

*Economy,
 Efficiency
 and
 Effectiveness
 at the
 Department
 of
 Health
 and
 Human
 Services*



Semiannual Report

October 1, 1990 - March 31, 1991

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
P.L. 101-576	Chief Financial Officers Act of 1990

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-7b 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 3801, et seq., 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 March 31, 1991. 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.

Over the years, OIG has worked to protect the integrity of departmental programs and the health and welfare of the beneficiaries of those programs. In addition, OIG is responsible for oversight of departmental management activities, and has been actively involved in the Department's program to ensure effective internal controls. Moreover, OIG participates 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 administers the Medicare and Medicaid programs.*
- The Social Security Administration manages the Nation's Retirement, Survivors and Disability Insurance program, the Supplemental Security Income program and Part B of the Special Benefits to Disabled Coal Miners (Black Lung) program.*
- The Public Health Service 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 provides Federal direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families.*

* Effective April 15, 1991, the Department has been reorganized. A new operating division, the Administration for Children and Families, will combine the programs of the Family Support Administration, the Office of Human Development Services (except for the Administration on Aging), and the Maternal and Child Health Block Grant of the Public Health Service.

- *The Office of Human Development Services 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 comprises 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 for overseeing audit work done by others. Audits are conducted to fulfill OIG's responsibilities under the Inspector General Act, and to address high priority areas of interest to the Secretary, the Congress and program administrators. Audits assess the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent reviews of HHS programs and operations in order to reduce waste, abuse and mismanagement, and to promote economy and efficiency throughout the Department. They focus on HHS's role in administering the Nation's critical health and human services programs, and are designed to provide sustained and balanced coverage in these areas. The OIG's auditors conduct their work in accordance with the Government Auditing Standards (Yellow Book) published by the U.S. General Accounting Office, the American Institute of Certified Public Accountants (AICPA) standards and AICPA Statements on Auditing Standards.

The Office of Investigations (OI) protects the integrity of HHS programs and the well-being of legitimate HHS beneficiaries by investigating allegations of fraud and abuse by service providers and illegal benefit seekers. Its investigations result in criminal prosecutions, administrative sanctions and civil actions against wrongdoers, including monetary penalties and exclusion from HHS programs. The OI proposes systemic changes to remedy program flaws discerned during investigations, to prevent future fraudulent activities. Special Fraud Alerts are issued to warn agencies and organizations of illegal schemes which drain the trust funds or victimize beneficiaries. Exclusion of unscrupulous and incompetent medical care providers from program participation prevents their further enrichment or harm to patients. The OI also oversees State Medicaid fraud control units which investigate and prosecute provider fraud and abuse in the Medicaid program.

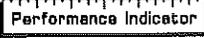
The Office of Evaluation and Inspections conducts short term management and program evaluations that focus on issues of concern to the Department, the Congress and the public. Over one-third of the inspections are requested by the Secretary, the operating divisions or the Congress. Program inspections offer the Department's managers a fast, unbiased, highly reliable way of gathering information about their programs. Inspections are usually completed within 6 to 9 months to ensure that pertinent information is available before decisions are made. Inspections contain findings and recommendations which assist program managers in improving

quality of care for the Department's clients, improving program efficiency, identifying and correcting program vulnerabilities and identifying areas for cost savings.

In recognition of the Department's responsibility to meet the important social goals and pressing health needs of the American public, the Secretary has set specific objectives and established program directions for the operating divisions designed to achieve those objectives. The Secretary's goals for HHS are to:

- ensure the necessary support for biomedical research.
- prevent disease and social pathology.
- improve access to health care for all Americans.
- maximize the cost-effectiveness of health care services.
- strengthen the American family.
- promote personal responsibility for health and social fitness.
- maintain the integrity of the Social Security and Medicare programs.

The OIG's activities support those goals by promoting high quality, cost-effective health care and human services, improved access to health care for all Americans, and the integrity of the Social Security and Medicare trust funds. In addition, OIG is focusing particular attention on the Department's efforts to improve its financial systems and accelerate the development and auditing of financial statements pursuant to the recently enacted Chief Financial Officers Act.

The development of ways to report on program performance is an area of new and growing interest in financial reporting. There is an increasing focus on accomplishment reporting as an integral element of financial reporting. Financial results pertaining to a particular accounting period are more meaningful when related to information on program or agency outputs. Therefore, we are identifying performance measures which result from our work and may be usable for reporting. Throughout the body of this semiannual report, we have tagged some of our write-ups as "performance indicators" by marking them with the symbol . These audits, inspections and investigations offer an assessment as to whether the programs reviewed are achieving their desired goals and present some quantifiable result.

In this first semiannual report for Fiscal Year (FY) 1991, we will focus on our accomplishments in the areas of program and management improvement. The semiannual report covering the second half of FY 1991 will highlight our statistical accomplishments for the entire fiscal year.

We wish to thank the Department's managers and the Members of the Congress whose continued assistance has helped us to realize our accomplishments. We look forward eagerly to meeting the challenges of the 1990s.

*Richard P. Kusserow
Inspector General*

HIGHLIGHTS

In the past, we have sought to balance the presentation of each of our semiannual reports, emphasizing equally our monetary results, successful prosecutions and sanctions activities, and recommendations relative to program and management efficiency and effectiveness. While each of those areas continues to be of major importance to the Office of Inspector General (OIG), we have chosen in this spring's report to highlight our efforts in improving departmental financial and program management through effective internal controls, and enhancing the quality of health care and support services under the Department's many programs.

MAINTAINING THE INTEGRITY OF THE DEPARTMENT'S PROGRAMS AND OPERATIONS

One of OIG's statutory responsibilities is to protect the integrity of the Department's programs and activities. The OIG's oversight activities in these areas cover both operational and financial areas.

Oversight of the Department's Financial Activities and Systems

One statute that heavily impacts OIG's work in the area of financial management is the Federal Managers' Financial Integrity Act (FMFIA) of 1982. The FMFIA establishes a Governmentwide framework for improving and monitoring the effectiveness of internal accounting and administrative controls to detect fraud, waste and abuse. In reports mandated by the Act, Federal agency heads must state whether their internal control systems and accounting systems conform to the requirements set out by the Comptroller General. Throughout the year, OIG provides technical assistance to Department managers in developing, improving and implementing effective FMFIA programs. The OIG annually reviews and tests the Department's FMFIA implementation. The OIG assesses managers' segmentation of operations, risk reviews and internal control/systems reviews. Based on this testing, OIG prepares an annual report on FMFIA implementation which the Secretary considers in assuring the President and the Congress as to the adequacy of the Department's FMFIA program. A more complete description of OIG's role may be found on page 1. In addition, chapters I, II, IV and V highlight OIG audits, inspections and investigations completed during this period which relate to material weaknesses and/or high risk areas within the Department.

Complementing the FMFIA is the recently enacted Chief Financial Officers (CFO) Act of 1990. The purpose of the CFO Act is to improve the general and financial management practices of the Federal Government in order to make Government operations more efficient and effective, and to prevent waste, fraud, abuse and mismanagement. The OIG will be very much involved with the CFOs' efforts to improve financial management. While the new requirements entail a sizeable

increase in OIG's responsibilities and workload, a significant level of this workload is already being performed, and is built into OIG's annual work plan. Moreover, OIG has been auditing the Social Security Administration's (SSA) combined financial statements since 1988.

The following examples illustrate work performed in this period prior to passage of the CFO Act which will be relevant to the production and audit of the financial statements:

- In an audit of SSA's combined financial statements for Fiscal Years (FYs) 1989 and 1990, OIG found that, except for the effects, if any, of particular uncertainties noted, the combined financial statements presented fairly, in all material respects, SSA's financial position at September 30, 1989 and 1990. (See page 42)
- The OIG conducted a review of the integrity of the Department's civilian payroll system with respect to controls over timecard security and unemployment compensation. The OIG concluded that a material weakness should be declared Departmentwide concerning controls over timecard security as management could not provide reasonable assurance that the Department's payroll system was safeguarded from fraud and abuse. (See page 11)
- In a review of the Department's Working Capital Fund, OIG found that accounting records generally contained accurate, supported data and that the Fund had made considerable progress in correcting deficiencies noted in an earlier audit. (See page 12)

There are other similar examples of OIG's ability to draw on work done previously, which could have a direct bearing on the timing and extent of our financial audit work. For a full discussion of OIG's work in connection with the CFO Act, see page 3.

Overseeing the Integrity of the Department's Programs

During this past half year, OIG has completed a number of studies, audits and investigations to comply with our responsibilities in the oversight of the Department of Health and Human Services (HHS) programs. For example:

- In a review of the internal controls over Medicaid prescription drugs in one locality, OIG learned that there was a growing demand nationwide for illegally obtained prescription drugs, and that the 15 most abused prescription drugs were available under the Medicaid program. To help narrow down the field of possible abusers of the system, OIG developed its own computer software package. The OIG offered that package to the Health Care Financing

Administration (HCFA) for use in planning oversight reviews of State internal controls over Medicaid prescription drugs. (See page 37)

- The OIG issued a report advising SSA of the advantages of maintaining and disseminating a computer software package for detecting invalid Social Security numbers (SSNs). In earlier studies, OIG found a high incidence of SSN discrepancies in public and private records outside SSA. The OIG's computer package is a viable substitute for full SSN verification in situations where the requesting organization does not have access to SSA's enumeration verification system. (See page 49)
- The most common crime involving HHS programs is misuse of SSNs, accounting for nearly half of OIG convictions. Use of false SSNs to obtain or maintain eligibility for benefits severely drains the trust funds. Innocent individuals whose SSNs are usurped by others suffer harassment and poor credit ratings they do not deserve. Beyond individual and immediate Department consequences, however, use of false SSNs in bank and credit card fraud, trade in illegal drugs, money laundering and other schemes costs taxpayers many millions each year. The OIG identified almost \$4 million in fines, restitutions and recoveries from conviction of crimes in which use of a false SSN was a major factor. (See page 50)
- About a year ago OIG began sending SSA lists of individuals convicted of crimes against the Social Security programs. The list is used to screen persons who seek to become representative payees for beneficiaries who, for reason of age or physical condition, are unable to manage their own finances. The screening is one of a number of steps being taken by SSA, partially as a result of OIG investigations and congressional mandate, to assure the reliability of representative payees, particularly high-risk payees.
- Several investigative initiatives, particularly in the health care area, are proving effective in protecting the trust funds and recovering program losses sustained. The OIG is concentrating on civil actions against many unscrupulous providers to accomplish several goals. First, successful civil action is as effective as criminal action in removing these providers from further program reimbursement. Second, rules of evidence for civil cases are somewhat less stringent than those for criminal cases, and proof is therefore less difficult to establish. Third, pursuit of civil action diminishes the load on the overburdened criminal system, and the time and expense entailed. Finally, civil judgments and settlements can mean far greater monetary returns. Although less than 10 percent of the more than 700 successful actions arising from OIG investigations were

civil actions, the resulting judgment and settlement amounts totaled well over one-third of all OIG investigative recoveries during this reporting period.

- The OIG is concerned about the impact physician kickbacks and joint venture deals have on the Department's health care programs. Supplier payments to physicians for referring patients for items or services directly or indirectly may increase Medicare costs. The more complex cases, in which physicians have financial interests in laboratories or other health care service organizations, also may cause overutilization. Under Federal statute anyone who offers, solicits or receives payment in exchange for referrals for items or services payable by Medicare or Medicaid may be fined, imprisoned and excluded from these programs. The OIG has drafted regulations which clarify circumstances, or "safe harbors," in which specific payment practices are permissible even though they could encourage referrals which lead to Medicare reimbursements. These regulations are undergoing final review by the Administration. At the same time, OIG is aggressively investigating abusive, illegal kickbacks and joint ventures to eliminate the damage and recoup losses inflicted by these activities. (See page 31)
- In reports on management efficiency in Head Start, OIG recommended improvements in the program's automated information systems, evaluation of grantee performance and identification of grantees with management or operational problems. (See page 75)
- A series of audits throughout the Nation showed that grantees receiving rural housing and rural water treatment, and food and nutrition funds through community services discretionary grants were often not achieving grant objectives and not spending in accordance with grant terms. The OIG concluded that weaknesses in grants administration within the Office of Community Services contributed to the grantees' problems. (See page 69)

ENSURING ACCESS TO AND QUALITY OF HEALTH CARE SERVICES

In order to better serve the taxpayers and the beneficiaries of the Department's programs, the Secretary has identified several areas for intensive effort by the Department. Among the priorities identified by the Secretary are improving preventive health care and the availability of health care to the underserved, and expanding the use of cost-effective, high quality medical care. In support of these Secretarial initiatives, OIG has focused a number of program reviews on the kinds of health care services the Department provides, how it provides those services, and ways to enhance preventive health care efforts and improve both the access to and quality of health care services. The following items are examples of OIG's work in these areas during this reporting period:

- The problem of mismedication among the elderly and steps the Department could take to improve compliance with drug regimens were discussed in detail in previous OIG reports. In a current report, OIG examined the role of the community pharmacist. Strong evidence exists to indicate that clinical pharmacy services can be used to alleviate mismedication and associated health problems. However these services are not widely available in community settings. The report discusses the barriers to the availability of these services and makes recommendations for improvements to both HCFA and the Public Health Service (PHS). (See page 22)
- In a review of American and Canadian licensure and discipline activities, OIG found that licensing authorities have started to focus their efforts on preventive measures rather than disciplinary activities. However, Canadian licensing authorities regularly use quality assurance mechanisms not typically employed by their American counterparts. By complementing their disciplinary efforts with an array of preventive measures, State medical boards could make significant contributions to the quality of medical care provided in the United States. (See page 62)
- The OIG conducted a review of The Food and Drug Administration's (FDA's) regulatory process for medical devices and found that FDA cannot meet all of its regulatory responsibilities, partially because of resource limitations, but also because the medical device regulation is unclear and the process is too cumbersome. The findings and recommendations of this report were presented by the Inspector General at congressional hearings. The report provided essential information to the Congress in developing and enacting the Safe Medical Devices Act of 1990, particularly the provisions concerning preproduction quality assurance and civil monetary penalties. (See page 60)
- A series of investigations uncovered widespread corruption in FDA's generic drug approval process. Now a parallel group of investigations is resulting in the conviction of generic drug companies and officials for selling adulterated drugs, subverting bioequivalency studies, falsifying documents, and lying to FDA investigators. Completion of the investigations and prosecutions will create opportunities to establish a more reliable generic drug industry, revitalize flagging public confidence, and assure user health and safety. (See page 58)
- Exclusion from HHS program participation has by far the most immediate effect of all OIG activities on the well-being of HHS beneficiaries. Of the 565 exclusions issued during the past 6 months, 40 percent were imposed because the health care professionals had lost their license to practice. Another 25 percent

were excluded because of conviction of program-related crimes, and some 13 percent for conviction of controlled substance use or patient abuse. Refusal to allow criminal, incompetent or malicious providers to treat Medicare patients means that they will not have the opportunity to victimize them. (See page 28)

- The OIG reviewed the implementation of the Comprehensive Perinatal Care Program which provides supplemental funds to community and migrant health centers in an effort to reduce infant mortality. The report identifies means by which PHS can expand perinatal services to cities with high infant mortality rates. (See page 59)
- Two reports on human immunodeficiency virus infection among street youth discuss steps the Department can take to improve this group's access to health care, and furnish information on the range of services provided by the Department. (See page 56)
- Two reports issued on adolescent steroid use describe the nonmedical uses of steroids. One from the user perspective discusses patterns and trends, motivations and influences, effects and awareness of health results. (See page 57)
- The OIG conducted a survey of New Jersey Medicare beneficiaries' satisfaction with the new carrier's performance in processing their claims. Although problems were noted with the toll-free number, 78 percent of the beneficiaries surveyed rated the services as good or very good. (See page 23)

A number of projects are currently underway that will expand the Department's knowledge of these as well as other issues related to adequate health care for all citizens. Some will focus on maternal and child health issues, such as assessing the capacity of community and migrant health centers to provide high quality, timely perinatal care to high risk women in the face of increasing demand for these services. Others will study how and why consumers use home testing devices and kits; review enrollment practices in health maintenance organizations; examine the effects of hospital mergers on availability of care; and assess the quality of service provided by Medicaid managed care organizations.

IMPROVING SUPPORT SERVICES

A number of initiatives in the Department focus on ways to improve the quality of human services, which includes making these services more accessible to individuals and families who need them. Expansions in the Head Start program, implementation of the Family Support Act

and increased efforts to prevent homelessness are some of the efforts the Department is engaged in to support families in need and assist them in becoming self-sufficient.

The OIG has completed several significant reports during this period on major social issues confronting the Department. In these reports, OIG has sought to provide the operating and staff divisions with information on the effectiveness and efficiency of existing programs in an effort to improve the service provided to HHS clients. The following examples illustrate OIG's work in these areas that was completed during this reporting period:

- An OIG study described the problems identified in the process of terminating parental rights so that children who cannot return to their homes can be freed for adoption. Recommendations were directed to both the States and the Administration for Children, Youth and Families to improve this process. (See page 74)
- In reviews on the effect of the McKinney Act and homelessness prevention programs, OIG found that the McKinney Act has helped meet emergency needs, but has not provided long term solutions to homelessness. While homeless prevention programs were found to be effective in keeping families in their homes, they assist only a small portion of the needy. (See page 74)
- An OIG audit disclosed that some Low Income Home Energy Assistance Program (LIHEAP) funds could be used more effectively if States were specifically allowed to consider subsidized housing energy benefits in determining LIHEAP awards. (See page 68)
- Two studies on services integration examined 13 initiatives undertaken to serve multi-problem inner city families, and provided an overview of large scale efforts by the Department to integrate services. The reports discussed barriers to integrated services and how certain agencies effectively implemented integrated services. (See page 77)
- The OIG found that the Department responded promptly and appropriately to Hurricane Hugo and the Loma Prieta earthquake. However, some problems were identified which should be corrected to improve response efforts in the event of future disasters. (See page 61)

The OIG is currently conducting reviews on a wide range of social services provided by the Department. Examples of work in progress include studies of: the effectiveness of programs funded by the Alcohol, Drug Abuse and Mental Health Administration in preventing the use and abuse of alcohol by young people; the awareness of Supplemental Security Income recipients as

to medical services available to them; how SSA provides integrated services to SSA clients; the ability of local welfare agencies to use community resources to provide training services to Job Opportunity and Basic Skills (JOBS) participants; and how JOBS programs are meeting child care and transportation needs.

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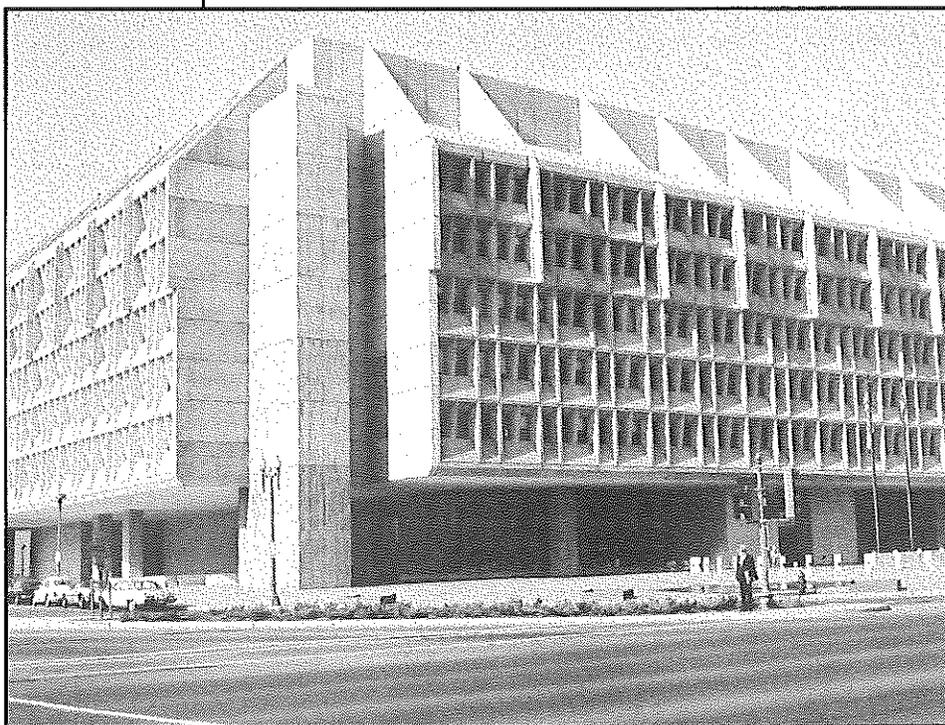
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**HHS AND
GOVERNMENTWIDE
OVERSIGHT**

CHAPTER I

HHS AND GOVERNMENTWIDE OVERSIGHT

INTRODUCTION

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities. The Department will spend \$236 million in FY 1991 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 payroll, lobbying activities, unemployment compensation, 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 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.

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:

- evaluating the adequacy of the Department's segmentation process to ensure that all inherent risk areas, particularly programmatic ones, are included in the FMFIA reviews;
- ensuring that Section 4 systems reviews are performed adequately, which is especially important in light of the requirements on preparing and auditing financial statements in the Chief Financial Officers Act of 1990;
- following up to monitor corrective action taken regarding weaknesses identified by OIG, the General Accounting Office 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.

At the close of calendar year 1990, OIG issued a report on its Fiscal Year (FY) 1990 testing of the Department's implementation of FMFIA. That testing focused primarily on the Department's efforts to: upgrade segmentation; expand Section 4 systems review activities; perform internal control reviews; and improve the FMFIA program through the Council on Management Oversight (Council). The OIG also evaluated the status of various actions taken to correct reported material weaknesses.

The OIG concluded that the Department's FMFIA program made significant progress during FY 1990. Early in the fiscal year, the Department, through the Council, placed emphasis on the operating divisions' efforts to expand segmentation. The Department updated Section 4 review guides and issued instructions prescribing June 30 as the deadline to complete annual systems reviews. Also, departmental managers identified the bulk of the material weaknesses that were

reported by the Secretary in FY 1990. This is in contrast to previous years in which the audit community identified the majority of these weaknesses.

Overall in 1990, there was increased senior management attention focused on the Department's FMFIA program. However, OIG found that the Department still needs to ensure that: all administrative and program areas with inherent risks are included in the program through expanded resegmentation; all accounting and program systems and subsystems receive either an adequate detailed or limited Section 4 review as specified in OMB Circular A-127; operating divisions comply with reporting and documentation requirements; and there is more active review and pursuit of those weaknesses that may have cross-cutting implications. (CIN: A-12-90-00040)

INTERNAL CONTROL WEAKNESS

- The OIG found that controls over the timecard recording and reporting system were inadequate to prevent or detect unauthorized alteration of timecards by employees. Inadequate controls preclude departmental management from demonstrating reasonable assurance that the civilian payroll system, through which over \$3.5 billion is disbursed annually, is safeguarded from fraud and abuse by employees. In fact, fraud has occurred. (CIN: A-12-90-00006) (See page 11)

THE CHIEF FINANCIAL OFFICERS ACT OF 1990

The passage of the Chief Financial Officers (CFO) Act of 1990 set before OIG a large complex of interrelated responsibilities. To conform with the requirements of the Act, OIG will expand its financial statement audit activity from 9 appropriations for FY 1990 to 60 appropriations for FY 1991.

The OIG will be very involved with all the CFOs' efforts to improve financial management. The OIG has recommended many of these changes for years: improving internal controls; working towards more uniform departmental accounting systems; establishing systems to produce information needed for financial managers; and interrelating FMFIA activities with financial statement preparation. The OIG will also be assisting the Department in attaining other objectives contained in the 5-year financial plan which the Act requires the Department to develop.

These new activities entail a very significant increase in OIG responsibilities and workload. However, we can report that our close work with the Congress and the Administration on this

legislation over a period of several years provided us the impetus for early preparation for these responsibilities.

We are pleased to report that plans are well advanced for undertaking the new responsibilities contained in the Act, and that a significant level of this workload is already being performed and is built into our annual work plan. Perhaps the most notable accomplishment thus far is OIG's audit of the Social Security Administration (SSA), the largest operating division in the Department of Health and Human Services (HHS). The OIG undertook the audit of SSA's financial statements three years ago. However, we have achieved other noteworthy accomplishments as well towards implementation of the CFO Act.

Both the Department's and OIG's activities related to the FMFIA process are important ingredients for developing the 5-year plan and for financial statement audits. This information on the most serious of the Department's control weaknesses has major impact on the financial statements the Department is required to produce. We have harnessed this information for strategic planning of financial statement audits. This information identifies key problem areas within HHS systems that interface with financial reporting systems. Many of these issues must be resolved before acceptable financial statements can be developed.

In addition, OIG has worked with the Department to identify the organizational components that must produce financial statements under the Act. The key financial systems which produce information and provide asset control for these entities are now being identified for increased audit attention, so that weaknesses are identified before financial statements are produced. This effort should enhance the quality of the financial statements we audit the first year.

Much of the audit work performed previous to passage of the CFO Act is relevant to the production and audit of financial statements. For example, in FY 1990, OIG conducted a review of the Department's payroll system to find weaknesses in controls in the area of time and attendance of employees. The review identified weaknesses throughout the time and attendance process that are collectively being reported as a material internal control weakness. As an added benefit, the results will be useful for planning an audit of the Department's payroll system in conjunction with financial statement audits. There are many similar examples of such audits conducted in the past.

We are also identifying current OIG work related to program performance for use in financial reporting. Program performance is a growing area of interest in connection with financial reporting, stemming from the perception that financial results for an accounting period are more meaningful if related to the outputs or accomplishments of that accounting period. We find that much of our work has dealt with assessment of program performance. This work may be useful in future financial reporting.

Further, OIG has developed information profiles on each of the operating divisions as a first step towards developing strategic plans for audits. These profiles include background, operating and financial information for each program, significant problems previously identified, technical accounting problems, financial management background and data on previous audits conducted.

In addition, an OIG task force was established to study the requirements of the CFO Act and the needs for changes in OIG in response to those new requirements. The task force recommended that a separate audit unit committed wholly to financial policy, technical assistance and audit should be established within OIG. This new audit unit, the Accounting and Financial Management Division, is in the process of being established. It will assure consistency of financial statement audits performed by the other four audit divisions and perform audits of departmentwide systems.

We also plan to make changes to OIG information systems to enhance the exchange of information between OIG investigative, inspections and audit components. Information related to departmental units subject to audit will be captured and summarized for use in planning the audits. The new audit unit will provide a focal point within OIG and a liaison position for exterior organizations to communicate with concerning CFO matters. The new audit unit will also assure coordination of audit efforts at the several HHS operating divisions. We look forward to reporting in the next semiannual report on our progress towards establishing this new audit unit and our achievements towards fulfillment of CFO requirements.

IMPLEMENTATION OF THE INSPECTOR GENERAL ACT AMENDMENTS OF 1988

The OIG and the Department share responsibility for the management integrity of HHS programs. The Office of the Assistant Secretary for Management and Budget (ASMB), as the Department's designated follow-up agency, has worked closely with OIG to ensure that the Department meets the reporting requirements of the Inspector General Act Amendments of 1988 (Public Law 100-504). The ASMB issued policy and processing guidelines to the operating divisions which detail the reporting requirements and emphasize the importance of these processes to the integrity of departmental programs. Each operating division now has an automated tracking system which contains information on all open OIG recommendations and the status of operating division actions on these recommendations. The ASMB and OIG are currently working on an automated follow-up and tracking module which will be used by all operating divisions. This system will provide both ASMB and OIG with direct access to status information on all open recommendations.

