



Department of Health and Human Services  
Richard P. Kusserow  
Inspector General  
**OFFICE OF INSPECTOR GENERAL**

# **SEMIANNUAL REPORT TO THE CONGRESS**

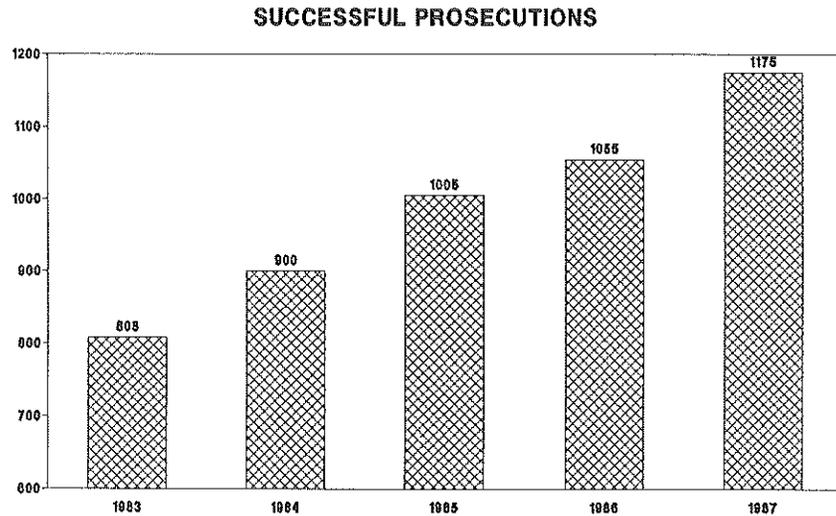
**April 1, 1987 - September 30, 1987**

SAVINGS \$ 5.4 Billion

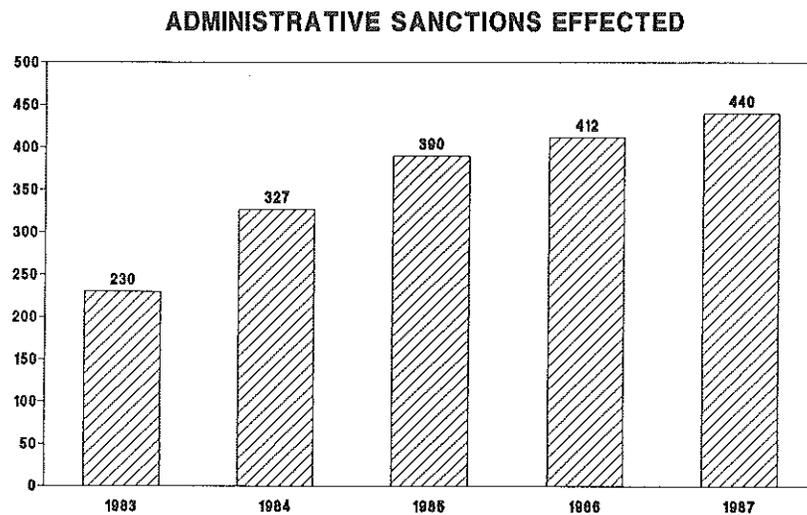
SUCCESSFUL PROSECUTIONS 1175

ADMINISTRATIVE SANCTIONS 440

maintain the integrity of these programs. Also, these prosecutions improve the quality of care provided to program beneficiaries.



- *Administrative Sanctions* - During the fiscal year, 440 health care providers and suppliers or their employees were administratively sanctioned, through exclusion or monetary penalties, for defrauding the Medicare and Medicaid programs or for providing substandard care or excessive services.



- *Medicare and Medicaid Fraud Convictions and Recoveries* - During the fiscal year, 571 convictions resulted from investigations of Medicare and Medicaid fraud by the OIG and federally supported State Medicaid Fraud Control Units (SMFCUs), with financial recoveries and savings of \$31 million.

The following examples highlight OIG findings and recommendations during the second 6 months of the fiscal year to improve quality of care, enhance program management and achieve cost savings. The parenthetical citations at the end of these descriptions refer to the actual OIG report, and the topics are explained in more detail in the referenced pages.

- The OIG has made several legislative recommendations which were incorporated in the Medicare and Medicaid Patient and Program Protection Act of 1987. The law expands the ability of the OIG to exclude health care providers from Medicare and Medicaid and other departmental programs. (See page 30.)
- Eighty-five percent of respondents to an OIG survey of Social Security clients rated the quality of service as good or very good. The results indicated an increase in client satisfaction during a period of staff reductions. (OAI-02-87-00041, see page 16.)
- Noncontributing retirees from Medicare-exempt State and local governments are likely to cost the program \$12.8 billion over the next 5 years. (CIN: A-09-86-62050, see page 31.)
- Elimination of an unnecessary Aid to Families with Dependent Children (AFDC) child support incentive would result in a 5-year Federal and State savings of over \$1.9 billion. (CIN: A-02-86-72606, see page 55.)
- Over \$192 million could be saved annually if the Health Care Financing Administration (HCFA) negotiates package rates for coronary artery bypass graft surgery. In addition, to assure quality of care, HCFA should require peer review of elective coronary artery bypass surgeries. (OAI-09-86-00076, see page 30.)
- Trust fund revenues could be increased by \$3.8 billion over 5 years if part-time State and local government employees were covered by Social Security. This would give these employees parity with their private sector counterparts. (CIN: A-02-86-62604, see page 15.)

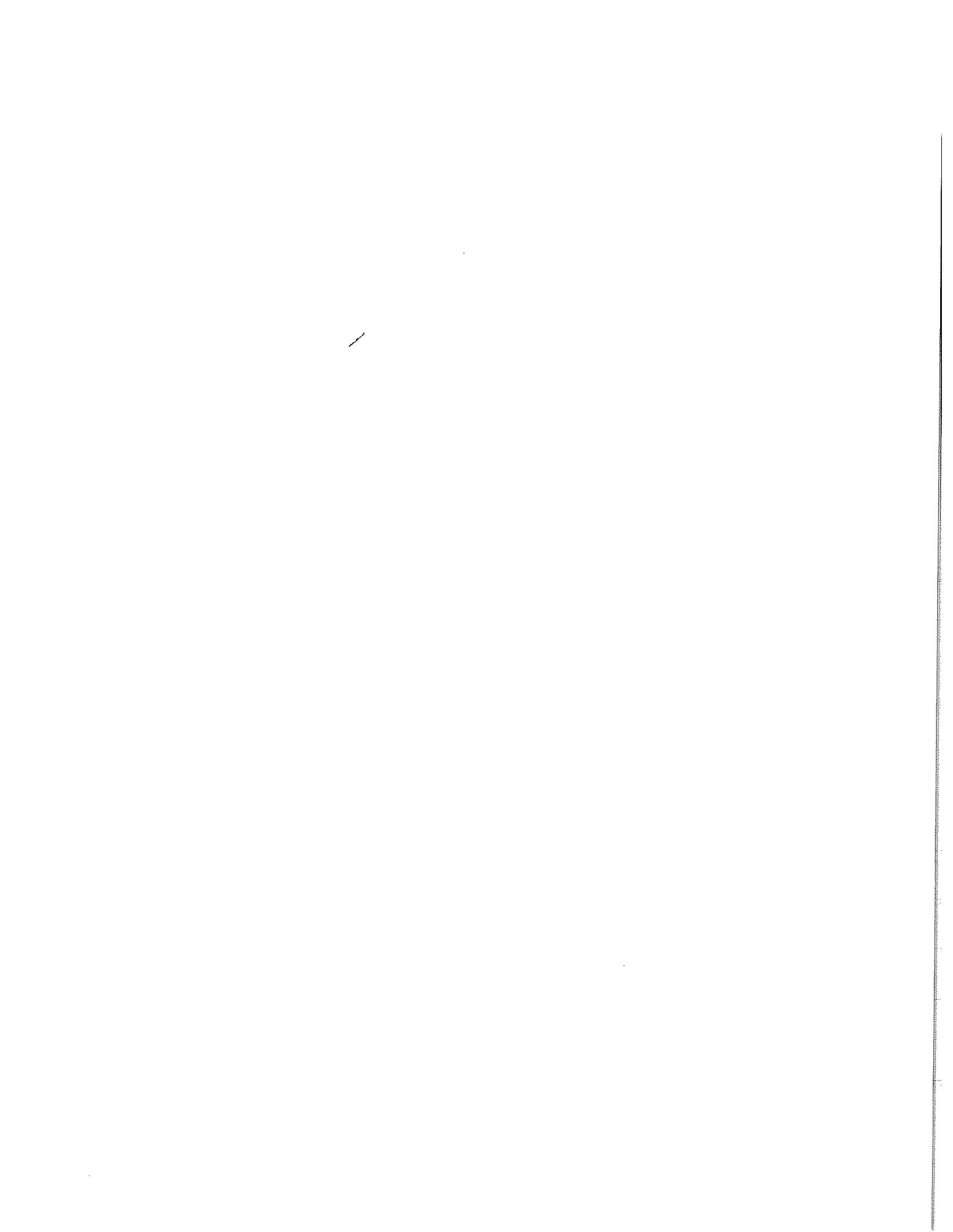
- An estimated \$100 million in Federal funds are surplus to State and local internal service fund accounts and should be recovered. (CIN: 09-60452, see page 8.)
- Requiring financially responsible citizen cosigners on loans to noncitizen borrowers would cut defaults under the Health Education Assistance Loan program. (CIN: A-12-87-02652, see page 49.)

## TABLE OF CONTENTS

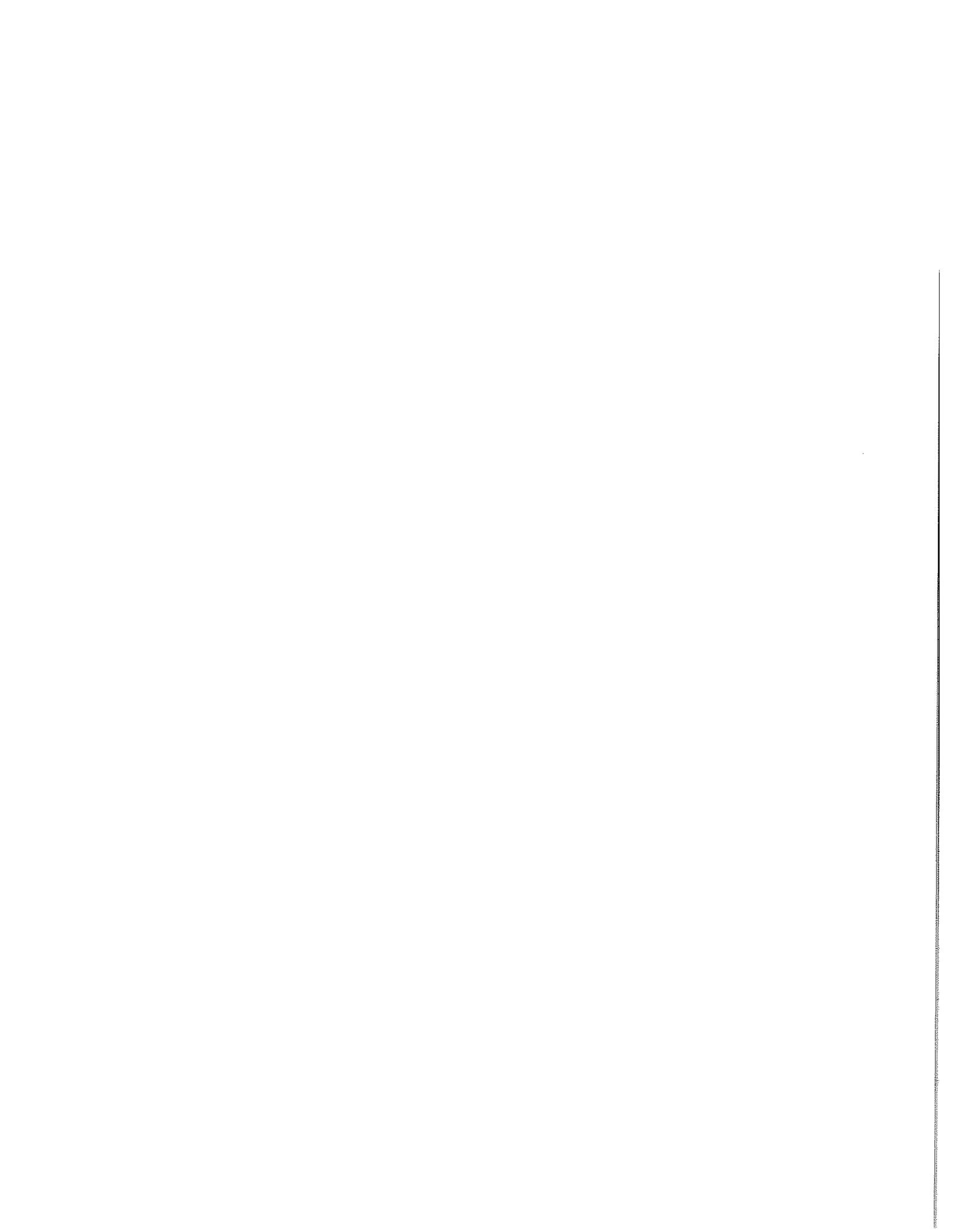
	Page
<b>CHAPTER I HHS AND GOVERNMENT-WIDE OVERSIGHT .....</b>	<b>1</b>
Overview .....	1
Department Employee Fraud .....	2
Audit Resolution .....	2
Debt Collection .....	3
Audit Network .....	5
Increased Savings Opportunities .....	5
Quality Control .....	6
The Camp System .....	7
State and Local Governments' Administrative Charges .....	8
Internal Service Funds .....	8
Self-Insurance Funds .....	9
Medicaid Claims .....	10
Questionable Costs .....	10
Electronic Data Processing Costs .....	10
Management of Automated Information Systems .....	11
 <b>CHAPTER II SOCIAL SECURITY ADMINISTRATION .....</b>	 <b>15</b>
Statistical Accomplishments .....	15
Program Overview .....	15
Bridging the Coverage Gap .....	15
Social Security Client Satisfaction .....	16
Systems Modernization Plan .....	18
Suspension of Benefits .....	19
False Identification and Social Security Numbers .....	19
Undocumented Alien-Related Fraud .....	20
Unemployment Compensation .....	20
Bank Fraud .....	20
Disability Benefits Fraud .....	20
Survivors Benefits and Representative Payee Fraud .....	21
Deceased Beneficiary Fraud .....	22
Credit for Recovered Benefits .....	23
Microcomputer Procurement and Security .....	23
Overpayment Accuracy .....	24
Waiver Review Process for RSDI and SSI .....	25
Financing SSA Building .....	25

<b>CHAPTER III HEALTH CARE FINANCING ADMINISTRATION . . . . .</b>	<b>29</b>
Statistical Accomplishments . . . . .	29
Program Overview . . . . .	29
Medicare and Medicaid Patient and Program Protection Act . . . . .	30
Coronary Artery Bypass Graft Surgery . . . . .	30
State and Local Government Retirees . . . . .	31
Medicare Hospital Revenues . . . . .	32
HMO Termination . . . . .	33
Multiple Surgical Procedures . . . . .	34
Effects of Changes in the Current Procedures Terminology Manual for Colonoscopies . . . . .	34
Organ Transplants . . . . .	34
Medicare Contractors . . . . .	35
Contractor Embezzlement . . . . .	35
Debridement of Decubitus Ulcers . . . . .	36
Overpayments by Intermediaries . . . . .	36
Investigative Authorities . . . . .	36
False Claims . . . . .	37
Kickbacks . . . . .	38
Sanctions for Criminal Convictions . . . . .	38
Corporate Suspensions . . . . .	39
State Licensing Board Actions on OIG Referrals . . . . .	39
Civil Monetary Penalties . . . . .	39
Duplicate Payments for Dually Enrolled Medicare and Veterans Administration Beneficiaries . . . . .	41
Medicare Carrier Pensions . . . . .	41
Anti-Deficiency Violation . . . . .	41
Peer Review Organizations . . . . .	42
PRO Sanctions . . . . .	42
Contractor-Referred Sanctions . . . . .	43
Nursing Home Certification . . . . .	43
Ambulatory Surgery . . . . .	43
Illegal Drug Substitution . . . . .	44
Medicaid Overpayments . . . . .	44
Medicaid Claims Processing System . . . . .	44
Reconciliation of Medicare and Medicaid Ambulance Payments . . . . .	44
State Medicaid Fraud Control Units . . . . .	45
 <b>CHAPTER IV PUBLIC HEALTH SERVICE . . . . .</b>	 <b>49</b>
Statistical Accomplishments . . . . .	49

Program Overview .....	49
State Baby Doe Programs and Infant Care Review Committees ...	49
Health Education Assistance Loans .....	49
Questioned Costs .....	50
<b>CHAPTER V FAMILY SUPPORT ADMINISTRATION .....</b>	<b>55</b>
Statistical Accomplishments .....	55
Program Overview .....	55
Aid to Families with Dependent Children .....	55
Child Support Enforcement Collections .....	56
Child Support Enforcement--Absent Parent Medical Liability .....	56
Aid to Families with Dependent Children Error Rate .....	57
Shared Living Arrangements .....	57
Emergency Assistance .....	58
Aid to Families with Dependent Children Fraud .....	59
Aid to Families with Dependent Children Recipients and Concealed Income .....	59
Illinois Welfare Project .....	60
Multijurisdictional Fraud in Aid to Families with Dependent Children Program .....	60
Wisconsin and Indiana Aid to Families with Dependent Children	61
Grantee Auditor Fraud .....	61
<b>CHAPTER VI OFFICE OF HUMAN DEVELOPMENT SERVICES .....</b>	<b>65</b>
Statistical Accomplishments .....	65
Program Overview .....	65
Foster Care Payments .....	65
Day Care Contract Fraud .....	65
Community Systems Development Under the Older Americans Act	66
Questioned Costs .....	66
APPENDIX A Budgetary Savings and Recoveries .....	69
APPENDIX B Dollar Consequences of OIG Findings Awaiting Action .	79
APPENDIX C Professional Articles Authored by OIG Staff .....	87



# **HHS AND GOVERNMENT-WIDE OVERSIGHT**



## Chapter I

### HHS AND GOVERNMENT-WIDE OVERSIGHT

The Office of Inspector General (OIG) has oversight responsibilities for the Department of Health and Human Services (HHS) programs as well as for internal management functions including payroll, personnel, procurement and debt collection. In addition, OIG efforts focus on issues that cut across HHS programs and activities of all Federal agencies. Participation in the President's Council on Integrity and Efficiency (PCIE) also carries significant responsibilities for involvement in Government-wide efforts to reduce fraud, abuse, waste and mismanagement.

#### OVERVIEW

Departmental and Government-wide responsibilities require the combined resources and expertise available within the OIG to address mandated responsibilities and to assist in Government efforts to protect beneficiary welfare and prevent waste of tax dollars.

The OIG's role in PCIE activities typically involves participation on task forces to address developing programmatic or management approaches where the potential for fraud, abuse or mismanagement has been identified. The PCIE's activities also involve multiagency efforts to uncover fraud and abuse across programmatic lines.

Follow up on suspected fraud by Department employees is an ongoing OIG responsibility which can involve program operations or internal administration. Such fraud undermines the efficiency and effectiveness of departmental operations and inhibits the provision of HHS benefits to aged, disabled and needy individuals.

A major OIG responsibility is audit oversight of HHS and other Federal funds. Under Office of Management and Budget (OMB) Circulars A-73, A-87, A-88, A-110, and A-128, the OIG has been assigned greater responsibility for audits of Federal program funds at State and local governments, colleges and universities, and nonprofit organizations than any other audit organization in the Federal Government. The OIG's responsibilities include reviewing administrative costs charged to the Federal Government by State and local governments and all federally charged costs at 95 percent of all colleges and universities.

In addition, the OIG has responsibility for overseeing the audit work performed by nonfederal auditors, principally certified public accountants and State auditors, at 211 State agencies, 16 State governments and thousands of local governments, colleges, nonprofit organizations and hospitals receiving Federal funds. About 50 percent of Federal funds awarded to these entities comes from HHS programs. Additional OIG responsibilities include setting audit policy for the Department and developing audit plans and guides to assure that all audits are conducted in accordance with generally accepted Government auditing standards.

**DEPARTMENT  
EMPLOYEE FRAUD**

During the second half of Fiscal Year (FY) 1987, the OIG, as part of its oversight responsibilities, took action on the following cases of employee fraud:

- In Oklahoma, an active duty officer with the Public Health Service (PHS) had to resign his commission, was fined \$10,000 and had to make restitution of money obtained from billing Medicare, Medicaid and private insurers for services to Indian Health Service patients. He had also concealed the fact that his surgical privileges had been permanently revoked in Missouri and that he was performing off-duty work in a Texas hospital some distance away, for which he earned \$36,000 a year in addition to his PHS compensation. He received a suspended jail sentence and 5 years probation, with a 2-year prohibition from receiving any reimbursement from any provider which bills Medicare or Medicaid. The State medical board revoked his license.
- An employee of the Centers for Disease Control was sentenced to 5 years probation, full restitution and a special assessment for illegally obtaining more than \$38,000 by submitting travel advance forms in the names of other persons. She used actual and fake identities and Social Security numbers (SSNs), forged authorizing signatures, picked up cash advances and later submitted false justification forms.
- Another employee with PHS also forged cash advances, for which she received a 5-year probated sentence and was ordered to repay almost \$13,000.
- An employee with the Health Education Assistance Loan program was given a suspended sentence and a year's supervised probation on condition of full restitution of more than \$600 in travel expense monies she had picked up for other employees and pocketed herself.

**AUDIT  
RESOLUTION**

The extent of OIG oversight responsibilities is reflected in the following information on Department audit resolution. This information is provided in accordance with the Senate Appropriations Committee report pertaining to the Supplemental Appropriations and Recissions Act of 1980 (Public Law 96-304).

