
SERVICES**

The Medicare program spends nearly \$1 billion annually for over three million anesthesia services provided to beneficiaries. The OIG found that anesthesia services provided during cataract removal, hernia repair, and pacemaker implant vary. We found that, for these procedures, local standby anesthesia is provided more frequently than general anesthesia. Standby anesthesia generally does not require the full range of services associated with general anesthesia. We recommended that HCFA establish a policy to reimburse local standby anesthesia at a lesser rate than general anesthesia. HCFA agreed and will make a regulatory change. Implementation of this new policy will save \$84 million in FY 1987.

**INAPPROPRIATE
DISCHARGES AND
TRANSFERS**

The OIG conducted a review of 3,706 cases which were identified by the PROs as instances of premature discharges and inappropriate transfers occurring under Medicare's prospective payment system (PPS). During the time period covered by the study (October 1983 - May 1985), the PROs, while having the authority to handle identified instances of poor quality of care, had not as yet received specific instructions on how to deal with instances of premature discharges and inappropriate transfers. Rather, PROs were instructed to refer

these cases to HCFA for analysis in instances where patients were admitted to a facility within 7 days of an earlier discharge for the same health condition. Subsequently, in July 1985, HCFA issued instructions to the PROs clarifying how to deal with inappropriate discharges and transfers that are identified.

Based on the findings of this review it appeared that many PROs did not effectively use the authority or process available to them to address instances of premature discharge and inappropriate transfer.

The PROs are now increasing review and sanction activities against physicians/providers demonstrating abusive patterns on quality of care. The new PRO scope of work will emphasize attention to quality of care issues.

A recent program review revealed problems with Medicare hospital inpatients not understanding their rights when they were being discharged from a hospital but felt they should be allowed to remain for a longer period of time. While procedures called for the patient to receive a written notice in these instances, we found that cases of premature discharge are more likely to occur following verbal discussion between a patient and the physician rather than when a formal denial notice has been issued.

PATIENT DISCHARGE NOTICES

For this reason, we as well as PROs and patient advocate groups, have urged that written notification be issued to all patients upon admission, spelling out their benefits and responsibilities concerning Medicare hospital coverage. The right of patients to appeal discharge decisions and the review responsibilities of the PRO should be explicitly stated. HCFA has issued instructions to hospitals, PROs and fiscal intermediaries to implement a policy of providing such notice to all patients upon admission to the hospital.

As reported in the previous semiannual report, prospective payment system hospitals are paid a rate based on the diagnosis related group (DRG) assigned to the Medicare patient. Reviews of the validity of assignments to DRG 88, Chronic Obstructive Pulmonary Disease, and DRG 82, Respiratory Neoplasms, found that 60 percent of the cases were erroneously assigned to DRG 88 and 40 percent were erroneously assigned to DRG 82. We also found unnecessary admissions at the rate of 5 and 7.5 percent respectively.

DRG MISCLASSIFI- CATION

To reduce the number of erroneous DRG assignments, the OIG recommended that HCFA instruct PROs to educate physicians and coders in the identification of principal and secondary diagnoses, and consider focused review of these and similar DRGs. We also recommended that HCFA establish a mechanism to

resolve issues that arise from DRG validation questions and end the favorable waiver presumption for unnecessary admissions.

HCFA is implementing our recommendations through instructions to PROs. New procedures will result in potential savings of \$39.6 million annually.

**PERCUTANEOUS
TRANSLUMINAL
CORONARY
ANGIOPLASTY
(PTCA)**

Percutaneous Transluminal Coronary Angioplasty (PTCA) is an alternative approach to coronary bypass surgery and it is generally performed in the catheterization lab as opposed to the operating room. The procedure utilizes a special balloon catheter introduced through an artery and directed across the obstructing lesion in the coronary artery to relieve obstruction.

PTCA was originally assigned to DRG 108 which represents major open heart procedures. Our evidence suggests this to be an inappropriate assignment with resulting significant overpayments. The more appropriate classification for PTCA would be to DRG 112, Vascular Procedures Except Major Reconstruction.

HCFA agreed with this recommendation and included the reassignment of this procedure along with other classification changes in a final rule issued September 3, 1985. That rule took effect May 1, 1986. Correction of this error will save \$107.9 million annually.

**MEDICARE
CONTRACTORS**

During this 6-month period, we assessed the allowability of administrative costs incurred by Medicare intermediaries and carriers and recommended disallowances of \$3.1 million in costs considered unallowable for reimbursement. Unallowable costs included unsupported charges for claims processing system changes and duplicate charges for accrued annual leave.

Ongoing Reviews in Health

Because PPS is a new reimbursement mechanism, especially close monitoring is needed to quickly identify wasteful program features. Accordingly, our ongoing activities are focusing on emerging PPS payment issues such as the appropriateness of hospital earnings under the mechanism. Following are highlights of these and several other ongoing reviews in the health care area.

**INDIRECT MEDICAL
EDUCATION (IME)**

Teaching hospitals receive an 11.59 add-on percentage to the PPS rate for "indirect medical education" (IME) costs associated with their training activities. This factor, legislatively authorized, is twice that in effect prior to PPS. In 1985

OIG reported that IME payments under PPS were excessive and recommended a return to the 5.79 percent pre-PPS rate for savings of \$600 million annually. The Administration's FY 1987 legislative proposals include this recommendation. In addition, the Department has proposed regulations to curb the rate of growth of IME payment.

The Consolidated Omnibus Budget Reconciliation Act of 1985 reduced the indirect medical education factor to 8.1 percent for patient discharge occurring during the period May 1, 1986 through September 30, 1988 and to 8.7 percent thereafter. This is a positive first step toward reducing excessive IME payments. However, since most teaching hospitals made large profits from the Medicare PPS in 1984, we are continuing to study their financial need for even this level of IME payment.

Hospitals' psychiatric, rehabilitation and alcohol units meeting certain requirements are exempt from PPS and their costs paid on a reasonable cost basis as they were prior to PPS. Although paid separately, these units' costs and patient discharges were included in cost data used to develop both the hospital specific portion as well as the Federal portion of the PPS rates.

PPS EXEMPT UNITS

Results of an ongoing OIG review indicate that inclusion of exempt unit cost/patient data significantly inflates hospital PPS payments. Our analysis of 69 exempt units showed that the involved hospitals' net PPS payments were increased \$16.2 million. Nationwide, this overstatement would be significantly more.

In certain circumstances involving Medicare beneficiaries with end stage renal disease (ESRD), employer group health plans are primary payers of beneficiaries' health care and Medicare the secondary payer. However, a review in one State disclosed that non-hospital based facilities were routinely billing and collecting from both Medicare and employers' insurance companies for the same dialysis services, with often no subsequent refunds to Medicare. This occurred because the fiscal intermediary had not instructed facilities to make refunds to Medicare.

END STAGE RENAL DISEASE (ESRD)

We expanded our review to three other States and found similar problems. Evidence suggests that overall Medicare overpayments could be in excess of \$17 million. We will be recommending that HCFA take steps to correct this situation and initiate recovery action as warranted.

**PEER REVIEW
ORGANIZATIONS
(PROs)**

During 1984 HCFA awarded 53 fixed-price contracts and one cost contract to PROs to review the necessity and appropriateness of Medicare admissions to acute care hospitals. The contracts covering a 24-month period were valued at more than \$300 million. In 1986 HCFA will be renewing these PRO contracts for another 2-year period. As with the current contracts, OIG will perform preaward audits on technically acceptable proposals. We are also performing financial audits of 46 of the current PROs to assist departmental contracting officials by (1) providing verified base line data on the cost of PRO operations in 46 States during the first year of the current contract, (2) projecting levels of profit or loss on the audited contracts and (3) facilitating Government estimates of PRO operations in the second 2-year contract period.

Data on individual PROs has been provided to HCFA to aid current negotiations. A consolidated report summarizing the results of the 46 audits will be issued to HCFA by late spring.

Legal and Administrative Sanctions of Wrongdoers

OIG health care investigations resulted in 42 convictions and \$10 million in recoveries and savings. In addition, we collected \$1.7 million in civil monetary penalties from 23 settlements and excluded 90 providers from participation in the Medicare and Medicaid programs.