The ASMB established a formal conflict resolution process to ensure timely settlement of disagreements between OIG and the operating divisions when informal negotiations fail. Usually OIG and the operating divisions can resolve differences without resorting to this formal process.

However, during the prior six month period, two issues were elevated to the formal level and resolved. In both instances, action has been taken to implement the substance of OIG's recommendations.

In the first case, OIG recommended that the Office of Human Development Services (HDS) support State efforts relating to board and care issues by designating a unit to disseminate information which States could use in administering board and care facilities. While HDS agreed that this was a necessary function, it recommended that the Assistant Secretary for Policy and Evaluation (ASPE) be the focal point for these activities in the Department. The ASPE agreed to assume responsibility for these activities and has submitted an implementation plan for doing so.

The second case involved an OIG recommendation to the Public Health Service (PHS) that it develop a process for identifying emerging mobile health services and their providers. The PHS indicated that there was no focal point within the agency for systematically collecting and analyzing information on mobile health services. However, PHS agreed to identify mobile health services as an area where further research is needed. In their publication, "Research Agenda for Primary Care: Summary Report of a Conference," issued in February 1991, PHS discusses the need to study mobile health services as an avenue for improving access to primary care service. The PHS also agreed that the Health Resources and Services Administration, through the Bureau of Health Care Delivery and Assistance, would continue to collect information from grantees on their experiences with mobile health services and disseminate that information to appropriate State entities.

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.

	<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 ¹	250	\$307,213	\$13,555
B. Which were issued during the reporting period	<u>224</u>	<u>\$135,844</u>	<u>\$39,839</u>
Subtotals (A + B)	474	\$443,057	\$53,394
Less:			
C. For which a management decision was made during the reporting period ² :	267	\$312,723	\$13,534
(i) <i>dollar value of disallowed costs³</i>		\$279,903	\$479
(ii) <i>dollar value of costs not disallowed</i>		\$32,820	\$13,055
D. For which no management decision had been made by the end of the reporting period	207	\$130,334	\$39,860
E. Reports for which no management decision was made within 6 months of issuance	10	726	0

¹ The opening balance was adjusted to reflect a downward reevaluation of recommendations in the amount of \$125.2 million.

² Audits on which a management decision had not been made within 6 months of issuance of the report: CIN: A-01-89-05031, Audit of the Commonwealth of Massachusetts (\$118,000); CIN: A-03-90-03328, Review of Grant Expenditures Incurred under Grant Number H62/CCH303018-01 Awarded to Howard University (\$97,156); CIN: A-04-90-04009, Audit of Costs Claimed for Reimbursement under the Food and Drug Administration Contract Number 223-85-1101 (\$23,444); CIN: A-05-90-00018, Review of Family Planning Services under Title X of the Public Health Service Act, Grants Number 05-H-000283-16 and 17 (\$22,585); CIN: A-08-90-14088, Audit Report on Internal Service Fund Balances at Larimer County, Colorado (\$67,475); CIN: A-08-90-14089, Audit Report on Internal Service Fund Balances for Weld County, Colorado (\$57,800); CIN: A-08-90-14090, Audit Report on Internal Service Fund Balances at Adams County, Colorado (\$204,415); CIN: A-08-90-14091, Audit Report on Internal Service Fund Balances at Arapahoe County, Colorado (\$115,042); CIN: A-08-90-14140, Audit of the Crow Central Education Commission (\$7,000); CIN: A-09-90-07111, Audit of the Yomba Shoshone Tribe of Nevada (\$12,832). Due to administrative delays, many of which were beyond management's control, resolution of these audits was not completed within 6 months of issuance; however, based upon discussions with management officials responsible for these audits, resolution of these outstanding recommendations is expected before the end of the next semiannual reporting period.

³ A detailed listing will be included in the semiannual report covering the period April 1, 1991 through September 30, 1991.

B. 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.

**TABLE II
OFFICE OF INSPECTOR GENERAL REPORTS
WITH RECOMMENDATIONS THAT FUNDS BE PUT TO BETTER USE**

	Number	Dollar Value (in thousands)
A. For which no management decision had been made by the commencement of the reporting period ¹	74	\$4,614,956
B. Which were issued during the reporting period	<u>67</u>	<u>\$1,024,464</u>
Subtotals (A + B)	141	\$5,639,420
Less:		
C. For which a management decision was made during the reporting period ² :		
(i) dollar value of recommendations that were agreed to by management		
(a) based on proposed management action	25	\$177,099
(b) based on proposed legislative action ³	<u>10</u>	<u>\$3,601,000</u>
Subtotals (a+b)	35	\$3,778,099
(ii) dollar value of recommendations that were not agreed to by management	<u>14</u>	<u>\$69,851</u>
Subtotals (i + ii)	49	\$3,847,950
D. For which no management decision had been made by the end of the reporting period ⁴	92	\$1,791,470
E. Prior decisions implemented in the period (See Appendix C) ⁵		
(i) based on management action	1	\$19,000
(ii) based on legislative action	27	\$2,620,800

¹ The opening balance was adjusted to reflect an upward reevaluation of recommendations in the amount of \$2,937.1 million.

² The OIG and the Social Security Administration (SSA) have agreed that final action on a previously reported management decision (CIN: A-13-86-62640, Audit Report on Penalty and Interest on FICA, \$844,000,000) is not within SSA's authority. The SSA will be removing this item from its table without resolution of the recommendation. The OIG will follow up with the Department of Treasury to pursue resolution of this recommendation.

³ The OIG has reported as "management decisions made during the period" those line items in the President's FY 1992 budget that relate directly to OIG recommendations contained in issued reports. Management does not report these decisions in its table.

⁴ Management decisions have not been made within 6 months of issuance on 4 reports. Resolution of CIN: A-07-90-00262, Review of Asset Reversions from Pension Plan Terminations Occurring after the Implementation of the Prospective Payment System (\$92,000,000) and CIN: A-07-89-00134, Medicare Is Losing Millions of Dollars from Terminations of Pension Plans (\$27,600,000), will be through the departmental conflict resolution process. The SSA is negotiating with the Immigration and Naturalization Service to resolve the recommendation in OEL-05-88-01060, SSNs for Noncitizens (\$8,200,000). The Indian Health Service is currently finalizing its analysis of the recommendations in CIN: A-09-89-00136, Improvements Are Needed in Planning and Justifying the Construction of Indian Health Service Housing (\$16,475,000), and resolution is expected during the next semiannual reporting period.

⁵ 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 111 of the Department's regulations under development and 90 legislative proposals during this reporting period.

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 throughout this semiannual report.

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 audited capital lease payments claimed for Federal financial participation by the State of Michigan. The review found that the State overcharged Federal programs about \$2.7 million during the 3-year period ending September 30, 1988 because it did not properly claim costs associated with equipment capital leases. In addition, OIG questioned approximately \$130,000 for computer equipment costs claimed, since it was acquired without the required Federal approvals.

The OIG proposed that Michigan remove future capital lease payments for equipment from allocations to Federal programs and recover the costs based on applicable Federal regulations. Also, the State should improve its controls to assure that all necessary approvals are obtained, and should refund \$2.8 million to the Federal Government. While the State did not fully concur, the Department's Division of Cost Allocation agreed with the recommendations. (CIN: A-05-90-00095)

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 703 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 1,472 nonfederal audit reports containing \$85.5 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	1,142
Reports issued with major changes	285
Reports with significant inadequacies	<u>45</u>
Total audit reports processed	1,472

Of those reports with significant inadequacies, 8 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.

CONTROL OF AUDIT DISALLOWANCES

A material weakness was identified in the controls over audit disallowances involving the Office of Human Development Services and the Office of the Secretary. The deficiency resulted in failure to record as debts in the Department's accounting systems \$43.1 million of \$58.4 million in audit disallowances for FYs 1987 and 1988. At least \$3.3 million in interest charges should have been accrued on the unrecorded amounts.

The OIG recommended that ASMB closely monitor the correction of the reported problems to ensure that the actions taken effectively remedy the deficiencies. The Department's appointment of a debt collection officer and initiation of reconciliations between OIG's automated control system and the Department's accounting records are showing progress in correcting the problems. (CIN: A-12-89-00144)

UNEMPLOYMENT COMPENSATION

Performance Indicator

The OIG examined the effectiveness of the Department's unemployment compensation (UC) program, administered by the Assistant Secretary for Personnel Administration (ASPER). The Department reimbursed States over \$766,000 for UC claims by 883 individuals during the third quarter of FY 1989. The OIG projected that 29 percent of the cases totaling more than \$135,000 involved unsupported claims during that quarter.

The OIG believes that the Federal UC program is flawed. Since the Federal Government reimburses all State UC payments, there is little incentive for States to deny benefits to former Federal employees, even in the most questionable cases. Nevertheless, there are a number of weaknesses within the process over which the Department has direct control and the responsibility for preventing. While the Department has developed adequate UC procedures, their effective implementation remains a serious concern to OIG. The Department should respond to States in a timely and complete manner, appeal improper UC payments and seek relief where payments are not justified. The ASPER should develop and implement a corrective action plan to provide for review and oversight of this area. (CIN: A-12-90-00004)

UNAUTHORIZED ALTERATION OF TIMECARDS

In a review of the Department's employee time and attendance (timecard) recording and reporting system, OIG found material weaknesses in controls to prevent or detect erroneously prepared

timecards or the unauthorized alteration of timecards. None of the seven timecard collection centers sampled were found to have adequate safeguards against unauthorized access to certified timecards. Timecards could be retrieved and altered, or bogus timecards could be substituted. Most timekeepers did not compare and reconcile the employees' earnings and leave statements to the employees' administrative time and leave records at the end of every pay period for possible errors. The majority of leave approving officials did not perform periodic reviews of both forms for any of their employees. Three-quarters of the timecards sampled contained data which could not be supported by documentation on file with timekeepers. Since nearly three-quarters of the timecards had been returned to the timekeeper after the approving official's certification, the information on the timecards was not safeguarded by separation of duties.

The OIG believes the material weakness in controls over timecard security renders management unable to demonstrate reasonable assurance that the Department's payroll system is safeguarded from fraud and abuse by employees. In fact, the OIG review was initiated by an occurrence of fraud which OIG investigated. The OIG believes that timecard recording and reporting warrant close attention due to the large size of the civilian payroll system. (CIN: A-12-90-00006)

WORKING CAPITAL FUND: FY 1989

The OIG conducted a review of the Working Capital Fund's (WCF) activities during FY 1989. In addition, OIG followed up to ensure that WCF had initiated correction of the 13 minor weaknesses identified during its audit of WCF's financial statements for FY 1988. The OIG found that WCF's accounting records were generally accumulating accurate, supported data and that WCF had made progress correcting the past deficiencies. However, annual financial statements for FY 1989 had not been completed at the time of OIG's review. The OIG believes that a concerted effort is required to complete timely annual financial statements for use by the Board of Governors of the WCF. (CIN: A-12-90-00017)

LOBBYING ACTIVITIES AT HHS

In January 1991, the results of OIG's first annual evaluation of lobbying activities at HHS were provided to the Congress. In FY 1990, Public Law 101-121 amended title 31 of the United States Code to prohibit recipients of Federal grants, contracts, loans or cooperative agreements from using appropriated funds to lobby the Federal Government, and it specifically requires disclosure of lobbying with nonappropriated funds. The Act mandates annual submission of a report by OIG to the Congress at the time of the HHS budget proposal.

The OIG found that the Department has instituted internal procedures that implement the law's requirements. The Department's FY 1990 report cited that 10 disclosure forms were received, 9 of them relating to grants. Five of the disclosures were filed because grant applicants paid lobbying/consulting firms sums ranging from \$4,600 to over \$54,000, and either the grantees or their lobbyists contacted members of the Congress for the stated purpose of garnering support for

grantee applications. Four other disclosures involving lobbying reflected more modest expenditures, and the tenth was apparently filed for completeness only. (CIN: A-12-90-00045)

AUDIOVISUAL PROJECT OVERSIGHT

This report assessed the oversight provided by the Office of the Assistant Secretary for Public Affairs (ASPA) for the Department's audiovisual (AV) proposals and contracts. Reviews by ASPA are designed to: avoid duplication of effort or development of superfluous materials; contribute to cost-effectiveness by assuring adherence to sound production and procurement practices; assure that materials are consistent with departmental and governmental policies and regulations; and avoid the production and use of materials that might misrepresent the Department or be detrimental to the achievement of program goals. In FY 1990, ASPA reviewed 80 audiovisual proposals valued at approximately \$16 million from various offices throughout the Department. In OIG's opinion, ASPA's procedures do not ensure that all of the Department's audiovisual proposals are receiving effective, timely review and approval as required. (CIN: A-12-90-00038)

VALUE ENGINEERING

The OIG determined that the Department had not implemented a value engineering (VE) program in accordance with OMB Circular A-131 and the Federal Acquisition Regulations to identify and reduce nonessential procurement and program costs. The OIG recommended that the Department develop and implement a formal VE program, working with the operating and staff divisions to establish criteria and guidelines to identify those programs and projects that are most appropriate for VE. The ASMB countered that it had already established a streamlined program that met the requirements of the OMB Circular. The OIG believes that, to be effective, departmental policy and program guidance on VE should be more formalized to assure a minimally acceptable level of activity on VE among the agencies, consistency of VE program implementation among the agencies and complete dissemination to all affected offices through some codified method. The ASMB reiterated its contention that the program already established was a formal VE program. (CIN: A-09-90-00088)

ACQUISITION OF COPIERS

The OIG conducted a follow-up review to assess the effectiveness of corrective actions taken in response to a 1987 OIG report on the acquisition of copiers within the Office of the Secretary (OS) and PHS. In the earlier report, OIG estimated that the Department could save \$5.1 million over 5 years if the rented copiers in OS and PHS were purchased. Also, OIG proposed that the Department's printing manual be revised to require a cost analysis to support the acquisition of a copier. The ASMB agreed to revise the manual as recommended.

The follow-up audit revealed that ASMB had issued a policy letter requiring a lease-versus-purchase analysis prior to the acquisition of a copier. However, in OIG's opinion, the letter did not adequately substitute for a formal revision to the printing manual. The OIG also found that, although the percentage of rented copiers declined from 30 percent to 5.8 percent, the average cost per copy remained constant at \$0.02 per copy. The unavailability of cost data precluded further analysis. The OIG recommended that ASMB appropriately revise the HHS printing manual and require the collection of copier cost and usage data. The Deputy Assistant Secretary for Management and Acquisition agreed with the OIG findings and recommendations. (CIN: A-12-90-00035)

HOTLINE REFERRAL FOLLOW-UP

The OIG manages the HHS hotline which receives complaints and allegations of fraud, waste and abuse. Incoming hotline cases are reviewed and referred to one of the five operating divisions. Prior to August 1989, the divisions were required to inform OIG of actions taken on all hotline referrals within 60 days. Effective August 1, 1989, OIG adopted a new procedure which no longer requires the operating divisions to respond back to it on routine cases where OIG follow-up does not appear to be necessary. In such routine referrals, the appropriate operating division is required to develop the case, take any corrective action deemed necessary, and maintain controls so that a post review of the actions taken may be done in the future.

The OIG found that the Health Care Financing Administration lacks proper controls on these routine referral cases and that SSA, while having controls, lacks timely follow-up procedures. The OIG recommended that all operating divisions establish and follow proper procedures. All the divisions agreed to the recommendation. (OEI-12-90-01060)

EMPLOYEE FRAUD AND MISCONDUCT

The OIG has oversight responsibility for the investigation of allegations of Department employee wrongdoing where it affects internal programs. Most of the thousands of 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 former researcher at the National Institutes of Health was sentenced in Maryland for steering business to a laboratory in which his wife was a major stockholder and employee. In return for his actions, the laboratory had his house painted and paid off a second mortgage on the house. He was sentenced to 3 years probation, fined \$12,000 and ordered to pay a \$100 assessment. The judge ordered the relatively light sentence because of his contribution to mankind through his research relating to acquired immune deficiency syndrome. The former owner of the laboratory was sentenced to 30 days incarceration and 2 years probation.

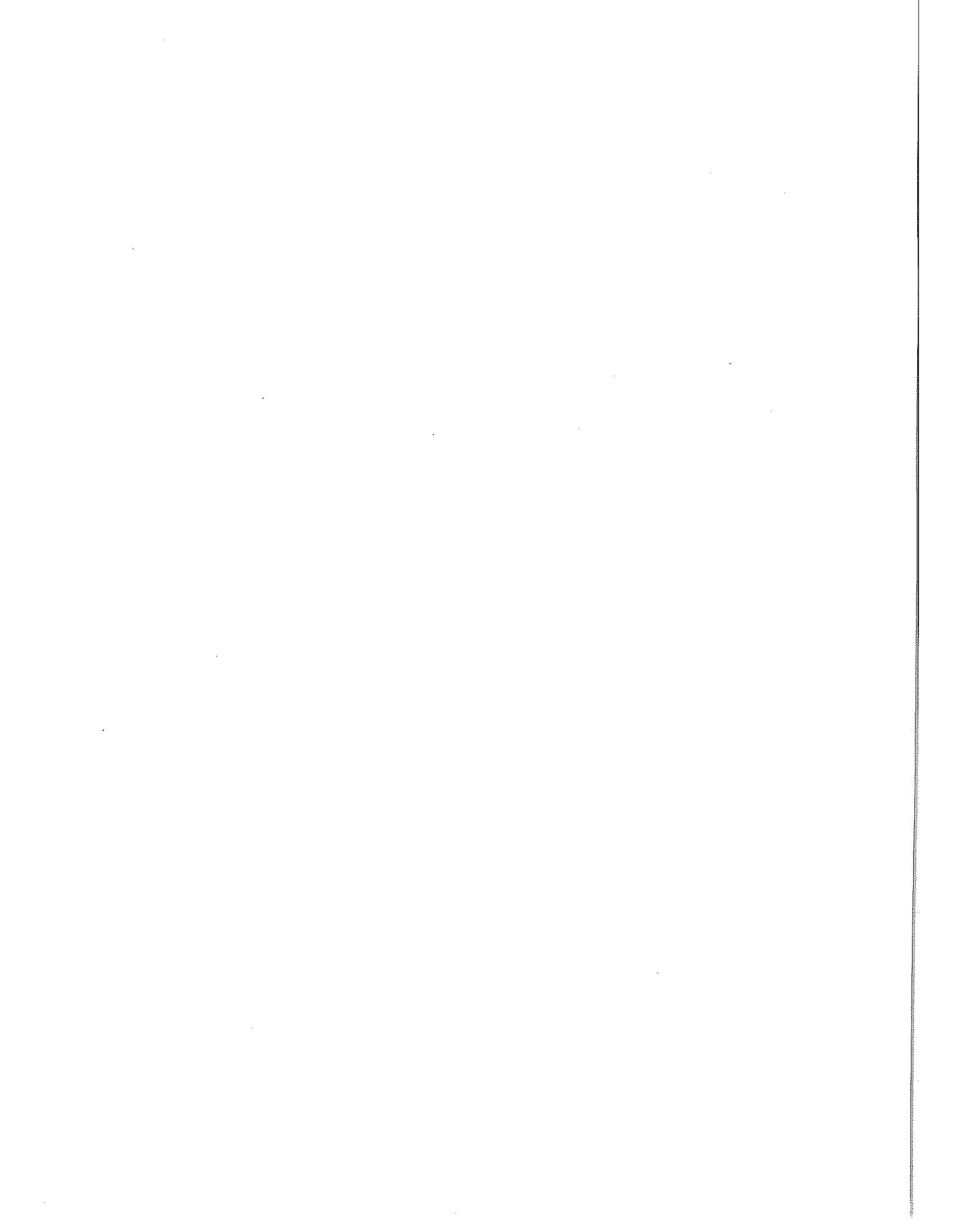
- A former public affairs specialist with the Indian Health Service in South Dakota was sentenced to 2 years probation and fined \$1,000 after conviction of travel voucher fraud. He had filed at least 15 false lodging receipts totalling \$5,300. Some of the false receipts were filed in connection with travel during a temporary work detail in Washington, D.C., where he worked on the staff of a Senate Select Committee during 1988 and 1989.
- A service representative in Florida was ordered to pay \$5,000 in fines and restitution for embezzling money from SSA. He had also cashed the checks returned for a deceased beneficiary to support his drug habit. As part of his sentence, he was ordered to enter a drug rehabilitation program.

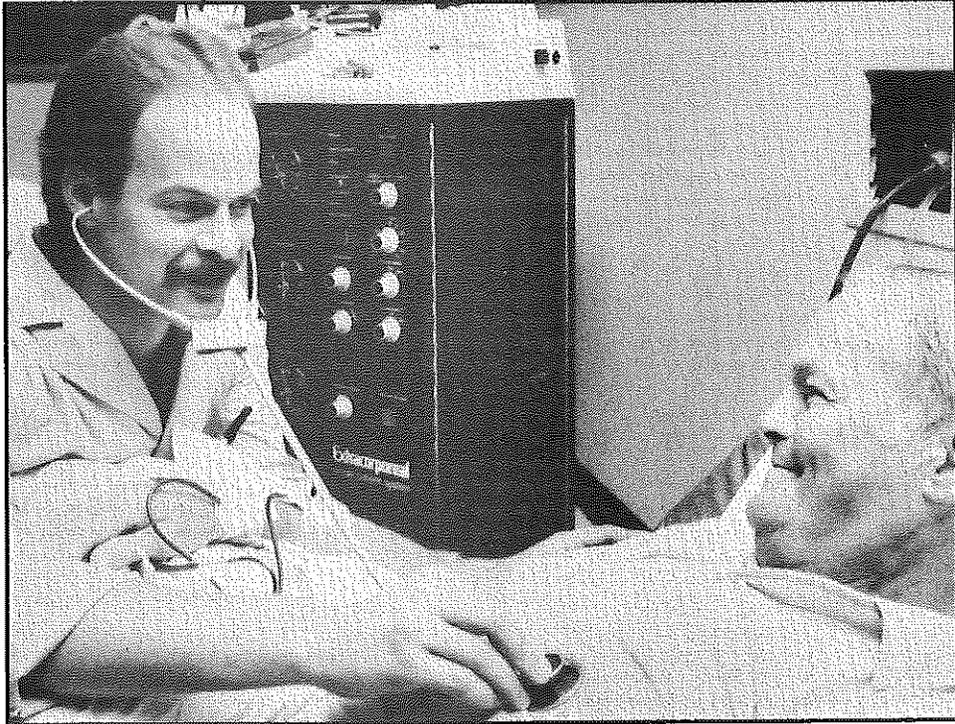
INVESTIGATIVE PROSECUTIONS

During this semiannual reporting period, OIG investigations resulted in 729 convictions. Also during this period, 623 cases were presented for prosecution to the Department of Justice and, in some instances, to nonfederal prosecutors. Criminal charges were brought by prosecutors in 474 cases.

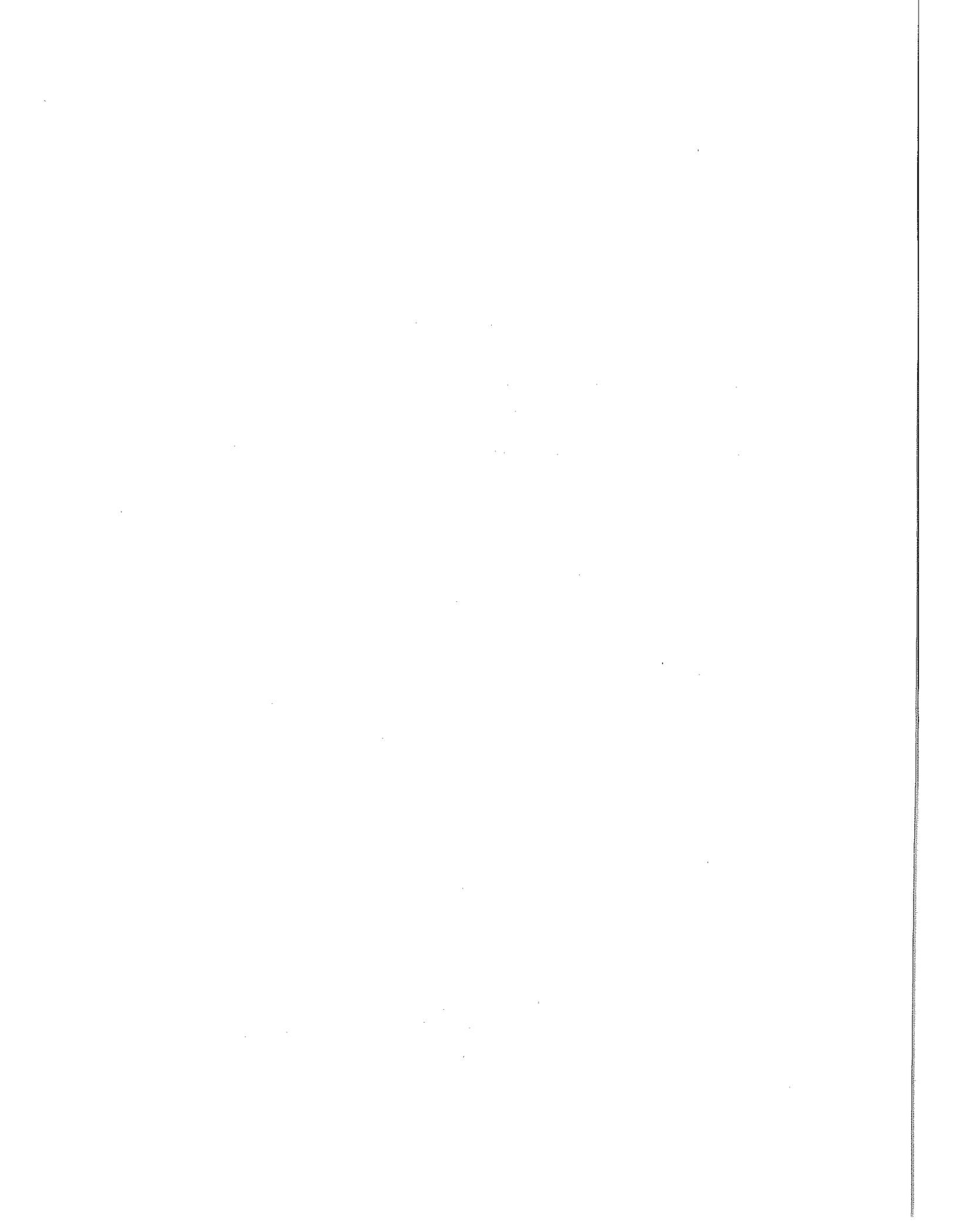
COOPERATION WITH OTHER LAW ENFORCEMENT AGENCIES

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 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 \$ 11.4 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 Fiscal Year (FY) 1991, 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 1991 expenditures for Medicare Part A are expected to exceed \$68 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 1991 expenditures for Medicare Part B are expected to be over \$44 billion.

