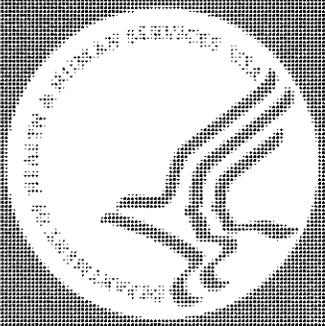
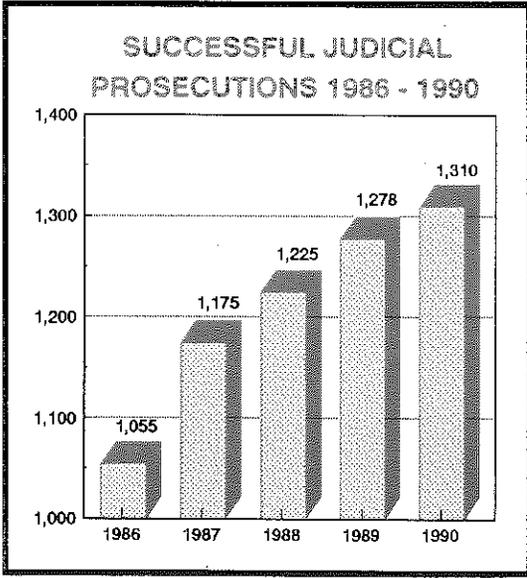
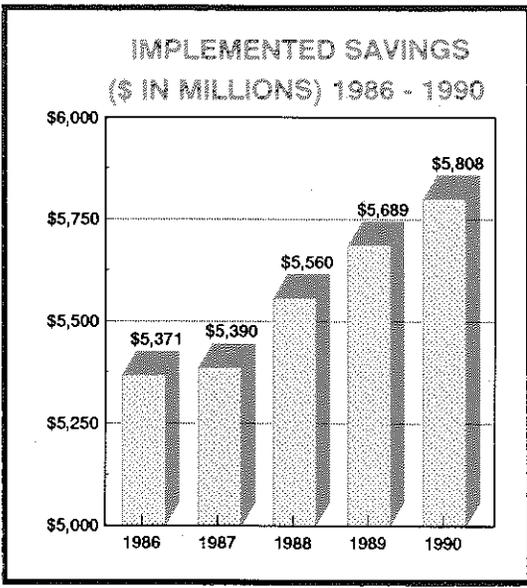
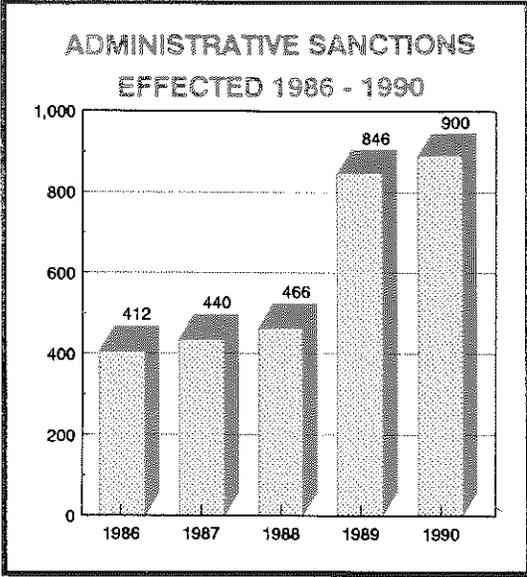


Shaw



Semiannual Report

April 1, 1990 -
September 30, 1990

Office of Inspector General

Richard P. Kusserow
Inspector General

STATUTORY AND ADMINISTRATIVE

RESPONSIBILITIES

The Inspector General Act of 1978 (Public Law 95-452), as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to the Congress. A selection of other statutory and administrative reporting and enforcement responsibilities and authorities are listed below:

AUDIT AND MANAGEMENT REVIEW RESPONSIBILITIES AND OFFICE OF MANAGEMENT AND BUDGET CIRCULARS

P.L. 96-304	Supplemental Appropriations and Rescissions Act of 1980
P.L. 96-510	Comprehensive Environmental Response, Compensation and Liability Act
P.L. 97-255	Federal Managers' Financial Integrity Act
P.L. 97-365	Debt Collection Act of 1982
P.L. 98-502	Single Audit Act of 1984
P.L. 99-499	Superfund Amendments and Reauthorization Act of 1986
P.L. 100-504	Inspector General Act Amendments of 1988
P.L. 101-121	Governmentwide Restrictions on Lobbying

Office of Management and Budget Circulars:

A- 21	Cost Principles for Educational Institutions
A- 25	User Charges
A- 50	Audit Follow-up
A- 70	Policies and Guidelines for Federal Credit Programs
A- 73	Audit of Federal Operations and Programs
A- 76	Performance of Commercial Activities
A- 87	Cost Principles for State and Local Governments
A- 88	Indirect Cost Rates, Audit, and Audit Follow-up at Educational Institutions
A-102	Uniform Administrative Requirements for Assistance to State and Local Governments
A-110	Uniform Administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and Other Nonprofit Organizations
A-120	Advisory and Assistance Services
A-122	Cost Principles for Nonprofit Organizations
A-123	Internal Controls
A-127	Financial Management Systems
A-128	Audits of State and Local Governments
A-129	Managing Federal Credit Programs
A-133	Audits of Institutions of Higher Education and Other Nonprofit Institutions

General Accounting Office "Government Auditing Standards"

CRIMINAL AND CIVIL INVESTIGATIVE AUTHORITIES

Criminal investigative authorities include:

- Title 18, United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs
- Title 42, United States Code, sections 261, 263a(l), 274e, 290dd-3, 300w-8, 300x-8, 406, 408, 707, 1320a-7(b) and 1383(d), the Social Security and Public Health Service Acts
- Title 26, United States Code, section 7213
- Title 5, United States Code, section 552a(i)

Civil and administrative investigative authorities include over 75 civil monetary penalty and exclusion authorities such as those at:

- Title 42, United States Code, sections 1320 a-7, 1320 c-5, 1395l, 1395m, 1395u, 1395dd and 1396b, the Social Security Act
- Title 31, United States Code, section 3802, the Program Fraud Civil Remedies Act

FOREWORD

I am pleased to submit this semiannual report on the activities of the Department's Office of Inspector General (OIG) for the 6-month period ending September 30, 1990. This Semiannual Report of the U.S. Department of Health and Human Services (HHS) OIG is being issued in accordance with the provisions of the Inspector General Act of 1978 (Public Law 95-452), as amended.

The OIG has statutory authority and responsibility to protect the integrity of departmental programs and the health and welfare of the beneficiaries of those programs. The OIG ensures that HHS services are provided as intended, in an effective manner and at the lowest reasonable cost.

While all managers are responsible under the Federal Managers' Financial Integrity Act for identifying potential for loss, for establishing and evaluating controls and strengthening safeguards where needed, OIG provides the oversight required to ensure that these systems of checks and balances are in place and working effectively. In addition, OIG takes part in coordinating Governmentwide activities to reduce fraud, waste and abuse and to improve management processes.

The OIG's work also covers the five operating divisions of the Department. Each operating division is covered in a separate chapter in this report:

- The Health Care Financing Administration (HCFA) administers the Medicare and Medicaid programs.*
- The Social Security Administration (SSA) manages the Nation's Retirement, Survivors and Disability Insurance program, the Supplemental Security Income (SSI) program and Part B of the Special Benefits to Disabled Coal Miners (Black Lung) program.*
- The Public Health Service (PHS) promotes biomedical research, disease cure and prevention, and the safety and efficacy of marketed food, drugs and medical devices, measures the impact of toxic waste sites on health, and conducts other activities designed to ensure the general health and safety of American citizens.*
- The Family Support Administration (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.*

- *The Office of Human Development Services (HDS) includes a variety of programs that provide social services to American children, families, older Americans, Native Americans and the Nation's developmentally disabled.*

The OIG is comprised of three components - the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. A complete listing of OIG audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

The Office of Audit Services (OAS) is responsible for conducting audit services for HHS and overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

The Office of Investigations (OI) conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by service providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute provider fraud and patient abuse in the Medicaid program.

The Office of Evaluation and Inspections (OEI) conducts short term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress and the public. The inspection reports provide policy makers and managers with analyses and recommendations which can be used to improve the cost efficiency of departmental programs, the quality of service that the programs provide to clients and the laws that govern the programs.

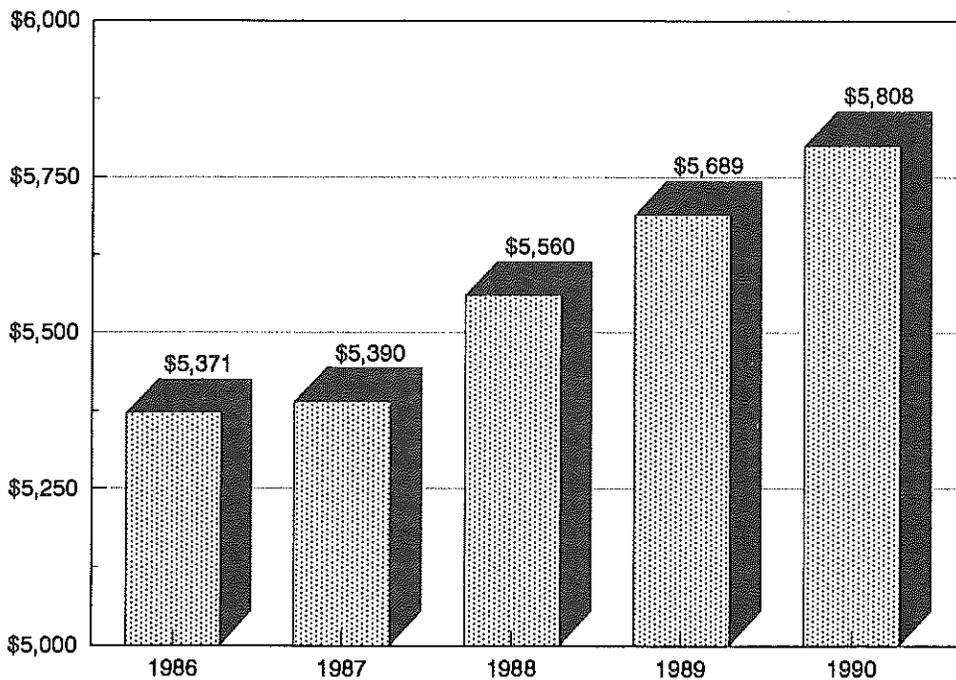
We wish to acknowledge the support and cooperation of departmental managers and Members of the Congress, without which our achievements would not have been possible.

*Richard P. Kusserow
Inspector General*

REPORT HIGHLIGHTS

Monetary Benefits - Over the last 5-year budget cycle, \$27.8 billions of dollars in settlements, fines, restitutions, receivables and savings have resulted from Office of Inspector General (OIG) activities and implementation of OIG recommendations.

**IMPLEMENTED SAVINGS (\$ IN MILLIONS)
1986-1990**



The following items highlight monetary benefits resulting from OIG activities and implementation of OIG recommendations made during the second half of the fiscal year:

- By accelerating the payroll tax deposits of large employers, the Social Security Administration (SSA) will save \$3.1 billion. (Page A-1)
- The Health Care Financing Administration (HCFA) will save \$64 million by requiring Medicare carriers to implement effective claims screening procedures to detect noncovered ambulance services. (Page A-1)

- By encouraging the States to perform systematic reviews of all child support cases to establish new support orders or modify existing ones where appropriate, the Family Support Administration (FSA) will save over \$43 million in the first year. (Page A-1)
- The HCFA will save \$35 million annually by requiring that actual time, rather than rounded time, be the basis for computing Medicare payments for anesthesia services. (Page A-1)
- The Office of Child Support Enforcement has revised their audit guide to reflect the regulatory provision requiring a check for potential medical coverage for all eligible children, resulting in savings of \$32 million annually. (Page A-2)
- The PHS will save \$10 million in the first year by establishment of a ceiling salary of \$120,000 for individuals involved in federally sponsored research supported by funds from the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration. (Page A-2)

The following items highlight OIG findings and recommendations made during the second half of the fiscal year which, if implemented, would result in significant cost savings or recoveries:

- The OIG recommended that the Office of Human Development Services pursue legislative and policy changes to limit the amount of foster care administrative costs the States can claim, which would result in potential savings of as much as \$2.3 billion over 5 years. (Page 84)
- The OIG determined that the Government could save at least \$537 million by reducing the Fiscal Year 1991 appropriation for State Legalization Impact Assistance Grants. (Page 77)
- The OIG estimates that \$205 million in improper Medicaid payments have been made to five States for services ineligible for Federal financial participation. (Page 40)
- An OIG inspection found that HCFA could save over \$55 million per year if Medicare payments for intraocular lenses were reduced to no more than \$150. (Page 25)
- The OIG recommended that SSA issue original Social Security numbers for noncitizens based on electronic transfer of data collected by the Immigration and

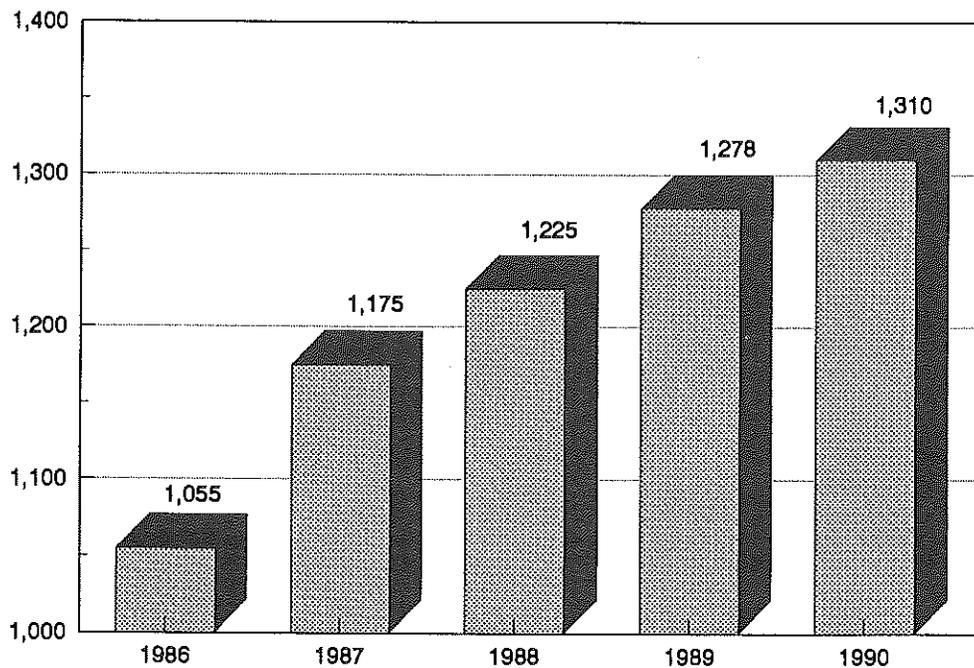
Naturalization Service and the Department of State, resulting in annual cost savings of more than \$8.2 million. (Page 55)

Internal Control Weaknesses - The Federal Managers' Financial Integrity Act (FMFIA) requires Federal agency heads to establish a continuous process for the evaluation and improvement of the internal administrative, accounting and financial control systems for which they are responsible, and to report annually to the President and the Congress on the status of their internal control and accounting systems.

Chapter I discusses OIG's role in the Department's FMFIA program. In addition, Chapters II, III, IV and VI discuss material weaknesses in the internal control systems of the Department's operating divisions. The OIG tracks the most significant nonmonetary findings and recommendations and publishes them in a separate report called Program and Management Improvement Recommendations (the Orange Book).

Successful Judicial Prosecutions - As a result of investigations by OIG over the past 5 fiscal years, numerous individuals and entities were successfully prosecuted for engaging in crimes against HHS programs as illustrated below.

SUCCESSFUL JUDICIAL PROSECUTIONS 1986 - 1990

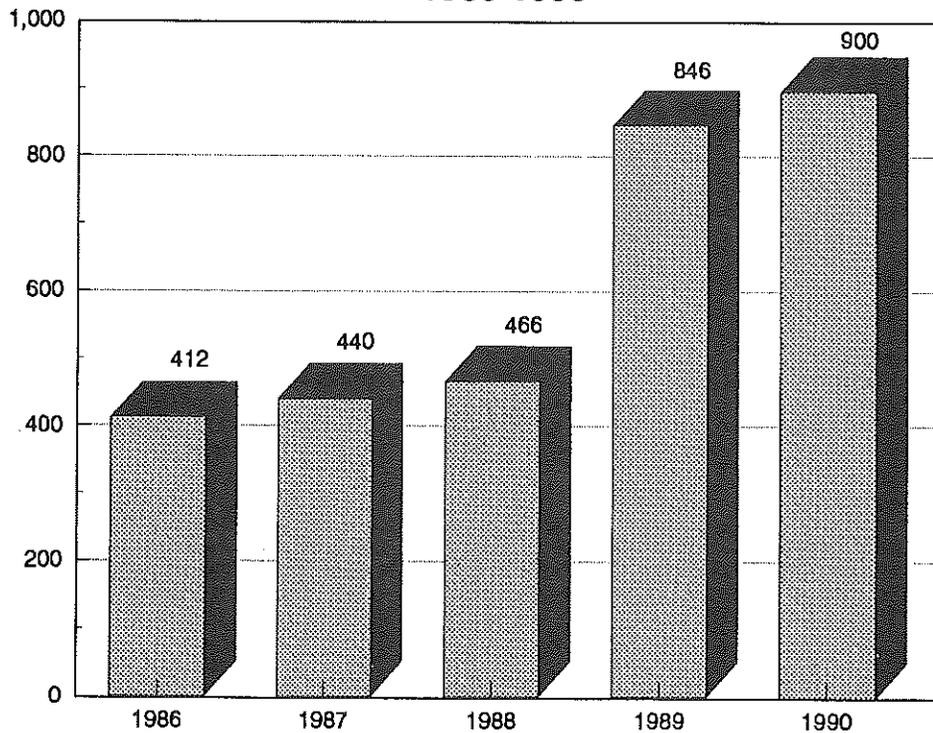


During the second half of FY 1990, OIG investigative activities resulted in 694 successful prosecutions. Appendix D shows the Federal and State jurisdictions in which these prosecutions were accomplished. The following items highlight some of the significant achievements:

- A Texas home health agency, its owner/operator, and its controller were sentenced to pay \$1,386,300 in fines, restitutions and special assessments for forging physician signatures, altering nurses' notes, making false ledger entries and carrying "ghost" employees on the payroll to inflate Medicare reimbursements.
- The owner of a Florida medical clinic was sentenced to 5 years in prison and \$24,000 in restitution for submitting claims for chemotherapy when he actually performed chelation therapy.
- Sixteen doctors and physicians' assistants were sentenced in New York for accepting kickbacks of \$50 to \$300 for each referral they made to a durable medical equipment company.
- At a South Carolina quilting company, the plant manager, three supervisors and the bookkeeper were convicted of using false Social Security numbers to conceal the status of nearly 100 illegal alien employees.
- Three generic drug company officials and two former officials of the Food and Drug Administration were convicted in an ongoing investigation of corruption in the generic drug approval process.
- A benefit authorizer for SSA was sentenced to 12 months in jail for manipulating her disabled husband's records to obtain \$98,900.
- A Wisconsin man who worked for a county sheriff's department was sentenced to 15 months incarceration for concealing employment in order to collect Supplemental Security Income benefits.

Administrative Sanctions - Since FY 1986, numerous health care providers and suppliers or their employees were administratively sanctioned for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries, or for controlled substance abuse or loss of licenses.

ADMINISTRATIVE SANCTIONS EFFECTED 1986-1990



In FY 1990, a total of 192 physicians were excluded from Medicare and Medicaid for the following reasons:

- 124 were excluded due to loss of their State license to practice on grounds relating to professional competence, professional performance or financial integrity.
- 51 were excluded due to conviction of crimes relating to Medicare, the State health care programs or private health insurance (usually false claims).
- 13 were excluded due to quality of care concerns, i.e., failure to render care which meets professionally recognized standards of health care or rendering unnecessary services. Each of these exclusions was imposed on the recommendation of the peer review organization (PRO) in the particular State where the physician practiced, after review by teams of physicians, usually including board-certified specialists.
- 2 were excluded for submitting false claims.
- 1 was excluded because of prior exclusion from a State Medicaid program.

- 1 was excluded for failure to repay a government education loan.

The following items highlight OIG administrative sanctions imposed during the second half of the fiscal year:

- The owner/operator of several New York ambulance companies was excluded for 25 years for obtaining more than \$1 million in Medicare reimbursement by filing false claims.
- Two sisters who were supervisory employees of a Maine residential care facility were excluded for 25 years for padding Medicaid cost reports with phantom contractors and employees.
- A nurse's aide in Texas was excluded for 20 years for abusing an 85-year-old nursing home patient.
- A California dentist whose license was revoked for gross negligence was excluded indefinitely.
- The owner/operator of physical therapy clinics in several States was excluded for 2 years and had to pay more than \$1 million to settle civil and criminal liabilities for charging Medicare for personal expenses.
- Three management officials of a Utah community mental health center were each excluded for 15 years for misusing public funds.

Significant Recommendations for Program and Management Improvement - Recommendations made by OIG during the second half of the fiscal year relating to quality of care, the welfare of beneficiaries, and management and program effectiveness are discussed in Chapters I through VI of this semiannual report.

TABLE OF CONTENTS

	PAGE
CHAPTER I HHS AND GOVERNMENTWIDE OVERSIGHT	
Introduction	1
The Federal Managers' Financial Integrity Act	1
Resolving OIG Recommendations	3
A. Questioned Costs	3
B. Disallowances from OIG Questioned Costs	4
C. Funds Put to Better Use	9
Legislative and Regulatory Review	10
Governmental Accounting	10
A. Underfunded Pension Costs	10
B. Capital Lease Payments	11
C. Internal Service Fund	11
Nonfederal Audits	12
A. Local Government Compliance	12
B. Quality Control	12
Standards of Ethical Conduct	13
Employee Fraud	13
Program Fraud Civil Remedies Act	14
Investigative Prosecutions and Receivables	15
Cooperation with Other Law Enforcement Agencies	18
CHAPTER II HEALTH CARE FINANCING ADMINISTRATION	
Overview of Program Area and OIG Activities	19

	PAGE
Internal Control Weaknesses	21
Opportunities for Program and Management Improvement	21
Resident Abuse in Nursing Homes	22
Hospital Closure: 1988	23
Medicare Secondary Payer: Unrecovered Funds	25
Overview of Intraocular Lens Costs	25
Medicare Payments for Clinical Laboratory Tests	26
Nonphysician Services	26
Medicare Carrier Assessment of New Technologies	26
Kickbacks	28
Indirect Medical Education Payments	28
Medication Regimens: Causes of Noncompliance	29
Extracorporeal Shock Wave Lithotripsy	29
Medicare Hospital Payments	30
Physicians' Claims Processing	30
Sanction Authorities	30
A. Patient and Program Protection Sanctions	31
B. Civil Monetary Penalty Settlements	32
Medicare Part A Cases	33
Fraud Involving Durable Medical Equipment	34
Medicare Enrollees' Prior Catastrophic Coverage	34
Home Health Care	35
Hospital Cost Report Information System	35
Bad Debts Incurred for Medicare Beneficiaries	36
False Claims	36
Dialysis Reimbursement Rates	37

	PAGE
Medical Transportation Fraud	37
Cost Allocation System	38
Asset Reversions from Pension Plan Terminations	38
Pension Plan Reversion: Minnesota	39
Improper State Claims for Federal Medicaid Funds	39
A. Institutions for Mental Diseases	39
1. Illinois	39
2. Indiana	40
3. New York	40
B. Medicaid Inpatient Psychiatric Benefits for Children	40
C. Overpayments	41
1. Illinois	41
2. California	41
D. Less than Effective Drugs	41
E. Medicare Premiums for Medicaid Buy-in Enrollees	42
F. Abusable Drugs	42
State Medicaid Fraud Control Units	43

CHAPTER III SOCIAL SECURITY ADMINISTRATION

Overview of Program Area and OIG Activities	45
Opportunities for Program and Management Improvement	46
Audit of SSA's Financial Statements - Fiscal Year 1988	47
Use of Credit Reporting Agencies	47
Serving Non-English Speaking Clients	47
Capacity Management	48
Unresolved Issues Between SSA and Treasury	49

	PAGE
Credit For Recovered RSDI Benefits	49
User Fee for Attorney Fee Payments	49
Processing Controls for RSDI Diary Actions	50
RSDI Benefits Fraud	50
Verification of Representative Payee SSNs	51
Delayed Payee Development Alerts	51
Representative Payee Fraud	52
Overpayments in Terminated Collection Status	52
Deceased Beneficiaries	54
SSNs for Noncitizens	55
Fraudulent Social Security Numbers	56
Payments for Vocational Rehabilitation	58
Disability Benefits Fraud	58
SSI Benefits Fraud	59

CHAPTER IV PUBLIC HEALTH SERVICE

Overview of Program Area and OIG Activities	61
Internal Control Weaknesses	62
Opportunities for Program and Management Improvement	62
Mobile Health Services	63
Public Cholesterol Screening	63
Youth Access to Cigarettes	64
Medical Device Review Process	65
State Discipline of Pharmacists	66
State Medical Boards and Medical Discipline	66
FDA Program-Related Investigations	67

	PAGE
FDA's Generic Drug Management Information System	67
Implementing User Fees in FDA	68
Internal Controls in IHS Health Care Delivery Programs	69
Construction of IHS Housing	70
Cost Effectiveness of Contracting Out Inpatient Care	70

CHAPTER V FAMILY SUPPORT ADMINISTRATION

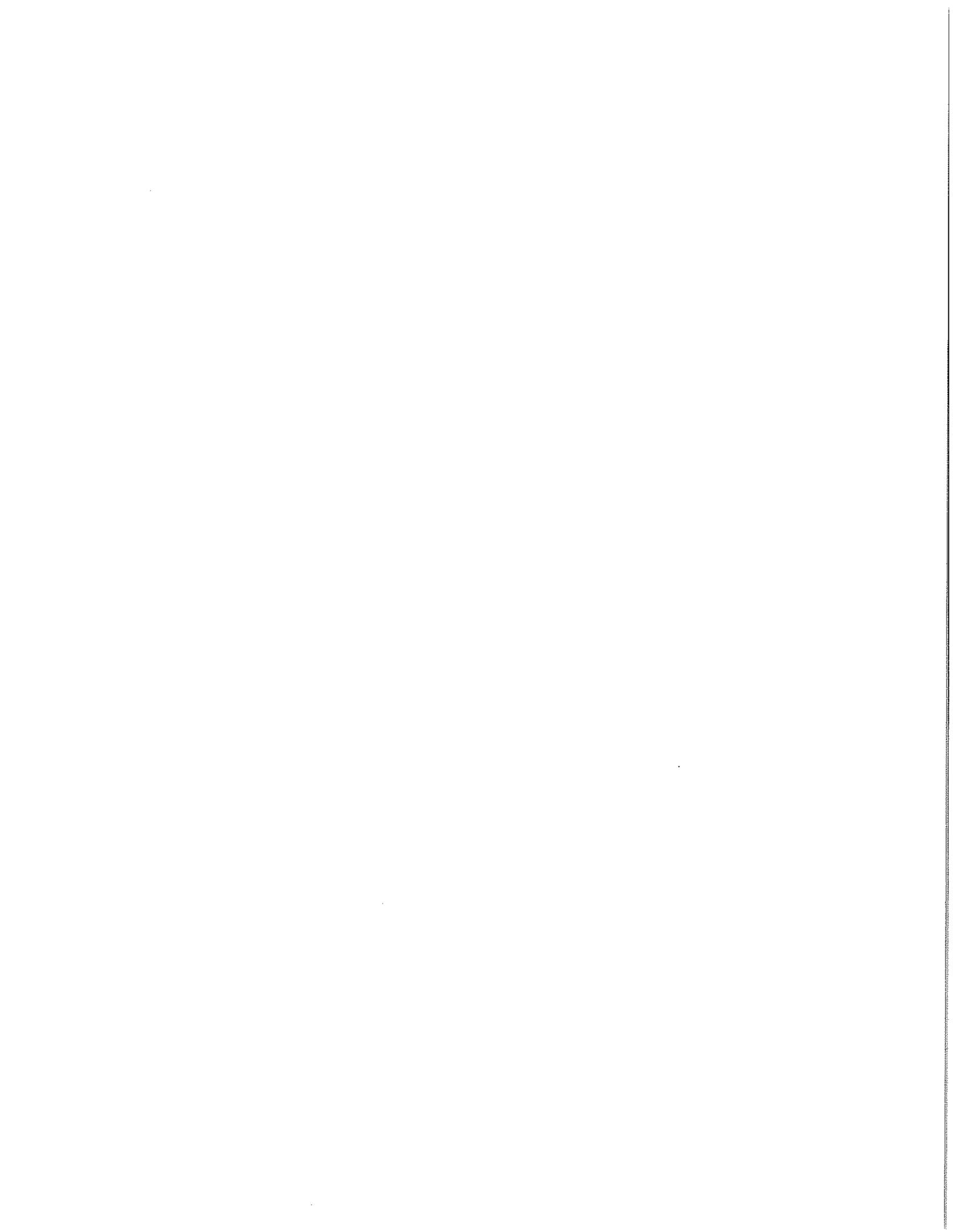
Overview of Program Area and OIG Activities	73
Community Services Discretionary Grants	74
Use of Discretionary Grant Funds	74
A. Alabama	74
B. Texas	75
Community Action Program Fraud	75
Child Support Enforcement Collections	75
AFDC Fraud	76
Reversionary Interest in Real Property	77
State Legalization Impact Assistance Grant Expenditures	77

CHAPTER VI OFFICE OF HUMAN DEVELOPMENT SERVICES

Overview of Program Area and OIG Activities	79
Internal Control Weaknesses	80
Opportunities for Program and Management Improvement	80
Board and Care Regulations and Enforcement	80
Crack Babies	82
Boarder Babies	82
Awarding and Monitoring Discretionary Grants	83
Foster Care	83

	PAGE
A. Administrative Costs	84
B. New York	84
C. District of Columbia	85
D. Ohio	85
Day Care Center Fraud	85
Reversionary Interest: Multipurpose Senior Centers	85
APPENDIX A - Implemented OIG Recommendations to Put Funds to Better Use	A-1
APPENDIX B - Unimplemented OIG Recommendations to Put Funds to Better Use	B-1
APPENDIX C - Congressional Hearings	C-1
APPENDIX D - Successful Prosecutions by Federal District and State Authorities	D-1
LIST OF ACRONYMS	Inside back cover

HHS AND GOVERNMENTWIDE OVERSIGHT



CHAPTER I

HHS AND GOVERNMENTWIDE OVERSIGHT

INTRODUCTION

This chapter addresses the Office of Inspector General departmental management and Governmentwide oversight responsibilities. The Department will spend in excess of \$225 million in FY 1990 to provide overall direction for departmental activities and to provide common services such as personnel, accounting and payroll to departmental operating divisions.

The OIG's departmental management and Governmentwide oversight include reviews of implementation of the Federal Managers' Financial Integrity Act, debt management activities, grants and contracts and audit resolution. The OIG also participates in interagency efforts through the President's Council on Integrity and Efficiency (PCIE) and the President's Council on Management Improvement to prevent losses to and abuses of Federal programs in general.

In addition, OIG has oversight responsibility for audits conducted of certain Government grantees by nonfederal auditors, principally public accounting firms and State audit organizations. The Office of Management and Budget (OMB) Circulars A-87, A-88, A-110, A-128 and A-133 assign audit oversight responsibility to OIG for about 50 percent of all Federal funds awarded to State and local governments, hospitals, colleges and universities, and nonprofit organizations.

During this reporting period, \$38.7 million in expenditures by the Office of the Secretary were questioned as to their allowability under law, regulation or cost principles.

THE FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

The Congress enacted the Federal Managers' Financial Integrity Act (FMFIA) of 1982 (Public Law 97-255) in response to continuing disclosures of waste, loss, unauthorized use, and misappropriation of funds or assets across a wide spectrum of Government operations. The goal of this legislation was to help reduce fraud, waste, and abuse, as well as to enhance management of Federal Government operations through improved internal control and accounting systems.

The FMFIA program, as established by law and reinforced by OMB Circulars A-123 and A-127, placed with management the primary responsibility for adequate internal control and accounting systems. It requires agency heads to report annually on the status of the Department's internal

controls and accounting systems to the President and the Congress and provides for disclosure and correction of material weaknesses.

The Act provides the necessary Governmentwide discipline to identify and remedy long-standing internal control and accounting system problems that hamper effectiveness and accountability, potentially cost the taxpayer billions of dollars and erode the public's confidence in Government.

Although the Inspector General's role is not specified in the statute, OIG has been actively involved in the Department's FMFIA program since effective internal control systems are a primary mechanism for preventing and detecting fraud, waste and abuse.

The OIG's role in the Department's program includes:

- identifying material weaknesses in internal controls or material nonconformances in accounting systems as an integral part of OIG reviews of Department activities;
- following up to monitor corrective action taken regarding weaknesses identified by OIG, the General Accounting Office (GAO) and the operating and staff divisions of the Department;
- advising top management on internal control issues; and
- reviewing the Secretary's FMFIA annual report to the President and the Congress on the status of internal controls.

On July 2, 1990 OIG issued an interim report on the progress made by the Department under FMFIA during the first 6 months of FY 1990. The OIG observed that the Department's management has afforded a higher priority to the FMFIA program through increased oversight and the development of a strategy to address the deficiencies identified in prior years. Department components have expanded FMFIA coverage into new program areas. However, more needs to be done by some components to institutionalize the process throughout the year, in both program and administrative areas. Further, OIG expressed concern that two operating divisions had not performed any internal control reviews during the first half of the fiscal year.

There has been notable improvement, primarily by PHS, in the number of material weaknesses identified and being reported by the operating divisions themselves. Thus far, the Office of the Assistant Secretary for Management and Budget has been notified of 13 new material weaknesses that Department program managers plan on reporting for FY 1990. Material weaknesses identified by OIG are discussed in Chapters II, III, IV and VI of this semiannual report.

RESOLVING OIG RECOMMENDATIONS

The tables and schedules below summarize actions taken on OIG recommendations to recover funds or to put them to better use.

A. Questioned Costs

The following chart summarizes the Department's responses to OIG's recommendations for the recovery or redirection of questioned and unsupported costs. Questioned costs are those costs which are challenged because of a violation of law, regulation, grant, etc. Unsupported costs are those costs questioned because they are not supported by adequate documentation. This information is provided in accordance with the Supplemental Appropriations and Rescissions Act of 1980 (Public Law 96-304) and the Inspector General Act Amendments of 1988 (Public Law 100-504).