**BETTER
COORDINATION
OF SANCTION
AUTHORITIES**

We are improving on implementation of the various sanction authorities to obtain maximum preventive and deterrent effect. Three actions occurring this period illustrate our success with fraudulent schemes in the durable medical equipment industry and kickbacks for using certain pacemakers and heart-monitoring devices. Each case is described below.

Seat-Lift Chairs

- In our last semiannual report we described problems with seat-lift chairs. We sent HCFA a Fraud Alert warning that "blitz" advertising of durable medical equipment companies contained false representation and could result in Medicare program abuse. In some instances, doctors merely signed standardized approval forms for patients to obtain the chairs. In other instances, doctors complained that the companies delivered chairs to patients who would never have thought of obtaining them, delivered them before medical approval was given, and then repossessed them—to the distress of the patients—when medical necessity approvals were denied.

We have had two convictions during this period involving seat-lift chairs and are working on several other cases. More importantly, our investigations have highlighted underlying problems, and we have recommended preventive measures which can have a widespread effect. HCFA issued a reminder that carriers should adhere strictly to Medicare guidelines.

In addition, in one region we worked with the Medicare carriers to develop a questionnaire for physicians who authorized these chairs. The questionnaire had to be completed to the satisfaction of the carrier before any claim was reimbursed. Medicare payments for the chairs fell sharply. The carriers have estimated a savings of \$5.6 million in this region alone.

- Another investigative area which illustrates effective use of our various authorities has been the ongoing investigation of the pacemaker industry. In 1984 we obtained the prosecution of a major pacemaker company for kickbacks to doctors using its products and an order for restitution of \$240,000. A recent follow-up investigation involved a cardiologist in Rhode Island who was convicted for taking kickbacks and engaging in poor medical practices. In addition to receiving 10 years in jail and a \$70,000 fine, he had to pay \$100,000 in civil fines and penalties for submitting false Medicare claims. The State also suspended his license to practice medicine.
- Acting on a complaint that a Pennsylvania osteopath was paying kickbacks to other physicians who would prescribe his heart-monitoring devices for patients, we conducted an investigation which resulted in the physician being convicted for false billings and kickbacks. In addition to being imprisoned and fined \$100,000, the physician was suspended from the Medicare and Medicaid programs for 9 years by the OIG.

**Pacemaker
Kickbacks**

**Heart-Monitoring
Devices**

In addition to detecting and dealing with criminal fraud, we are chartered to police our health care programs for those individuals who would endanger beneficiaries through patient abuse. Through our sanctioning authorities we can exclude from the Medicare program providers engaging in abusive behavior. Included in these authorities is exclusion upon the recommendation of PROs. We made our first exclusion based on recommendation of a PRO during this period. An Arkansas practitioner was found to have not met professionally recognized standards of medical care and was excluded from the Medicare program for 1 year. As in all such exclusions, he must reapply and show he has improved his professional conduct before he can again participate in the program.

**PRO-RELATED
SANCTIONS**

The California PRO has been particularly active, and has made recommendations that resulted in 3-year program exclusions of a hospital and a physician during this period.

- The PRO recommended permanent exclusion of a mental health hospital because its quality of care was inappropriate and unnecessary and did not meet professionally recognized standards. A review showed that violations were serious, in that there was potential for patient harm. The American Association of Retired Persons issued a statement in support of the exclusion. The hospital was excluded 3 years. Since the exclusion from Medicare would mean a loss to the hospital of about \$1 million this year alone, it attempted to get a temporary injunction to prevent the exclusion until an appeal could be made to an administrative law judge. The request for an injunction was denied and the exclusion is now in force.
- An anesthesiologist was excluded because, in a substantial number of instances, he did not provide care that met professionally recognized health standards. He refused to recognize the problem and comply with his obligations. As with the other PRO-recommended exclusions, he must reapply for participation in Medicare/ Medicaid and must show improvement in his professional conduct.

**SANCTIONS FOR
FRAUD
CONVICTIONS**

Conviction of Medicare or Medicaid program-related fraud results in mandatory sanctions. A Texas ophthalmologist who was previously convicted of submitting false claims and obstructing justice, and sentenced to prison, has been suspended from program participation for a minimum of 25 years.

Recently we suspended both a hospital director and his wife from the Medicare and Medicaid programs for 5 years for engaging in fraudulent behavior. The conspiring respiratory provider and his company were suspended for 10 years from program participation.

Other examples of providers who were sanctioned as a result of our investigative work include the following:

- A New York physician was suspended for 5 years after being convicted for aiding and abetting an unlicensed person to practice medicine, prescribing controlled substances and submitting false claims.
- The president of a New Jersey ambulance company was suspended for 10 years for submitting 350 false claims over a 3-year period.
- A laboratory supervisor at a South Dakota hospital was suspended for 10 years after being convicted for defrauding the Government by ordering hospital supplies and materials for use in his private service. This scheme cost Medicare an estimated \$36,000.

- A former co-owner of a Pennsylvania hospital was suspended for 5 years after being convicted for filing a false cost report and conspiring with a co-defendant to receive cash kickbacks from persons doing business with the hospital.

In those cases of unjust enrichment resulting from fraud or abuse, Congress provides civil monetary penalty authority to recover and return to the programs the lost money, with penalty. Examples of this authority exercised during this period include the following:

CIVIL MONETARY PENALTIES

- A major Philadelphia oxygen supplier must pay \$750,000 in civil monetary penalties for submitting claims for Pennsylvania residents to the New Jersey carrier because that carrier reimbursed at a higher rate. This practice is not allowed by Medicare regulations.
- A husband and wife team of hospital anesthesiologists must pay \$468,000 in civil fines and restitution for submitting false Medicare and private insurance claims during 1980-81. The couple attempted to transfer \$1.4 million to India and the Netherlands shortly before they were arraigned in March 1984. Their plans were foiled by an alert OIG agent and the U.S. Attorney. The assets that were frozen were used to pay civil restitution and penalties of \$278,000 to Medicare and overcharges of \$190,000 to a private insurer.
- A Wisconsin physician made a \$300,000 settlement with the OIG for submitting Medicare claims for undocumented services and falsifying diagnoses in order to support billings for expensive tests. In addition, he routinely upgraded services such as brief office visits which he billed as higher-paying intermediate office visits.
- A Nebraska group of anesthesiologists and nurse-anesthetists agreed to a \$180,000 settlement for Medicare claims improperly submitted and reimbursed. The settlement also included a payment of over \$16,000 to the Nebraska Department of Social Services for improper Medicaid claims.
- As the result of an investigation by the OIG and the PRO, an Arkansas physician paid \$150,000 in restitution and penalties. The physician also was excluded from participation in the Medicare and Medicaid programs for 2 years. The investigation disclosed that the physician was altering the results of patients' laboratory tests to justify their admission to a hospital. He also sought Medicare reimbursement for bacteriological tests which had been performed free of charge by the State health department.

- A joint settlement was reached between the OIG, the Maryland Medicaid Fraud Control Unit (MFCU) and the Justice Department with the former owner of a metropolitan ambulance company. He paid \$125,000 in civil monetary penalties and \$35,000 to the Maryland MFCU. He was also suspended from the Medicare and Medicaid programs for 25 years. The provider was convicted of falsifying patients' medical condition in order to charge Medicare and Medicaid for unnecessary ambulance services. During a 2-year period, he submitted false claims amounting to \$53,000.

JOINT INVESTIGATIONS

Joint investigations with other Federal, State and local government and private agencies make good use of the skills of all the participants, and increase the probability of obtaining convictions. These collaborative efforts can also shorten the time required to conduct health care investigations. The following cases are examples of this work:

- Working with a private insurance company and the local prosecutor's office, we obtained the conviction of an Ohio hospital administrator. He embezzled approximately \$126,000 from the hospital's general account, including almost \$53,000 in Medicare monies.
- An Oklahoma doctor was convicted of Medicaid fraud uncovered with the assistance of the U.S. Postal Service and IRS.

STATE MEDICAID FRAUD CONTROL UNITS (SMFCUs)

Most of our Medicaid cases are handled jointly with the State Medicaid Fraud Control Units, for which the OIG has oversight responsibilities. The 36 SMFCUs now in existence obtained an estimated 123 convictions during this period. Shown below are a few of the OIG/SMFCU cases which occurred during the last 6 months.