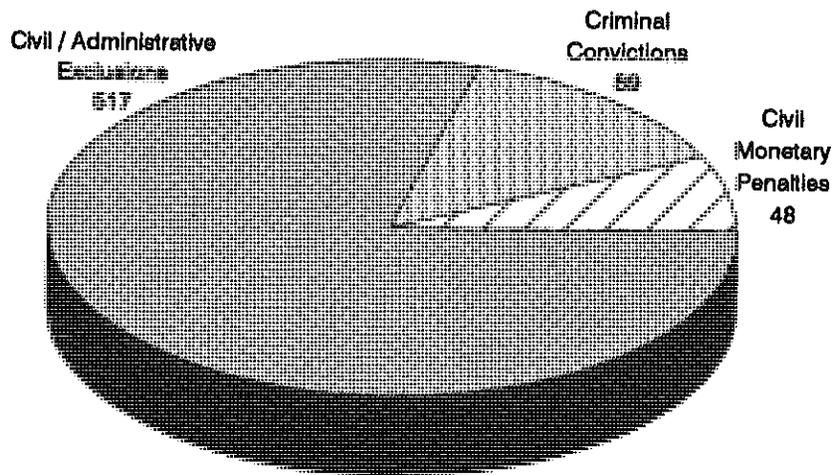
The Medicaid program provides grants to States for medical care for more than 27 million low-income people. Federal grants are estimated at \$48 billion in FY 1991. Federal matching rates are determined on the basis of a formula which measures relative per capita income in each State. Eligibility for 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. In recent years, significant changes in Medicaid have expanded eligibility and services for pregnant women and children, especially low-income women and children who, for various reasons, are ineligible for assistance under the AFDC program. The Omnibus Budget Reconciliation Act (OBRA) of 1990 includes a provision to phase in coverage of children through age 18 below 100 percent of the poverty level.

The Office of Inspector General (OIG) activities which pertain to the health insurance programs administered by the Health Care Financing Administration (HCFA) help ensure cost-effective health care, 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 improve inefficient health care delivery systems and reduce unnecessary expenses.

The financial impact of the prospective payment system on hospitals, the increases in Part B expenditures, the implementation of physician payment reforms and the Clinical Laboratory Improvement Amendments 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.

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 the first half of the fiscal year, OIG was responsible for a total of 654 successful actions against wrongdoers.

HEALTH CARE PROGRAMS Successful Criminal, Civil and Administrative Litigations



INTERNAL CONTROL WEAKNESS

- The Department's 1990 Federal Managers' Financial Integrity Act report noted improvements in the Medicare secondary payer program (MSP), which was identified as both a high risk area and as a material weakness. It was estimated that the Medicare program was paying out as much as \$1 billion a year unnecessarily because primary payers were not always identified. The OIG issued a related management advisory report identifying numerous proposals for improving the MSP program which should be addressed by HCFA. (CIN: A-09-89-00151) (See page 19)
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MEDICARE AS SECONDARY PAYER: SURVEY OF CONTRACTOR OPERATIONS

Performance Indicator

Legislative changes in the 1980s that made Medicare the secondary payer to employer group health plans (EGHPs) for aged, disabled, and end stage renal disease beneficiaries have saved Medicare billions of dollars. However, HCFA estimates that as much as \$1 billion is still lost annually because MSP situations are not properly identified, and because insurance companies often do not pay when they are required to be the primary payers. An OIG survey disclosed several problem areas including the following: noncompliance by private insurers; lack of routine data matches by contractors to identify MSP leads; an ineffective regional data exchange system used to share Medicare information among contractors; contractors not withholding payment of the initial Medicare claim until EGHP information was received; and lack of adequate carrier staffing to keep up with current processing activities. The OIG made numerous proposals for improving the MSP program, including recommendations to resolve differences among contractors in identifying problem insurers, closely monitor contractor recoveries and increase MSP funding. In addition, OIG included a listing of contractor suggestions. The HCFA generally agreed with OIG's conclusions and suggestions. (CIN: A-09-89-00151)

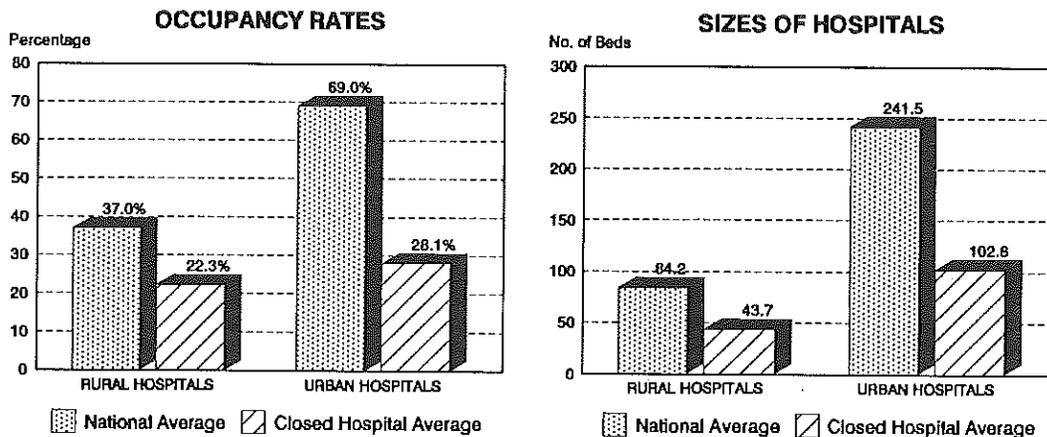
FINANCIAL ARRANGEMENTS BETWEEN HOSPITALS AND HOSPITAL-BASED PHYSICIANS

The OIG identified potential violations in the financial arrangements between some hospitals and hospital-based physicians. These agreements require physicians to pay more than the fair market value for services provided by the hospitals, or compensate physicians for less than the fair market value of goods and services that they provide to hospitals. These illegal arrangements may lead to policies and practices which encourage greater utilization of the services of hospital-based physicians or may force hospital-based physicians to perform more procedures to compensate for lower incomes.

The OIG recommended that contracts between hospitals and hospital-based physicians be based on the fair market value of services provided, and be unrelated to physician income or billings. (OEI-09-89-00330)

HOSPITAL CLOSURE: 1989

In recent years, hospital closures have generated increasing public and congressional concern. This is the third report issued by OIG to analyze trends in hospital closure and the effects of the phenomenon. The OIG found that 76 hospitals closed in 1989, 12 fewer than in 1988. The hospital closures in 1989 were similar to those in 1987 and 1988. Most of the hospitals were small and had low occupancy.



When the hospitals closed, few patients were affected and most had emergency and inpatient medical care available within 20 miles. (OEI-04-90-02440)

HOSPITAL MERGERS

This report describes the effects of hospital mergers on the availability of hospital services based on an assessment of eight hospital mergers that occurred in 1987. In all cases, one or both merging hospitals suffered from declining occupancy, lagging revenues, and/or rising costs before the merger. Respondents at all of the hospitals indicated that the mergers made the hospitals stronger institutions and provided benefits, such as quality professional staff, job security and more sophisticated equipment. None of these mergers drew community opposition and none were challenged by antitrust enforcement agencies. In all eight merger cases, the availability of hospital services was maintained or improved. Of the 16 merging hospitals, 4 ceased to provide general acute care after the merger. (OEI-04-90-02400; OEI-04-91-00500)

HEALTH SERVICE BROKERS

The OIG conducted a study to identify mechanisms used by health service brokers to control medical costs in the private sector that might be suitable for government health care programs. The OIG found that: effective provider networks control network membership, regularly assess utilization of services and remove service intensive providers; targeting specific goods and services for bulk purchases at different levels in the distribution chain produces savings and maintains patient access; and individual case management can improve quality of care, increase efficiency and make better use of benefits for chronically ill or terminally ill patients.

The OIG concluded that many private sector mechanisms for controlling health care costs appear to have potential applications for Medicare, Medicaid and other Department programs. However, the Department will have to give careful consideration to the legislative obstacles and administrative impediments that currently prevent the transfer of these private sector cost control mechanisms to the public sector. Each departmental operating division should study the mechanisms used by the private sector to determine whether any can and should be adapted to its programs. (OEI-05-89-00510)

HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Payments for surgical services performed in hospital outpatient departments (OPDs) increased 111 percent between 1985 and 1987. The Congress, in an effort to contain Medicare expenditures for OPD surgical services, based OPD reimbursement on a blend of ambulatory surgical center (ASC) rates and the lower of a hospital's cost or charges. The OIG conducted a study to compare the amount Medicare would have paid for the facility component of surgical services performed in OPDs and the amount Medicare would have paid had these services been performed in ASCs.

Based on an analysis of OPD bills for Calendar Year 1988, OIG determined that Medicare OPD reimbursement exceeded by \$89 million the amount that would have been paid to ASCs for similar services. The OIG estimates an increase in this payment difference to \$109 million for 1989 and to \$283 million for 1995. The OIG recommended that HCFA continue with a legislative proposal to pay for OPD services at ASC rates. Empirical data showed that full parity would result in a 12.5 percent reduction in the amount paid to OPDs, which would save an estimated \$1.04 billion over the 5-year budget cycle. The FY 1991 President's budget proposed a 13 percent reduction. The OBRA 1990 changed the formula to a blend of 42 percent of the hospital's cost and 58 percent of the fees for the same services performed outside the hospital. (CIN: A-14-89-00221)

OUTPATIENT SURGERY: MEDICAL NECESSITY AND QUALITY OF CARE

Performance Indicator

The OIG conducted an inspection to compare the necessity for and quality of care provided by OPDs to that provided by ASCs for four high volume outpatient surgical procedures. The OIG found that the outpatient setting was appropriate for 99.5 percent of the surgeries performed, and there was no statistically significant difference between the sites for the remainder of cases. There were no major differences between OPD and ASC patients in sex, age or physical condition. The number of medically unnecessary upper gastrointestinal (GI) endoscopies and colonoscopies performed were almost evenly divided between ASCs and OPDs. For the 93.4 percent of surgeries with documentation, 85.6 percent had adequate care. Although ASCs had more cases of poor and questionable care than OPDs, the difference between the sites was not statistically significant. High volume ophthalmologists were more likely to provide medically unnecessary services and render poor or questionable care than non-high volume ophthalmologists.

In preliminary comments, HCFA agreed to add upper GI endoscopies to the list of procedures recommended for PRO review. However, it disagreed with the recommendation to intensify review of high volume ophthalmologists, contending that current review procedures are adequate. The OIG continues to believe that a more intensive review of these services is warranted. (OEI-09-88-01000)

THE CLINICAL ROLE OF THE COMMUNITY PHARMACIST

Performance Indicator

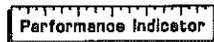
The incidence of mismedication among the elderly is relatively high and reflects a number of systemic weaknesses in the health care delivery process. The problems associated with mismedication present a significant threat to the health of the elderly. In addition, there is an ongoing cost borne by the Medicare and Medicaid programs for the incidence of drug-related illness among beneficiaries.

Although there is strong evidence that clinical pharmacy services add value to patient care, these services are not widely provided in community settings. Among the barriers that limit the availability of these services are the focus on product and price rather than provision of clinical services in the retail pharmacy industry; impediments to communication and collaboration between the community pharmacist and physicians; inadequate patient profile information; and uneven patient demand for clinical pharmacy services.

The OIG's primary recommendation was that the Public Health Service (PHS) and HCFA develop a strategy to reduce the barriers to clinical pharmacy services, particularly for ambulatory elderly patients, through use of Medicaid waivers, Medicaid demonstration projects, and research and demonstration grants. The OIG also proposed that the National Institute on Aging take a

leadership role in developing risk indicators and treatment priorities for elderly, ambulatory patients. The PHS agreed with the recommendations and has begun implementation activities. The HFCA disagreed with the recommendations, indicating that it believes that current State Medicaid initiatives are adequate. The OIG continues to believe that a combined approach is warranted. (OEI-01-89-89160; OEI-01-89-89161)

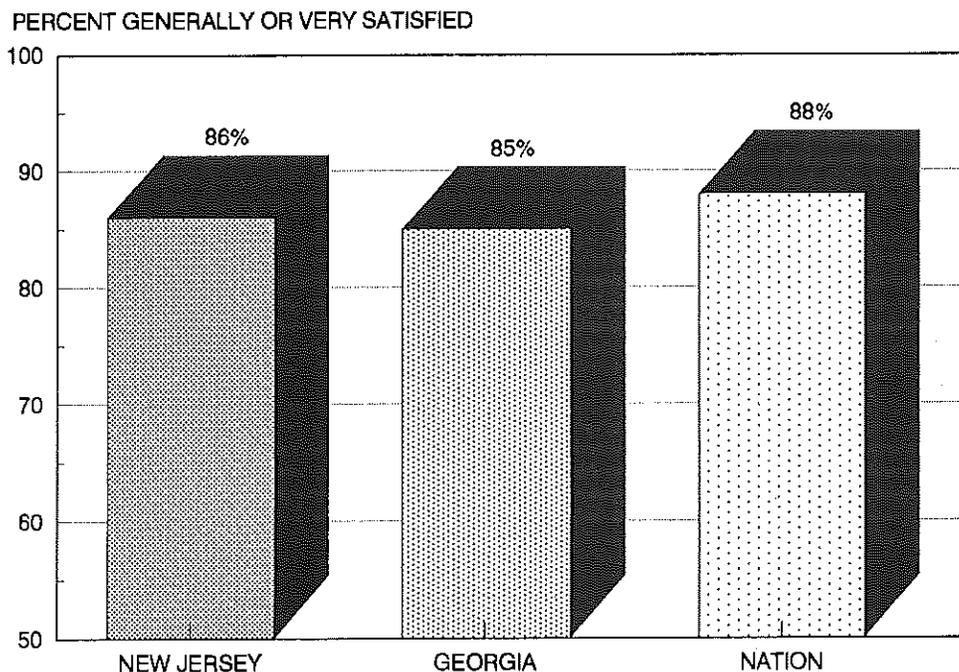
MEDICARE BENEFICIARY SATISFACTION: NEW JERSEY



At HCFA's request, OIG conducted a survey to assess beneficiary satisfaction with the Medicare program in New Jersey following the change of carriers in that State at the beginning of 1989. Where appropriate, New Jersey responses were compared to those from similar surveys conducted earlier in Georgia and nationwide.

As in Georgia and nationwide, beneficiaries in New Jersey expressed overall satisfaction with the way Medicare has processed their claims, as illustrated below.

BENEFICIARY SATISFACTION WITH MEDICARE CLAIMS PROCESSING



Further, beneficiaries reported that information on Medicare was readily available. Most were aware of and made use of the carrier's toll-free telephone number, and were generally satisfied with the service it provided. However, they did note problems in using the number, such as

frequent busy signals, which were also identified in the Georgia and nationwide surveys. Seventy-eight percent of New Jersey Medicare beneficiaries surveyed rated overall Medicare services as good or very good. The HCFA was generally pleased that the survey results reflected positively on the new carrier's efforts to encourage beneficiary contact and promote beneficiary education. (OEI-02-90-02040)

CARRIER PROCESSING PERFORMANCE

Performance Indicator

At the request of the Secretary and HCFA, OIG conducted a review of the Medicare Part B carrier in Georgia, Aetna Life Insurance Company. The OIG determined that the carrier was processing claims with a degree of accuracy that was close to meeting the performance standards prescribed by HCFA, but needed to continue its efforts in this area since it did not meet those standards on a consistent basis. The OIG found that the carrier continued to have problems processing claims on a timely basis and was in need of improvement in this respect. A comparison of the physicians' billing practices disclosed that they were comparable to those of physicians in other States. (CIN: A-04-90-02021)

FALSE CLAIMS

The most common fraud investigated by OIG against health care providers is the filing of false claims or statements in connection with the Medicare and Medicaid programs, as illustrated in the following cases:

- A consent judgment was signed in New York whereby a physician, his friend and a management company had to pay \$469,500 for Medicare fraud. The physician had been suspended from the Medicare and Medicaid programs in 1985. Prior to being suspended, he obtained a New York license and provider number for his brother, an anesthesiologist in Texas. From 1985 to 1987 he continued to treat Medicare patients, submitting 4,000 claims under his brother's provider number. All checks were deposited into the account of the management company, of which his friend was the sole stockholder. The consent judgment was the result of a civil complaint filed after the physician had been convicted of Medicare fraud.
- A former Deputy Inspector General was sentenced in the District of Columbia to serve 2 years in jail and pay a fine of \$5,000. He was also required to pay a special assessment of \$150. He was found guilty earlier on two counts of making false claims, two counts of forgery and one count of obstruction of justice. After leaving OIG, he joined a D.C. law firm representing defendants in civil actions arising from the Medicare and Medicaid programs. While representing a group of anesthesiologists, he submitted false witness statements

to the Department of Justice disputing issues in the OIG civil case against his clients.

- In Illinois, an anesthesiologist and his corporation were ordered to make restitution of \$10,300 and pay \$1,000 in fines. They had billed Medicare for the services of a certified nurse anesthetist at a hospital as supervised by an anesthesiologist. Investigation showed that the anesthesiologist worked full-time at a clinic and therefore could not have been at the hospital.
- A man was sentenced in Massachusetts to 37 months incarceration for representing himself as a licensed podiatrist in filing Medicare and private insurance claims. He had collected \$147,500 from Medicare and \$51,700 from private insurers. After originally losing his license in New York in 1976, he subsequently lost licenses in New Jersey and Massachusetts for concealing the New York revocation on his license applications.
- A Maryland surgeon had to pay \$200,000 for filing false Medicare claims. He had billed for pre- and post-operative care on separate claims, upcoded surgeries and showed inappropriate levels of care for hospital visits. Evidence of unbundling of services which should have been included in global fees was found as far back as 1980.
- A New York psychologist was sentenced for Medicare fraud to 5 years probation, 3 months home detention and 200 hours community service. He was also ordered to pay \$17,500 in restitution and \$20,000 in fines. The psychologist billed Medicare for daily 1-hour psychotherapy sessions for hospital inpatients, starting with the dates of their admission and continuing through the dates of discharge. The dates billed included some when the psychologist was on vacation and sick leave.

MEDICARE REIMBURSEMENT FOR EPOGEN

Medicare covers approximately 93 percent of patients with chronic renal disease who require dialysis or kidney transplant. Epogen is used for the treatment of anemia associated with chronic renal failure. Based on certain assumptions about market penetration, the method by which Epogen would be dispensed and the average dose per patient, HCFA established an interim flat rate to pay for Epogen as an add-on to the prospective payment rate for dialysis services. The OIG found that the key assumptions made in developing the interim rate were no longer valid. As a result, OIG estimated that in the first year Medicare expenditures could reach approximately \$265 million, with gross profits to providers in excess of \$100 million. Accordingly, OIG recommended that HCFA eliminate the flat interim rate and establish a payment rate based on

actual units of Epogen administered up to a capped amount. The OBRA 1990 based the payment rate on 1,000 units rounded to the nearest 100 units. (CIN: A-01-90-00512)

MEDICARE PREPROCEDURE REVIEW

Performance Indicator

The Consolidated Omnibus Budget Reconciliation Act of 1985 mandated 100 percent peer review of certain surgical procedures. The OIG determined that this process is not cost-effective. In 1989, peer review organizations (PROs) responsible for 17 States and representing over half the Medicare eligible population, denied 0.07 percent of requests for cataract extraction surgery. The PROs thus expended \$13.3 million on these reviews to save \$1.4 million on surgery denials. The cost-effectiveness of 100 percent preprocedure review for other procedures is also doubtful, as only 0.15 percent of all requests subject to preprocedure review were denied.

The HCFA disagreed with OIG's recommendation to substitute a targeted, more intensive review of cataract surgery for the current mandatory review. The OIG continues to believe that a targeted preprocedure review is a more effective, efficient approach than the 100 percent mandatory review process. The HCFA agreed to examine the cost-effectiveness of preprocedure review for other surgical procedures. (OEI-03-89-01520)

MONITORED ANESTHESIA CARE

When an anesthetist takes part in the care of a patient under local anesthesia and renders certain specified services, the service is referred to as monitored anesthesia care (MAC). In a review of the adequacy and implementation of Medicare's coverage and reimbursement instructions for MAC, OIG found that carriers have not implemented HCFA's instructions that MAC be reasonable and medically necessary to qualify for reimbursement.

The OIG recommended that HCFA require carriers to develop and implement a claims review process to apply existing MAC coverage instructions; strengthen MAC guidelines by adding procedures for case by case coverage; and consider paying a lower amount for MAC than for general anesthesia in view of the fact that other insurers have more restrictive coverage and reimbursement policies than Medicare. (OEI-02-89-00050)

ANESTHESIA CONVERSION FACTORS

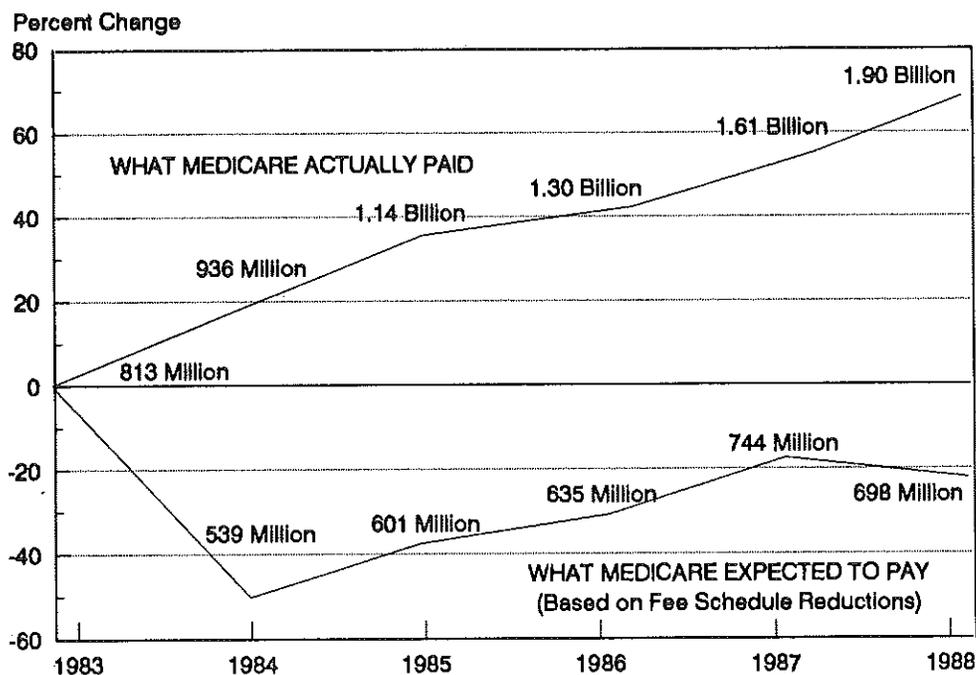
The OIG studied the conversion factors used in the payment formula for Medicare anesthesiology services. The conversion factors, along with base units and time units, influence the amount that Medicare pays for these services. The OIG's review of the conversion factors implemented by HCFA effective March 1, 1989 showed that payments varied for the same service from one carrier to another and within the same carrier. A comparison of the different conversion factors established for each locality showed no correlation between the conversion factor and the geographical cost index for each locality.

The OIG's report suggested a number of approaches to eliminate unexplained variations in the conversion factors, which would result in overall reductions in annual allowable charges for anesthesiologist services of 3.6 percent to 12.4 percent, or \$34.6 million to \$119.3 million. The OIG recommended that HCFA consider these methodologies, or similar ones, to reduce payments for anesthesiologists' services. The OBRA 1990 requires the Secretary to estimate a national weighted average conversion factor and reduce it by 7 percent. (CIN: A-07-90-00296)

ENSURING APPROPRIATE USE OF LABORATORY SERVICES

The OIG conducted an inspection to examine the forces that encourage utilization of laboratory services and to consider various solutions to control laboratory use. The chart below illustrates the escalation that has occurred in Medicare expenditures for clinical laboratory services from 1983 through 1988, and clearly demonstrates that adoption of the fee schedule did not reduce Medicare expenditures for laboratory services or slow the rate of growth.

GROWTH IN LABORATORY EXPENDITURES DESPITE REDUCTIONS IN PAYMENT



The OIG concluded that rolling laboratory reimbursement into office visit payments appears to be a promising strategy for curbing the use of laboratory services. Laboratory roll-ins (LRIs) would consolidate Medicare reimbursement for individual laboratory tests into the recognized charge for physician office visits. Implementation of the LRI would provide physicians with incentives to

ensure appropriate use of clinical laboratory services and lower Medicare's administrative costs. However, a statutory change would be needed to implement LRI. An additional OIG report will address the financial implications that should be considered before implementation of LRI. (OEI-05-89-89150)

QUALITY ASSURANCE IN INDEPENDENT PHYSIOLOGICAL LABORATORIES

The OIG conducted a study to assess quality assurance in independent physiological laboratories (IPLs). Services in IPLs qualify for Medicare reimbursement if the laboratory meets all State and local licensure requirements, the diagnostic services are ordered by a referring physician, and the services are determined to be reasonable and necessary by the Medicare carrier.

The OIG recommended that HCFA issue Medicare coverage guidelines and instructions clarifying what the term "physiological" means with respect to IPLs, what tests IPLs are allowed to perform and what testing sites are permissible. In addition, HCFA should promote stronger quality assurance in IPLs through Federal regulation, State regulation and/or an independent certification program. The cost of such regulation or certification should be financed by provider fees. Any proposal addressing quality assurance should include a quality control program, written testing standards, and credentialing of staff or an equivalent standard. The PHS expressed support for stronger quality assurance in IPLs. Although declining to implement the recommendations, HCFA has initiated an independent review of IPLs to determine if standards should be developed. (OEI-03-88-01400)

SANCTION AUTHORITIES

During this reporting period, OIG imposed 565 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. The majority of the exclusions were based on loss of license to practice, conviction of program-related crimes, or conviction of controlled substance abuse or patient abuse.

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:

- A man and one of his sons, owners of two diagnostic treatment centers in New York, were excluded from the Medicare and Medicaid programs for 45 years for Medicaid fraud. A second son was excluded for 35 years. They had been convicted of systematically looting more than \$16 million of the \$32 million their clinic received from Medicaid for supposedly treating the city's poor from 1980 until 1987. They falsely billed Medicaid for close to 400,000 phantom patient visits. They also programmed the center's computer to generate phony claims and backup charts for as many as 12,000 fictitious visits a month. One son was sentenced to 8 1/3 years in jail, the other to 5 to 15 years, and the father to 7 to 21 years. Their corporation was sentenced to pay restitution of \$32 million.
- A registered nurse in New York was excluded for 45 years. The nurse was convicted of second-degree murder in the deaths of two patients, in addition to manslaughter and criminally negligent homicide in two other patients' deaths.
- A Tennessee pharmacist and pharmacy were each excluded indefinitely from the Medicare program because of termination from the Medicaid program. The Medicaid termination was based on actions by the Tennessee licensing board, which found that drugs were being dispensed without authorization.
- A Minnesota pharmacist's license was revoked because his continued practice of pharmacy and access to controlled substances would constitute a danger to the public health, safety and welfare. The OIG excluded him indefinitely from program participation.
- In New York, a Soviet national who owned a durable medical equipment company and his corporation were excluded for 20 years. He had been convicted earlier of using fraudulent physicians' prescriptions in filing Medicare claims. The program was defrauded of \$226,000. He is being held by the Immigration and Naturalization Service pending deportation.
- The Texas PRO found that in two cases involving three admissions, a physician failed to address a patient's abnormal laboratory values prior to discharge, failed to treat a urinary tract infection, and failed to make any attempt to determine the cause of chest pain, renal failure or liver dysfunction. The physician was excluded for 5 years.
- An Indiana dentist was excluded indefinitely as a result of the licensing board's revoking his license due to incompetence.