	<u>Number</u>	<u>Dollar Value</u> (in thousands)	
		<u>Questioned</u>	<u>Unsupported</u>
A. For which no management decision had been made by the commencement of the reporting period	211	\$168,944	\$50,907
B. Which were issued during the reporting period	<u>246</u>	<u>\$414,388</u>	<u>\$13,446</u>
Subtotals (A + B)	457	\$583,332	\$64,353
Less:			
C. For which a management decision was made during the reporting period: ¹	249	\$150,926	\$25,922
(i) dollar value of disallowed costs ²		\$98,317	\$626
(ii) dollar value of costs not disallowed		\$52,609	\$25,296
D. For which no management decision had been made by the end of the reporting period	208	\$432,406	\$38,431
E. Reports for which no management decision was made within 6 months of issuance	0	0	0

¹ Previously reported management decisions on 21 reports were amended during the current period. The net value of these amendments was \$14.9 million, primarily due to reversal of amounts sustained by management by the departmental appeals board. Amendments to previously reported management decisions are not reflected in current period totals.

² See detailed listing beginning on page 4.

B. Disallowances from OIG Questioned Costs

The following schedule represents significant examples of the dollar amounts identified for recoupment during the period April 1990 through September 1990 as a result of management decisions in favor of audit and inspection findings and recommendations. Disallowances for this period totaled \$125.3 million and were comprised of OIG audit and inspection disallowances of \$98.3 million and HCFA program disallowances of \$27 million. The first part of this schedule, Audit and Inspection Disallowances, corresponds to Table I, line C(i), page 3.

Audit and Inspection Disallowances

- Improperly claimed payments to institutions for mental diseases by the State of Illinois (CIN: A-05-89-00086) \$17,003,500
- Overclaim of Medicaid claims payments by the Colorado Department of Social Services (CIN: A-08-89-00211) 10,181,100
- Reimbursement for excess Medicaid funds received by Missouri intermediate care facilities for the mentally retarded (CIN: A-07-89-00173) 6,837,000
- Overclaim of Medicare reimbursement for indirect medical education payment adjustments by two health care providers (CIN: A-06-88-00069) 5,475,300
- Overcharge for administrative costs by the State of Ohio (CIN: A-05-90-00038) 4,938,600
- Overclaim for Medicaid reimbursement for inpatient care of youth psychiatric patients at privately operated facilities by the Missouri Department of Social Services (CIN: A-07-89-00225) 3,749,100
- Improperly claimed Medicare pass-through costs by a New York City hospital (CIN: 02-89-01011) 3,440,500
- Overpayments made to medical providers under title XIX of the Social Security Act by the State of Illinois (CIN: A-05-89-00071) 2,395,200
- Unallowable claims made by the Pennsylvania Department of Public Welfare under the Refugee Resettlement program (CIN: 03-89-00258) 2,304,100
- Overclaim of reimbursable bad debts by the National Medical Care, Inc. Facilities under Medicare's end stage renal disease program (CIN: A-01-89-00511) 2,201,700
- Single audit disclosed unallowable charges to HHS programs in New York (CIN: A-02-90-07457) 2,185,000
- Overclaim of administrative charges by the State of North Carolina (CIN: A-04-86-60505) 2,150,800
- Overclaim of administrative costs by the State of North Carolina (CIN: A-04-89-05136) 2,114,400
- Improperly claimed costs by the New York State Department of Social Services (CIN: A-02-90-01015) 2,075,600
- Unallowable charges by a Head Start grantee in New Jersey (CIN: A-02-90-05406) 2,050,200

Audit and Inspection Disallowances

- Improperly claimed administrative costs by the State of New Jersey Department of Human Services (CIN:A-02-88-02025) \$1,974,300
- Overclaim of administrative costs by Albany Medical College (CIN: A-02-88-02018) 1,821,900
- Overpayments for oxygen concentrator rentals that did not meet Medicare reimbursement guidelines (CIN:A-04-89-02104) 1,800,000
- Disallowance for Medicare and Medicaid costs claimed by the Wisconsin Department of Health and Social Services (CIN: A-05-90-00049) 1,498,500
- Refund of excess pension fund contributions made by Blue Cross and Blue Shield of Central Ohio (CIN: A-07-89-00181) 1,059,200
- Ineligible payments claimed by the Texas Department of Human Services under the title IV-E Foster Care program (CIN: A-06-90-00026) 971,300
- Reimbursement for retained earnings surpluses accumulated in internal service funds for the State of Louisiana (CIN: A-06-89-00069) 921,600
- Overcharge of administrative costs by Blue Cross of California (CIN: A-09-90-00057) 889,600
- Reimbursement for payments for less than effective drugs by the State of Indiana (CIN: A-05-89-00081) 870,300
- Reimbursement for payments for less than effective drugs by the State of North Carolina (CIN: A-04-90-02000) 816,100
- Reimbursement for payments for less than effective drugs by the Commonwealth of Virginia (CIN: 03-89-00221) 813,400
- Overcharge of administrative costs incurred under Medicare Part A program by a health care provider (CIN: A-05-90-00040) 769,400
- Audit of the New Jersey General Fund disclosed unallowable charges (CIN: A-02-88-07179) 764,600
- Reimbursement by the New Jersey Department of Human Services for payments made for less than effective drugs (CIN: A-02-89-01021) 736,000
- Improperly received Medicaid funds by the Washington Department of Social and Health Services (CIN: A-10-89-00166) 696,500
- Reimbursement by the Iowa Department of Human Services for payments made for less than effective drugs (CIN: A-07-89-00200) 647,100
- Refund of surpluses in the internal service fund operated by the State of Illinois (CIN: A-05-89-00062) 610,200
- Reimbursement of ineligible costs by the Ohio Department of Human Services (CIN: A-03-89-00227) 570,800
- Reimbursement for payments made by the Missouri Department of Social Services for less than effective drugs (CIN: A-07-89-00199) 555,200

Audit and Inspection Disallowances

- Single audit disclosed unallowable charges to HHS programs in California (CIN: A-09-90-07157) \$519,000
- Improperly claimed Medicare costs paid to Blue Cross Blue Shield of Florida (CIN: A-04-90-02014) 517,600
- Overclaim for maintenance costs charged to Title IV-E Voluntary Foster Care Program by the Iowa Department of Human Services (CIN: A-07-89-00183) 496,600
- Overcharge of Medicaid payments to intermediate care facilities and community residential facilities by the Indiana Department of Public Welfare (CIN: A-05-89-00100) 492,800
- Overclaim for Medicaid reimbursement for inpatient care of youth psychiatric patients provided at facilities operated by the State of Missouri (CIN: A-07-90-00278) 441,400
- Reimbursement for Medicaid overpayments to nursing homes by the Ohio Department of Human Services (CIN: A-05-89-00106) 419,400
- Overcharge of administrative costs by Sumter County Opportunity, Inc (CIN: A-04-89-06959) 415,500
- Unapproved costs claimed by the Georgia Department of Human Services (CIN: A-04-90-06268) 385,100
- Refund of pension costs charged to the Medicare program by a terminated Medicare contractor (CIN: A-07-89-00201) 375,900
- Overclaim for administrative costs by the Michigan Department of Public Health (CIN: A-05-89-05419) 339,200
- Improperly claimed costs under the Medicaid program by the Ohio Department of Human Services (CIN: A-05-89-00087) 313,400
- Reimbursement for payments made by the South Carolina Health and Human Services Finance Commission for less than effective drugs (CIN:A-04-89-02098) 288,100
- Overcharge of administrative costs claimed under Health Insurance for the Aged and Disabled by a carrier (CIN: A-02-88-01023) 283,700
- Reimbursement for the Federal Government's portion of refunded FICA taxes received by the Illinois State Employees' Retirement System (CIN: A-05-89-00027) 282,500
- Overcharge of administrative costs by Blue Shield of Massachusetts (CIN: A-01-89-00513) 232,600
- Overclaim for administrative costs by the Louisiana Health Service and Indemnity Company (Blue Cross Blue Shield United of Louisiana) (CIN: A-06-90-00069) 189,900
- Overclaim of Federal funds by the Lau-Fay-Ton Community Action Agency (CIN: A-04-90-05114) 183,500
- Overclaim of administrative costs by the Florida Department of Health and Rehabilitative Services (CIN: A-04-90-05001) 179,600
- Overcharge of administrative costs by Blue Cross of Massachusetts (CIN: A-01-89-00510) 171,100

Audit and Inspection Disallowances

• Unallowable charges made by subrecipients to a Community Services block grant in New Mexico (CIN: A-06-90-06104)	\$159,100
• Single audit disclosed overpayment of costs charged to Federal programs in Oregon (CIN: A-10-90-07049)	158,700
• Unallowable costs claimed for reimbursement under the Medicare program by Cooperativa de Seguros de Vida de Puerto Rico (CIN: A-02-88-01038)	148,200
• Reimbursement for payments for less than effective drugs by the West Virginia Department of Human Services (CIN: A-03-89-00224)	141,600
• Reimbursement of payments for less than effective drugs by the Colorado Department of Social Services (CIN: A-08-89-00232)	135,900
• Reimbursement of unused comprehensive perinatal care program funds by a health care provider (CIN: A-02-90-06259)	130,200
• Overclaim of Medicare Part B administrative costs by the General American Life Insurance Company of St. Louis (CIN: A-07-90-00302)	128,000
• Reimbursement for payments for less than effective drugs by the State of Illinois (CIN: A-05-89-00102)	127,700
• Overclaim of administrative costs by Blue Cross and Blue Shield of Oklahoma (CIN: A-06-90-00013)	122,300
• Unallowable charges by the Gila River Indian Community (CIN: A-09-90-07305)	121,300
• Ineligible charges by the Puerto Rico Department of Labor and Human Resources under the Work Incentive program (CIN: A-02-89-07429)	114,300
• Overpayment to the Refugee Resettlement program administered by the Maryland Department of Human Resources (CIN: A-03-89-00256)	112,800
• Unallowable charges by a Head Start grantee in New Jersey (CIN: A-02-90-05441)	110,400
• Single audit disclosed unallowable charges to HHS programs in South Dakota (CIN: A-08-89-06614)	108,000
• Single audit disclosed unallowable charges to Federal program in Washington (CIN: A-10-90-07265)	106,500
• Overclaim of administrative costs incurred under Part B of the Health Insurance for the Aged and Disabled program by Blue Cross and Blue Shield of Montana (CIN: A-08-89-00223)	105,300
• Overpayment for administrative costs incurred under Part A of the Health Insurance for the Aged and Disabled Program by Blue Cross and Blue Shield of Montana (CIN: A-08-89-00222)	104,500
• Overpayment of costs by the Michigan Department of Social Services (CIN: A-05-89-05428)	103,300
• Overpayment of funds for the Low Income Home Energy Assistance program administered by the Georgia Department of Human Resources (CIN: A-04-89-00097)	97,400

Audit and Inspection Disallowances

- Overclaim of administrative costs by Blue Cross and Blue Shield of Utah (CIN: A-08-90-00256) \$94,100
- Reimbursement of Head Start funds by the Florida Department of Health and Human Services (CIN: A-04-89-08283) 82,600
- Recovery of overpayments made under Medicare Part B for same-day catheter and anesthesia services (CIN: A-04-89-01022) 80,000
- Reimbursement for less than effective drugs by the Oregon Department of Human Resources (CIN: A-10-90-00001) 75,800
- Unallowable charges by a Head Start grantee in New York (CIN: A-02-90-05434) 74,400
- Unallowable charges claimed under the Office of Community Services discretionary grants program in Alabama (CIN: A-04-89-03501) 66,300
- Overcharge of administrative costs by the Pueblo of Acoma (CIN: A-06-89-05205) 63,700
- Unallowable charges by a Head Start grantee in Alabama (CIN: A-04-89-06323) 58,800
- Overclaim by a Head Start grantee in Texas (CIN: A-06-89-05226) 57,400
- Overpayment to the Red Lake Bank of Chippewa Indians (CIN: A-05-90-05159) 52,500
- Overclaim of administrative costs incurred under Part B of the Health Insurance for the Aged and Disabled Program by Blue Cross and Blue Shield of Utah (CIN: A-08-90-00257) 50,900
- **Disallowances under \$50,000** **\$809,900**
- TOTAL DISALLOWANCES** **\$98,316,900**

HCFA Program Disallowances

- State Agency claimed costs in excess of customary charges \$9,800,000
- State Agency claimed unallowable contract costs 6,300,000
- Overpayment of reimbursed costs to State agency 2,700,000
- State agency's failure to use audited rates resulted in overpayment 2,200,000
- Medicaid program charged twice for acute care hospital costs 2,000,000
- Medicaid payment exceeded State plan limits for other prescribed drugs 1,700,000
- Failure to meet plan of reduction for facility 1,700,000
- Violation of the approved State plan for reimbursed in-house pharmacy costs 600,000
- TOTAL HCFA PROGRAM DISALLOWANCES** **\$27,000,000**

C. Funds Put to Better Use

The following chart summarizes reports which include recommendations that funds be put to better use through cost avoidances, budget savings, etc.

	Number	Dollar Value (in thousands)
A. For which no management decision had been made by the commencement of the reporting period ¹	47	\$2,212,677
B. Which were issued during the reporting period	<u>60</u>	<u>\$1,588,283</u>
Subtotals (A + B)	107	\$3,800,960
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management ²		
(a) based on proposed management action	28	\$1,884,258
(b) based on proposed legislative action	<u>0</u>	<u>0</u>
Subtotals (a+b)	28	\$1,884,258
(ii) dollar value of recommendations that were not agreed to by management	<u>6</u>	<u>\$238,874</u>
Subtotals (i + ii)	34	\$2,123,132
D. For which no management decision had been made by the end of the reporting period ³	73	\$1,677,828
E. Prior decisions implemented in the period (See Appendix A) ⁴		
(i) based on management action	18	\$184,000
(ii) based on legislative action	10	\$3,329,000

¹ The opening balance was adjusted to reflect an upward reevaluation of recommendations in the amount of \$535.5 million.

² The Health Care Financing Administration agrees with the recommendation in report OEL-07-89-01664, Overview of IOL Costs, but does not agree with the dollar amount of the recommendation. This report is being reported as a concurrence in the table at OIG's valuation of \$55.1 million.

³ Management decisions had not been made within 6 months of issuance on 5 reports: CIN: A-07-89-00134, Medicare Is Losing Millions of Dollars from Terminations of Pension Plans, \$27,600,000; CIN: A-03-86-60223, Premium Matching Rate for Skilled Professional Medical Personnel and Support Staffs Is No Longer Justified, \$360,000,000; CIN: A-02-86-60202, Potential Savings on Medicaid Payment of Medicare Deductible and Coinsurance Amounts, \$100,000,000; CIN: A-03-85-50228, Elimination of Federal Financial Participation in Premiums Paid Under the Buy-In Program Would Save Billions, \$364,000,000; and OAI-01-86-00108, Organ Acquisition Costs: An Overview, \$4,000,000. These reports are being handled through the departmental conflict resolution process.

⁴ The OIG reports implemented savings on line E in its Table II which includes management and congressional actions. Management reports final action on line C of its table when management has taken all actions deemed necessary and within its authority to implement the IG recommendation. Implemented savings reported by the IG are based upon completion of both management's final action and congressional action in the case of recommendations implemented through legislation.

LEGISLATIVE AND REGULATORY REVIEW

Section 4(a) of the Inspector General Act of 1978 requires the Inspector General to review existing and proposed legislation and regulations, and to make recommendations in the semiannual report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In carrying out its responsibilities under Section 4(a), OIG reviewed 123 of the Department's regulations under development and 267 legislative proposals.

In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigative experience and recommendations highlighted in this and previous semiannual reports. Recommendations made by OIG for legislative and regulatory change can be found in the body of this semiannual report.

The OIG also develops regulations for civil monetary penalty and exclusion authorities which the Inspector General administers. On April 2, 1990, the Department published proposed rulemaking in the Federal Register to implement OIG sanction and civil monetary penalty provisions in the Medicare and Medicaid Patient and Program Protection Act (P.L. 100-93).

These regulations have been designed to protect program beneficiaries from unfit health care practitioners, and to improve the antifraud provisions of the Department's Medicare and other health care programs. The proposed regulations set forth OIG's new statutory authority to control who may obtain payment for services furnished to program beneficiaries and to provide an expanded list of activities that can, and in some cases must, serve as a basis for exclusion from eligibility for such payment. Final regulations should be issued in early 1991.

GOVERNMENTAL ACCOUNTING

Each year, State and local government entities receive over \$100 billion in Federal grant funds. It is estimated that Federal agencies pay at least \$8 billion for administrative costs of State and local governments.

As part of its governmentwide cognizance responsibilities as defined in OMB Circular A-87 to ensure that administrative costs are being charged in accordance with the appropriate Statewide cost allocation plan, OIG has continued its efforts to identify cost containment areas and/or areas where costs are being inappropriately charged. During this period, OIG performed the following work.

A. Underfunded Pension Costs

In West Virginia, the Public Employees Retirement System (PERS) is funded through employee and employer contributions. However, the Federal Government shares in pension costs of State

employees engaged in federally funded programs.

The OIG found that \$12.7 million of \$16.3 million contributed by the Federal Government to the West Virginia pension system was unallowable because the State violated the consistency provisions of Office of Management and Budget Circular A-87. Under these provisions, the Federal Government will pay the employer's contribution for employees engaged in federally funded programs at the same contribution rate used by the State for employees engaged in State funded programs.

During the 4-year audit period, the State underfunded PERS by about \$45 million. In addition, the State withdrew about \$19.1 million from PERS for financing State operating expenses and health insurance costs of retirees that were previously paid by the State. The estimated Federal share of the withdrawn funds was \$3.8 million. The OIG recommended that the State charge federally funded programs the same employer's contribution rate used in State funded programs; stop withdrawing funds from PERS to finance State operations; and make a financial adjustment to the Federal Government of \$19.7 million, which includes \$3.2 million in interest on unallowable charges. (CIN: A-03-90-00453)

B. Capital Lease Payments

The OMB Circular A-87 states that interest in any form is an unallowable charge to the Federal Government. The OIG conducted an audit to determine whether three New York State agencies had charged the Federal programs they administer for interest costs relating to their capital lease payments. Additionally, the review sought to examine whether the State agencies had accounted for their capital lease payments in accordance with generally accepted accounting principles. The OIG found that the State agencies had charged Federal programs with unallowable interest expense applicable to capital leases.

The OIG proposed that the State of New York establish procedures at the departmental level to properly account for capital leases and ensure that the related interest costs are not charged to the Federal Government in the future. The OIG also recommended that the State refund \$11.9 million to the Federal Government, consisting of \$3.8 million in unallowable interest costs and \$8.1 million in excess costs claimed over and above the permitted use allowances and depreciation charges. Further, OIG proposed that the State refund the Federal share of additional improper interest and excess costs allocated to Federal programs up to the time a final settlement of these issues is made. (CIN: A-02-88-02018)

C. Internal Service Fund

An OIG review disclosed that the State of Ohio billed Federal grants and contracts \$10.3 million (\$4.9 million Federal share) more than their recorded costs during the period July 1, 1982 through June 30, 1988.

The OIG recommended that Ohio refund \$4.9 million to the Treasury, and perform periodic functional cost center reconciliation comparing actual costs to billed amounts, making prompt adjustments for over or under charges. (CIN: A-05-90-00038)

NONFEDERAL AUDITS

The OIG has oversight responsibility for audits of certain Government grantees conducted by nonfederal auditors, principally public accounting firms and State audit organizations. The OMB Circulars A-87, A-88, A-110, A-128, and A-133 assign audit oversight responsibility to OIG for about 50 percent of all Federal funds (approximately \$50 billion) awarded to State and local governments, hospitals, colleges and universities and nonprofit organizations. All but 3 of the 50 States receive more funds from HHS than from any other department. The OMB has assigned HHS audit cognizance of 23 State and 919 local governments. In addition, OIG is assigned cognizance at about 75 percent of all colleges and universities. The OIG analyzes audit reports for indicators of grantee noncompliance with Federal regulations, initiates audit resolution procedures on reported recommendations and maintains a quality control review process to identify substandard audit work. The most recent guidance included in OMB Circular A-133 requires biennial reviews of nonprofit institutions, but encourages annual reviews.

A. Local Government Compliance

The OIG also continues an active role in implementing the Single Audit Act (Public Law 98-502) because of the magnitude of HHS funding to State and local governments. A major component of OIG's workload has been to assist State and local governments and their auditors in planning and performing single audits. The OIG is working with the States, for which it is assigned cognizance, to establish systems to assure compliance of local governments with the Single Audit Act. These systems complement the monitoring system at the Bureau of the Census by filling the gap in the Government's knowledge on compliance by local governments.

B. Quality Control

To ensure that all audits meet generally accepted Government auditing standards, uniform procedures are used to review nonfederal audit reports. During this reporting period, OIG reviewed and processed 1,646 nonfederal audit reports containing \$10.8 million in recommended cost recoveries. The reports also identified many opportunities for improving management operations. The following table summarizes those results:

Reports issued without changes or with minor changes	1,312
Reports issued with major changes	297
Reports with significant inadequacies	<u>37</u>
Total audit reports processed	1,646

Of those reports with significant inadequacies, 6 were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. The OIG referrals of inadequate audit work result in significant disciplinary action against the accounting firms involved.

STANDARDS OF ETHICAL CONDUCT

The OIG conducted an inspection to determine how well professional employees of the Department of Health and Human Services (HHS) understood the standards of ethical conduct. Six hundred professional HHS employees averaged 16.8 correct answers (73 percent) on a 23-question true/false ethics survey. Training was found to have had a positive effect on scores. Those employees who had training scored an average of 17.5, while those who did not scored an average of 16.3.

Interviews with a representative group of HHS managers disclosed that most believed their own understanding of the ethics standards and that of their staffs was adequate. However, over half felt that the Department was not doing enough to make employees aware of the ethical standards, and just over half believed that the standards of conduct were not uniformly enforced.

The OIG recommended that the Office of General Counsel (OGC), in consultation with the Assistant Secretary for Personnel Administration (ASPER), develop an ethics education program for all employees, and establish a system of ethics newsletters and bulletins with information on problems, weak areas and changes in the standards of conduct. The OIG also proposed that, for guidance purposes, they distribute within the Department the standard table of penalties for correcting misconduct developed by the President's Council on Integrity and Efficiency and adopted by the Office of Personnel Management. The OGC and ASPER have set 1991 training objectives that implement OIG's recommendations. (OEI-02-90-00710)

EMPLOYEE FRAUD

The OIG has oversight responsibility for the investigation of allegations of Department employee wrongdoing where it affects internal programs. Most of the approximately 1,300 persons employed full time by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities as illustrated in the following cases:

- A Social Security benefit authorizer was sentenced in Maryland for benefits fraud. The employee was given 12 months incarceration, to be followed by a 3-year supervised release, and full restitution of \$98,900. She used her position to manipulate her disabled husband's benefits record to obtain the money, to which he was not entitled. She signed over her Federal pension and agreed to sell a home she inherited to pay back the money. (~~5-90-00691-2, Christine Lee~~)
(3-89-0387-6, Bettina Williams)

- A 20-year SSA employee was sentenced to 5 years probation and restitution of \$6,950. The telephone service representative used her position to generate checks amounting to \$69,500 over a period of 7 years. In handing down the sentence, the judge took into consideration the fact that she supported seven children and several ill relatives. (S-90-00691-6, Christine Lee)
- A purchasing agent was convicted of stealing about \$3,000 worth of prescription drugs from the National Institutes of Health (NIH), including birth control pills, controlled substances, and over-the-counter products. By placing orders for NIH researchers through her computer, the agent was able to order and receive unauthorized products for a short period of time before being detected by internal controls in the procurement process. She was sentenced to 2 1/2 years probation and ordered to pay full restitution, a \$2,500 fine and \$25 special assessment. (W-88-00098-4, Edna Hughes)
- A clerk formerly with the National Institute of Occupational Safety and Health (NIOSH) was sentenced to 2 years probation on the condition that she repay \$4,000 she embezzled from NIOSH. She also had to pay a \$50 fine. She made up fake vouchers for study funds and collected the money for her own use. (S-89-00526-6, Lori Bullock)

PROGRAM FRAUD CIVIL REMEDIES ACT

The Program Fraud Civil Remedies Act (PFCRA), passed in October 1986, established administrative penalties for anyone who makes a false claim or written false statements to a Federal agency. It was modeled after the civil monetary penalty law for the Medicare and Medicaid programs, which OIG is responsible for enforcing. Under PFCRA, any person who makes a claim or statement to the Department, knowing, or having reason to know, that it is false, fictitious or fraudulent may be held liable in an administrative proceeding for a penalty of up to \$5,000 per claim or statement. In addition, that person may be subject to an assessment of up to double the amount of each claim falsely made. The OIG is responsible for investigating allegations of false claims or statements, and for reporting at the end of each fiscal year investigations completed under PFCRA and referred for administrative action.

To date, OIG has investigated numerous cases involving potential PFCRA violations. The violations included such actions as:

- Making false statements on an application for supplemental security income.
- Misrepresenting information regarding marital status, income and resource information on an application for Public Health Service Medical Education funds.

- Providing false information on an application for reinstatement to the Medicare and Medicaid programs.

The OIG has referred 20 cases for review by the Office of General Counsel (OGC), all but one of them within FY 1990. The OGC has referred two of these cases to the Department of Justice for clearance, declined ten (with the option of further development on two), and returned four to OIG for further development. The remaining four are under consideration by OGC.

INVESTIGATIVE PROSECUTIONS AND RECEIVABLES

During this semiannual reporting period, OIG investigations resulted in 694 convictions. Also during this period, 1,643 cases were presented for prosecution to the Department of Justice and, in some instances, to nonfederal prosecutors. New criminal charges were brought by prosecutors in 1,313 cases.

In addition to terms of imprisonment and probation imposed in the judicial processes, more than \$29.4 million was ordered or returned as a result of OIG investigations.

The following table presents details of the amount of fines, savings, restitutions, settlements and recoveries accruing from judicial or administrative processes resulting from OIG investigative findings. The figures include both actual and ordered recoupments for the Treasury of the United States, the Social Security and Medicare trust funds, and departmental programs victimized by fraud and abuse.

Recoveries

- Texas-based nursing home claimed unallowable Medicaid costs (8-88-00019-9, NAA Holding Company) \$548,000
- California clinic improperly billed Medicare for services supposedly performed in two hospitals (8-89-04211-9, Arka Rosenberg) 368,400
- Iowa hospital billed Medicaid for noncovered emergency room services (8-90-00167-9, William Meyer) 220,700
- Durable medical equipment (DME) company in Illinois billed Medicare for equipment for nursing home patients after they were no longer there (5-85-01292-9, Simpol Respiratory) 198,000
- Three Ohio State employees received Federal funds while working in the governor's office 156,400 (5-86-01167-6)
- Iowa man concealed his work to collect Social Security Administration (SSA) benefits 80,700 (8-85-00368-6, Albert Garrison)
- Tennessee-based insurance company used Medicare as primary payer for beneficiaries covered by private insurance (4-89-00458-9, Provident Life and Accident) 68,000
- California man received supplemental security income (SSI) payments under own and deceased brother's names (9-87-00164-6, Harold Dow) 58,600

Recoveries

- Texas man concealed return to work to continue to receive disability benefits \$58,500
(6-89-00415-6, Ernest Medallin)
- Massachusetts man denied father's being deceased to continue deposit of SSA checks 50,700
(1-90-00046-6, Keith Chabot)
- Georgia woman cashed deceased mother's SSA benefit checks (4-89-00533-6, Katherine Arnold) 50,000

Judgments and Settlements

- Georgia owner of nursing home and eight clinics charged personal expenses on Medicare cost reports (4-87-01328-9, 4-90-30022-9, Joseph Gertzel)..... 1,793,000
- Medical groups in California paid kickbacks for physician referrals 1,000,000
(9-90-34322-9, Hawthorne Community Medical Group)
- Illinois ophthalmologist filed false Medicare claims (5-89-20019-9, Dennis Ryll)..... 925,000
- Florida neurologist billed Medicare for consultations and electromyography services not rendered (4-88-30006-9, Hooshang Hashmand)..... 705,900
- Hospital in New York billed Medicare Part B for arterial blood punctures performed by hospital-employed staff (2-89-20862-9, Beckman Downtown)..... 486,200
- Pennsylvania university filed Medicare claims for routine visits as though they were comprehensive first time visits (3-88-20110-9, Hahnemann University)..... 380,000
- Gynecologist/obstetrician billed Medicare and Medicaid for multiple deliveries for same patient, deliveries performed by other doctors and services not provided 378,000
(6-90-30027-9, Upendra Kulkarni)
- Pennsylvania ambulance company billed Medicare for ambulance trips for patients transported in nonambulance vehicles (3-90-20185-9, Metropolitan Ambulance)..... 300,000
- Pharmacist in Minnesota billed Medicaid for generic substitutions, excess quantities and refills not dispensed (5-90-20013-9, Joseph Noon)..... 167,300
- Florida health maintenance organization charged Medicare for unnecessary services 160,000
(4-89-20003-9, CAC Ramsay, Inc.)
- Massachusetts ophthalmologist submitted false claims to Medicare 130,000
(1-88-20201-9, Fred Greenberg)
- Ambulance company in Indiana billed Medicare and Medicaid for transporting nursing home patients by ambulance to dialysis center when they were merely wheeled there 117,100
(5-84-20358-9, Patient Transfer)
- Illinois anesthetist billed Medicare and Medicaid for services actually performed by nurse anesthetists (5-90-20008-9, William Lee)..... 102,000
- Massachusetts podiatrist filed Medicare claims for surgery which x-rays showed was not performed (1-90-20247-9, David Harow)..... 100,000
- Texas doctor billed Medicare and Medicaid for laboratory services he did not have equipment to perform (6-89-30593-9, Jacques Kestelyn)..... 100,000
- Ophthalmologist in Ohio billed Medicare for unnecessary and nonperformed laser surgeries 95,000
(5-87-30002-9, Doyle Campbell)
- Colorado physician submitted Medicare claims for routine or follow-up visits as though they were part of comprehensive compilations for care (8-88-20191-9, Bruce Wilson)..... 65,000

Judgments and Settlements

- Colorado hospital billed Medicare for multiple units of emergency services when single units were rendered (8-88-30167-9, St. Anthony Hospital) \$62,100
- Maryland doctor under contract to treat mental health patients also billed Medicare (W-88-30112-9) 55,900
- Pennsylvania physicians accepted kickbacks from laboratory for referrals 51,900
(3-86-00695-9, Frederick Colella)

Fines and Restitutions

- Owner of a Texas home health agency falsified records to collect from Medicare 1,386,300
(6-88-00212-9)
- Michigan ambulance company billed Medicare for transportation not provided 219,900
(5-88-00557-9)
- Virginia chiropractor billed Medicare and Medicaid under a physician's name 188,500
(3-85-00839-9, Paul Neaton)
- Office manager of New York DME company submitted claims to Medicare for items never delivered (2-88-00912-9, Anne Moore) 137,100
- Massachusetts podiatrist filed Medicare claims for surgery which x-rays showed was not performed (1-86-00024-9, David Harow) 110,000
- SSA employee manipulated husband's files to obtain disability benefits 102,200*
(3-89-00387-9, Bettina Williams)
- New Jersey civilian contract specialist continued to receive SSA disability benefits after returning to work (2-88-00197-6) 93,900
- DME company paid kickbacks to New York physicians for Medicare and Medicaid prescriptions (2-89-00039-9, Douglas Esposito) 88,600
- Illinois woman cashed deceased mother's SSA checks (5-88-00842-6) 76,900
- Michigan man collected SSA disability insurance and did not report returning to work 69,300
(5-88-00103-6, John Pennington)
- Woman in California cashed deceased husband's benefits checks (9-88-00456-6, Esther Jakobson) 69,200
- DME supplier in South Dakota billed Medicare for catheter drainage kits that were really diapers (8-87-00076-9, Douglas Washington) 67,900
- Pennsylvania man receiving SSA disability benefits returned to self-employment using son's SSN (3-85-00016-6, Robert Rankins) 67,500
- Director of weatherization project of Massachusetts community action program paid kickbacks 66,000
(1-86-00069-2, Derek Dora)
- Fiscal officer embezzled funds from Massachusetts community health center 65,000
(1-89-00104-4, Joseph Owumi)
- Colorado man concealed employment to receive disability benefits 64,600
(9-89-00556-6, Frederick Medermott)
- Illinois man concealed work to collect disability benefits 64,000
(5-87-00803-6, Patrick Price)
- Bookkeeper of Wisconsin health department embezzled funds 63,000
(5-89-00564-4, Rose Churchill)
- Owner of a Tennessee medical supply company submitted false claims to Medicare for oxygen concentrators (4-87-01049-9, Martha Smelser) 57,700

Fines and Restitutions

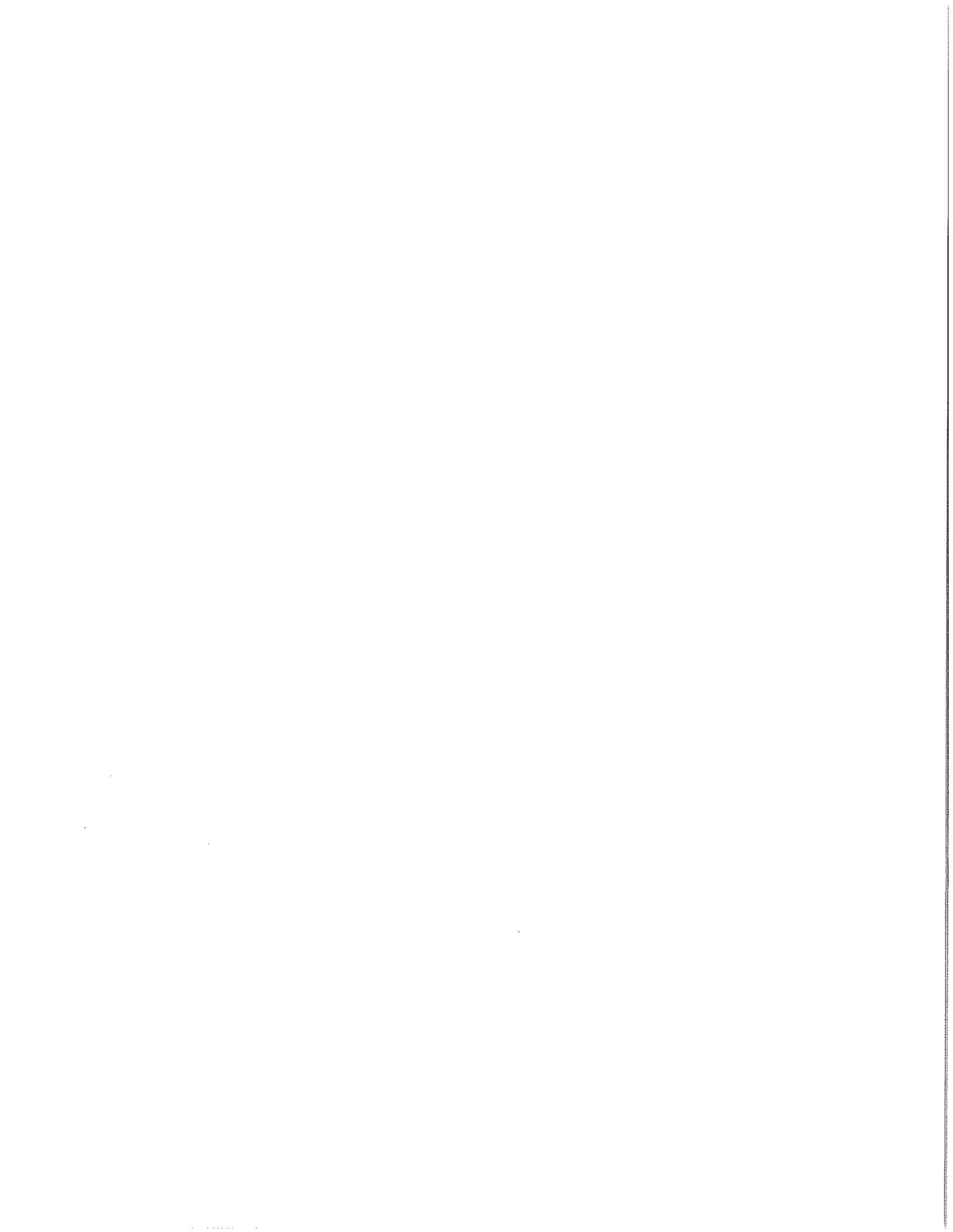
- Massachusetts man concealed marriage and home ownership to receive SSI benefits \$56,300*
(1-88-00188-6, Ronald McFarlane)
 - Ohio physician billed Medicare for work she did not do 54,000
(5-88-00933-9, Anne Deblanco)
 - Illinois doctor billed Medicare for unsubstantiated psychotherapy sessions 51,800
(5-86-00270-9, John Crawford)
 - Generic drug company official paid gratuities to Food and Drug Administration employee 50,100
(W-88-00110-3, Raju Vegesna)
- Other receivables which did not meet the \$50,000 threshold for individual reporting: \$17,163,229

**Includes recoveries.*

COOPERATION WITH OTHER LAW ENFORCEMENT AGENCIES

Many Federal, State, and local law enforcement and regulatory agencies depend on OIG expertise for assistance in identifying, locating, investigating, and prosecuting individuals who have improperly used Social Security numbers (SSNs) in a broad range of illegal activities, including bank and credit card frauds, licensing and income tax fraud, welfare fraud, drug trafficking, and racketeering as well as fraud in programs such as student loans, food stamps and unemployment compensation. Other agencies also benefit from OIG investigations, such as private health insurers, State Medicaid programs, and drug regulatory entities. Many of the cases in which OIG participates result in monetary fines, recoveries, restitutions or savings for these agencies. During this period, monetary fines, recoveries, restitutions or savings from these cases amounted to close to \$16.6 million for other public or private entities.