Reports with Questioned Costs		
	<u>Total</u>	<u>Over 6 Months</u>
Unresolved audits, March 31, 1987	276	5
Unresolved audits, Sept. 30, 1987	193	4 <sup>1</sup>
	<u>Number</u>	
Reports issued during period	233	
Reports resolved during period	241	
	<u>Amount</u> <u>(in millions)</u>	
Costs sustained during period	\$118.9 <sup>2</sup>	

A summary of HHS' debt collection activities is shown in the following chart: **DEBT COLLECTION**

Summary of Receivables, Collections and Write-offs (in millions) <sup>3</sup>		
Receivables at beginning of FY 1987		\$3,386.90
Add: New receivables during period		6,349.46
Less:		
Collections	\$5,172.00	
Offsets	595.25	
Write-offs	264.84	
Total		6,032.09
Receivables as of June 30, 1987 <sup>4</sup>		\$3,704.27

Disallowances shown in the following chart are OIG-recommended disallowances, such as identified overcharges to the Medicaid program. Disallowances involving public assistance programs are, by law, collected through

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

<u>OPDIV</u>	<u>Number</u>	<u>Amount</u>
OHDS	2	\$12,022
PHS	1	6,217
OS	1	13,981
Totals	4	\$32,220*

\* Does not include one report for which resolution has been delayed pending Grants Appeal Board decision.

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

<sup>3</sup> Includes audit disallowances as shown in the following chart.

<sup>4</sup> This is the most current departmental data available and covers through June 30, 1987.

reduction of future Federal payments. Other receivables include health professions and nursing student loans, and hospital and health maintenance organization facility construction loans.

The large increase in new receivables and collections during the first 9 months of FY 1987 are due to HCFA now recording (as recommended by the OIG) the Medicare portion of payroll taxes and the corresponding collection.

<b>OIG Audit Disallowances Included in Departmental Summary (in millions)</b>		
Beginning FY 1987 receivables		\$181.15
New receivables added		194.10
Subtotal		375.25
Collections	\$16.71	
Offsets <sup>5</sup>	55.95	
Write-offs	53.79	
Total		126.45
Receivables as of September 30, 1987 <sup>6</sup>		\$248.80

The Department is responding promptly to OIG concerns over the accounting and reporting of audit disallowances and collections. A particular concern has been the reporting of disallowances collected by offset of future Federal payments. A uniform departmentwide standard and process will be in place shortly for recording and recovering these disallowances.

Because the Department is now on an annual fiscal year reporting cycle, debt collection activities through September 30, 1987 are not available for purposes of preparing this Semiannual Report. However, the OIG's March 31, 1988 report will include comparable data for FY 1986 and 1987 to reflect the change in fiscal year reporting. That report will also include the result of OIG reviews of individual operating division debt collection activities and procedures.

<sup>5</sup> Offset collections include reductions and adjustments made to expenditure reports, as well as reductions of current and future awards, other than public assistance awards made in lieu of cash collections.

<sup>6</sup> This table shows the most current departmental data available for collections, offsets and write-offs which covers the period through June 30, 1987. The new receivables added figure is based on OIG data as shown in Appendix A, Section III and covers the period through September 30, 1987.

To meet audit oversight responsibilities, the OIG combines in-house OIG staff resources, contracted audit services, and nonfederal audits into an audit network. This network not only ensures broad audit coverage, but enhances OIG's capability to provide more audit services for Department management and operating agency officials.

## AUDIT NETWORK

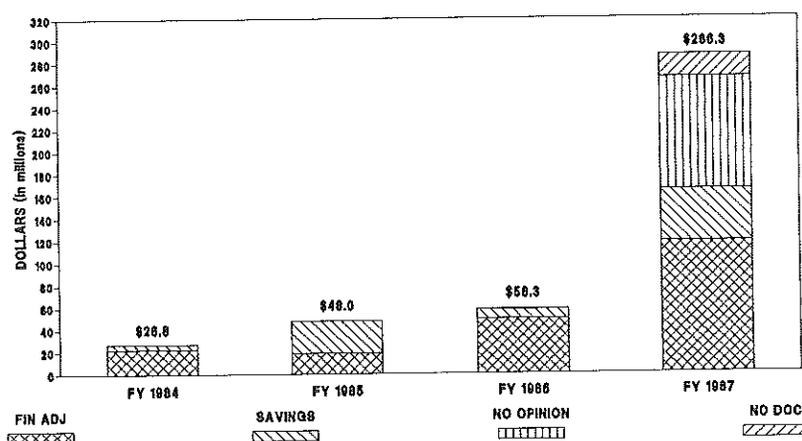
The OIG network operates in the following way: nonfederal auditors perform mandated reviews at recipient entities, identifying and reporting problem areas. To assure quality audits and identify areas needing further review, the OIG conducts desk reviews of all reports and working paper reviews of selected audits. After audit leads are identified, the OIG either directly or through contracts with independent auditors, makes further reviews and develops areas of concern.

The network approach takes full advantage of the potential for identifying significant savings and dollar recoveries, as well as providing Government-wide leadership in the accounting and auditing field. The OIG FY 1987 efforts resulted in the identification of potential cost savings and recoveries of over \$286.3 million and significant input into changes required to Federal rules and regulations, such as cost principles for State and local governments (OMB Circular A-87).

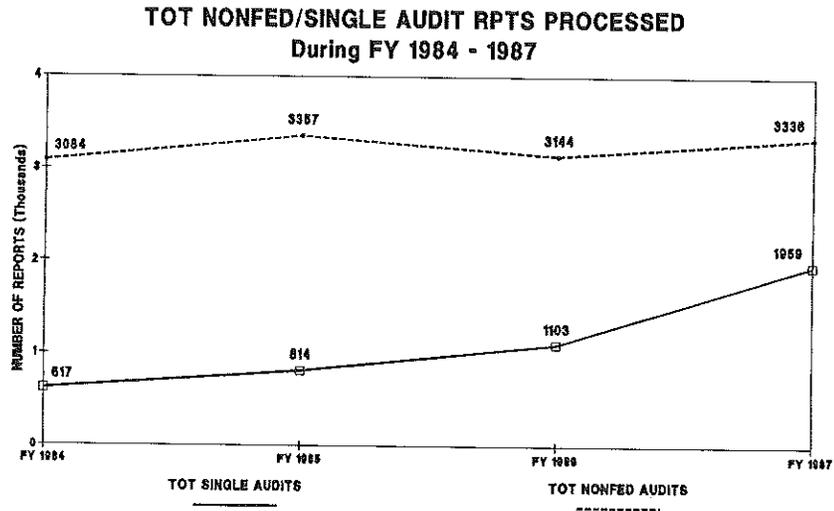
## INCREASED SAVINGS OPPORTUNITIES

The tremendous growth in findings resulting from nonfederal audits is depicted below and includes recommended cost recoveries and savings, "no opinion" findings, and "lack of documentation" findings.

**TOTAL NONFED DOLLAR FINDINGS**  
FY 1984 - 1987



As indicated below, the OIG single audit workload has more than tripled since FY 1984, specifically from 617 audits in FY 1984 to 1,959 in FY 1987. Single audits (nonfederal audits of all Federal funds at an entity) are conducted under OMB Circular A-128 and audits of colleges, universities and nonprofit entities are conducted under OMB Circular A-110.



**QUALITY CONTROL**

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to process nonfederal audit reports, perform quality control reviews, and refer substandard audit reports to appropriate State and professional organizations.

The OIG performs desk reviews of all submitted audit reports, as well as working paper reviews of selected audits. Based on the results of these reviews, recommendations are made to Federal users regarding the degree of reliance that should be placed on the audit report and professional judgments are made as to the overall quality of the work performed.

During FY 1987, the OIG processed 3,336 nonfederal audit reports containing \$118.2 million in recommended cost recoveries. The reports also identified 5,692 opportunities for improving management operations. The following table summarizes these results.

Reports issued without modification	2,317
Reports issued with modification	705
Returned to auditor	285
Unacceptable reports	29
<b>Total audit reports processed</b>	<b>3,336</b>

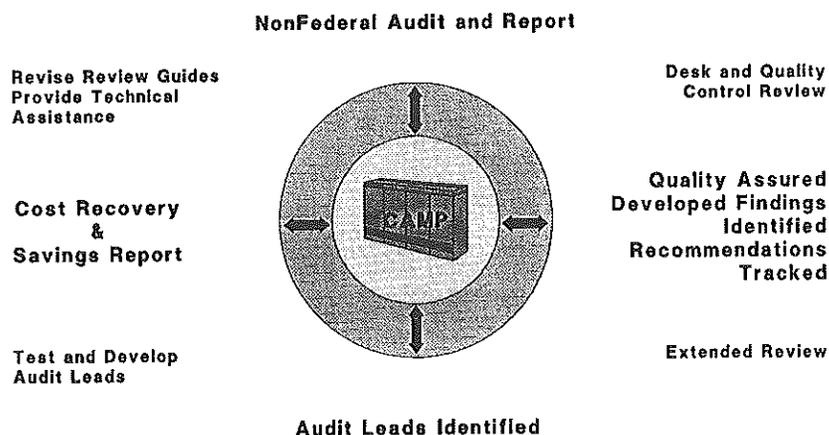
Of those reports found unacceptable, seven were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. In addition, work is continuing with professional auditing associations and State boards of accountancy to improve audit quality.

The core of the nonfederal audit quality control system is the Computerized Cognizant Agency Management Package (CAMP). This nationwide computerized system is linked to OIG's desk review checklist procedures and quality control reviews. It is specifically designed to:

## THE CAMP SYSTEM

1. Provide a basis for managing and controlling the nonfederal report workload.
2. Maintain a record of problems with reports by program, auditee and auditor.
3. Maintain a data base of information that can be analyzed for systemic problems in federally funded programs, problems at auditees in the administration of programs, and repetitive problems encountered with the quality of audits.
4. Track the status of audits.
5. Provide an up-to-date universe of entities for which the OIG has cognizance.
6. Generate management reports.

## EXTERNAL AUDIT RESOURCE CONCEPT



**STATE AND LOCAL  
GOVERNMENTS'  
ADMINISTRATIVE  
CHARGES**

The network approach, using CAMP, combines OIG analysis of nonfederal audit reports for identifying audit leads with the judicious use of audit resources to develop those leads. This approach effectively enables OIG to carry out its responsibilities under OMB Circular A-87 for audit of administrative costs charged by State and local governments to Federal programs.

Each year, State and local governments and other entities allocate an estimated \$6 billion in administrative costs to Federal programs. In auditing these costs, OIG focuses on issues that cut across all HHS programs and, in many instances, programs of all Federal agencies. These audits examine the methods used by the State or locality to determine the administrative costs charged to Federal programs as well as the allowability of the costs charged. The overall objectives of the audits are to improve the accounting process, strengthen Government cost principles and contribute to Government-wide savings. Examples of issues being studied are: internal service operations, such as motor pools and computer centers; self-insurance funds; pension plans and funding policies; and post-retirement health insurance costs. Millions of dollars are being overcharged to Federal programs through questionable accounting and management practices and through poor documentation of data used to provide the basis for determining the costs charged to Federal programs. In all of these efforts, the OIG works closely with the Department's Office of the Assistant Secretary for Management and Budget and regional divisions of cost allocation.

Examples of significant audit reports resulting from the work of the network of auditors are described in the following items.

**Internal Service Funds**

The OIG estimated that \$100 million in Federal funds received under programs administered by all Federal Departments are surplus to State and local internal service fund accounts. Of this amount, about \$40 million has been recovered or recommended for recovery. Given the pervasive nature of this problem, the OIG has made recommendations to OMB for Government-wide action.

Internal service funds are used by central service agencies of State and local governments to account for goods and services provided to other agencies within the State and local government. Typical examples of internal service funds include: data processing centers, purchasing departments and motor pools. These funds are intended to operate on a break-even basis through user charges. Generally, charges for goods and services are allocated to programs (both State and Federal) administered by the service agency.

The OIG's nationwide review of internal service fund activities disclosed that some State and local governments are profiting when providing goods and

services to federally funded programs. These profits (surpluses) result because, contrary to Federal regulations, States charge Federal programs for goods and services at rates in excess of actual costs.

The OIG recommended that OMB:

1. Instruct other Federal agencies with responsibility for reviewing cost allocation plans for major cities and other local governments to specifically include reviews of internal service fund provisions.
2. Revise Circular A-87 to require recipients of Federal funds to account for and report internal service fund activities in individual proprietary accounts, thus highlighting fund activities.
3. Revise the "compliance supplement" to OMB Circular A-128 to include reviews of internal service fund activities as a general compliance test when conducting audits under the provisions of the Single Audit Act.

In addition, the OIG recommended that the Federal Inspectors General include, as a test item, a screening for internal service fund activities during desk and quality control reviews of single audit reports.

The Department is focusing on this area and requiring all States and major local governments under HHS cognizance to submit, as part of their central service cost allocation plans, detailed information on internal service funds for review by departmental cost allocation staff. (CIN: 09-60452)

As recommended by the OIG, OMB has instructed other Federal agencies responsible for review of governmental entities' cost allocation plans to also include reviews of internal service funds in their evaluation of the plans.

As an adjunct to internal service fund reviews, OIG in a nationwide effort is studying States' billings for self-insurance costs.

## **Self-Insurance Funds**

The States established centralized self-insurance funds to provide property and tort liability insurance to individual State agencies. Generally, self-insurance costs are billed to each State agency based on factors which reflect the relative risk and loss experience of each State agency.

An OIG review in one State disclosed that the State had accumulated a surplus of \$12.4 million in its self-insurance funds as of June 30, 1985. The surplus occurred because billing rates were set higher than justified by loss experience.

The OIG estimated that about \$2.2 million of the surplus represented excessive charges to Federal programs.

Recommendations called for the State to make a financial adjustment to eliminate the accumulated surplus, and to adjust billing rates at least annually to eliminate surpluses or deficits. Departmental officials agreed with OIG recommendations. Reviews continue in other States. (CIN: A-10-86-60450)

**Medicaid Claims** In one State, nonfederal auditors performing a single audit identified about \$18 million in denied Medicaid claims (i.e., unsupported charges) which the State had not deducted from Medicaid expenditures reported for Federal sharing. The Federal share amounted to about \$9 million. State auditors recommended an appropriate financial adjustment as well as procedural changes.

On the basis of the desk review, the OIG concluded that this audit generally met the requirements of OMB Circular A-102, Attachment P. Accordingly, OIG requested the State's response to the recommendations contained in the single audit report. (CIN: A-02-87-07059)

**Questionable Costs** As the lead Federal cognizant agency for one State, the OIG coordinated and participated with other Federal agencies in a joint review of the audit report and working papers prepared by a nonfederal auditor. In addition to findings on internal control weaknesses and noncompliance with program regulations, the audit report identified \$4.6 million of questionable costs. Of this amount, \$1.5 million related to HHS programs and included such deficiencies as follows:

1. Medicaid funds were used for services rendered to ineligible individuals.
2. Funds of the Low-Income Home Energy Assistance program were used to purchase items such as jackets and sleeping bags which were not related to the purpose of the program.
3. Funds were questioned because Alcohol, Drug Abuse and Mental Health Services block grant program requirements were not followed.  
(CIN: A-10-87-05131)

**Electronic Data Processing Costs** Another nonfederal audit report included a finding that the propriety of \$82.5 million in electronic data processing costs allocated to State and Federal programs could not be verified by either the State auditor or the independent auditor. The State's response to OIG's request for information on the amount that was allocated to HHS programs will be used in a proposed OIG audit that will build upon the single audit work. (CIN: A-02-87-07064)

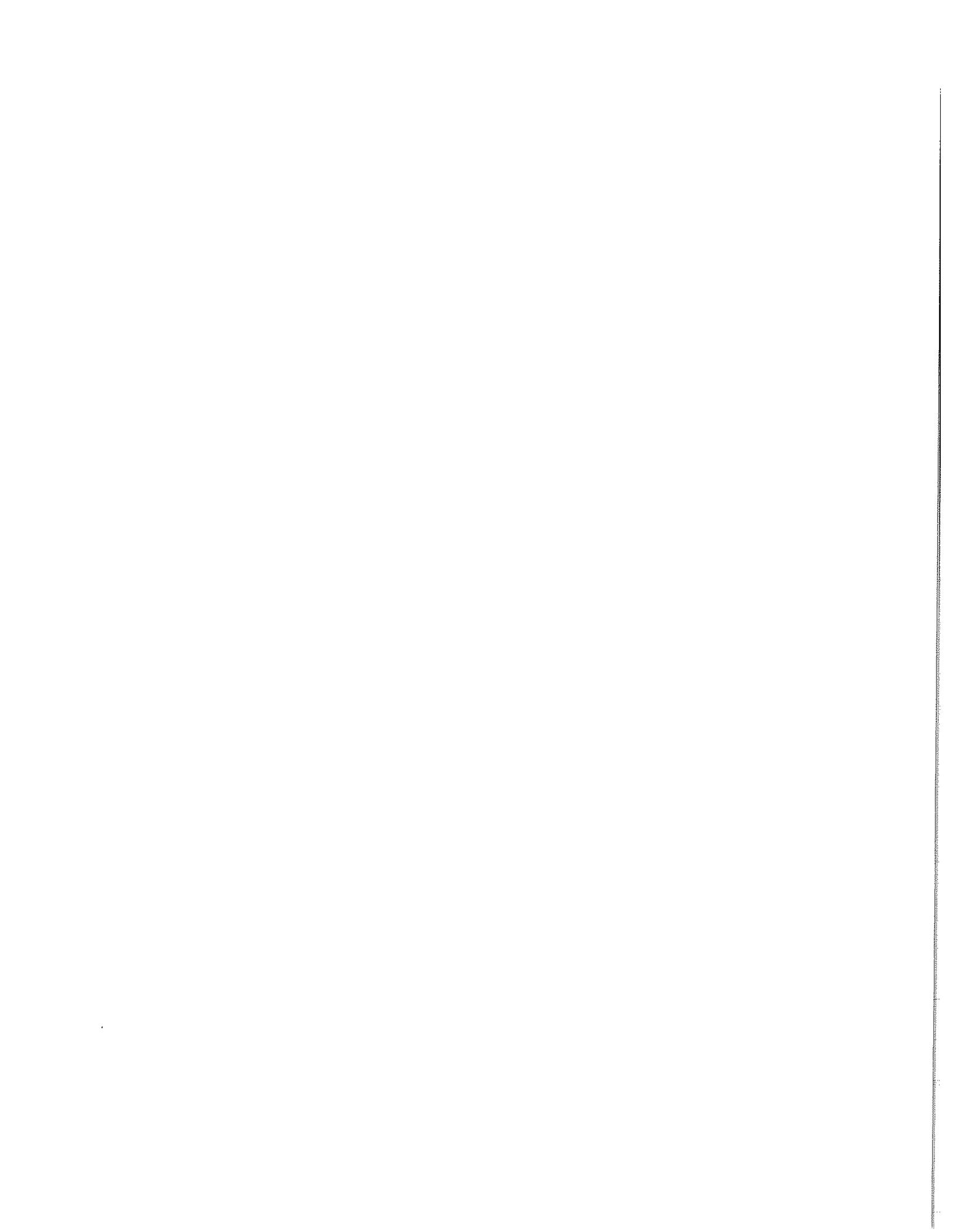
To prevent unauthorized use of data and ensure the reliability of Federal computer systems, numerous directives, guides, policies, regulations and orders have been issued by the Office of Management and Budget, the General Accounting Office, the National Bureau of Standards and others. Federal managers have been inundated by the burgeoning stream of control directives and confounded by the specialized language used in the guidance. In many cases, managers cannot with any certainty, answer fundamental questions about their systems.

The OIG and the Assistant Secretary for Management and Budget, under the auspices of the President's Council on Integrity and Efficiency and the President's Council on Management Improvement, synthesized the multitude of directives which contain overlapping and sometimes confusing guidance on how to protect automated information systems. Using plain, understandable language, the finished product, "Model Framework for Management Control Over Automated Information Systems," presents a framework to help managers establish internal controls and document compliance with Federal requirements for automated information systems. The model is currently being considered for Government-wide adoption.

## **MANAGEMENT OF AUTOMATED INFORMATION SYSTEMS**



# **SOCIAL SECURITY ADMINISTRATION**



## Chapter II

### SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) trust funds could save over \$4 billion with implementation of Office of Inspector General (OIG) recommendations made during the second half of Fiscal Year (FY) 1987 for legislative action, more efficient program management and tightened internal and fiscal controls. Investigations resulted in a total of 980 convictions in FY 1987 and 571 during this reporting period. A total of \$16.8 million in fines, savings, restitutions and settlements resulted from investigations during FY 1987.

#### STATISTICAL ACCOMPLISHMENTS

In FY 1988, SSA will pay Retirement, Survivors and Disability Insurance (RSDI) benefits estimated at \$214 billion from trust funds financed principally from payroll taxes. The SSA will also pay benefits totaling \$11.2 billion under the needs-based Supplemental Security Income (SSI) program and \$900 million under its Black Lung program. Both programs are financed from general revenues. For the first time, SSA will issue financial statements. These statements will cover FY 1987 activities and will be audited by the OIG.

#### PROGRAM OVERVIEW

Providing mandatory Social Security coverage for State and local government employees not participating in a public employees' retirement system would increase trust fund revenues by more than \$3.8 billion over the 5-year budget cycle. These employees are disadvantaged because they are not currently acquiring retirement, survivors or disability insurance benefits under a State or local plan. Social Security coverage would fulfill this important need.

#### BRIDGING THE COVERAGE GAP

Under Section 218 of the Social Security Act, employees of State and local governments can be brought under Social Security coverage through voluntary agreements between States and the Secretary of Health and Human Services. However, the State or local government entities (over 82,000 nationwide) may exclude certain or all categories of their employees from coverage. For example, part-time, temporary or student workers may be excluded from the Social Security program.