- A nurse in Arizona whose license was suspended for misappropriating patient medications and diverting patient medication for her own or another's use was excluded indefinitely.
- A Missouri pharmacist was excluded for 6 years because of a drug-related conviction. He was convicted of interstate commerce of adulterated and misbranded drugs and the delivery of these drugs in exchange for payment.
- A Maryland physician's assistant who was convicted of obstruction of justice was excluded for 5 years. He had altered records that had been subpoenaed during an investigation of his employer for Medicaid fraud.
- On the basis of a PRO recommendation, a Washington State physician was excluded for 7 years. In six cases the physician had failed to evaluate, identify or adequately diagnose symptoms. He had also failed to fulfill a corrective action plan developed by the PRO to remedy the problems identified with his care.
- After being convicted of not reporting patient abuse, a Texas nursing home administrator was excluded for 5 years.
- A New York physician was excluded for 5 years after being convicted of receiving kickbacks from a provider of oxygen therapy.

B. Civil Monetary Penalties

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:

- An administrative law judge (ALJ) imposed penalties of \$100,000 and assessments of \$80,000 against a physician and an eye hospital in Texas. The physician submitted fraudulent Medicare and Medicaid claims amounting to \$40,000 on 271 items or services after he had been suspended from these programs. The ALJ found that he knew the terms and dates of his suspension and engaged in a deliberate scheme to circumvent it. For his earlier conviction of Medicare and Medicaid fraud he was sentenced to 9 years in jail, fined \$50,000 and excluded from the programs for 25 years.
- A group of Massachusetts anesthesiologists agreed to pay \$238,000 to settle its liability under the CMP law. The group billed Medicare for the insertion of

intravenous lines and catheters, which had already been reimbursed as part of the overall anesthesia service. The group also billed separately for supervision of pump oxygenators during surgery.

- A California hospital signed an agreement to pay \$3.25 million in settling a dispute over Medicare claims. A qui tam suit filed by a former administrator of the hospital alleged that it had fraudulently billed between \$800,000 and \$900,000 in Medicare claims. Hospital employees had upgraded the codes on patient file jackets, usually switching the principal and secondary diagnoses, thereby substituting more costly procedures and services for those actually administered to the patients. Relying on the jacket notations, billing personnel submitted inflated claims for Medicare payment.
- An ALJ assessed a Texas anesthesiologist \$100,000 for Medicare fraud. In 1988, the anesthesiologist was charged with 88 counts of having falsified the amount of time spent by his anesthetist employees during surgeries. He pled guilty to one count and received an automatic 5-year exclusion from participation in the Department's programs. The exclusion was reduced on appeal to 2 1/2 years, but the anesthesiologist illegally filed another 172 claims while under exclusion. The ALJ decided he was liable on all 260 counts and imposed the assessment, a \$150,000 penalty and a 10-year exclusion.
- A New York laboratory agreed to pay \$1 million to settle Medicare fraud charges. The lab submitted 300 claims for arterial blood gas tests performed on hospital patients as being done by doctors working for the lab. The tests were really performed by hospital technicians, as were the analyses for which Medicare was billed, and were already included in reimbursements to the hospital.
- A Pennsylvania hospital had to pay \$36,262 for filing hundreds of false Medicaid claims for venipunctures, as well as questionable laboratory charges for blood chemistry tests. When the hospital performed routine venipunctures on Medicaid patients, it submitted claims for elaborate procedures not performed, in an attempt to obtain payment.

KICKBACKS AND JOINT VENTURES

Performance Indicator

Referrals are an integral part of many organizations' business when special outside expertise, services or items are required. The giving of discounts, credits, goods and other benefits in exchange for referrals is often standard, acceptable practice. The medical profession relies heavily on referrals because of its pervasive specialization. If referrals related to Medicare or Medicaid patients are made in exchange for remuneration, however, both the giver and receiver

may violate the Federal anti-kickback statute. Outright payments for referrals are clear examples of kickback violations, and they may directly or indirectly increase Medicare/Medicaid costs. Where physicians have a financial interest in a health care organization to which they make referrals and share in the profits, such as a partnership or joint venture, payment for referrals is more subtle but may still be illegal. These arrangements also can result in overutilization of services. The OIG has drafted regulations related to the most recent revisions to the anti-kickback statute, clarifying areas of specific payment practices ("safe harbors") which would not be subject to criminal prosecution or administrative sanctions. These regulations are undergoing final review by the Administration.

Since 1987, OIG has received more than 1,250 allegations of violations of the anti-kickback statute. After screening the allegations, OIG opened some 800 cases. Close to 500 convictions, judgments and settlements have been obtained as a result of OIG investigations. The following judicial actions have been obtained thus far this year:

- The chief financial officer of a health management corporation was sentenced in North Carolina to 37 months imprisonment for Medicaid and bankruptcy fraud. His corporation managed four nursing homes in North Carolina and South Carolina. He executed an elaborate scheme in which a food supplier added \$1,000 to each bill, which was paid to a dietary consultant who in turn paid kickbacks to him. He was also sentenced to 3 years probation, during which he must perform 120 hours community service each year and pay \$63,000 in restitution, plus \$400 in special assessments.
- In two judicially approved actions, the president of a California physicians' group and the representative of a hospital group were granted pretrial diversions in lieu of prosecution for a referral fee arrangement. The actions were taken in light of the fact that their organizations had entered a \$1 million settlement with the Government.
- Two physicians sentenced to probation in New York brought to 18 the number sentenced for accepting kickbacks from a durable medical equipment supplier. A total of 25 health care professionals were arrested in the case, including three husband and wife teams. Almost \$90,000 has been ordered in fines, restitutions and special assessments from the professionals for accepting \$50 or more for each referral to the supplier. The supplier and one other physician are awaiting sentencing, and administrative sanctioning actions were initiated on each individual convicted.
- The owner of a California diagnostic clinic was sentenced to 3 years probation and ordered to pay \$1,400 in restitution, a \$5,000 fine and \$5,000 for the cost of

an investigation into Medicare fraud. The clinic submitted unnecessary patient billings and paid kickbacks for referrals in the form of rent subsidies.

- In a global settlement authorized by the court, a physician in Montana was put in a pretrial diversion program after agreeing to a monetary penalty in lieu of other civil penalties. The physician had prescribed home health services to be rendered by a home health agency in which he had a 50 percent ownership.
- In New York, a man was convicted and sentenced to 4 months home detention after a pharmacist reported he had offered him fraudulent prescriptions for nebulizers. Since no nebulizers would be dispensed, the man proposed that he, the pharmacist and doctors writing the prescriptions share the proceeds from Medicare claims for the prescriptions.

RECOVERY BILLING FRAUD

Certain billing agencies offer a service which includes auditing a medical service provider's records of patient care to determine whether all services rendered were actually billed. It is common for these firms to perform this service for a percentage of the income produced. Some firms engaged in this type of business have attempted to inflate the amounts to be recovered by upcoding services, unbundling services, and billing for items or services not actually provided. If successful, these activities increase the amount the billing agency realizes.

Investigations by OIG into fraudulent recovery billing practices resulted in convictions of three billing agencies during this period. One of these companies was sentenced to 3 years probation and ordered to pay \$25,000 for its activities on behalf of a Massachusetts ophthalmic practice. This agency "recovered" over \$400,000 by billing field of vision tests included in a general examination and previously reimbursed as separate glaucoma tests. The ophthalmic clinic has agreed to pay more than \$3 million to resolve Federal civil and administrative claims for its part in the scheme. Investigations into other fraudulent billing schemes throughout the nation are continuing.

PROCESSING MEDICARE CLAIMS FOR RAILROAD RETIREMENT BENEFICIARIES

Performance Indicator

An OIG review found that discontinuing the use of a separate carrier to process Medicare claims for railroad retirement beneficiaries would save \$9.1 million annually. In addition, provider billings would be simplified since the providers of service would no longer need to separate and submit Railroad Retirement Board Medicare claims to a different carrier. Further, railroad retirement beneficiaries would have greater assurance that their claims would be processed timely and not be routed to the wrong carrier for payment.

In February 1989, HCFA submitted a legislative proposal to streamline the Medicare claims processing system by allowing railroad retirement Medicare beneficiaries, their physicians and suppliers to bill the same Part B carriers as other Medicare beneficiaries. The OIG believes that this proposal, which was not adopted by the Department, has merit and should be reintroduced by HCFA. (CIN: A-14-90-02528)

PREMIUM COLLECTION FOR CIVIL SERVICE ANNUITANTS

In an earlier audit, OIG had recommended that HCFA, in conjunction with the Office of Personnel Management (OPM), perform a reconciliation of premium billings and collections to identify annuitants for whom premium collections should be initiated, and to undertake recovery action for premium arrearages thus identified. Further, OIG had recommended that HCFA coordinate with the Social Security Administration to ensure the correction of a computer-related problem. In a follow-up review, OIG found that these two proposals had been implemented, and estimated that these actions would increase trust fund revenues by about \$14.4 million over a 5-year period. However, OIG noted a difference of nearly \$1 million between HCFA billings and OPM remittances in 1989. Accordingly, OIG recommended that HCFA undertake another reconciliation of their records with OPM, identify the deficiency in the billing and collection process that caused the difference, and adjust the OPM accounts receivable balance on the basis of the results of this reconciliation and the previous reconciliation. (CIN: A-03-90-00619)

HOME OFFICE COSTS AT END STAGE RENAL DISEASE FACILITIES

At HCFA's request, OIG conducted a review to determine the reasonableness, allowability and allocability of the home office costs reported by National Medical Care, Inc. (NMC) at 23 selected facilities for Calendar Year 1988 in accordance with prescribed Medicare principles of reimbursement. The OIG found that NMC charged Medicare approximately \$7 million in unallowable home office costs. The OIG recommended that NMC establish procedures to exclude from future cost reports the unallowable charges identified in the review. Where such costs are under appeal, they should be identified in accordance with HCFA guidelines. In addition, OIG recommended that HCFA instruct the fiscal intermediaries to make the appropriate adjustments to the selected facilities' cost reports for 1988. The HCFA agrees with OIG's recommendations and will instruct the appropriate fiscal intermediaries to adopt the recommendations. (CIN: A-01-90-00510)

FIXED PRICE CONTRACT APPEAL

The HCFA requested OIG to audit a claim for additional administrative costs for Blue Cross and Blue Shield of Colorado under a Medicare fixed price contract. The claim was denied by HCFA and subsequently appealed to the Armed Services Board of Contract Appeals for \$10.3 million. The appeal contended that HCFA's negotiation process for the contract did not provide for reasonable prices for performing change order tasks, and did not consider the impact of the

change orders on costs necessary to perform the functions agreed to in the base contract. The OIG audit disclosed that the carrier's records only supported \$1.3 million in uncompensated costs due to the change orders. The HCFA commented that audit results should be helpful in efforts by the Office of General Counsel to resolve issues in the case. (CIN: A-08-90-00303)

MEDICARE PART B: ADMINISTRATIVE COSTS

An OIG audit revealed that about \$2 million of the costs claimed by Pennsylvania Blue Shield (PBS) during the period October 1, 1985 through September 30, 1987 were unallowable under applicable Federal regulations. The OIG recommended that PBS make several procedural improvements and a financial adjustment of \$2 million. (CIN: A-03-89-02005)

MEDICARE PART B: SUBCONTRACTING PROCESS

Based upon a review of the latest subcontractor procurement by Blue Cross and Blue Shield of Florida (BCBSF), OIG concluded that HCFA needs to improve its review and monitoring of subcontract procurements by Part B carriers. The OIG was unable to assess the extent of HCFA's involvement in the review, monitoring and approval of the BCBSF procurement because HCFA failed to adequately document the basis for its approval actions. In addition, some HCFA written guidelines were outdated and did not reflect current policies and procedures. The OIG recommended that HCFA take the necessary actions to improve its operating procedures and internal controls related to subcontracting by Medicare carriers. The HCFA believes that a structured process already exists for reviewing, monitoring and approving Medicare subcontract procurements. (CIN:A-04-89-02080)

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 owners of an ambulance company in New York were sentenced for Medicare fraud. They billed for ambulance transportation when ambulettes were used. Each was given 6 months in prison, all but 5 months of which were suspended. They were also given 2 years probation and ordered to perform 100 hours of community service each year. In a civil judgment, the company and its owners agreed to pay \$485,370 over 5 years, for a total of \$588,350 including interest.
- After a month-long trial, a Minnesota transportation company and its two owners were convicted of theft and ordered to make restitution of \$768,000 to Medicare, Medicaid and a private health insurer. They billed for basic life support transportation when they actually performed special wheelchair transportation.

- In Louisiana, the owner of a transportation company was sentenced to make restitution of \$50,000 for defrauding the Medicaid program. He had billed Medicaid individually for conveyance of several individuals at a time. He was also fined \$5,000, ordered to pay \$5,000 for the cost of investigation and told to pay \$20 a month for the cost of a 4-year supervised probation.

HOSPITAL EMBEZZLEMENTS

During this reporting period, convictions were obtained against a union president and several hospital officials for embezzlement of hospital funds which included Department monies:

- A union president in Pennsylvania was sentenced to 3 years and 10 months in prison after being found guilty of racketeering in relation to a union-owned and -operated hospital. His son, who was his assistant at the hospital, was found guilty of embezzlement and sentenced to 2 years in prison. A former union staff member was sentenced to 5 years probation, with 6 months home detention, and ordered to repay money which she had received as a consultant at the hospital but for which she performed no services. Total fines, restitutions and recoveries ordered amounted to more than \$662,800. The father and son had used the hospital to award no-show jobs and financial benefits to friends and other union officials. Their embezzlement involved hospital and legal funds which included Medicare and Department block grant monies.
- A former administrator of a Pennsylvania hospital was sentenced to a year and a day in prison, and another to 18 months, for embezzlement of hospital funds which included Medicare and Medicaid monies. A third former manager was placed on probation and fined. Total restitution and fines ordered amounted to \$40,900. The three had embezzled large sums of money and falsified entries on the hospital's cost reports to make it appear that the money was paid to vendors.

ACCESS TO MEDICAID COVERED PRENATAL CARE

In the early 1980s, the Congress provided a way for more women to receive temporary assistance with pregnancy-related health care through Medicaid. This preventive prenatal care was aimed at reducing the incidence of infant mortality and low birth weight babies. In order to identify barriers to implementation of optional eligibility expansions for Medicaid covered prenatal care services, as well as effective techniques to promote their implementation, OIG performed a descriptive analysis of the eligibility expansions in a study at the State and local level. The OIG determined that the level of State implementation of optional authorities for Medicaid covered prenatal care varies widely, and that significant barriers still exist to accessing and delivering these services. However, successful practices for enhancing access to and delivery of such services were identified in some States.

Based on in-depth State and local interviews with key informants and recipients, as well as onsite observations, OIG made preliminary recommendations on the essential elements of a model system including: active outreach to potentially eligible individuals; elimination of the asset test as a condition of eligibility; guaranteed continued eligibility until 60 days postpartum; and simplification of the eligibility process. The OBRA 1990 legislated a number of the recommendations, including continuous eligibility for pregnant women who would otherwise lose eligibility due to a change of income throughout pregnancy and 60 days postpartum. (OEI-06-90-00162)

MEDICAID PRESCRIPTION DRUG PROGRAM: DISTRICT OF COLUMBIA

In a prior audit of the Medicaid drug program in the District of Columbia (D.C.), OIG recommended steps to be taken to improve procedures for identifying recipients with the greatest potential for abuse or misuse to control and reduce their access to prescription drugs. In a follow-up audit, OIG found that D.C. had revised its internal controls over recipients who abuse or misuse drugs. However, the controls did not specifically key in on physicians, outpatient facilities and pharmacies that were involved in particularly high volume prescription drug transactions. The OIG recommended that D.C. develop a computerized system to focus on abusable drugs and the drug utilization patterns of prescribers, dispensers and recipients. The OIG offered HCFA its computer program for their use. The District agreed to implement OIG's recommendations. (CIN: A-03-89-00216)

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 ages 22 to 64 in institutions for mental diseases, and for those who are age 21 at admission. The OIG found that New York State improperly claimed over \$35 million (over \$17 million Federal share) as the cost of services provided to Medicaid recipients ages 21 to 64 at two psychiatric hospitals during the period October 1, 1986 through September 30, 1989. The OIG proposed recovery of the \$17 million Federal share, and recommended that New York cease to claim Federal financial participation for the cost of services provided to patients ages 22 to 64 and those age 21 at admission for the two hospitals in question. Further, OIG recommended that New York identify and return the Federal share of similar unallowable Medicaid payments to the two hospitals for periods prior to and after the one covered by the OIG review. Although New York State disagreed, HCFA concurred with the findings and recommendations. (CIN: A-02-90-01006)

B. Outpatient Psychiatric Services

Federal financial participation (FFP) is available for outpatient psychiatric services. An OIG review at three mental health facilities in New York for the period April 1, 1983 to December 31, 1988 disclosed that the State improperly claimed at least \$3.1 million (Federal share) in Medicaid reimbursement for outpatient mental health services. As a result of an absence of claims monitoring by the State, claims were made for services not rendered and claims were not supported by appropriate documentation. In addition, two of the three providers did not obtain the necessary State operating certificates for the programs they operated. The OIG recommended that the State refund \$3.1 million to the Federal Government and make procedural changes to ensure that future claims are properly billed by certified providers. While the State did not agree, HCFA concurred with the findings and recommendations. (CIN: A-02-89-01025)

C. Upper Payment Limit Requirements for Prescription Drugs

Federal regulations enable the Federal and State Governments to take advantage of marketplace savings available for multiple source drugs. The HCFA identified certain of these drugs and established upper payment limits for each. States cannot claim FFP for payments exceeding the HCFA aggregate upper payment limit for the drugs. An OIG audit disclosed that the State of Pennsylvania claimed almost \$5.5 million in excess of HCFA's aggregate upper limit from October 29, 1987 through October 28, 1988, for which the State received FFP of over \$3.1 million. The OIG recommended that the State establish internal controls to ensure compliance with HCFA's aggregate upper payment limit requirements. The OIG also recommended a financial adjustment of the \$3.1 million and an additional financial adjustment for a subsequent period. The State disagreed. (CIN: A-03-89-00233)

D. Personal Needs Funds

Medicaid patients in long-term care facilities are allowed to exclude a personal needs allowance (PNA) each month from their income in determining their contribution to their costs of care under Medicaid. The OIG found that Massachusetts had collected PNA fund balances of deceased nursing home patients who were Medicaid recipients, but did not establish procedures to assure that such balances for those recipients with no next of kin were credited to the Medicaid program to cover the cost of recipient care in accordance with Federal requirements. The OIG recommended that the State credit the Medicaid program for \$5.5 million (\$2.7 million Federal share) of recovered PNA funds and establish procedures to ensure that all future recoveries of PNA funds of deceased Medicaid recipients with no next of kin be reported pursuant to Federal requirements. The State disagreed, but HCFA officials concurred. (CIN: A-01-89-00006)

E. Family Planning Services

The OIG conducted a review to determine the effectiveness of New York's Medicaid Management Information System (MMIS) in ensuring that only eligible family planning services were being claimed for enhanced FFP. The OIG found that none of the 180 claims selected for review were totally related to the provision of family planning services. As a result of the

improper claiming of enhanced FFP, New York received over \$1.1 million in excess Federal reimbursement. The OIG recommended a financial adjustment for the \$1.1 million in unallowable FFP claimed. Further, OIG proposed that MMIS procedures be improved to assure the proper identification and claims for family planning services. The State and HCFA concurred with the findings and recommendations. (CIN: A-02-90-01011)

DONATIONS AND PROVIDER TAXES

Medicaid regulations relating to sources of State financial participation permit the use of public and private donations in the States' share of financial participation in the Medicaid program. However, the regulations do not address limiting States' use of any tax revenue for their share of Medicaid costs. In February 1990, HCFA issued a notice of proposed rulemaking that would have required the States to offset the amount of a donation or tax against legitimate Medicaid expenditures, unless the tax was paid pursuant to a law of general applicability. The HCFA asked OIG to determine States' actual and planned uses of donations and provider-specific taxes. Results of a nationwide survey showed that 15 States were using or planning to use such programs during FY 1990, whereby providers were subsidizing the State's share with funds that could generate almost \$500 million in Federal expenditures. This distorts the Federal/State financial partnership in the Medicaid program. The potential for future increases in the uses of donations and taxes is inestimable. The OIG recommended that limits of the types contemplated in the proposed rules be put into place.

Before HCFA could take action on the recommendation, the Congress passed the OBRA 1990, which continued the current moratorium on the issuance of final regulations regarding the use of voluntary contributions for a State's share of Medicaid expenditures until December 31, 1991. The law also permits States to receive Federal matching payments for the State share of Medicaid expenditures that are derived from provider-specific taxes. (CIN: A-14-90-01009)

STATE MEDICAID FRAUD CONTROL UNITS

Medicaid health care provider payments currently exceed \$50 billion dollars annually, representing 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 first half of FY 1991, OIG administered \$29 million in grants to the MFCUs. The MFCUs reported 350 convictions and \$10 million in fines, restitutions and overpayments collected for the period July 1 through December 31, 1990.



**SOCIAL SECURITY
ADMINISTRATION**

CHAPTER III

SOCIAL SECURITY ADMINISTRATION

OVERVIEW OF PROGRAM AREA AND OIG ACTIVITIES

Fifty-six 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 Insurance (RSI), and Disability Insurance (DI) programs, popularly called Social Security, are the largest of the Social Security Administration (SSA) programs. In Fiscal Year (FY) 1991, SSA will pay approximately \$269 billion in cash benefits to approximately 40 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 insured workers.

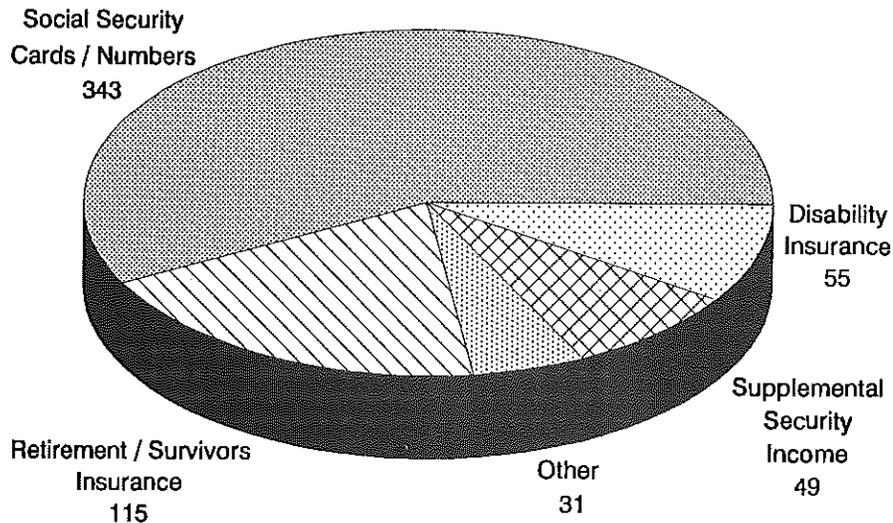
The Supplemental Security Income (SSI) program is a federally administered, means-tested assistance program that provides a nationally uniform, federally-funded floor of income for the aged, blind and disabled. Beginning January 1974, SSI replaced State and county run assistance programs for the aged, 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 1991, SSA will pay SSI benefits in excess of \$16 billion to over 4 million recipients.

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 Office of Inspector General (OIG) is currently undertaking a number of important initiatives with respect to SSA programs and operations, such as monitoring client satisfaction with SSA services, evaluating and assessing the quality of service provided in SSA field offices, 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.

As illustrated in the chart below, investigations resulted in a total of 593 convictions during the first half of FY 1991.

SOCIAL SECURITY PROGRAMS Criminal Convictions



AUDIT OF SSA'S FINANCIAL STATEMENTS: FYS 1989 AND 1990

This report presents the results of OIG's examination of SSA's combined statements of financial position as of September 30, 1990 and 1989, and the related combined statements of financing sources and expenses and trust fund balances, and cash flows for the fiscal year then ended. The OIG's February 1990 opinion on the FY 1989 combined financial statements was qualified for the uncertainty of revenue amounts credited provisionally to the trust funds, and for the reasonableness of the net book value of receivables and equipment. The issue relating to the provisional credit of revenue remains unresolved. In the current audit, OIG was again unable to satisfy itself as to the net book value of receivables and equipment.

In OIG's opinion, except for the effects, if any, of the problems noted above, the combined financial statements presented fairly, in all material respects, the financial position of the Social Security Administration at September 30, 1990 and 1989, and the financing sources and expenses and trust fund balances, and the cash flows for the fiscal years then ended, in conformity with generally accepted accounting principles for Federal agencies. (CIN: A-13-90-00044)

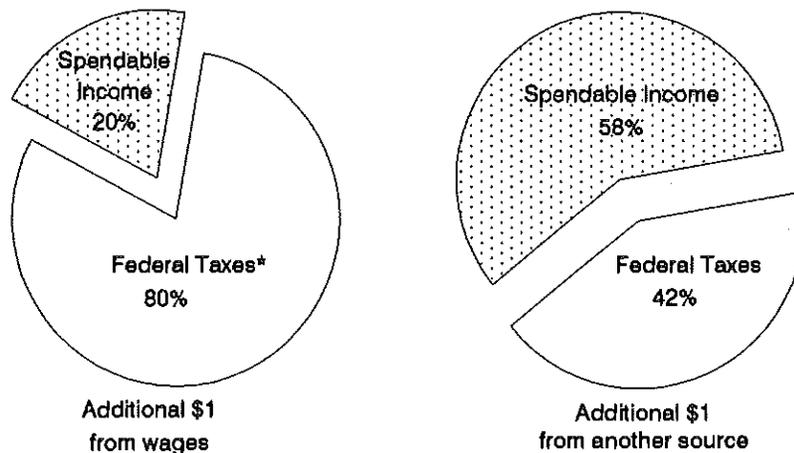
RETIREMENT EARNINGS TEST

The current retirement earnings test (RET) allows a beneficiary to earn up to a specified annual limit known as the annual exempt amount (AEA) before loss of any benefits. Proponents of change argue that the RET discourages beneficiaries from working and penalizes beneficiaries who must supplement their income by working. Opponents believe that altering the RET would be costly to the trust fund in the short run.

The OIG analyzed the issues related to the RET to determine its impact on beneficiaries, the trust fund and work activity. While making no recommendations, OIG suggested that if policymakers determine that it is in the national interest to provide additional incentives for work, that goal could be met more effectively by raising the AEA amount than by eliminating the RET. The OIG also suggested accelerating the increase in the delayed retirement credits applied to the benefits of those who postpone their retirement past age 65.

As illustrated in the following chart, the marginal impact of the RET is most severe on the middle income beneficiary. Such a beneficiary has a marginal tax rate of 80 percent when an additional dollar of income is from wages, but a marginal rate of 42 percent when the additional dollar of income is from sources other than work.