HEALTH CARE FINANCING ADMINISTRATION



CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

In FY 1990, the Medicare program will provide health care coverage for an estimated 34 million individuals. Medicare Part A (hospital insurance) provides, through direct payments for specified use, hospital insurance protection for covered services to persons 65 or older and to certain disabled persons. Financed by the Federal Hospital Insurance Trust Fund, FY 1990 expenditures for Medicare Part A including catastrophic are expected to exceed \$65 billion.

Medicare Part B (supplementary medical insurance) provides, through direct payments for specified use, insurance protection against most of the costs of health care to persons 65 and older and certain disabled persons who elect this coverage. The services covered are medically necessary physician services, outpatient hospital services, outpatient physical therapy, speech pathology services, and certain other medical and health services. Financed by participants and general revenues, FY 1990 expenditures for Medicare Part B are expected to be over \$43 billion.

The Medicaid program provides grants to States for medical care for more than 25 million low-income people. Federal grants are estimated at \$40 billion in FY 1990. Federal matching rates are determined on the basis of a formula which measures relative per capita income in each State. Eligibility for the Medicaid program is, in general, based on a person's eligibility for cash assistance programs, typically Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). States may also cover certain individuals who are not eligible for SSI or AFDC.

The OIG activities which pertain to the health insurance programs administered by the Health Care Financing Administration (HCFA) help curtail health care costs, improve quality of care and reduce the potential for fraud, waste and abuse. Through audits, evaluations and inspections, OIG recommends changes in legislation, regulations and systems to reduce unnecessary expenditures and improve inefficient health care delivery systems.

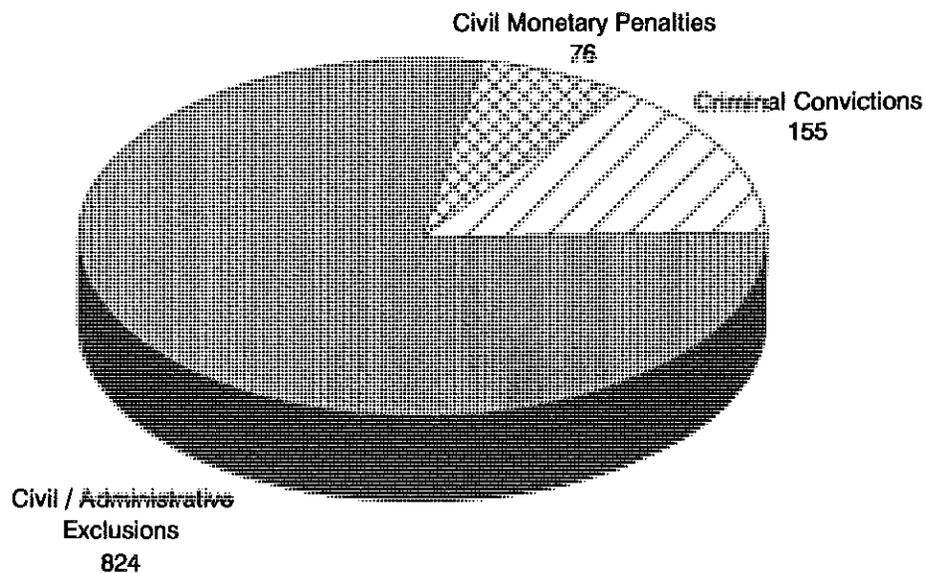
The financial impact of the prospective payment system (PPS) on hospitals, the increases in Part B expenditures, the implementation of physician payment reforms and the Clinical Laboratory Improvement Act of 1988, medical effectiveness, and the cost implications of changes in health care technology and delivery will continue to be of particular interest to OIG. The OIG's reviews identify innovative cost containment techniques, probe for improper cost shifting and validate the

adequacy of intermediary audits of hospitals' Medicare cost reports. Reviews detect overutilization of physician and related services and reduce vulnerabilities in payment systems. The OIG also seeks to identify mechanisms to contain increasing Medicaid costs, including monitoring States' collection of overpayments and costs claimed for treating patients residing in institutions for mental diseases and facilities for the mentally retarded.

As a result of actions taken in support of OIG recommendations in the second half of the fiscal year, Medicare and Medicaid will save over \$327 million (see Appendix A). During this reporting period, OIG identified program areas where legislative action, more efficient management and tightened internal and fiscal controls could result in significant additional savings. An additional \$283.3 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. In these instances, recommendations for financial adjustments and appropriate procedural changes were made.

Fraud and abuse of the Medicare and Medicaid programs or their beneficiaries may result in criminal, civil and/or administrative actions against the perpetrators. During this fiscal year, OIG was responsible for a total of 1,055 successful actions against wrongdoers.

HEALTH CARE PROGRAMS Successful Criminal, Civil and Administrative Litigations



INTERNAL CONTROL WEAKNESSES

The OIG identified the following material weaknesses within HCFA in the second half of FY 1990:

- Significant cost allocation problems exist in the area of HCFA's administrative expenses. (CIN: A-14-89-02036) (Page 38)
- Internal controls inherent in HCFA's procedures for administering the Department's less than effective drug provisions were inadequate to prevent improper Federal reimbursements totaling \$16 million in 23 States. (CIN: A-03-89-00220) (Page 41)
- Material weaknesses in internal accounting and administrative controls at Blue Cross of Massachusetts resulted in approximately \$10.7 million in duplicate payments to Worcester City Hospital. (CIN: A-01-90-00500) (Page 30)

OPPORTUNITIES FOR PROGRAM AND MANAGEMENT IMPROVEMENT

The following examples illustrate significant program and management weaknesses identified by OIG within HCFA during this reporting period:

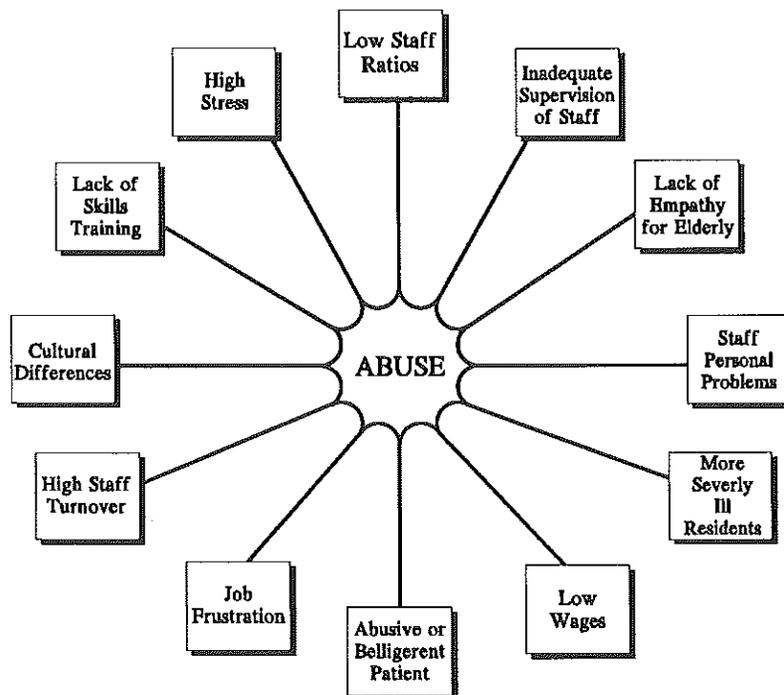
- The OIG determined that Medicare was paying nearly twice as much as physicians for the same clinical tests. (CIN: A-09-89-00031) (Page 26)
- The OIG found that Medicare carriers have no system in place to ensure that payments for a new technology decrease in response to decreasing costs for delivering an item or service. (OEI-01-88-00010) (Page 26)
- In a follow-up to a study done by the General Accounting Office, OIG found that HCFA had failed to implement an important recommendation to improve the process for identifying the amount of noncovered care in postpayment reviews of home health agencies. (CIN: A-14-90-03100) (Page 35)
- The OIG found that analysis of national nursing home abuse statistics was not possible because of variations in the definitions and types of abuse statistics collected under existing Federal and State requirements. (OEI-06-88-00360; OEI-06-88-00361) (Page 22)

RESIDENT ABUSE IN NURSING HOMES

The OIG conducted a study to examine the nature of abuse and ways to prevent it, and to review existing processes for resolving physical abuse complaints. For purposes of the study, abuse was defined as mistreatment or neglect of nursing home residents. The OIG reports reflect the perceptions of knowledgeable individuals who are involved in the resolution of abuse complaints, or those who have an interest in nursing home or elder issues.

Nearly all respondents indicated that abuse was a problem in nursing homes, though opinions differed as to the severity of the problem. Physical, verbal and emotional neglect, and verbal and emotional abuse were perceived as the most prevalent forms of abuse. While nursing home staff, medical personnel, other patients, and family or visitors were all believed to contribute to abuse, aides and orderlies were seen as the primary abusers in all categories except medical neglect. Several factors were seen as contributing to abuse by nursing home staff, as illustrated below.

FACTORS CONTRIBUTING TO ABUSE BY NURSING HOME STAFF



The OIG also noted weaknesses in State and Federal systems for reporting and resolving abuse complaints.

The OIG recommended that HCFA require ongoing training for direct care staff on the aging process and ways to cope with confrontational situations. In addition, HCFA should mandate stronger reporting, investigation, resolution and follow-up of abuse incidents as a condition of participation in the Medicare and Medicaid programs by nursing homes. The OIG further proposed that the Administration on Aging (AoA) collect and disseminate information on nursing home practices which decrease stress, and foster staff stability and adequate supervision. The AoA should also promote public awareness of the issues and the use of volunteer ombudsmen in all nursing homes. The HCFA and AoA should jointly develop common definitions and categories of abuse for all State and Federal reporting purposes.

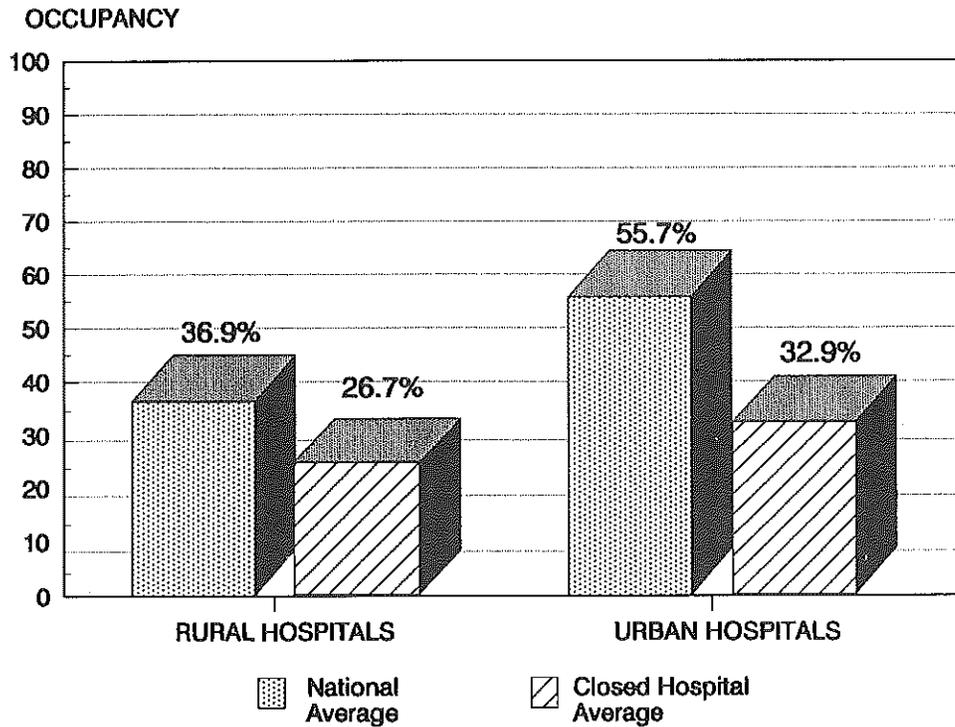
The several departmental operating and staff divisions which commented on the report were in general agreement with the findings and recommendations. The HCFA indicated that it has taken a number of actions to implement the OIG recommendations. (OEI-06-88-00360; OEI-06-88-00361)

HOSPITAL CLOSURE: 1988

The closure of hospitals in recent years has generated increasing public and congressional concern. At the request of the Secretary of Health and Human Services, OIG prepared a report in May 1989 describing the nationwide phenomenon of hospital closure in 1987. In response to the Secretary's request for additional analysis, OIG undertook a second study to examine the characteristics of, reasons for and impact of hospital closure in 1988.

The OIG found that 88 general, acute care hospitals closed in 1988, of which 4 have since reopened. Four new general, acute care hospitals opened in 1988. Eight which had closed in prior years reopened in 1988. The OIG found that occupancy rates for closed rural and urban hospitals were lower than the national averages, as illustrated below.

OCCUPANCY RATES



The OIG concluded that the reasons for hospital closure in 1988 were identical to those reported for 1987. No single factor or event caused hospitals to close. Rather, a number of factors gradually weakened the hospitals' financial condition. Hospitals that closed were reported to have had declining revenues due to fewer admissions, lower third-party reimbursement and increasing uncompensated care; and rising costs due to increasing demands for new medical technology, skilled personnel, and facility repair and renovation. Further, OIG determined that emergency care and inpatient medical care were available nearby in most communities where hospitals had closed. Only 11 percent of residents with a hospital still open within 10 miles indicated that they had a serious problem obtaining hospital care due to closure. However, 40 percent of residents who no longer have a hospital within 10 miles reported such a problem.

The OIG recommended that HCFA develop precise criteria for targeting Rural Health Care Transition Grants, giving a higher priority to remote hospitals. The HCFA should assure that the first seven states chosen to participate in the Essential Access Community Hospital program will adequately test the effect of the program on access to care. The OIG also recommended that HCFA and PHS consult with one another on their similar programs for improving access to medical care in rural areas. Both PHS and HCFA agreed with the recommendations. (OEI-04-89-01810; OEI-04-89-00742)

MEDICARE SECONDARY PAYER: UNRECOVERED FUNDS

The OIG conducted a study to determine the extent of unrecovered funds related to Medicare secondary payer (MSP) provisions, and to develop viable options to deal with MSP overpayments.

Based on a random sample of Medicare Part B beneficiaries, OIG found that significant overpayments continue to occur due to failure to identify primary insurance sources. The OIG study projected a loss to the Medicare program of at least \$385 million for FY 1988. Ninety-seven percent of the identified overpayments were the result of unidentified spousal insurance coverage.

The OIG recommended that HCFA revise all Medicare claims forms to require the submission of spousal insurance information before the claims can be paid. In addition, HCFA should prioritize the information received from the Social Security Administration (SSA) and develop those cases with an indication of a working spouse. The OIG also recommended the establishment of a voluntary disclosure and recovery program whereby insurers, employers or third-party administrators would be allowed to make restitution of improper payments without threat of future Government action on those claims. Finally, OIG recommended that HCFA propose legislation to require insurers to provide their health insurance data, including eligibility and claims information, to HCFA.

In preliminary comments HCFA agreed with the recommendations, and indicated that action has already been taken to revise the claims forms and prioritize the information received from SSA. The HCFA also agreed to develop the recommended legislative proposals, but disagreed with the recommendation to require insurers to provide health insurance data to HCFA. (OEI-07-90-00764)

OVERVIEW OF INTRAOCULAR LENS COSTS

The OIG conducted studies on intraocular lens (IOL) prices in Indian Health Service (IHS) hospitals and Canadian hospitals, as well as prices for IOLs available through the Federal Supply Schedule (FSS).

The OIG found that the average cost of an IOL is \$155 in IHS hospitals and \$110 in Canadian hospitals. On the FSS, IOLs are available for between \$95 and \$198. No direct correlation was found to exist between IOL volume and price.

Medicare's reimbursement rate for IOLs is considerably higher than the price established in other markets. The HCFA could save \$55.1 million annually if the Medicare reimbursement rate were reduced to no more than \$150. The HCFA agreed to explore further reductions in the Medicare reimbursement rates for IOLs. The HCFA is currently gathering data to determine the bottom

line costs of IOLs to ambulatory surgical centers (ASCs) and to plot the trend in IOL costs since implementation of the \$200 ASC IOL allowance. This data, along with OIG data, will be used to update facility payment rates effective July 1, 1992. (OEI-07-89-01660; OEI-07-89-01664; OEI-07-89-01661)

MEDICARE PAYMENTS FOR CLINICAL LABORATORY TESTS

An OIG audit determined that Medicare, which pays for tests based on fee schedules, was paying nearly twice as much as physicians for the same clinical tests. Much of the payment difference was attributable to the way in which Medicare reimbursed profiles, or batteries of tests, ordered as a group by physicians.

The OIG recommended that HCFA seek legislation to bring the Medicare fee schedule allowances in line with the prices physicians are paying for tests purchased from independent laboratories; develop policies and procedures to more appropriately handle profiles; and work with contractors to further streamline the processing of laboratory bills.

The HCFA commented that it favors Medicare competitive prices for tests, but did not believe the Congress would be willing to provide the necessary legislative authority. Nevertheless, HCFA agreed to take corrective action on each of the problems highlighted in the report. (CIN: A-09-89-00031)

NONPHYSICIAN SERVICES

Under existing law and regulations, PPS hospitals should not bill separately for nonphysician services, such as radiology work and electrocardiograms, provided on the day before admission to the same hospital or during an inpatient stay. The costs of such services are included in the PPS rates for each diagnostic related group.

An OIG audit revealed that improper Medicare payments of about \$40 million were made to PPS hospitals by fiscal intermediaries for the period February 1, 1986 to November 30, 1987. The OIG also found that beneficiaries of such services were unnecessarily charged about \$12 million as their coinsurance and deductible share in such payments. Improper claims were not denied payment because the intermediaries' computer edits were inadequate. Subsequent computer matches of payments indicate that the problem seems to be continuing. The HCFA agreed to take corrective actions in response to the OIG recommendation. (CIN: A-01-90-00516)

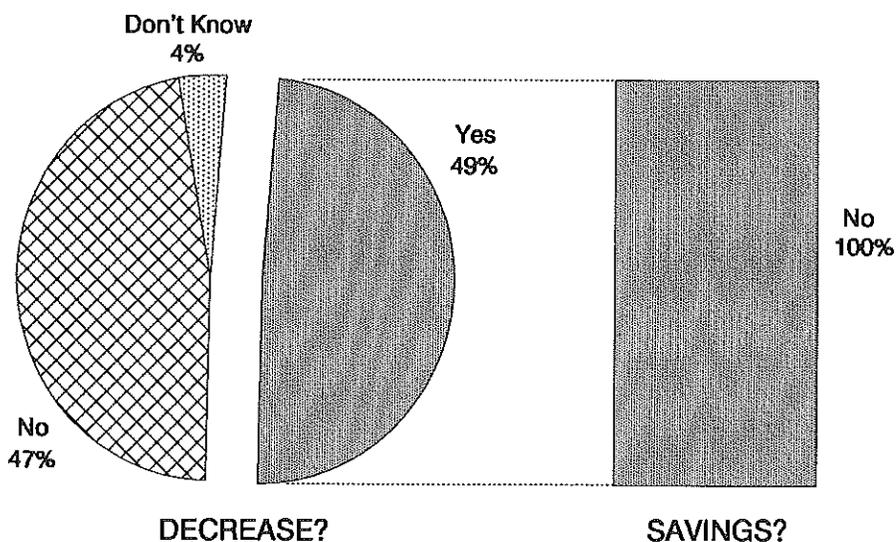
MEDICARE CARRIER ASSESSMENT OF NEW TECHNOLOGIES

In their role as processors of approximately 400 million claims filed annually for health care items and services, the Medicare carriers are required to identify and make coverage and pricing

decisions about almost all new health care technologies. An OIG inspection examined the manner in which the carriers administer their technology assessment responsibilities.

The OIG found that carriers desire additional and more timely information from HCFA on coverage and pricing matters for new technologies. In addition, OIG noted a wide and unwarranted variation in coverage and pricing decisions among the carriers. Further, while half the carriers agreed that the costs of new technologies decrease over time, there is no system to provide for a corresponding decrease in Medicare payments for these technologies.

DO NEW TECHNOLOGY COSTS TEND TO DECREASE WITH USE AND ARE THERE MEDICARE SAVINGS?



Source: all Medicare carriers as reported to Office of Inspector General, HHS, 1988.

The OIG recommended that HCFA continue to improve its own capability and that of the carriers to identify emerging technologies and to make more informed, explicit and consistent coverage and pricing decisions concerning new technologies. Moreover, OIG proposed that HCFA seek legislative authority to broaden the bases upon which it can establish reimbursement amounts for new and emerging technologies other than physician services. This authority should be available to HCFA both at the time of the initial coverage decision and as the technology matures. The HCFA generally concurred with the findings and recommendations, and noted that it has undertaken numerous recent initiatives to improve technology assessment. At HCFA's request, OIG will conduct an additional study aimed at assessing the effectiveness of these initiatives. (OEI-01-88-00010)

KICKBACKS

Under Federal statutes, anyone who offers, pays, solicits or receives payment for referral of patients covered by the Medicare or State health care programs is subject to fines, imprisonment and exclusion from these programs. The following cases are examples of kickback cases successfully concluded during this reporting period:

- In New York, sixteen doctors and physician's assistants were sentenced for accepting kickbacks from a durable medical equipment (DME) company. A total of \$88,600 was ordered in fines and restitutions. The individuals sentenced were among 25 arrested for accepting kickbacks of \$50 to \$300 for each referral to the DME company. (2-89-00039-9, Douglas Esposito)
- A chemical company salesman was the first person to be sentenced in a kickback case spanning Wisconsin, New York and Florida. The case was initiated after an outraged hospital employee reported that the salesman had offered him a "premium" in return for ordering his company's cleaning products. The salesman pled guilty after reviewing evidence obtained from taped conversations and search warrants of company offices. He was sentenced to 2 years probation because of his advanced age, fined \$5,000 and ordered to pay restitution of \$3,400. (5-87-00808-9)

INDIRECT MEDICAL EDUCATION PAYMENTS

An OIG review found that the intermediary's audits failed to disclose that two Louisiana hospitals had overclaimed indirect medical education costs of about \$5.4 million for FY 1985 through FY 1988. The overclaims occurred because the hospitals incorrectly determined the number of interns and residents associated with the program.

Under the Social Security Act, payments are made to hospitals operating approved medical education programs. These payments are intended to compensate them for the additional costs associated with the educational process. During the year, PPS hospitals receive interim payments based on estimates of the Federal portion of their annual Medicare inpatient revenue. The intermediary then audits cost report data to determine whether any adjustments are necessary.

The OIG recommended that the intermediary amend its audit procedures to place greater emphasis on the indirect medical education adjustment, and recover the overpayments made to the two hospitals. The intermediary and HCFA were in general agreement with the OIG findings and are implementing the recommendations. (CIN: A-06-88-00069)

MEDICATION REGIMENS: CAUSES OF NONCOMPLIANCE

The OIG conducted a study to determine the reasons many elderly people fail to follow prescription drug regimens and what the Department can do to improve compliance with drug regimens in this population group.

Research has shown that a significant proportion of elderly people do not correctly follow their physicians' instructions for taking prescription medications. Medication utilization problems may affect the health and quality of life of a sizeable number of elderly persons. These problems may also result in unnecessary health care spending. There were found to be many interrelated variables contributing to noncompliance with drug regimens. These variables fell into four main categories: physiological factors, behavioral factors, treatment factors and health care provider/patient interaction. Researchers have found that education, based on individual patient needs, is the most effective form of intervention for noncompliant behavior.

The OIG recommended that HCFA initiate demonstration projects to determine which forms of physician, pharmacist and patient education work best to improve compliance. The PHS should promote research on medication compliance, and evaluate current programs which promote the education and training of health care practitioners on improving compliance. The AoA should continue their educational efforts and direct some discretionary grant money to programs aimed at medication compliance problems among minority elderly groups. Both HCFA and PHS agreed with the recommendations and are pursuing a number of research and demonstration projects. The PHS is in the process of evaluating current programs and will consider modification to funding priorities in FY 1992 based on the results. (OEI-04-89-89121; OEI-04-89-89122)

EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

The OIG conducted a study of Medicare charges for extracorporeal shock wave lithotripsy (ESWL), a noninvasive procedure for treating kidney stones. The study found that physician allowances for ESWL established by many carriers were unreasonable. Of 20 carriers reviewed, 13 set maximum allowable charges averaging \$1,525, while the remaining 7 set maximum allowable charges averaging \$748. Larger allowances could not be justified by differences in the services provided, geographic areas or physician specialty.

The carriers used three general methodologies to establish reasonable charges for new procedures. The ESWL allowed charges were linked to payments for kidney stone surgery, medical consultants' recommendations and private plan charges, or medical procedures and inherent reasonableness. The carriers with the higher maximum allowances had generally linked them to a surgical procedure or relied on medical consultant's advice, while the carriers with the lower allowances linked them to medical procedures.

The HCFA did not agree with OIG's initial recommendations to address the unreasonable allowances. Subsequent to HCFA's comments, legislation was enacted that reduced payments for overpriced procedures in 1990 and phased in a fee schedule system beginning in 1992. The scheduled reductions for 245 procedures (including ESWL) are limited, leaving many of them still significantly overpriced after 1990. Therefore, OIG recommended that HCFA seek legislation to reduce payments for ESWL and the other procedures by the full amount by which they are overpriced. (CIN: A-09-89-00082)

MEDICARE HOSPITAL PAYMENTS

In order to protect the Medicare trust fund, HCFA's guidelines require that fiscal intermediaries establish and maintain strong internal accounting and administrative controls over payments they make to providers. An OIG audit found material weaknesses in internal accounting and administrative controls at Blue Cross of Massachusetts, resulting in approximately \$10.7 million in duplicate payments under two reimbursement methods to one hospital. The OIG recommended that Blue Cross implement effective internal accounting and administrative controls to detect and prohibit such duplicate payments in the future; complete an audit at the hospital to establish final liability; recover any overpayments; and charge any appropriate interest on the overpayments. Blue Cross agreed with the findings and recommendations and instituted corrective action. The HCFA agreed to report the deficiencies as a material internal control weakness under FMFIA. (CIN: A-01-90-00500)

PHYSICIANS' CLAIMS PROCESSING

At the request of the Secretary and the Acting Administrator of HCFA, OIG conducted a review of the Medicare Part B carrier in Georgia, Aetna Life Insurance Company (Aetna-Georgia) and its subcontractor for medical review/utilization review (MR/UR), Healthcare COMPARE (HCC). The review focused on concerns expressed by the Georgia medical community regarding denials and adjustments to their claims by the MR/UR function at Aetna-Georgia. To test the MR/UR determinations, OIG contracted with an independent physician-consultant. The review covered the 3-month period ending December 31, 1989. The OIG found the MR/UR policies and processing protocols of the carrier consistent with HCFA guidelines. The OIG concluded that the carrier and its subcontractor had processed physician claims in accordance with Medicare laws, regulations and HCFA's guidelines. The OIG recommended that HCFA continue to evaluate the impact of independent MR/UR on the Medicare program expenditures. (CIN: A-04-90-02008)

SANCTION AUTHORITIES

During this reporting period, OIG imposed 900 sanctions, in the form of exclusions or monetary penalties, on individuals and entities for engaging in fraud or abuse of the Medicare and Medicaid programs and/or their beneficiaries.

A. Patient and Program Protection Sanctions

The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can now be made for conviction of fraud against a private health insurer, obstruction of an investigation and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse. The following cases are examples of some of the sanctions imposed during this reporting period:

- The owner and operator of several New York ambulance companies was excluded from the Medicare and any State health care programs for 25 years. He had been convicted of filing false Medicare claims for more than 4 years, obtaining about \$1 million to which he was not entitled. A false claims suit against him was settled earlier for \$4.2 million. (2-89-41270-9)
- The husband and wife co-owners of several DME companies in Texas were each excluded for 20 years after being convicted of a scheme to defraud the Medicare program. Their companies were also excluded for the same period of time. (6-89-40829-9)
- A 25-year exclusion was imposed on two sisters, both supervisory employees of a residential care facility, who stole money by creating phantom employees and phantom contractors whose salaries and expenses were included in the cost reports submitted to the Maine Medicaid program. (1-90-40086-9)
- After being convicted of breaking the arm and bruising the face of an 85-year-old bedridden nursing home patient, a nurse's aide in Texas was excluded for 20 years. (6-89-40147-9)
- Three management officials of a Utah community mental health center were each excluded for 15 years after conviction for misusing public moneys. (8-89-40748-9)
- A Pennsylvania pharmacist, convicted of distributing controlled substances without legitimate medical purpose, was excluded for 10 years. (3-90-40054-9)
- After surrendering his license during a formal disciplinary proceeding, a Minnesota doctor was excluded indefinitely. (5-89-40101-9)
- A California dentist whose license was revoked for being grossly negligent was excluded indefinitely. (9-89-40398-9)

- A Pennsylvania pharmacy and pharmacist were excluded indefinitely as a result of their being barred from participation in the Pennsylvania Medicaid program. (3-90-40182-9)
- A Florida osteopath was excluded for defaulting on repayment of his Public Health Service (PHS) scholarship obligation. He will remain excluded until PHS indicates the default has been made good or the obligation has been resolved. (4-89-00000-9)

B. Civil Monetary Penalty Settlements

Under the civil monetary penalty (CMP) authorities enacted by the Congress, health care providers may be assessed thousands of dollars in fines and penalties for each false item claimed against Medicare and Medicaid. The following cases are examples of some of the more significant settlements made during the past 6 months:

- In Georgia, the owner/operator of physical therapy clinics and a nursing home had to pay more than \$1 million to settle criminal and civil fraud charges. The company pled guilty to defrauding Medicare by billing for the owner's personal expenses such as jewelry, cars, vacations and costs associated with show dogs. Many of the billings were disguised as salaries for employees. The owner, his wife, the nursing home and clinics he operated in eight States had to pay more than \$900,000 to settle civil charges and \$100,000 in criminal fines. An additional \$182,000 in legitimate Medicare reimbursement was also withheld. The owner will not be allowed to participate in the Medicare and Medicaid programs for 2 years, and thereafter may submit only audited cost reports. (4-80-30022-9, Joseph Gentzel)
- A Louisiana corporation specializing in gynecology and obstetrics agreed to pay the Department and the State \$378,000, and was prohibited from participating in Medicare, Medicaid and State health care programs for 5 years. One of the corporation doctors misrepresented the services provided to some beneficiaries by billing for multiple deliveries to the same patient, billing for deliveries performed by other doctors, and billing for services which were not provided on the noted dates or were not provided at all. About 18 percent of approximately 2,000 claims submitted by the corporation over a 15-month period were false or fraudulent. (6-90-30077-9, Upendra Kulkarni)
- An ambulance company serving several Pennsylvania hospitals agreed to pay a settlement of \$300,000 to avoid potential civil and administrative penalties law. The company submitted claims for ambulance trips for patients who were transported in vans or nonambulance vehicles, which are not covered under the Medicare program. (3-90-20185-9, Metropolitan Ambulance)

- A doctor in Texas agreed to pay approximately \$100,000 to avoid potential civil and administrative action. The doctor billed the Medicare and Medicaid programs for laboratory services he did not have the equipment or resources to perform. (6-89-30593-9, Jacques Kestelyn)
- An Ohio ophthalmologist signed an agreement to pay the Government \$95,000 for filing false Medicare claims. In 1987, he was found guilty in a jury trial of billing for unnecessary and unperformed laser surgeries. He was fined \$75,400 and ordered to serve 14 months in a Federal penitentiary. He was later excluded from the Medicare and Medicaid programs, and his medical license was revoked. (5-87-30002-9, Doyle Campbell)
- Another ophthalmologist in Massachusetts had to pay \$130,000 for submitting false Medicare claims related to cataract surgery. He billed separately for procedures performed at one time. (1-88-30201-9, Fred Greenberg)

MEDICARE PART A CASES

The most common method of obtaining undeserved reimbursement from Medicare for hospitals and home health agencies is misrepresentation of expenses on cost reports. These reports serve as a basis for prospective payments to these organizations. The following cases illustrate some of the successful investigations in this area:

- A Texas home health agency, its owner/president and its controller were sentenced to pay \$1,386,300 in fines, restitutions and special assessments for submitting false claims to Medicare. The owner/president forged physicians' signatures on certification forms, and the controller directed employees to alter nurses' notes, add services to Medicare claims and use the forged forms. He also made false ledger entries and carried "ghost" employees on payroll records. (6-88-00212-9, Alternative Health Care)
- The osteopath owner of an Oklahoma hospital and clinic was convicted for filing false Medicare and Medicaid claims. The hospital filed claims for the services of a man posing as a physician's assistant who was also on probation for theft of controlled drugs. During the investigation by OIG, the hospital employees left, forcing the hospital to shut down operations. Because of his age and medical condition, the owner was sentenced to 2 years probation and ordered to make restitution of \$1,400. (6-89-00272-9, Glen Moots)

- A California laboratory billed Medicare Part A for tests as performed in hospitals when they were really done in doctors' offices. The Medicare carrier collected the resulting overpayment of more than \$368,400. (9-89-0431-9, Arka Rosenberg)

FRAUD INVOLVING DURABLE MEDICAL EQUIPMENT

Fraud in the DME industry continues to be a source of major concern to OIG. Seat lift chairs, wheelchairs, transcutaneous electrical nerve stimulators, oxygen equipment, home dialysis systems, and similar equipment are reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this prescription by engaging in aggressive sales practices, tricking physicians into signing authorizations, and even forging physician signatures. Some suppliers simply bill for items never delivered. The following cases are examples of some of the actions taken against suppliers during this reporting period.