- In Texas an ophthalmologist was convicted on a 74-count indictment filed against him as the result of a joint OIG SMFCU investigation. The doctor had not only billed Medicaid for work not performed, and upgraded services, but also passed along inflated costs of goods purchased from a "dummy" corporation.
- A Georgia dentist was convicted of billing Medicaid for oral exams and fluoride treatments not performed, and for unallowable charges.
- An Ohio psychologist was convicted for submitting false claims to Medicaid and a private insurance company. His office manager was also convicted.

In what has been said to be the largest Medicaid fraud scheme in terms of dollars, the Illinois MFCU obtained the conviction of 11 persons. Included were pharmacists, physicians associated with a drug company and 20 clinic-pharmacies which sold sedatives and cough syrup containing codeine to drug addicts. Medicaid recipients frequently visited several physicians to get prescriptions, or they forged prescriptions to obtain quantities of high priced drugs. The Medicaid recipients then traded the high priced drugs to the pharmacists for the sedative/cough syrup substances. The pharmacists then sold the higher priced drugs through their own pharmacies or to other pharmacies or wholesalers. The scheme cost Medicaid nearly \$20 million before it was uncovered. Among the 40 people indicted earlier in the scheme, the 11 that were convicted were ordered to repay \$15 million. Three other doctors were found mentally incompetent to stand trial, and two other defendants died of drug overdoses while awaiting trial.

**RECORD
MEDICAID FRAUD
CASE**

Three podiatrists were convicted for billing Medicare or Medicaid for services which they did not perform such as nail surgery, nail removals, therapy and x-rays. Two of the cases occurred in Texas and one in Iowa. Together they billed Medicare or Medicaid for a total of more than \$120,000 for services they said had been performed in nursing homes. A Montana physician was found guilty of submitting false claims for nursing home visits he did not make.

**FRAUD IN
NURSING HOMES**

In South Carolina the owner, public accountant and office manager of a nursing home, and the owner of a medical supply company were convicted for false Medicaid reports, kickbacks and perjury. The nursing home officers submitted reports to Medicaid which inflate the interest costs on buildings and equipment. All but the office manager were involved in a kickback scheme where the nursing home paid money to the supply company, which then paid an investment company which made payments to the nursing home owner. The trials of two other defendants will be held separately at a later date.

The employees of health care providers and insurance companies occasionally are found to take advantage of their positions to defraud the Medicare program. A New Jersey woman who had worked as a receptionist for 2 providers pled guilty to embezzling \$27,000 in Medicare and private insurance company funds. She had forged the providers' names on checks received from Medicare and private insurers, and deposited the checks in her personal bank account. She also stole cash from the providers.

**PROVIDER AND
INSURER EMPLOYEE
FRAUD**

A New York couple developed one of the largest schemes we have uncovered for stealing money from a Medicare carrier. The wife was a senior claims examiner for the carrier, and used her position to mail fraudulent checks

amounting to more than \$850,000 to various addresses. The husband, the mastermind of the scheme, and two other conspirators were also convicted.

**NATIONAL ANTI-
FRAUD
ASSOCIATION**

The OIG has been concerned for some time that providers defrauding Federal and State health care programs might be preying on private health insurance companies, either at the same time or as a result of being excluded from the public programs. We recently joined with private insurance companies and State licensing and law enforcement agencies to form a National Health Care Antifraud Association. The purpose of the Association is to present a total health care industry front, on a nationwide basis, in the fight against fraud. Our efforts are based on the understanding that a prosecutor might hesitate to spend the time and effort required to take action against a provider who defrauded one part of the industry of a few thousand dollars. By pooling information from the entire industry, the crime may exceed hundreds of thousands or even millions of dollars, and therefore be much more attractive for prosecution. The Association is planning its first annual conference in November 1986. Several workshops will be conducted on techniques for identifying fraudulent schemes and instituting necessary controls.

CHAPTER II

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) continues to account for over two-thirds of the HHS budget. In fiscal year 1986 over 50 million Americans will receive over \$213 billion in benefits from SSA's income maintenance programs. The Old-Age, Survivors, and Disability Insurance (OASDI), Supplemental Security Income (SSI), and Part B Black Lung Benefit programs are federally administered. The Aid to Families with Dependent Children (AFDC), Low-Income Home Energy Assistance (LIHEA), U.S. Repatriate, and Refugee Resettlement (RR) programs are State administered (these programs, among others, have been transferred to the new Family Support Administration).

During this period, OIG focused significant resources on reviewing the effectiveness of SSA's processes for correcting and recovering overpayments and the adequacy of the trust funds' accountability for contributions received and for reimbursements made to Treasury. Primary attention focused on SSA's Title II programs (Old-Age, Survivors, and Disability Insurance) because of the large Federal expenditures involved. The OIG is also reviewing on a continuing basis SSA's implementation of its computer Systems Modernization Plan (SMP).

OIG reviews during this 6-month period identified \$157.9 million that could be saved by full implementation of procedural recommendations.

Legislative Reforms

Congress, as part of the 1983 Amendments to the Social Security Act, revised the Social Security benefit formula to eliminate "windfall" benefits to workers with less than lifelong careers in covered employment. This "windfall elimination provision" (WEP) also applied to persons receiving periodic payments based on noncovered foreign employment. SSA recently proposed a legislative change to exclude all foreign pensions from WEP.

WINDFALL FORMULA REVISION

Our review of SSA's proposal showed that there is a rational basis for exempting certain foreign pensions from WEP but not all foreign pensions. For example,

totalization benefits (resulting from agreements with foreign countries on combining a worker's partial coverage under national social security systems) are already prorated to allow for less than a full career in the country paying benefits. However, we determined that exclusion of other foreign public pensions from WEP would cost the trust funds about \$36 million over a 5-year period. As a result of our review, SSA had revised its proposal. It will now propose to exempt from the windfall elimination provision only foreign totalized benefits based on combined U.S. and foreign work.

Program Administration

ASSISTANCE SYSTEMS TRANSFERS SSA will match 90 percent of States' costs to develop and install statewide automated AFDC claims processing and information retrieval systems. The Office of Family Assistance (OFA) has developed a general system design called Family Assistance Management Information System (FAMIS) to provide States with a standard approach for AFDC systems development. In addition, OFA has encouraged transferring systems between States as an alternative to each State developing its own system.

A system transfer from one State to another can reduce the cost as well as time required to develop a new system, thus enabling system benefits to be achieved more quickly and minimize the developmental risks associated with untested approaches and technologies. We found that, prior to the availability of a transferable system, States' requests for FAMIS funding only gave minimal consideration to system transfers. However, since OFA demonstrated the feasibility of system transfers, they have met with greater success.

We estimate that the public assistance programs (primarily AFDC, Food Stamp and Medicaid) could save \$449.8 million over the next 3 years if OFA would more effectively promote transferring of FAMIS-type systems. SSA agrees with our recommendations and has taken several steps to promote systems transfers. In addition, the Administration has proposed reducing the Federal match rate over a 3-year period to 50 percent. If Federal financing is so lowered, States would have an even greater incentive to share technology in this area.

REFUNDS OF EXCESS FICA TAXES Refunds for overpaid FICA taxes are paid to taxpayers by IRS through tax return adjustments on behalf of SSA. The Treasury general fund is reimbursed by annual trust fund transfers, based on the amount of estimated taxes subject to refund.

OIG found that transfers made were generally accurate and based on sound computation methods except for calendar years 1978 and 1979 which were transition years when SSA changed from a quarterly to an annual wage reporting cycle. Estimates of excess wages were used to determine transfer amounts for those years and still remain provisional. More importantly, we found a mathematical error which caused \$49 million to be incorrectly transferred to the general fund in May 1980, and which was not corrected.

OIG recommendations call for SSA to correct 1978 and 1979 data base inaccuracies and finalize transfers. Also, adjustments should be made to future excess wage estimates to recover the \$49 million over-transfer. SSA agrees to finalize and correct transfers once sufficiently accurate data is available.

SSA's primary method for accounting and controlling overpayments from their initial identification to final settlement is called the Recovery of Overpayments Accounting Records (ROAR) system. Incorrect payments, such as forged endorsements, are not legally defined overpayments and are included in a special payment amount (SPA) data field on SSA's master beneficiary record (MBR) file. Treasury is responsible for collecting these payments upon notification by SSA.