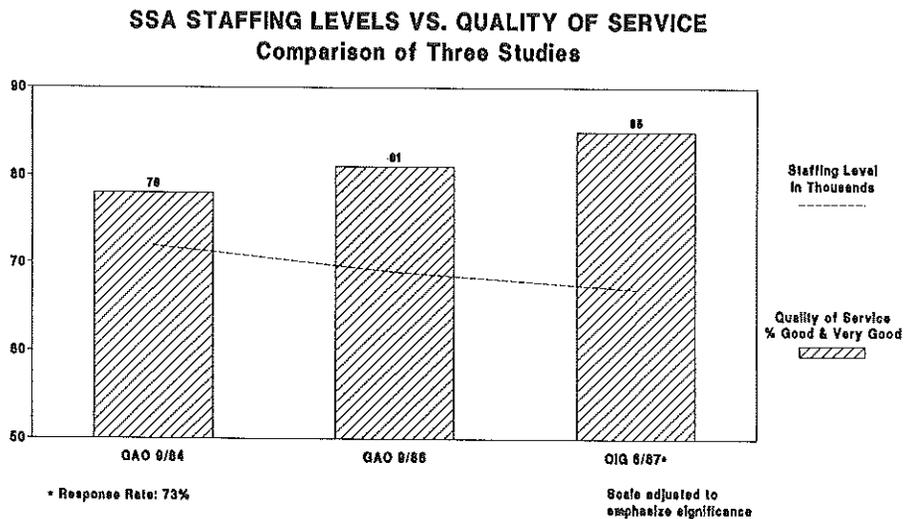
The OIG found that such noncovered employees do not build retirement, disability or survivor protection and that the continuity and portability of their Social Security coverage is broken. Furthermore, a primary reason for excluding these employees, namely, the administrative burden to governmental agencies,

is no longer valid since Medicare coverage (which involves the same administrative process) is now compulsory for all new State and local government employees. Additionally, mandatory Social Security coverage for just part-time employees would result in an estimated increase in trust fund revenues of \$3.8 billion over a 5-year period.

The OIG recommended that SSA propose legislation to require mandatory Social Security coverage for all State and local employees who are excluded from coverage and who are not members of a retirement system. The SSA agreed and intends to seek the necessary legislation. (CIN: A-02-86-62604)

**SOCIAL SECURITY  
CLIENT  
SATISFACTION**

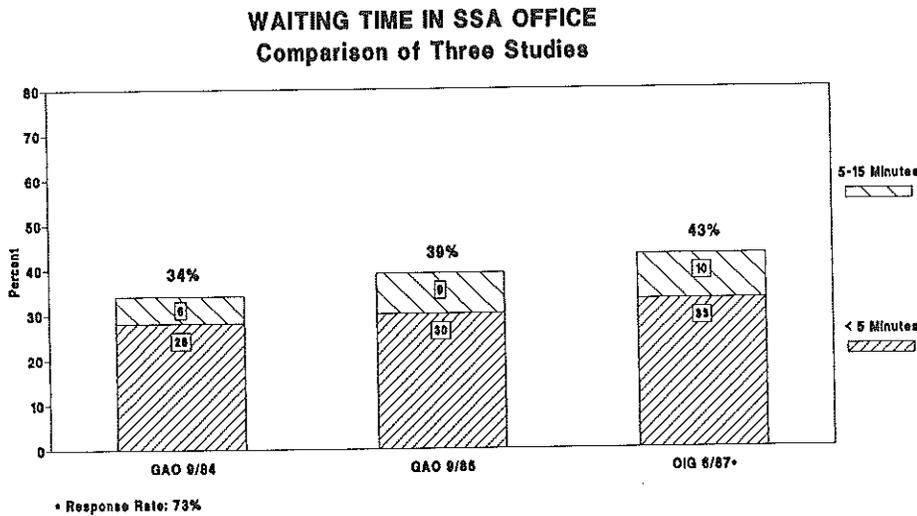
An OIG survey of Social Security clients found high satisfaction with SSA services. The quality of SSA services was rated good or very good by 85 percent of the respondents who were asked to rate the overall quality of SSA's service as very good, good, fair, poor or very poor. This represents a statistically significant increase in client satisfaction over prior surveys conducted by the General Accounting Office (GAO) which found 78 percent satisfaction in September 1984 and 81 percent in September 1986. The OIG survey, as shown in the chart below, found SSA client satisfaction increased during a period when SSA reduced staff.



Furthermore, respondents rated SSA services as either somewhat or much better than services received at other Government agencies.

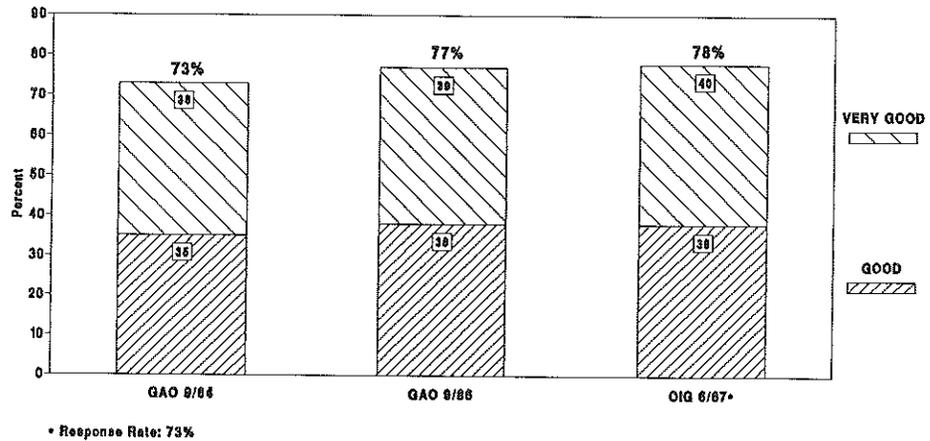
Clients expressed satisfaction with clarity of SSA mail, district office waiting time and service, and telephone service. For those respondents who received mail

from SSA, 76 percent rated it as generally easy or very easy to understand. The number of district offices' visitors served within 15 minutes continues to increase from the 34 percent in the 1984 GAO survey, to 39 percent in the 1986 GAO survey, to 43 percent in the OIG survey. As shown in the chart below, the number of visitors being served within 5 minutes has also increased.



The OIG study also found that with reduced waiting times, the quality of service remained high. Respondents were asked to rate the quality of service received during their visits to the district offices. In one question, they were asked how good a job SSA did in handling the reason for the visit. Ratings for doing a good or very good job for the first and second GAO surveys were 73 percent and 77 percent, respectively. The OIG survey received responses of good or very good from 78 percent of the respondents, as shown

**QUALITY OF SERVICE DURING VISIT  
Comparison of Three Studies**



Finally, on telephone service, 75 percent of the respondents said SSA employees did a good or very good job of handling the reason for their calls, and 89 percent reported that the employees were generally courteous or very courteous. The satisfaction with telephone service is significant, given that 60 percent of those surveyed would prefer contacting SSA by telephone in the future (versus 40 percent who prefer office visits).

About 28 percent of survey respondents used the opportunity to elaborate on Social Security service. Positive comments which either expressed gratitude for the benefits or satisfaction with the caliber of SSA service included:

"I am thankful for the survivors benefits for myself and my children."

"One of the hardest things to do is deal with people. I think SSA does a very good job."

"Truly an outstanding organization. People are knowledgeable and extremely helpful. Other agencies should take some lessons." (OAI-02-87-00041)

**SYSTEMS  
MODERNIZATION  
PLAN**

February 1987 marked the completion of 5 years of SSA's efforts to modernize its software and hardware computer systems. The SSA has significantly improved computer hardware by purchasing and installing up-to-date large scale computers and data storage devices. However, in the area of software improvement (SSA's most important and difficult systems challenge), progress has been less than originally planned.

The OIG has had continued concern about SSA's software improvement program and previously issued audit reports which recommended actions to make software more maintainable. The OIG found that delays in the Systems Modernization Plan (SMP) progress have been mainly the result of the complexity of the SSA programs; the inadequate attention given to software engineering standards and procedures; unsuccessful efforts in software contracting; and increasingly complex computer technology which correspondingly requires high-technology specialists.

The focus of a recent OIG task force review of the SMP was to identify steps that could be taken within the next 2 years (short term) to make SMP as efficient as possible. Included in actions recommended was the establishment of an advisory board (including the Commissioner of Social Security, the Inspector General, the Assistant Secretary for Management and Budget, and a General Services Administration (GSA) representative) to assist SSA in quickly addressing SMP problems. Congressional and departmental officials informally agreed with recommendations made.

The OIG concluded that RSDI benefits should be suspended to another group of persons confined for committing a felony: those found not guilty by reason of insanity (NGRI). A recent U.S. Court of Appeals decision upheld the constitutionality of the Social Security Act in denying RSDI payments to incarcerated felons. One basis for this decision was the congressional rationale for suspending benefits, i.e., the prisoner's minimal needs were being provided by the State and, therefore, payment of RSDI benefits was not justified. This same rationale also supports the suspension of benefits to NGRIs in State or Federal mental institutions.

#### **SUSPENSION OF BENEFITS**

The OIG recommended that SSA seek legislation to suspend RSDI benefits to confined NGRIs. Resultant savings to the trust funds are estimated at \$52 million over a 5-year budget cycle. The SSA agreed philosophically with the OIG recommendation, but due to serious legal, equity and administrative issues pertinent to this proposal, SSA did not believe it was appropriate to seek such legislation. (CIN: A-07-86-62615)

False identification is a multi-billion dollar problem affecting both Government and businesses. In 1982, a Senate subcommittee estimated that crimes involving false identification cost the American public and businesses \$24 billion annually. The Social Security number (SSN) or card is a key document in creating false identification. The following are highlights of OIG investigations of SSN fraud.

#### **FALSE IDENTIFICATION AND SOCIAL SECURITY NUMBERS**

**Undocumented  
Alien-Related Fraud**

The sale of SSNs to illegal aliens is a thriving business and is illustrated in the following examples:

- In Georgia, three persons working at an ethnic restaurant who had never legally entered the United States were sentenced to a total of 13 years probation, 400 hours of community service and an \$150 assessment. They had used false SSNs to obtain alcohol work permits and a driver's license.
- An alien merchant sailor who had jumped ship and evaded deportation for more than 12 years was given a 3-year suspended sentence, fined \$100 and placed on 3 years probation with the understanding that he would leave the country and not attempt to reenter illegally. He had used a fake SSN in an application for a passport and to obtain a driver's license.

**Unemployment  
Compensation**

- In Michigan, the last of 19 persons was sentenced for his part in an elaborate \$250,000 scheme involving the establishment of false identities and fraudulent use of SSNs to obtain unemployment compensation. The defendants applied for the benefits and then, either by diverting mail of defunct businesses or having mail directed to businesses owned by one of them, responded positively to State queries on the employment status of their "employees." Over half were given jail terms ranging from 1 to 5 years, with the remainder receiving suspended terms.

**Bank Fraud**

The use of fraudulent SSNs has a significant impact on the entire credit system of the United States. Because of its responsibilities for assuring the integrity of the SSN system, the OIG frequently assists the Federal Bureau of Investigations (FBI), Secret Service and other Federal law enforcement agencies in myriad investigations which otherwise would not be within its program purview. The following cases are examples of investigations in which the OIG was involved:

- A known Chicago area drug dealer was apprehended by the FBI in Florida in connection with fraudulent bank loans. Convicted of both SSN and bank fraud, he was sentenced to a year and a day in prison and ordered to make restitution of \$28,000 to the bank.
- In Illinois, an alderman was sentenced to 1 year and a day in prison, with fines and restitution of more than \$6,000 upon conviction for bank fraud and misuse of an SSN. He used a false name and SSN to open an account in which he deposited funds stolen from a mortgage company.

**DISABILITY  
BENEFITS FRAUD**

By concealing work activities and other information from SSA, certain individuals fraudulently obtain Social Security benefits. The following are examples of successful judicial prosecutions of cases involving disability benefits fraud:

- The owner and manager of a chain of retail shoe stores in the State of Washington had to repay more than \$87,000 that he had illegally obtained in disability payments. After obtaining disability eligibility for a heart condition, he began acquiring the shoe stores. When questioned by SSA, he claimed his wife owned the stores. An investigation showed that he actually managed and operated the stores.
- In Hawaii, the director of a senior center was placed on 3 years probation and ordered to pay fines and restitution of more than \$25,000. She had signed a statement claiming she was not working. However, a match of her wages and benefit status showed she was ineligible for disability benefits.
- Filing wage information under a different name, a California man received more than \$37,000 in SSI payments to which he was not due. He filed four false statements in which he claimed that he had no wages from employment. He was given a jail sentence and ordered to make full restitution.
- Also in California, a man was sentenced to 5 years in jail (suspended), placed on probation for 5 years, and ordered to make full restitution of more than \$17,000 in SSI payments. He had returned to work as a receiving clerk while obtaining the benefits.
- In Maryland, a man was sentenced to 60 months of supervised probation and restitution of \$17,800 for theft of SSA benefits. He had been working for a trucking firm on a continuous basis for 5 years while receiving disability benefits.

By falsifying or concealing events and relationships, some individuals hope to capitalize on the possibility of obtaining and using benefits intended for minors or incapacitated persons. The following cases are examples of successful actions resulting from OIG investigations of these individuals.

#### **SURVIVORS BENEFITS AND REPRESENTATIVE PAYEE FRAUD**

- A woman in Texas was given a suspended 3-year sentence and placed on probation with supervision for 5 years. A year after she had given up her child for adoption, she filed false applications for survivors benefits for her child and herself. She stated that the child was living with her. She was overpaid more than \$28,000.
- In Indiana, a school teacher was sentenced to 4 years probation and ordered to make restitution of more than \$25,000, which he and his mother had illegally obtained from SSA. They had collected widow's benefits on two husbands, one of whom his mother had never legally married.

- In Michigan, a man was sentenced to 3 years probation with the special conditions that he make restitution of more than \$4,500, obtain psychological evaluation and participate in an alcohol and substance abuse program. He had obtained benefits for two sons who did not live with him and to whom he contributed no support.
- A California woman was sentenced to 4 years probation, restitution of \$12,400 and 150 hours of community service. She had been the representative payee for her brother and had continued to cash his checks for 3 years after his death by making false statements about his death.
- A Wisconsin woman concealed the fact that her son had married and moved to another community. She filed a false redetermination report indicating that her son was still single and living with her. She was sentenced to 5 years probation and ordered to make restitution of \$7,500, the total amount she had defrauded SSA.
- Two days before a Michigan beneficiary died of cancer, his wife applied to be his representative payee. A standard letter was sent by SSA to him asking if he would object to his wife being his representative payee. Since there was no objection, payment was commenced. She was convicted, given a suspended sentence, and ordered to make full restitution of \$16,600.

**DECEASED  
BENEFICIARY  
FRAUD**

Another type of fraud against SSA programs is to convert benefits which continue to be sent to deceased persons, either because the person's death goes unreported to SSA, or because relatives or friends deliberately conceal it from SSA. The following are examples of some of these cases.

- In New Mexico, a woman was sentenced to 6 months confinement in a halfway house, 1-year suspended imprisonment, 2 years probation and restitution of \$16,800 within 1 year. She had withdrawn SSA payments from her deceased grandfather's bank account in which she was a joint signer.
- In Oklahoma, a woman was sentenced to 5 years imprisonment (suspended), 5 years probation, fines and restitution of \$20,000 and participation in an alcohol abuse program. She had endorsed and cashed Social Security retirement checks issued to her father for 4 years after his death.
- In Indiana, a man with an extensive criminal record, including armed robbery and theft, concealed the death of his mother and conspired with a confederate to forge and cash her SSA checks. He received a sentence of 6

years imprisonment. The confederate was subsequently sentenced to 3 years imprisonment suspended with 3 years probation.

- An Indiana woman found guilty in State court of forgery of Social Security benefit checks sent to her deceased mother had to make restitution of \$6,000. She was also sentenced to a 5-year probationary program where she is confined to her residence unless she obtains approval of the probation department.

The OIG found that the SSA trust funds are losing \$5 million annually in investment income because not all recovered benefit payments are being credited timely. The SSA transfers funds to Treasury to cover payment of RSDI benefit checks. Payments subsequently found to be erroneous and recovered by Treasury are restored (credited) to the trust funds.

#### **CREDIT FOR RECOVERED BENEFITS**

Under a 1984 agreement, SSA and Treasury instituted procedures that provided for earlier crediting of certain types of recoveries, e.g., returned uncashed checks and cash refunds made through SSA district offices. The agreement was deficient because other types of recoveries (stopped checks, for example) were included only through inference. Also, dates that Treasury agreed to credit the trust funds were not always equitable. For example, in the case of cash refunds, Treasury agreed to credit the trust funds 2 working days after the refund was deposited in a Federal Reserve Bank. Crediting the trust funds on the date of deposit would have been more equitable.

Although the agreement resulted in an additional \$900,000 in investment income to the trust funds in 1985, another \$5 million in annual earnings was possible had all recoveries been credited at the earliest equitable date. However, to obtain timely crediting of all recoveries, SSA will need to provide Treasury with additional data relative to each benefit payment which has been recovered, e.g., the deposit date of cash refunds.

The SSA agreed with OIG recommendations to (1) furnish Treasury all data necessary for timely crediting, and (2) negotiate an amended agreement with Treasury specifically covering recoveries not previously included. (CIN: A-04-86-62618)

The OIG found that SSA had not established necessary controls over the procurement, use and physical security of its microcomputers. This raises concerns about SSA's forthcoming office automation project which involves SSA's spending, between now and 1992, about \$70 million to purchase up to 9,000 microcomputers and 41,000 software packages.

#### **MICROCOMPUTER PROCUREMENT AND SECURITY**

The OIG's review showed that SSA's past microcomputer procurements were neither economical nor efficient. From October 1984 to February 1986, SSA issued numerous separate procurements which caused delays in receiving equipment and prevented SSA from obtaining volume discounts. Also, by not obtaining site licenses for commonly used software, SSA not only lost discounts of 45 to 85 percent, but lost the flexibility of copying software for use on any microcomputer on site.

The review also showed that microcomputer-to-mainframe links at SSA headquarters have significantly increased the vulnerability to improper disclosure by authorized users of information without corresponding controls being established to reduce risk. Controls are not sufficient to prevent or detect improper disclosure of sensitive information downloaded by authorized microcomputer users. In addition, microcomputers, peripheral equipment and software are not being adequately safeguarded from damage, theft, loss, environmental hazards and unauthorized use.

The OIG made a number of recommendations to correct these weaknesses. The SSA generally agreed with OIG's recommendations and is acting to address the deficiencies reported. In addition, at SSA's request, OIG is looking into the implementation and usage of microcomputers being delivered under a recently awarded contract. (ACN: 15-72643)

**OVERPAYMENT  
ACCURACY**

The OIG's review of the accuracy of overpayment collection data generated by SSA's Recovery of Overpayments, Accounting, and Reporting System found that a software malfunction in the system resulted in collections shown as received by program service centers for RSDI cases being understated by \$150 million as of December 31, 1985. This difference causes a corresponding overstatement of accounts receivable for RSDI overpayments. Although the difference does not have an adverse impact on beneficiaries or the RSDI trust fund, it does represent a serious weakness in internal controls. At a minimum, the software malfunction has resulted in erroneous reports to OMB and Treasury.

Additionally, the malfunction could cause erroneous base data to be included in SSA's National Debt Management System, a major debt collection initiative. The OIG recommended that SSA identify and correct the software malfunction and reconcile the differences in reported collections. The SSA agreed with all recommendations and plans to make the necessary software changes to correct the malfunction. (CIN: A-03-86-62608)

An OIG study of the current SSA process for waiving overpayments to beneficiaries found the processes inadequate for ensuring that maximum recovery is made wherever possible. A proposed “folderless” process for reviewing RSDI overpayments was also found to be inadequate. Currently, the decision to waive SSI overpayments is made by field office staff who meet with the beneficiary to determine if the beneficiary is without fault in causing the overpayment and can afford to repay. The only review of these decisions is by field office supervisors who are required to review waiver request decisions for overpayments of \$1,000 or more. There is no ongoing assessment of the quality and appropriateness of these decisions.

#### **WAIVER REVIEW PROCESS FOR RSDI AND SSI**

Decisions on beneficiary requests for waivers of RSDI overpayments are not made in field offices, but in the program service centers (PSCs) where the decision maker does not meet with the beneficiary. However, if the decision is to deny the request, it is sent to the field office where staff hold a conference with the beneficiary to ensure that all relevant information is obtained and issues discussed. Field office decisions are sent to PSCs where they are reviewed for technical compliance. Waiver review committees review a sample of these decisions for errors and significant trends. The proposed “folderless” waiver review process would eliminate the PSC staff and waiver review committee reviews.

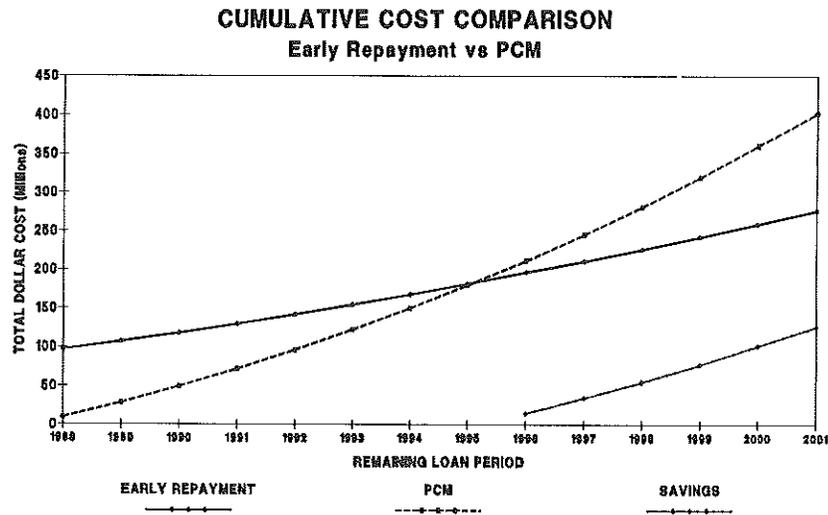
Based on this review of procedures, the OIG recommended that SSA eliminate the required 100 percent supervisory review of SSI waiver decisions for \$1,000 or more. Instead, SSA’s Office of Assessment should monitor the process through a systematic review of a sample of all waiver decisions. A similar review to monitor RSDI overpayment waiver decisions should also be implemented when the “folderless” waiver review process is adopted. (OAI-NOV-0005)

Paying off the mortgages on three SSA program service center buildings would result in a one-time trust fund savings of \$126 million. These buildings—located in Chicago, Illinois; Philadelphia, Pennsylvania and Richmond, California—house three of SSA’s six program service centers. The buildings are financed under the purchase contract method (PCM) of financing, authorized by the Public Buildings Amendments of 1972. Under PCM, a building for Government use is financed by private lenders and the Government makes periodic payments covering principal, interest and local property taxes for a period up to 30 years.