COMPARISON OF SPENDABLE INCOME FOR MIDDLE-INCOME BENEFICIARIES WHEN ADDITIONAL INCOME IS EARNED VERSUS UNEARNED



*Includes benefits withheld under the retirement earnings test

The OIG concluded that the AEA increase would bring about increased work activity for the low and middle income retirees most impacted by the RET, by sheltering them from excessively high reductions in spendable income. The SSA noted that the OIG analysis will be useful in addressing future congressional considerations of the RET. (CIN: A-13-89-00022)

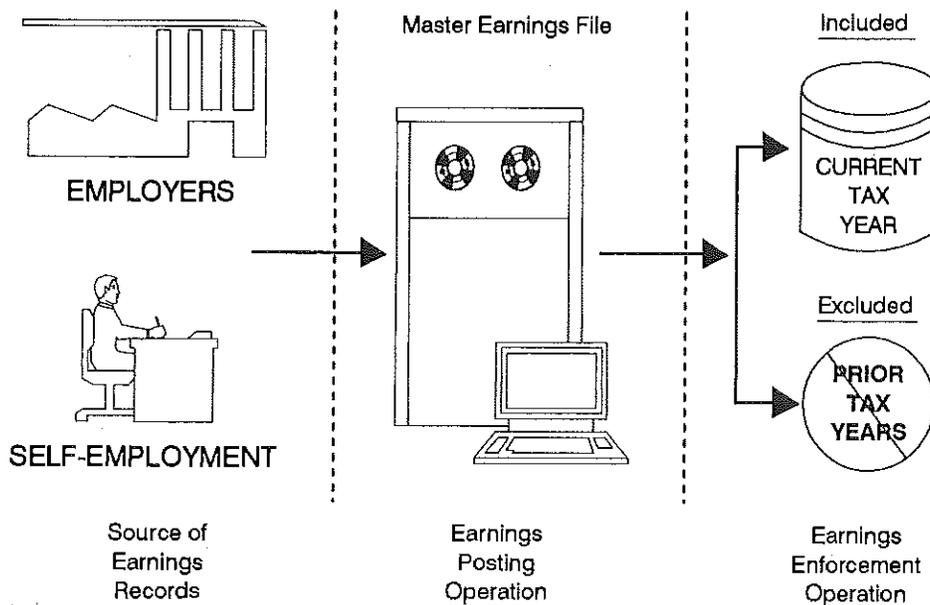
EARNINGS ENFORCEMENT OPERATION

Performance Indicator

The OIG estimates that the Social Security trust funds lost amounts ranging from \$52 to \$63 million for tax years 1985 through 1988 because late posted earnings were not included in SSA's earnings enforcement operation. The SSA's earnings enforcement operation is an automated control to ensure that beneficiaries accurately report their earnings. It compares current tax year earnings reported by employers and self-employed individuals with earnings information on the master beneficiary record as reported by beneficiaries.

The OIG found that only current tax year earnings postings to SSA's master earnings file are used for matching purposes. Reports from previous years are not used for earnings enforcement purposes, as illustrated below.

CURRENT ENFORCEMENT OPERATION



Exclusion of late posted earnings resulted in SSA not detecting approximately 73,000 beneficiaries who failed to report their earnings for tax years 1985 through 1988. To correct the problem, OIG recommended that SSA modify the enforcement program to include late posted earnings, and identify and initiate recovery of overpayments based on late postings for tax years 1985 through 1988. The SSA believes OIG estimates may be overstated. The OIG and SSA have agreed to await the results of the next earnings enforcement run to determine if a revision in the estimated losses is warranted. However, SSA has agreed to modify its earnings enforcement operation to include late posted earnings reports. Once the systems modifications are implemented, SSA can begin recovery action for tax years not precluded by the rules of administrative finality. (CIN: A-13-89-00031)

OVERPAYMENTS DUE TO INACCURATE CURRENT YEAR EARNINGS ESTIMATES

The OIG performed a follow-up review to determine whether actions taken by SSA improved the effectiveness of the annual earnings test direct mail follow-up (DMF) to prevent Retirement, Survivors and Disability Insurance (RSDI) overpayments. In a 1987 OIG audit report, OIG recommended that SSA require beneficiaries to respond to the DMF if their earnings exceeded or were expected to exceed the earnings amount exempted by law, and to reduce or suspend the benefits of beneficiaries who fail to respond. The SSA generally agreed with those recommendations. The OIG's follow-up review showed that actions taken by SSA in response to the earlier recommendations have improved the effectiveness of the DMF. The SSA required beneficiaries with the greatest potential for excess income to respond to the DMF or face reduction of benefits, and it reduced the benefits of some beneficiaries who failed to respond. As a result of these actions, SSA's Chief Financial Officer considered the 1987 DMF to be a "major success." (CIN: A-03-90-02700)

SYSTEMS ARCHITECTURE

The OIG performed a review, with the assistance of the Systems Research and Applications Corporation, to evaluate the long term benefits and risks of processing data largely through mainframe computers in the National Computer Center (NCC), and to examine alternative methods of processing data. A major risk associated with centralized automatic data processing architecture is in the area of back-up and recovery. In the event of an NCC disaster, SSA field offices would have no means for processing claims until the NCC was restored or replaced.

The SSA has not moved to a distributed architecture because of the expected costs. The OIG recommended that SSA perform a cost analysis of the effect a distributed processing architecture would have on NCC hardware and telecommunications requirements, and study the feasibility of designing future application software and upgrades to be portable to a distributed environment. The OIG also recommended that SSA assess the cost of a catastrophic failure at the NCC and reevaluate the adequacy of its current back-up/recovery contingency plan in light of that cost.

The SSA generally agreed with the recommendations and recently initiated pilot studies to determine the appropriate mix of mainframes, minicomputers and local work stations. (CIN: A-13-89-00041)

IMPROVEMENTS NEEDED IN THE "800" TELEPHONE SYSTEM

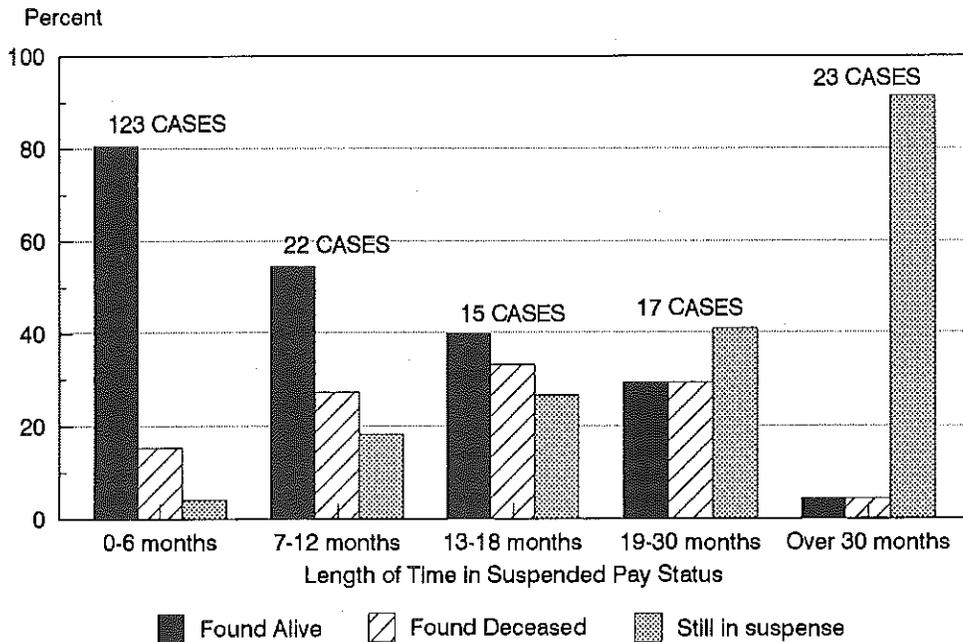
Because the SSA programs affect nearly every American, its telephone service needs to be responsive to the diverse needs of callers. In efforts to improve service to the public, SSA expanded telephone service using a single, toll-free "800" number starting October 1988. A heavy investment was made in new facilities, equipment and personnel, and by January 1990 the plans called for shifting all calls to a nationwide network of 37 telephone centers. The shift away from local telephone service has raised several concerns. However, on balance, OIG believes this new service should be allowed to develop over several years to demonstrate the potential for optimum client satisfaction.

An OIG review indicated that further improvements are necessary. The OIG found that the number and varying size of telephone centers hinder service delivery and operational efficiency. Also, SSA could make better use of flexible staffing and technology to increase the accessibility, timeliness and accuracy of telephone service. Finally, SSA needs to demonstrate the feasibility of a full-service "800" center that could both improve responses to callers' needs and effectively screen requests for the local office staff who can then better serve the public with face to face visits. The SSA has referred most of OIG's recommendations to an executive level work group for full evaluation. (CIN: A-09-90-00071)

TIMELY RESOLUTION OF SUSPENDED PAYMENTS

The OIG conducted a review of the records of direct deposit RSDI beneficiaries whose payments were suspended for incorrect address (S6) or for miscellaneous reasons (S9). The OIG concluded that SSA needs to resolve these suspensions in a more timely manner so as to reinstate payments to eligible beneficiaries, or terminate the benefits of ineligible or deceased beneficiaries and pursue recovery of any incorrect payments. The review disclosed that SSA took 6 months or longer to resolve 26 percent of the suspensions, and that 21 percent were still in suspense at least 18 months after the initial suspense action. Unresolved suspensions result in unpaid benefits to entitled beneficiaries and make recovery of incorrect payments more difficult. As illustrated by the following graph, the longer a case remains in suspension, the less likely it is to be resolved.

STATUS OF SUSPENDED CASES BASED ON LENGTH OF SUSPENSION



Sample of 200 beneficiaries

The OIG recommended that SSA establish controlled alerts and follow up on them to ensure timely resolution of S6 and S9 suspension cases. To protect against fraud, OIG proposed that SSA either separate key personnel duties or establish a compensating control to ensure that the beneficiary is alive before reinstating payments. The SSA agreed that enhanced follow-up on suspension cases is necessary, and expects to make appropriate policy and procedural changes by the end of FY 1991. Although OIG recommended that SSA search death records when unable to locate beneficiaries, SSA believed it would be more cost-effective to improve its matching with State death information. (CIN: A-13-89-00027)

PROCESSING DEATH ALERTS

The objectives of SSA's death alert control and update system (DACUS) are to ensure that benefits for deceased individuals are properly terminated and to produce a national file of death information. The DACUS receives death data from several sources and produces an alert for field offices to resolve when information does not agree with SSA data. The OIG performed an audit to test the effectiveness of SSA field offices in processing DACUS alerts and stopping payments in a timely manner, and to assess the adequacy of internal controls to prevent fraud and abuse. The OIG found that field offices were reasonably effective in terminating benefits to deceased individuals, although alerts were not always resolved in a timely manner, causing millions of dollars in improper payments. The OIG recommended that SSA ensure that field

offices comply with instructions for processing death alerts and that SSA provide for separation of duties in processing alerts to address an existing vulnerability to employee fraud. The SSA generally concurred and is in the process of implementation. (CIN: A-09-90-00044)

INTERCEPTING ELECTRONIC FUND TRANSFERS TO DECEASED BENEFICIARIES

The OIG estimates that SSA could save at least \$2.9 million annually in administrative costs and unrecoverable benefit payments by using mailgrams to intercept erroneous direct deposit electronic fund transfers (DD/EFTs) made to beneficiaries who die after the 23rd of the month. That is the approximate date on which SSA authorizes the Department of Treasury to make payments due on the 3rd of the next month. The SSA currently uses mailgrams to direct the U.S. Postal Service to stop delivery of checks to beneficiaries who die after payment has been authorized, but SSA does not have a process to stop DD/EFT payments.

Exploratory work is being done to fit an intercept capability into the system through which SSA routes payments electronically to the financial institutions selected by those beneficiaries who choose direct deposit. However, implementation of that feature is expected to take 2 to 3 years. In the interim, OIG believes that it would be cost-effective to contract for mailgram service similar to that used to intercept checks. The SSA did not concur, believing that there would be major problems in sending mailgrams to large financial institutions. However, OIG recommends that SSA reconsider its position. (CIN: A-13-89-00037)

FRAUD INVOLVING 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:

- A 27-year-old mother of four was sentenced in Pennsylvania to 4 months in-house detention in lieu of prison, with orders to look for work. She had converted to her own use her deceased grandfather's retirement benefits. She was also ordered to pay restitution of \$11,680.
- A 72-year-old woman was sentenced in New York to serve 3 months in a correctional institution for cashing and using her deceased friend's Social Security benefits. After her companion died, the woman opened a joint account

into which she deposited the checks. A short time later she would withdraw the funds for her own use. She also was sentenced to 5 years probation and ordered to make restitution of \$38,600.

- Another New York woman was sentenced to 1 full year of probation which will be renewed year by year until \$25,300 is repaid in benefit funds sent to her deceased mother.
- An Oklahoma woman was ordered to serve 1 month home detention and 5 years probation, and to repay \$3,730 for negotiating Social Security checks sent to her deceased mother-in-law.

PROJECT CLEAN DATA

Prior OIG studies on the accuracy of Social Security numbers (SSNs) in records outside SSA indicated that many public and private institutions do not verify the accuracy of SSNs. Those institutions that do verify SSN accuracy using a system other than SSA's had a 20 percent median SSN discrepancy rate. Such SSN discrepancies may result in problems for employers, employees, IRS and SSA.

In an effort to address this problem, while acknowledging SSA's concerns about resource and systems limitations should usage of their verification system increase, OIG reviewed the use of a software package it had developed (Project Clean Data) to identify invalid SSNs. This package analyzes the SSN configuration in conjunction with data in the user files, so that there is no disclosure of personal information from SSA files. The OIG found that Project Clean Data is an effective system that employers and others could use to detect invalid SSNs without straining SSA resources. The SSA should develop, maintain, and widely disseminate a software package patterned after Project Clean Data to complement the existing enumeration verification system. For organizations, such as financial institutions, it may be appropriate to charge a user fee to cover the costs of providing the initial software and subsequent updates. (OEI-12-90-02360)

ENHANCING INCOME TAX REFUND OFFSET

In an earlier report, OIG recommended that SSA obtain the SSNs of former auxiliary beneficiaries to facilitate debt collection through tax refund offset or through offset against other Social Security payments the individual may subsequently receive. The SSA agreed that having the SSNs of all auxiliary beneficiaries would facilitate debt collection, but deferred taking action until SSA gained additional legislative authority in the area of debt collection. The necessary authority to recover overpayments from former beneficiaries by means of offsetting income tax refunds was provided by the recently enacted OBRA 1990. Consequently, OIG recommends that SSA determine the SSNs of the overpaid former auxiliary beneficiaries for whom SSNs are

unknown, and institute recovery actions if current benefits are being paid or include these debtors in future income tax refund offset efforts. (OEI-12-91-00610)

FRAUDULENT SSNS

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. Investigations by OIG resulted in almost \$4 million in fines, restitutions and recoveries from crimes in which use of a false SSN was a major factor. Many of the cases also involved the commission of crimes not directly related to Department programs.

- A Massachusetts man was sentenced to 6 months in jail for SSN fraud. He was out on bail on State charges, which included aggravated rape and kidnapping, when he applied for an SSN and a passport using the identity of a deceased infant. He is currently serving 9 to 15 years in prison on the State charges.
- In Texas, a man was sentenced to 17 years in prison for importing marijuana, illegally possessing a firearm and misusing SSNs. Indicted in 1977 for importing marijuana, he became a fugitive. He assumed several false identities and SSNs, enabling him to elude capture, obtain a pilot's license, purchase an airplane and import drugs from Mexico. He was captured in January 1990.
- An Ohio man was sentenced to 20 years in jail for mail fraud and misuse of a SSN. He used a false SSN in his application to sell insurance because he had lost his license. He executed various schemes in which he cashed in insurance policies or earned huge commissions on insurance people had not bought.
- In Missouri, a man was sentenced to 21 months in a Federal prison for misusing SSNs. For 8 years he had used the identity of a man in New York to get drivers licenses and credit cards. He was found after the New York man contacted police because he could no longer get credit.
- Two individuals, one a postal employee, were given 12- and 15-month prison sentences in Texas as a result of SSN violations. They were among several persons arrested in a sting operation at a flea market. A search of the postal employee's residence turned up items of stolen mail. The postal employee also had to pay a \$2,000 fine.
- The vice president of a Texas bank was sentenced to 5 years probation and ordered to pay a \$25,000 fine for committing bank and SSN fraud. After

investing and losing \$500,000 of a customer's funds, he issued false savings certificates and took funds totaling \$300,000 from two other customers' accounts. To cover the thefts, he made up 40 notes using false names and SSNs.

- A New York woman drew a sentence of 3 1/2 to 10 years in a State prison for using false SSNs in credit fraud and check kiting. She had been targeted for prosecution by a white collar crime task force because of repeated violations over a period of 8 or more years. She had agreed to plead to violations that carried a maximum of 3 years in prison. While waiting for sentencing, she took several thousand dollars worth of checks from her employer. This activity was noted in her sentencing report, and the judge gave her the additional time plus ordering restitution of \$47,000.
- In Vermont, an alien was sentenced to 12 months in jail for student loan fraud. After defaulting on a loan he obtained to attend school in Virginia, the man used a false SSN to apply for another student loan in Vermont. He was ordered to pay \$13,842 in restitution. He had a lengthy criminal record, mainly for check fraud.

NEW CARDS FOR NEW BRIDES

The OIG conducted a study to determine the feasibility of having States provide SSA with name change and other data in order to allow issuance of a corrected Social Security card as part of the marriage registration process. If a name change is not properly reported to SSA, an individual's earnings may not get posted to his or her earnings record, resulting in possible reduction or denial of monthly benefits. Unreported marriages also present significant problems for States in their efforts to administer programs such as Aid to Families with Dependent Children.

The SSA has already developed a process for issuing Social Security cards at birth using States' computerized vital statistics data. The OIG recommended that SSA actively pursue the acquisition of computerized marriage records from States having this capability, and target its public information efforts to newlyweds explaining the importance of reporting name changes to SSA. In preliminary comments, SSA indicated that there are a number of obstacles to implementation of the first recommendation. They agreed to consider actions to implement data matches with States in the future. (OEI-06-90-00820)

WEAKNESSES IN REPRESENTATIVE PAYEE PROCEDURES

The OIG performed a review to determine whether SSA's procedures provided adequate assurance that representative payees were properly using Social Security benefits on behalf of beneficiaries. The OIG found that: accounting forms are overly complex and cause many unacceptable answers which require that reports be processed manually; financial data reported by payees is neither verified nor used to detect misuse; a computer system deficiency omitted

printing the amount of conserved funds on the accountability report, which hindered identification of potential misuse; there was inadequate documentation as to the selection decision regarding prospective payees; and some representative payees were not mailed the required accounting reports due to lack of coding of the beneficiary's record. The OIG recommended specific improvements consonant with its findings. The SSA agreed with most recommendations, has taken action to implement some recommendations and is considering ways to implement others. (CIN: A-07-90-00266)

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 woman employed as a social worker at a South Dakota Indian reservation was sentenced to two months in prison for converting to her own use SSA benefits intended for two children. Acting as the children's representative payee, the woman took checks paid into tribal funds on their behalf and forged another tribal employee's name to cash them. She was ordered to pay restitution of \$5,080.
- The representative payee for an Ohio man who was a disability beneficiary was sentenced to prison for embezzling the beneficiary's Medicare checks. The beneficiary was unaware of the theft of almost \$5,000 in Medicare payments for his surgery until he received collection notices from physicians and contacted the Social Security office for assistance.
- A California couple was ordered to be imprisoned for the first 90 days of an 18-month term, with the balance suspended, after conviction for concealing the marriage of their disabled daughter. They also had to repay \$64,900 they had received since 1972 on her behalf.
- In Oklahoma, a woman who used her daughter's benefits and payments to purchase cocaine and abortions was sentenced to a suspended 5-year prison term and ordered to make restitution of \$29,500. The woman had lied that she had custody of the child. She was also ordered to submit to drug abuse counseling and psychological testing.

NONRESIDENT ALIEN TAXES

The OIG performed a follow-up review regarding alien tax cases involving benefit payments for retroactive periods. Since 1984, SSA has been required by law to withhold a 15 percent tax from RSDI benefits payable to nonresident aliens residing in countries not having a tax treaty with the United States. The OIG found that since 1984, SSA has been unable to develop policies and procedures to effectively process alien tax cases involving benefit payments for retroactive periods. As a result, SSA has not collected over \$7.7 million in taxes during the period from 1984 through 1990. The OIG recommended that SSA use automated systems to identify cases and facilitate collection. The SSA's automated data processing plan now includes a project to address this issue. (CIN: A-13-90-00041)

SANCTIONED PHYSICIANS' CLAIMS FOR DISABILITY BENEFITS

In an inspection conducted in 1986, OIG found that SSA's disability determination process was vulnerable to manipulation by unscrupulous physicians. Sanctioned physicians were believed to pose the greatest risk, since they have evidenced a diminished credibility through their actions to defraud the Medicare and Medicaid programs. In this report, OIG recommended that SSA use the listing of sanctioned physicians generated by OIG to identify those who are applying for disability benefits and to stringently review the medical evidence submitted in connection with such claims. The SSA is currently reevaluating the report's recommendation. (OEI-12-91-00600)

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 Louisiana, a man was sentenced for disability benefits fraud to 5 years supervised probation, 100 days of which are to be spent in a halfway house. He also must make full restitution of \$66,800 he and his family obtained by his making false statements.
- A Montana man was sentenced for Social Security fraud to 30 days in jail and ordered to pay \$78,100 restitution. He began receiving disability benefits in 1975. In 1981 he bought a bar, but he continued to claim that he had no earned income. He also did not let SSA know that the daughter for whom he was representative payee no longer lived with him.
- An alleged organized crime figure was sentenced in New York for conspiracy to obstruct justice, Social Security disability fraud and failure to file income taxes.

The man pled guilty to leaking information arising from a grand jury investigation of a well-known organized-crime family. For this he was sentenced to 30 months imprisonment and fined \$250,000. For concealing income obtained by engaging in extortion while receiving Social Security benefits, he was given a concurrent 18-month prison sentence and ordered to repay \$128,200. For failing to file income taxes, he had to serve 5 years probation and repay all taxes, interest and penalties.

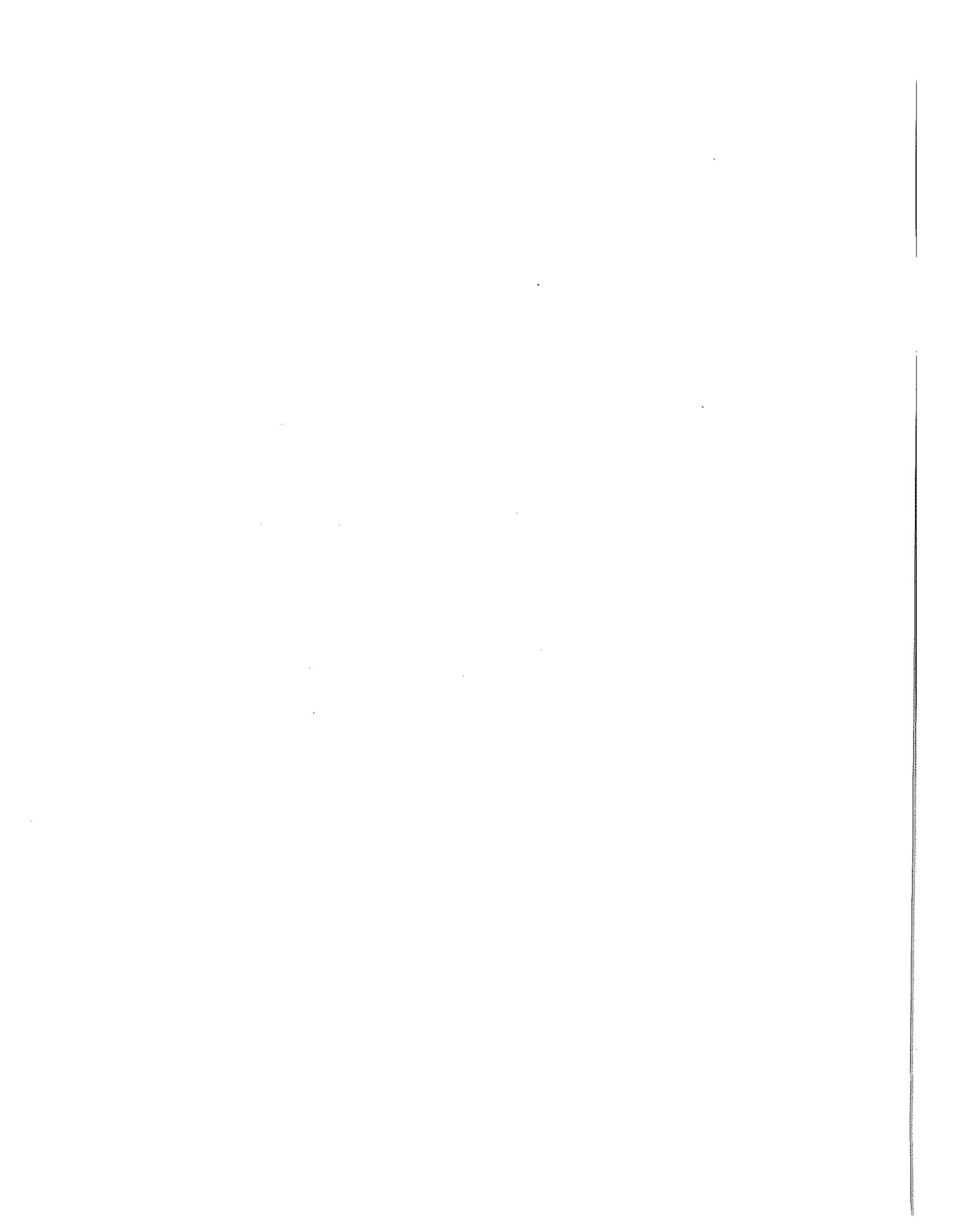
SSI BENEFITS FRAUD

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 Massachusetts man, his mother and his wife were convicted for conspiracy and other violations related to a scheme in which the family used false SSNs to fraudulently obtain \$160,000 in unemployment benefits from Massachusetts and six other States. His mother and father also admitted guilt in fraudulently obtaining \$59,000 in SSI benefits. The son was sentenced to 12 months in prison, the mother to 21 months home detention and the wife to 6 months home detention. Sentencing of the father is pending. A total of \$71,450 has been ordered thus far in restitution.
- A Maryland woman was convicted for impersonating an SSI recipient for 15 years. After the legitimate recipient moved to Pennsylvania in 1975, her roommate impersonated her and cashed the SSI checks that continued to arrive. The theft was discovered in 1989 when the legitimate recipient applied for assistance from SSA. Her impersonator was ordered to make restitution of \$45,000 in \$100-a-month payments. She also received a suspended 5-year prison sentence, with 5 years supervised probation.
- In Wisconsin, a man was sentenced to 60 days in jail for SSI fraud. While noting his family hardships, his absence of a police record, and his complete acceptance of responsibility, the judge declared nonetheless that some imprisonment was required as a deterrent to others. The man also was ordered to repay the \$12,100 he had converted to his own use after the death of the SSI beneficiary, his retarded son.