CONTROLLING OVERPAYMENTS AND INCORRECT PAYMENTS

Prior to 1979, all overpayments and incorrect payments were posted to the SPA data field and SSA employees had to manually establish overpayments on the ROAR system. In 1979, SSA made systems improvements which allowed for automatic posting from the MBR to the ROAR file.

Our review of a sample of 258 payments recorded in the SPA field between 1978 and 1983 showed that overpayments of approximately \$44 million were erroneously included in the MBR file but not on the ROAR system because of miscoding and other employee errors. Recommendations call for SSA to actively seek recovery of overpayments where appropriate and ensure that only incorrect payments are posted to the SPA field.

OIG reviewed SSA's procedures for control and recovery of overpayments resulting from improper cashing of replacement checks by OASDI and SSI beneficiaries. These overpayments occur because beneficiaries, after claiming nonreceipt of benefit checks, cash both the original and replacement checks. The Treasury Department reports the negotiation of both checks to SSA. This double check negotiation (DCN) results in overpayments totaling about \$10 million annually.

BENEFIT REPLACEMENT CHECKS

We found that SSA loses accountability for about \$1.4 million of these overpayments annually, thus resulting in losses of Federal funds. Weak procedural

controls in processing Treasury notifications of DCNs was the major failure in controlling OASDI DCN overpayments—the bulk of the overpayments.

OIG recommended the establishment of centralized record systems to control OASDI DCN cases. SSA generally agreed with our recommendation, noting that an automated control of OASDI DCN cases would be incorporated into their National Debt Management System which is under development. In the interim, SSA will use tighter manual controls to help ensure more accurate processing of these cases.

ADMINISTRATIVE FINALITY RULES

Under current Title II “administrative finality” rules, SSA is prohibited from correcting overpayment errors based on initial determinations made more than 4 years previously unless fraud or other similar circumstances are involved. Instead, SSA must continue paying benefits, even when it is discovered that beneficiaries are erroneously entitled or are being paid more than the correct amount.

Since 1981, SSA has been considering a proposal to revise these rules by expanding the conditions under which initial determinations could be corrected. A Notice of Proposed Rulemaking (NPRM) was issued nearly 2 years ago to so revise the regulations. However, final action has not been taken. Our review of the NPRM showed that beneficiaries would be protected as the proposal does not require retroactive collection of overpayments. Also, the trust funds would be protected from making future excess payments. Savings to the trust funds would average \$6.6 million a year for the next 5 years.

We recommended that SSA give full support to the proposed revisions so the regulatory changes can be implemented without further delay. SSA agreed stating that the NPRM was in the final stages of its clearance process.

INTEREST ON STATES’ DELINQUENT FICA CONTRIBUTIONS

State and local government employee and employer Social Security contributions are collected by the States which in turn are required to forward them to SSA in accordance with a prescribed deposit schedule. Generally, contributions not received by the due dates are considered delinquent and interest is to be assessed.

Although SSA has authority to assess interest on delinquent contributions, procedures have not been developed establishing time frames for States to pay interest charges. We found that about \$5.7 million of interest had not been assessed or collected on delinquent contributions deposited to the trust funds in 1982, 1983 and 1984. Secondly, SSA does not have an automated system to

monitor delinquent contributions and thus ensure timely assessment and collection. Although such a system is under development, it has not yet been implemented.

We recommended that SSA promptly compute, assess and collect interest on delinquent contributions. Our report is currently with SSA for comment.

Under the 1980 Refugee Act, States are reimbursed for cash, medical assistance and social services provided to refugees and entrants, as well as for reasonable administrative costs. An OIG review found that one State improperly charged the program \$2.1 million primarily for payments made to recipients who were not properly registered for employment—a program requirement.

REFUGEE/ENTRANT PROGRAM

Recommendations call for the State to make a financial adjustment of \$2.1 million and appropriate administrative improvements.

In the 1970's, inadequate software was identified as a major underlying factor for SSA's systems problems. Software upgrade, therefore, was given special emphasis in SSA's Systems Modernization Plan (SMP). The most difficult systems modernization effort in SSA's SMP is improvement of its software and the creation of a software engineering environment, i.e., the procedures, practices, standards and technological approach to software.

SOFTWARE ENGINEERING

In past reports, OIG has pointed out problems which could affect the success of the SMP such as the need for better planning, improved software engineering standards, and a methodology for implementing internal controls. GAO and GSA have recently expressed similar concerns. SSA addressed some of the questions we raised in its October 1985 SMP report.

However, our findings still suggest that certain past causes of delays such as changes in management or organization and lack of clear goals could further delay software development plans. We recommend that improved software engineering practices be made a major SSA monitoring initiative with quarterly reporting of tangible progress to HHS management. Our evidence indicates that this high level, continuous commitment to and visibility of software engineering would significantly enhance chances for success. Our report is currently with SSA for review.

Recent investigations have revealed schemes against the Social Security Administration's enumeration process by aliens legally admitted but not authorized to work. The schemes were designed to get SSA to issue unrestricted duplicate SSN cards to the aliens.

ISSUANCE OF UNRESTRICTED SSN CARDS

The aliens were initially issued SSN cards with the legend "Not Valid for Employment." The aliens later applied for replacement cards alleging a domestic place of birth. The replacement cards were issued without the non-work legend based on the allegation of domestic birth. The enumeration system failed to prevent the issuance of the unrestricted replacement cards due to the lack of an adequate mechanism to alert the material discrepancies in the allegations of place of birth.

SSA will, based on our recommendations, establish a more effective enumeration system control which will close the loophole. This control will require that SSA query the enumeration record prior to issuing a replacement card to determine if the last established record reflects a non-work interview code or a foreign place of birth. Cases excepted from the SSN issuance process by these controls will require resolution of citizenship/alien status before a replacement card is issued.

CONVERSION OF BENEFITS

Recent reviews revealed that Social Security overpayments have occurred in cases where life benefits have been automatically converted to survivor benefits. The beneficiaries in these cases had remarried and failed to notify SSA.

When benefits are automatically converted to survivor benefits as the result of the death of the primary beneficiary, there is no requirement for a personal contact with the survivor, nor is a new application required. Our review of the language of the award certificate which is mailed in these cases reveals that it does not include any instructions on reporting responsibilities, nor is there any provision for obtaining the beneficiary's agreement to report events which affect eligibility. Consequently, the beneficiary cannot be expected to be aware of the need to report certain events, and it would be difficult to establish intent if fraud were involved.

In order to correct this problem, SSA is revising the death conversion awards procedure. The revised conversion award notice includes a new "rights and responsibilities" booklet and a reference that includes the events that must be reported. The planned implementation date of the new notice is July 1986.

Legal and Administrative Sanctions of Wrongdoers

Investigative activities resulted in 490 convictions, \$7.5 million in investigative recoveries, and another \$12.5 million in 1-year savings obtained by cutting off the illegal payments.

One of the most effective tools in detecting fraud over the years has been SSA's match of beneficiary rolls against State and Medicare death records. Screening and following up on SSA's "hits" has become a part of our regular workload, of which the following cases are examples:

DEATH MATCHES

- A California man collected his mother's benefits for 6 years after her death in 1979. He was found guilty of obtaining \$25,000 illegally and ordered to make full restitution.
- A representative payee in California continued cashing her aunt's checks for 10 years after the aunt had died. She was convicted and ordered to make full restitution of over \$40,000.
- In an ongoing death match in New York, 23 persons were found guilty of stealing \$235,000 in benefits sent to deceased relatives or friends. In one of the cases a man cashed his deceased father's checks for 2 years, and in a separate action his wife was convicted of cashing her deceased father's checks.

Other highly productive projects in which the OIG has been engaged over the last 2 years involve working with State and local government agencies with whom we have mutual program interests.

FEDERAL, STATE AND COUNTY COOPERATION

Through our Baltimore office the OIG has been investigating and referring cases for prosecution through the Maryland judicial system. As a result of OIG work, 43 persons were convicted in Maryland State courts in FY 1985, and 37 thus far in FY 1986, for crimes involving Social Security card violations and theft of Government monies.

At the national level the OIG encourages States to participate in our AFDC States Benefits Project. In this project we serve as an active partner in obtaining and verifying evidence for AFDC prosecutions. Since this program began, 639 convictions and \$5.5 million in investigative recoveries have been realized. During this 6-month period 126 convictions and \$578,000 were obtained through State prosecutions.