- The office manager of a New York DME company was sentenced to 30 months in jail for Medicare fraud. She conspired with the company owner to submit more than 600 false claims to Medicare for items such as oxygen concentrators which were never delivered. She must also pay \$137,000 restitution and a \$50 special assessment. The company owner was also convicted and sentenced earlier. (2-86-00912-9, Anne Moore)
- In Tennessee the owner of a DME company was sentenced to 3 months in prison, fined \$4,400 and ordered to make restitution of \$53,300 for defrauding Medicare. She falsified results of arterial blood gas tests to use in certificates of medical necessity for oxygen concentrators. (4-87-01049-9, Martha Smelcer)

MEDICARE ENROLLEES' PRIOR CATASTROPHIC COVERAGE

In a review performed prior to repeal of the Medicare Catastrophic Coverage Act (MCCA) of 1988, OIG studied the extent of prior coverage for two of the legislation's major benefits: the elimination of hospital coinsurance and liability for only one hospital deductible a year. The OIG issued this report in the event that the Congress considers a similar expansion of benefits in the future.

The OIG found, based on the study sample, that enrollees' need for the new coinsurance and deductible benefits may have been overestimated when the Congress was considering the MCCA. The OIG's sample indicated that in 1987 enrollees paid only 9 percent of coinsurance payments, with the remaining 91 percent paid by other sources. For deductible requirements, OIG found that enrollees paid only 11 percent of the deductibles while 89 percent was paid by other means.

The OIG recommended that the need for such coverage be accurately determined if legislative proposals for catastrophic coverage are reconsidered. The HCFA questioned some of the findings and suggested that OIG consider reviewing the results of another survey which found a wide variation in insurance coverage from State to State. The OIG believes that this other survey had a different focus and sees no need to expand its own study in light of the repeal of MCCA. (CIN: A-09-90-00046)

HOME HEALTH CARE

The OIG performed a follow-up review of a 1986 General Accounting Office (GAO) report to determine whether actions taken by HCFA had resolved the problems noted. The GAO reviewed the Medicare home health program to determine the status of efforts to strengthen internal controls designed to prevent payment for services not covered by Medicare. In addition, GAO sought to determine how many chronically ill elderly had home health care needs that were unmet by either Medicare or other care givers. The principal GAO finding was that weaknesses in internal controls at the fiscal intermediaries and HCFA contributed to improper payments of approximately \$600 million for home health services during FY 1984.

The OIG determined that HCFA had implemented GAO's recommendation to clarify home health coverage criteria, and was in the process of instituting national prepayment utilization screens for home health services. The HCFA had also expanded the contractor performance evaluation program to assess the accuracy of intermediary home health coverage determinations and to further study factors contributing to unmet needs for home care assistance. However, OIG found that HCFA had not implemented the GAO recommendation to require the use of statistically valid sampling methods for identifying the amount of noncovered care in postpayment reviews of home health agencies. The OIG was informed that implementation of this recommendation is scheduled for January 1, 1991. The OIG believed this proposal to have merit and suggested that it be implemented on schedule or as soon as possible. (CIN: A-14-90-03100)

HOSPITAL COST REPORT INFORMATION SYSTEM

The OIG performed an audit of the Hospital Cost Report Information System (HCRIS), a national database of hospital financial and statistical information generated from Medicare cost reports. The data is gathered and transmitted to HCFA by insurance companies who act as fiscal intermediaries for Part A of the Medicare program. The HCRIS is maintained and administered by HCFA. Information from this database is used by a variety of Federal and State agencies, the Congress and private consultants. The purpose of the review was to ascertain the degree of accuracy of selected data contained in HCRIS.

Overall, OIG found the HCRIS database to be well maintained, well managed and generally accurate. The internal controls at HCFA and at the fiscal intermediaries were determined to be

adequate. However, OIG recommended that HCFA execute a written disaster recovery plan for the data center and identify HCRIS as a critical application to be recovered in an emergency. The HCFA agreed to develop a disaster recovery plan. Further, OIG recommended that HCFA report the audit as a completed alternative internal control review under the provisions of Office of Management and Budget Circular A-123. (CIN: A-07-88-00120)

BAD DEBTS INCURRED FOR MEDICARE BENEFICIARIES

The OIG studied the continuing escalation in Medicare bad debt payments to acute care hospitals. These annual payments increased from \$159 million to \$399 million over the last 3 years. Average payments per hospital during this period increased from \$42,000 to \$91,000.

To address the cost escalation problem, OIG's management advisory report offered a number of policy options for HCFA's consideration. These options included eliminating Medicare reimbursement for the bad debts; limiting bad debt payments to hospitals that incur losses under Medicare's PPS; or including an amount to cover bad debts in the PPS rates. (CIN: A-14-90-00339)

FALSE CLAIMS

The range of individuals convicted during this period for fraud against the Medicare and Medicaid programs is illustrated by the following cases:

- An Illinois physician was sentenced to 1 year in a work release program, during which he is to live at the Salvation Army, for submitting false billings to Medicare and private insurers. He also must pay restitution of \$100,000 and a fine of \$53,200. Investigators from OIG and the Postal Inspection Service produced evidence that he had billed for services not provided and for tests and services which were not medically necessary. He had used the name of a doctor who suffered from amnesia to bill Medicare, endorsed the checks with the doctor's name and put the money in an account to which the doctor had no access. As part of his sentence, he must perform 600 hours of community service and serve 5 years probation, during which he cannot practice medicine for remuneration. (5-87-00124-9, Bruce Livingston)
- A man was sentenced in Florida to 5 years in prison and \$24,000 in restitution after being convicted of conspiracy and Medicare fraud. He had instructed the billing clerk in his medical clinic to submit claims for chemotherapy when he had actually performed chelation therapy. Earlier he had lost his medical license for pressuring people to whom he had given free electrocardiograms to enter his diet program. (4-85-01600-9, Surindar Bedi)

- A Medicare carrier employee in Indiana was sentenced in State court for forgery of Medicare checks. As an employee in the carrier's mail room, she opened returned checks. She and a sister-in-law, who was convicted earlier, forged endorsements and cashed the checks for their own use. Investigation by OIG indicated that they had obtained a minimum of \$13,000 from 54 checks, although she was convicted of forging only two. She was given a suspended 2-year prison sentence and 1 year of probation, and ordered to undergo substance abuse evaluation and counseling. (5-87-00802-9, Shelley Boswell)

DIALYSIS REIMBURSEMENT RATES

Medicare reimbursement rates for dialysis services differentiate between freestanding and hospital providers. In FY 1989, payments totaled \$2 billion for kidney dialysis treatments provided to Medicare beneficiaries. These payments averaged \$125 per treatment for freestanding facilities and \$129 for hospitals. Audits conducted by OIG since 1986 indicate that while the average cost for performing dialysis treatments for Medicare beneficiaries has been decreasing, no correlating decreases in the Medicare prospective payment rates have been made. The HCFA, with OIG assistance, has accumulated cost data for 1985 and is presently accumulating data for 1988 to compute a new composite rate.

The OIG's current audit of the 1988 home office costs of the largest chain of owned and managed freestanding facilities participating in Medicare shows that its costs have decreased from \$117 per treatment when the rates were established in 1980, to \$89 in 1988. Due to the prominence of this chain, their audited costs have a significant impact on the median cost of providing a dialysis treatment. Using Medicare audited costs and the current composite rate, this facility chain earned \$36, a 29 percent profit margin, for each treatment in 1988.

Both the 1985 and the current 1988 audited data justify a decrease in the Medicare payment rate for end stage renal disease dialysis services. Facilities have become more efficient in their operations which has enabled them to reduce treatment costs since 1980. Medicare payment rates should be reduced to reflect this cost efficiency. (CIN: A-14-90-00215)

MEDICAL TRANSPORTATION FRAUD

The OIG continues to obtain convictions of ambulance companies and their officers for Medicare and Medicaid fraud as illustrated by the following examples:

- The former vice president of a Michigan ambulance company was sentenced to 15 months in prison for Medicare fraud. He signed a promissory note to repay the Government \$219,900 in monthly installments. He had pled guilty to billing

Medicare for transportation of Medicare patients by ambulance when they were actually transported by van. (5-88-00557-9, Shan Sawyer)

- A Rhode Island ambulance company and its owner were convicted in State court of Medicare and Medicaid fraud. The company was fined \$4,600 and ordered to repay more than \$45,000 to Medicare and the Rhode Island and Massachusetts Medicaid programs. The company owner was given a 3-year suspended prison sentence. The company billed for ambulance services for people in wheelchairs and for routine, nonmedically necessary transportation and inflated mileage. The case was investigated by OIG and the State Medicaid fraud control unit. (1-86-00466-9, Rhode Island Ambulance, David Chappel)

COST ALLOCATION SYSTEM

The OIG performed an audit of the system used by HCFA to allocate program management costs of \$1.4 billion during FY 1988. The audit showed that HCFA's system for allocating administrative costs was not in conformance with the principles and standards established by the Comptroller General.

Within the four areas which account for 98 percent of HCFA's program costs, the review identified significant cost allocation problems only in the area of HCFA's administrative costs. This area represents approximately 17 percent (or \$236 million) of HCFA's program management costs. The OIG found that the system did not accurately or equitably allocate administrative costs among the general fund and the trust funds, or between the two trust funds. The OIG recommended that HCFA establish a cost allocation system that conforms to the requirements established by the Comptroller General. Further, OIG proposed that the Assistant Secretary for Management and Budget (ASMB) provide guidance to HCFA in implementing the system and periodically monitor the system to ensure that it is properly maintained. The OIG also recommended that HCFA include a synopsis of the material nonconformance in the Department's annual Federal Managers' Financial Integrity Act (FMFIA) report.

The HCFA agreed that action needs to be taken to improve its cost allocation system, and to report the deficiencies as a material internal control weakness under FMFIA. The ASMB agreed to provide guidance to HCFA on its cost allocation system to assure consistency with other systems in the Department. (CIN: A-14-89-02036)

ASSET REVERSIONS FROM PENSION PLAN TERMINATIONS

The OIG concluded that HCFA's reimbursement policy does not allow Medicare to receive its fair share of pension asset reversions when hospitals terminate their defined benefit pension plans. Asset reversions are created when pension assets exceed liabilities for benefits earned up to the pension plan termination dates. The OIG estimates that, under present procedures, Medicare would receive only about 5 percent of the total profits realized by 81 hospitals which

terminated their pension plans between October 1, 1983 and December 31, 1988. Yet, on a national basis, Medicare paid about 31.5 percent of the pension plan contributions that created those profits. Accordingly, Medicare's equitable share of the asset reversions should be about \$109.4 million, rather than the \$17.4 million that would be payable under current policy.

The OIG recommended that HCFA promulgate and implement regulations to ensure that, in the future, Medicare shares in pension asset reversions at a rate commensurate with its contributions to the accumulation of the excess assets. In addition, OIG urged that HCFA develop and recommend legislation to enable Medicare to receive its equitable share of asset reversions for pension plan terminations which occur prior to the implementation of the proposed regulations. The HCFA maintains that OIG's recommendations conflict with the conceptual idea of the PPS system now in place. However, OIG continues to support its recommendations and the matter will be going before the Audit Resolution Council. (CIN: A-07-90-00262)

PENSION PLAN REVERSION: MINNESOTA

Federal regulations require that an adjustment to previously allowable costs under Medicare be made when an occurrence, such as a pension plan termination, reduces the contractor's obligation for payment. At HCFA's request, OIG audited pension costs charged to Medicare by Blue Cross and Blue Shield of Minnesota (BCBSM), a Medicare contractor that terminated a defined benefit pension plan. The audit found that BCBSM received excess assets from Medicare contributions as a result of changes in the pension plan. The OIG recommended that the contractor return Medicare's share of the reversion in excess of \$5 million. The BCBSM and HCFA agreed to a settlement. (CIN: A-07-90-00263)

IMPROPER STATE CLAIMS FOR FEDERAL MEDICAID FUNDS

The costs of the Medicaid program are shared by the Federal and State Governments. However, the law and regulations stipulate that the Federal Government will share in the cost of care and treatment only when certain criteria are met.

A. Institutions for Mental Diseases

Medicaid law precludes Federal matching for patients under age 65 in institutions for mental diseases (IMDs), except for patients in qualified psychiatric hospitals under age 21, and in certain cases for patients under age 22.

1. Illinois

An OIG audit determined that Illinois should make a financial adjustment of approximately \$34 million (Federal share \$17 million) for inappropriate claims for payment to 13 IMDs made between October 1, 1986 and December 31, 1988. In addition, OIG recommended that the State

establish controls to preclude such ineligible claims in the future. Both HCFA and the State concurred with the findings and recommendations. (CIN: A-05-89-00086)

2. Indiana

Based on a review of an Indiana hospital, OIG concluded that the facility had the overall characteristics of an IMD. Accordingly, OIG found that approximately \$1 million in Medicaid funds had been improperly claimed by the State as Federal reimbursement for patient care. The OIG recommended that the State make a financial adjustment of \$1 million and implement controls to identify similar facilities having the characteristics of an IMD. Although the State disagreed, HCFA concurred with the findings and recommendations. (CIN: A-05-89-00091)

3. New York

An OIG review in New York disclosed that the State improperly claimed nearly \$390,000 (Federal share) in Medicaid reimbursement for patients aged 21 to 64 at five of nine psychiatric hospitals included in the audit. The improper claims occurred because of problems related to an edit in the State's Medicaid management information system (MMIS) and an absence of claims monitoring by the State. The OIG recommended the recovery of the Federal share of improper payments and the modification or addition of edits to the State's MMIS to prevent improper claims from being paid. (CIN: A-02-89-01031)

B. Medicaid Inpatient Psychiatric Benefits for Children

Presently, 37 States and the District of Columbia offer inpatient psychiatric services for individuals under age 21 as an optional Medicaid service at a cost approaching \$1 billion per year. For services to be eligible for Federal financial participation, the law and implementing regulations require a formal certification of need for inpatient psychiatric care. A team, consisting of physicians and other qualified personnel, must make a determination that inpatient services are necessary and can reasonably be expected to improve the patient's condition. By this means, the Congress sought to assure that eligible youths would be helped and placed back into society, and that controls were in place to protect them from being locked up.

As a result of a HCFA regional office alert, OIG found serious problems in five States visited, where Medicaid agencies had not required certifications of need. Further, with the exception of the regional office which initially identified the problem, monitoring activities had apparently not identified and addressed these noncompliance problems. Consequently, thousands of youths have entered psychiatric facilities in these States without the required assurances as to the need for inpatient care. The OIG estimates that \$205 million (Federal share) in improper payments have been made to the five States.

The OIG recommended that HCFA reemphasize the requirements for certifications of need to all States providing inpatient youth psychiatric services and that coverage of this area be included in HCFA's monitoring visits. The HCFA concurred with the first recommendation, but intends to

postpone the initiation of any monitoring actions until all OIG reports on the individual States are issued. (CIN: A-06-89-00048; CIN: A-07-89-00225; CIN:A-02-89-01031; CIN: A-04-89-01025)

C. Overpayments

Overpayments to providers are generally not reimbursable under Medicaid. When a State determines that an overpayment has occurred, it must return the Federal share regardless of provider appeals or whether actual collections of the overpayments have been made.

1. Illinois

The OIG found that Illinois had improperly claimed nearly \$4.8 million (Federal share about \$2.4 million) for uncollectible overpayments between July 1, 1980 and June 30, 1989. The OIG recommended that the State make the appropriate financial adjustment and establish procedures to ensure that uncollectible overpayments are not claimed for Federal reimbursement. Officials at HCFA and the State agreed with the findings and recommendations. (CIN: A-05-89-00071)

2. California

The OIG determined that for FY 1981 through FY 1985, California failed to credit the Federal Government with its share (\$14.9 million) of overpayments made to hospitals. The State's practice was to refund the Federal share only after recoveries had been made from providers. The OIG recommended that California return the \$14.9 million to the Federal Government and develop procedures to promptly return the Federal share of overpayments. The State disagreed with the OIG findings and recommendations. (CIN: A-09-89-00165)

D. Less than Effective Drugs

Effective October 1, 1982, the Federal Government does not pay for drugs determined to be less than effective (LTE). An OIG audit in 23 States found that almost \$16 million in Federal funds were improperly paid for LTE drugs prescribed for and dispensed to Medicaid recipients. The review concluded that HCFA does not have an adequate system of internal controls to prevent Medicaid reimbursement to State agencies for purchases of LTE drugs, and that this inadequacy constitutes a material internal control weakness under the FMFIA.

The OIG found that HCFA did not provide States with a list of LTE drugs, as recommended in a prior OIG report, until September 1989. Moreover, HCFA has yet to enter into a memorandum of understanding with the Food and Drug Administration (FDA) to establish an ongoing system to identify and maintain a compendium of all LTE drugs for dissemination to States. In addition, OIG noted that due to the lack of a fully effective drug withdrawal system in FDA, LTE drugs sometimes remained in the marketplace long after they were determined to be less than effective.

The OIG recommended that HCFA report the material weakness in internal controls; develop and implement a corrective action plan to include execution of a memorandum of understanding with FDA to implement systemic improvements in the administration of the Department's procedures as they relate to LTE drugs; and devise a more efficient system of withdrawing LTE drugs from the marketplace. The HCFA generally agreed to the procedural recommendations for improvement, but did not believe there was a material internal control weakness. The Public Health Service, with one exception, agreed in principle with the recommendations. (CIN: A-03-89-00220)

E. Medicare Premiums for Medicaid Buy-in Enrollees

The buy-in program makes it possible for States to enroll eligible Medicaid recipients in the Medicare Part B program, thus shifting to the Federal Government more of the financial burden of providing health care to the nation's elderly and poor. The OIG conducted a follow-up review to determine whether actions taken by HCFA had resolved problems noted in a prior OIG report. That report had recommended that HCFA, working with the Social Security Administration (SSA), periodically reconcile the SSA master beneficiary record (MBR) with the HCFA third-party master tape (TPM) to ensure proper billings for buy-in enrollees.

The current review showed that HCFA has continued its aggressive implementation of the OIG recommendations. By implementing OIG recommendations, HCFA has recovered about \$8.1 million from State agencies and should increase Part B trust fund revenues by about \$13 million over 5 years. These recoveries and savings should increase because HCFA intends to continue periodic reconciliations of the MBR to the TPM to ensure that State agencies are billed properly for Medicaid recipients enrolled in the buy-in program. The OIG believes, therefore, that no additional audit recommendations are warranted. (CIN: A-03-90-00620)

F. Abusable Drugs

The OIG issued a report on its national initiative to improve States' internal controls over prescription drug abuse and diversion under the Medicaid program. With the assistance of the United States Drug Enforcement Administration (DEA), OIG developed a computer program that identified physicians, pharmacies and recipients with the greatest potential for involvement in trafficking and abusing Medicaid prescription drugs. The OIG offered the computer program to all States that wished to improve their internal controls over prescription drugs.

The OIG initiative culminated in the distribution of a video cassette to every State Medicaid director in the country, except those who had previously requested OIG assistance. The video explains the OIG initiative and discusses in some detail the preliminary results in New Mexico, where State officials requested the program software for incorporation into their existing system of internal controls.

The OIG has since received inquiries from officials and law enforcement agencies in other States, and expects additional State requests for the computer program as a result of the video solicitation. The OIG is prepared to assist every respondent in testing the effectiveness of existing controls or in incorporating the OIG program into existing systems of controls.

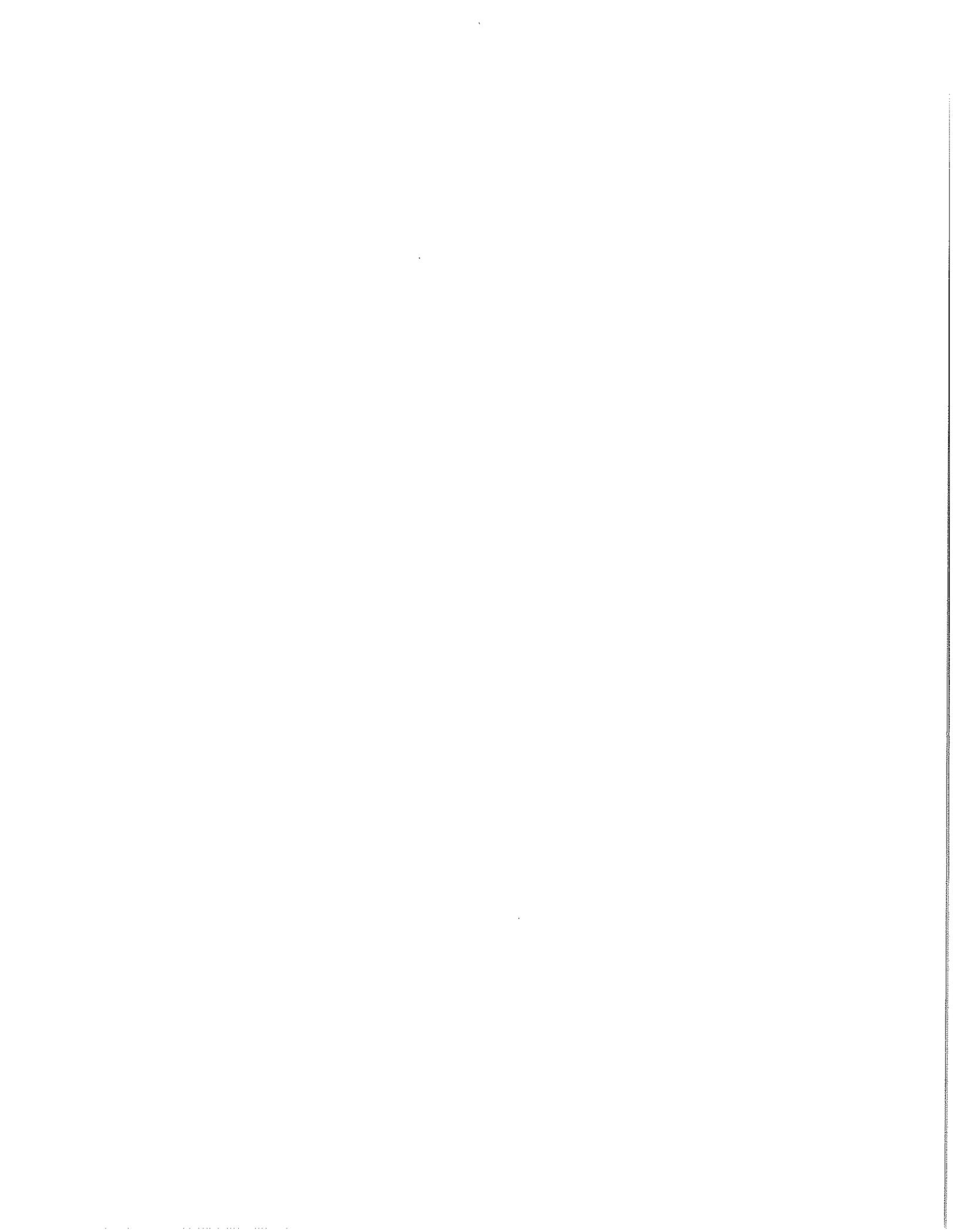
The OIG recommended that HCFA focus its limited oversight resources on those States that do not respond to ensure that prescription drugs purchased with Medicaid dollars are not diverted to street pushers and users. The OIG will provide the computer program software and whatever technical assistance deemed necessary by HCFA. (CIN: A-03-90-00204)

STATE MEDICAID FRAUD CONTROL UNITS

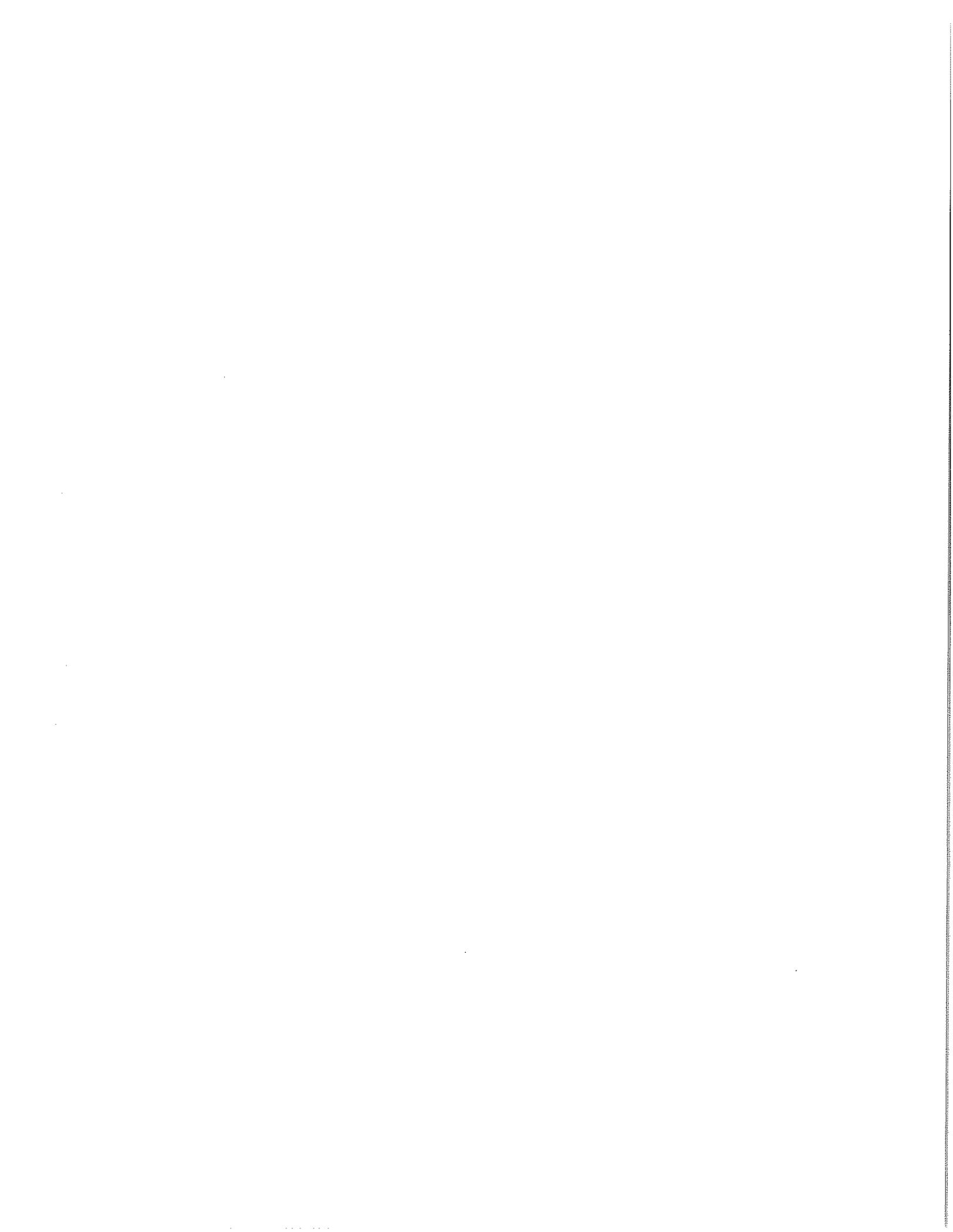
During FY 1989, Medicaid health care provider payments exceeded \$50 billion dollars. These payments represent a 270 percent increase over the \$18 billion dollars expended in 1978. Medicaid fraud control units (MFCUs) are currently responsible for investigating fraud in more than 91 percent of all Medicaid health care provider payments.

Thirty-nine States now have units and are receiving funds and technical assistance from OIG. Following the mandate of the Congress, the MFCUs bring to prosecution persons charged with defrauding the Medicaid program and those charged with patient abuse and neglect. They also work with local survey and utilization review units to draft proposed regulations governing providers to ensure that these regulations will stand up in court.

During the second half of FY 1990, OIG administered \$24.4 million in grants to the MFCUs and conducted nine State recertifications and technical assistance visits. The MFCUs reported 388 convictions and \$17.2 million in fines, restitutions and overpayments collected for the period January 1 through June 30, 1990.



SOCIAL SECURITY ADMINISTRATION



CHAPTER III

SOCIAL SECURITY ADMINISTRATION

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

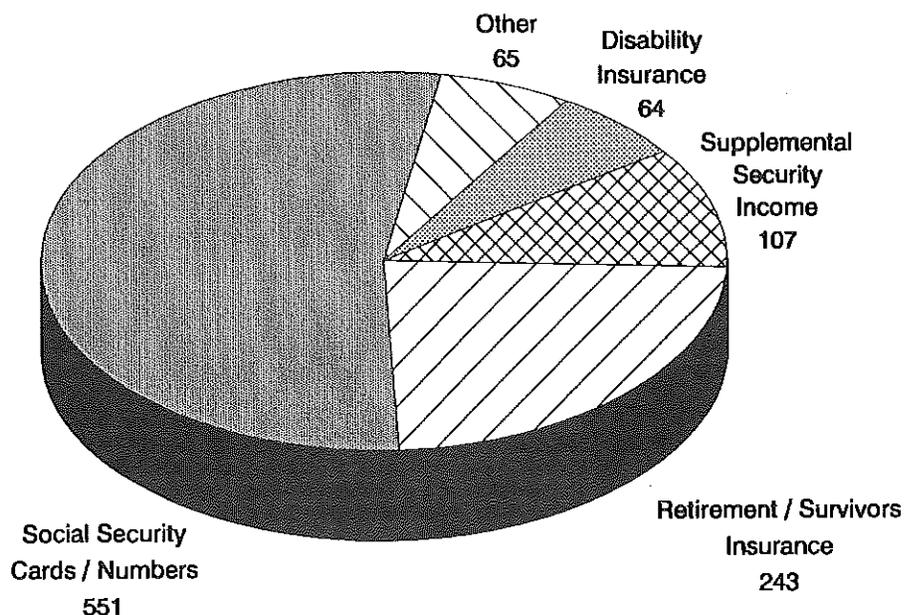
Fifty-five years ago, the Social Security Act established a national insurance system that would be financed through payroll taxes collected from workers and employers and would pay benefits to workers in their old age. The Retirement, Survivors, and Disability Insurance (RSDI) program, popularly called Social Security, is the largest of the Social Security Administration (SSA) programs. In FY 1990, SSA will pay approximately \$243 billion of these benefits to more than 39 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retired and disabled workers, spouses, certain divorced spouses, children and disabled children of retired and disabled workers. Benefits are also provided to widows and widowers, certain surviving divorced spouses, children, and dependent parents of deceased-worker beneficiaries.

The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally-funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, blind and disabled that were funded by a mix of Federal and State money. Federalization of assistance for these categories permitted the establishment of uniform eligibility criteria. In FY 1990, SSA will pay SSI benefits in excess of \$11 billion.

In addition, program expenditures under the Black Lung program will total approximately \$900 million. These monies pay eligible miners, their dependents and survivors. The SSA continues to administer certain claims, although the administration of the program was transferred to the Department of Labor in 1973.

The OIG is currently undertaking a number of important initiatives with respect to SSA programs and operations, such as monitoring client satisfaction with SSA services, conducting reviews of SSA's implementation of the Federal Managers' Financial Integrity Act, reviewing SSA's procurement activities and assessing the effectiveness of SSA's systems modernization efforts. During this reporting period programmatic savings totaled over \$3 billion. An additional \$64.1 million in program expenditures were questioned as to their allowability under law, regulations or cost principles. As illustrated in the chart below, investigations resulted in a total of 1,030 convictions during this fiscal year.

SOCIAL SECURITY PROGRAMS Successful Judicial Prosecutions



OPPORTUNITIES FOR PROGRAM AND MANAGEMENT IMPROVEMENT

The following examples illustrate significant program and management weaknesses identified by OIG within SSA during this reporting period:

- The OIG reported on three problem areas involving SSA and the Department of the Treasury which are affecting the Social Security trust funds and require resolution. (CIN: A-04-90-03004) (Page 49)
- The OIG identified weaknesses in SSA's current diary control system which may result in incorrect payments as well as poor service to the affected beneficiaries. (CIN: A-13-88-00024) (Page 50)
- The OIG determined that SSA needs to do more to have in place a fully operational capacity planning management system. (CIN: A-13-89-00035) (Page 48)
- The OIG determined that SSA should do more to recognize and address the needs of non-English speaking populations by clarifying agency policy on providing interpretative services, assessing bilingual staffing needs and encouraging outreach to community-based agencies. (OEI-02-89-00630) (Page 47)

AUDIT OF SSA'S FINANCIAL STATEMENTS - FISCAL YEAR 1988

This report presents the results of OIG's examination of SSA's combined financial statements for the year ended September 30, 1988. In addition to OIG's opinion letter dated January 10, 1989, there are separate reports on SSA's system of internal accounting controls and on SSA's compliance with laws and regulations.