**PUBLIC
HEALTH
SERVICE**



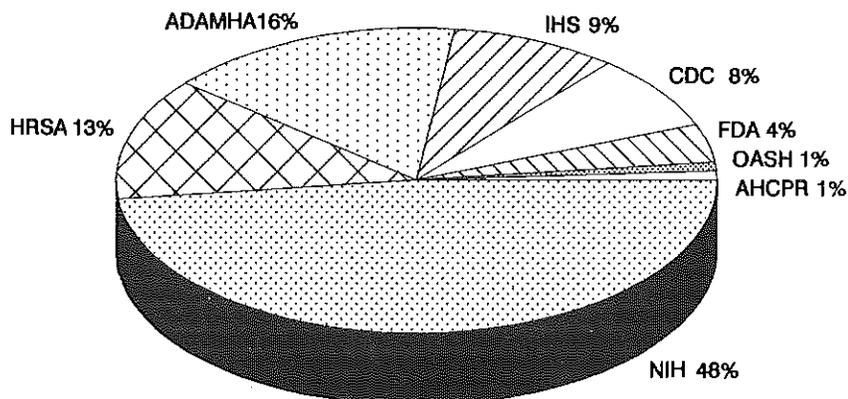
CHAPTER IV

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 conduct biomedical and behavioral research on mental and addictive disorders and to assist States in refining and expanding treatment and prevention services through ADAMHA's science-based leadership; 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 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 \$16.2 billion in Fiscal Year (FY) 1991.

**DISTRIBUTION OF PHS RESOURCES
(FY 1991 Budget \$16.2 Billion)**



The Office of Inspector General (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. The PHS audit division concentrates on issues within PHS, such as acquired immune deficiency syndrome, medical effectiveness, substance abuse and biomedical research. In addition, this division has responsibility for audits of colleges and universities which are awarded contract and grant funding by the Department of Health and Human Services (HHS). 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.

INTERNAL CONTROL WEAKNESSES

- The Department's 1990 Federal Managers' Financial Integrity Act (FMFIA) report discussed a high risk area concerning management of IHS. During this reporting period, OIG issued a follow-up report regarding contracting practices in the Oklahoma City area office, which concluded that some improvements were made but more needs to be done in various areas. (CIN: A-06-89-00066) (See page 62).
- The second high risk area addressed in the Department's 1990 FMFIA report involved the material weakness in FDA's oversight of the generic drug process. The Department reported that some generic drug firms had been able to obtain approval for their products by submitting falsified data or by substituting the brand name drug for testing. During this reporting period, OIG investigated allegations which called into question the therapeutic value of many generic drugs. (See page 58)

HUMAN IMMUNODEFICIENCY VIRUS INFECTION AMONG STREET YOUTH

The OIG issued two reports on human immunodeficiency virus (HIV) infection among street youth. The first report looked at the scope and nature of the problem and the services that address the problem. Street youth, who have diverged from society's mainstream and fallen through the safety net, face a greater risk of becoming infected with HIV than other adolescents. While the infection rate for all adolescents nationwide appears to be less than 1 percent, for certain high risk subpopulations of adolescents the rate may be as high as 70 percent. Basic survival needs of street youth overwhelm education efforts aimed at reducing high risk behavior. Gaps in research, categorical requirements and access barriers to services compound the problem

of the high infection rate in this population. The OIG recommended that PHS conduct additional research on the infection rate, behavior change strategies and protocols. It also recommended that PHS, in concert with the Office of Human Development Services (HDS), design and implement a strategy to curb HIV infection among street youth in six cities with large populations of street youth and high rates of HIV infection. The PHS and HDS agreed and implementation of a number of the recommendations is underway.

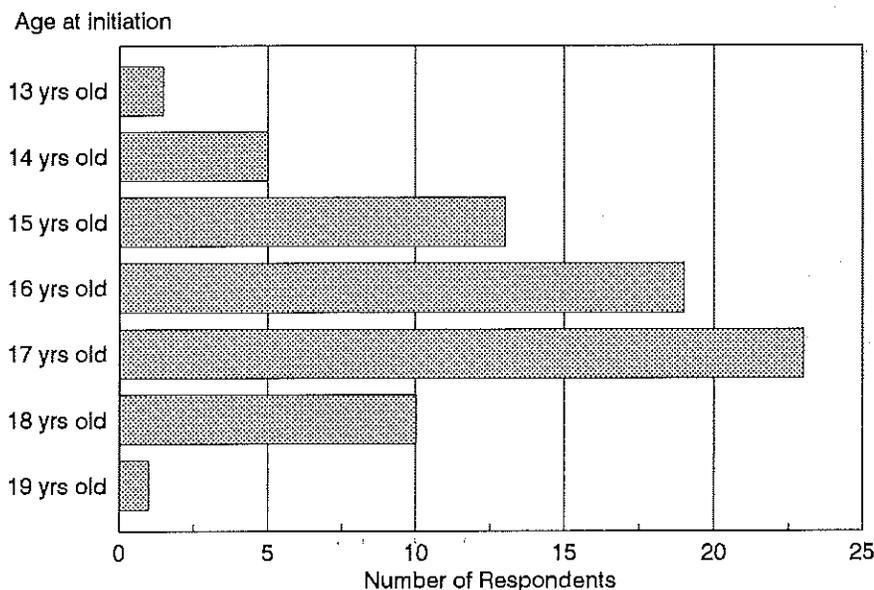
The second report provided information on the range of activities sponsored by HHS. It included summary descriptions of and contacts for several initiatives, grants and other resources. Although the report focused on the specific problem of HIV infection among street youth, many of the resources listed addressed larger issues, such as HIV infection in general and the needs of runaway, homeless and other high risk youth. (OEI-01-90-00500; OEI-01-90-00501)

ADOLESCENTS AND STEROIDS

The OIG examined adolescent steroid use from a user point of view, noting patterns and trends, motivations and influences, effects and awareness of health risks. A second report described the nonmedical use of steroids by adolescents.

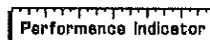
The OIG found that more adolescents are now using steroids and that male competitive athletes are the primary users. Users start young, as illustrated below, and continue using for a long time.

AGE AT WHICH RESPONDENTS BEGAN USING STEROIDS



Adolescent users often take more than one steroid at a time, take large doses, and use steroids more intensely over time. They use steroids to enhance appearance and athletic ability. They are most influenced to use steroids by users they know personally and by famous role models, and they are encouraged to continue by the results they obtain. Although users report both psychological and physical changes after starting to take steroids, most discount warnings about the associated risks. Former users quit for various reasons including undesirable effects experienced, concern about health risks and life changes. Current users show signs of denial and some appear to be dependent on the steroids. Many of the users are mainstream students pursuing socially acceptable goals, and do not stand out as belonging to a drug subculture. The OIG recommended that the Department develop a national education strategy to increase adult and adolescent awareness of the steroid problem, and take the Federal lead on research to expand our understanding of the risks and motivations involved in steroid use. The PHS agreed with the recommendations, but indicated that it would delay implementation pending recommendations from the Interagency Task Force on Anabolic Steroid Use. (OEI-06-90-01080; OEI-06-90-01081)

GENERIC DRUG INVESTIGATIONS



Over the past 2 years, three generic drug companies, five company officials and a consultant, and five FDA employees were convicted and sentenced for giving and receiving illegal gratuities. The convictions and sentencings culminated a series of investigations into corruption in FDA's generic drug approval process. To gain the competitive edge of being the first to market a generic equivalent of a widely sold brand-name drug, company representatives paid off review chemists and other FDA employees to receive favorable processing of their generic equivalents. The scandal reached all the way to the head of FDA's generic drug division, and resulted in a restructuring of the division and the approval process.

As traumatic as the discovery of payoffs has been, however, the subsequent discovery of fraud and false statements in generic drug applications has more serious implications. During this reporting period a major generic drug company and two managers of another major company were convicted on charges related to selling adulterated drugs, subverting the bioequivalency studies required for FDA approval, changing manufacturing practices without FDA approval, and falsifying documents and lying to FDA investigators to conceal these activities. Although no one appears to have been physically harmed, the therapeutic value of many generic drugs is now questionable and the entire industry is suspect. Investigation is continuing, with the expectation of further convictions.

CONVICTIONS IN THE GENERIC DRUG CORRUPTION CASE

<u>Title</u>	<u>Conviction/Plea Date</u>	<u>Charge</u>
FDA Employees:		
Chemist	5/17/89	Accepted illegal gratuities
Supervisory Chemist	5/25/89	Interstate travel in aid of racketeering, accepted illegal gratuities
Chemist	7/25/89	Accepted illegal gratuities
Consumer Safety Officer	3/30/90	Accepted illegal gratuities
Director, Division of Generic Drugs	10/31/90	Perjury
Industry Companies and Officials:		
Vice President, Pharmaceutical Company	5/15/89	Paid illegal gratuity
Senior Vice President, Pharmaceutical Company	7/17/89	Paid illegal gratuity
President, Pharmaceutical Company	7/19/89	Paid illegal gratuity
Pharmaceutical Company	7/17/89	Paid illegal gratuity
Pharmaceutical Company	7/17/89	Paid illegal gratuity
Consultant	3/16/90	Interstate travel in aid of racketeering, offering unlawful gratuity
Pharmaceutical Company	3/30/90	Use of interstate facilities in aid of racketeering
President, Pharmaceutical Company	4/2/90	Interstate travel in aid of racketeering
President, Laboratory Company	4/20/90	Interstate travel in aid of racketeering

COMPREHENSIVE PERINATAL CARE PROGRAM

The OIG conducted a study to assess the initial implementation of the Comprehensive Perinatal Care program (CPCP), which provides supplemental funds to community and migrant health centers for services aimed at reducing infant mortality. The OIG found that PHS has approved CPCP grants consistent with the purposes of this special initiative to reduce infant mortality. The PHS has begun gathering basic information from grantees to assess CPCP services. However, in

some cases, PHS has had limited information on how grantees planned to spend CPCP funds. Further, many areas of the country with high rates of infant mortality have not been receiving CPCP funds.

The OIG recommended that PHS improve its grant approval process to assure adequate accountability for CPCP funds, and strengthen its technical assistance to community and migrant health centers so that more of them apply for CPCP funds with high quality grant proposals. The OIG also urged PHS to reexamine its approach for allocating CPCP funds to assure that these funds are targeted to areas of greatest need. The PHS concurred with the recommendations. (OEI-01-90-00460)

FDA MEDICAL DEVICE REGULATION

In 1976, Congress passed the Medical Device Amendments to the Food, Drug and Cosmetic Act to provide a comprehensive set of regulatory controls for the marketing of medical devices. The OIG conducted a study to describe FDA's regulatory process for selected medical devices that have been recalled, and to identify vulnerabilities and strengths in the system.

The OIG found that FDA is unable to meet all of its regulatory responsibilities, primarily because of limited resources. The medical device reporting (MDR) regulation is unclear and some regulatory actions take too much time to process and implement, limiting FDA's enforcement ability. The OIG recommended that FDA develop alternative strategies, such as charging user fees, to obtain the resources necessary to meet all of its regulatory requirements; clarify the MDR regulation; and seek legislative authority to impose civil monetary penalties and initiate recalls. The findings and recommendations in this report were presented in congressional testimony in July 1990. This information was instrumental in developing and enacting certain provisions of the Safe Medical Devices Act of 1990, including those authorizing FDA to initiate recalls, requiring manufacturers to report recalls and imposing civil monetary penalties. (OEI-09-90-00040)

REGULATION OF HEMOPERFUSION MEDICAL DEVICES

An OIG review conducted for the Chairman, Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce, focused on whether FDA used appropriate procedures to review the medical device premarket notification submissions made by two competing companies. A research and development corporation had charged FDA with impropriety in its premarket review of the corporation's new hemoperfusion medical device and that of its competitor. Hemoperfusion devices are used to cleanse the blood of foreign matter, such as metals and drugs. The OIG determined that the corporation's specific allegations were unsubstantiated. However, OIG found that FDA had failed to: follow up on problems noted during a facility inspection of the corporation's competitor; respond to each of the corporation's complaints in a timely and complete manner; and account for the number and disposition of

photocopies made of the corporation's premarket submission documents containing sensitive, proprietary data. The OIG proposed several steps to be taken to address the weaknesses identified. The PHS agreed with all of the recommendations and stated that it plans to take appropriate corrective actions. (CIN: A-15-90-00043)

HEALTH EDUCATION ASSISTANCE LOANS

As a result of departmental concerns about the financial stability of the Health Education Assistance Loan (HEAL) program, OIG examined the effectiveness of recent regulatory reforms in the program and the possible effectiveness of further reforms, specifically performance standards and risk-sharing. The PHS has projected that the Student Loan Insurance Fund will not have sufficient funds to pay the increasing number of claims.

Regulatory reforms already in place include entrance and exit conferences, needs analysis, lender-conducted credit checks and litigation after collection efforts fail. Schools and lenders generally support the existing reforms and have noted some changes, such as reduction in the numbers of high risk borrowers, smaller loan requests from students and increased collections due to the threat of litigation. However, they all indicate that it is too soon to judge the overall impact of the recent reforms. Both schools and lenders agreed that performance standards would be effective, although almost all of them opposed their use. The OIG recommended and PHS agreed that performance standards should be implemented without delay. The PHS believes that the final rule implementing performance standards will be issued in the fall of 1991. (OEI-02-90-00980)

COPING WITH TWIN DISASTERS

The OIG conducted an inspection to evaluate the Department's response to Hurricane Hugo and the Loma Prieta earthquake, and to identify ways to improve response efforts in the event of future disasters. In major disasters, PHS is the lead agency to provide emergency medical and health services under the overall direction of the Federal Emergency Management Agency (FEMA). The OIG determined that the Department responded promptly and appropriately to the earthquake and the hurricane to restore program operations and provide direct disaster relief. However, OIG found that the Department did not have clearly defined, up-to-date plans for restoring programs in future disasters. The Department also experienced internal communication problems as well as communication and coordination problems with FEMA; and had inadequate arrangements for funding disaster response activities. The OIG recommended that the Office of the Secretary and PHS clarify HHS disaster recovery roles and responsibilities; issue guidelines to improve disaster planning; establish backup communication systems and regional command posts; and improve procedures to pay for disaster relief expenditures. The PHS is taking action to implement the recommendations. (OEI-09-90-01040)

QUALITY ASSURANCE ACTIVITIES IN THE UNITED STATES AND CANADA

In both the United States (U.S.) and Canada, medical licensure authorities are directing their attention to preventive quality assurance activities focused on licensed physicians. These preventive efforts are intended to minimize the need for disciplinary action. They involve initiatives to identify physicians who have knowledge, skill or practice deficiencies, or to offer educational opportunities to physicians in order to correct such deficiencies or to prevent their emergence. These measures are fueled by a heightened concern for continued competency assessment, and an increased awareness of the costs associated with a strictly punitive approach to addressing poor medical practice. In Canada, the Provincial Colleges of Physicians and Surgeons regularly employ quality assurance mechanisms which are not being used by their U.S. counterparts, including mortality reviews and random audits of physicians' practices. State medical boards in the U.S., with the guidance and support of their State legislatures, can choose to complement their licensure and discipline activities with a full array of preventive initiatives. The OIG recommended that PHS provide demonstration funding to State medical boards on using random practice audits as preventive, quality assurance measures. This report and OIG congressional testimony in June 1990 were instrumental in legislative changes requiring peer review organizations to notify State boards when a physician has committed a sanctionable offense and when a physician has been terminated, suspended or sanctioned by Medicaid. (OEI-01-89-00561)

NATIONAL PRACTITIONER DATA BANK

Information maintained by the National Practitioner Data Bank is confidential and cannot be disclosed outside the Department except as specified in the Data Bank regulations. Because the term "authorized agent" is not defined in statute or regulation, it is possible that an authorized agent could be a credential verification business, employment agency, physician recruiter, etc. The policy for registration of these agents does not assure that they are reputable or responsible. In order to strengthen controls over the use of authorized agents, PHS should consider requiring such agents to meet certain conditions. If a company or organization, the agent should be incorporated, licensed or otherwise legally permitted by a State to do business. The proposed agent should possess secure storage facilities and have procedures in place to ensure meeting confidentiality practices. There should be a certification from the health care entity that it has supplied the authorized agent with a copy of the regulation and guidelines relating to the disclosure of Data Bank information. (OEI-12-90-00530)

IHS CONTRACTING PRACTICES

The OIG conducted a follow-up review to assess actions taken to correct contracting deficiencies identified in a previous audit at IHS' Oklahoma City Area Office (OCAO). The OIG concluded that while certain improvements had been made, these improvements did not provide the necessary assurance that Federal funds were being properly spent, that Federal property was

being properly accounted for or that intended health care services were being furnished to the Indian people.

The OIG recommended that IHS implement post-award monitoring of contract compliance and document all contract compliance evaluations; establish post-award monitoring performance standards for all project officers; establish a process to ensure that project officers are provided with evaluations and data on a contractor's performance; establish a process for the review and approval of public vouchers by the project officer; provide additional staffing for closing completed contracts; and assess and address the staffing problems in the OCAO. The PHS concurred with all of OIG's proposals. At the conclusion of the audit, OCAO officials began to take positive steps to address the recommendations. (CIN: A-06-89-00066)

CONTRACT PRE-AWARD AUDITS: FY 1989

The OIG prepared a summary of its findings with respect to the PHS contract pre-award reviews conducted by the Office of Audit Services (OAS) in FY 1989. The OIG's examination disclosed that a majority of the proposals reviewed contained overstated projected costs, which totaled approximately \$47 million. In addition, OIG found that, in those cases where pre-award reports had been resolved, PHS had sustained the preponderance of OIG's findings.

While OIG found that the efforts of PHS and OAS in the pre-award process resulted in considerable savings to the Department, the number of proposals reviewed prior to the issuance of an award was relatively small considering the total number of awards made by PHS in 1989. The OIG concluded that additional benefits could accrue to PHS programs if more proposals were subject to pre-award evaluation, and recommended that PHS consider increasing the number of proposals to be reviewed by OAS. The PHS concurred fully. (CIN: A-02-90-02505)

COMMUNITY BASED ORGANIZATION PROJECTS FOR HIV PREVENTION

In FY 1989, in accordance with a request from CDC, OIG performed a total of 66 recipient capability audits of community based organizations (CBOs) nationwide. The audits involved potential awards of approximately \$9.9 million authorized by the Congress to provide technical assistance to minority CBOs to work with their communities to achieve a decrease in the risk of HIV transmission. The audits were intended to reduce the chance of awarding funds to inexperienced or incapable organizations.

The OIG found basic accounting and internal control deficiencies at most of the 66 organizations that were examined. Based on OIG's findings, CDC awarded funds to 59 CBOs, denied funding to 6 CBOs, and awarded over \$1 million to other, more capable organizations. A seventh CBO was not funded due to lack of additional funds. The CDC classified 14 of the 59 CBOs funded as "exceptional organizations," thus requiring them to comply with the rules for organizations with

poor program or business management practices. The CDC placed all 59 CBOs under the Department's advancement ceiling plan, under which the CBOs are required to submit monthly disbursement reports to CDC for review. (CIN: A-04-89-00122)

LIFE-SAVERS FOUNDATION OF AMERICA

The OIG conducted a review at Life-Savers Foundation of America, Inc. (Life-Savers) pursuant to a request by several members of the Congress. The National Marrow Donor Program, Inc. (NMDP), an organizational component of the American Red Cross until October 1990, provided OIG with a total of 14 allegations made by patients and organizations against Life-Savers related to accounting and payment issues.

The OIG review disclosed that none of the five principal allegations were substantiated. The OIG found that Life-Savers: has generally maintained complete and accurate account records; reasonably sought a judicial interpretation of whether the transfer of certain funds was proper; received tax-deductible contributions from the public and foundations, and used these funds to assist patients in recruiting donors; acted in accordance with guidelines established by the NMDP and Life-Savers when it refused to pay for laboratory tests which would benefit an individual patient or test ineligible donors; used a uniform fee to allocate costs to recruitment drives; and accumulated extra capital which was available to expand the registry. (CIN:A-09-90-00156)

REIMBURSEMENTS FOR COMMISSIONED CORPS DETAILEES

In a review of reimbursements for PHS Commissioned Corps detailees, OIG found that the Department is not sufficiently charging other Federal and nonfederal agencies for the full cost of the Commissioned Corps officers assigned or detailed to them. The audit report presents opportunities for the recovery of all appropriate costs associated with Commissioned Corps officers detailed outside the Department. The OIG found that HHS did not recover about \$12 million of the \$49 million in costs related to Commissioned Corps officers detailed outside the Department for Calendar Year 1988. The OIG recommended that HHS require PHS to revise its policies and procedures to require recovery of all appropriate costs from other agencies for services provided by these detailees, and charge recipient Federal and nonfederal agencies all appropriate costs for these services. The Department agreed to recover all appropriate costs if necessary legislative action is taken. (CIN: A-15-89-00002)

COMMISSIONED CORPS IDENTIFICATION CARDS

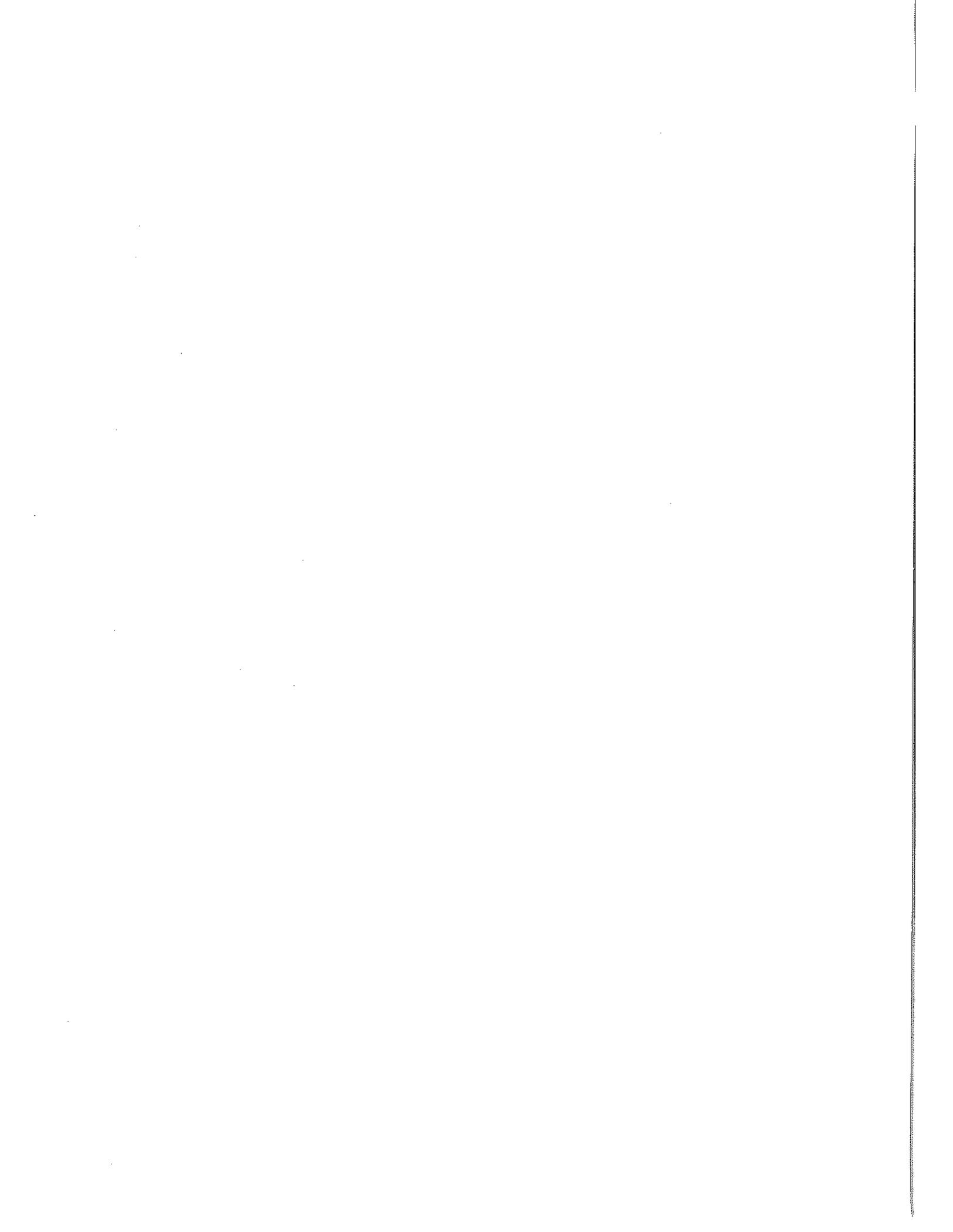
In a review of the internal controls over the issuance of Commissioned Corps identification cards in the Dallas Region, OIG found that a PHS clerk was able to fraudulently issue a card to a minor so he could gain entrance to an establishment requiring proof of age. Moreover, seven other identification cards for which the clerk was responsible were missing. Commissioned Corps identification cards may be used to gain access to commissaries and other military facilities, as

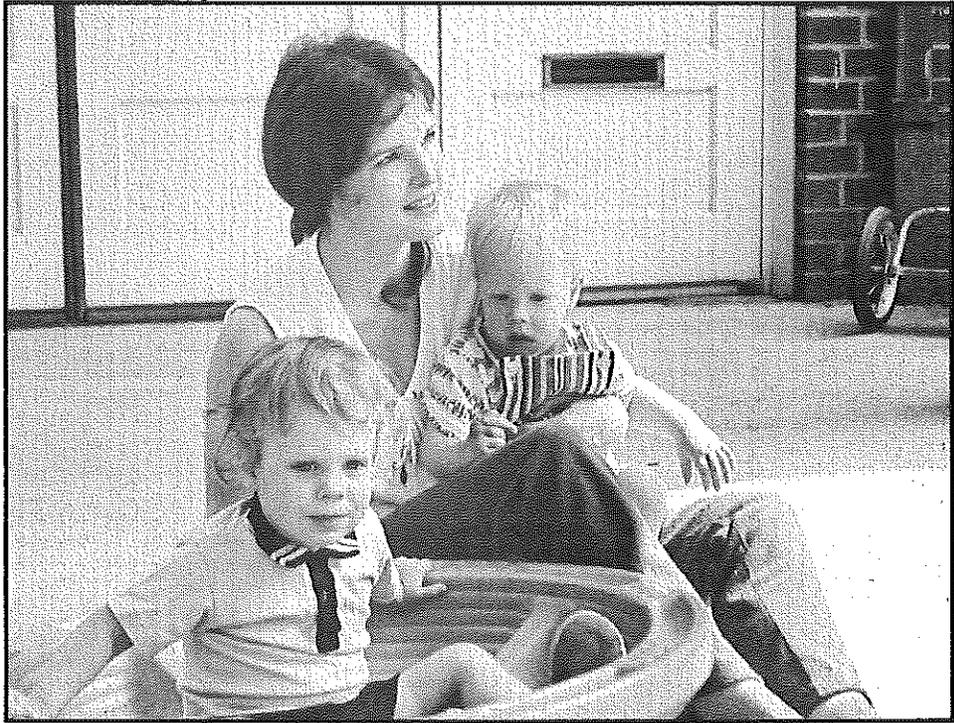
well as other military benefits. The PHS acknowledged that there have been no internal control reviews, as required by FMFIA, that encompassed the issuance of Commissioned Corps identification cards. A review scheduled for FY 1991 had been postponed until FY 1993 because of other priorities. Given the above noted fraudulent activity, OIG recommended that PHS immediately conduct reviews of its controls over the issuance of Commissioned Corps identification cards. The PHS advised that remedial and disciplinary actions had been taken in the case involving fraud, and that in view of those actions, PHS planned to hold to its previously established schedule for reviewing the identification card issuance process. The OIG continues to believe that the internal control review should be conducted in FY 1991. (CIN: A-15-91-00010)