AFDC STATES BENEFITS PROJECT

Project Payback is another effort implemented over 2 years ago after the OIG found that large numbers of suspected fraud cases were not being pursued because the violators did not meet prosecutive criteria. Rather than allow the violations to continue unimpeded, we began sending letters to the violators that

PROJECT PAYBACK

established our presence in the collection process and we demanded repayment. During this period our office issued 395 demand letters and identified potential recoveries of \$2.5 million.

**INTERNATIONAL
SSA FRAUD**

An area of the Social Security system that had evaded scrutiny over the years has been benefit payments sent to persons in foreign countries. Project INTERFACE (International Fraud Analysis and Claims Evaluation) was established to investigate fraud in Social Security programs occurring outside the jurisdiction of the United States. With assistance from the Department of State's Foreign Service posts around the world and the Veterans Administration in the Philippines, SSA receives, develops and adjudicates claims for foreign beneficiaries. When fraud is suspected, the case is referred to the OIG for fraud determination and handling. In the little more than a year that this project has been running, \$1.7 million has been realized, \$700,000 of it during this 6-month period.

**MASS JUDICIAL
ACTIONS**

Eight mass judicial actions were taken involving 69 persons. The following examples are a few of the more noteworthy situations.

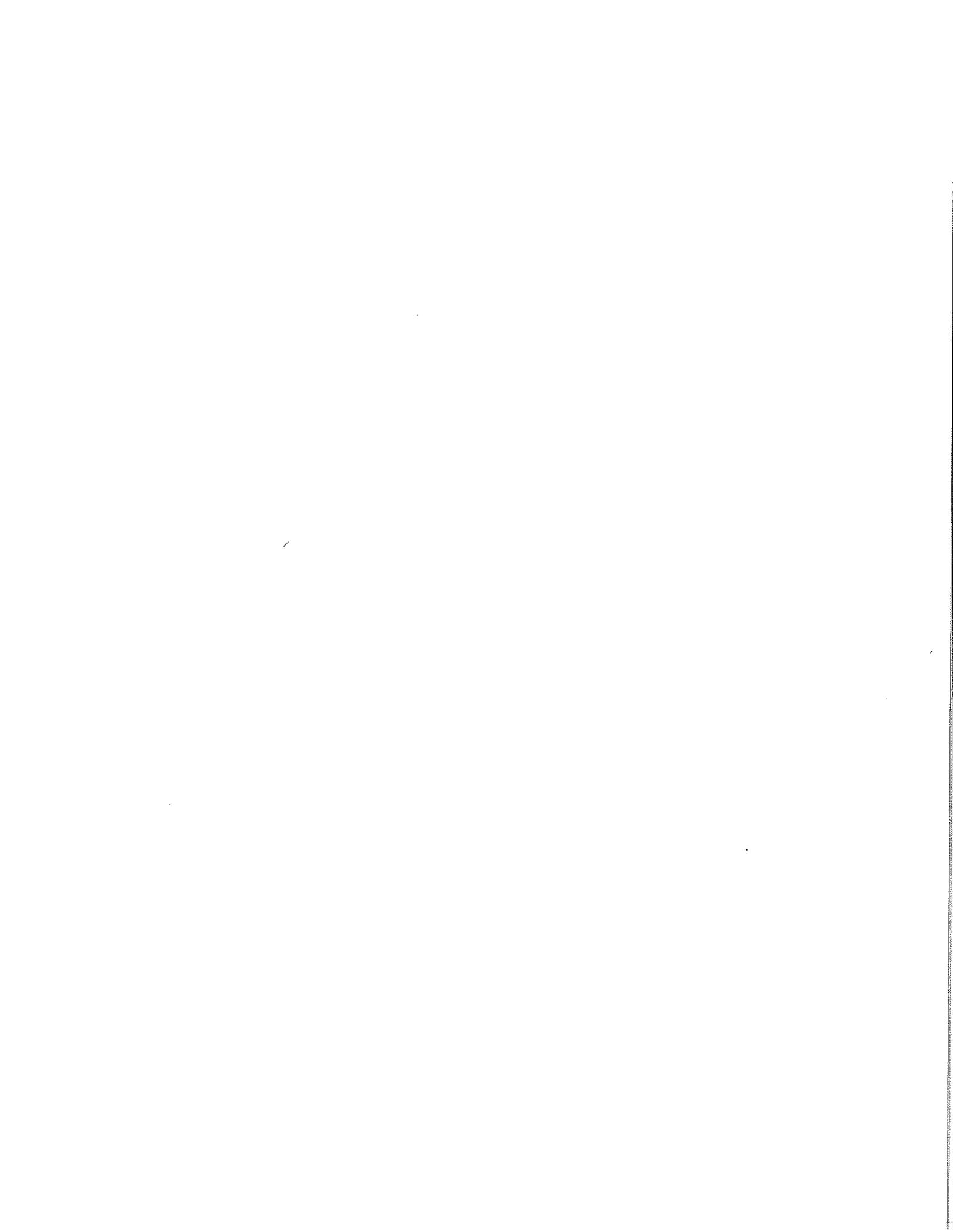
- In Washington, D.C. the OIG worked with the U.S. Attorney's Office to obtain the first mass action involving Social Security fraud in the city. In this action seven persons were indicted on charges that they fraudulently received \$137,000 in Social Security checks.
- In Oklahoma three mass indictments were made involving 21 persons. The indictments charge that the persons claimed they were disabled or unemployed or that they converted relatives' benefits to their own use.
- In Chicago 15 persons were charged with falsely claiming enrollment in various schools and colleges to obtain a total of more than \$75,000 in student benefits.

**FALSE
IDENTIFICATION**

Criminals frequently forge Social Security cards as a basis for false identification in order to exploit Government benefit programs and the tax system, to transact banking and money laundering activities, and to obtain credit cards. The OIG is participating in two joint task forces involving Federal and State investigative agencies. The OIG's participation is directed towards the illegal use of Social Security cards and account numbers by persons and organizations engaged in narcotics trafficking, and by foreign nationals engaged in fraudulent activities against U.S. Government programs. Since the OIG began participating in these efforts in February 1986, two indictments have been obtained.

As part of the OIG's regular caseload pertaining to false identification, the following are some of the more interesting cases:

- Eighteen persons were convicted on charges of defrauding the Ohio Bureau of Employment Services of more than \$1.2 million in unemployment benefits. All had used false SSNs in a scheme which centered around a "dummy" company owned and operated by two of the conspirators. The two owners recruited the other conspirators to file for unemployment compensation listing the dummy firm as their last employer. Those recruited would split their weekly benefits with the owners of the company. The scheme operated for 5 years.
- A Chicago attorney was sentenced to 16 years in prison for SSN misuse and filing false income tax returns. He used phony SSNs and bank accounts which enabled him to conceal \$288,000 in income from IRS over a 4-year period.
- The owner and three employees of a Nebraska auto dealership conspired to file false wage and tax statements. The three men had part of their wages paid to their wives' Social Security accounts so that they could continue receiving Social Security benefits and disability payments.
- A Minneapolis attorney was sentenced to 10 years in jail and ordered to make full restitution of \$231,000 for using fictitious SSNs to file fraudulent currency transaction reports.
- A New York man was convicted of counterfeiting Social Security and naturalization documents. Agents searched the man's apartment and discovered a printing press, aluminum offset plates used to produce counterfeit Social Security cards, U.S. entry cards, naturalization papers and numerous other identification documents.



CHAPTER III

GRANTS AND INTERNAL SYSTEMS

Grants and Internal Systems (GIS) reviews cover program activities of the Public Health Service (PHS) and the Office of Human Development Services (OHDS) as well as HHS internal management functions of payroll, personnel, procurement, and debt collection. Projected FY 1986 expenditures in the GIS area are \$9.2 billion, PHS; \$5.7 billion, OHDS; and \$126 million for departmental administration.

A major thrust of the OIG's effort has been: (1) reviewing departmentwide debt collection and cash management activities, (2) determining the adequacy of internal controls, (3) improving security at the Department's electronic data processing (EDP) facilities, (4) reviewing the efficiency and effectiveness of selected programs and (5) identifying opportunities to cut costs through improved efficiency of Department operations.