The report on internal accounting controls discusses weaknesses requiring corrective action in each of SSA's three major accounting systems. The report on compliance with laws and regulations discloses that accounting for and reporting administrative expenses for the SSI program did not fully comply with requirements, and SSI benefit overpayment receivables were used as budget authority in excess of actual collections. The SSA did not agree with all of OIG's findings and recommendations. (CIN: A-13-89-00032)

USE OF CREDIT REPORTING AGENCIES

An OIG audit assessed the usefulness of employing credit reporting agencies to help collect SSA debt that would otherwise be placed in the terminated collection file. The OIG found that approximately 76,000 debts valued at nearly \$88 million were terminated between January 1, 1983 and March 31, 1986 because debtors could not be located or were uncooperative, and that the use of credit reporting agencies could have assisted in the collection of over 45,000 of these debts worth more than \$52 million.

The OIG recommended that SSA seek legislative authority to use credit reporting agencies to locate debtors who cannot be found through other debt collection methods. The SSA should also refer to the credit reporting agencies those debtors who refuse to cooperate with SSA's collection efforts.

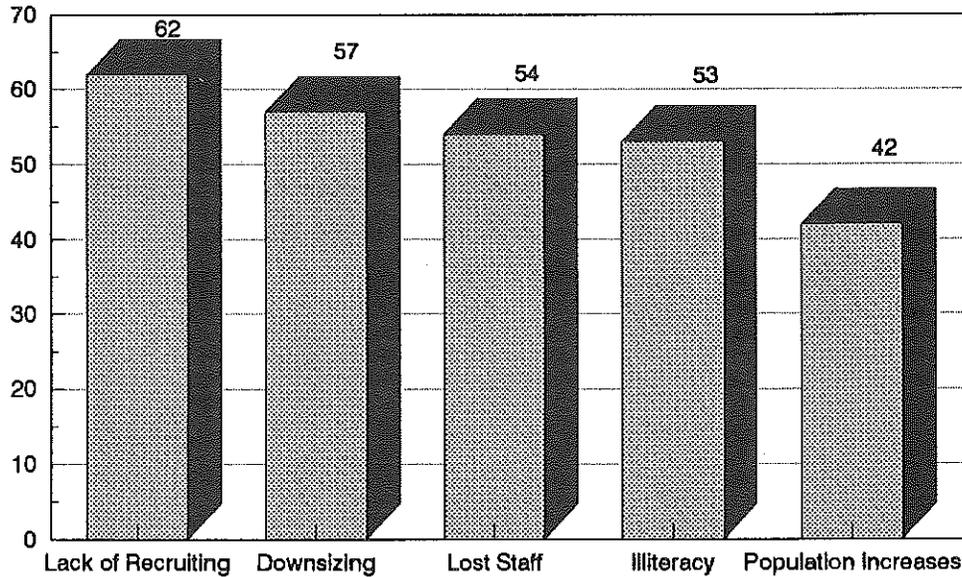
The SSA concurred with the thrust of the recommendations, but declined to implement them, preferring to concentrate its efforts on obtaining legislative authority to use income tax offsets as a means of improving debt collection. The OIG believes that the two approaches complement one another and urges SSA to pursue both legislative strategies. (CIN: A-03-89-02610)

SERVING NON-ENGLISH SPEAKING CLIENTS

The OIG determined that SSA has not given sufficient priority to the needs of non-English speaking clients, who typically conduct their business with SSA in person, without appointments and often without interpreters. There is a reported shortage of bilingual staff in field offices, causing these clients to wait longer to be served and sometimes to be sent away with appointments for later dates. Adding to the problem is the limited ability of regional managers to recruit and hire bilingual staff.

MAJOR OBSTACLES AFFECTING SSA SERVICE TO NON-ENGLISH SPEAKING CLIENTS

Percent citing obstacle as major



The OIG recommended that SSA do more to recognize and address the needs of non-English speaking populations by establishing a clear policy on the agency's responsibility for providing interpreter services; assessing bilingual staffing needs and assigning resources where such needs are identified; and encouraging outreach to community-based agencies to assist these clients in their business with SSA. The SSA generally agreed with the findings, and cited actions they are taking or plan to take to implement the recommendations. (OEI-02-89-00630)

CAPACITY MANAGEMENT

The OIG, assisted by the Systems Research and Applications Corporation, reviewed SSA's computer capacity management process. The review showed that SSA has improved its capacity management process significantly since 1987. Also, SSA's capacity planning workload forecasting products demonstrated a need for additional computer resources, which SSA is in the process of obtaining.

The OIG determined, however, that SSA needs to do more to have in place a fully operational capacity planning management system. Further improvements and benefits could be achieved in the following areas: the projection of central processing resource requirements; the collection and reporting of data on computer activities; the use of systems modeling to help analyze

performance and predict future requirements; proactive performance management to identify potential problems; upper-level management support and priority for capacity planning; and the reporting and packaging of information to executive-level management. The SSA generally agreed and is taking steps to address the recommendations. (CIN: A-13-89-00035)

UNRESOLVED ISSUES BETWEEN SSA AND TREASURY

The purpose of this management advisory report was to inform SSA that several recommendations from prior OIG reports involving SSA and Treasury management of the Social Security trust funds remain unimplemented. The reports covered three subject areas: reclamation procedures for incorrect payments; transfers to the trust funds for unnegotiated checks; and treatment of penalties and interest collected by the Internal Revenue Service. The OIG concluded that various deficient conditions exist which are depriving the trust funds of recoveries and revenues due them.

The OIG believes that the negotiation process between SSA and Treasury has reached a standstill on these issues. The OIG recommended that the Board of Trustees of the trust funds initiate action to request renewed negotiations between SSA and Treasury with the goal of developing mutually agreeable policies and procedures. (CIN: A-04-90-03004)

CREDIT FOR RECOVERED RSDI BENEFITS

This follow-up audit found that SSA had partially implemented previous OIG recommendations and realized savings of about \$4.8 million over the past 4 years. However, if the prior recommendations had been fully implemented, OIG estimates that SSA would have realized additional savings of \$12 to \$16 million. The OIG recommended that SSA continue to take steps to be credited at the earliest equitable date for all recovered RSDI payments as recommended in the prior audit, and provide instructions to each program service center on the exact document credit dates that should be reported. The SSA concurred and advised that an automated data processing project was underway that would fully implement the recommendations in the prior audit. (CIN: A-04-89-03029)

USER FEE FOR ATTORNEY FEE PAYMENTS

An OIG management advisory report pointed out the opportunity for SSA to recover as much as \$5 million annually in administrative costs by assessing attorneys a user fee. This fee would be for SSA's processing of payments to attorneys resulting from their legal representation of Social Security claimants. The OIG recommended that SSA determine the administrative costs of processing attorney fee payments, and take the necessary steps to assess attorneys the applicable user fees in accordance with Office of Management and Budget Circular A-25. The SSA welcomed the recommendation on principle, but believed that a user fee could not be processed without enactment of legislation expressly authorizing SSA to do so. The SSA also stated that

the Congress is considering legislation to modify the attorney fee process. (CIN: A-13-90-00026)

PROCESSING CONTROLS FOR RSDI DIARY ACTIONS

The OIG reviewed SSA's processing controls for RSDI diary actions at two program service centers (PSCs). A diary is a control over an unfinished claim, operating as a reminder to technical staff that an action should be taken at some future designated time.

The OIG estimated that nearly 13 percent of 820,000 diary actions sampled for a 1-year period were unacted on more than 30 days after the diary's maturity date. Incomplete actions on diariied cases result in an indeterminable amount of incorrect payments as well as poor service to the affected beneficiaries.

The SSA has plans to replace the current diary control system and has developed specifications for a new system. The OIG suggested that SSA modify its present plans by distributing instructions to PSC personnel emphasizing the importance of prompt completion of diariied actions; incorporating into managers' merit pay contracts standards regarding the processing of diariied cases; and, once the new system is in place, performing internal control reviews to assess whether it is adequate to ensure prompt completion of diariied actions.

The SSA questioned the findings and recommendations. The OIG believes that the study findings were valid and its conclusions worthy of reconsideration by SSA. (CIN: A-13-88-00024)

RSDI BENEFITS FRAUD

One of the largest categories in OIG convictions for SSA fraud during this period was retirement and survivors benefits, of which the following are examples:

- A man and his wife were sentenced in Louisiana to 5 years in prison and restitution of more than \$600,000 to SSA and private insurers which they had obtained in a fake death scheme. In 1985, the man was reported as falling off a ferry and drowning in New Zealand. His wife filed for and received private insurance and SSA's survivors insurance for herself and her two children. Lloyds of London refused to pay a \$1.88 million death benefit because someone believed to be the same man had jumped off a ferry four days earlier in Australia but was rescued. In May 1989, the man was arrested in New Zealand for shoplifting and extradited to the United States. (6-89-00677-6, Milton Harris)

- A woman in Texas signed a pretrial diversion agreement whereby she would repay the remaining \$7,800 of \$17,000 she had received by concealing her marital status. She had married and obtained divorces on three separate occasions without notifying SSA. She was planning to marry a fourth time while continuing to receive survivor's benefits. Because the woman had no criminal history and had three small children, the prosecuting attorney opted for a pretrial diversion agreement. She had already repaid \$9,200 of the amount illegally obtained. (6-88-00587-6, Mary Rodriguez)
- Another Texas woman also must repay \$23,800 to SSA and \$2,200 to the Department of Veterans Affairs (VA). The woman concealed income from her work at several schools from SSA and concealed her income and remarriage from VA in order to continue to receive benefits. (6-88-00050-6, Myrtle Hightower)

VERIFICATION OF REPRESENTATIVE PAYEE SSNS

In response to congressional, judicial and public concern over its representative payee procedures, SSA has developed screening guides to assist in the selection and monitoring of representative payees. These guides will help in determining the suitability of the applicant to act as a beneficiary's representative payee. The effectiveness of the screening activity is dependent in part upon the accuracy of the payee applicant's SSN.

The OIG found that SSA is not using its automated SSN verification process for representative payee applicants and recommended that SSA proceed with implementation of a separate representative payee data base currently being developed. The SSA agreed, and indicated that it is in the process of automating the SSN verification process for representative payees and developing a separate data base. (OEI-12-90-02010)

DELAYED PAYEE DEVELOPMENT ALERTS

The OIG uncovered a systemic problem in SSA's process of identifying claims which have been in suspense for long periods of time pending representative payee development. Claims in suspense status for this reason are alerted on the basis of the date of credit action (DOCA), rather than the date of suspension or termination (DOST). However, the DOCA is subject to change by actions processed against the record that have nothing to do with the suspension. A beneficiary could therefore remain in suspense status with no alert generated if intervening debit/credit actions were processed against the record altering the DOCA. The DOST is a definitive point in time that is only changed by an action that removes or alters the suspension. Accordingly, OIG recommended that SSA use the DOST as the starting point for controlling payee development. (OEI-12-90-02420)

REPRESENTATIVE PAYEE FRAUD

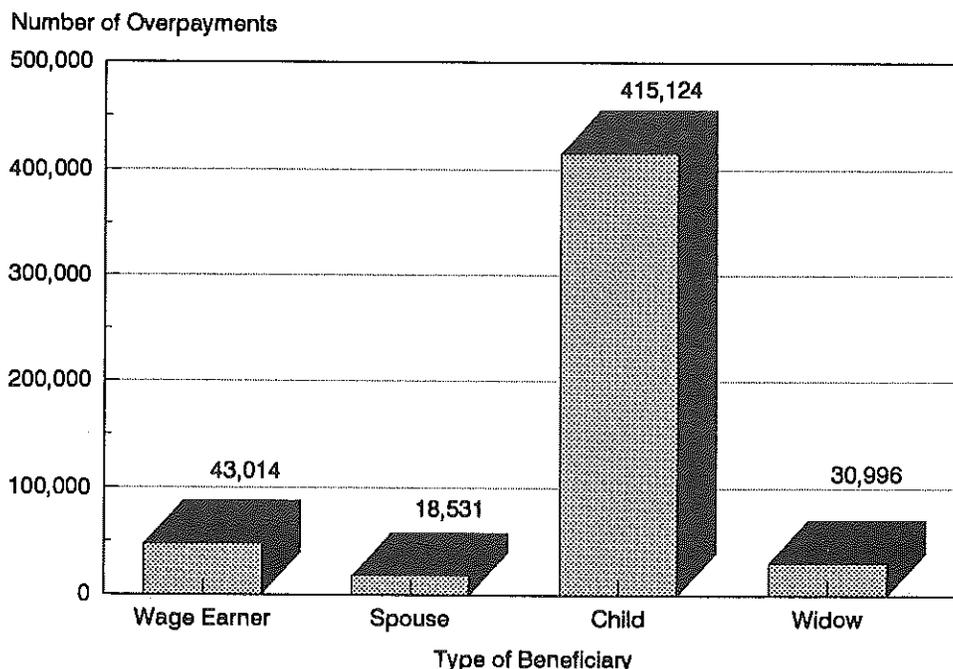
By falsifying or concealing events or relationships, some individuals hope to capitalize on the possibility of obtaining and using benefits intended for minors or incapacitated persons. The following cases are examples of successful actions resulting from OIG investigations of these individuals.

- A California man and his former wife were sentenced to prison for 25 and 15 years to life, respectively, for the murder of a 17-year-old boy. The man had committed the murder at the request of his ex-wife, who was the victim's sister and representative payee. They continued to receive and negotiate the victim's Social Security checks after his death. Agents from OIG who testified at the trial helped establish gain as a motive for the crime. (9-89-04383-6, Earl Weston & Jody Clements)
- A 17-year-old Maryland girl obtained \$27,000 in reinstatement of Social Security benefits denied her father who had been killed in service. An aunt who gained custody of the girl and became her representative payee managed to spend the entire sum in 90 days in support of a drug habit. Convicted in State court of theft and embezzlement, the aunt was sentenced to 4 years in prison, 3 of which are to be suspended if she pays back the money. (3-88-00857-6, Fannie McKnight)
- In Texas a woman was given a suspended 5-year prison term and ordered to repay \$7,800 in retirement benefits for her mother. The woman had served as representative payee for her mother and did not notify SSA when she died. The fraud was uncovered when an anonymous complainant sent a note to an SSA office, written on the back of a program which was handed out at the funeral service. (6-88-00706-6, Mary Spencer)

OVERPAYMENTS IN TERMINATED COLLECTION STATUS

The OIG estimated that SSA could recover about \$16.8 million in overpayments which had been placed in terminated collection status. These overpayments generally related to former child beneficiaries who either had no earnings or could not be located at the time that SSA ended collection efforts.

RSDI OVERPAYMENTS IN TERMINATED COLLECTION STATUS



An additional \$63.5 million is potentially collectable. Under current procedures, overpayments for which SSA terminated collection actions will remain outstanding until the liable individuals are reentitled to benefits.

The OIG recommended that SSA match selected overpayment records in terminated collection status with the Internal Revenue Service (IRS) taxpayer file. Collection efforts could then be initiated for those individuals who had reported new addresses to IRS. The procedure could be repeated periodically in future years to recover additional overpayments from the updated SSA and IRS files.

The SSA indicated that its first priority for collections is to obtain congressional authority to offset overpayments against Federal income tax refunds. In addition, SSA asserted that the OIG recommendations would not be cost effective to implement. The OIG agrees that SSA's first priority should be to seek income tax refund offset authority. However, OIG disputes SSA's methodology for computing cost effectiveness. (CIN: A-09-89-00069)

DECEASED BENEFICIARIES

Benefits may continue to be sent to a deceased beneficiary because the person's death goes unreported to SSA or because relatives or friends deliberately conceal it from SSA. Deliberate concealment of death to use such benefits constitutes fraud against SSA programs. Since the success of OIG's computer matching project Spectre in the early 1980s, matches of State death records against SSA beneficiary rolls have become a required mechanism for detecting this kind of fraud.

These and other computerized matches result in a continuing investigative workload for OIG. The following cases are representative of those successfully concluded during this reporting period:

- An Iowa man was sentenced to 10 years in prison for Social Security benefits fraud. He failed to report to SSA the death 10 years ago of the woman who had raised him and with whom he lived in Detroit. He continued to cash her benefits checks, and when he moved to Iowa he opened a bank account into which he had the checks deposited directly. Threatened with having the benefits cancelled, he had his sister call SSA and pose as the deceased beneficiary. He received more than \$25,700 to which he was not entitled. (8-89-00096-6, Robert Haynes)
- In New York a woman employed by the United States Environmental Protection Agency was given a suspended 1-year prison sentence and 5 years probation, and ordered to make full restitution of \$10,000. She forged and cashed her deceased aunt's benefit checks, using the money for travel expenses and as payment for her son's rent. (2-88-00835-6, Barbara Cunningham)
- A rabbi was convicted in Wisconsin of stealing 39 benefit checks deposited into the account of his father, who died in 1981 in Florida. Using as a guideline a proposal by a national nonprofit Jewish educational organization, the judge sentenced him to 6 months home detention and assessed him \$11,900 in costs. He also was required to undergo a year of personal and family religious counseling, and he himself must counsel Wisconsin prisoners for a year. (4-88-00355-6, Sanford Parsons)
- An Oklahoma minister was placed on 5 years probation with a special condition that he spend 6 months in a house of detention. He was also ordered to make restitution of \$48,800 which he and his wife obtained by cashing the widow's benefit checks sent to his wife's grandmother. Investigation revealed that the grandmother had died in a Texas State mental hospital on November 1, 1961. The couple changed her address to Oklahoma and continued to cash her checks for 28 years. The theft was discovered after SSA decided to contact all beneficiaries over 100 years old and could not locate the grandmother. The wife

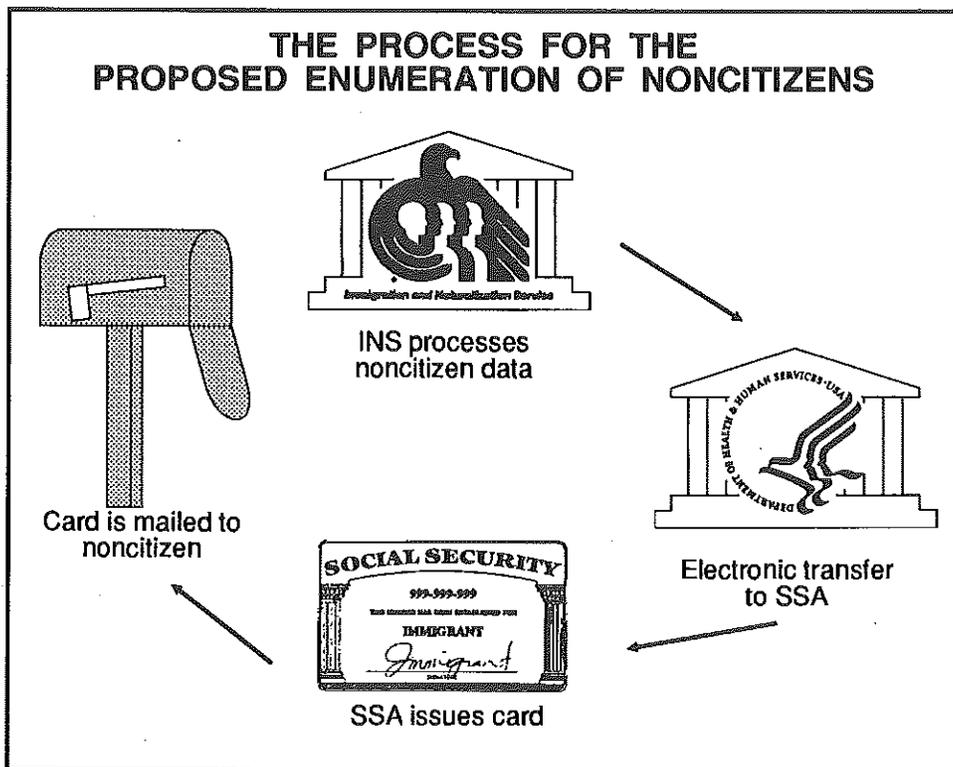
was sent for psychiatric evaluation at a Federal institution to determine competency to face charges. Found competent, she pled guilty and was also sentenced to house detention. (6-89-00866-6, Jessie + Rosie Barnes)

SSNS FOR NONCITIZENS

The SSA requested that OIG conduct an inspection to determine the efficacy of having the Immigration and Naturalization Service (INS) assume responsibility for processing initial applications for SSNs for noncitizens entering the country. The SSA and INS had developed SSN application procedures for amnesty applicants under the Immigration Reform and Control Act of 1986.

The INS obtains and records much of the information required by SSA to issue a valid SSN. The SSA respondents felt that INS is in a better position to verify the documentation presented by noncitizens, and that the INS handled the enumeration process efficiently.

The OIG recommended that SSA issue original SSNs for noncitizens based on electronic transfer of data collected by INS and the Department of State. The noncitizen would not have to appear personally at the SSA field office for a personal interview.



Using electronic data transfer from INS to SSA will result in annual cost savings of more than \$8.2 million.

The SSA, INS and the Department of State will explore use of electronic transfer of data to provide noncitizens with original SSNs on a trial basis. (OEI-05-88-01060)

FRAUDULENT SOCIAL SECURITY NUMBERS

Along with birth certificates and drivers' licenses, the SSN or Social Security card is a foundation document in creating false identifications. These identifications are then used by individuals to perpetrate crimes involving billions of dollars. Many of the cases also involved the use of fraudulent SSNs in the commission of crimes not directly related to Department programs. Particularly ubiquitous is their use in bank loan and credit card scams, as shown in the following examples:

- In Texas, OIG assisted the Federal Bureau of Investigation (FBI) and the United States Attorney in winning guilty pleas from two brothers for illegally obtaining more than \$5 million in loans. The two men conspired with another relative and a bank officer to have the money credited or deposited to bank accounts they set up using phony SSNs. One brother was sentenced to 27 months in Federal prison and full restitution. The other was given 3 years probation and fined \$50. The third conspirator had been sentenced to prison earlier. (6-89-00008-6, Eddie Taylor)
- As a result of a project in Wisconsin, four individuals were convicted for setting up bank accounts with false SSNs. Dubbed "Project Chameleon," it was a proactive effort of OIG, the FBI and the United States Attorney. Under the tutelage of OIG and FBI agents, banks reported suspicious SSNs used in account applications. The OIG checked the SSNs, the FBI made fast arrests to prevent check kiting and passing of bad checks, and the OIG and FBI developed the evidence for prosecution. The project is being phased out because the banks have become so alert in checking SSNs that losses are prevented.
- An African national was sentenced in Baltimore to 98 days incarceration and a \$50 fine for SSN fraud. As part of his plea agreement, he also had to promise not to return to the United States after he is deported. He obtained a Virginia driver's license under someone else's name and SSN, which he then used in applying for bank accounts and credit cards. (3-89-00607-6, Vemi Adebolas)
- The owner of a boat dealership in Texas was sentenced to 4 years in jail for bank loan and Social Security number fraud. He also was ordered to repay \$114,536.

He had arranged for the fraudulent loans to be processed by a friend who worked in the bank. (6-88-00101-6, Steven ~~Groves~~ Groves)

False SSNs figured prominently in a case involving an insurance policy scam:

- A man and woman in Virginia were given prison terms for drawing up fake insurance policies using phony names and SSNs. They collected more than \$80,000 in commissions and bonuses. The man was sentenced to 2 years in prison and ordered to pay more than \$71,000. The woman was given 18 months, \$9,000 in restitution and a \$25,000 fine. The pair's scam was discovered as a consequence of the man's car being towed while he was testifying as a character witness for his father and brother who were convicted in a credit card scheme. (3-89-00476-6, Sharon Buhls and Robert Lominac)

Two other major cases during this period illustrate employers' use of fraudulent SSNs to conceal illegal or nonexistent employees.

- In what is believed to be the largest case of its kind in the Southeast, outside of Florida, managers and other officials of a South Carolina quilting company were convicted of using false SSNs to conceal employment of nearly 100 illegal aliens. Mexican go-betweens were paid to bring in the laborers, for whom living facilities and jobs were arranged. (4-89-00457-6, Alfred Mizhir)
- The managers of a grain company in Texas were sentenced to 6 months in prison for fraudulent use of SSNs. The couple had placed on the payroll bogus employees, using various names and SSNs including those of former employees. They then issued checks to these employees, negotiating them through an Oklahoma bank account as a "favor" to the employees. They also were sentenced to 3 years probation, with the condition that each make restitution of \$30,000 to the grain company. (6-89-00224-6, Berta and Lonny Buckner)

Finally, false SSNs frequently are integral to highly dangerous or exotic schemes such as drug smuggling and kidnapping.

- A man was sentenced in Louisiana on charges related to SSN fraud, then turned over to Texas authorities for kidnapping his own child. He had used a deceased person's birth certificate to obtain a new SSN, employing it to conceal his son's whereabouts and to obtain bank loans on which he defaulted. His parents signed pre-trial diversion agreements for having allowed the new Social Security card to be sent to their business address. (6-89-00625-6, Jesse Grantham)

- A Texas man was sentenced to 13 years and 3 months in Federal prison for smuggling narcotics and using a false SSN. When arrested after flying in from Mexico with 650 pounds of marijuana, he used a driver's license and Social Security card in the name of another person to conceal his true identity. The U.S. Customs Service requested assistance from an OIG investigator, who proved the false identity and testified at the trial at which the man was convicted. (6-89-00844-6, Curtis O'Brien)
- An illegal alien was sentenced in New Mexico to 21 months in jail for using another person's SSN and identity to purchase guns and an airplane. The man totally assumed the identity of a California citizen with a similar name. He reputedly was bringing drugs into the country from Mexico and flying out guns. He will begin to serve his sentence after finishing a term in Oregon, where he had been convicted of selling drugs and had broken parole. (6-89-00786-6, Francisco Mendez)

PAYMENTS FOR VOCATIONAL REHABILITATION

The OIG conducted a study to determine if SSA payments to State vocational rehabilitation agencies increased the number of disabled beneficiaries who are rehabilitated.

Overall, the OIG found that data from the sampled States indicated an upward trend toward participation of SSA beneficiaries in rehabilitation. This was especially evident in New York and Pennsylvania, which have developed sophisticated screening and referral processes. However, OIG found little evidence that the SSA payments for vocational rehabilitation are inducing States to increase the number of SSA beneficiaries they serve. This is partially due to the cumbersome process for filing claims and SSA's frequent failure to make payments on a timely basis.

The OIG recommended options to simplify the payment system and strengthen the linkage between the payments and State actions to rehabilitate SSA beneficiaries. The SSA indicated that several workgroups have been established to study the issues discussed in the OIG report. They noted that several of the options would require legislative changes and additional funding. (OEI-07-89-00950)

DISABILITY BENEFITS FRAUD

The two primary ways individuals manage to obtain disability benefits fraudulently are by feigning a disability condition or using false SSNs to conceal employment or other income. During this reporting period, several persons were successfully prosecuted for disability fraud:

- In New Jersey, a civilian contract specialist with the Department of Army was sentenced to 4 months detention for continuing to collect disability benefits for himself and his family while working. He also has to repay more than \$93,800.

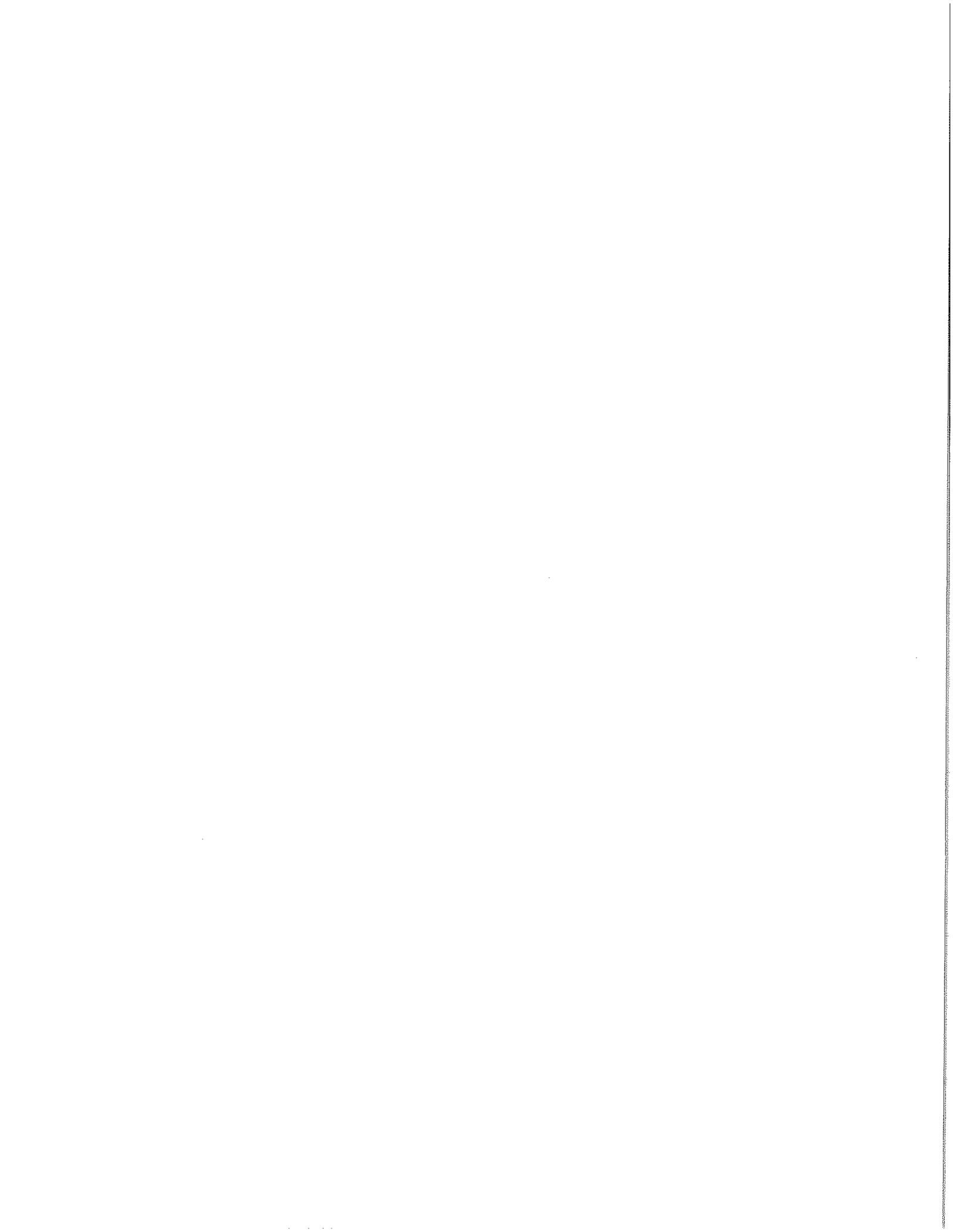
After receiving benefits as the result of injuries in a car accident in 1978, he failed to inform SSA of his return to work. (2-88-00197-6, Richard Dinnerman)

- An Iowa man was given a 3-year sentence for disability fraud, suspended except for 4 months in a Federal medical facility. From 1979 through 1986 he collected \$80,700 in disability benefits while working at various jobs. His work included stints with the Internal Revenue Service and the State Department of Social Services, and serving as a county magistrate. The SSA is recovering the overpayment. (8-85-00368-6, Albert Garrison)
- A man in Texas was sentenced to 3 years in Federal prison and fined \$50 for disability benefits fraud. He became entitled to disability benefits in 1970. In 1973, he obtained a second SSN by slightly changing his name, changing his date of birth and place of birth and showing different parents. Using the second SSN, he worked at least 15 years undetected, obtaining an overpayment of more than \$135,000 for himself and his family. (6-88-00710-6, Joe Sparkman)
- A \$30,000-a-year employee of the New York City Department of Environmental Protection was sentenced to 4 months in prison, 4 months home detention and full restitution of \$58,000 in disability benefits. He used fake birth certificates to get an additional Social Security card for himself and one for a fictitious child, to collect illegal benefits. (2-89-00171-6, Lawrence Gatzke)

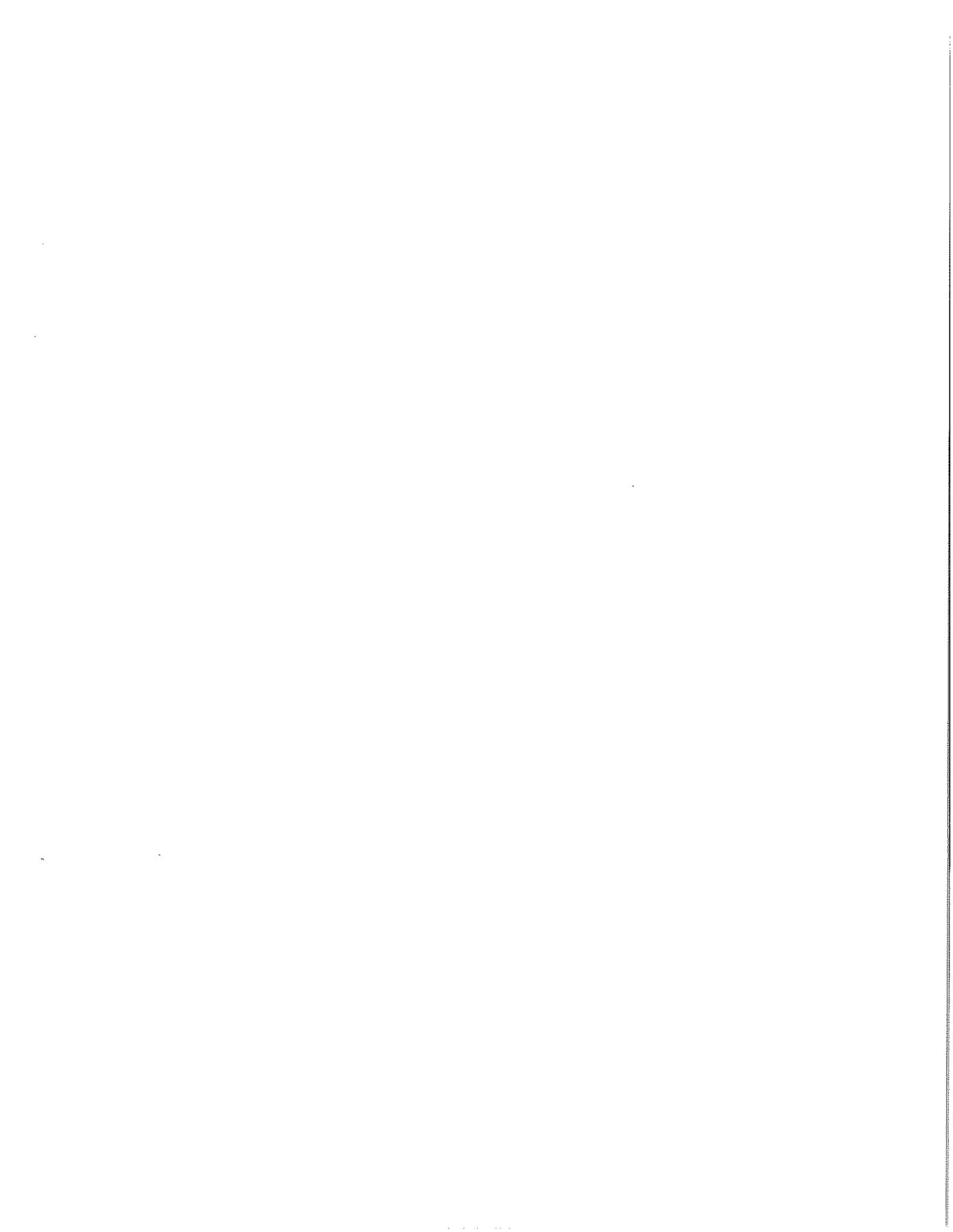
SSI BENEFITS FRAUD

A common violation of the SSI program involves the concealment of earned or unearned income in order to continue receiving benefits. The following cases are examples of some of the successful prosecutions completed during this reporting period.