#### **FINANCING SSA BUILDINGS**

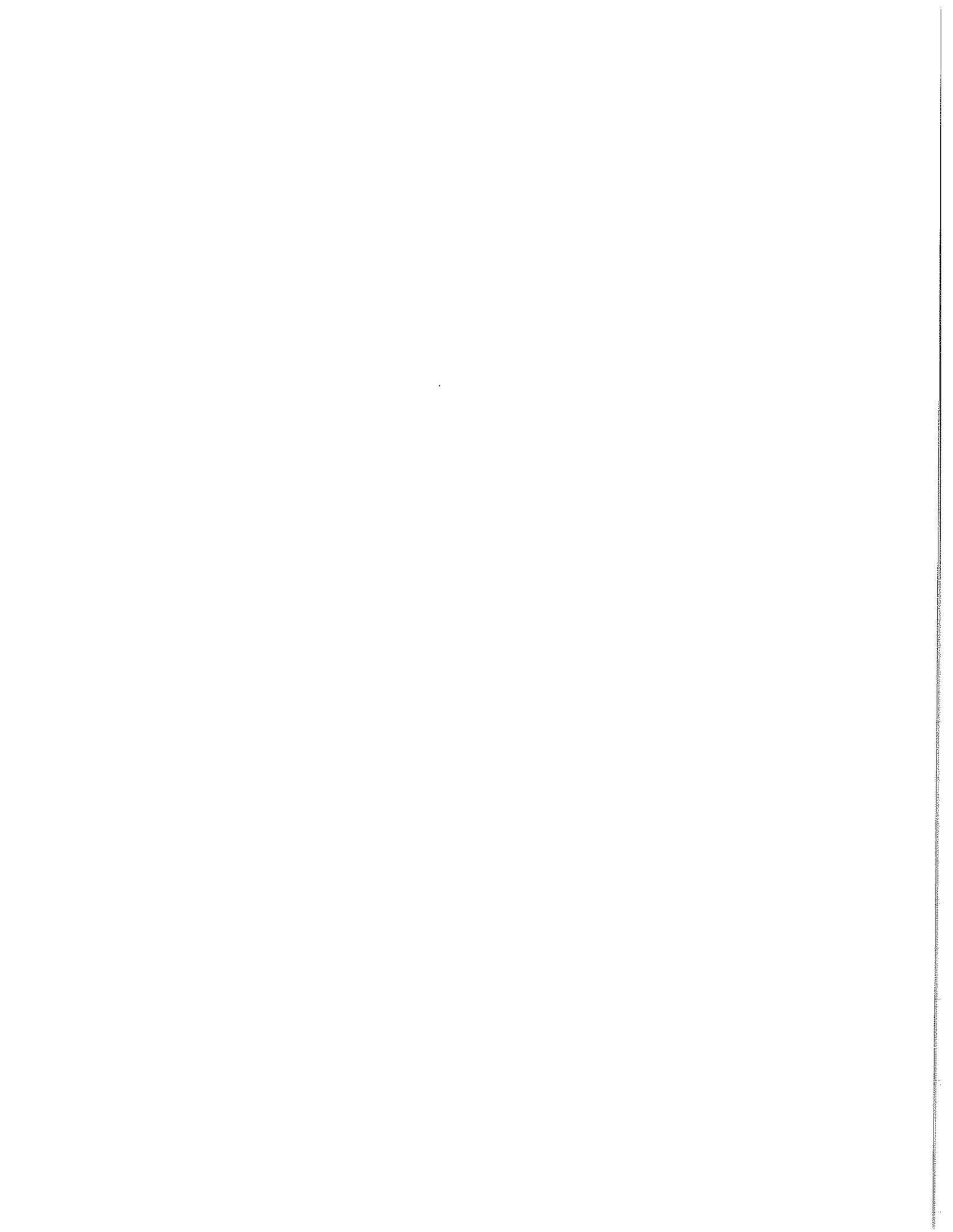
The OIG’s analysis of early repayment of the loans versus continued payments under PCM showed that savings of \$126 million to the trust funds would result from early repayment because the liability for local property taxes would be

eliminated and the mortgages could be paid with trust fund monies which are currently invested at rates lower than interest rates being paid on the mortgages.



The OIG recommended that SSA use trust fund monies to liquidate the remaining mortgages, provided it had assurance that GSA would continue to charge the actual cost of space usage rather than the commercially equivalent rate. The SSA agreed in principle but is reserving action until it has analyzed the financial and legislative implications of the OIG recommendations.  
(CIN: A-09-86-62611)

# HEALTH CARE FINANCING ADMINISTRATION



## Chapter III

### HEALTH CARE FINANCING ADMINISTRATION

Savings to the Medicare and Medicaid programs of \$1.85 billion resulted during the second half of Fiscal Year (FY) 1987 from actions taken on Office of Inspector General (OIG) recommendations. During this period, the OIG identified program areas where legislative action, more efficient management and tightened internal and fiscal controls could result in annual savings of over \$286 million. Another \$98.7 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. In these instances, recommendations called for financial adjustments and appropriate procedural changes.

#### STATISTICAL ACCOMPLISH- MENTS

During FY 1987, OIG was responsible for 558 successful actions against persons or entities who violated provisions of the Department's health care programs; 332 of the total number of actions occurred within the second 6 months of FY 1987. The numbers of actions by type during the year were as follows:

<u>Successful Prosecutions</u>	<u>Number</u>
Judicial	118
Administrative	<u>440</u>
Total	558

In addition, the State Medicaid Fraud Control Units (SMFCUs), for which OIG has oversight responsibility, reported 263 successful actions for the period, for a total of 453 for FY 1987. Total OIG and SMFCU monetary returns in fines, penalties, restitutions, recoveries and savings amounted to \$31 million for the year.<sup>1</sup>

In FY 1987, the Medicare and Medicaid programs, administered by the Health Care Financing Administration (HCFA), provided health care payments for more

#### PROGRAM OVERVIEW

<sup>1</sup> Reporting period for SMFCUs was July 1, 1986 through June 30, 1987

than 51 million of the Nation's elderly, poor and disabled. Total Federal payments are estimated at \$98.3 billion: \$71.6 billion for Medicare, and \$26.7 billion for Medicaid. Medicare Part A is financed by the Federal Hospital Insurance and Supplementary Medical Insurance trust funds; Medicaid is financed from Federal and State general revenues.

**MEDICARE AND  
MEDICAID PATIENT  
AND PROGRAM  
PROTECTION ACT**

The OIG has made several legislative recommendations which have been incorporated in the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93). This important legislation is a major step toward protecting the Nation's elderly and poor from unfit or unscrupulous practitioners and safeguarding these individuals from inappropriate or inadequate care. In addition, by expanding the OIG's exclusion authority, it facilitates the ability of the OIG to eliminate fraud and abuse in Medicare, Medicaid and other departmental programs.

The law strengthens and expands the ability of the OIG to exclude from Medicare and Medicaid health care providers and practitioners. The law authorizes exclusion of any practitioner whose license has been revoked or suspended in any State. Furthermore, the law now allows the OIG to exclude individuals or entities convicted of neglect or abuse of a patient under any Federal or State law. Finally, providers and practitioners who have been convicted of fraudulent activities under the Medicare and Medicaid programs are excluded from participation for a minimum of 5 years. Other new exclusion authorities relate to convictions for obstruction of an investigation, a controlled substance violation, and a suspension or exclusion from any Federal program.

In addition, the law creates a clearinghouse network which enhances cooperation between Federal and State authorities in tracking and monitoring potentially dangerous health care practitioners who attempt to practice bad medicine by moving from State to State. This clearinghouse will expand the data bank provisions in section 422 of the Health Care Quality Improvement Act of 1986. Civil monetary penalties, under existing statutes, are clarified and expanded.

The law, now known as Public Law 100-93, is the culmination of a long term effort by the OIG, the General Accounting Office (GAO), and the Department of Health and Human Services (HHS) in identifying deficiencies in the health care system. This law was passed by the Congress on July 29, 1987 and signed by the President on August 18, 1987.

**CORONARY  
ARTERY BYPASS  
GRAFT SURGERY**

An OIG study found that hospitals and surgical teams that perform more than 200 coronary artery bypass graft (CABG) surgeries per year have better outcomes in terms of mortality rates, lengths of stay and charges. Contracting with

selected high volume surgeons and facilities would assure quality of care in the most efficient and economical settings. Some of these high volume providers are offering all-inclusive package prices for CABG surgery which cover both hospital and physician costs (see figure below). The OIG compared these package prices with the program payments that were made for a sample of Medicare beneficiaries and found that over \$192 million could be saved each year if HCFA were able to negotiate similar rates for all Medicare beneficiaries who undergo CABG surgery. The review also found that there is considerable controversy surrounding the medical necessity of CABG surgery for certain patients.

### Medicare Mean Allowance Compared With Package Prices



**The Medicare mean is based on the Inspection sub-sample of 6 to 12-day hospital stays.**

The OIG recommended that HCFA require the peer review organizations (PROs) to review the medical necessity of elective coronary bypass surgeries. In addition, the study recommended that HCFA develop quality of care criteria for CABG surgery providers so that selective contracts can be negotiated. A demonstration project was suggested that would involve package pricing in a "preferred provider option" for Medicare beneficiaries. In response to OIG recommendations, HCFA will include CABG surgery on the mandatory review list for PROs and has initiated action to develop quality of care criteria for the procedure. The HCFA has agreed to consider proposals for package pricing of CABG surgery at selected sites. (OAI-09-86-00076)

The OIG estimated that retirees from Medicare-exempt State and local governments could cost the program \$12.8 billion over the next 5 years. Medicare Part A is primarily financed by payroll taxes on employers and workers. When Medicare was enacted in 1965, State and local governments were exempted

**STATE AND LOCAL  
GOVERNMENT  
RETIREES**

from mandatory participation. Even though workers were primarily employed by exempt organizations during their careers, they may qualify automatically for benefits under Part A, if they are entitled to Social Security benefits.

The OIG reviewed 1986 data on 117,000 of an estimated 2 million retirees from exempt agencies and found that:

1. The 85.3 percent who were age 65 or older were enrolled in Part A, qualifying through Social Security earnings or spousal entitlement.
2. The trust fund expended about \$7.8 billion on behalf of retirees from exempt agencies over the last 5 years and could expend another \$12.8 billion during the next 5 years.
3. The exempt government agencies, which had contributed little or nothing to the Medicare trust fund, shifted the medical costs of their retirees onto Medicare by making it the primary, or first payer. Though not illegal, the practice is unfair to those employers who pay Medicare payroll taxes.

The OIG recommended that HCFA at least consider seeking legislation to make Part A the secondary payer for retirees from exempt government agencies, should the President's proposal to extend Part A coverage to all exempt workers not be accepted. (Only workers hired after March 31, 1986 are now covered.) The final report is at HCFA for comment. In responding to the draft report, HCFA supported the OIG recommendation but noted that the secondary payer premise would not be a simple measure to implement, and would likely generate opposition from the exempt organizations. (CIN: A-09-86-62050)

**MEDICARE  
HOSPITAL  
REVENUES**

Prior OIG reports have shown that hospitals realized Medicare revenue over expenditures of approximately 14 percent in Fiscal Years 1984 and 1985 from the implementation of Medicare's prospective payment system (PPS). The revenues were realized partially because of HCFA's use of overstated initial (1984) PPS rates that were based on inflated hospital inpatient operating costs.

Various studies into the nature of these high rates of return identified flaws in the base year (1981) hospital inpatient operating cost data used by HCFA to set initial PPS rates. These flaws caused an identified overstatement of at least 6.84 percent in the standardized average Medicare cost per discharge. These averages were used to derive the Federal portion of the PPS rates for 1984, the first year PPS rates were used. The overstatement occurred because the following costs were included in unaudited baseline hospital cost data used in setting PPS rates.

<u>Item</u>	<u>Percentage Overstatement of Baseline Costs</u>
Capital costs separately paid as a pass-through	2.70%
Exempt unit costs reimbursed separately from PPS	.96
Education costs separately paid as a pass-through	.20
Unallowable costs due to use of unaudited data	<u>2.98</u>
Total Overstatement	6.84%

Since these errors have not been corrected in the annual PPS rate updates since 1984, future PPS rates should be reduced by at least this level to deflate the PPS rates to their proper initial values.

The OIG continues to recommend that HCFA seek congressional authority, if deemed necessary, to recompute PPS rates using more accurate and current audited cost information, and rebase the rates after full transition to a 100 percent Federal rate. Pending action on this recommendation, HCFA should consider hospital profits under PPS as well as hospital behavioral changes resulting from PPS-related efficiencies when recommending the level of increase in PPS rates during annual updates. (CIN: A-14-87-00104)

After intensive monitoring by HCFA and reports issued by OIG, the International Medical Centers (IMC), a Florida Health Maintenance Organization (HMO), had its Medicare contract terminated by HCFA. The OIG found that IMC's Medicare and Medicaid enrollment was significantly higher than the Federal enrollment standard. This standard helps to assure that quality of care meets community standards. The standard also serves to assure that the basic reimbursement rate is valid since it is based on premiums the HMO charges private enrollees.

## **HMO TERMINATION**

The IMC was not making a reasonable effort to comply with the enrollment standard which calls for a maximum of 50 percent Medicare and Medicaid enrollment in risk-based HMOs. In May 1986, OIG reported to HCFA the failure by IMC to meet this standard. Despite HCFA's efforts to bring IMC into compliance, Medicare enrollment at that time comprised 72 percent of the HMO's total enrollment. Subsequently, the HMO submitted a marketing plan in which it was to achieve the 50 percent enrollment composition by April 1, 1988, by increasing commercial enrollment.

In March 1987, the HMO's Medicare enrollment had increased to 79 percent, while commercial enrollment had steadily dropped from 27 percent in June 1986 to 21 percent in March 1987. In view of the HMO's negative progress towards meeting the enrollment standard, OIG notified HCFA that continuing a contractual relationship would be inconsistent with the effective and efficient implementation of the program. In accordance with OIG's recommendation, HCFA terminated the HMO's contract effective July 31, 1987.

(CIN: A-14-87-00203)

**MULTIPLE  
SURGICAL  
PROCEDURES**

The OIG recommended that HCFA request that three carriers who paid excessive amounts for second surgical procedures review their policies. An OIG review of Medicare carriers' reimbursement policies disclosed that 35 carriers limited reimbursement for secondary surgical procedures to 50 percent of the reasonable charge. However, three carriers paid 75 to 100 percent of the reasonable charge for some or all secondary surgical procedures which results in millions of dollars in unnecessary expenditures.

Pursuant to OIG recommendations, HCFA agreed to contact the three carriers for reexamination of their policies. However, HCFA stated that its authority to establish a uniform payment limit is narrowly constrained by law. Therefore, HCFA does not plan to establish a national limit for multiple surgeries as was also recommended by OIG. (CIN: A-03-86-62008)

**EFFECTS OF  
CHANGES IN THE  
CURRENT  
PROCEDURES  
TERMINOLOGY  
MANUAL FOR  
COLONOSCOPIES**

The OIG determined that changes in colonoscopy codes in the current procedures terminology manual could result in excess Medicare payments of about \$20 million. This manual change was based on a determination that certain colonoscopy codes were being used to bill for sigmoidoscopies, a lesser procedure. The American Medical Association coding committee corrected the coding problem by eliminating the code for the lesser colonoscopy procedure, leaving a coding choice of either a colonoscopy or a sigmoidoscopy. However, the base payments for sigmoidoscopies would be inflated, if HCFA includes the overpriced colonoscopy billings with sigmoidoscopy billings in its reasonable charge update. The OIG recommended that HCFA disregard the erroneously billed colonoscopies when establishing prevailing charge levels for the sigmoidoscopy codes. (OAI-NOV-0002)

**ORGAN  
TRANSPLANTS**

An OIG study of organ transplantation, described in a series of reports, has resulted in several recommendations for Medicare savings and more appropriate patient care. Two of these reports are summarized below.

- The OIG reported that at least \$37.5 million in savings would be generated in the first year through inclusion of organ acquisition in the Medicare prospective payment system. Specifically, OIG recommended that HCFA amend the existing diagnosis related group (DRG) for kidney transplantation to include all costs for organ acquisition, as well as transplantation; and that the same approach be taken for heart, liver and any other transplants covered by Medicare in the future.

The study found that kidney acquisition systems, which accounted for \$102 million in Medicare expenditures in 1985, have wide variation in costly pretransplant laboratory testing procedures, unnecessary duplication of testing, kidney wastage and generally limited fiscal oversight.

The HCFA generally concurred with the findings, cited efforts which implemented certain recommendations and proposed some alternative approaches on others. (OAI-01-86-00108)

- The other report in the series identified \$18.3 million that Medicare could save in the first year if steps were taken to increase the access of kidney dialysis patients to kidney transplants. Only 10 to 11 percent of dialysis patients were found to be on a transplant waiting list even though kidney transplant surgeons report that 20 to 25 percent are medically suitable for a transplant. A major factor contributing to the low percentage of dialysis patients receiving transplants is the failure of some dialysis facilities to provide their patients with an adequate opportunity to receive a transplant.

The OIG recommended that HCFA (1) ensure that there is more intensive oversight of facilities having low transplant referral rates, (2) see that State survey teams conduct a more outcome-oriented review of these facilities, (3) require that patient care plans be signed by dialysis patients and medical professionals, and (4) work with PHS to encourage professional societies to provide guidance on which dialysis patients are medically suitable candidates for kidney transplants. The HCFA was generally supportive of the recommendations but raised a number of detailed operational concerns with respect to implementation of some recommendations. (OAI-01-86-00107)

The OIG assessed the allowability of costs incurred by Medicare intermediaries and carriers and recommended disallowances of \$12.3 million. Unallowable costs included duplicate payments, improperly allocated costs and inadequately documented costs.

## **MEDICARE CONTRACTORS**

In addition, OIG cases and studies focused on the following contractor-related problems, including the following case.

### **Contractor Embezzlement**

- In New York, the former president of a company which processed Medicare carrier claims was sentenced to incarceration for embezzlement and wire-tapping. In a related civil action he was ordered to pay the company damages of \$900,000. He had funneled company funds through accounts opened by two other corporate officers, which he used to buy personal items such as expensive watches, furniture, art and renovations on his home. He and the other officers also used the funds to start a small antique business. When it appeared the company had discovered his activities, he installed wiretapping devices in order to eavesdrop on board meetings.

### **Debridement of Decubitus Ulcers**

Lack of carrier controls caused Medicare to pay excessive amounts for physician billing for debridement of decubitus ulcers. In one case, a physician was falsely billing the Medicare program for daily debridement of large decubitus ulcers which were actually smaller than indicated on the bill and for patient examinations that were more frequent than medically necessary. This physician billed the Medicare program almost \$2 million in 1 year for debridement of decubitus ulcers.

The OIG recommended that HCFA advise carriers to establish procedures to identify any patient who receives more than four debridements per month for medical review. Also, the OIG recommended that carriers identify any provider who bills in excess of \$1 million for any one procedure code in a 1-year period. The HCFA is currently considering the recommendations as part of a comprehensive examination of medical review screens and edits. (OAI-NOV-0001)

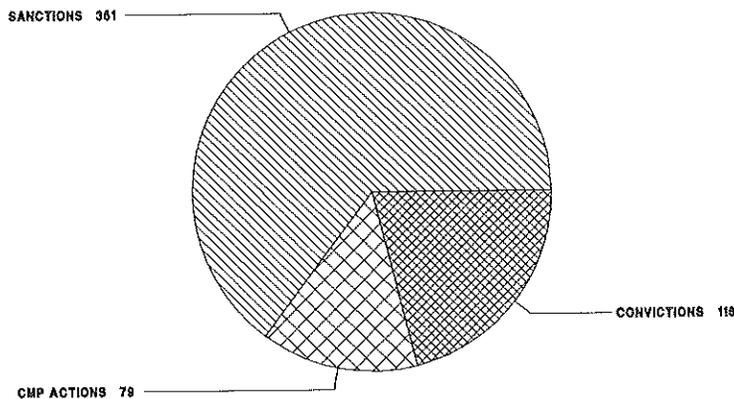
### **Overpayments by Intermediaries**

The OIG's review of cash management and overpayment practices at selected intermediaries disclosed that one intermediary had not assessed interest of over \$1.1 million on overpayments identified on late filed provider cost reports or those subsequently identified. Also, the intermediary had made duplicate payments to providers totaling \$500,000. Several procedural changes were recommended as well as the recovery by the intermediary of \$1.6 million in unassessed interest charges and duplicate payments. Both HCFA and the intermediary agreed with OIG recommendations. (CIN: A-14-86-62156)

### **INVESTIGATIVE AUTHORITIES**

The OIG has statutory authorities which permit several avenues of pursuit of those who violate the Department's health care programs. Remedies for fraud or the provision of substandard care can take the form of criminal prosecution, monetary penalties and exclusion from the Medicare and Medicaid programs. During this period, the OIG was responsible for a total of 331 actions against wrongdoers. Successful actions for FY 1987 totaled 558.

**JUDICIAL & ADMINISTRATIVE ACTIONS  
FY 1987**



Conviction of individual health care practitioners and suppliers for fraud most commonly results from prosecutions related to the filing of false claims against the Medicare program, as illustrated in the following cases. **FALSE CLAIMS**

- A Texas physician received 5 years deferred adjudication, had to repay the Medicare and Medicaid programs \$37,500 and was ordered to pay \$40 a month for the deferral period, as the result of a conviction for filing false claims. As another condition of probation, he voluntarily withdrew from participation in the programs for 2 to 2 1/2 years.
- A psychiatrist in Georgia was sentenced to 5 years probation, fined \$6,000 and ordered to pay restitution of \$8,600 for billing Medicare for psychotherapy to patients when he was out of town.
- An Arizona psychiatrist and a chiropractor were each sentenced to 3 years probation, with total fines and restitutions of \$14,600, for a scheme in which chiropractor services were billed under the psychiatrist's Medicare provider number. They were barred from participation in the Medicare and Medicaid programs for 5 years. The psychiatrist was also ordered to complete 288 hours in a work program.
- A pharmacy in Wisconsin had to pay \$10,000 in a civil settlement for billing Medicaid for drugs not dispensed and for overbilling.

**KICKBACKS** Successful actions against health providers engaging in kickbacks will be enhanced by the Medicare and Medicaid Patient and Program Protection Act of 1987, which gives authority to define both criminal behavior and payment arrangements that can result in exclusions from the programs. The following actions were completed against such providers under authorities existing before this legislation became effective.