From October 1, 1985 through March 31, 1986, we identified opportunities for cost savings of \$50.8 million through increased efficiency of program operations and management. Recommended financial adjustments for this same period amounted to \$38 million.

Public Health Service

Public Health Service (PHS) spending focuses on biomedical research, disease prevention, the safety and efficacy of marketed drugs and other medical products as well as other activities to promote better health for Americans. During the reporting period, our reviews surfaced opportunities to achieve more efficient use of program funds with resultant annual savings of \$49.0 million.

NIH, with 1985 research spending of \$2.7 billion, funds over half the federally sponsored research at the Nation's colleges and universities. A significant and rapidly increasing portion of this funding is for indirect costs, i.e., university administrative support activities (overhead) which cannot be attributed to any one project.

NIH RESEARCH COSTS

In accordance with departmental policy, research proposals approved by NIH include only the direct costs of a project such as researchers' salaries and equipment. Indirect costs are left open-ended and paid based on an institution's current negotiated rate for indirect costs. Thus, institutions can receive increased indirect costs resulting from: (1) using provisional indirect cost rates which, when finalized, result in increased award amounts; (2) rebudgeting proposal costs resulting in changes to the indirect cost base; and (3) using higher indirect cost rates during multi-year grants.

Also, past OIG reviews have shown that institutions often charge unallowable indirect costs to Federal research which inflate the indirect cost rate. As the indirect cost rate increases during a grant period, so does overall funding. This practice of leaving indirect costs open-ended is costly and should be eliminated.

We recommended that Department policy be revised to establish the total cost of the grant award including indirect costs at the time of the award. The Government would then be obligated to pay no more than the amount awarded. According to Department estimates, adoption of our recommendation would result in first year savings of about \$35 million, and \$7 million annually thereafter.

SMOKELESS TOBACCO

Due to widespread public health concerns, the OIG conducted a national survey of young smokeless tobacco users at the request of the Surgeon General. The survey included over 500 respondents in 31 school systems in 16 different States. We found use of smokeless tobacco by high school, junior high and even elementary school students has increased greatly in recent years. Many youth do not know the health risks involved. These young users are already experiencing serious health effects, such as addiction; receding gumlines and sores; and blisters and ulcers on their gums, lips, cheeks or tongues. Many have mouth lesions, which research shows have a risk of turning into oral cancers.

The OIG concludes that users of smokeless tobacco are a growing national problem with potential serious health consequences and recommended that the Surgeon General: launch an educational public media campaign on risks, support school health educational efforts, seek funding for basic research on smokeless tobacco use and risks, and provide strong national leadership on the smokeless tobacco issue.

Study findings and recommendations have been endorsed by the Surgeon General. The HHS Secretary delivered a public service radio message on the issue, and study results have been widely shared with public health experts,

educators and health professional associations. Subsequent to our study, the President signed Public Law 99-252, the Comprehensive Smokeless Tobacco Health Education Act of 1986, which directs the Secretary to undertake a number of activities relating to smokeless tobacco.

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

UNEARNED INTEREST

Based upon this review, the OIG recommended to the Office of Management and Budget (OMB) that Circular A-110 be revised to require all Federal agencies' nonprofit grantees, not otherwise exempt, to maintain Federal funds in bank accounts which pay interest and return this interest to the Federal Government. OMB has agreed to this recommendation. Implementation will result in 1-year savings of \$14 million across all Federal agencies.

Office of Human Development Services

Office of Human Development Services (OHDS) spending provides a variety of social services to American children, youth and families, older Americans, Native Americans and the Nation's disabled. During this reporting period, OIG identified questionable costs of \$4.8 million.

Audits of Head Start program grants are made by nonfederal auditors. Each nonfederal report is reviewed by OIG for matters requiring immediate action (possible fraud or abuse), conformance to established Federal guidelines, and findings requiring action by the Department before being issued to the Office of Human Development Services. During this period, we evaluated 483 reports which recommended adjustments of \$3.2 million in costs charged to the program. These reports also cited over 517 deficiencies in grant administration such as problems with accounting, internal controls and recordkeeping practices.

HEAD START AUDITS

Title IV-E Foster Care grants are awarded to States to assist in providing eligible children with routine care and maintenance. Costs of specialized services such

FOSTER CARE

as social services are to be claimed under Title XX and subject to the specific regulations and cost limitations of that program.

Our review of one State's claim under Title IV-E for a recent 18-month period, identified \$1.4 million for unallowable social services costs, such as those for counseling and therapy. The State had not claimed these costs under Title XX as it had already reached its cost ceiling for that program. In addition, we identified \$200,000 for payments made to ineligible facilities.

We recommended that the State make a financial adjustment of \$1.6 million and appropriate procedural changes.

Departmental Management

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

INTERNAL CONTROLS

The 1982 Federal Managers' Financial Integrity Act (FMFIA) requires Federal agencies to establish a continuous process for evaluation and improvement of internal administrative and accounting control systems and to annually report to the President and Congress on the status of their systems. The Assistant Secretary for Management and Budget manages the Department's FMFIA effort.

The Department in 1985 progressed in meeting FMFIA objectives by more clearly identifying areas for internal reviews, upgrading review guides and training staff. However, as discussed below, milestones for completing internal reviews were not always met.

- Timeliness and adequacy of FMFIA actions varied by Department component. As of September 30, 1985, the Department had not resolved all material weaknesses identified in 1983 and 1984 in the areas of cash management, payroll and general ledger accounting procedures. Correction of these weaknesses is included in the Department's multi-year corrective action plan.

- With the exception of HCFA, SSA and OS, operating and staff components generally did not meet the target date of September 30, 1985 for completion of internal control reviews for specifically targeted areas. Because these reviews were completed late, OIG did not have an opportunity to thoroughly evaluate results. PHS, OHDS and OCS did not complete any reviews in time for our evaluation.

We recommended that the Assistant Secretary for Management and Budget (ASMB): (1) take more aggressive action to enforce the FMFIA work schedule in Department components; (2) require closer attention by Department officials in performing, documenting, testing and reporting results of reviews; and (3) require annual and quarterly accomplishment reports from Department components. ASMB, as well as other Department officials generally agreed with our findings and are initiating corrective actions.

Public Law 96-499 requires Federal agencies to reimburse States for unemployment compensation (UC) paid to eligible former Federal employees. The Department of Labor (DOL) pays the States' bill for all Federal agencies, and in turn, bills each agency for their share. Federal agencies provide State Employment Security Agencies (SESAs) with wage and separation information for former employees who apply for unemployment benefits.

UNEMPLOYMENT COMPENSATION

Our analysis of 48 cases from 9 States showed that 20 lacked the necessary information to determine if the claimants met UC eligibility criteria. Our further analysis of personnel files revealed that individuals were, in fact, ineligible for UC benefits. As a result, improper payments of about \$79,000 were made to the 20 claimants.

The Department can save about \$1.3 million annually if proper front-end procedures are instituted to prevent ineligible claims. The Assistant Secretary for Personnel Administration concurred with our findings but indicated that it was too early to predict the size of the estimated savings.

OIG reviews of physical security at NIH EDP facilities and at 16 Medicare contractors disclosed weaknesses in (1) physical access to facilities, (2) disaster recovery and contingency planning and (3) the use and protection of passwords for accessing computers. These weaknesses increase the vulnerability of the computer systems to fraud, embezzlement, unauthorized disclosures, destruction and misuse. Our recommended actions were generally accepted. Our report on Medicare contractors is currently with HCFA for comment.

PHYSICAL SECURITY AT EDP FACILITIES

TIME SHARING Since 1973, the Department's operating and staff divisions have used a relatively expensive commercial on-line time sharing service to assist in preparation of the annual budget, health facility planning, personnel and other administrative reports. Our review showed that these contracted services rely on customized software which could be replaced at substantial savings by generalized software used with in-house mainframe and microcomputers. For example, we found that the charges to connect into the contractor's systems are five times greater than those for connecting into an in-house computer. Moreover, because of processing shortcomings, data has to be manually re-keyed by the different inputting offices. OIG recommended modifying and using in-house system capability which could save HHS about \$2.6 million over 5 years or over \$500,000 annually, improve operations and reduce the staff time required to input data and create reports. The Department is in general agreement with our recommendations.