- A Wisconsin man who worked for the county sheriff's department in Milwaukee while receiving SSI benefits was sentenced to 15 months incarceration, 36 months probation and restitution of close to \$22,000. The man began collecting SSI benefits for an emotional disability in 1969. In 1976 he had a lobotomy. In 1987 he started working with the sheriff's department, but did not notify SSA of his employment. (5-89-00114-6, Douglas Hintzmann)
- In the State of Washington, a man who was getting SSI benefits and assistance from the Department of Housing and Urban Development (HUD) was found to have assets of more than a quarter of a million dollars. He was sentenced to 3 years probation and ordered to perform 100 hours of community service. He was also directed to make restitution of \$10,000 to SSA and \$12,400 to HUD. (X-96-00207-6, Frank Luketa)



PUBLIC HEALTH SERVICE



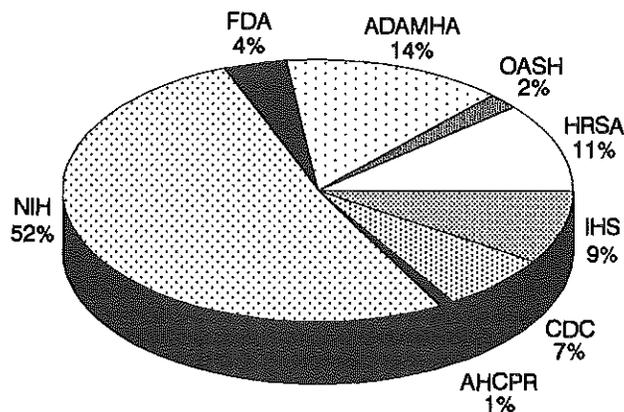
CHAPTER IV

PUBLIC HEALTH SERVICE

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The activities conducted and supported by the Public Health Service (PHS) represent this country's primary defense against acute and chronic diseases and disabilities. The PHS's programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. The PHS encompasses: National Institutes of Health (NIH), to advance our knowledge through research; Food and Drug Administration (FDA), to assure the safety and efficacy of marketed food, drugs and medical devices; Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), to assist States in uncovering the physiological and behavioral bases for understanding, preventing and treating mental illnesses and alcohol and substance abuse; Centers for Disease Control (CDC), to combat preventable diseases and protect the public health; Health Resources and Services Administration (HRSA), to support through financial assistance, the development of our future generation of health care providers; Indian Health Service (IHS), to improve the health status of Native Americans; Agency for Toxic Substances and Disease Registry (ATSDR), to address issues related to Superfund toxic waste sites; and the newly established Agency for Health Care Policy and Research (AHCPR), to enhance the quality and appropriateness of health care services and access to services through scientific research and the promotion of improvements in clinical practice, and in the organization, financing and delivery of services. The PHS will spend approximately \$14 billion in FY 1990.

DISTRIBUTION OF PHS RESOURCES (FY 1990 Budget \$14 Billion)



This year, OIG is continuing to respond to commitments made to the Secretary, the Congress and the Assistant Secretary for Health to increase oversight of PHS programs and activities. A separate PHS audit division concentrates on issues within PHS, such as acquired immune deficiency syndrome (AIDS), medical effectiveness, substance abuse, biomedical research and scientific misconduct. In addition, since the majority of contract and grant funding provided by HHS to colleges and universities is awarded by PHS, this division has responsibility for audits of these institutions. The division provides the resources to conduct internal and external reviews promoting: effective and efficient program operations; compliance with laws and regulations; financial accountability; as well as prevention and detection of fraud, waste and abuse. The Office of Evaluation and Inspections conducts evaluations of PHS program areas which focus on the quality and responsiveness of services provided by PHS.

During the second half of FY 1990, programmatic savings totaled \$10 million. In addition, OIG identified questionable charges to PHS programs of \$1.5 million.

INTERNAL CONTROL WEAKNESSES

The OIG identified the following material weakness within PHS in the second half of FY 1990:

- The OIG disclosed internal control weaknesses in FDA's medical device review process. (CIN: A-15-89-00065) (Page 65)

OPPORTUNITIES FOR PROGRAM AND MANAGEMENT IMPROVEMENT

The following item is an example of a significant management weakness identified by OIG within PHS during this reporting period:

- The FDA does not have adequate procedures for preventing conflicts of interest where employees have financial interests in industries other than those regulated by the agency. The OIG noted that an employee had recommended that FDA purchase equipment from a firm in which the employee had reported a financial interest. The FDA inadvertently discovered this violation during an unrelated administrative review. The PHS informed OIG that it has made substantial changes to its system of reporting financial interest by its employees. (OI-HQ-90-004)

MOBILE HEALTH SERVICES

At the request of the Chairman, House Subcommittee on Regulation and Business Opportunities, OIG conducted two inspections on mobile health services. One provides a national overview of the type and prevalence of mobile health services, the quality of these services and the degree of regulation. The second provides a description of health care providers that serve medically underserved and uninsured populations in public settings or that make physician house calls.

Providers deliver all kinds of services in mobile settings, from public cholesterol screenings to physician house calls. The greatest benefit of mobile services is that they reach people who would not otherwise seek or receive health care. Regulation of mobile health services varies widely for some services and is nonexistent for others. Respondents agreed that mobile health services can improve access to care, but they question the quality and the costs of such services.

The OIG recommended that PHS study the costs and benefits of mobile vans and physician house calls and work with States to develop a process for identifying emerging mobile health services and their providers. The PHS and HCFA should develop priorities and protocols for regulating the various types of mobile health services. The HCFA should consider the appropriate weight for payments for physician primary and urgent house calls. The PHS and HCFA agreed with the recommendations and have taken steps to implement them. (OEI-05-89-01331; OEI-05-89-01332)

PUBLIC CHOLESTEROL SCREENING

In response to a request by the Chairman of the House Subcommittee on Regulation and Business Opportunities, OIG conducted an inspection to examine the prevalence, conduct and regulation of cholesterol screening in public settings. Demand for cholesterol screening is increasing significantly. Thus far, the Federal role in screening has been one of research and public education through the National Cholesterol Education Program (NCEP).

The OIG found that the effectiveness of public cholesterol screening is compromised by frequent instances of poor quality assurance, inadequate onsite counseling and lack of referral to a physician when appropriate.

NONCOMPLIANCE WITH NCEP GUIDELINES



Environment Should Allow Privacy and Confidentiality

Blood not collected in private	92%
Results not kept confidential	73%
Discussions not confidential	82%
Persons doing analysis subject to distraction	56%



Rules of Infection Control Should Be Observed

Work area dirty	11%
Staff did not wear gloves	35%
Staff did not change gloves with each new screenee	50%
Container marked "Biohazardous Waste" not used for disposal of lancets/needles	56%



Good Sample Collection Techniques Should Be Used

Finger "milked" to obtain blood	58%
Screenees not advised to sit 5 minutes	87%



There Should Be Counseling and Physician Referral

Screenees not cautioned that:	
▪ Single measurement not a diagnosis	83%
▪ Test just an indication of level	68%
Screenees with tests over 200 not told to see own physician	61%
List of physicians for referral purposes not available	82%

In addition, OIG determined that current State and Federal regulation of public screening is minimal.

The OIG recommended that the Department discourage public screening that is not regulated and does not meet the education, counseling and referral requirements of the NCEP guidelines. The OIG believes that the Clinical Laboratory Improvement Amendments (CLIA) of 1988 are the appropriate mechanism for federally regulating public cholesterol screening, and that HCFA should not apply the waiver which would exempt providers from the performance standards and inspection provisions of the law. The HCFA expressed general agreement with the OIG findings and recommendations and indicated that public cholesterol screening would not be waived under CLIA of 1988. The PHS submitted a detailed corrective action plan which will encourage adherence to the NCEP guidelines in cholesterol screening. (OEI-05-89-01330)

YOUTH ACCESS TO CIGARETTES

At the request of the Secretary of Health and Human Services, OIG conducted an inspection of State laws regarding the sale of cigarettes to minors. Research has documented that millions of youth smoke, despite the existence of laws in 44 States and the District of Columbia prohibiting such sales to minors.

For the study, OIG contacted 44 State health and law enforcement agencies, reviewed 11 active State and local enforcement efforts, and conducted 1,200 interviews with students, parents, vendors and local public officials.

The OIG found that State youth access laws are not being enforced, and that children can easily buy cigarettes. In the few areas where enforcement is active, it has generally resulted from community concern and local leadership. Active enforcement employs a variety of methods, primarily administrative in nature. Among the most commonly used techniques are vendor licensing, with appropriate revocation or suspension following a prescribed number of violations, fines, stings, restrictions on vending machines and warning signs.

Each of the 6 States which do not have laws limiting cigarette sales to minors reported legislative activity in the past 18 months. One State, Kentucky, passed a law making it illegal to knowingly sell cigarettes to a minor. The five remaining States without such laws predict further legislative activity in the coming year. (OEI-02-90-02310; OEI-02-90-02311)

MEDICAL DEVICE REVIEW PROCESS

The Food, Drug and Cosmetic Act authorizes the FDA to regulate medical devices using a three-tiered class system, and establishes a premarket notification process. Class III devices must undergo premarket approval in order to be proven safe and effective. At least 90 days prior to marketing a device, a manufacturer must submit to FDA a premarket notification, in accordance with section 510(k) of the Act. Devices determined to be substantially equivalent to a pre-1976 device or a Class I or Class II post-1976 device may be marketed. Those found not to be substantially equivalent are placed into Class III and require premarket approval.

The OIG conducted a review to determine if problems existed in FDA's medical device 510(k) premarket notification program. While no evidence of illegal acts was uncovered during this review, the OIG found that there were weaknesses in the process that could raise questions as to whether the process ensures the fair treatment of device manufacturers and whether devices reviewed are substantially equivalent.

The OIG determined that FDA does not have a management information system that tracks individual reviewer workload and productivity; lacks written policies and procedures for sequencing 510(k) reviews and documenting review decisions to ensure timely, fair, and complete 510(k) evaluations; does not use critical information to make determinations of substantial equivalence, such as review of the product sample, verification of testing data, and premarket inspections of manufacturer facilities; lacks a comprehensive quality control program to independently evaluate and critique the adequacy of reviewed submissions; and has not established adequate controls and written policies and procedures restricting industry access to 510(k) medical device reviewers, safeguarding submission files, and assuring the physical

security of its reviewing offices. Applying the Federal Managers' Financial Integrity Act (FMFIA) criteria, the OIG concluded that these internal control weaknesses, when taken as a whole, could materially affect the integrity of the 510(k) process.

The PHS agreed with many of the OIG's recommendations. The PHS concurred with the need to disclose weaknesses in the FMFIA reporting process, but disagreed that the weaknesses taken as a whole, constitute a material internal control weakness in the 510(k) process. (CIN: A-15-89-00065)

STATE DISCIPLINE OF PHARMACISTS

The OIG conducted an inspection to assess the disciplinary practices of State boards of pharmacy. Although States have taken important steps to strengthen State pharmacy boards in recent years, there are serious limitations in State boards' disciplining of pharmacists.

The OIG found that in many States there were few of the most serious types of disciplinary actions taken during the period 1986 through 1988. Most of those actions were related to drug diversion and self-abuse of drugs, rather than quality of care issues. The ability of many pharmacy boards to protect the public is hampered by insufficient legal authorities, time consuming disciplinary processes, and inadequate resources.

The OIG recommended that State governments ensure adequate authority and resources for pharmacy boards and streamline the disciplinary processes so boards can discipline more effectively and efficiently. The PHS should assist the National Association of Boards of Pharmacy in its efforts to provide leadership to State pharmacy boards. A number of recommendations were directed to various professional organizations. (OEI-01-89-89020)

STATE MEDICAL BOARDS AND MEDICAL DISCIPLINE

The OIG conducted an inspection to assess the disciplinary practices of State medical boards. While the boards have made significant progress in improving their disciplinary capability, they still face major limitations that impede their performance. These include severe staffing shortages, insufficient investigative authority, and incomplete case information provided by Federal or federally-funded referral sources.

In response to these and other limitations, OIG presented a number of recommendations to PHS, the Health Care Financing Administration (HCFA), and the Administration on Aging (AoA). Particularly notable among them is one calling for PHS to convene a national meeting addressing the importance and limitations of the State medical boards, and another urging that HCFA propose legislation mandating that the PROs share case information with the boards when the first sanction notice is sent to the physician.

The PHS concurred with the recommendation. The HCFA did not agree with the cited recommendation, indicating that it was unnecessary because current legislation and regulations allow for data exchange when appropriate. The OIG continues to believe that the proposed legislation is important. (OEI-01-89-00560)

FDA PROGRAM-RELATED INVESTIGATIONS

Since its inception, OIG has conducted investigations of potential criminal violations relating to FDA programs and operations at the request of FDA officials. Recently, the authority to conduct such investigations was temporarily delegated by the Secretary to OIG and the number of FDA investigations grew substantially to approximately 200 cases by early 1990.

The following paragraphs describe some of the successes during this period resulting from OIG investigations.

- Three officials of generic drug companies and two former FDA officials were convicted and sentenced for giving and receiving gratuities. The drug company officials made the gifts in an attempt to obtain faster approval of their generic drug applications. These actions bring to 12 the total number of persons and entities convicted and sentenced in this ongoing investigation. (W-88-0010-4, W-90-0009-3)
- A self-professed "godfather" of steroid distribution was sentenced in New York to 6 months in prison, a \$5,000 fine and 1 year of strictly supervised probation. He claimed in court to have assisted in training several international body-builders. He stated that the steroids provided were for their benefit because they enabled them to earn a living. The case was jointly investigated by OIG and the United States Customs Service. (2-89-00665-3, Ricky Rondinalli)
- Another New York investigation involved a pharmacist trafficking in steroids. As a result of a joint undercover investigation by OIG and the U.S. Customs Service, the pharmacist was convicted for the illegal distribution of steroids, sentenced to three years probation and fined \$5,000. (2-89-00190-3, Adnan Sawwan)

FDA'S GENERIC DRUG MANAGEMENT INFORMATION SYSTEM

Because an effective management information system (MIS) is critical to strengthening the management and oversight of the generic drug review process, the OIG sought to determine whether the generic drug review MIS is reliable, and whether it produces reports needed by FDA officials to effectively monitor the system. The OIG determined that data contained in the generic drug MIS was generally reliable, although certain reports concerning the assignment of applications to reviewers were inaccurate. The OIG also found that the MIS was not producing

reports FDA needs to effectively monitor day-to-day operations or to detect indications of possible manipulation of the generic drug review process.

The PHS generally agreed with OIG's preliminary findings and recommendations, except for the recommendation to report that there is a material weakness in the generic drug MIS. In its final report, OIG agreed that the weakness did not have to be reported separately because the Secretary had already included inadequate controls over the generic drug review process as a material weakness in his 1989 report to the Congress and the President. The OIG recommended, however, that FDA revise its action plan for generic drugs to incorporate actions to correct weaknesses in the generic drug MIS.

Although PHS agreed that the MIS should track the progress of applications in elapsed days, it disagreed as to the events to be captured. The PHS also agreed to include in the MIS data information on the type and frequency of deficiencies found during the application review process. (CIN: A-15-89-00063)

IMPLEMENTING USER FEES IN FDA

Over the past several years, HHS budget proposals have included provisions for user fees to support various program activities previously funded through general appropriations. Such proposals have never been enacted into law by the Congress. At the suggestion of the Office of Management and Budget, OIG conducted a study to provide an analytic framework for the discussion and consideration of additional user fees in HHS, using the FDA as an example.

In conducting this study, OIG synthesized previous work on user fees; evaluated the experiences of selected Federal agencies and programs with established user fees; and considered the views of program officials, affected industry representatives and others regarding the possibility of user fees in FDA.

User fees represent an application of the "benefit principle" of taxation: those who benefit from governmental provision of a service should be required to pay for it. However, administering and collecting fees can represent a substantial investment of agency resources and time. Numerous factors should be taken into account when developing the pricing and fee structure of a user charge, as illustrated below.

CONSIDERATIONS FOR PRICING USER FEES

- Cost of providing the service or product
- Marginal cost of providing the service or product
- Externalities, e.g., public benefits
- Effect on user behavior
- Demand for service or product
- Intensity of demand
- Value of service or product/benefit received from the service or product
- Horizontal equity
- Vertical equity
- Ability of the user to pay

The OIG recommended that policy makers contemplating FDA user fees consider: the activities to be included or supported by the fee; the timing of the assessment; the setting of the fee; where and how the fee should be deposited; and the relation of the fee to the process. (OEI-12-90-02020)

INTERNAL CONTROLS IN IHS HEALTH CARE DELIVERY PROGRAMS

An OIG audit concluded that there is inadequate internal control review coverage in the area of IHS' delivery of health care services. The Office of Management and Budget guidelines for implementing the FMFIA of 1982 direct Federal agencies to segment their operations and programs into internal control areas, perform risk assessments and correct any weaknesses identified. The guidelines allow existing oversight processes to be used as alternatives for internal control reviews if they adequately incorporate the requirements of internal control reviews.

In August 1989, PHS reported that it would accept surveys conducted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as alternative internal control reviews in IHS, and that it would delay additional internal control reviews of health care delivery services until 1992. The IHS operates a number of health facilities and funds contract health services that

have not been subject to JCAHO surveys. Moreover, the surveys address neither patient eligibility for IHS services nor the reasonableness of costs charged to Federal agencies for providing services. In addition, PHS has included all of IHS' diverse health delivery service programs in one internal control area, making evaluation of controls over these activities extremely difficult. The OIG recommended that IHS segment its programs and activities into manageable internal control areas, assess the adequacy of its existing oversight programs, and otherwise assure that internal control objectives for the delivery of health services are effectively met. The PHS stated that it was in the process of incorporating into the FMFIA process additional existing reviews of the quality and cost of care provided under IHS programs and that, therefore, this was not a material weakness; OIG disagrees. While this was seen as an important first step, OIG urged that PHS evaluate internal controls over all aspects of IHS health delivery service programs by the end of FY 1990. (CIN: A-15-89-00068)

CONSTRUCTION OF IHS HOUSING

The OIG determined that IHS is constructing more housing units than are necessary to adequately house its staff working at IHS hospitals and clinics in remote locations. In 1986, IHS developed new procedures intended to better determine the number of new housing units required. However, OIG found that incomplete and inaccurate information was sometimes used in implementing these new procedures. The OIG estimates that there may not be a need to construct 125 of the 286 housing units planned; the cost of these 125 units is over \$16 million.

The OIG recommends that PHS take action to reevaluate those housing projects in the advanced planning and initial construction phases, and modify or cancel any unnecessary projects. The PHS should also strengthen its reviews at the headquarters level to prevent the type of deficiencies noted in the audit report. Further, OIG believes that the preparation of inaccurate or incomplete project justifications and the need for strengthening the review and approval process for planned construction projects meet the criteria for material weaknesses under the Federal Managers' Financial Integrity Act.

The PHS agreed with most of the procedural recommendations, but did not agree that there were material weaknesses in the IHS project justification process or the PHS review and approval process. While OIG noted some improvements made by IHS, PHS' reply indicates that these improvements have not been fully implemented. The OIG believes, therefore, that the report recommendations are appropriate. (CIN: A-09-89-00136)

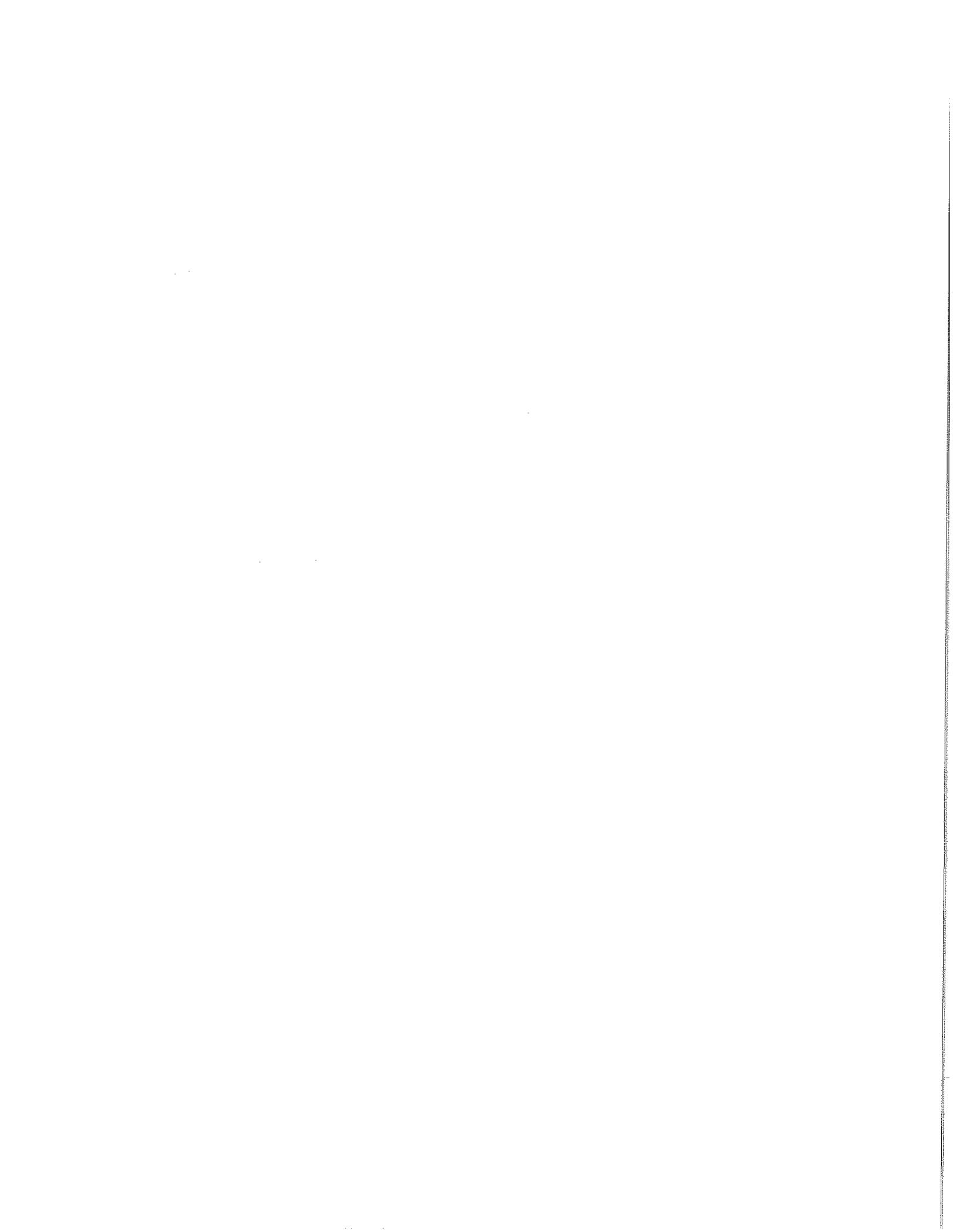
COST EFFECTIVENESS OF CONTRACTING OUT INPATIENT CARE

A 1982 GAO report recommended that IHS evaluate the use of community hospitals as a cost effective alternative to providing inpatient care at IHS hospitals. In 1984, IHS studied seven of the nine hospitals cited by GAO, and determined that in all cases the continuance of in-house care was cost effective. In 1986, IHS recognized that the rates being paid under Medicare's

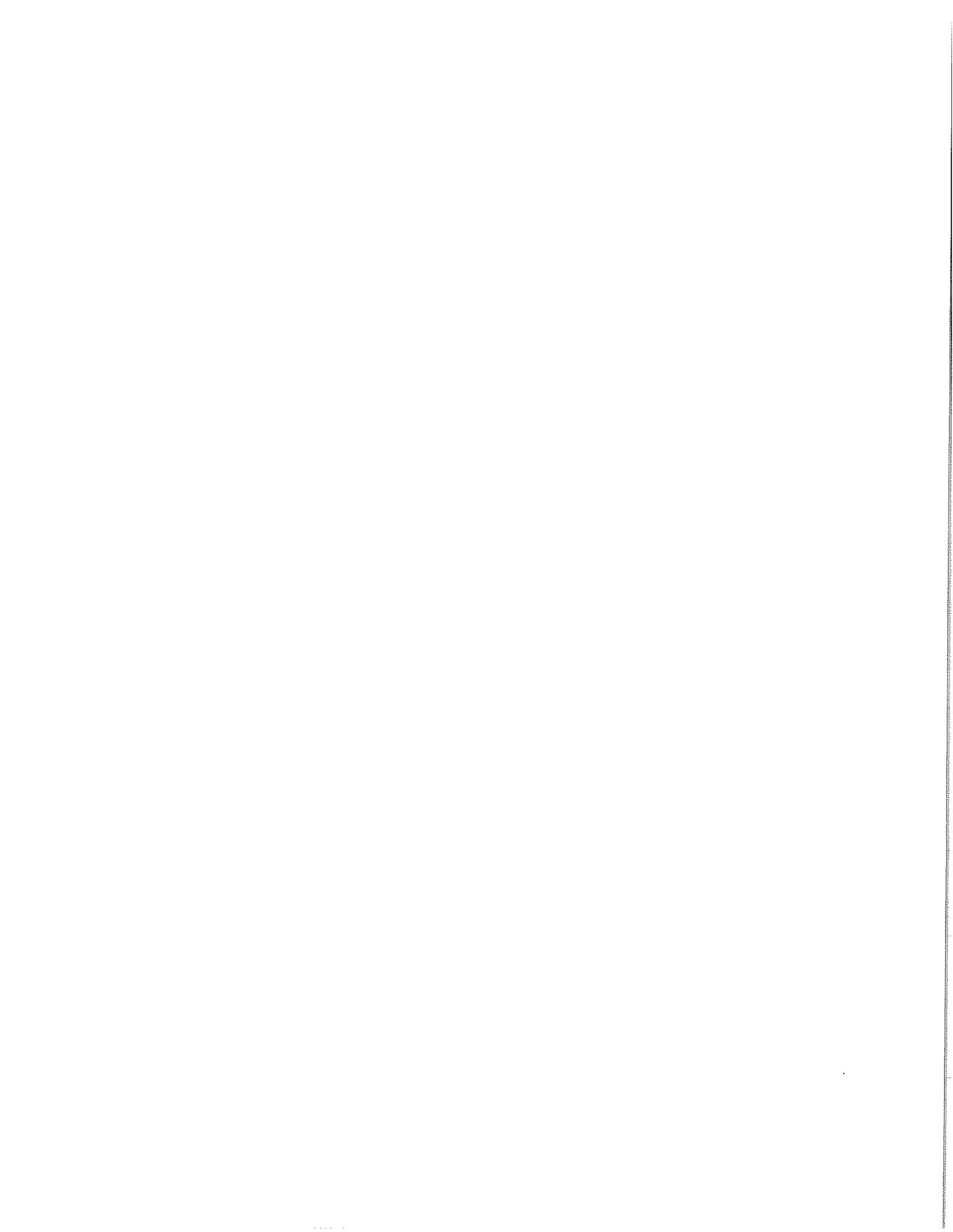
prospective payment system (PPS) were substantially lower than billed charges at most IHS locations. Accordingly, IHS changed its policy to limit payments for contracted inpatient care to amounts no higher than those allowable under PPS.

The OIG conducted an audit to determine the potential for savings through the use of alternative means of providing inpatient care currently provided at low utilization IHS hospitals. Of particular interest was whether lower costs could be obtained in contracting with community hospitals as a result of the 1986 change in reimbursement policy. The OIG identified cost savings of more than \$140,000 at one IHS hospital and close to \$39,000 at another which would have resulted if IHS had contracted out these services to community hospitals in FY 1987. Based on these results, OIG recommended that IHS reevaluate the 9 IHS hospitals identified earlier by GAO and evaluate the 10 additional hospitals identified by OIG to ascertain whether inpatient services at any or all of these IHS facilities could be contracted out on a cost effective basis. The OIG further recommended that, in those instances where savings could be achieved through contracting with non-IHS providers, IHS take immediate action to do so or reduce the cost of providing inpatient care in-house to make it comparable to the contract rates.

The PHS agreed with the recommendations. The IHS has implemented a policy to review all IHS hospitals with an average daily load of less than 15 patients, and expects to complete an evaluation of those hospitals identified by GAO and OIG by September 30, 1991. (CIN: A-06-89-00001)



FAMILY SUPPORT ADMINISTRATION



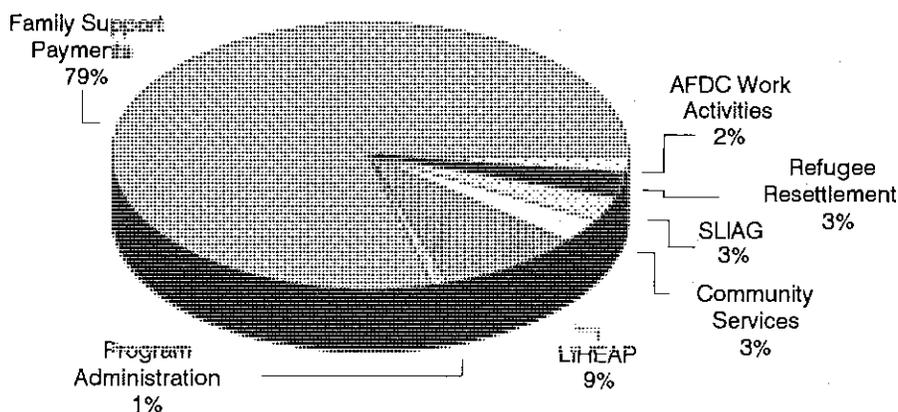
CHAPTER V

FAMILY SUPPORT ADMINISTRATION

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The Family Support Administration (FSA) provides Federal direction and funding for State, local and private organizations as well as for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Family support payments to States encompass: Aid to Families with Dependent Children (AFDC), a cooperative program among Federal, State and local governments which reaches 3.8 million families consisting of 11 million individuals each month; the Child Support Enforcement (CSE) program, which provides grants to States to enforce obligations of absent parents to support their children by locating absent parents, establishing paternity when necessary, and establishing and enforcing child support orders; and Child Care, which frees eligible welfare mothers for training and employment. The Low Income Home Energy Assistance program (LIHEAP) provides block grants to the States and Indian tribes to help offset the increased cost of fuel for recipients of AFDC, food stamps, supplemental security income, as well as certain other individuals. Other programs include Emergency Assistance, Refugee and Entrant Assistance, Community Services, Job Opportunities and Basic Skills (JOBS) training and Work Incentive programs. The FSA is also responsible for the State Legalization Impact Assistance Grants (SLIAG) program, created by the Immigration Reform and Control Act of 1986 (Public Law 99-603). Expenditures for FSA programs will total \$15.2 billion for FY 1990.

DISTRIBUTION OF FSA RESOURCES (FY 1990 Budget \$15.2 Billion)



The OIG performs audits to review recipient eligibility, determine the fairness of program benefits, and evaluate the economy and efficiency of operations. Implementation of the Family Support Act of 1988 (Public Law 100-485) is one of the Department's highest priorities. The OIG is actively involved in monitoring that implementation to detect fraud, waste and mismanagement of Government monies. In addition, OIG is undertaking several inspections and audits to review implementation of the strengthened CSE provisions of the Act, and the new provisions designed to help meet the costs of the new child care, training and other components of welfare reform. During this reporting period, programmatic savings exceeded \$75 million and OIG recommended recovery of \$2.2 million in questionable grantee charges.

COMMUNITY SERVICES DISCRETIONARY GRANTS

The objective of this review was to determine whether discretionary grants have been managed so as to accomplish program objectives and to comply with applicable administrative requirements.

The OIG found that a general absence of management attention has resulted in a material weakness in this area. Lack of established policies, procedures and internal administrative controls resulted in inadequate assurance that the program's statutory goals were being met and that the program's operations were safeguarded from fraud, waste and abuse. For example, program announcements contained statements and instructions that did not conform to Federal requirements; grants were awarded on a noncompetitive basis without adequate documentation or independent review; and there was inadequate monitoring of grantee performance.

The OIG recommended that FSA report a material weakness under the FMFIA, and finalize its corrective action plan to clarify responsibilities and duties relating to the administration of grant programs. Further, OIG recommended that FSA conduct an internal control review to assure that effective actions have been taken to establish proper stewardship over grant funds. The FSA generally concurred with the recommendations and corrective actions are underway. (CIN: A-12-90-00022)

USE OF DISCRETIONARY GRANT FUNDS

A. Alabama

The OIG performed an audit to determine whether \$250,000 in Federal grant funds awarded to a community services program in Alabama for the period September 30, 1987 through March 31, 1989 were properly utilized and whether program objectives were accomplished. Grant funds awarded are subject to the provisions of the Community Services Block Grant Act and must be expended in accordance with an approved work program and for the demonstrable benefit of low-income residents. The OIG concluded that, by locating a business in a thriving community and hiring individuals from related industries and other communities without regard to their

economic status, the grantee had, in effect, defeated the purpose of the grant. These conditions appear to have arisen because the grantee placed a greater priority on business success and the potential for profit than on its stated goal of creating permanent jobs for low-income residents.