- In New York, 20 successful prosecutions against ambulance company owners, their employees; doctors and employees of the Medicaid fiscal agent have resulted to date from a project jointly worked with the FBI. Thirteen have been given sentences of up to 3 years.

This project, which focused on fraud in the health care transportation industry, is nearing completion. Total convictions from the project were as follows:

<u>Type of Violator</u>	<u>Number of Convictions</u>
Ambulance/Ambulette Company Owners	8
Ambulance/Ambulette Company Employees	3
Physicians	6
Medicaid Fiscal Agent Employees	2
Other	<u>1</u>
Total	20

The crimes have involved kickbacks, false claims and obstruction of justice. The principal scheme was to pay kickbacks to doctors referring patients to particular medical transportation companies which would then bill the Medicaid program. To assure that the fraud went unnoticed, employees of the Medicaid fiscal agents were bribed. Over \$1 million in false claims were involved.

- In Rhode Island, a third conviction was obtained in a scheme in which a durable medical equipment (DME) supplier paid hospital respiratory therapists for patient referrals for a period of 8 years. The chief respiratory therapist at a major hospital was sentenced to 2 years in prison and ordered to pay a \$10,000 restitution. The supplier and a former chief respiratory therapist at another hospital were convicted and sentenced earlier.

**SANCTIONS FOR  
CRIMINAL  
CONVICTIONS**

Section 1128(a) of the Social Security Act requires that individuals convicted of crimes against the Medicare or Medicaid programs be suspended from participation in these programs. Examples of such sanctions follow:

- An Ohio physician was suspended from Medicare and Medicaid for 15 years after having been convicted of falsely billing Medicare for laser eye surgery that he did not perform.
- A Massachusetts nursing home manager was barred from participation for 10 years, after being convicted for diverting nursing home Medicaid funds to his own use and filing false charges on a cost report.
- A Mississippi pharmacist was barred from Medicare and Medicaid participation for billing Medicaid for prescriptions that were unauthorized by physicians.
- A physician in Utah was suspended for 15 years after being convicted of billing Medicaid for services he did not render.

A business may be suspended from Medicare and Medicaid under section 1128(b) if an officer, director or manager of the business or an individual who has more than 5 percent ownership is suspended from the program under section 1128(a). The following are examples of such suspensions:

#### **CORPORATE SUSPENSIONS**

- Three New York DME supply companies were suspended for 20 years because they were being managed, directed and partially owned by an individual who had been suspended.
- An ambulance company in New Jersey was suspended for 3 years because its manager had been suspended under section 1128(a).

State medical licensing and discipline boards place significant importance on cases, referred by the OIG, of physicians sanctioned for fraud or abuse of the Medicare and Medicaid programs or patients. A recent analysis of information obtained from the Federation of State Medical Boards shows that licensure action has been taken on 109 of 292 sanctioned physicians that the OIG referred to individual State licensing boards. Since many of the boards are reluctant to release any information on their actions prior to a final determination, which may take as much as 2 years, the above figures are likely an understatement of the number of cases where boards have acted on OIG referrals. While it is not possible to account for all cases where a final determination has not been made, experience to date indicates that action may be pending on a substantial number of the additional sanctioned physicians.

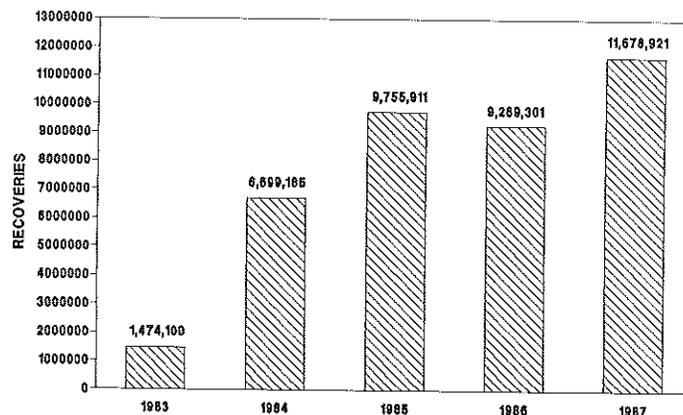
#### **STATE LICENSING BOARD ACTIONS ON OIG REFERRALS**

The Congress authorized OIG to impose civil monetary penalties (CMP) against health care providers who perpetrate fraud and abuse. Under these authorities,

#### **CIVIL MONETARY PENALTIES**

the OIG recovered \$11.7 million in funds lost through fraudulent Medicare and Medicaid claims.

### CIVIL MONETARY PENALTIES FROM 1983 THRU 1987



Examples of some of the settlements and administrative adjudications made during this 6-month period include the following:

- A hospital agreed to pay \$450,000 for improperly billing the Medicare, Medicaid and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) programs for inpatient psychiatric services rendered by nonphysicians, for services that were not adequately documented in the patient's medical records, and for using improper billing codes.
- Two anesthesiologists paid over \$320,000 in penalties, interest and restitution for billing the Medicaid program and Blue Shield for services claimed to be personally performed, but which were actually provided by hospital staff anesthetists.
- An administrative law judge ordered a physician to pay a civil penalty of \$67,500, an assessment of \$13,000, and barred the physician from participating in the Medicare or Medicaid programs for 3 years. The judge found 313 instances in which the provider billed for hospital admissions and visits which were not performed.
- An independent laboratory billed Medicare for tests performed on hospital in-patients. Medicare had already paid for these tests as part of the per diem

rate for the patients' hospital stays. The laboratory agreed to pay \$75,000 in penalties, assessments and restitution.

- An administrative law judge imposed a penalty of \$13,500 and a 5-year suspension from the Medicaid and Medicare programs upon a dentist who had improperly charged Medicaid recipients \$973 for services in order to receive more money than Medicaid allowed for those services.

A clinic had contracted with the Veterans Administration (VA) to render care to patients and was being reimbursed by the VA on a daily rate basis. The OIG discovered that in some cases the clinic's patients were also Medicare beneficiaries and the clinic submitted claims to both the VA and the Medicare carrier for the same service resulting in excess payments by Medicare.

#### **DUPLICATE PAYMENTS FOR DUALY ENROLLED MEDICARE AND VETERANS ADMINISTRATION BENEFICIARIES**

The OIG recommended that HCFA establish a system that provides Medicare contractors with the identity of those beneficiaries whose care is paid in whole or part by the VA. The HCFA has advised the OIG that efforts are underway to develop a system which will provide the information necessary to determine the proper payer; once implemented, HCFA expects to undertake retroactive recovery efforts on a national basis. (OAI-NOV-0003)

An OIG review found that Medicare overcontributed \$2.7 million to a terminated contractor's pension plan. This overcontribution was primarily attributable to the forfeiture of pension costs that occurred when the Medicare contract was terminated. Previous pension contributions were calculated on both earned and projected benefits. When the contract terminated, Medicare was liable only for the benefits earned by the Medicare work force.

#### **MEDICARE CARRIER PENSIONS**

The HCFA agreed with the OIG recommendation that the carrier refund the overcontribution and has requested special pension audits of 21 other terminated contractors. (CIN: A-07-86-62020)

As a result of the Gramm-Rudman-Hollings legislation, Medicare contractors' (intermediaries and carriers) FY 1986 budgets were reduced. While HCFA reflected the decrease in the apportionment to one of its bureaus, the bureau failed to make the necessary budgetary adjustments. As a result, obligations were processed that exceeded the bureau's third-quarter FY 1986 apportionment by \$817,847, in violation of the anti-deficiency provisions of Public Law 93-344. This violation was reported to the Congress and to the Executive Office of Management and Budget by the Secretary on February 5, 1987.

#### **ANTI-DEFICIENCY VIOLATION**

The OIG reviewed corrective actions taken by HCFA to prevent a future anti-deficiency violation. It was determined that HCFA had initiated a centralized control point for the pre-certification for the availability of funds at their Division of Accounting. This action transfers funds control from the HCFA operational components and should prevent future anti-deficiency violations. (CIN: A-14-87-02008)

#### **PEER REVIEW ORGANIZATIONS**

Two OIG reports on PRO contract proposals identified unallowable costs of \$11 million. The PROs were established to evaluate the quality of care and the necessity of hospital admissions under Medicare's PPS. At HCFA's request, the OIG performed preaward audits of contract proposals from PROs for initial HCFA contracts and for renewals and amendments to existing contracts. Two audits involving a new contract and a renewal contract resulted in over \$1.9 million in costs being eliminated from the proposals (e.g., unallowable salaries, fringe benefits and profits in excess of HCFA guidelines). Twelve audits of amendments to existing contracts disclosed unallowable costs of more than \$6.2 million for salaries, fringe benefits and physician advisor fees.

Another PRO contract audit resulted in more than \$2.9 million in cost savings. An OIG audit showed that the proposals submitted by the PRO for sanction activities and the use of assistant surgeons at cataract surgery included overhead and general administrative costs that had already been included and paid for under the original contract. The HCFA used the results of this and other OIG audits in their contract negotiations. (CINs: A-09-86-61662 and A-09-87-00060)

#### **PRO SANCTIONS**

In addition to sanctions resulting from convictions, health care providers can be excluded or required to pay a monetary penalty as a result of a PRO determining that the provider: (1) furnished unnecessary services, (2) failed to provide services that met professionally recognized standards of care, or (3) failed to document the services as required by the PRO. The following are examples of this activity:

- An Iowa doctor was excluded for 1 year for violating all three of the requirements in six cases. Among the problems identified by the PRO were admitting patients to an acute care setting when the care could have been provided at a lower level, failing to order proper tests, failing to do blood studies and failure to prepare a discharge summary.
- A New Jersey osteopath received a 1-year exclusion under this authority. This physician improperly treated fluid and electrolyte imbalance, incompletely

replaced potassium and did not restrict fluids in a patient with severe electrolyte disturbance.

- On the basis of a recommendation from the Texas PRO, a physician was excluded for 2 years. Among the problems identified with this physician's care were lack of knowledge in treating cardiovascular illness, failure to order diagnostic tests and ordering a patient discharged from the emergency room without personally examining him.

Under section 1862(d)(1) of the Social Security Act, providers can also be excluded if a referral from a Medicare contractor shows they have provided excessive and unnecessary services or poor quality of care. The following are examples of such cases:

#### **CONTRACTOR-REFERRED SANCTIONS**

- A Colorado physical therapist was excluded for 10 years for providing excessive and unnecessary therapy services to Medicare patients.
- A physician in the State of Washington was barred from participation for 10 years after it was determined that he provided excessive, poor quality, and medically unnecessary services to Medicare beneficiaries. It was also found that there were instances where he provided excessive and inappropriate medications that may have been life threatening.

An OIG review in one State found that initial certifications of new intermediate care facilities (ICFs) were sometimes based on inspections performed before the facilities were operational and treating patients. To be properly surveyed and certified for participation under Medicaid, certain evaluations must be made after the facility is operational.

#### **NURSING HOME CERTIFICATION**

During a 3 1/2-year period, Federal payments of \$2.6 million were made to 5 new ICFs and 70 new ICFs for the developmentally disabled during periods when those facilities were not properly certified. The HCFA concurred with OIG findings and recommended financial adjustment and procedural changes to ensure proper Medicaid certifications. (CIN: A-05-86-60241)

A prior OIG review in one State showed that substantial savings could result if certain common surgical procedures were performed in an outpatient setting rather than an inpatient setting. The follow-up review disclosed that the State Medicaid agency had taken action on OIG recommendations related to the establishment of an ambulatory surgical program. The State has included more than 400 ambulatory surgical procedures in their State plan and is continuing to

#### **AMBULATORY SURGERY**

identify additional procedures. The State's actions should result in an annual cost savings of about \$1.2 million. (CIN: A-06-87-00024)

**ILLEGAL DRUG  
SUBSTITUTION**

A joint Federal and State investigation resulted in the identification of 11 pharmacies which were billing Medicaid for brand name drugs while actually dispensing lower-priced generic equivalents. In addition to successful criminal dispositions, five pharmacies had to pay penalties and assessments totaling \$60,000. They also received brief suspensions from participation in the State Medicaid program. Actions are pending against the remaining pharmacies.

**MEDICAID  
OVERPAYMENTS**

Reviews conducted by the OIG in five States and the District of Columbia found that the Federal Government had not been credited with over \$18.4 million for overpayments made to Medicaid providers or on behalf of ineligible recipients. Once a State determines that an overpayment has occurred, it must promptly return the Federal share whether or not the overpayment has been recovered.

In one State, the Federal share of overpayments amounted to \$9.1 million and was identified through provider audits made by the State agency. The HCFA agreed with OIG recommended financial adjustments for the amounts of identified overpayments. (CINs: A-09-86-60255, A-05-86-60227, A-04-86-60230, A-03-86-60207, A-03-87-00200, A-03-87-00209 and A-03-87-60206)

**MEDICAID CLAIMS  
PROCESSING  
SYSTEM**

The review of one State's automated Medicaid claims processing system disclosed material weaknesses in controlling access to computer programs and files, use of utility programs, program change procedures, edits for potential duplicate claims for physician services, and maintenance of a provider master file. The OIG recommended that the State be required to correct each of the weaknesses reported, thus, reducing the potential for fraud, waste and abuse in the State's Medicaid program. The HCFA concurred with OIG recommendations and is working with the State to ensure correction of these deficiencies. (ACN: 15-72696)

**RECONCILIATION  
OF MEDICARE AND  
MEDICAID  
AMBULANCE  
PAYMENTS**

As part of a joint Federal and State investigation, the OIG determined that duplicate payments were made by Medicare and Medicaid for ambulance transportation provided to the same beneficiary. Medicaid reimbursed the ambulance service provider at face value and also paid the coinsurance for the Medicare claim. Medicare then fully paid the claim submitted to them by the provider minus the coinsurance. Both programs provide reimbursement for ambulance service, however, Medicare provides a more limited ambulance benefit. Medicare, in this situation, should not have provided reimbursement.

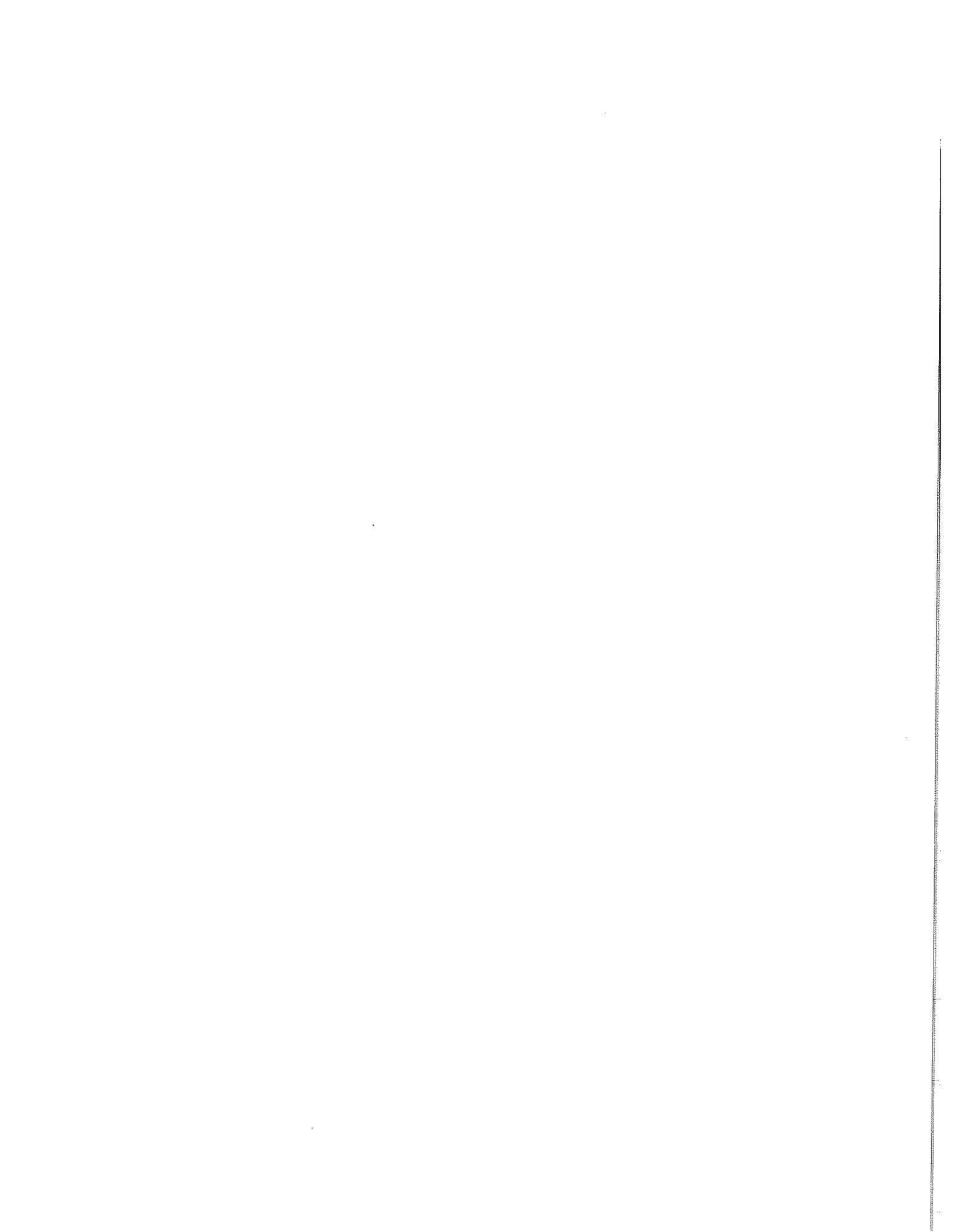
The OIG recommended that HCFA direct States to process Medicare claims prior to Medicaid claims, develop a prepayment screen which would determine whether prior payment had been made, and reconcile payment records periodically to catch duplicates which have evaded the pre-payment screen. (OAI-NOV-0004)

The 38 SMFCUs in FY 1987 received \$44.1 million in Federal grants to investigate fraud in the Medicaid program. During the period from July 1, 1986 through June 30, 1987, the SMFCUs reported 453 convictions, and almost \$8.5 million in fines, overpayments and restitutions. The OIG conducted recertification reviews of 14 SMFCUs to assure that they were abiding by grant regulations. Several disallowances resulting from previous recertification reviews were finalized: \$13,000 from Hawaii, \$25,699 from Wisconsin, and \$193,135 from Rhode Island.

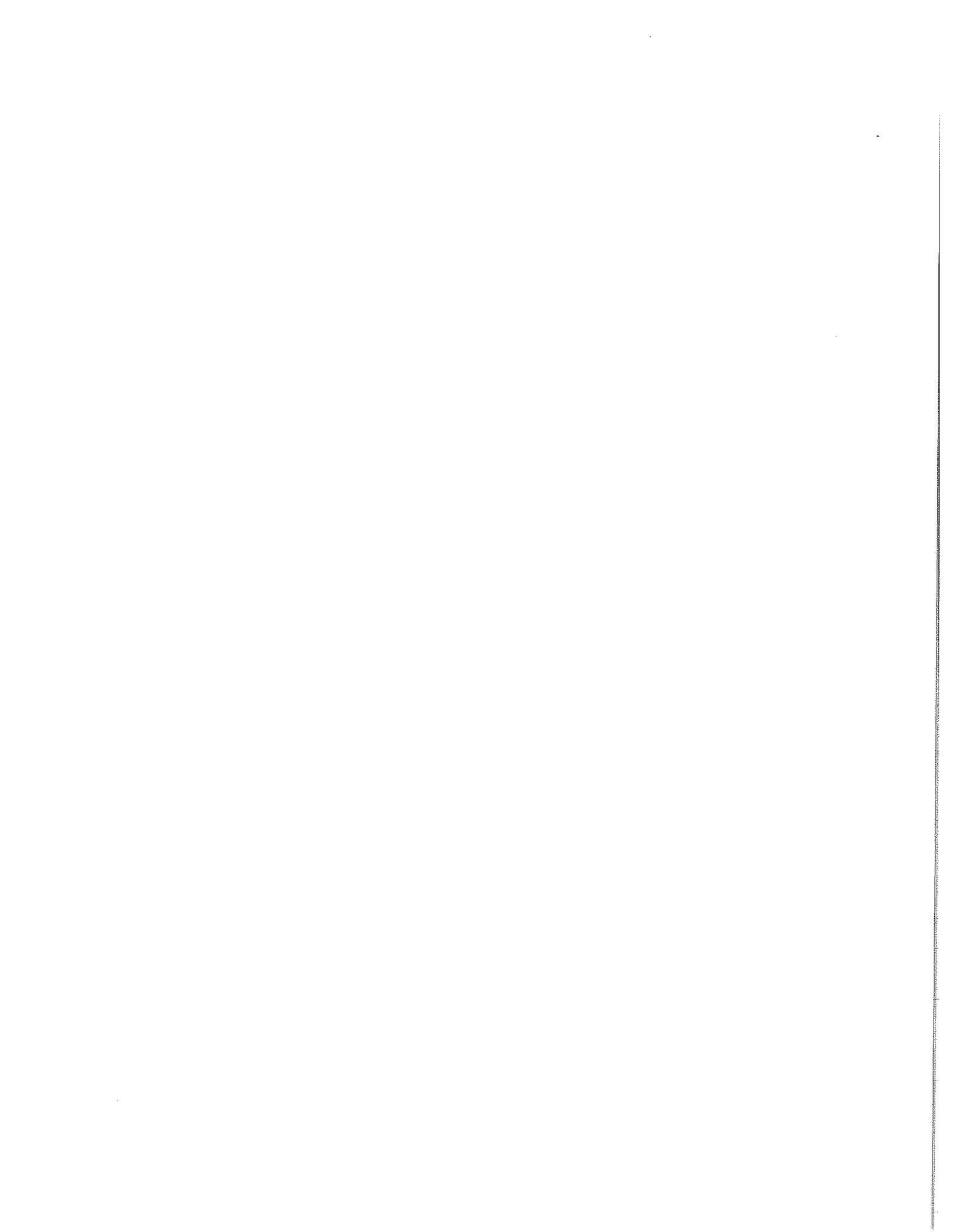
#### **STATE MEDICAID FRAUD CONTROL UNITS**

The following cases are examples of the kind of investigations conducted by the SMFCUs:

- The Colorado SMFCU investigated the billing and collection agency of a university health sciences center, resulting in an indictment for Medicaid billing discrepancies. The health sciences center settled the case by repaying the State Medicaid agency \$470,000.
- The Massachusetts SMFCU conducted an investigation that led to a clinical laboratory's refunding \$125,000 to the State for overpayments received from the Medicaid program.
- A Pennsylvania nursing home owner pleaded no contest to a charge that he illegally received more than \$20,000 from Medicaid by falsely claiming personal expenses as costs for the home's operation.
- A Florida SMFCU investigation resulted in a nursing home assistant pleading guilty to one count of abuse, neglect or exploitation of an aged person or a disabled adult, and one count of battery.