HOSPITAL-RELATED FRAUD

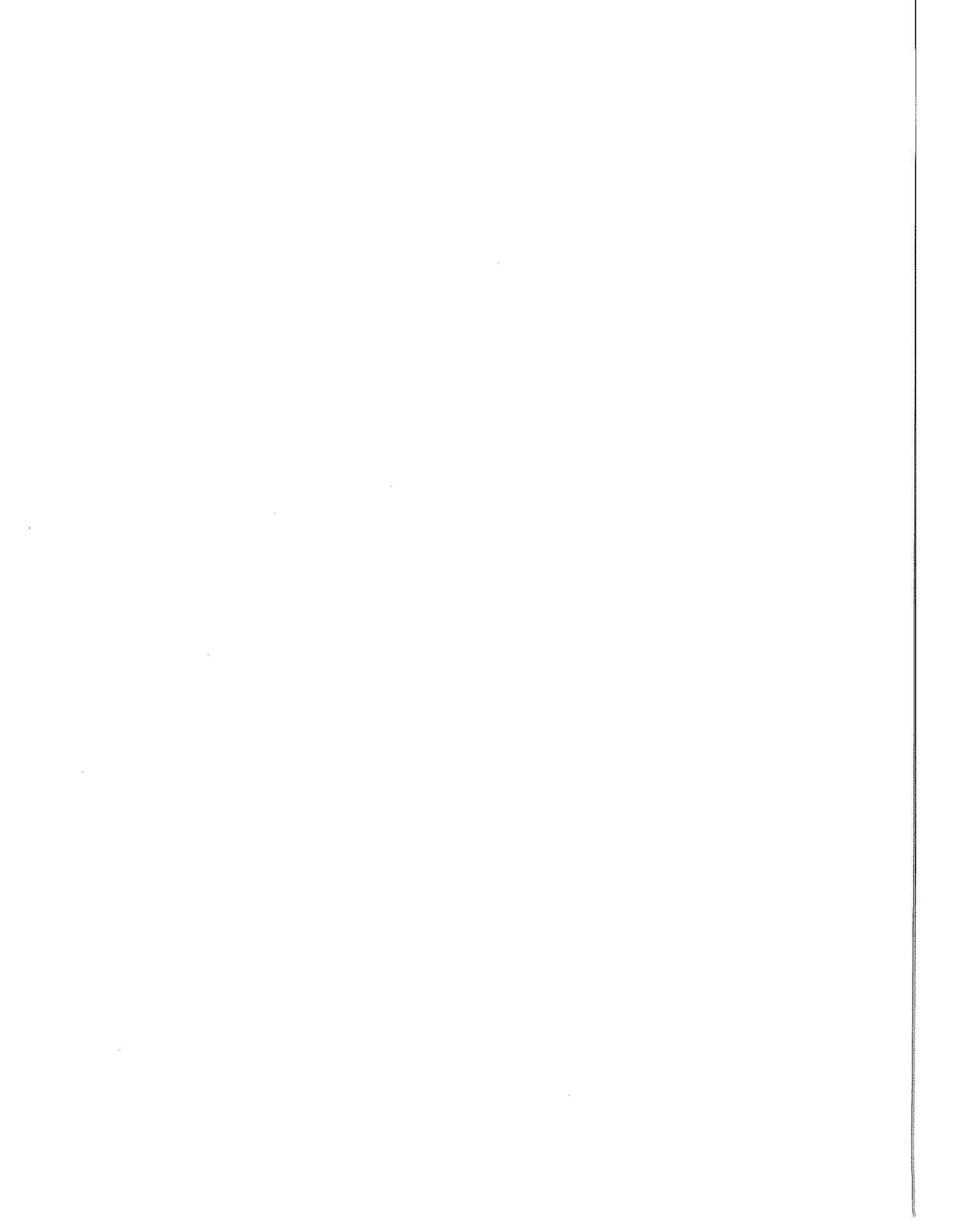
In two instances, employees of hospitals supported by PHS or IHS funds were convicted of abusing their positions in handling hospital funds:

- The purchasing agent of a community health center in Mississippi which was supported by PHS funds was sentenced to a year and a day in prison for his part in a kickback scheme. He made out checks totaling more than \$500,000 to two companies for supplies, most of which were never delivered. The company owners paid the agent kickbacks from the checks and pocketed the remainder. The father and son who owned the companies were also sentenced to a year and a day incarceration and ordered to pay \$175,200 in fines and restitutions.
- The former head cashier of an IHS hospital in Oklahoma was given a suspended sentence for embezzling hospital funds. He was ordered to pay restitution of \$5,210 and serve 3 years probation and 160 hours of community service.





**FAMILY
SUPPORT
ADMINISTRATION**



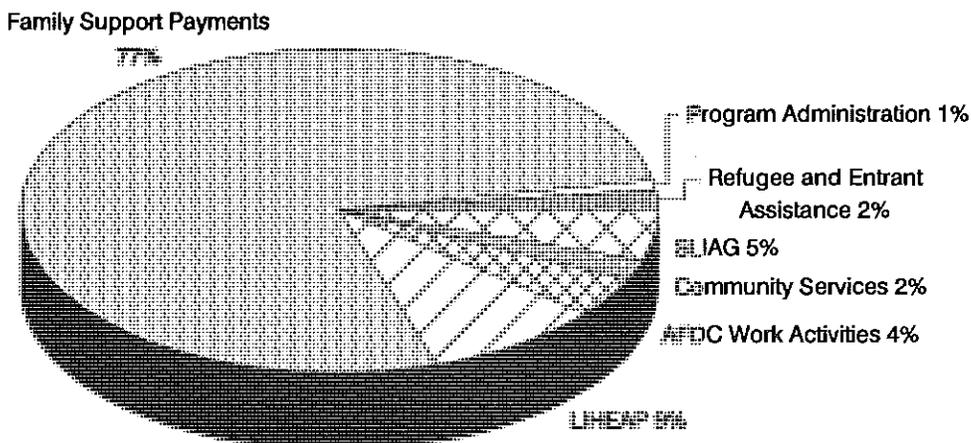
CHAPTER V

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 4.3 million families consisting of 12.4 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 low income households, including recipients of AFDC, food stamps and Supplemental Security Income. Other programs include Emergency Assistance, Refugee and Entrant Assistance, Community Services, and Job Opportunities and Basic Skills Training (JOBS). 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 \$18.3 billion for Fiscal Year (FY) 1991.

DISTRIBUTION OF FSA RESOURCES (FSA 1991 Budget \$18.3 Billion)



The Office of Inspector General (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.

Future OIG work in this area will focus on JOBS implementation, child support enforcement activities and implementation of the Child Care Development Block Grant. Specific areas of work include: a survey of States to describe how they measure and collect outcome information for JOBS; an assessment of how States are implementing transitional medical assistance for JOBS participants; a study of the effectiveness of State wage withholding and waivers for child support payments; and a survey of State policy, procedures and service delivery under the Child Care Development Block Grant.

INTERNAL CONTROL WEAKNESSES

- The Department's 1990 Federal Managers' Financial Integrity Act (FMFIA) report discussed a material weakness concerning the lack of established policies, procedures and administrative controls in the management of discretionary grants. During this reporting period, OIG issued reports relating to grantees in FSA's economic development, community food and nutrition, and rural housing and rural facilities programs. (Multiple CINs) (See page 69)

- The Department's 1990 FMFIA report discussed a material weakness related to a backlog of low income energy assistance program compliance issues which inhibit FSA's ability to ensure that grantees are complying with policies and using funds in accordance with specified requirements. In an OIG review of this program in four States for this reporting period, over 90 percent of the sampled funds provided to tenants in subsidized housing were found to duplicate benefits provided by the Department of Housing and Urban Development and the Farmers' Home Administration. (CIN: A-04-90-00005) (See page 68)

LIHEAP FUNDS

The OIG concluded that an opportunity exists to better utilize a portion of the estimated \$145 million in LIHEAP funds paid to recipients living in federally subsidized housing. An OIG audit disclosed that some LIHEAP funds were not being used effectively because they often duplicated

other Federal energy assistance received through Department of Housing and Urban Development or Farmers' Home Administration programs. Current legislation does not specifically permit States to consider other energy assistance in determining LIHEAP benefits, although some States currently do so. Other States have been prohibited from doing so by court action or the threat of court action. The OIG recommended that FSA continue its efforts to seek a legislative change to explicitly permit States the option of considering subsidized housing energy benefits in determining LIHEAP awards. (CIN: A-04-90-00005)

CASH MANAGEMENT BY STATE CHILD SUPPORT AGENCIES

The OIG and the Office of Child Support Enforcement (OCSE) performed a joint review of cash management practices in 21 States which identified significant control weaknesses over the handling of cash. Problems identified included: interest and other income not offset against child support expenditures; inadequate controls for handling unidentified payments; collections deposited late and/or in noninterest-bearing accounts; and undistributable/unidentified collections inadequately allocated between the Federal and State Governments. The deficiency in States' management of cash was reported as a material weakness in the Department's 1990 FMFIA report. Audit reports have been issued to the individual States involved. In response to the identified need to work with States to improve controls over the handling of funds, OCSE issued an information memorandum to the child support community which discussed frequently cited problems in internal funds control with actions recommended to overcome them. (CIN: A-12-90-00015)

COMMUNITY SERVICES DISCRETIONARY GRANTS

A. Mexican American Unity Council

The OIG audited two Office of Community Services (OCS) discretionary grants awarded to Mexican American Unity Council, Inc. (MAUC) to determine whether grant funds were properly utilized, grant matching requirements were met and program objectives were accomplished. The audit disclosed significant deficiencies for both grants in MAUC's oversight of compliance with the grant objectives and its management of the grant funds. The OIG recommended that MAUC refund nearly \$1.6 million. The OIG also recommended that for any future Federal grants, MAUC ensure that grant goals are met and documented; its accounting system provides better control over Federal funds; requests for grant advances are limited to the Federal share of estimated monthly outlays for each specific project; and reported expenditures relate to the funded grant program. The MAUC agreed with the procedural findings and recommendations, but disagreed with the need for the suggested financial adjustment. However, MAUC provided no additional documentation or information which would cause OIG to alter its recommendations. (CIN: A-06-90-00052)

B. Mora Economic Self-Development Cooperative

The OIG audited a grant of over \$48,000 awarded to the Mora Economic Self-Development Cooperative for a 1-year period ending September 29, 1988. The primary grant objectives were to train and provide new jobs in supermarket retailing to 30 young low-income individuals, and to increase supermarket sales. The grantee contracted with the owner of a supermarket to accomplish these goals. The OIG found that the primary grant objectives were not fully accomplished. The contractor provided training to only 22 individuals, of whom 10 were current or former employees. In addition, the market could not increase sales and was therefore unable to provide the 30 new jobs proposed. The OIG recommended that nearly \$11,000 of grant payroll expenditures relating to the training of current and former supermarket employees be returned to the Government. The grantee agreed that grant objectives were not fully met, but disagreed as to the need to return the \$11,000. (CIN: A-06-90-00062)

C. Community Food and Nutrition Grantees

Performance Indicator

The OIG conducted a review of 13 grantees funded under OCS's community food and nutrition discretionary grant program. The objectives of the review were to determine whether the grantees accomplished project objectives, complied with the terms and conditions of the grants, and properly accounted for and utilized OCS grant funds and property. The audits disclosed that seven grantees did not fully accomplish one or more of their major program objectives; two did not have controls in place to ensure that funds were used to serve low-income people; seven grantees claimed \$59,900 in costs that were not allowed, with nearly \$46,000 set aside for OCS determination; six grantees did not comply with reporting requirements; and nine had other management deficiencies in the grant. The OIG recommended that the grantees refund \$59,900 of costs questioned and that OCS make determinations on the acceptability of the \$46,000 set aside. (CIN: A-01-90-02513; CIN: A-02-90-02015; CIN: A-02-90-02016; CIN: A-03-90-03330; CIN: A-04-90-00016; CIN: A-04-90-00017; CIN: A-05-90-00093; CIN: A-05-90-00096; CIN: A-06-90-00079; CIN: A-07-90-00314; CIN: A-07-90-00316; CIN: A-09-90-00101; CIN: A-09-90-00103)

D. Rural Housing and Rural Facilities Grantees

Performance Indicator

The OIG conducted reviews of 18 grantees funded under OCS's rural housing and rural facilities discretionary grant program. The OIG found that seven of the grantees could not demonstrate accomplishment of one or more of their major program objectives. In addition, 14 of the grantees failed to meet matching requirements; expend grant funds for allowable program activity; account properly for grant funds and property; and provide accurate and timely technical and financial reports. The OIG recommended that the grantees refund over \$355,000 of costs questioned, and make procedural changes. (CIN: A-01-90-02506; CIN: A-01-90-02507; CIN: A-03-90-03327; CIN: A-04-90-00006; CIN: A-04-90-00004; CIN: A-05-90-00042; CIN: A-05-90-00043; CIN: A-05-90-00044; CIN: A-05-90-00045; CIN: A-05-90-00046; CIN: A-06-91-00035; CIN: A-06-90-00027; CIN: A-06-90-00022; CIN: A-07-90-00279; CIN: A-09-90-00056; CIN: A-09-90-00055; CIN: A-09-90-00075; CIN: A-09-90-00009)

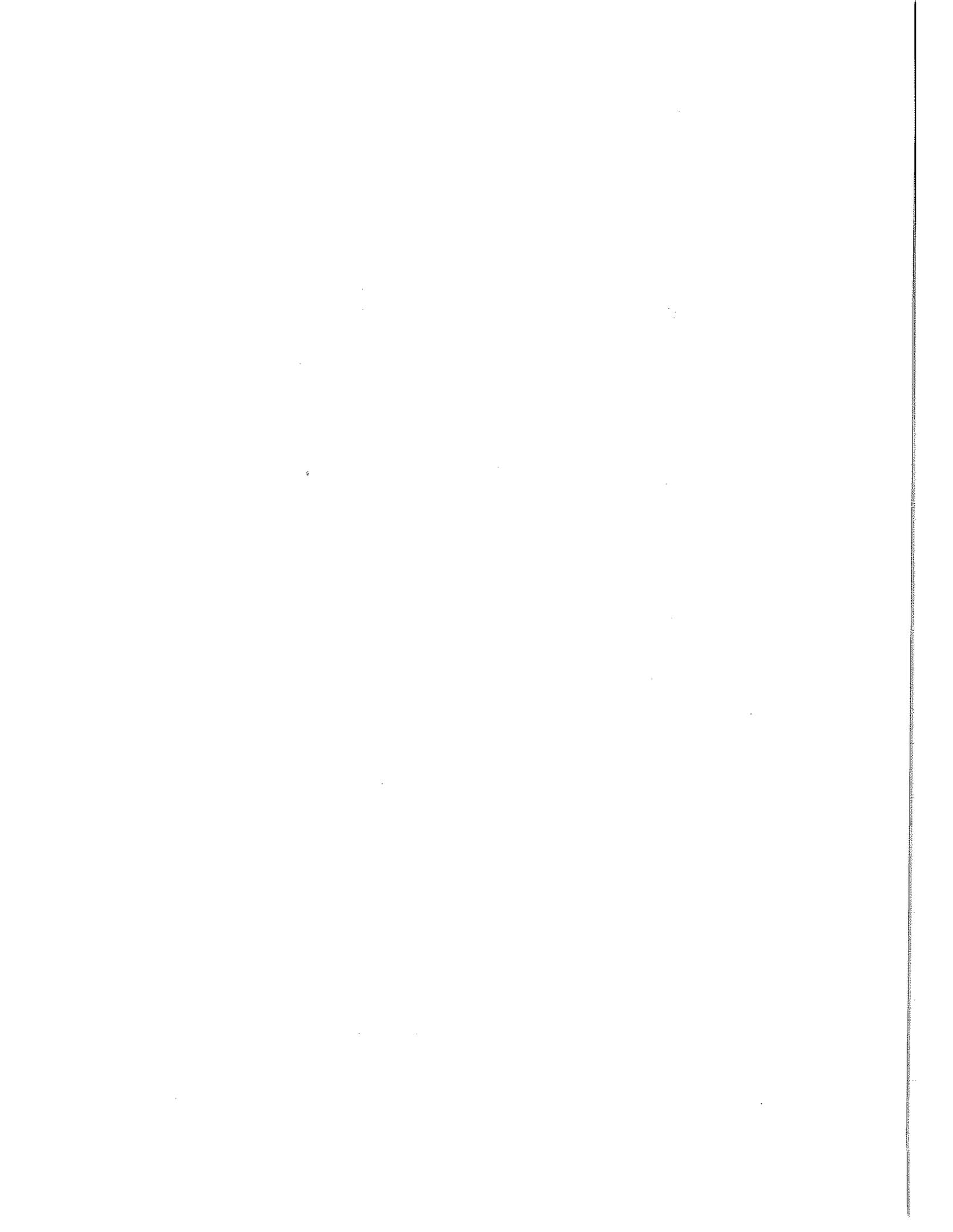
CONTROL OF AFDC OVERPAYMENTS: CONNECTICUT

An OIG audit revealed that Connecticut's reporting of AFDC overpayment balances was inaccurate. The State's quarterly report for September 30, 1989 indicated an outstanding balance of AFDC overpayments of \$2.4 million. The OIG found that the actual amount outstanding as of this date was \$29 million. In addition, the processing of \$12 million in potential overpayments at the State's district offices was delayed; outstanding overpayments to former AFDC recipients were not being recovered; \$5.6 million in outstanding overpayments to current AFDC recipients was not being recovered through reductions of their grant awards; and the identification of \$4.5 million in overpayments outstanding for 5 years or more was precluded. The OIG recommended that the State take steps to improve its overpayment processing systems to adequately monitor and control recovery of AFDC overpayments. Further, OIG recommended that the State establish a policy as to how long an account should be maintained on file before it is considered uncollectible for Federal reporting purposes. The State agreed with the findings. (CIN: A-01-90-02505)

AFDC FRAUD

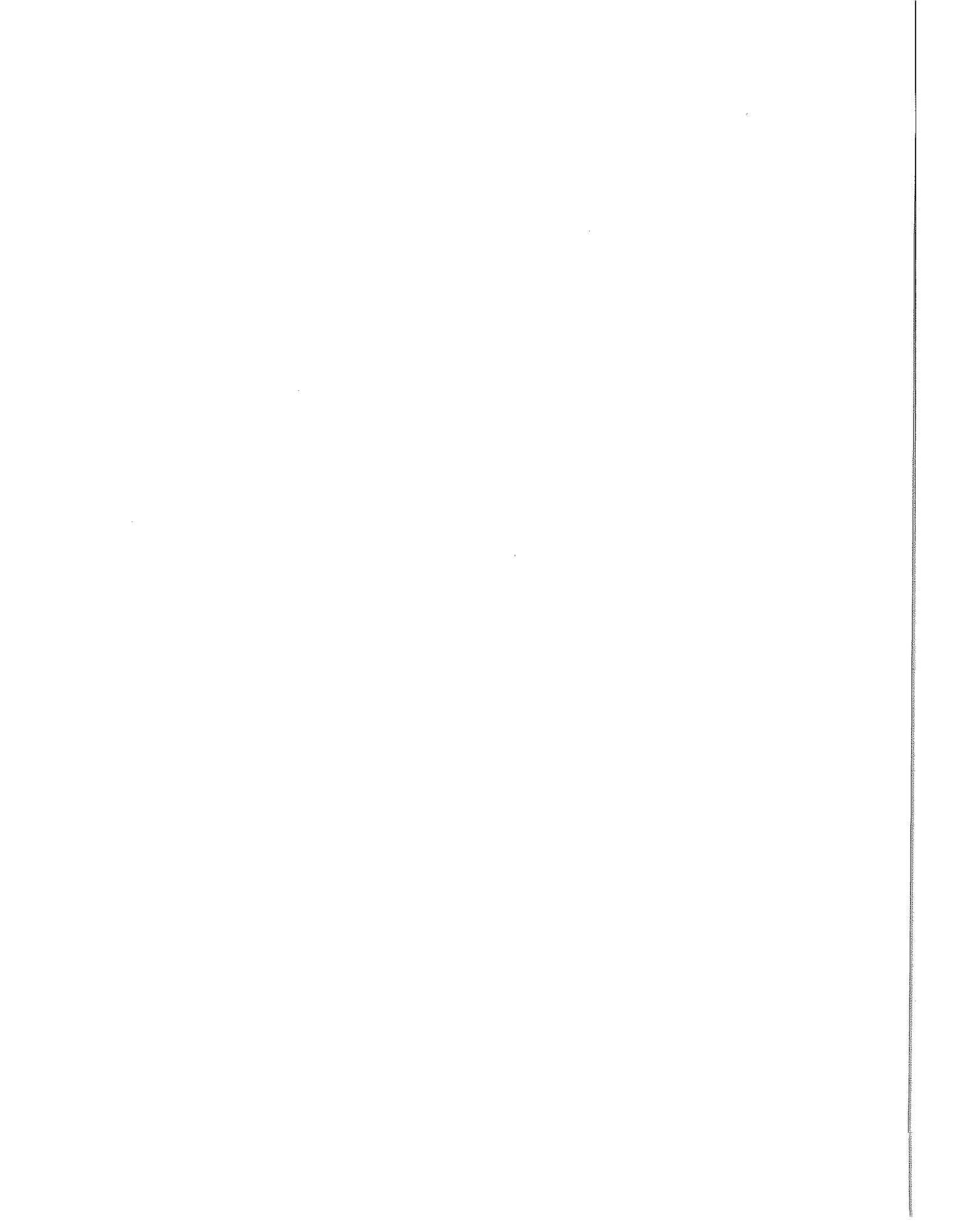
Welfare assistance provided under the AFDC, Medicaid and food stamp programs is based on State determinations of eligibility. As a result, welfare fraud is usually perpetrated by making false claims about one's circumstances, such as claiming a nonexistent dependent child or concealing income which would 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. The following cases are examples of successful OIG investigations during this period:

- A Pennsylvania man who used homeless people in a welfare scheme was sentenced to 2 to 4 years in jail and ordered to pay restitution of \$50,000. After four people testified that he gave them fraudulent birth certificates with which they got Social Security numbers (SSNs) and set up 30 welfare accounts, he pled guilty to theft, conspiracy, forgery and fraud. The man would drive the homeless persons to welfare offices where they received and cashed checks and got food stamps. He then gave them a little money and kept the rest and the stamps for himself.
- In Massachusetts, three women and three men were convicted for welfare fraud. One woman was sentenced to jail for 5 years, two men for 2 1/2 years and the other man for 2 years. A total of \$105,000 was ordered in fines and restitutions. They were the last of eight persons sentenced for a 5-year scheme in which phony identities were created with fraudulent birth certificates and false SSNs to obtain \$275,000 in benefits under the AFDC program.





**OFFICE OF
HUMAN
DEVELOPMENT
SERVICES**



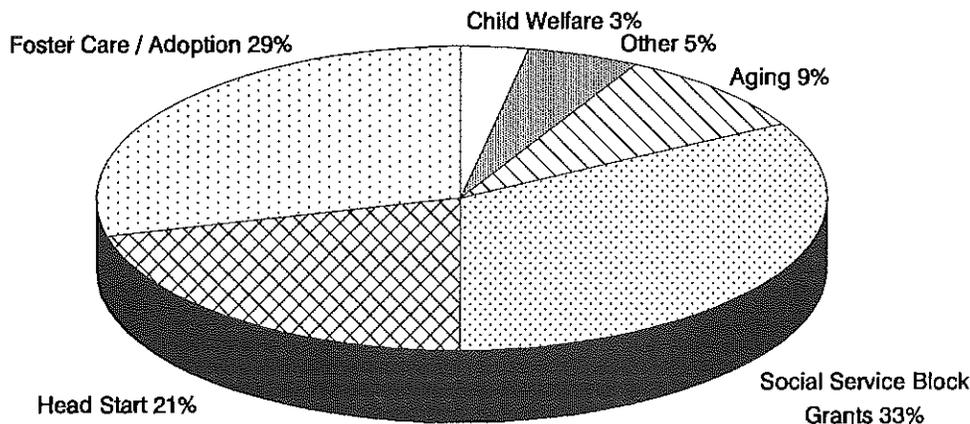
CHAPTER VI

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, persons with developmental disabilities, older Americans and Native Americans. Head Start is a \$1.9 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 be approximately \$8.4 billion for Fiscal Year (FY) 1991.

DISTRIBUTION OF HDS RESOURCES (FY 1991 Budget \$8.4 Billion)



STATE AND LOCAL PERSPECTIVES ON THE MCKINNEY ACT

The Stewart B. McKinney Act (McKinney) constitutes the major Federal response to homelessness. McKinney's 17 programs are funded by 6 Federal agencies and address needs ranging from emergency food and shelter to education and job training. In response to a request from the Interagency Council on the Homeless, OIG conducted a study to obtain State and local perspectives on the impact of the McKinney Act in their efforts to combat homelessness. In a companion report, OIG looked at homeless prevention programs to determine their effectiveness. The OIG found that while McKinney has enhanced communication at both the State and local levels, few understand the various McKinney programs or how they fit together. McKinney has helped meet emergency needs, but has not provided long term solutions to homelessness. The OIG also found that although homelessness prevention programs help keep families in their homes, these programs assist only a small portion of the needy.

The OIG recommended that the Federal Government structure McKinney to facilitate more comprehensive and integrated services; improve coordination at the State and local levels to reduce fragmentation, enhance planning and simplify funding; promote homeless prevention programs as an effective approach to reducing homelessness for families; strengthen accountability and oversight at Federal, State and local levels; and identify and implement ways to assist the homeless through traditional Federal programs. (OEI-05-90-01090; OEI-07-90-00100)

BARRIERS TO FREEING CHILDREN FOR ADOPTION

Performance Indicator

The Adoption Assistance and Child Welfare Act of 1980 introduced broad reforms in the Federal funding and regulation of State foster care services. For those children who cannot return to their families, agencies are encouraged to investigate other options which offer the children a stable family relationship. Adoption is the preferred method for most children who cannot return home. The OIG conducted a study to identify problems in the process of terminating parental rights that delay or prevent children from leaving foster care and entering permanent adoptive homes. Seventy-five percent of the respondents in the State survey indicated that the inability of child welfare agencies to meet "reasonable effort" requirements to reunite children with families is the primary barrier to implementing permanent adoption plans. Few States have defined what constitutes "reasonable efforts," making it difficult for State agencies to determine the legally adequate level of help they must provide in order to guarantee that parental rights due process have been met. Some States have developed initiatives to improve the timeliness and effectiveness of their termination of parental rights processes.

Among other things, OIG recommended that States mandate by statute well-defined, expedited tracks for freeing children who will clearly not return home in a reasonable period and clearly define time and service requirements for "reasonable efforts." The Administration for Children, Youth and Families (ACYF) should disseminate information on permanency planning training

and effective practices for implementing permanency plans, and through the Department's discretionary funding authority provide seed monies for implementation of treatment programs that deal with current family issues. The ACYF should also move quickly to complete and implement the national child welfare data base which would provide administrators with information on programs, policies and common problems in assisting families and children who require foster care services. (OEI-06-89-01640)

HEAD START

Head Start is a national program providing comprehensive developmental services primarily to low-income preschool children and their families. The Secretary's FY 1991 budget includes the largest single program increase in the history of the Head Start program (\$400 million), a key component in achieving the readiness of all children to start school.