The OIG recommended that the grantee refund to Office of Community Services (OCS) \$66,360 of Federal funds expended for cost elements not in the approved budget; assure that its for-profit subsidiary hire low-income unemployed individuals as proposed; and obtain a required independent audit of that subsidiary. Further, OIG proposed that OCS assure that grant objectives were met and determine the allowability of the remaining \$183,640 of Federal expenditures claimed. Grantee officials generally disagreed with OIG's findings and recommendations. (CIN: A-04-89-03501)

B. Texas

The OIG conducted an audit of a 1985 and 1987 grant (totaling \$1.4 million) awarded by OCS to a local private, nonprofit council for the purpose of creating job opportunities for low-income people. The audit disclosed significant deficiencies in the management of the grant funds as well as failure to meet program objectives. The Federal share of proceeds from the sale of property funded under the 1985 grant and interest earned on the 1987 grant funds were not returned to the Federal Government. Moreover, the 1987 grant funds were not spent for the grant purposes.

The OIG recommended that the grantee refund \$1.5 million, and ensure for any future grants that goals and objectives are met and documented; its accounting system provides better control over Federal funds; and reported expenditures relate to the funded grant program. (CIN: A-06-90-00052)

COMMUNITY ACTION PROGRAM FRAUD

In 1986, OIG and the FBI received allegations of kickbacks and false billings in the weatherization program administered by a community action program agency in Maine. The program was operated through contracts with local construction companies, and was administered by a man who was also the local mayor. Initial investigation showed a substantial amount of missing materials paid for with program funds. Eventually it was proved that the program director/mayor and a house inspector had received kickbacks from contractors for payments for work they did not do. The mayor, house inspector and three contractors were given prison terms. (86-00069-2, Derek Dore)

CHILD SUPPORT ENFORCEMENT COLLECTIONS

The OIG, in concert with FSA, conducted reviews of cash management practices in nine States. These audits identified significant control weaknesses in eight of the States reviewed. Some of the problems identified were: interest and other income not being offset against child support

expenditures; inadequate control over the handling of undistributable payments; untimely deposits of collections and/or deposits in noninterest bearing accounts; and poor management control over outstanding checks, reconciliation of cash balances and physical security.

The FSA issued a bulletin to the States requesting that they review their operations for weaknesses in controls over the handling of child support collections. The FSA and OIG are coordinating the review of 12 additional States to determine the national extent of this problem. (CIN: A-12-90-00015)

AFDC FRAUD

One form of welfare assistance, which includes Medicaid, food stamps and AFDC benefits, is based on State determinations of AFDC eligibility. As a result, welfare fraud is usually perpetrated by making false claims about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would render the applicant ineligible. Suspected fraud is discovered through a variety of mechanisms, ranging from disclosure by a disgruntled acquaintance or relative to computer matches of welfare lists against worker compensation rolls or income tax returns. Individual cases of welfare fraud typically involve relatively small amounts of money and little notoriety and, therefore, are relatively low on the agenda of prosecutors. The OIG seeks to make prosecution attractive by grouping several cases for convenience of prosecution and maximum deterrent effect. For example, for the last 2 years, OIG, Secret Service and FBI agents have worked with the Illinois Department of Public Aid and the United States Attorney in investigations leading to several mass indictments of individuals who have made false statements to receive welfare checks and food stamps. Close to 100 persons have been indicted thus far in three mass indictment actions in this project, dubbed "Operation Wel-Cheat", representing more than \$800,000 in illegal benefits. Those convicted had generally failed to report their employment or marriage in order to continue to receive benefits.

The following cases are examples of AFDC fraud in other areas of the Nation:

- A Massachusetts woman used multiple names and SSNs to conceal assets and earned income which would have precluded her eligibility for AFDC benefits. She was ordered to make restitution of \$44,000. (7-89-00011-6, Venus White)
- In New Mexico, an employee of the State Human Services Department was discovered to have manipulated the computer system to generate AFDC checks. She was ordered to repay the \$3,600 she illegally obtained. (6-89-00591-6, Carmen Rodriguez)
- The OIG assisted a California district attorney in proving that a woman had concealed the receipt of SSA benefits for her children to receive welfare and food stamps. (9-90-06016-6, Deidre Harris)

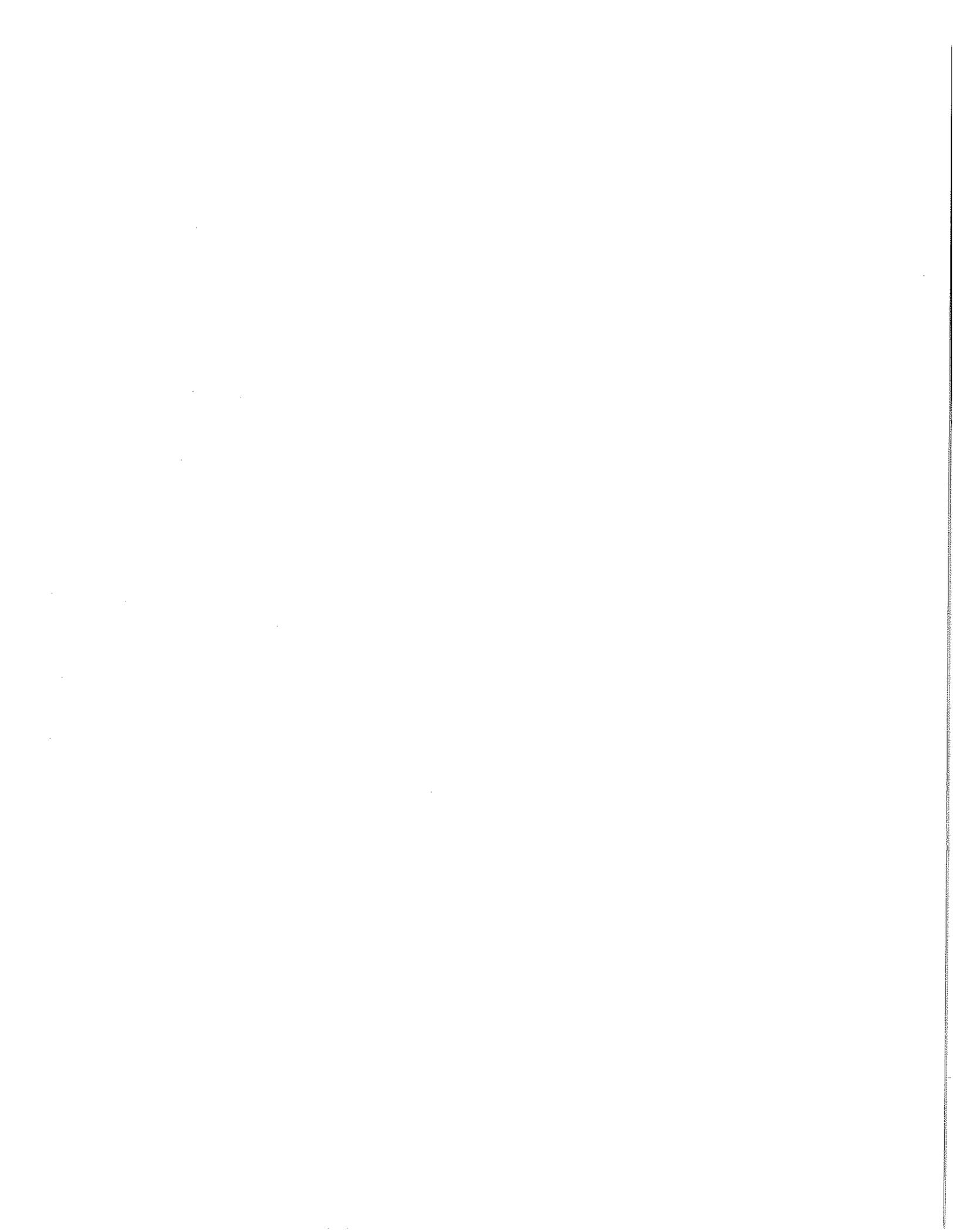
REVERSIONARY INTEREST IN REAL PROPERTY

The OIG reported that the Office of Community Services (OCS) management information system does not have the capability to adequately control and monitor property acquired by grantees with Federal funds. For example, OIG found that one grantee sold property without OCS approval and did not reimburse the Federal share of the proceeds. In order to protect the interests of the Federal Government, OIG recommended that OCS revise its system to identify, track and monitor property from the initial issuance of the grant to final disposition of the property. The FSA agreed to report this as a material internal control weakness under FMFIA. (CIN: A-12-90-00020)

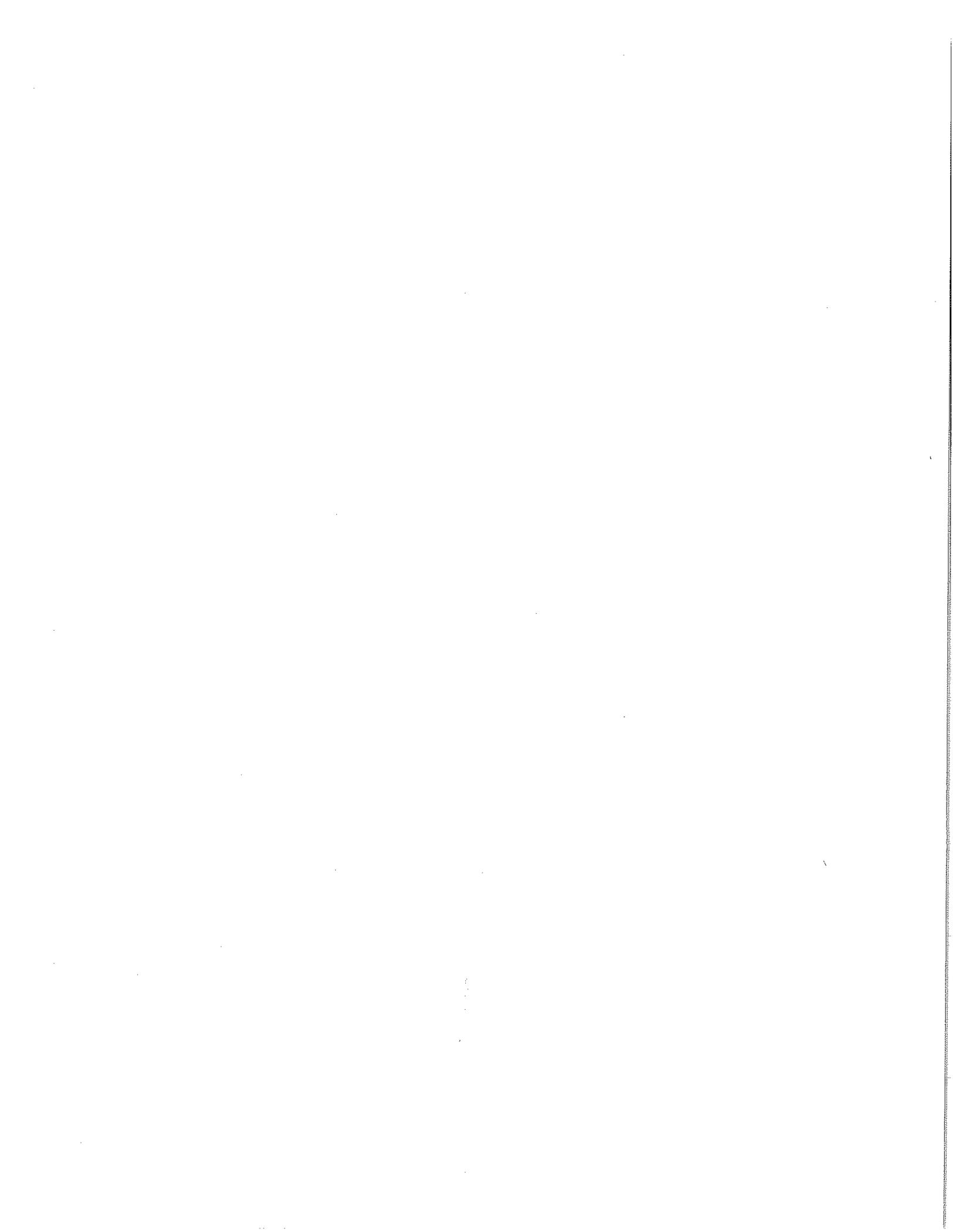
STATE LEGALIZATION IMPACT ASSISTANT GRANT EXPENDITURES

The OIG conducted an inspection to determine if SLIAG appropriations are adequate to cover the States' program costs through FY 1991 and to estimate the States' expenditures through FY 1994. The study was done at the request of the Senate Labor, Health and Human Services and Education Appropriations Subcommittee.

Based on OIG's findings and a model developed to project cost data, OIG estimated that the amount of appropriations needed for the States' portion of SLIAG in FY 1991 is between \$0 and \$459 million. This supports the recommendation of an earlier OIG study to reduce the FY 1991 appropriation by \$500 million. The FSA supported the findings and recommendations. (OEI-07-90-02260)



OFFICE OF HUMAN DEVELOPMENT SERVICES



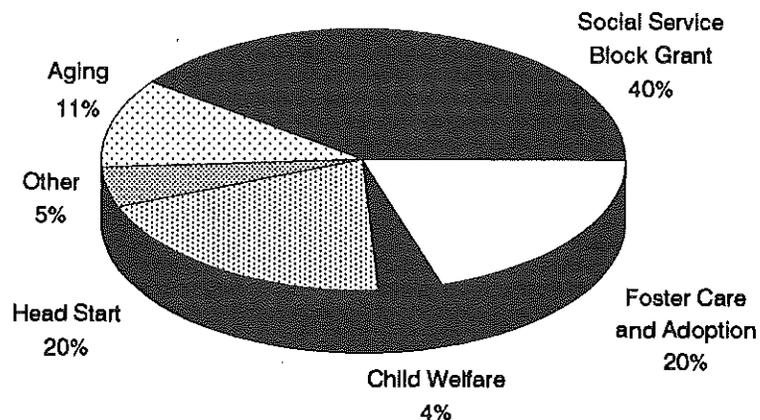
CHAPTER VI

OFFICE OF HUMAN DEVELOPMENT SERVICES

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

The Office of Human Development Services (HDS) oversees a variety of programs that provide social services to the Nation's children, youth and families, developmentally disabled, older Americans and Native Americans. Head Start is a \$1.3 billion per year program which provides comprehensive health, educational, nutritional, social and other services primarily to pre-school children and their families who are economically disadvantaged. Foster Care and Adoption Assistance is an entitlement program that provides grants to States to assist with the cost of foster care and special needs adoptions, maintenance, administrative costs to manage the program and training for staff. The goal of this program is to strengthen families in which children are at risk, reduce inappropriate use of foster care, and facilitate the placement of hard-to-place children in permanent adoptive homes when family reunification is not feasible. The programs for the aging provide for supportive centers and services, congregate and home-delivered meals and in-home services for the frail elderly. Expenditures for HDS programs will exceed \$6.9 billion for FY 1990.

DISTRIBUTION OF HDS RESOURCES (FY 1990 Budget \$6.9 Billion)



During this reporting period, OIG identified questionable grantee charges to HDS programs of \$110.3 million.

INTERNAL CONTROL WEAKNESSES

The OIG identified the following material weakness within HDS in the second half of FY 1990:

- Regulations are needed to protect the Federal Government's reversionary interest in multipurpose senior centers when these facilities are no longer used for their intended purposes. (CIN: A-12-89-00133) (Page 85)

OPPORTUNITIES FOR PROGRAM AND MANAGEMENT IMPROVEMENT

The following examples illustrate significant program and management weaknesses identified by OIG within HDS during this reporting period:

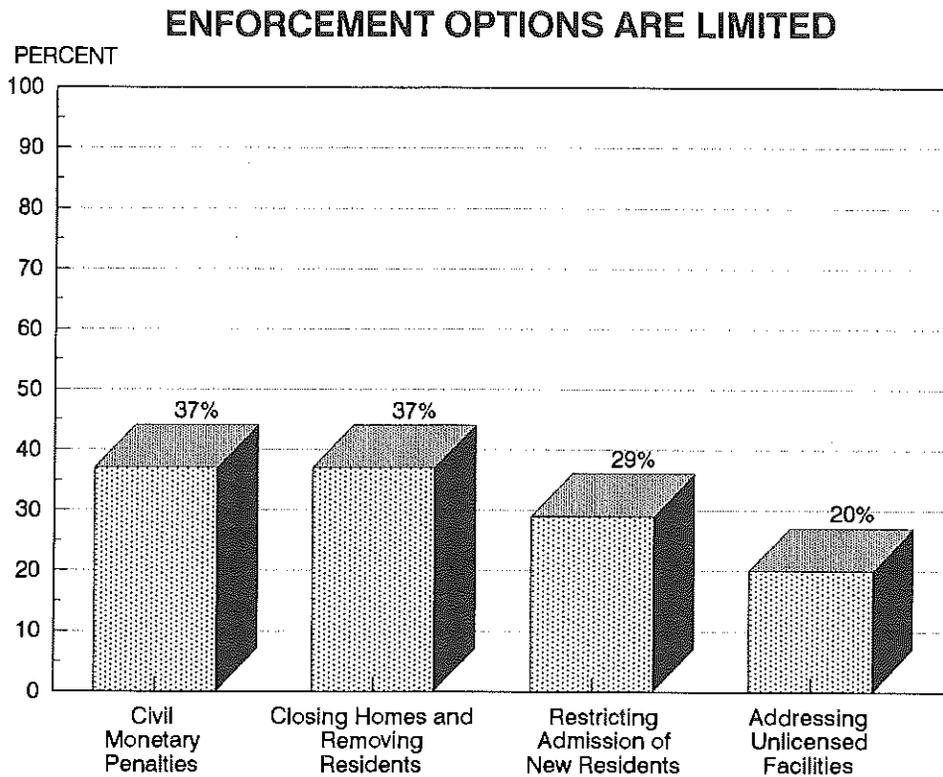
- The OIG found that the past process of overseeing discretionary grant funds within HDS was seriously flawed. (CIN: A-12-89-00142) (Page 83)
- Comprehensive case management is needed to help drug addicted mothers and their babies. (OEI-03-89-01540) (Page 82)
- The HDS needs to evaluate obstacles to placement of drug exposed babies, including policies on family reunification, voluntary termination of parental rights, and restrictions on foster care and adoption. (OEI-03-89-01541) (Page 82)

BOARD AND CARE REGULATIONS AND ENFORCEMENT

The OIG conducted an inspection to assess existing State board and care regulations and enforcement activity. The term "board and care" refers to nonmedical community-based living arrangements which provide shelter, food and protective services to a dependent population of elderly and disabled individuals.

The OIG found that although State standards adequately address certain basic safety and service requirements, weaknesses exist in other important areas, such as the level of care needs of

residents, staff training, dealing with unlicensed facilities and complaints, and coordination among responsible agencies, providers and consumers. The OIG further determined that while the States carry out basic enforcement activities, there are several serious weaknesses in this area as well. Among these is the fact that State standards often severely limit their enforcement options, as illustrated below.



Moreover, OIG found that HHS plays a limited role in matters affecting board and care facilities, and there is little contact among the various HHS agencies which have responsibility for board and care homes and their residents.

The OIG recommended that States reevaluate their board and care standards; improve their ability to identify and deal with unlicensed facilities; make use of sanctions such as civil monetary penalties, restrictions on new admissions and the closing of homes; and assure that their procedures for resolving complaints are adequately publicized. Further, OIG recommended that HDS support States' efforts by designating a unit to disseminate information on operational efficiencies, effective enforcement techniques, research and States' best practices; provide technical assistance relating to board and care; and coordinate departmental activities relative to board and care. The HDS disagreed with the recommendation that the departmental coordinating unit be located in HDS due to staffing and resource constraints. (OEI-02-89-01860)

CRACK BABIES

The OIG conducted a study to examine how crack babies are affecting the child welfare system in several major cities. When crack babies are identified, local child welfare agencies are usually notified to provide protective services, social services or foster care. While some State and local governments have done studies on aspects of the crack baby problem, little data is currently available at the national level.

Only two-thirds of the cities visited could provide the number of crack babies reported to the child welfare system. These cities handled 8,974 crack baby cases during the previous year. The OIG estimates the cost for hospital delivery, prenatal care, and foster care through age 5 for these 8,974 babies will approximate \$500 million. Already overburdened caseworkers are struggling to cope with crack baby cases which are time consuming and complex. These cases often need a variety of services including emergency placements, foster care, parental drug treatment and services for special needs children. Several hospitals indicated that they have started to perform child welfare functions because local welfare agencies are overwhelmed. Interagency coordination and professional case management is necessary for dealing with crack baby cases. Most crack babies go home with their mother or a relative. Many of these babies go into foster care. Very few are adopted.

The OIG made a number of recommendations which focus on actions which can be accomplished without additional authorities or significant funding. State and local governments should encourage outreach to provide prenatal care to pregnant women; reduce barriers to placement of crack babies in foster homes; develop guidelines and training for child welfare workers; and establish reporting and tracking systems. Among the recommendations made to HDS, the Public Health Service (PHS) and the Health Care Financing Administration (HCFA) were: disseminate effective practices; focus service strategies on serving the family; coordinate departmental activities; conduct short and long term research; promote drug abuse training; and continue to support targeted outreach and prenatal care. The PHS, HDS and HCFA generally agreed with the recommendations. (OEI-03-89-01540)

BOARDER BABIES

This report describes the extent of the boarder baby problem in several cities of varying size around the country. A boarder baby is an infant who remains in the hospital even though medically ready for discharge. This may result from legal complications, questions about the parents' ability to care for the babies, or a lack of care alternatives.

The OIG found that boarder babies usually have serious medical problems, which are often due to fetal exposure to drugs. There are a number of complex legal obstacles to placement of these babies, such as establishing legal abandonment and terminating parental rights. Some of the

cities visited in the survey have been successful in making timely placements. Their successes have resulted in significant decreases in hospital overstay and the number of boarder babies.

The OIG recommended that HDS and PHS identify effective practices in those cities which have reduced their boarder baby populations and disseminate this information to other cities which might profit from it. In addition, PHS should support research on ways to reduce boarder baby hospital stays. (OEI-03-89-01541)

AWARDING AND MONITORING DISCRETIONARY GRANTS

Approximately 1,800 discretionary grants are funded annually by HDS, amounting to about \$165 million. The OIG found that in the past, the grant awards were not always made in compliance with HDS policies and procedures at five of the program components within HDS. Consequently, effective oversight of grant funds was seriously flawed.

The offices cited included the Administration on Aging; the Administration on Developmental Disabilities; the Administration for Native Americans; and the Office of Policy, Planning and Legislation. Specifically, awards were made out of rank order without required written justifications; written justifications for awards contradicted peer review findings without explanation; written justifications were unsigned; and written justifications were so vague and brief that the rationale for the decision was not clear.

The HDS reported six material weaknesses in the FY 1989 FMFLA report. Each office listed above and the Office of Management Services were cited for lack of adherence to all policies and procedures related to the monitoring of its discretionary grants. The HDS has informed OIG that corrective action has been completed on some of the recommendations and a corrective action plan has been developed for the others. (CIN: A-12-89-00142)

FOSTER CARE

Public Law 96-272 amended the Social Security Act, creating title IV-E, Federal Payments for Foster Care and Adoption Assistance. Title IV-E foster care is a program in which the Federal, State and local governments share the costs of cash assistance for certain families with dependent children. The program offers an alternative to traditional AFDC home care when a judicial determination has been made that continuing care in a child's own home would be contrary to the child's well-being. Federal financial participation (FFP) is available to the States for expenditures made to licensed or approved foster family homes and nonprofit private child care institutions.

A. Administrative Costs

Title IV-E administrative costs have increased from \$142.7 million to \$400 million during the 4-year period ending September 30, 1988. Under current regulations, HDS projects that the Federal share of such costs will exceed \$1 billion during FY 1992.

The OIG concluded that the term "administrative costs" is a misnomer in the context of foster care, because it includes costs for activities related to social services. The lack of discrete accounting by States makes it difficult to determine the relation of the increased administrative costs to new or expanded services for foster children.

The primary reasons for the cost increases were determined to be an expanded definition of allowable activities which may be claimed by the States; a broad interpretation of the expanded definition by the Departmental Appeals Board; and the States' use of consultants to maximize Federal reimbursement.

In OIG's opinion, legislative approaches are required to contain the escalating administrative costs. One feature that must be addressed is the open-ended funding mechanism of the program. The OIG recommended that HDS continue to pursue legislative and policy changes which would limit the amount of administrative costs which the States could claim. The OIG also presented options for legislative proposals to be considered to reduce these administrative costs. Depending on the action taken, savings could be as much as \$2.3 billion over 5 years. (CIN: A-07-90-00274)

B. New York

An OIG review sought to determine whether foster care maintenance payments claimed for FFP by New York State for the City of New York were made on behalf of eligible children, and to ascertain the amount of administrative costs claimed for FFP that were associated with ineligible maintenance payments.

The review found that payments made on behalf of 202 of 300 sampled case records were unallowable for FFP either entirely or in part. Based on these results, OIG estimated that claims for maintenance payments of at least \$141.3 million (\$70.6 million Federal share) were unallowable for FFP. Further, OIG estimated that at least \$61.4 million (\$30.8 million Federal share) of claimed administrative costs associated with ineligible maintenance payments were also unallowable for FFP.

The OIG recommended that New York State process a financial adjustment in the amount of \$101.5 million. (CIN: A-02-87-02016)

C. District of Columbia

In a review of foster care payments by the District of Columbia, OIG found that of \$15.6 million in claimed foster care maintenance payments, \$11.8 million (\$5.9 million Federal share) was ineligible for FFP.

The review disclosed that approximately half of the unallowable FFP related to maintenance payments made to foster care homes and institutions through the District's computerized payment system. Two prevalent instances of noncompliance were the lack of required judicial determinations and the ineligibility of foster care facilities.

The remaining half of the unallowable FFP related to voucher payments made to organizations under contract with the District. In these cases, the services provided by the organizations did not meet the Federal definition for maintenance payments; payments reportedly made to contractors could not be supported by documentation; and the method used to allocate costs to the title IV-E program was unreasonable.

The OIG recommended that the District of Columbia make a financial adjustment of approximately \$5.9 million and improve its administration of the title IV-E program. (CIN: A-03-88-00551)

D. Ohio

The OIG determined that Ohio should improve its accounting and internal control systems relating to payments and claiming of costs. The OIG found that payments were claimed over the statewide maximum rate; total expenditures claimed for a month exceeded the total amount the county agencies paid to the foster care provider for the same month; and children were living in unlicensed foster care homes for short periods of time, ranging from 1 week to several months.

The OIG recommended that Ohio make a financial adjustment in the amount of \$2.4 million (\$1.4 million Federal share). (CIN: A-05-90-00071)

DAY CARE CENTER FRAUD

In Texas, seven more persons were convicted in a series of investigations into title XX day care center fraud. In all, about 45 parents and center employees were convicted over the past 2 years for furnishing false identification to boost enrollment figures of children in day care centers.

(6-86-00121-5)

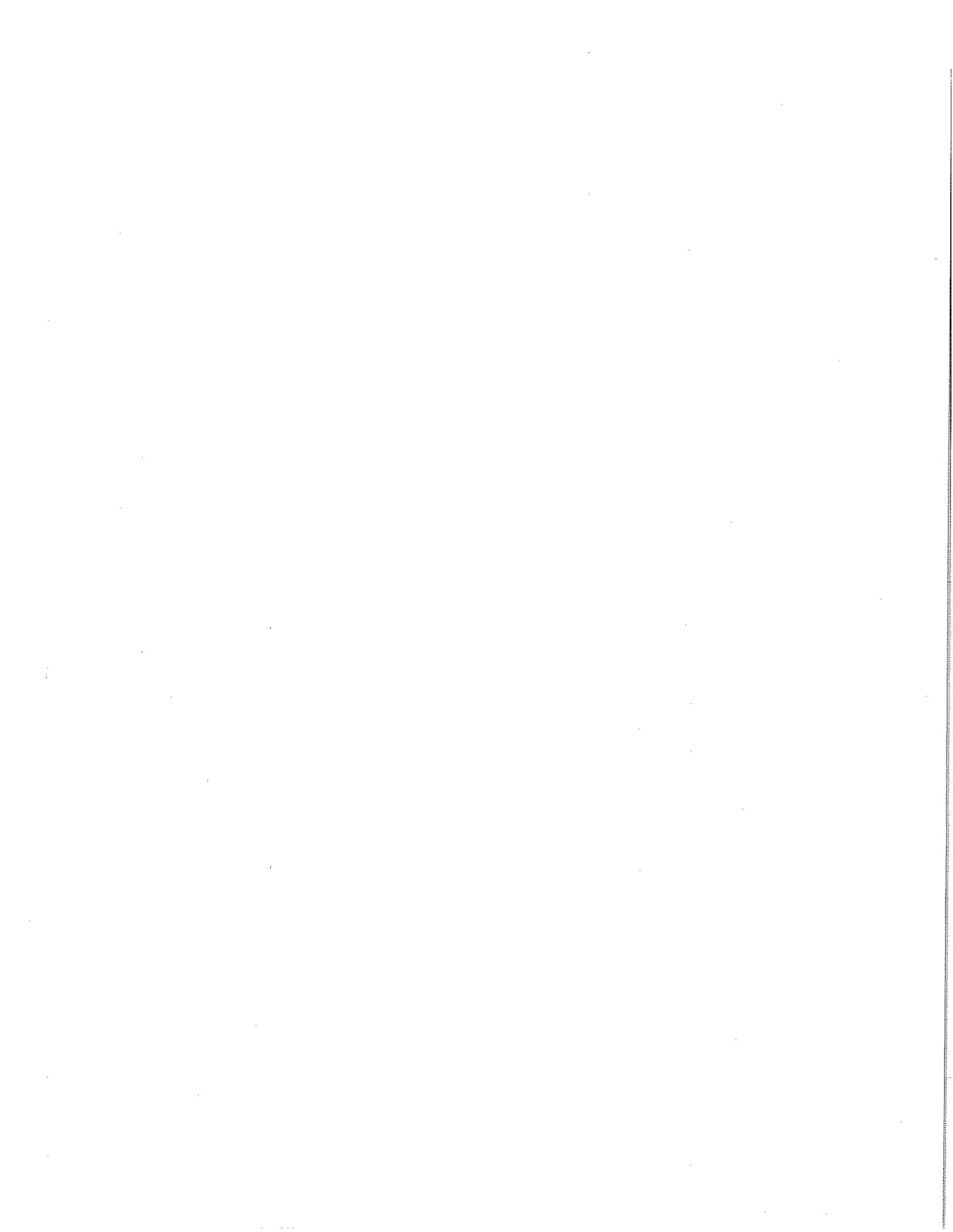
REVERSIONARY INTEREST: MULTIPURPOSE SENIOR CENTERS

The OIG conducted a review to determine whether the Administration on Aging (AoA) was protecting the reversionary interest of the Federal Government in administering funds involving multipurpose senior centers (MSCs) under the Older Americans Act. The OIG determined that

inadequate management information hinders the ability of AoA to ensure that the Federal Government receives its fair share (the original investment plus its share of the increased value) in the event that the properties are sold or cease to be used to provide services to senior citizens.

The OIG recommended that AoA establish a management information system that ensures complete and timely documentation of the acquisition, construction and/or renovation of MSCs using Federal grant funds. Program officials concurred with OIG's recommendation and will report this as a material internal control weakness. (CIN: A-12-89-00133)

APPENDICES



APPENDIX A

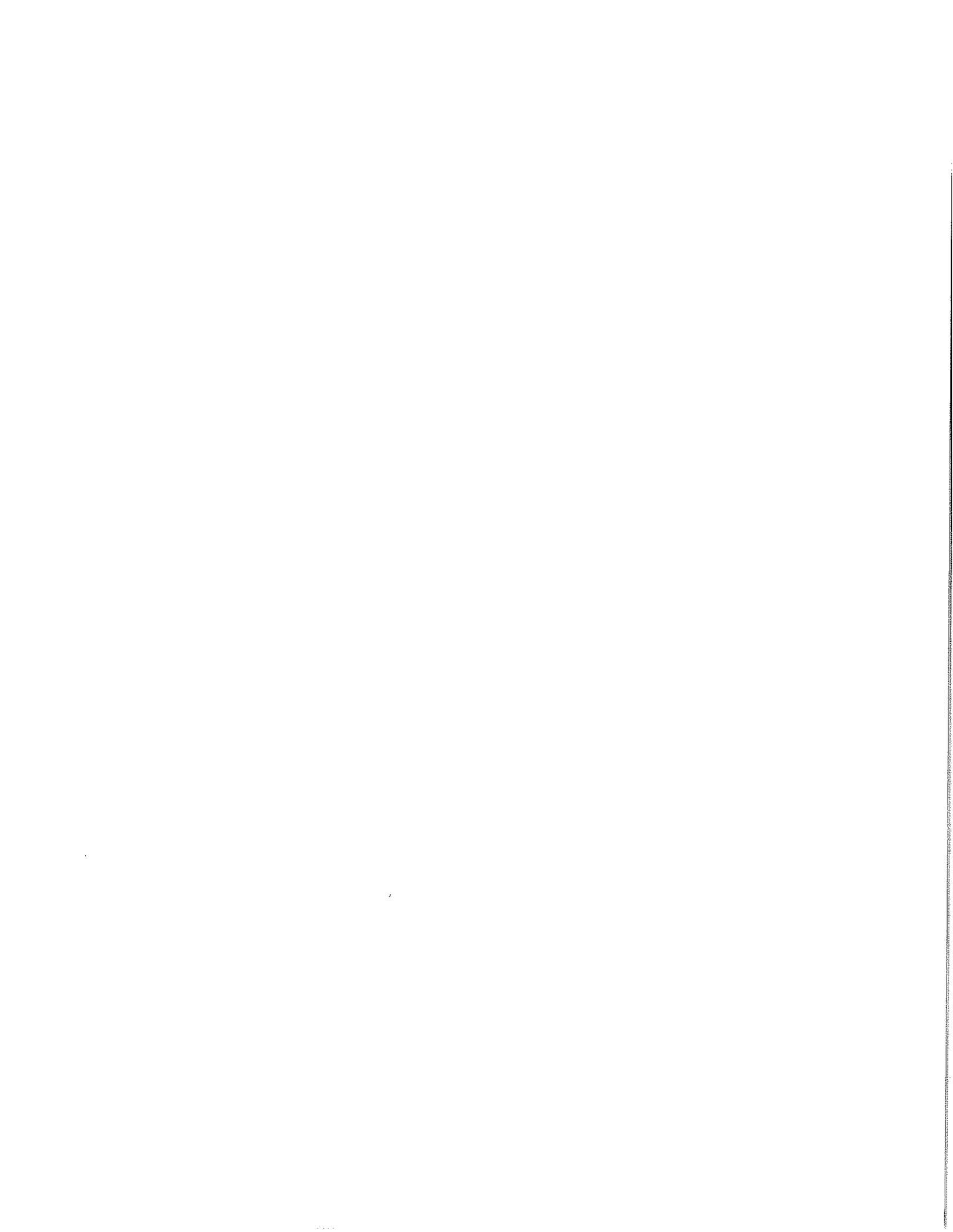
IMPLEMENTED OIG RECOMMENDATIONS TO PUT FUNDS TO BETTER USE APRIL 1990 THROUGH SEPTEMBER 1990

The following schedule is a quantification of actions taken in response to OIG recommendations to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. The amounts shown represent funds or resources that will be used more efficiently as a result of documented measures taken by the Congress or by management to implement OIG recommendations, including: actual reductions in unnecessary budget outlays; deobligations of funds, reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, or insurance of bonds. Total savings during this reporting period amounted to \$3513 million.