**PUBLIC HEALTH SERVICE**



## Chapter IV

### PUBLIC HEALTH SERVICE

During the second half of Fiscal Year (FY) 1987, savings of \$57.7 million resulted from management action on Office of Inspector General (OIG) recommendations. Questionable charges to the Public Health Service (PHS) programs totaled \$8.2 million.

#### STATISTICAL ACCOMPLISH- MENTS

The PHS encompasses: the National Institutes of Health (NIH); Food and Drug Administration (FDA); Centers for Disease Control (CDC); Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA); and the Health Resources and Services Administration (HRSA). These agencies promote biomedical research, disease prevention, safety and efficacy of marketed food and drugs, and other activities designed to ensure the general health and safety of American citizens.

#### PROGRAM OVERVIEW

In a national study concerning severely disabled infants, referred to as baby does, the OIG found that all States receiving Federal child abuse funding have procedures for responding to baby doe reports. Most hospitals where babies are born or treated have designated liaisons to report suspected baby doe cases to the State child protection service (CPS) agencies. Ten acute infant care hospitals visited during the inspection have committees which review potential baby doe cases and develop hospital policies regarding medical treatment for these infants.

#### STATE BABY DOE PROGRAMS AND INFANT CARE REVIEW COMMITTEES

The 1984 amendments to the Child Abuse Prevention and Treatment Act require State CPS agencies to establish procedures for handling reports of suspected withholding of medical treatment from severely disabled infants and to have liaisons designated in hospitals to insure the immediate referral of potential baby doe cases to CPS. The amendments also require HHS to publish model guidelines encouraging such hospitals to establish infant care review committees which would recommend hospital policies and to review potential baby doe cases. (OAI-03-87-00018)

The OIG found that the default rate of noncitizen Health Education Assistance Loan (HEAL) borrowers is twice the rate of citizens. The HEAL program insures loans made by nonfederal lenders to students in various medical disciplines. Virtually all students, including noncitizens with permanent resident status, are

#### HEALTH EDUCATION ASSISTANCE LOANS

eligible and may borrow up to a total of \$80,000 within a 4-year period at \$20,000 annually. At the close of Fiscal Year 1986, the program had insured over \$1 billion in principal and accumulated interest.

The OIG's review disclosed that noncitizens are defaulting twice as frequently as citizens. As of October 1986, noncitizens had a default rate of 21 percent compared to 9 percent for citizens, and accounted for almost \$1.1 million in default claims paid by the HEAL program. If noncitizens continue to default at the current rate, OIG estimated that they will cost the HEAL program \$6.9 million over the next 4 to 6 years.

Noncitizens can easily leave the country without repaying their debts. Of 56 noncitizen defaulters reviewed, 10 are known to have left the country, and HEAL officials cannot locate about half the remaining 46 and suspect they have also left the country.

Special controls are needed to prevent a significant drain on the HEAL program's limited resources. Consequently, OIG recommended that PHS seek legislation to give lenders the authority to require that financially responsible citizens cosign HEAL loans to noncitizen borrowers. The PHS agreed to seek the necessary legislation. (CIN: A-12-87-02652)

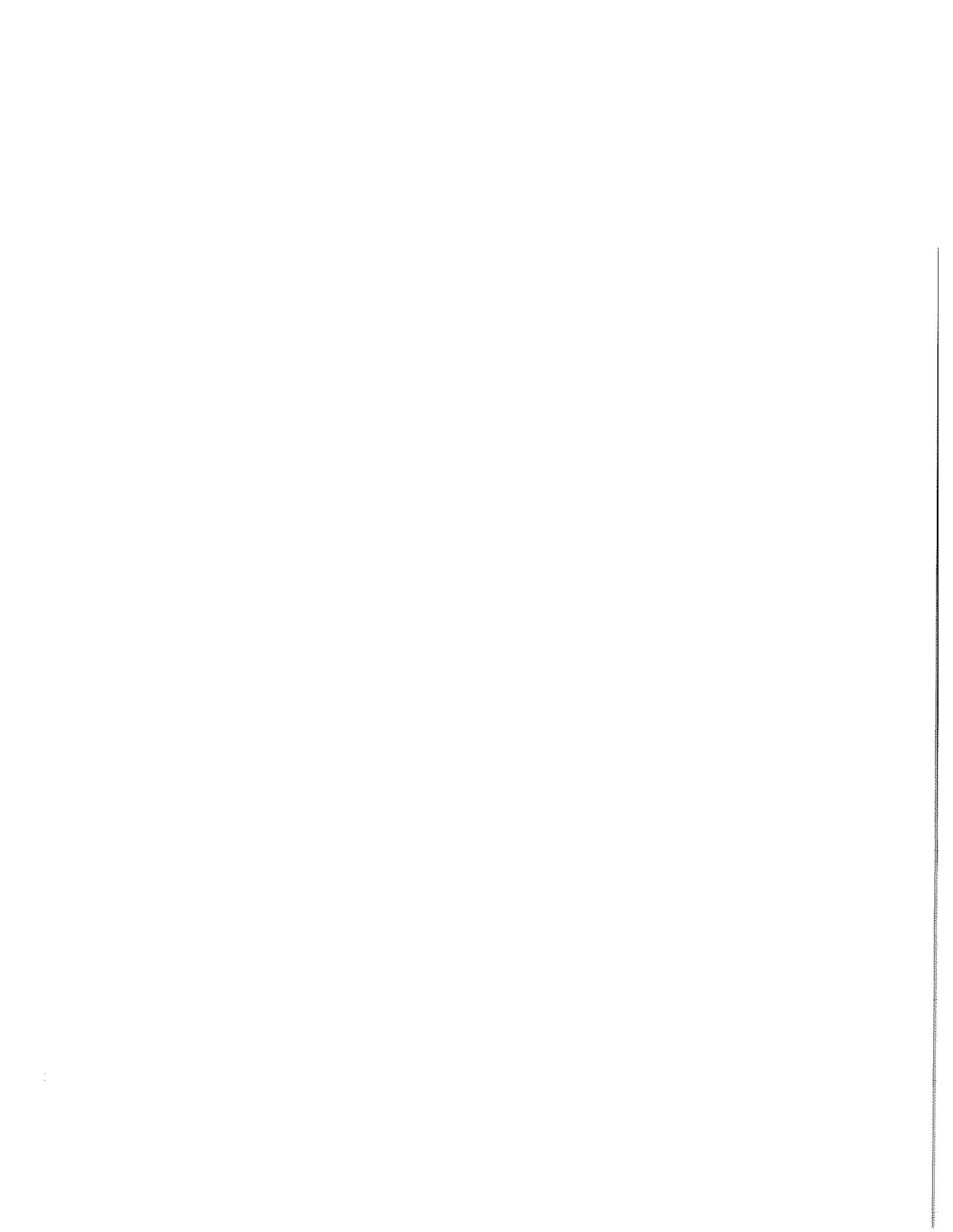
**QUESTIONED COSTS** During this 6-month period, OIG reports identified questionable grantee charges to PHS programs of \$8.2 million. These reports included results of OIG reviews and results of conducted nonfederal audits, such as those performed by State auditors of PHS block grant programs and of Federal funds at State health agencies and for independent auditors of Federal program funds at colleges and universities.

Prior to issuing nonfederal audit reports to PHS, OIG reviews the reports for matters that require immediate action such as possible fraud or abuse, conformance to established Federal standards and guidelines as well as findings that require departmental action. The following are examples of OIG and nonfederal audit results of PHS programs during the last 6 months.

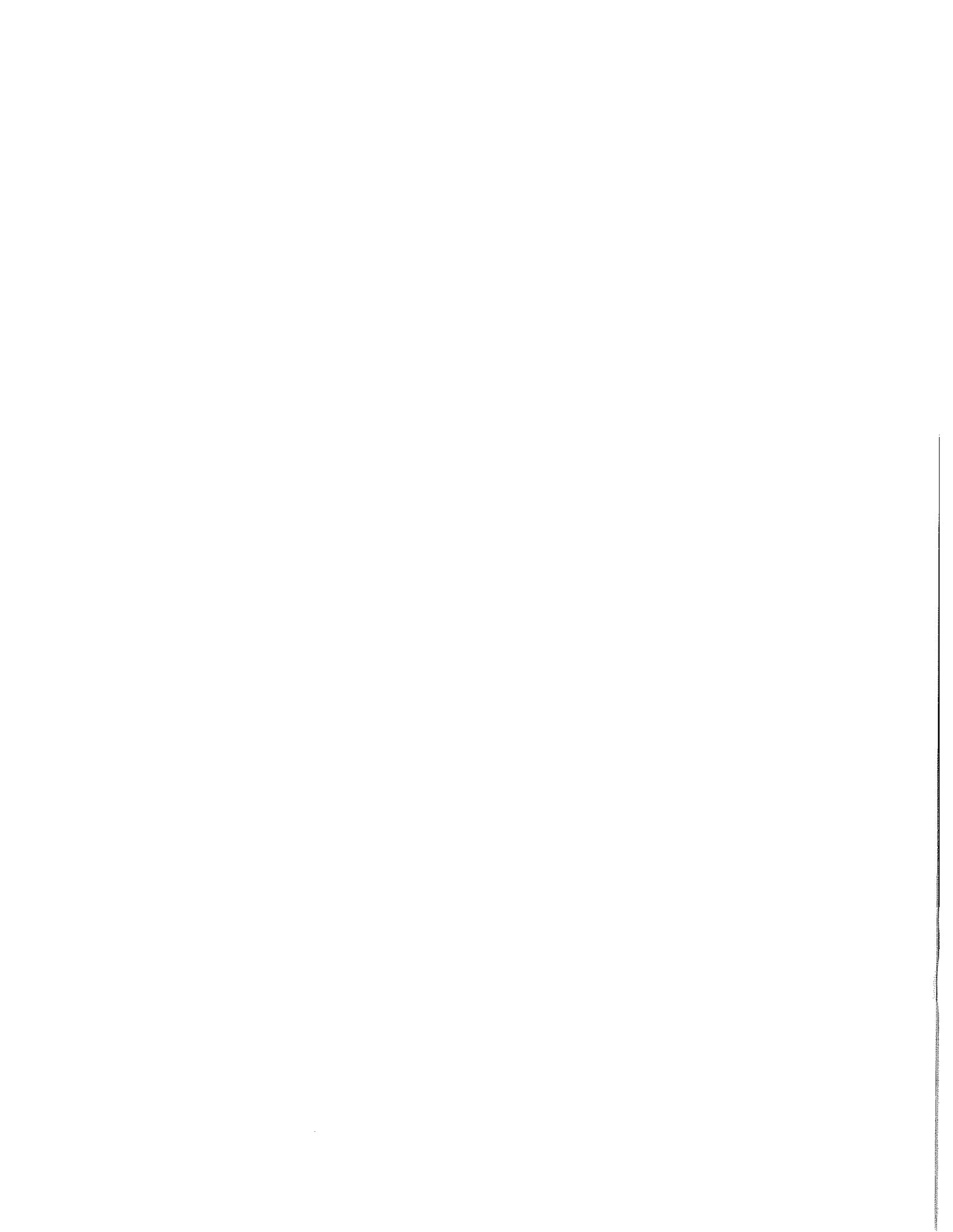
- A State audit disclosed that charges to two ADAMHA grants by the State's health agency were unsupported by formal accounting records. The unsupported costs of \$922,000 charged to the grants were recommended for recovery. (CIN: A-03-87-06013)
- An OIG audit of a proposed contract with the National Heart, Lung and Blood Institute identified an error in the proposal that overstated indirect costs

and general and administrative costs by \$484,000. A corresponding adjustment in the award was recommended. (CIN: A-09-87-00066)

- An OIG preaward audit of a proposal submitted in response to a National Cancer Institute solitication, identified unsupported costs of \$481,000 in such categories as staff benefits, research overhead and general and administrative costs. (CIN: A-09-87-05296)
- Another OIG preaward audit of a proposal for an NIH contract identified overstated indirect and direct costs of \$317,000. (CIN: A-05-87-00070)
- An OIG review of an NIH grantee's proposed indirect cost rate resulted in downward adjustments of \$288,190. Included in the grantee's proposal were unreasonable rental costs, unallowable general and administrative expenses and use charges for equipment purchased with Federal funds. (CIN: A-02-87-02013)
- A State audit of a maternal and child health block grant identified \$231,000 in overpayments and unallowable costs charged to the block grant program by the State public health agency. Appropriate recommendations for recovery were made. (CIN: A-05-87-05020)



# **FAMILY SUPPORT ADMINISTRATION**



## Chapter V

### FAMILY SUPPORT ADMINISTRATION

The Office of Inspector General (OIG) continues to direct audit emphasis to reviewing recipient eligibility, determining the fairness of program benefits, and evaluating the economy and efficiency of operations. During this reporting period, the OIG recommended improvements in the Family Support Administration (FSA) programs that could result in annual savings of \$527.4 million as well as recommended recovery of \$31.0 million in questionable grantee charges.

#### STATISTICAL ACCOMPLISHMENTS

The FSA provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. These programs include: Aid to Families with Dependent Children (AFDC), Emergency Assistance (EA), Child Support Enforcement, Low Income Home Energy Assistance (LIHEA), Refugee and Entrant Assistance, Community Services and Work Incentive programs. Expenditures for these programs totaled \$13.3 billion in Fiscal Year (FY) 1987.

#### PROGRAM OVERVIEW

The OIG estimated that elimination of an unnecessary child support enforcement incentive would result in a 5-year Federal and State savings of over \$1.9 billion.

#### AID TO FAMILIES WITH DEPENDENT CHILDREN

One of the goals of the Child Support Enforcement program is to obtain child support from absent parents; thereby, reducing assistance costs for families in the AFDC program. As an incentive to the AFDC parent to provide information on locating the absent parent, Congress in 1984, amended the Social Security Act to require that the first \$50 of each month's child support collected from the absent parent be paid to the AFDC family. This \$50 payment (referred to as the \$50 disregard) is not counted in determining the family's AFDC grant.

The OIG's review disclosed that the \$50 disregard has not improved collection from absent parents. In a sample of 271 AFDC cases reviewed in five States, virtually all information used to locate absent parents was collected in routine preacceptance or redetermination interviews or provided routinely on application forms.

Processing the disregard payment and recomputing the family's food stamp budget (the Food Stamp program does not disregard the \$50 collection) has proved expensive. One State estimates these added administrative costs at \$500,000 annually. Also, the provision is inequitable, since a noncooperating family can receive the disregard payment if collection efforts are successful, while a cooperating family receives no disregard payment if collection efforts are unsuccessful.

The FSA agreed that the usefulness of the disregard payment is questionable, and supported the OIG recommendation to seek legislation to eliminate the disregard provision. Estimated 5-year savings from eliminating the provision would total about \$1.9 billion (\$1.1 billion Federal share). (CIN: A-02-86-72606)

**CHILD SUPPORT  
ENFORCEMENT  
COLLECTIONS**

An OIG review found that AFDC child support collections could be increased substantially by systematically pursuing cases previously closed, modifying lower court orders and collecting overdue child support. By matching the absent parent's Social Security number (SSN) with the Social Security Administration's (SSA) earnings records, the absent parent's employer location and wage information could be obtained.

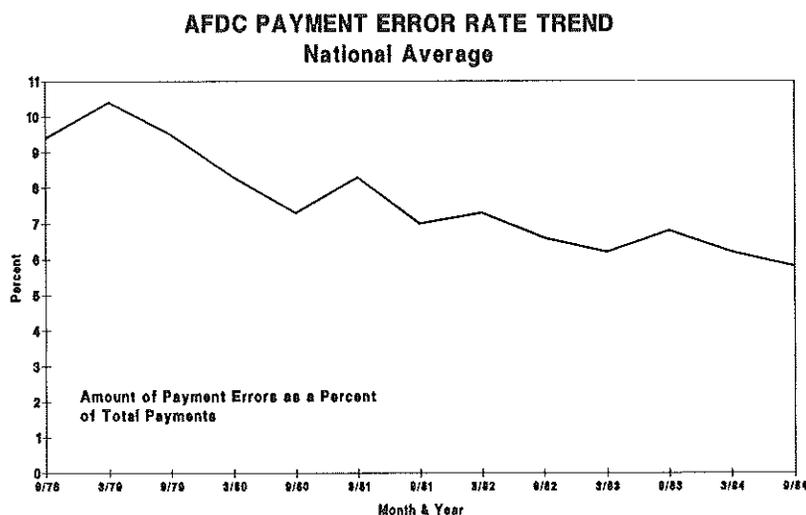
The OIG reviewed 4,684 AFDC child support cases in 12 States where no support order had been established, the monthly payment was \$50 or less per child, or where child support arrearages existed. By reopening the cases where the absent AFDC parent earns in excess of \$10,000, the OIG estimated that more than \$317 million in additional child support could be collected. The Federal share of these collections would result in savings of \$103.4 million. (OAI-05-86-00033, OAI-05-86-00034, OAI-05-86-00035, and OAI-05-86-00097)

**CHILD SUPPORT  
ENFORCEMENT—  
ABSENT PARENT  
MEDICAL LIABILITY**

A study conducted by OIG determined that if absent parents had their dependent children enrolled in available employer group health insurance, the Medicaid program would save \$33 million annually. Only 43 percent of court-issued support orders require the absent parent to provide medical support for their dependent children. Sixty percent of the absent parents' employers provide dependent group health insurance that could be used by parents to pay for their dependents' health care. In 35 percent of the cases, the absent parent already has dependent insurance yet Medicaid is paying for the child's medical care. (OAI-07-86-00045)

In FY 1985, misspent funds in the AFDC program cost Federal and State governments \$918 million based on the national error rate of 6.15 percent. In that year, only 7 of the 54 jurisdictions administering the AFDC program had reached the legally required 3 percent error rate standard for overpayments in the AFDC program. Based on the FY 1985 data, each percentage point drop in the national error rate represents an estimated annual savings of \$149 million.

### AID TO FAMILIES WITH DEPENDENT CHILDREN ERROR RATE



The OIG's study of issues relating to error reduction identified management approaches and practices that have been proven successful in reducing eligibility errors. The FSA implemented most of OIG's recommendations for specific measures they could take to assist States in their efforts to reduce errors. However, because of several on-going studies of the program, further action is not being taken at this time. In addition, the OIG provided each Governor and State AFDC director with a copy of the inspection report which highlights successful practices used by those States with an error rate less than the 3 percent national standard. (OAI-04-86-00024)

The OIG found that AFDC's failure to recognize the economies of shared living arrangements results in an annual assistance increase of \$147 million nationally to households receiving two or more AFDC grants.

### SHARED LIVING ARRANGEMENTS

Current law permits AFDC families living together to receive separate AFDC grants. However, when grant amounts are determined it does not recognize the

economies of shared living arrangements. Since each grant provides for common expenses, such as rent and utilities, a household with two or more AFDC family units receives more cash assistance than a comparable one-family AFDC household.

From a review of more than 7,800 nationally representative AFDC cases, OIG estimated that households with two or more AFDC grants receive about 20 percent, or \$147 million, more in cash assistance annually than comparably-sized households qualifying for only one grant.

The following is an example of the difference in monthly assistance using data from one State.

<u>Household A (two AFDC grants)</u>	<u>Grant amount</u>
Family 1 (1 Adult and 2 Children)	\$ 587
Family 2 (1 Adult and 1 Child)	<u>474</u>
Total, Household A	\$1,061
<u>Household B (one AFDC grant)</u>	
Family 1 (2 Adults and 3 Children)	<u>\$ 796</u>
<u>Difference</u>	<u>\$ -265</u>

Although not adopting the specific approach the OIG recommended, FSA did agree to seek legislative change to require that AFDC, like other assistance programs such as the Food Stamp program, consider the economies of shared living arrangements when determining grant amounts. (CIN: A-09-86-62615)

**EMERGENCY ASSISTANCE**

Noncompliance with the 30-day statutory limit for EA payments will cost the Federal Government at least \$110 million over the next 5 years.

Public Law 90-248 provides for EA benefits not to exceed 30 consecutive days a year to families with children under 21 who are facing destitution. The intent of the law was to provide quick help to such families under one of two circumstances: (1) while eligibility for regular AFDC benefits was being documented; or (2) if crisis assistance rather than long term aid was the family's real need.

An OIG review in two States disclosed that emergency payments are not limited to 30 days, and in some cases extend for 12 months or more. This situation exists because FSA regulations and policy transmittals extend EA coverage to include payments which arose before or extend after the 30-day emergency period.

According to an Office of General Counsel opinion, FSA cannot legally approve EA benefits beyond the 30-day limit provided by statute.

The OIG found that in FY 1986, \$18 million was claimed by two States for EA benefits paid beyond the statutory 30-day limit. Furthermore, based on FY 1987 estimates, over the next 5 years these two States alone will claim \$110 million for EA benefits not legally authorized.

The OIG recommended that FSA revise its regulations to comply with the statute. The FSA agreed with the recommendation and has developed a Notice of Proposed Rule Making (NPRM) which will restrict Federal sharing for EA benefits to no more than 30 days over any 12-month period. The NPRM is currently under review. (CIN: A-01-87-02301)

By far the largest number of successful actions involving grant recipients were taken against individuals defrauding the AFDC program, which is funded by the Department but administered by the States. Thus, most cases of AFDC fraud are prosecuted through State judiciary systems. The OIG involvement ranges from supplying documentary evidence and expert witnesses to actual investigative assistance in these cases.

#### **AID TO FAMILIES WITH DEPENDENT CHILDREN FRAUD**

To meet State income eligibility requirements for AFDC, some individuals do not inform welfare officials of income from work, pension or sponsor.