NONFEDERAL AUDITS In November 1985 the Inspector General testified before the House Subcommittee on Legislation and National Security on critical weaknesses sometimes found in nonfederal audits of HHS grantees, such as: inadequately developed audit findings, missing reports and schedules, failure to properly evaluate internal controls, and problems in the review of compliance with laws and regulations. The IG also discussed ongoing efforts to identify substandard work and to impose appropriate sanctions.

The proportion of audits performed by certified public accountant (CPA) firms and State auditors continues to grow in both numbers and dollar volume. During the 6-month period October 1, 1985 through March 31, 1986, we issued 1,368 reports containing recommendations for cost recoveries of \$13.3 million and identified opportunities for improving the efficiency of grantee management systems. A summary of the results of our reviews during this 6 months follows:

Reports issued without modifications	1,126
Reports issued with modifications	242
Returned to auditor	143
Unacceptable reports	<u>3</u>
Total audit reports processed	1,514

In a separate effort to deal with quality of nonfederal audits, we formally recommended to the President's Council on Integrity and Efficiency (PCIE) that it provide leadership in (1) defining substandard audit work, (2) prescribing a uniform Government-wide system for recording and reporting substandard work, (3) prescribing uniform penalties, (4) developing uniform referral procedures, (5) tracking disciplinary actions and (6) maintaining a dialogue with the American Institute of CPAs on matters of common concern.

For the fiscal year ended September 30, 1985, debt due the Department decreased \$241 million, collections increased \$489 million and write-offs of accounts receivable amounted to \$404 million compared to \$378 million for the previous fiscal year. It should be noted that in line with changed Treasury reporting requirements, these data are reported for the fiscal year rather than for the semiannual calendar year as it had been in the past. (See summary on page 38.)

DEBT COLLECTION

Much of the increase in collections, \$329 million, was due to payments on receivables HCFA established, such as those for the buy-in program, prompted by debt collection initiatives recommended by OIG. The major write-off of receivables in FY 1985 was for OASDI overpayments that SSA determined to be uncollectible.

We continue to monitor the Department's debt collection activities on a quarterly, cyclical basis. For the period ended September 30, 1985 we examined OS, OHDS and HCFA. We also assessed action taken to date in resolving prior problems in meeting debt reporting requirements of Office of Management and Budget (OMB), Treasury and the Department.

- OS and OHDS - The OIG previously reported that, due to accounting errors, \$1.1 million in audit disallowances had not been recorded on OHDS programs as receivables; nor had interest been accrued on those disallowances. Also, the system of aging audit disallowance receivables was not formalized, and proper accountability over sustained audit disallowances was not maintained. While some improvements in the controls for recording sustained audit disallowances had been made, our current review showed that:

Recorded audit disallowances of about \$580,000 were not reported to Treasury as required.

Accrued interest receivable of about \$990,000 on audit disallowances was not recorded.

Accounts receivable were not properly aged; thus delinquent accounts are not always referred to claims collection as required.

- HCFA - Since our last review, HCFA has conducted an analysis of premiums owed by States for the buy-in program which covers eligible Medicaid recipients under Medicare. This action resulted in an additional \$87 million in buy-in receivables being reported. HCFA also completed a review of and are setting up receivables for Medicare premiums owed by third party group payers (employers, unions, etc.) which elect to pay for individuals. However, our review showed that:

HCFA excluded program disallowances of \$390 million from accounts receivable statistics on the debt report submitted to Treasury for this period. We brought this matter to the Department's attention.

Interest on \$107 million of audit disallowances under appeal was not recorded in the general ledger as required by OMB Circular A-50.

Interest on \$43 million in delinquent receivables relating to State buy-in premiums had not been recorded. HCFA is currently acting to correct this situation.

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

Reports with Costs Questioned

	<u>Total</u>	<u>Over 6- months old</u>
Unresolved audits, September 30, 1985	287	5
Unresolved audits, March 31, 1986	196	3 ¹
	<u>Number</u>	
Reports issued during period	257	
Reports resolved during period	348	
	<u>Amount (in millions)</u>	
Costs questioned during period	\$106.6	
Costs sustained during period	\$ 45.6 ²	

¹ These three reports are with the Social Security Administration for resolution; have related monetary findings of \$3,117,917; and do not include 3 ICF/MR reports which cannot be resolved pending resolution of court cases.

² 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 Period Ended		Write-Offs for Period Ended	
	<u>9/30/84</u>	<u>9/30/85</u>	<u>9/30/84</u>	<u>9/30/85</u>	<u>9/30/84</u>	<u>9/30/85</u>
Audit Disallowances	\$ 212 ¹	\$ 238	\$ 72	\$ 85 ³	\$ 3	\$ 1 ³
Owed by Public ²	<u>3,664</u>	<u>3,397</u>	<u>1,263</u>	<u>1,739³</u>	<u>375</u>	<u>403³</u>
Total	\$3,876	\$3,635	\$1,335	\$1,824	\$378	\$404

¹ Debts due to recommended audit disallowances which have been sustained by the program as of the dates shown.

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

³ In line with Treasury's changed reporting requirements, amounts shown are for the fiscal year, whereas amounts in prior reports were on a 6-months basis for the calendar year.

UNENACTED LEGISLATIVE RECOMMENDATIONS

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

- Exclude from program participation health professionals who are in default on PHS loans and scholarships.
- Establish a minimum suspension period for persons convicted of Medicare/Medicaid crimes.
- Exclude from program participation those guilty of kickbacks in the Medicare/Medicaid programs.
- Exclude from program participation health professionals who have been sanctioned by State licensing authorities.
- Require the reporting of all final adverse actions made by a State licensing authority.
- Clarify administrative sanctions for circumventing the prospective payment system.
- Sanction those who falsify information on "conditions of participation" applications.
- Exclude based on Peer Review Organization findings of Medicaid violations.
- Exclude from Medicaid/Medicare those who have been sanctioned by other Federal and State health care programs.
- Impose Medicare sanctions on those who have been found to abuse the Medicaid program.
- Exclude from Medicare and Medicaid those convicted of (1) fraud or financial abuse; (2) neglect or abuse of patients; or (3) drug trafficking in connection with the delivery of health care services or with a Federal, State or local program.

- Sanction those who do not grant immediate access to the OIG in the performance of statutory functions.
- Exclude from Medicare/Medicaid those who make false or excessive claims.
- Exclude from Medicare/Medicaid those who furnish excessive or unnecessary services under the Medicaid program.
- Exclude from Medicare/Medicaid those who do not provide information necessary to verify their claims for payment.
- Exclude from participation entities who fail to make required disclosure that they are owned or controlled by individuals sanctioned under Medicare/Medicaid.
- Exclude providers from participation in Medicaid when a State agency finds good cause.

Civil Monetary Penalties:

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

Appendix B

UNENACTED PROGRAM RECOMMENDATIONS October 1985 Through March 1986

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
HEALTH CARE FINANCING ADMINISTRATION		
Multiple Visits in SNFs:		
Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005)	HCFA is looking into alternative reimbursement methods which address the issue raised by our review.	\$268/year
Elective Surgeries:		
Increase use of outpatient facilities for elective surgeries under Medicaid. (ACN: 09-50205)	HCFA indicates that it will soon implement our recommendations.	\$110/year
Prescription Drugs:		
Better curbs needed on Medicaid prescription drug costs. (ACN: 06-40216)	The Department is considering our recommendations.	\$72/year
Home Health Services:		
Establish effective Medicare utilization controls over home health services. (ACN: 06-52011)	HCFA does not agree with our recommendations. It has, however, issued a revised billing form and plans to have regional intermediaries process these claims. HCFA believes that these actions will correct the problems reported.	\$17/year
Pacemaker Monitoring:		
Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017)	HCFA has issued guidelines on frequency of phone monitoring, and is still considering the reclassification issue.	\$6 year