OIG Recommendation	Status	Savings in Millions
Accelerate Payroll Taxes:		
Accelerate payroll tax deposits of large employers. (CIN: A-09-89-00075)	Section 7632 of the Omnibus Budget Reconciliation Act (OBRA) of 1989 accelerated tax deposit requirements for large employers.	\$3,100
Capital Related Costs:		
Discontinue inappropriate Medicare payments for hospital capital costs. (CIN: A-14-52083; CIN: A-09-52020)	Sections 6002 and 6110 of OBRA 1989 reduced capital-related payments by 15 percent for hospital cost reporting periods beginning before October 1, 1991.	103
Durable Medical Equipment:		
The HCFA should take a number of specific actions to reduce inappropriate payments for oxygen concentrators, seat lift chairs (SLCs), power-operated vehicles (POVs) and transcutaneous electrical nerve stimulation (TENS) devices. (OAI-04-87-00017; OAI-02-88-00100; OAI-02-88-01110; OAI-02-88-00060; CIN: A-05-87-00138)	Section 6112 of OBRA 1989 specified that the Medicare economic index update for 1990 for DME is zero percent, reduced payments for SLCs and TENS devices by 15 percent, and directed that motorized wheelchairs be treated as routinely purchased items.	81
Ambulance Claims:		
The HCFA should require Medicare carriers to implement effective claims screening procedures to detect noncovered ambulance services. (CIN: A-04-86-62006)	The HCFA has directed all carriers to use its Common Procedures Coding System to effectively screen ambulance claims for origin and place of services codes.	64
Non-AFDC Child Support Payments:		
States should perform systematic review of all child support cases, including non-AFDC, targeting those where absent parents earn more than \$10,000 annually, and establish new or modify existing child support orders. (OAI-05-88-00340)	The FSA has encouraged States to begin periodic review of all child support cases and, when appropriate, establish new orders or modify existing ones. Many States have taken the recommended action with positive results.	43.4
Anesthesia Services:		
Actual time providing anesthesia should be the basis for computing payment. (CIN: A-07-89-00193)	Section 6106 of OBRA 1989 specified that anesthesia time units are to be based on actual time and not rounded up.	35

OIG Recommendation	Status	Savings in Millions
<p>PRO Disallowances: Eliminate from contract awards and subsequent contract amendments, unallowable and overstated costs included in peer review organization (PRO) cost proposals.</p>	<p>The HCFA used OIG findings in reducing third cycle/ 1988-1990 PRO contract awards and extensions.</p>	33
<p>Coordinate Third Party Liability Information: The Office of Child Support Enforcement (OCSE) should enforce current regulations regarding medical support by amending its Program Results Audit Guide and applying penalties to States found negligent in applying those regulations. (OAI-07-88-00860)</p>	<p>The OCSE has amended its Program Results Audit Guide to reflect the new medical support regulations and has penalized negligent States.</p>	32
<p>Cost of Research at Colleges and Universities: The PHS should establish \$120,000 as the maximum salary rate for federally supported research at colleges and universities. (CIN: A-12-89-00128)</p>	<p>Section 217 of Public Law 101-166, the 1990 NIH Appropriations Act, specifically establishes \$120,000 as the ceiling salary for individuals involved in federally supported research supported by NIH and ADAMHA funds.</p>	10
<p>Medicare Premiums for Medicaid Buy-in Enrollees: The HCFA, working with SSA, should periodically reconcile SSA's master beneficiary record (MBR) with HCFA's third party master tape (TPM) to ensure proper billings. (CIN: A-03-90-00620)</p>	<p>The HCFA has reconciled the MBR and TPM files on an ongoing basis, which has resulted in substantial recoveries.</p>	8.1
<p>Outmoded Procedures: The HCFA should monitor usage patterns of phonocardiograms in Michigan and hyperbaric oxygen in Louisiana and take remedial action if necessary. (OAI-12-89-01170)</p>	<p>As a result of OIG contact with the Michigan carrier, they reduced allowed charges for phonocardiograms from \$1.8 million to \$0.032 million.</p>	1.3
<p>Using Computerized Files to Detect Unreported Marriages: The SSA should initiate action on the 4,616 identified unreported marriages. If appropriate, collection action should be taken. (CIN: A-09-87-00052)</p>	<p>\$1 million has already been added to accounts receivable. The SSA is continuing to work on \$4.2 million.</p>	1

OIG Recommendation	Status	Savings in Millions
<p>Payments Under the Disability Determination Program for Medical Appointments Broken by Claimants of Disability Insurance and Supplemental Security Income Benefits:</p>	<p>Eleven of 28 States changed to a nonpayment policy in anticipation of regulatory changes resulting in savings of \$650,000 of the estimated \$1.5 million.</p>	.6
<p>Identifying Unauthorized Multiple Payments to the Same Person at the Same Address:</p>	<p>\$600,000 has been added to accounts receivable. The SSA has begun recovery.</p>	.6
<p>The SSA should not pay for broken consultative examination appointments. (CIN: A-01-87-02004)</p>		
<p>The SSA should recover overpayments relating to 23 matches identified in our audit. (CIN: A-04-87-03001)</p>		



APPENDIX B

UNIMPLEMENTED OIG RECOMMENDATIONS TO PUT FUNDS TO BETTER USE

This schedule represents potential annual savings or one-time recoveries which could be realized if OIG recommendations were enacted by the Congress and the Administration through legislative or regulatory action or policy determinations by management. It should be noted, however, that the Congress normally develops savings over a budget cycle which results in far greater dollar impact statements. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

OIG Recommendation	Savings in Millions
• Limit Federal financial participation to one of several limitation methods: none in administration and training costs; only in administration and costs based on a percentage of maintenance costs; in program costs using a percentile limitation based on previous costs; or in administration and training costs based on specific fixed dollar amounts (CIN: A-07-90-00274)	\$2,355
• Require mandatory Social Security coverage for all part-time and temporary State and local government employees not participating in any employees' retirement system (CIN: A-02-86-62604)	2,300
• Extend Medicare Part A coverage to all State and local government employees (CIN: A-09-86-62050)	1,866
• The OMB should revise Circular A-87 to disallow the interest expense associated with unfunded actuarial liabilities (CIN: A-09-87-00031)	1,300
• Modify Medicare payments to teaching hospitals by reducing the prospective payment system adjustment factor (ACN: 14-52018; ACN: 09-62003; CIN: A-09-87-00100; CIN: A-07-88-00101)	1,030
• Further accelerate payroll tax deposits by large employers (CIN: A-09-89-00075)900
• The SSA should support a legislative change to restore equity to the accounting process by requiring IRS to compensate the trust funds for interest and penalties collected which exceed the cost of IRS's administration of the Social Security tax (CIN: A-13-86-64640)844
• Disproportionate share payments to hospitals should be ended without redistributing the funds to the prospective payment system (CIN: A-04-87-01004)800
• Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs (ACN: 09-62021; CIN: A-08-87-00003)640
• Extend the Medicare secondary payer provisions for end stage renal disease beneficiaries beyond the current 1-year limit (CIN: A-10-86-62016)600
• The FSA should support a legislative proposal to reduce the FY 1991 State expenditures under the State Legalization Impact Assistance Grants (OEI: 07-90-02260)537
• 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; CIN: A-03-86-62019)380
• Require recipients of Federal funds to deposit payroll taxes at the time Federal funds are drawn down to meet payroll needs (CIN: A-12-88-00110)360
• Eliminate premium matching rates under Medicaid (ACN: 03-60223)360

- The SSA and Treasury should redetermine the dollar value of unnegotiated checks so as to most completely reimburse the trust funds (CIN: A-04-87-03004)\$338.8
- Raise the Medicare Part B deductible to \$100 and appropriately index it (ACN: 09-52043)280
- Apply the "multiple visit" concept to Medicare payments for physician visits to patients in skilled nursing homes and hospitals (ACN: 03-42005)240
- New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services (CIN: A-06-86-62045)238
- The SSA should take action to allow recovery of certain SSA and SSI overpayments through income tax refund offset (OAI-12-86-00065; OAI-12-88-01290)193.7
- Eliminate the \$50 child support payment to the AFDC family (CIN: A-02-86-72606)175
- Round Medicare Part B premiums up to the next higher dollar (ACN: 09-52008; CIN: A-08-87-00003)175
- The HCFA should impose a registration fee to fund the laboratory registration and inspection process (OAI-05-88-00330)173
- Expand the requirements for mandatory reporting of tip income to include other types of business where tipping is a common practice (CIN: A-09-89-00072)134
- Reimbursement rates to rural referral centers (RRCs) should be based on the relationship of costs of RRCs to costs of urban and other rural hospitals (CIN: A-03-87-00001)127
- The SSA should resubmit its legislative proposal authorizing the adjustment of RSDI payments to recover overpayment from former SSI recipients (OAI-12-86-0029)120
- The HCFA should seek legislation to pay for inpatient services not requiring an overnight stay as outpatient services, or pay for these services at the lower of actual charges or the DRG amount (CIN: A-05-89-00055)115
- Increase use of outpatient facilities for elective surgeries under Medicaid (ACN: 09-50205)110
- The HCFA should issue regulations to implement the 1985 COBRA provisions giving PROs authority to deny Medicare reimbursement for patients receiving substandard medical care (OAI-09-88-00870)110
- The HCFA should develop separate dialysis rates for independent and hospital based ESRD facilities (CIN: A-01-87-00500)109
- Limit Medicaid "buy-in" payments for Medicare deductible and coinsurance to the Medicaid fee schedule (ACN: 02-60202)100
- Require that SSA initiate collections on selected terminated overpayments by tracing selected overpayment records through the IRS taxpayer file (CIN: 09-89-00069)80.3
- Eliminate the current 8 percent ceiling on insurance premiums over the life of a HEAL loan; link insurance premium assessments to risk categories; require a 20 percent cost-sharing by lenders; permit lenders to require co-signers; eliminate Federal guarantee for loan amounts in case of death or disability; and impose a lender's processing fee for default claims filed (ACN: 12-73276)74.7
- Require that households with multiple AFDC family units be budgeted as a single economic unit for determining the amount of the grant award (ACN: 09-72615)73.5

OIG Recommendation**Savings
in Millions**

• Require Medicare carriers to implement effective claims screening procedures to detect noncovered ambulance services (ACN: 04-62006)	\$64
• Mandate that Medicaid beneficiaries obtain second surgical opinions for selected surgeries (ACN: 03-30211)	63
• Round down to the next whole dollar Medicare Part B and other payments for Medicare services (ACN: 03-62006; ACN: 14-52085)	63
• Exclude conventional eye wear from Medicare coverage for beneficiaries receiving intraocular lens implants (CIN: A-04-88-02038)	60
• Disallow State sales tax charged to Federal programs (CIN: A-04-86-00040)	54
• The SSA should seek legislative authority to use credit reporting agencies to locate RSDI debts (CIN: 03-89-02610)	52.4
• Use trust fund monies to liquidate the remaining mortgage balances on the three program service centers' contract method of financing (CIN: A-09-86-62611)	48
• The OIG identified three premarketing approval functions where FDA has not proposed a user fee (CIN: A-01-87-02522)	30.9
• Require fiscal intermediaries to implement computer edits to prevent improper payments to hospitals for nonphysician services reimbursed through DRG rates (CIN: A-01-86-62024)	28
• The HCFA should expand the list of procedures subject to the TEFRA outpatient limitation and make the list uniform among all carriers (CIN: A-07-86-62041)	22
• The SSA should define attainment of age as occurring on one's birthday instead of following the common law that age attainment occurs on the day before a person's birthday (CIN: A-09-89-0073)	21.4
• The OIG recommended procedures to improve SSA's accounting for payments after death and processing death terminations (CIN: A-04-87-03007)	20
• Minimize premature admissions for Medicaid elective surgeries (CIN: A-09-86-60213)	18.5
• The FSA should revise the EAF regulations to limit EA benefits to one period of 30 consecutive days or less in 12 consecutive months (CIN: A-01-87-02301)	18
• Revise Medicare regulations to prohibit suppliers from billing directly for urological and enteral therapy supplies and require that nursing homes include the cost of such products in their per diem rates (ACN: 06-42002)	17
• Cost and performance standards should be developed for disability case processing (OAI-06-88-00820)	14.5
• The HCFA should work to develop realistic and effective measures to prevent overutilization of oxygen concentrators (CIN: 04-89-02076)	12.4
• Eliminate Medicare coverage of extracranial-intracranial bypass surgery (CIN: A-09-87-00005)	10.7
• The Puerto Rican Department of Treasury should promptly remit to SSA unpaid contribution balances due for periods prior to January 1, 1987 (CIN: A-02-87-00008)	10.7
• Reclassify pacemaker monitoring under Medicare from the current physician-assisted service to the lower paying routine service (ACN: 08-52017)	6

OIG Recommendation**Savings
in Millions**

- All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charges (CIN: A-03-86-62008)\$5.2
- The SSA should take appropriate action on cases of unreported beneficiary marriages identified by OIG (CIN: A-09-87-00052)5.2
- The SSA should use automated systems to identify retroactive nonresident alien taxes due and develop procedures to facilitate collection (CIN: A-13-86-62658)4.4
- The HCFA should ensure that dialysis patients are afforded a full and fair opportunity to receive a kidney transplant (OAI-01-86-00107)3.7
- The SSA should have HHS' Division of Cost Allocation review the State of Arkansas' statewide cost allocation plan to prevent excessive rental charges for office space (CIN: 06-87-00076)2.7
- Improve Medicare Part B premium collection procedures on civil service annuitants (CIN: A-03-86-62009)2.4
- Weak procedural controls and a system deficiency resulted in lost accountability for overpayment due to improper cashing of replacement checks (ACN: 13-62635)1.3
- The SSA should not pay State agencies for consultative examinations that are canceled or otherwise not kept (CIN: A-01-87-02004)0.9

APPENDIX C

CONGRESSIONAL HEARINGS

The Office of Inspector General testified before numerous House and Senate hearings during the second sessions of the 101st Congress. The following list summarizes these appearances during the second session of the 101st Congress. Narrative descriptions highlighting OIG testimony follow the list.

Date	Topic	Congressional Committee/Subcommittee
February 7, 1990	FY 1991 Budget Request	Senate Appropriations Committee
March 1, 1990	Developments in the Generic Drug Industry	Subcommittee on Housing and Consumer Interests, House Select Committee on Aging
March 5, 1990	Medicare Part B Claims Processing in Georgia	Subcommittee on Health and the Environment, House Committee on Energy and Commerce
March 8, 1990	Crack Babies	Subcommittee on Children, Families, Drugs, and Alcoholism, Senate Committee on Labor and Human Resources
March 19, 1990	Treatment of Medicaid Patients in New York City	Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations
March 28, 1990	FY 1991 Budget Request	Subcommittee on Labor, Health and Human Services, Education and Related Agencies, House Appropriations Committee
April 4, 1990	False Claims Act	House Committee on the Judiciary
April 5, 1990	Administrative Costs for Foster Care	Subcommittee on Human Resources, House Committee on Ways and Means
April 25, 1990	Inspector General Investigative Authority	Senate Committee on Governmental Affairs

Date	Topic	Congressional Committee/Subcommittee
April 30, 1990	Crack Babies	Subcommittee on Health and the Environment, House Committee on Energy and Commerce
June 8, 1990	State Medical Boards and Medical Discipline	Subcommittee on Regulations and Business Opportunities, Senate Committee on Small Business
June 13, 1990	Civil Monetary Penalties	House Committee on Government Operations
June 14, 1990	Medicare Fraud and Abuse	Subcommittee on Health, House Committee on Ways and Means
June 20, 1990	Revenue Recovery Billing Process for Medicare	Permanent Subcommittee on Investigations, Senate Governmental Affairs Committee
June 22, 1990	Medicare Part B Claims Processing in Georgia	Subcommittee on Exports, Tax Policy and Special Problems, Senate Committee on Small Business
June 27, 1990	State Legalization Impact Assistance	Subcommittee on Labor-HHS-Education, Senate Committee on Appropriations
July 12, 1990	Tobacco Control	Subcommittee on Health and the Environment, House Committee on Energy and Commerce
July 11 & 12, 1990	Medicare Secondary Payer	Permanent Subcommittee on Investigations, Senate Governmental Affairs Committee
July 17, 1990	Regulation of Medical Devices	Subcommittee on Health and the Environment, House Committee on Energy and Commerce
July 30, 1990	Health Care Fraud in Florida	Subcommittee on Oversight, House Committee on Ways and Means

Date	Topic	Congressional Committee/Subcommittee
September 14, 1990	Medicaid Issues (HealthPASS)	Subcommittee on Health and the Environment, House Committee on Energy and Commerce
September 18, 1990	Chief Financial Officer Legislation	Subcommittee on Legislation and National Security, House Committee on Government Operations
September 25, 1990	Medicare Fraud and Abuse	Subcommittee on Oversight, House Committee on Ways and Means

HIGHLIGHTS OF OIG TESTIMONY

Developments In The Generic Drug Industry

The House Aging Committee, Subcommittee on Housing and Consumer Interests, held this hearing to review recent problems in the generic drug industry and to explore guidelines for older Americans who rely on generic drugs.

The OIG reported on the findings of two studies: "Medicare Drug Utilization Review" and "Vulnerabilities in the Food and Drug Administration's Generic Drug Approval Process." We found internal control weaknesses, such as lack of adequate guidelines for review of approvals, lack of proper review of applications, and arbitrary assignments of applications to reviewers. As a result of this work, the Secretary included the generic drug process as a material weakness in his 1989 report required by the Federal Managers' Financial Integrity Act. The OIG recommended a series of tighter policies and procedures for the approval process, accurate documentation and the development of overall sweeping standards which apply to the entire system.

Medicare Part B Claims Processing in Georgia

The OIG testified before the Subcommittee on Health and the Environment about the administration of Part B of Medicare in Georgia. Using the specific problems set forth by the change in the Part B carrier in Georgia, the subcommittee was interested in general aspects of oversight and management; the respective roles and responsibilities of various agencies; the development and implementation of medical review criteria; whether sufficient resources are being allocated to the administration of the program; and whether the administration of the program is promoting quality care.

The OIG reported on the findings of two reports done at the Secretary's request: one on the carrier's performance and the other on the satisfaction of health care beneficiaries in Georgia. Two conclusions drawn were that the new carrier was generally processing claims in accordance with Medicare laws, regulations and HCFA guidelines, and that Georgia beneficiaries have the same high service satisfaction levels as those nationwide in most cases.

Crack Babies

The hearing addressed the growing problem of drug exposed infants, or "crack babies." The OIG testimony discussed our "Crack Babies" report which estimated frequency, rising costs of care and treatment throughout the life of a child, and the problems of detection and lack of drug testing in hospitals. In particular, the report cited that child welfare systems were trying to cope with many of these problems, but in many cases, local efforts are understaffed and underfunded. In addition, the report cited the lack of coordination between hospitals and the State welfare programs. The report recommended increased case management, training and support services.

False Claims Act

This oversight hearing addressed the 1986 False Claims Act Amendments, particularly the qui tam provisions. Under the qui tam provisions of the False Claims Act, an individual may initiate a civil suit on behalf of the United States, and may share in any monetary recovery. Before the private individual proceeds, however, the Government must investigate the allegations and decide whether or not to assume prosecuting responsibility for the suit. The OIG was asked to discuss its involvement in a number of cases which have come to national attention. Since the 1986 statute, OIG has witnessed a steady growth of qui tam cases. Our testimony

pointed out several areas in the law which need improvement. For example, the 60-day allegation investigation period mandated by the statute is inadequate since the investigations are complex and often displace other priority investigations.

Treatment of Medicaid Patients in New York City

This hearing examined the quality of health care, particularly as related to Medicaid, in New York City. The OIG testified on our review of State medical boards, physician drug dispensing, and physician financial arrangements with other health providers. Our findings showed that although the number of complaints by patients about physicians increased, the oversight activity of State medical boards had changed little. The OIG recommended increasing renewal fees to cover enforcement costs and more timely case reports submitted concerning peer review organization regulations and Medicare carrier instructions. In addition, the number of physicians dispensing drugs for profit is on the rise. The OIG suggested a more aggressive program of State medical board sanctions and penalties, recommended increased program integrity activities and urged further cooperation between the Office of Investigations and the Medicaid fraud control unit in New York.

Administrative Costs of Foster Care

The subcommittee convened this hearing as the last of a 3-day discussion on Federal child welfare programs. In addition to continuing general exploration into ways to improve the system, the hearing focused on increasing costs and inadequate resources in the foster care program.

We were asked to discuss our report, "Crack Babies" and our work on title IV-E foster care program administrative costs. The OIG reports confirm rising administrative costs in the foster care program. This trend was attributed to: lack of standardization in the accounting process; the program's significant reliance on consultants; the classification of case management and other family service costs as administrative costs; and the impact of crack babies on the cost of foster care.

Inspector General Investigative Authorities

The Committee on Governmental Affairs convened this hearing to discuss the Office of Legal Counsel opinion which denied OIG authority to conduct certain kinds of investigations in selected regulatory programs. The Inspector General testified that rescinding or limiting our investigative jurisdiction would result in tremendous abuse and waste of Federal dollars. It is OIG's opinion that the Inspector General Act of 1978 intended that investigations be conducted against any person or organization suspected of fraud and not simply recipients of Federal dollars. This would include regulatory Government agencies and their beneficiaries.

Crack Babies

As part of the Subcommittee on Health and the Environment's effort to increase funding and support for the Medicaid program, OIG was asked to restate the findings and recommendations of OIG's report, "Crack Babies." The testimony was considered an important part of the Chairman's effort to draft new Medicaid related legislation.

State Medical Boards

This hearing examined the effectiveness of State medical boards and the problems they have with evaluating physician performance. State medical boards' licensing and discipline procedures are one way to regulate and insure proper care under Medicare and Medicaid. An OIG report, "Medical Licensure and Discipline," an update of a 1986 report, was the major focus of the testimony. The OIG testimony brought out that although progress has been made, the number of complaints to State boards is on the rise. Since 1986, the number of States that have hospital reporting laws has doubled, and States are increasingly granting protective immunity to State medical boards. However, the small number of peer review organization Medicare referrals continues to be an issue. The OIG attributed backlogs to many continuing problems, such as increasing referrals and staff shortages, and limitations on board authorities.

CMP Inflation Adjustment Act

Recent studies conducted by various interest groups and the President's Council on Integrity and Efficiency (PCIE) cited the impact that inflation can have on civil monetary penalties (CMPs). The Subcommittee on Legislation and National Security, Committee on Government Operations, called this hearing to discuss S. 535 which would institute a periodic review to examine CMPs for potential inflationary adjustments.

The OIG testimony shared our experience with CMP law and a recent PCIE study on CMPs. Accountability for these penalties is extremely decentralized and difficult to assess. The OIG supported S. 535 as a means to force regular examination of CMPs.

Medicare Fraud and Abuse

The Subcommittee on Health, Committee on Ways and Means, called this hearing to discuss waste in the Medicare program. The OIG testimony summarized our work dealing with the quality and necessity of outpatient surgery, preprocedure review by the peer review organizations and the pricing of the new drug Epogen. Our statement discussed specific procedures, namely cataract

surgery, upper gastrointestinal endoscopy, and colonoscopy, performed in ambulatory surgical centers and hospital outpatient departments. The testimony mentioned our continued endorsement of the second opinion program for those opting for elective surgery. The OIG recommended that HCFA increase and tighten its preprocedure review.

The Epogen study revealed that original projections about cost and use of the drug have been proven low in practice since both its cost and use are more widespread. The OIG recommended that HCFA consider reimbursing Epogen treatment based on units administered, which could save Medicare \$20 million annually.

Revenue Recovery Billing Process for Medicare

Senate hearings were held to examine the costs to American consumers of inflated and inaccurate medical bills. The focus was on revenue recovery firms, some of which submit inflated charges to insurance companies based on questionable audits of hospital bills. The OIG's testimony outlined three major techniques commonly used for this kind of fraud: "upcoding," "fragmentation," and "exploding." An independent source has concluded that misbilling may have accounted for \$5.5 billion of the \$115 billion paid to doctors last year.

State Legalization Impact Assistance Grant Expenditures

The OIG testified on our findings regarding the State Legalization Impact Assistance Grant (SLIAG) program and how much of the SLIAG appropriation should be carried over into the next fiscal year. Based on our review, our statement revealed that the States' cost estimates are imprecise and that FSA and the States should have more solid estimates within a year. The OIG estimated that SLIAG funding needed for FY 1991 is between \$0 and \$459 billion. The testimony suggested that Congress could take a more conservative approach in allocating money to the States because of the widespread uncertainty, particularly since State draw downs are consistently below appropriations. Specifically, OIG reaffirmed its earlier recommendation to reduce the FY 1991 appropriation by \$500 million.

Medicare Secondary Payer

The Senate Permanent Subcommittee on Investigations held a 2-day hearing on the problems with the Medicare secondary payer program. The focus was on whether, since 1983, private health care insurers have attempted to avoid their responsibility for paying health insurance claims before Medicare. The OIG testimony summarized our audit efforts to date, our recent report which showed that potential losses to Medicare are over \$500 million and our criminal investigation of a major insurance company that allegedly violated the Medicare secondary payer laws by continually billing Medicare first.

Tobacco Control Reform

The Subcommittee on Health and the Environment convened this hearing to collect data and positions on H.R. 5041, which proposes stringent restrictions on tobacco sales to minors, free samples and advertising. The OIG was asked to discuss the report, "Youth Access to Cigarettes." The study showed that although 45 States have laws prohibiting cigarette sales to minors, there is little enforcement. Vending machines are responsible for 16 percent of sales to youths. The most successful enforcement occurs as a result of local concern, and is achieved by a combination of sanctions and warnings including licensing, fines and warning labels.

Medical Devices

This hearing was held to discuss H.R. 3095 which amends the Food, Drug, and Cosmetic Act (FDCA) to improve the regulation of medical devices. The subcommittee was particularly interested in the present process of regulation of devices and the effectiveness of it.

The subcommittee had requested that OIG study premarket approval and postmarket surveillance of medical devices. The premarket process contains some internal control weaknesses including lack of consistency in areas such as testing, sequencing, workload controls and independent quality control criteria. The postmarket problems involved insufficient resources to monitor the industry and perform needed inspections; unclear regulations; and lengthy regulatory actions, resulting in delayed seizures or withdrawals of problem devices. We recommended that FDA augment the premarket notification process with selective testing, validation and inspections. We also recommended that FDA clarify regulations and seek legislation to require mandatory notification of voluntary recalls and to promptly initiate recalls.

Investigating Health Care Fraud in Florida

The Oversight Subcommittee, Committee on Ways and Means, requested that OIG testify on our progress in investigating health care fraud in Florida. Our statement focused on the variety of cases handled by our agents and the success we have had to date. Over the last 4 years, we have recouped approximately \$934,000 in criminal recoveries, \$210,000 in criminal restitutions and \$426,000 in criminal fines. We have also levied civil monetary penalties of over \$6 million. In addition, we pointed out the kinds of fraud being perpetrated on Florida residents, such as unauthorized or excessive testing, false billings and general provider fraud.

Medicaid Issues - HealthPass

This hearing was held to examine a variety of issues related to the Medicaid program. The OIG testified regarding our audit work related to the HealthPASS program in Philadelphia, Pennsylvania. HealthPASS is a primary care case management program under which the contractor receives a capitation fee for each Medicaid recipient enrolled in the program. We concluded that the Pennsylvania Department of Public Welfare had not acted prudently in awarding a new HealthPASS contract to Health Management Alternatives, Inc.

Chief Financial Officer Legislation

Two bills (S. 2840 and H.R. 5492) have been introduced thus far this congressional session to establish a chief financial officer (CFO) for the United States and a network of CFOs in each agency and to require annual audited financial statements. This hearing was held on these bills and an additional draft bill by the Chairman. The Inspector General testified in favor of chief financial officers and audited financial statements and offered to work with the committee in further refinements of pending legislation.

Medicare Fraud and Abuse

The Subcommittee held this hearing as follow-up to its July 30, 1990 hearing in Florida. The OIG testimony addressed a variety of Medicare fraud schemes that we have investigated and our recommendations for improvements which would deter future Medicare fraud.

APPENDIX D

SUCCESSFUL PROSECUTIONS BY FEDERAL DISTRICT AND STATE AUTHORITIES

FISCAL YEAR 1990

<u>JURISDICTION</u>	<u>FIRST HALF 1990</u>	<u>SECOND HALF 1990</u>	<u>TOTAL</u>
<u>Federal District</u>			
Northern Alabama	3	3	6
Middle Alabama	8	2	10
Eastern Arkansas	4	3	7
Western Arkansas	-	2	2
Central California	9	5	14
Eastern California	2	1	3
Northern California	8	9	17
Southern California	3	1	4
Colorado	18	16	34
Connecticut	4	1	5
District of Columbia	5	11	16
Northern Florida	9	1	10
Middle Florida	9	9	18
Southern Florida	-	7	7
Northern Georgia	8	5	13
Southern Georgia	1	-	1
Idaho	6	-	6
Central Illinois	14	18	32
Northern Illinois	23	18	41
Southern Illinois	3	1	4
Northern Indiana	2	2	4
Southern Indiana	2	2	4
Northern Iowa	3	1	4
Southern Iowa	4	1	5
Kansas	4	5	9
Eastern Kentucky	7	6	13
Western Kentucky	3	2	5
Eastern Louisiana	6	8	14
Middle Louisiana	3	3	6
Western Louisiana	1	-	1
Maine	2	5	7
Maryland	16	7	23
Massachusetts	10	6	16

Eastern Michigan	24	33	57
Western Michigan	3	4	7
Minnesota	7	12	19
Northern Mississippi	-	2	2
Southern Mississippi	1	-	1
Eastern Missouri	5	4	9
Western Missouri	5	2	7
Montana	-	4	4
Nebraska	2	3	5
Nevada	2	1	3
New Jersey	14	17	31
New Mexico	6	3	9
Eastern New York	11	27	38
Northern New York	2	1	3
Southern New York	14	11	25
Western New York	5	10	15
Middle North Carolina	1	6	7
Western North Carolina	-	2	2
North Dakota	-	6	6
Northern Ohio	6	5	11
Southern Ohio	8	19	27
Northern Oklahoma	1	1	2
Eastern Oklahoma	1	3	4
Western Oklahoma	5	4	9
Oregon	1	2	3
Eastern Pennsylvania	19	21	40
Western Pennsylvania	3	-	3
Puerto Rico	5	1	6
Rhode Island	1	-	1
South Carolina	27	65	92
South Dakota	1	-	1
Eastern Tennessee	1	3	4
Middle Tennessee	2	2	4
Western Tennessee	5	-	5
Eastern Texas	-	4	4
Northern Texas	14	17	31
Southern Texas	29	27	56
Western Texas	10	8	18
Utah	5	9	14
Vermont	2	-	2
Eastern Virginia	10	7	17
Western Virginia	2	-	2
Western Washington	4	3	7

Eastern Wisconsin	8	3	11
Western Wisconsin	4	3	7
Wyoming	1	2	3
Foreign	<u>1</u>	<u>-</u>	<u>1</u>
Subtotal	478	518	996

State Authorities

Alabama	1	-	1
Arkansas	-	8	8
Arizona	4	-	4
California	33	11	44
Colorado	8	8	16
Connecticut	1	-	1
Delaware	-	1	1
District of Columbia	-	2	2
Florida	2	2	4
Georgia	1	2	3
Iowa	2	10	12
Illinois	10	17	27
Indiana	12	4	16
Louisiana	3	2	5
Maine	-	2	2
Maryland	13	20	33
Massachusetts	2	8	10
Michigan	1	2	3
Minnesota	-	1	1
Missouri	3	2	5
Mississippi	3	5	8
Montana	1	1	2
North Carolina	1	-	1
New Jersey	1	-	1
New York	2	4	6
Ohio	22	12	34
Oregon	1	8	9
Pennsylvania	1	1	2
Puerto Rico	-	7	7
Rhode Island	-	2	2
South Dakota	-	2	2
Texas	2	3	5
Utah	1	1	2
Virginia	5	9	14
Washington	1	11	12

Wisconsin	1	7	8
Wyoming	<u>-</u>	<u>1</u>	<u>1</u>
Subtotal	138	176	314
TOTAL	616	694	1,310

ACRONYMS

ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
AIDS	acquired immune deficiency syndrome
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ASPER	Assistant Secretary for Personnel Administration
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control
CLIA	Clinical Laboratory Improvement Amendments
CMP	civil monetary penalty
CSE	child support enforcement
DEA	Drug Enforcement Administration
DME	durable medical equipment
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFP	Federal financial participation
FMFIA	Federal Managers' Financial Integrity Act
FSA	Family Support Administration
FY	fiscal year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HCRIS	Hospital Cost Report Information System
HDS	Office of Human Development Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
INS	Immigration and Naturalization Service
IOL	intraocular lens
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
LTE	less than effective
MBR	master beneficiary record
MCCA	Medicare Catastrophic Coverage Act
MFCU	Medicaid fraud control unit
MIS	management information system
MSC	multipurpose senior center
MSP	Medicare secondary payer
NCEP	National Cholesterol Education Program
NIH	National Institutes of Health
OBRA	Omnibus Budget Reconciliation Act
OCS	Office of Community Services
OGC	Office of General Counsel
OMB	Office of Management and Budget
PCIE	President's Council on Integrity and Efficiency
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
POV	power operated vehicle
PPS	prospective payment system
PRO	peer review organization
PSC	program service center
RSDI	Retirement, Survivors and Disability Insurance
SLC	seat lift chair
SLIAG	State Legalization Impact Assistance Grants
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TENS	transcutaneous electrical nerve stimulation
TPM	third-party master tape

**DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

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