#### **AID TO FAMILIES WITH DEPENDENT CHILDREN RECIPIENTS AND CONCEALED INCOME**

- An Illinois woman was ordered to repay more than \$70,000 in welfare payments that she had obtained by lying about her income and living arrangements. She had used part of the payments to purchase an apartment building.
- In Philadelphia, a woman was sentenced to 3 years probation and ordered to make restitution of \$10,000 in AFDC funds she had obtained illegally. Investigation of a complaint determined that she was fraudulently receiving SSI benefits as the representative payee for a disabled daughter. She also had received AFDC payments while being supported by the man with whom she lived.
- A Chicago Housing Authority employee was also sentenced to 3 years probation, fined \$2,000 and ordered to repay \$7,000 in AFDC and survivors benefits she had illegally obtained. Less than 60 days after being interviewed by OIG agents about concealing her employment and remarriage to collect SSA benefits on her first husband's account, she filed a false AFDC claim in

which she failed to report sick leave income and continued receipt of child's benefits for one of her sons.

- In California, a woman had to repay more than \$31,000 after follow-up on an anonymous tip that she was receiving a private pension income while obtaining SSI and AFDC benefits.
- An Oklahoma court sentenced a woman to 2 years imprisonment, 5 years probation and full restitution of nearly \$47,000 for using an SSN other than her own to obtain AFDC payments.
- Another woman employed under a fictitious SSN as a housekeeper in an Illinois hotel had to repay \$12,000 in AFDC benefits.

#### **ILLINOIS WELFARE PROJECT**

An Illinois project nearing completion, in which records of welfare recipients were matched against persons filing joint State income tax returns, has resulted thus far in 82 convictions and more than \$2.5 million in restitutions ordered. The following cases are examples of successful actions.

- One man was given 5 years probation, 400 hours of community service and more than \$26,000 in fines and restitutions when it was found that he was living with and supporting his wife while getting benefits. He also had to enroll in an alcohol program and receive psychological treatment and vocational training.
- Another man was placed on a pretrial diversion program for 12 months for his part in a scheme through which his wife received welfare benefits while they were living together and he was earning substantial wages. His wife had been sentenced previously to 4 years probation, ordered to make full restitution of almost \$25,000 and required to perform 250 hours of community service.

#### **MULTI-JURISDICTIONAL FRAUD IN AID TO FAMILIES WITH DEPENDENT CHILDREN PROGRAM**

Because the AFDC program is administered at separate local jurisdictions, some individuals believe they have an opportunity to obtain payments from one without the knowledge of the other, as illustrated in the following examples:

- A Wisconsin woman ended up receiving a prison sentence as the result of a 20-month stretch of receiving AFDC payments from welfare offices in three different counties. She used up to nine different aliases and several SSNs which had not been issued to her.
- A Chicago woman was sentenced to 3 years probation, \$3,000 restitution and 200 hours of community service for a scheme whereby she received AFDC payments in one State while working in another. The woman applied

for AFDC in Minnesota using her sister's address. Once she received approval, she returned to Chicago and began working. The sister held her AFDC checks until she went to Minnesota to cash them.

A computer match and follow-up investigations were launched in Wisconsin and Indiana by OIG, in cooperation with State officials, to uncover instances in which persons were receiving AFDC benefits in more than one State. The investigative scope was expanded when OIG discovered numerous incidents of AFDC recipients making a variety of false statements, which resulted in sizable program losses. During this reporting period, nine persons were convicted, and more than \$100,000 was ordered in restitution.

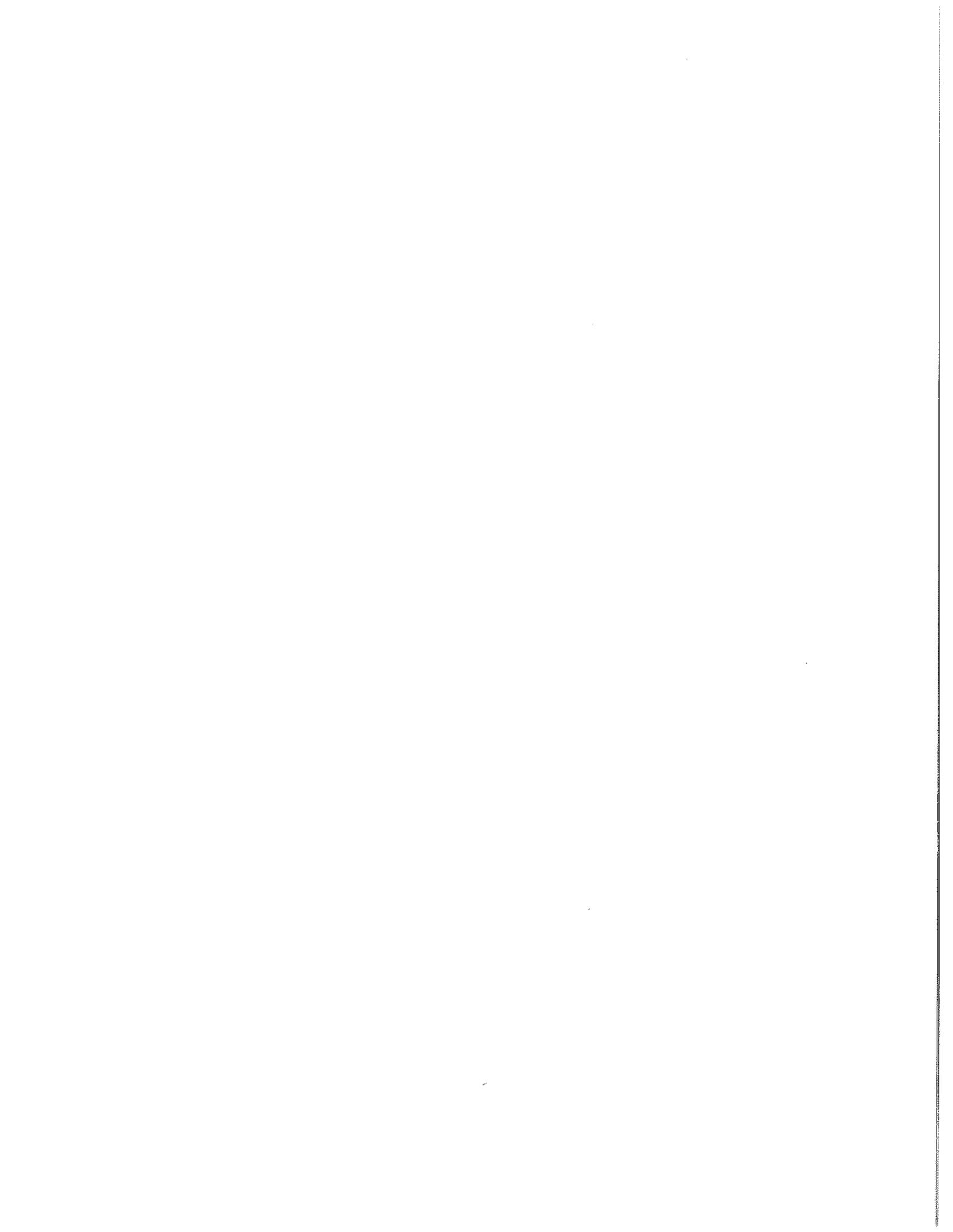
**WISCONSIN AND  
INDIANA AID TO  
FAMILIES WITH  
DEPENDENT  
CHILDREN**

The auditor for an Illinois agency which administers the Department's LIHEA program was sentenced to repay almost \$10,000 and perform 500 hours of community service. Investigations showed that the auditor had embezzled the money to open a videotape rental company.

**GRANTEE AUDITOR  
FRAUD**



**OFFICE OF HUMAN DEVELOPMENT SERVICES**



## Chapter VI

### OFFICE OF HUMAN DEVELOPMENT SERVICES

During this reporting period, the Office of Inspector General (OIG) identified questionable grantee charges to the Office of Human Development Services (OHDS) programs of over \$8.4 million.

#### STATISTICAL ACCOMPLISH- MENTS

The OHDS oversees a variety of programs that provide social services to the Nation's children, youth and families, disabled, older Americans and Native Americans.

#### PROGRAM OVERVIEW

Title IV-E of the Social Security Act provides for the care and protection of children in the Aid to Families with Dependent Children program who have been removed from the homes of relatives and placed in foster care. Such placements usually result from a judicial determination that continuance in the care of relatives would be contrary to the children's welfare. Implementing regulations provide that only payments to individuals or nonprofit child care institutions are eligible for Federal cost-sharing.

#### FOSTER CARE PAYMENTS

An OIG review in one State showed that for a 6-year period ending June 30, 1986, the State improperly claimed over \$1 million in Federal funds for payments made to profit-making child care institutions under the AFDC foster care program. The improper claims occurred because counties within the State incorrectly coded profit-making child care institutions as nonprofit or did not screen foster care claims.

The OIG recommended that the State make a financial adjustment totaling \$1 million and appropriate procedural changes. The State deferred action pending OHDS resolution of other foster care cost issues. (CIN: A-09-86-62641)

As the result of a joint investigation with State agents, the last of 20 persons was convicted of fraudulently obtaining funds through a Texas community action council. The council had contracted with the State to provide day care services and received Federal grant funds administered by the Department. After a review of 60 sample cases billed to the State showed numerous discrepancies, investigation uncovered total overpayments of more than \$92,000.

#### DAY CARE CONTRACT FRAUD

**COMMUNITY  
SYSTEMS  
DEVELOPMENT  
UNDER THE OLDER  
AMERICANS ACT**

An OIG inspection on selected area agencies on aging (AAAs) that had created comprehensive systems of services within their area found that the AAAs generally have been successful in community systems development which they universally consider their highest priority. Most AAAs identify closely with statewide networks, but are less knowledgeable about aging developments in other parts of the country. The Administration on Aging (AOA) is not regarded as a strong national leader by the AAAs visited. As a result of these findings, OIG recommended that AOA step up efforts to play a greater national leadership role to strengthen the national aging network.

The Older Americans Act provides for the establishment of a network of State and area agencies on aging to assist local communities in the development of comprehensive systems of services for the elderly. A companion report was also issued which described 17 innovative practices identified during site visits to 17 States and 25 AAAs around the country. (OAI-03-86-00038)

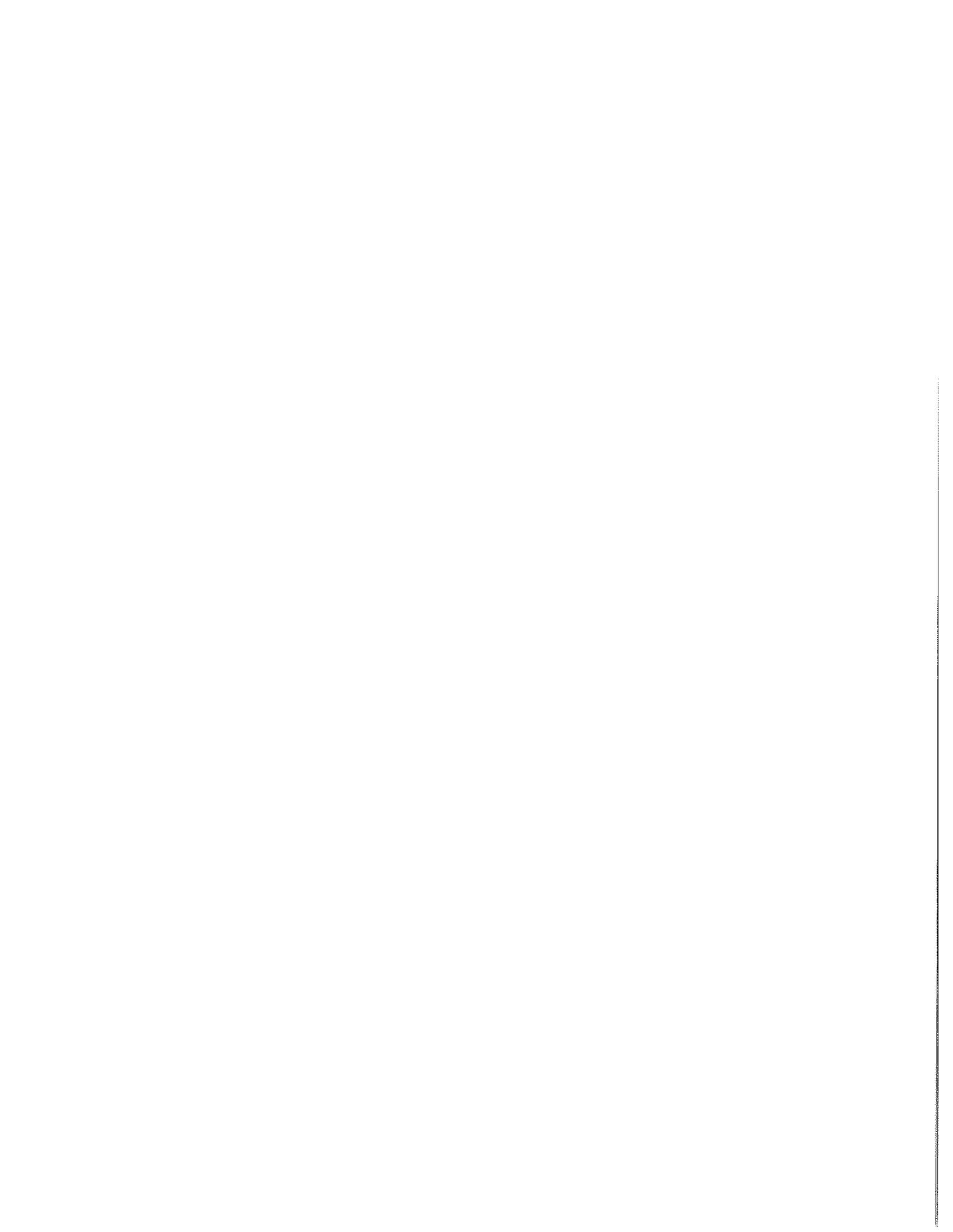
**QUESTIONED  
COSTS**

In addition to the unallowable foster care charges described on page 65, OIG reports identified a number of other questionable costs charged to OHDS programs. These reports included results of OIG reviews as well as those conducted by nonfederal auditors, such as State audits of the OHDS social services block grant program and independent audits of Head Start and other OHDS grant programs.

As discussed more fully in Chapter I, OIG prior to issuance, reviews all nonfederal audit reports for matters that require immediate action such as possible fraud or abuse, conformance to established Federal standards and guidelines as well as findings that require departmental action. Following are examples of OIG and nonfederal audit results during the last 6 months.

- A single audit report of a social services block grant by the State auditor disclosed that the State had overcharged the block grant program \$316,000 in indirect (overhead) costs. An appropriate financial recovery was recommended. (CIN: 05-87-05765)
- The same single audit discussed above identified unauthorized use of foster care funds. In this instance, \$204,000 in funds authorized for one foster care activity were used to finance another without prior OHDS approval. (CIN: 05-87-05765)
- An independent audit disclosed that a county Head Start program had earned interest income of \$382,000 on Federal program funds without appropriate credit to the Federal Government. These earnings were recommended for recovery. (CIN: 09-87-05205)

# APPENDIX A



## APPENDIX A

### BUDGETARY SAVINGS AND RECOVERIES APRIL 1987 THROUGH SEPTEMBER 1987

This appendix summarizes the dollar consequences of legislative, programmatic, judicial and administrative actions in favor of OIG audit, inspection and investigative reports during this period.

- I. **LEGISLATIVE SAVINGS**—This schedule documents the budgetary savings resulting from legislative actions on OIG recommendations. Savings are calculated using Congressional Budget Office (CBO) budget cycle figures pursuant to Public Law 98-344 (as amended) unless otherwise referenced. The amounts shown, totaling \$1,815 million for this period, represent funds or resources that will result in budgetary savings. Total legislative savings for FY 1987 amount to \$4,928 million.

OIG RECOMMENDATIONS	STATUS	SAVINGS IN MILLIONS
<b>PPS Capital Costs:</b>		
Discontinue inappropriate inappropriate Medicare PPS payments for hospital capital costs. (ACNs: 14-52083, 09-52032, 09-52002, 09-52020)	Section 9303 of the Omnibus Budget Reconciliation Act (OBRA) of 1986 reduced capital-related payments to PPS hospitals by 3.5 percent for FY 1987 cost reporting periods; by 7 percent for FY 1988 reporting periods; and by 10 percent for FY 1989 reporting periods. The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119) temporarily froze payments for the first 51 days in FY 1988 at 3.5 percent.	\$1,100
<b>PPS Hospital Profits:</b>		
OIG report and testimony pointed out that PPS payments should take into account large Medicare profits being earned by hospitals. (ACN: 09-62021)	Section 9302 of the Omnibus Budget Reconciliation Act of 1986 limited the FY 1987 increase in PPS payments to 1.15 percent.	\$340.0

	<b>SAVINGS IN MILLIONS</b>
● Amounts not refunded to the Federal Government—North Carolina— CIN: A-04-87-05000	\$9.1
● Uncollected overpayments to Medicaid institutional providers not credited to the Federal account—Pennsylvania—CIN: A-03-87-00200	\$9.1
● Undocumented and/or unallowable costs incurred for a variety of FSA and OHDS programs—Pennsylvania—CIN: A-03-87-06056	\$1.6
● Unallowable Medicaid costs claimed by State-owned Intermediate and Skilled Nursing Care Facilities—Arkansas—CIN: A-06-86-60154	\$2.6
● Payments to ineligible Medicaid recipients and incorrect payments to recipients under the Low Income Home Energy Assistance Program—Connecticut— CIN: A-01-87-05017	\$6.0
● Internal service fund surplus included amounts derived from overcharges to Federal programs—North Carolina—CIN: A-04-86-60505	\$1.6
● Public assistance program costs identified as unallowable by State auditors were not timely refunded to the Federal Government—California— CIN: A-09-86-62620	\$1.0
● Unallowable AFDC administrative costs which did not benefit the AFDC program—New York City—CIN: A-02-86-60252	
● Other audit determinations, complete listing is available upon request.	\$26.8

---

IV. INVESTIGATIVE RECOVERIES—This schedule represents the dollar amounts of fines, savings, restitutions, settlements and recoveries determined through judicial or administrative processes in support of OIG investigative findings. These figures include ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds, departmental programs and other entities victimized by fraud and abuse. A total of \$23.4 million resulted during this period and \$73.4 million for FY 1987.

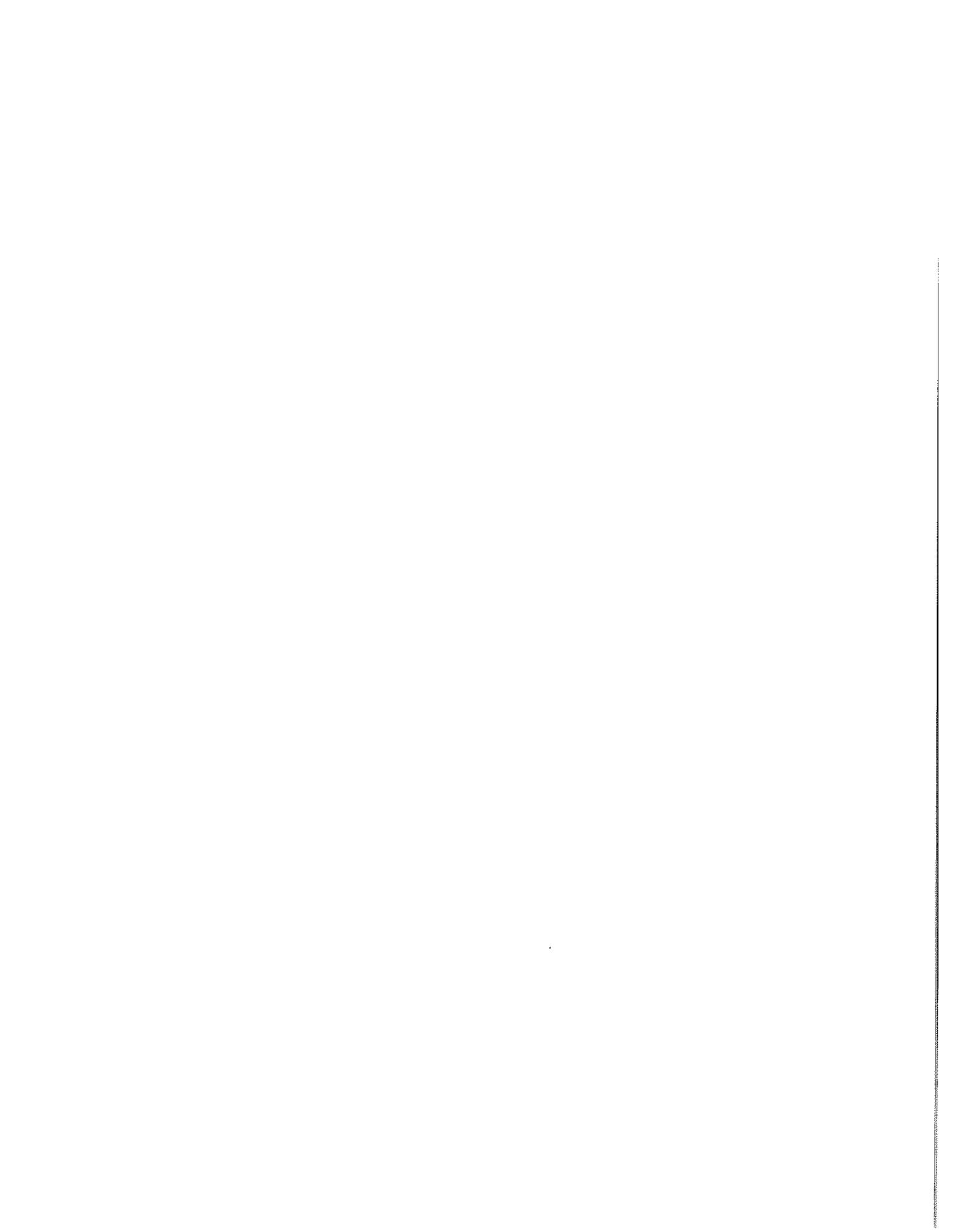
---

	<b>SAVINGS</b>
● Restitutions for scheme to collect unemployment insurance in Massachusetts using multiple SSNs	\$1,275,800
● Recoveries from Medicare check thefts in New York	\$775,000
● Recoveries from project on illegal sales of drugs	\$466,900
● Restitution from South Carolina mortgage company officials for false costs reports for nursing homes	\$452,000
● Restitutions and fines for scheme to collect unemployment insurance in Michigan using false identifies and SSNs and defunct or self-owned companies	\$354,000
● Restitution from California physician for falsely billing Medicaid for prescriptions	\$250,000
● Restitution from Colorado man for bank fraud and misuse of SSN	\$198,700
● Restitution and fines from a Pennsylvania radiologist for duplicate Medicare billings for doppler studies	\$170,600
● Recoveries from Kansas psychologist for Medicare claims for psychological testing of patients in adult care facilities which was actually performed by uncertified psychologist assistants	\$152,000
● Restitution and fines from a New York orthopedist for billing Medicare for surgery he did not perform	
● Restitution and fines from Indiana company for billing Medicare for ambulance services when wheelchair services were actually provided	\$120,000