OIG RECOMMENDATIONS	PROGRAM POSITION	PROJECTED SAVINGS IN MILLIONS
HEALTH CARE FINANCING ADMINISTRATION (Continued)		
Less-Than-Effective Drugs:		
Enforce regulations prohibiting Medicaid payments for less-than-effective drugs. (ACN: 03-60202)	HCFA is currently revising the State Medicaid Manual—an action it believes will adequately implement our recommendation.	\$4.9/year
Housekeeping Services:		
Clarify Medicaid regulations covering housekeeping services to require services to be related to a medical necessity. (ACN: 15-00200)	HCFA is evaluating alternatives to regulatory revision.	(To be determined)
SOCIAL SECURITY ADMINISTRATION		
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 Semiannual Report.)	SSA disagreed on grounds that charging interest would not be cost effective.	\$1.3/year
Administrative Finality:		
SSA should change regulations to extend from 2 to 4 years the time limit for correcting SSA payments and collecting overpayments, since SSA cannot validate earnings and recover millions in overpayments in the 2-year time frame. (First discussed in 10/82-3/83 OIG Semiannual Report.)	This matter is now under consideration by the Department.	\$50/year

APPENDIX C

ANALYSIS OF COST SAVINGS October 1985 Through March 1986

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
HEALTH CARE FINANCING ADMINISTRATION		
OIG report and testimony pointed out that PPS payments should take into account large Medicare profits being earned by hospitals. (ACN: 09-62021)	Recent legislation limited the increase in PPS payments to 0.5 percent for FY 1986, effective May 1, 1986.*	\$400.0
Require intermediaries and carriers to slow the Medicare payment cycle to conform to the 30-day payment cycle endorsed by OMB and thus maximize interest earned by the Health Insurance Trust Funds. (ACNs: 03-42004 and 03-52001)	HCFA has slowed the payment cycle to 16 working days for FY 1986 and 22 working days for FY 1987.	\$320.0
OIG recommended that HCFA develop procedures to assure that future collections from third party payers are promptly re-funded to the Medicare program. (P-85-7-040)	HCFA agreed and is taking steps to have hospital auditors assure that providers do not have inappropriate credit balances.	\$103.4

* Legislation referenced or affected refers to the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, signed into law on April 7, 1986.

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
HEALTH CARE FINANCING ADMINISTRATION (Continued)		
Remind States of use of lower-priced State Medicaid fee schedule for Part B deductible and coinsurance paid by States on behalf of Medicaid recipients eligible for the Medicare Buy-In Program. (ACN: 02-60202)	HCFA issued a policy memorandum implementing our recommendation in October 1985.	\$120.0
Establish separate reimbursement policies for general anesthesia and local standby anesthesia services. (P-02-98-0001)	HCFA concurred with this recommendation by memo dated January 22, 1986 and is in the process of issuing a regulation to implement this change.	\$84.0
Require Medicare contractors to use segmented accounting procedures for claiming pension costs. This method results in a more equitable direct charge of pension costs to Medicare than the indirect allocation method now being used. (ACN: 07-52013)	HCFA issued instructions on November 6, 1985, requiring contractors to use segmented accounting unless they can convincingly prove that Medicare is not a separate, recognizable segment of their operations.	\$75.0
Establish a national cap on the reimbursement for intraocular lens. (P-85-09-046)	HCFA transmittal #1129, October 1985, requires carriers to apply payment limitations for lens under the doctrine of "inherent reasonableness."*	\$75.0

* Legislation referenced or affected refers to the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, signed into law on April 7, 1986.

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
HEALTH CARE FINANCING ADMINISTRATION (Continued)		
Reassign the procedure, Percutaneous Transluminal Coronary Angioplasty (PTCA) from DRG 108 to DRG 112 to prevent significant overpayments to the Medicare program. (Action Memo to HCFA)	HCFA issued the final rule change on September 3, 1985 which took effect May 1, 1986. This savings figure (\$47.9) represents an additional amount that will be saved from our original projection of \$60 million included in our Semiannual Report for the period 10/1/84 - 3/31/85	\$47.9
Establish front-end controls to prevent duplicate VA and Medicare payments for nursing home care of Medicare eligible veterans. (Joint VA and HHS Report)	HCFA established the recommended controls.	\$40.0
Eliminate Medicare payment from unnecessary assistant surgeon services for cataract surgery and other operations. (ACN: 02-51001)	Recent legislation excludes from Medicare coverage payments for assistants at surgery for certain cataract operations and other operations.*	\$145.0**
Reduce the number of erroneous DRG assignments by instructing PROs to educate physicians and focus on DRG validation. (P-85-B-041 and P-05-85-00003)	In February 1986, HCFA responded that: Effective July 1986, the scope of work for PROs now includes focused DRG reviews and a requirement and that RRAs and ARTs be involved in the review process. HCFA has published a final rule ending favorable waiver presumption for unnecessary admissions on 2/21/86.	\$39.6

* Legislation referenced or affected refers to the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, signed into law on April 7, 1986.

** Savings based on Congressional Budget Office (CBO) estimate for 5-year budget cycle.

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
HEALTH CARE FINANCING ADMINISTRATION (Continued)		
Eliminate waiver of liability provision for Medicare Part A providers. (ACN: 03-62014)	Final regulations eliminating this provision for all providers were published in the <i>Federal Register</i> February 21, 1986. However, COBRA nullified the home health agency portion of these rules.	\$25.3
HCFA should improve procedures used by intermediaries for identifying hospital claims with accident diagnoses and determining whether Medicare is the secondary payer for these services. (P-3-08-5002-14, P-3-07-5001-32, P-01-4105-32 and P-08-5001-14)	HCFA has issued detailed procedures with an effective date of January 1986, and has conducted training sessions to insure that the secondary payer system is improved.	\$12.3
One State agency should make certain procedural changes to revise its cost reporting and settlement procedures for ICF/MRs and Institutions for Mental Diseases. (ACN: 10-60201)	The State agency implemented the recommended changes beginning with its FY 1985 claims for Federal sharing.	\$4.7
Total HCFA Related Reports:		14
Total HCFA Related Dollars:		\$1,492.2

OIG RECOMMENDATIONS	ACTION TAKEN	SAVINGS IN MILLIONS
SOCIAL SECURITY ADMINISTRATION		
SSA should prepare a legislative proposal to reduce the Federal matching rate for the State child support enforcement program administrative costs from 75 percent to 70 percent, and reduce the incentive payment from 15 to 12 percent. (P-04-86-300087)	Regulations to implement the new legislation were effective 10/01/83. This cost savings represents the four remaining years in the 5-year budget cycle. The first year savings were described in the Semiannual Report for the period 10/1/82 - 3/31/83.	\$265
OFFICE OF THE SECRETARY		
Change OMB Circular A-110 to require that all Federal agency grantees not statutorily exempt, maintain Federal funds in bank accounts which pay interest. (P-09-86-00055)	OMB drafted language to implement this recommendation in October 1985. OIG reviewed responses to the memo in March 1986.	\$14.0
Eliminate unallowable and overstated costs from indirect cost rate proposals of two educational institutions (ACNs: 05-51025 and 03-67003)	By adopting OIG recommendations, the Division of Cost Allocation (DCA) was able to establish indirect cost rates which were more equitable than those proposed—per DCA savings report dated December 31, 1985.	\$7.8
Recover duplicate payroll service fees included in one State's Statewide Cost Allocation Plan (SWCAP). (ACN: 08-54508)	Our recommended adjustment was made to the State's SWCAP.	\$1.8
Total Office of the Secretary related Reports:		3
Total Office of the Secretary related dollars:		\$23.6
Investigative Savings	Specific actions were taken to implement specific investigative findings	\$18.0

SUMMARY OF SAVINGS-RELATED REPORTS AND DOLLAR ACCOMPLISHMENTS
(October 1985 through March 1986)

Source	Issues	Dollars (in millions)
HCFA	14	\$1,492.2
SSA	1	\$ 265.0
Office of the Secretary	3	\$ 23.6
Savings from Investigations	N/A	\$ 18.0
Total	18	\$1,798.8
Agreements to Recover (Including recoveries from investigations)		\$ 254.7
Total		\$2,053.5

APPENDIX D

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 Health Services Block Grant programs.

DRG —

Diagnosis Related Groups, 468 groupings of diagnoses for which Medicare beneficiaries are treated in hospitals. These DRGs are the basis for Medicare payments for hospital service to beneficiaries under prospective payment system (PPS) adopted October 1983.

EDP —

Electronic data processing

EOMB —

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

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.

Practitioner —

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

PPS —

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

Provider —

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

Sanction —

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

SMFCU —

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

Supplier —

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

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