---

	<b>SAVINGS</b>
● Restitution, fines and penalties for false Medicaid billings in California for supplies for community care facilities	\$114,000
● Recoveries from New York case involving kickbacks to doctors and illegal billing of Medicaid for ambulance services	\$108,600
● Settlement with hospital for improper billing for services rendered by nonphysicians, inadequate documentation and wrong billing codes	\$450,000
● Settlement with a clinic for falsely billing therapy for nursing home patients as psychological testing	\$347,000
● Restitution, penalties and interest from anesthesiologists for billing Medicaid for services actually performed by hospital staff anesthesiologists	\$320,000
● Penalties and assessments from a physician for Medicare claims for non-covered services or services not rendered	\$225,000
● Settlement with dentist for billing Medicaid for services not rendered	\$104,100
● Other civil monetary penalties which did not meet the \$100,000 threshold for individual reporting	\$4,484,000
● Other investigative recoveries and savings which did not meet the \$100,000 threshold for individual reporting	\$12,907,000

## **APPENDIX B**



## APPENDIX B

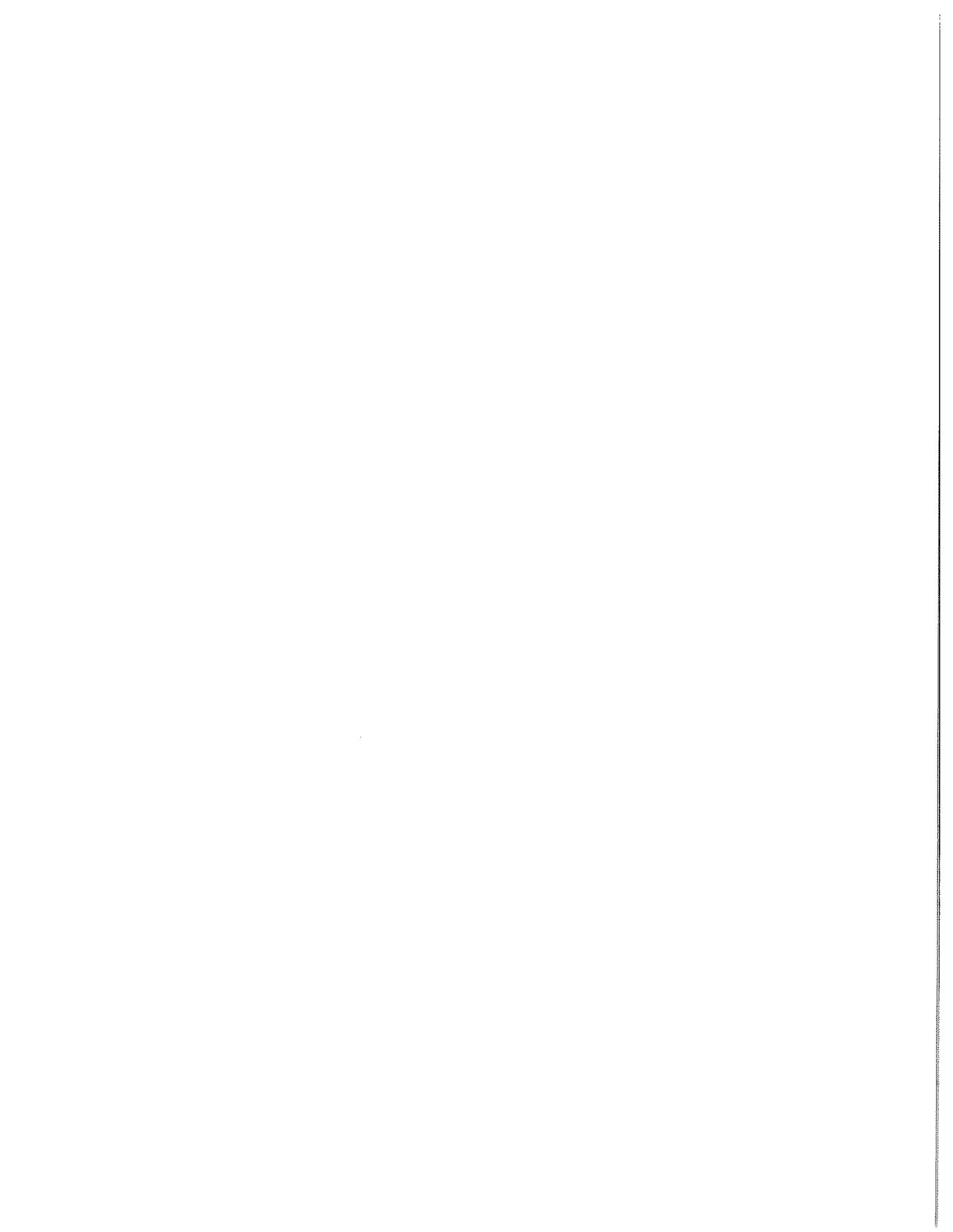
**DOLLAR CONSEQUENCES OF OIG FINDINGS AWAITING ACTION  
APRIL 1987 THROUGH SEPTEMBER 1987**

I. UNENACTED LEGISLATIVE RECOMMENDATIONS—This schedule represents the estimated savings over the budget cycle that could be realized if concurred in by the Congress and the Administration through legislative action.

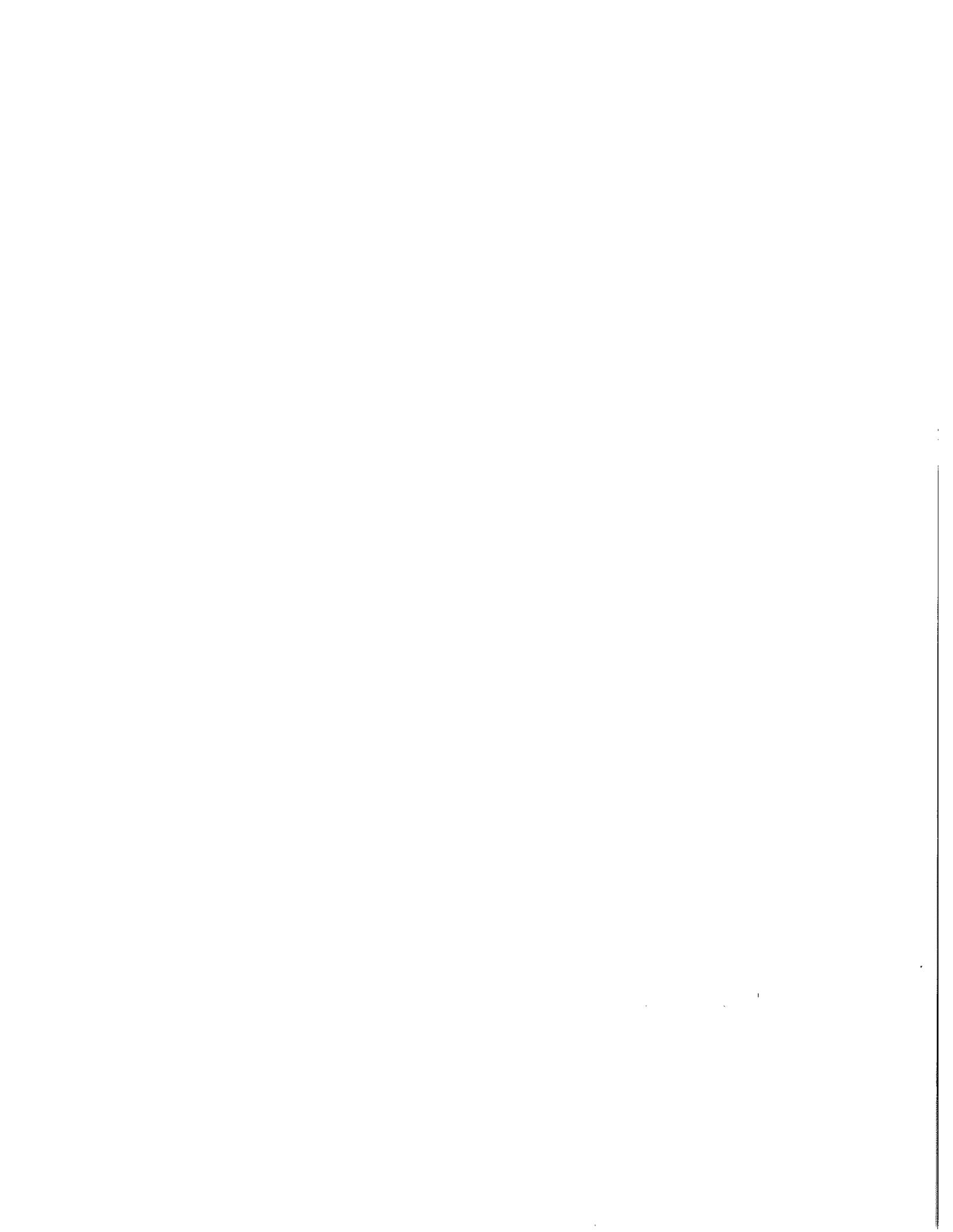
OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
<b>Matching Rates:</b>		
Eliminate premium matching rates under Medicaid. (ACN: 03-60223)	This proposal is included in the President's FY 1988 budget and legislative program.	\$385
<b>Medicare Deductibles:</b>		
Raise the Medicare Part B deductible to \$100 and appropriately index it. (ACN: 09-52043)	The President's FY 1988 budget includes a proposal to index the deductible to the Medicare Economic Index.	\$1,400
<b>Rounding Medicare Premiums:</b>		
Round Medicare Part B premium up to the next higher dollar. (ACN: 09-52008)	This proposal has not been included in the President's FY 1988 budget and legislative program.	\$875
<b>Buy-In Program:</b>		
Eliminate Federal financial participation in monthly Part B premiums paid by States on behalf of Medicaid recipients eligible for Medicare (Buy-In program). (ACN: 03-50228)	This proposal is not included in the President's FY 1988 budget and legislative program. However, the President's program includes a proposal to double the amount of the premium paid by States from 25 percent to 50 percent of program costs.	\$1,270

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
<p><b>Multiple Visits in SNFs:</b> Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals. (ACN: 03-42005)</p>	The HCFA has not adopted the multiple visit concept.	\$240.0
<p><b>Ambulance Claims:</b> Consider requiring use of "place-of-service" coding to detect non-covered ambulance services billed to Medicare. (ACN: 04-62006)</p>	The HCFA has not completely implemented corrective action.	\$64.0
<p><b>Pacemaker Monitoring:</b> Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower-paying routine service. (ACN: 08-52017)</p>	The HCFA issued guidelines as part of studies mandated by the Deficit Reduction Act of 1984, and is exploring alternative approaches to the problem.	\$6.0
<p><b>Late Payments to SSA:</b> The SSA should take the necessary regulatory steps to implement procedures for assessing interest on late State supplementation contributions. (ACN: 13-52637)</p>	The SSA disagreed on grounds that charging interest would not be cost-effective.	\$1.3
<p><b>Medicare as Secondary Payer - Automobile Accident Related Claims:</b> Under the provisions of the MSP program, HCFA should ensure identification of all beneficiaries involved in automobile accidents and uncovered by auto or liability insurance. (OAI-07-86-00092)</p>	The HCFA has concurred with OIG findings and is in general agreement with OIG recommendations.	\$15.2
<p><b>Child Support Enforcement - Absent Parent Medical Liability:</b> The FSA should enforce the provisions in regulations that require petitioning of courts for insurance coverage of dependent children. (OAI-07-86-00045)</p>	The FSA has concurred with OIG findings and is in general agreement with OIG recommendations.	\$111.0

OIG RECOMMENDATIONS	STATUS	PROJECTED SAVINGS IN MILLIONS
<p><b>Medicare as Secondary Payer - End Stage Renal Disease:</b> Under the provisions of MSP, HCFA should ensure identification of all ESRD beneficiaries covered by employee group health plans, and that proper billing for services has been made. (OAI-07-86-00092)</p>	The HCFA has concurred with OIG findings and recommendations and is developing instructions to fiscal intermediaries.	\$19.6
<p><b>Child Support Enforcement:</b> The FSA should require States to annually match SSNs of absent parents of AFDC children without support orders, with low support orders or in arrears against SSA's earnings records. Cases where the absent parent earns in excess of \$10,000 would be reopened. (OAI-05-86-00097)</p>	The FSA has agreed with OIG's findings. The FSA is arranging with SSA for States to obtain the required information where SSNs cannot be matched at the State level.	\$103.4
<p><b>Organ Acquisition Costs:</b> The HCFA should include Medicare costs for organ acquisition under the diagnostic related group system. (OAI-01-86-00108)</p>	The HCFA agrees in principle with the recommendations but requires additional investigation of the issues and development of cost data prior to reaching decisions on implementation.	\$37.5
<p><b>Access of Dialysis Patients to Kidney Transplantation:</b> The OIG sent to HCFA a series of recommendations that would help ensure that dialysis patients are afforded a full and fair opportunity to receive a kidney transplant. (OAI-01-86-00107)</p>	Both HCFA and PHS are collaborating with professional societies to develop guidelines for patient transplant suitability.	\$18.3
<p><b>Coronary Artery Bypass Graft Surgery:</b> The HCFA should negotiate selective contracts for CABG surgery and create a demonstration project involving package pricing. (OAI-09-86-00076)</p>	The HCFA has agreed to consider proposals for package pricing of CABG surgery at selected sites.	\$192.0



## APPENDIX C



## APPENDIX C

### PROFESSIONAL ARTICLES AUTHORED BY OIG STAFF

Champion, Phyllis R. and Siegel, Norman: "The OIG's Role in the PRO Sanctioning Process." *OCR Advisor*, May 1987.

The article outlined the role and the internal review process of the OIG in the peer review organization (PRO) sanctioning process that was in effect at the time the article was published.

Daugherty, Bruce: "Federal Credit Management and Debt Collection Improvements Act of 1987." *Association of Government Accountants Newsletter*, September 1987.

The article outlined provisions contained in a Senate bill (S.1270) intended to improve the Federal Government's management of debt collection.

Greer, Joanne G. and Greer, Thomas V.: "National Image: The Concept and Its Measurement." *Proceedings of the Joint International Conference of the American Marketing Association and the National University of Singapore*, Chicago, 1987.

This paper analyzed perceptions of the citizens of one country held by citizens of another country, and especially focused on perceptions about the United States held by citizens of Third World countries.

Greer, Joanne G. and Greer, Thomas V.: "Part I: Resources Allocation, Control, and Accountability: Problems in Evaluating Cost and Benefits of Social Programs." *Managing Finances, Personnel, and Information in Human Services, Second Edition*, Simon Slavin (ed), New York: Haworth Press, pp. 94-106, 1986.

This paper addressed the inconsistencies encountered across accounting systems and record keeping systems when attempting to place a dollar value on programmatic changes or initiatives.

Keene, Wallace O. and Ferris, John A.: "Framework for Management Control Over Federal Automated Systems." *Association of Government Accountants Newsletter*, September 1987.

The article described the "Model Framework for Management Control Over Automated Information Systems," a document which integrates a set of 55 EDP control requirements from numerous directives.

Krushat, Mark: "How will Diagnosis-Related Groups Affect Epidemiology Research?" *The American Journal of Epidemiology*, Volume 126, Number 1, July 1987.

The article presented a typology for the various, hypothesized effects that DRG coding may have for the future of epidemiological research using hospital records.

Mendicello, Edward P. and Drissell, Kayleen: "Medicaid Fraud Investigations." *Colorado Welfare Fraud Newsletter*, March 1987. (Reprinted in *The Law Enforcement Coordinating Committee Newsgram*, January 1987.)

The article described the Medicaid program in Colorado, outlining what services are mandatory, what services may be optionally provided, who qualifies and who in Colorado is responsible for investigating fraud and abuse of the Medicaid program.

Molnar, Jack: "Putting Computer-Related Crime in Perspective." *Journal of Policy Analysis and Management*, Volume 6, Number 4, Summer 1987.

The article stressed that most computer crimes are committed by data entry employees, not by hackers or high tech staff, and encouraged managers not to become so concerned with high tech criminals that they let their systems remain vulnerable to their data entry staff.

Raum, Jean: "The Social Security Program Today." *Association of Government Accountants Newsletter*, September 1987.

The article provided a brief overview of recent congressional actions to assure solvency of the SSA trust funds.

Snyder, Dennis W.: "Financial Statements for Government Organizations." *Association of Government Accountants Newsletter*, September 1987.

The article addressed the requirements that Federal agencies prepare financial statements which reflect the overall position and results of operations for the Government entity on an annual basis as required by Title 2 of the *GAO Policy and Procedures Manual for Guidance of Federal Agencies*, revised November 14, 1984.

Walsh, Donna M. and Drissell, Kayleen: "Misused Social Security Numbers." *Colorado Welfare Fraud Council Newsletter*, December 1986. (Reprinted in the *Law Enforcement Coordinating Committee Newsgram*, April 1987.)

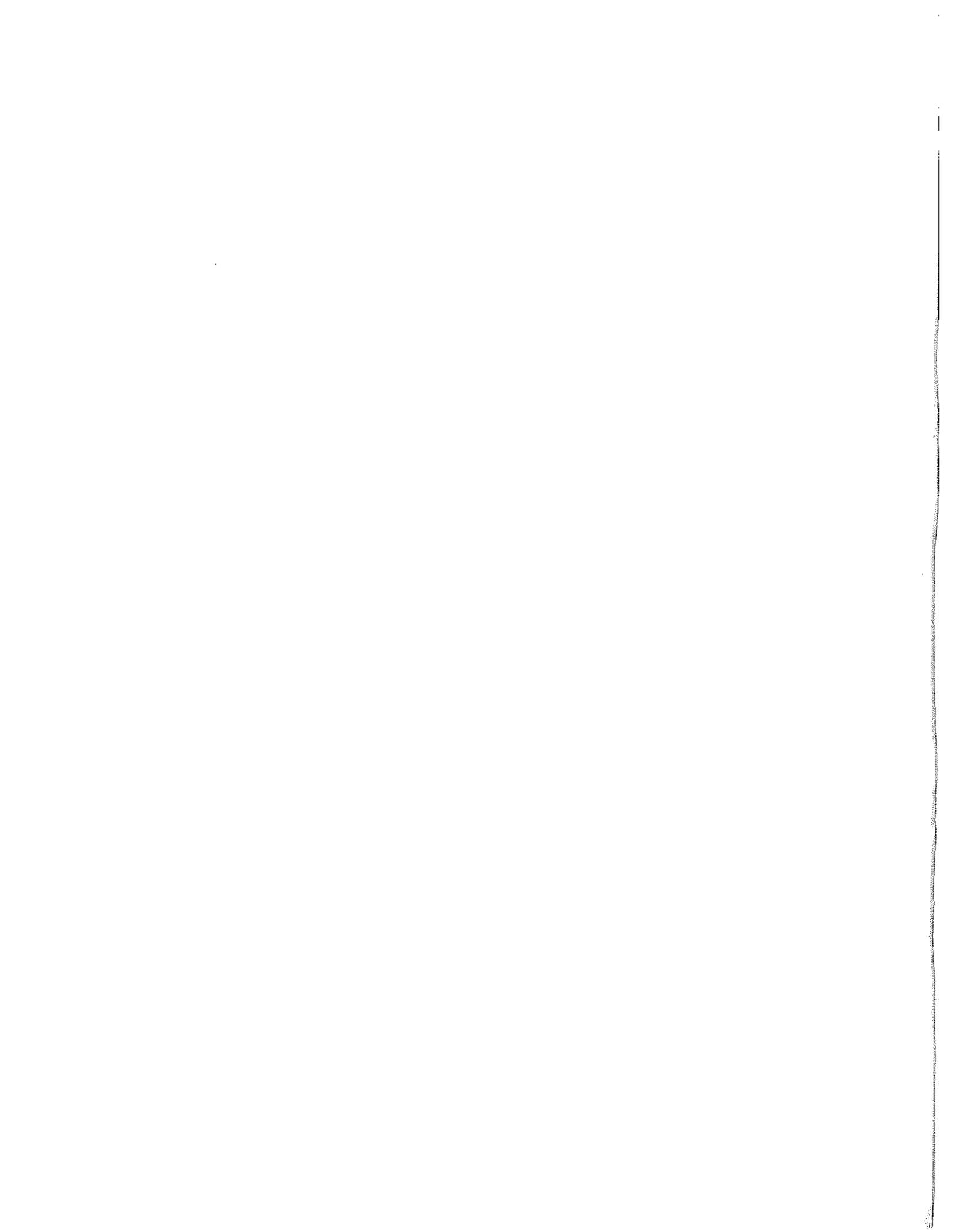
The article described violations, both State and Federal, which occurred when Social Security numbers were used improperly. It discussed data which is available when criminal violation of the program has occurred and informed the reader who to contact when a Social Security program violation is suspected.

White, William A. III: "Social Security Number Fraud is a Felony." *Alabama Peace Officers Journal*, Summer 1987. (Reprinted in the *Alabama Police Journal*, Winter 1987.)

The article outlines Social Security Number violations and the assistance that OIG can furnish in these cases.

Yessian, Mark and Handley, Elisabeth: "Overview of State Medical Disciplines." *Journal of American Medical Association*, February 1987.

The article was an outgrowth of an OIG study concerning medical licensure and discipline.



**DEPARTMENT OF  
HEALTH & HUMAN SERVICES**

Office of Inspector General  
330 Independence Avenue, S.W.  
Washington, D.C. 20201

---

Official Business  
Penalty for Private Use \$300



Postage and Fees Paid  
U.S. Dept. of H.H.S.  
HHS-391