A. Automated Management Information Systems

The OIG review of the automated management information systems employed by HDS revealed that the data maintained is incomplete and inaccurate, partly due to deficiencies in the information collected. This problem raises concerns as to the system's usefulness to program officials in evaluating program performance, analyzing costs of operating the program, and making program and administrative decisions. The OIG believes that the magnitude of the deficiencies constitutes a significant management concern in program evaluation and monitoring. The HDS has agreed to report this matter for inclusion in the Secretary's annual Federal Managers' Financial Integrity Act (FMFIA) report.

Additional analyses of data by OIG surfaced other issues with possible cost and program consequences: of all the Head Start grantees, school systems had the lowest cost per child per year; HDS procedures for reviewing budgeted administrative costs were inconsistent and, in some instances, inadequate; there was no apparent correlation between the age of an agency's accounting system and the number of internal control deficiencies within the system; and child to teacher ratios varied from one type agency to the next.

The OIG recommended that HDS develop a more complete, accurate and uniform information system. In addition, HDS should: determine if other types of Head Start agencies could participate in the costs of teachers and other costs as school systems do; require that regional reviews of administrative costs be based on itemized listings of budgeted costs; require Head Start agencies to routinely review and upgrade their accounting systems as needed; and ensure that agencies maintain appropriate class sizes when requirements are approved. The HDS generally concurred with the conclusions of the report. (CIN: A-04-90-00012)

B. Performance Evaluation and High Risk Determination

The OIG found that although HDS has established performance standards, it has not developed or implemented procedures necessary to effectively measure the performance of Head Start agencies. The OIG also concluded that HDS has not formalized procedures needed to effectively manage high risk agencies. As a result, \$56 million was awarded to several agencies that remained in high risk status for two or more years, of which approximately \$14 million may have been underutilized. The OIG believes that these deficiencies should be reported for inclusion in the Secretary's FMFIA report.

The OIG recommended that HDS establish and implement procedures needed to assure that: the extent of Head Start agencies' compliance with the performance standards is determined and used as a basis for establishing uniform ratings for all agencies; agencies whose management practices create high risk conditions are uniformly identified; high risk conditions, once identified, are corrected in a timely manner; and high risk agencies that are unable to operate successful Head Start programs are identified and excluded from participation in the program in a timely manner. The HDS generally concurred with the findings but not with the recommendations. (CIN: A-04-90-00009)

C. Self-Assessment

The regulations require each Head Start grantee to conduct an annual self-assessment of its program, but do not provide guidance on how self-assessment should be done. The OIG found that virtually all grantees are conducting self-assessment annually, as required, and that nearly all grantees use the Self Assessment Validation Instrument (SAVI) developed by ACYF for this purpose. The OIG recommended that the SAVI be improved by: elimination of the redundancy in the instrument; simplification of the terms used in the instrument to make it more appropriate for parents and others not familiar with Head Start terminology; and updating of the instrument to keep it current with changes in the program. The ACYF should also provide feedback and technical assistance to grantees when they submit their self-assessment findings, and develop and provide training and technical assistance to grantees on how to improve self-assessment. Further, OIG recommended that grantees provide feedback to self-assessment team members and all staff on the findings and actions resulting from self-assessment, and train team members thoroughly so that each understands his or her responsibility in the process. The HDS was supportive of the findings and recommendations. (OEI-04-89-00790)

INDEPENDENT LIVING PROGRAM

Title IV-E of the Social Security Act authorizes funds to States to assist eligible children in making the transition from foster care to independent living. In a review of the District of Columbia's Independent Living program (ILP), OIG determined that the District had received over \$635,000 in funds for the ILP which had to be spent by September 30, 1989 or be forfeited back to the Federal Government. Nearly \$242,000 in Federal cash was drawn against the award. Of this amount, only about \$12,000 was actually spent. Therefore, the balance of approximately

\$623,000 was forfeit. The OIG recommended that the District strengthen internal controls to ensure that stipends are paid only to eligible ILP participants that attend classes. In addition, OIG proposed that HDS monitor future spending by the District to ensure compliance with all Federal regulations and program requirements. Further, HDS should recover the unspent \$230,000 from the District and deobligate the forfeited \$623,000. The HDS fully concurred with the findings and recommendations. (CIN: A-03-90-00562)

SERVICES INTEGRATION

At HDS' request, OIG conducted two studies on services integration. The first examined 13 innovative services integration initiatives undertaken by public and private agencies for multi-problem inner city families. The second provided an overview of large scale institutional efforts undertaken by the Department over the last 20 years to promote the integrated management and delivery of social services. The OIG found that there are significant barriers to integrating services. Among them are the size and complexity of programs, specialization and bureaucratization, and funding limitations. While Federal initiatives have had little institutional impact, some local projects have succeeded. They have done so through a strong client focus, staff persistence and dedication, and building effective relationships with other agencies. Services integration can be instrumental in making social services more accessible to clients and more responsive to their needs. Both studies found that some degree of central authority and discretionary funding are important to sustain services integration projects. (OEI-09-90-00890; OEI-01-91-00580)

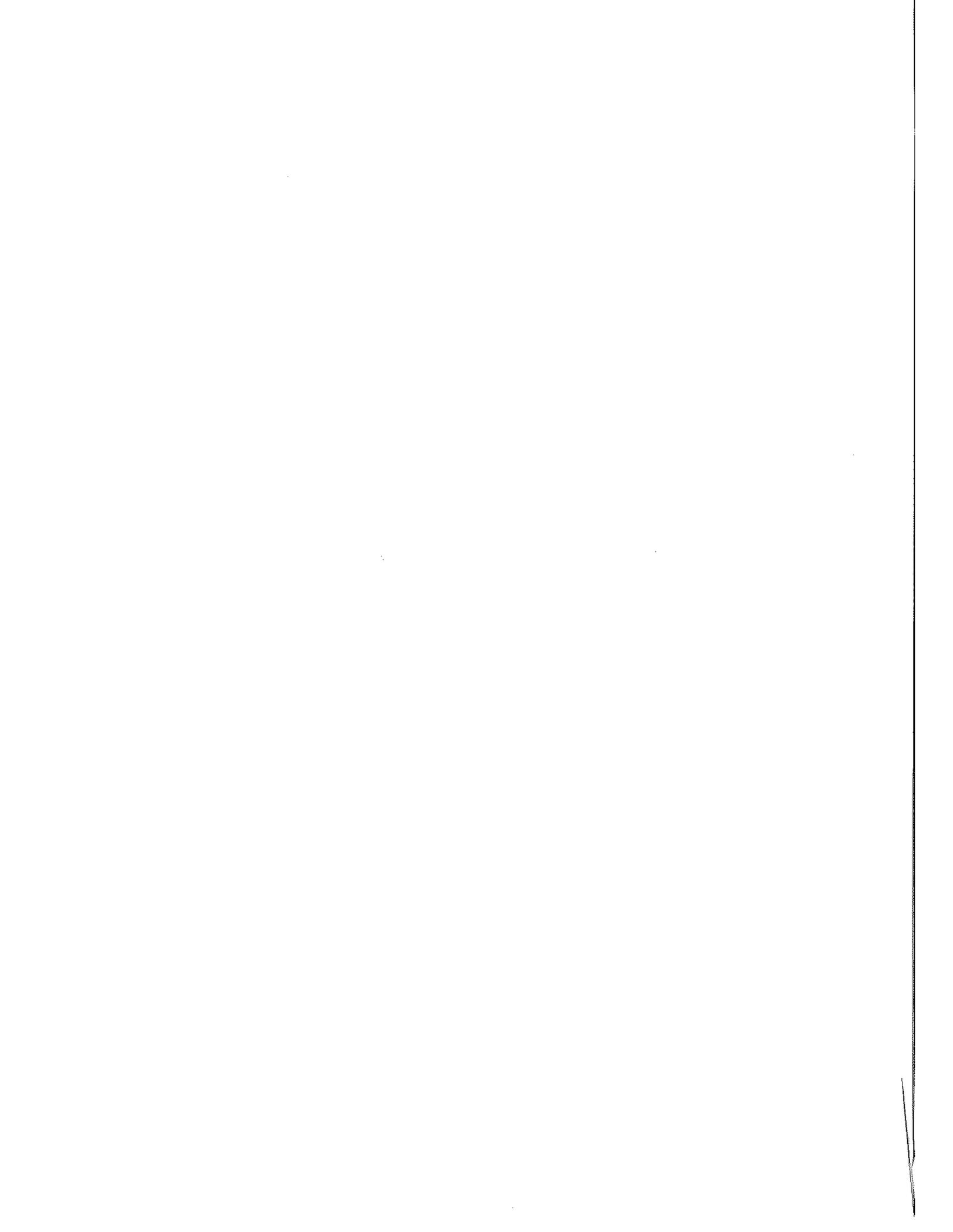
COST-SHARING FOR OLDER AMERICANS

At the request of the Commissioner on Aging, OIG conducted a study to assess the experience of State programs for the elderly which provide in-home and adult day care services on a cost-sharing basis. Under the Older Americans Act of 1965, financial assistance is available to States to develop new or improved social service and nutrition programs for older persons. State and area agencies on aging cannot charge fees for these federally funded services, although the law allows soliciting of contributions from recipients. States, however, are free to charge for services provided through State funding.

For the study, State and local officials in States with and without cost-sharing were interviewed, as were recipients in programs which require them to share costs. The OIG found that most recipients responded positively to cost-sharing, believing that it was fair and appropriate and that the services were worth the cost. State cost-sharing programs were considered to be effective despite limited funding and they appeared to operate efficiently. Officials in States with and without cost-sharing programs were generally in favor of cost-sharing for federally funded adult day care and in-home services. However, they strongly recommended educating the public on the need for and nature of this feature, and proposed exempting those unable to pay. Moreover, they stressed the need for careful planning, and for flexibility and discretion at the State and local

levels in implementing such cost-sharing. The Commissioner on Aging was supportive of the study's findings. (OEI-02-90-01010)

APPENDICES



APPENDIX A

UNIMPLEMENTED OIG RECOMMENDATIONS TO PUT FUNDS TO BETTER USE

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (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	Status	Savings in Millions
Indirect Medical Education:		
Modify Medicare payments to teaching hospitals by reducing the prospective payment system (PPS) adjustment factor. (ACN: 14-52018; ACN: 09-62003; CIN: A-09-87-00100; CIN: A-07-88-00101)	The President's Fiscal Year (FY) 1992 budget and legislative program includes a proposal to reduce the indirect medical education adjustment factor from 7.75 percent to 4.4 percent in FY 1992 and to further reduce the factor in subsequent years.	\$1,045
Discontinue Medicare Payments for Capital Cost Elements:		
Discontinue reimbursing hospitals on a reasonable cost bases for capital-related costs. (ACN: 14-52083)	The Omnibus Budget Reconciliation Act (OBRA) of 1990 provided for some reduction in capital payments. A prospective payment system for capital begins in FY 1991. A notice of proposed rulemaking was published on February 28, 1991.	920
Identify and Recover Medicare Secondary Payer Claims:		
Seek legislation to facilitate the identification and recovery of Medicare secondary payer (MSP) claims. (CIN: A-09-89-00100)	Recent legislation has helped in the MSP area but more work needs to be done.	900
Revise Accounting for Penalties and Interest:		
The Social Security Administration (SSA) should support a legislative change to restore equity to the accounting process by requiring the Internal Revenue Service (IRS) to compensate the trust funds for interest and penalties collected which exceed the cost of IRS' administration of the Social Security tax. (CIN: A-13-86-64640)	Based on information from IRS, SSA does not believe that the current accounting method disadvantages the trust funds. The OIG has requested that the Department of Treasury undertake a study of the current accounting method.	844
Hospital Diagnosis Related Group Rates:		
Rebase Medicare hospital PPS rates to correct for inclusion of overstated operating costs and to take into account hospital profitability. (ACN: 09-62021; CIN: A-08-87-00003; CIN: A-07-88-00111)	Although PPS rates have not been rebased, OBRA 1990 provides for the following update factors for large and other urban hospitals, applicable to payments for discharges occurring on or after January 1, 1991: for FY 1991, the market basket percentage increase minus 2.0 percentage points; for FY 1992, the market basket minus 1.6; and for FY 1993, the market basket minus 1.55.	640

OIG Recommendation	Status	Savings in Millions
Institute and Collect User Fees for Food and Drug Administration Regulations: Extend user fees to various functions performed by the Food and Drug Administration (FDA), possibly including premarket review and approval for drugs and devices. (OEI-12-90-02020)	Various legislative proposals are being considered which would result in the expansion of user fees across FDA functions. The President's FY 1992 budget includes proposals for user fees.	\$587
Extend Secondary Payer Provision: Extend the MSP provision for end-stage renal disease (ESRD) beneficiaries beyond the current 1-year limit to the period of time that ESRD beneficiaries are covered by an employer group health plan (EGHP). (CIN: A-10-86-62016)	The OBRA 1990 provisions partially implemented the OIG recommendation by extending the MSP provision for ESRD beneficiaries covered by an EGHP to 18 months.	503
Clinical Laboratory Tests: Set the Medicare lab fee schedules at amounts comparable to what physicians are paying, and ensure that profile tests are appropriately reimbursed. (CIN: A-09-89-00031)	The OBRA 1990 provisions reduced payments for laboratory tests by limiting the annual fee schedule increase to 2 percent and reducing the national cap to 88 percent.	426
Modify Payment Policy for Medicare Bad Debts: Seek legislative authority to modify bad debt payment policy. (CIN: A-14-90-00339)	The Health Care Financing Administration (HCFA) is considering OIG's recommendation.	400
Medicaid Premium Matching Rates: Eliminate premium matching rates under Medicaid. (ACN: 03-60223)	The proposal was not included in the President's FY 1992 budget and legislative program.	360
Limit Participation in Foster Care Administrative Costs: To contain the rapid increase in State claims for administrative costs in foster care, controls or caps are needed. (CIN: A-07-90-00274)	The President's budget for FY 1992 includes a proposal to limit participation.	340
Recover Retirement, Survivors and Disability Insurance and Supplemental Security Income Benefits through Income Tax Refund Offset: Actively support legislation to allow offset of income tax refunds to recover certain Retirement, Survivors and Disability Insurance (RSDI) overpayments. Take administrative action to recover certain Supplemental Security Income (SSI) overpayments through income tax refunds. (OAI-12-88-01290; OAI-12-86-00065)	The OBRA 1990 grants the legislative authority to recover RSDI overpayments through income tax refund offset. The SSA is in the process of implementing the recommendation. The SSA continues to negotiate with IRS to administratively implement the SSI refund offset by FY 1993.	193.7
Reduce Payments for Intraocular Lenses: Medicare should pay a flat \$150 for all intraocular lenses (IOLs). (OEI-07-89-01664)	The HCFA is currently prohibited by law from reducing the IOL reimbursement rate below the \$200 cap until 1992. However, HCFA agreed to consider a reduction in the IOL reimbursement rate and use the information provided by OIG when they update facility payment rates effective July 1, 1992.	169
Expand Mandatory Tip Reporting Requirements: Expand the requirements for mandatory reporting of tip income to include other types of businesses where tipping is a common practice. (CIN: A-09-89-00072)	The Treasury is conducting an in-house study before considering whether to endorse the proposal.	134

OIG Recommendation	Status	Savings in Millions
Recover Medicare Funds From Terminated Pension Plans: Recover Medicare's share of pension asset reversions from terminated pension plans. (CIN: A-07-90-00262; CIN: A-07-88-00134)	The HCFA is considering submitting a legislative proposal.	\$119
Hospital Admissions: Seek legislation to pay for covered services related to 1-day admissions without an overnight stay as outpatient services at the lower of cost or charges. (CIN: A-05-89-00055)	The HCFA disagreed with the proposal, stating that payments for less than 1-day stays are part of the overall PPS formula which is designed to average out the payments among all Medicare cases.	118
Recover Value Lost to the Trust Funds from Past Due Debts: Institute a policy change to allow recovery for each delinquent overpayment at the higher of the interest income lost to the trust funds or the value lost to the trust funds due to inflation. (OAI-03-88-00680)	The SSA believes that it needs clear statutory authority to take the recommended action. To date, SSA has not taken any action to obtain that authority.	112
Extracorporeal Shock Wave Lithotripsy: Apply inherent reasonableness factors to charges for extracorporeal shock wave lithotripsy (ESWL). (CIN: A-09-89-00082)	Although OBRA 1990 reduced payments for ESWL, these procedures are still overpriced.	110
Conventional Eye Wear: Exclude conventional eye wear from Medicare coverage for beneficiaries receiving IOL implants. (CIN: A-04-88-02038)	The OBRA 1990 limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant.	72
Use Credit Reporting Agencies to Help Collect Debts: The SSA should seek legislative authority to use credit reporting agencies to locate debtors and report certain delinquent debtors to credit reporting agencies. (CIN: A-03-89-02610)	The SSA will assess the utilization of income tax income offset before considering whether to seek authority to use credit reporting agencies.	52.4
Earnings Enforcement: Include late posted earnings in the enforcement operation and recover overpayments not previously detected. (CIN: A-13-89-00031)	The SSA agreed in principle and is evaluating the practical aspects of implementation.	52
Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance: Recoup part of unauthorized Medicare payments made on behalf of the Uniformed Services Treatment Program members. (CIN: A-14-90-00325)	The HCFA agreed to the recommendation. The OIG will verify the effectiveness of HCFA's corrective action plan.	50
Repay Mortgages Early: Use trust fund money to liquidate the remaining mortgage balances on three program service center buildings. (CIN: A-09-88-00131)	The SSA agreed in principle and has reduced the mortgages, but has not committed to paying them off. Full savings cannot be realized until the full mortgages are paid.	48
Inpatient Psychiatric Care Limits: New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045)	The proposal was not included in the President's FY 1992 budget and legislative program.	48

OIG Recommendation	Status	Savings in Millions
<p>Improve Recovery of SSI Overpayments through Cross Program Adjustment: More aggressively pursue cross program adjustment as a means of collecting the outstanding debts owed by former SSI recipients who are current RSDI beneficiaries. Resubmit a legislative proposal authorizing the adjustment of RSDI payments to recover overpayments from former SSI recipients. (OAI-12-87-00029)</p>	<p>This proposal was included in the Department's FY 1992 budget. The OIG continues to believe that cross program adjustment is an appropriate way to recover SSI overpayments.</p>	<p>\$36</p>
<p>Age Attainment: 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-09-89-00073)</p>	<p>The SSA did not concur since it believed administrative costs would outweigh savings and that short term savings would be offset by long range costs.</p>	<p>21.4</p>
<p>Accounting for Payments After Death: Procedures need to be improved in SSA's accounting for payments after death and processing of death terminations. (CIN: A-04-87-03007)</p>	<p>The SSA agreed and OIG expects improvements from SSA's new automated accounts receivable system.</p>	<p>20</p>
<p>Premature Admissions: Minimize premature admissions for Medicaid elective surgeries. (CIN: A-09-86-60213)</p>	<p>The HCFA's issuance of a notice of proposed rulemaking that will address these issues has been delayed until at least July 1993 by Section 4755 of OBRA 1990.</p>	<p>18.5</p>
<p>Tax Equity and Fiscal Reform Act Outpatient Limitation: Expand the list of procedures subject to the Tax Equity and Reform Act outpatient limitation and apply the limitation to physician services in additional settings. (CIN: A-07-86-62041; CIN: A-05-89-00059)</p>	<p>The HCFA has proposed to expand the outpatient limit to include additional settings. However, it has also recommended reducing the percent reduction in payment fees from the current 40 percent to 20 percent in all settings.</p>	<p>16.1</p>
<p>Halt Medicaid Payments for Less than Effective Drugs: Work with FDA to provide to all States periodic lists of less than effective drugs identified by FDA. (CIN: A-03-89-00020)</p>	<p>The OIG is awaiting HCFA's response to the final report.</p>	<p>16</p>
<p>Develop Cost Standards for Disability Determination Services: Formulate disability determination services (DDS) cost-per-case (CPC) standards as quickly as possible and adopt the reimbursement method for lab fees used by Medicare for use by the DDSs. (OAI-06-88-00822)</p>	<p>The SSA plans to develop a CPC standard by 1991. Development of regulations will depend upon experience gained in FY 1991 with issuance of CPC targets in conjunction with productivity-per-work-year based annual planning amounts.</p>	<p>15.3</p>
<p>Arterial Bypass Surgery: Eliminate Medicare coverage of extracranial-intracranial (EC/IC) bypass surgery. (CIN: A-09-87-00005)</p>	<p>The HCFA agrees and is drafting a proposed regulation to withdraw Medicare coverage of certain ineffective EC/IC surgery.</p>	<p>10.7</p>

OIG Recommendation	Status	Savings in Millions
<p>Improve Reclamation Procedures: Deficient Treasury procedures related to reclaiming check payments involving unauthorized endorsements caused losses to the trust funds. The SSA should negotiate with Treasury for more direct involvement in the reclaiming of checks. (CIN: A-04-87-03005)</p>	<p>Several problem areas between SSA and Treasury are still in need of negotiation and resolution, including reclamation.</p>	\$10.5
<p>Modify Earnings Enforcement Process: The SSA should modify its earnings enforcement operation to include late posted earnings reports, suspense reinstatements, and earnings adjustments and corrections. (CIN: A-13-89-00031)</p>	<p>The SSA's automated data processing (ADP) plan now includes initiatives to include late posted earnings, suspense reinstatements, and earnings adjustments and corrections.</p>	10
<p>Eliminate a Separate Carrier for Railroad Retirement Beneficiary Claims: Discontinue the use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (CIN: A-14-90-02528)</p>	<p>The HCFA is currently evaluating OIG's recommendation.</p>	9.1
<p>Issue Social Security Numbers for Noncitizens: Issue original SSNs for noncitizens based on electronic transfer of data collected by the Immigration and Naturalization Service (INS). (OEI-05-88-01060)</p>	<p>The SSA is awaiting an opinion from its General Counsel. Also, meetings are planned to discuss the proposal with INS.</p>	8.2
<p>Collect Nonresident Alien Taxes: Use automated systems to identify and collect alien taxes involving benefit payments for retroactive periods. (CIN: A-13-90-00041)</p>	<p>The SSA's ADP plan now includes a project to address this issue.</p>	7.7
<p>Abandoned Reclamations: The SSA and Treasury need to improve policies and procedures regarding abandoned reclamations. (CIN: A-04-89-03021)</p>	<p>Several problem areas between SSA and Treasury are still in need of negotiation and resolution, including abandoned reclamations.</p>	7.7
<p>Multiple Surgical Procedures: All carriers should uniformly limit reimbursement for second surgical procedures to 50 percent of reasonable charges. (CIN: A-03-86-62008)</p>	<p>Through physician payment reform, HCFA plans to establish payment for multiple surgeries based on 100 percent of the global fee for the highest value procedure, 50 percent for the next highest, 20 percent for the next highest, and 10 for each additional procedure.</p>	5.2
<p>Acquire Commercial Zip Code Software: The SSA should acquire commercial zip code software to help ensure accurate address information and quicker mail delivery. (CIN: A-13-87-02656)</p>	<p>The SSA began using the 9 digit zip code for SSI benefit checks in November 1990. Mailings of RSDI benefit checks include the 9 digit zip code beginning March 1991. The SSA also agreed to evaluate other uses for the commercial software which would result in additional savings.</p>	5
<p>User Fees for Attorneys: Determine administrative costs for processing attorney fee payments and assess user fees. (CIN: A-13-90-00026)</p>	<p>The SSA rejected this proposal since it believes it needs legislative authority.</p>	5

OIG Recommendation	Status	Savings in Millions
<p>Intercept Direct Deposit Transfer to Deceased Beneficiaries: The SSA should arrange for interception of erroneous direct deposit payments made to beneficiaries who died after the 23rd of the month. (CIN: A-13-89-00037)</p>	The SSA rejected OIG's proposal.	\$2.9
<p>Community Based Organization Projects for Human Immunodeficiency Virus Prevention: Determine if the Centers for Disease Control (CDC) awarded funds to applicants based on the results of OIG's recipient capability audits. (CIN: A-04-89-00122)</p>	The CDC agreed and awarded funds to 59 community based organizations and denied funding to 6 others based on the results of the OIG audits.	1
<p>Discontinue Payment for Broken Medical Appointments: The SSA should not pay State agencies for consultative exams that are canceled or otherwise not kept. (CIN: A-01-87-02004)</p>	The SSA has deferred action until after a year's experience with the new consultative examination regulations is acquired, although these regulations have not been released yet.	0.9

APPENDIX B

UNIMPLEMENTED OIG PROGRAM AND MANAGEMENT IMPROVEMENT RECOMMENDATIONS

This schedule represents recent OIG findings and recommendations which, if implemented, would result in substantial benefits. The benefits relate primarily to effectiveness rather than cost-efficiency. More detailed information may be found in OIG's Program and Management Improvement Recommendations (the Orange Book).

OIG Recommendation	Status
Kidney Acquisition Cost: The HCFA should support demonstration projects incorporating kidney transplantation and acquisition under a diagnosis related group. (OAI-01-88-01330)	The HCFA did not concur with this recommendation. The HCFA and OIG agreed that HCFA would explore various options that might reduce expenditures. The OIG is still awaiting possible solutions from HCFA.
Medicare Carrier Assessment of New Technologies: The HCFA should foster greater consistency among carriers in their coverage and pricing decisions, by providing carriers with selective access to comparative information on new technologies, reviewing carrier performance and working with the Public Health Service (PHS) to disseminate information on new health care technologies. (OEI-01-88-00010)	The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The HCFA has provided no evidence that these problems have been resolved. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.
Coping With Twin Disasters - HHS Response to Hurricane Hugo and the Loma Prieta Earthquake: The Office of the Secretary (OS) and the Office of the Assistant Secretary for Health (OASH) should clarify the Department of Health and Human Services (HHS) disaster recovery roles and responsibilities by defining precisely how they will implement the January 1990 transfer of primary disaster authority from OS to PHS, and clarifying the disaster relief and recovery responsibilities of all operating divisions and the regions. (OEI-09-90-01040)	The OASH has taken the lead in this area and has met with headquarters operating division emergency-preparedness officials. It is in the process of clarifying roles and responsibilities and plans to publish this information in the Federal Register once it is approved.
Coping With Twin Disasters - HHS Response to Hurricane Hugo and the Loma Prieta Earthquake: The OASH should issue guidelines to improve disaster planning. The plans of each operating and staff division should spell out lines of communication with each other, and should specify headquarters and regional lines of communication with the Federal Emergency Management Agency. (OEI-09-90-01040)	The OASH has undertaken the revision, updating and simplification of emergency planning and response guidance. The OASH will also coordinate the development of HHS Disaster Response Guides which will outline the types of emergency assistance provided by the Department.
Adolescent Steroid Use: The Department should develop a national steroid education strategy and conduct further medical and scientific research. (OEI-06-90-01080)	The PHS believes that implementation of specific programs should await completion of the report of the Interagency Task Force on Anabolic Steroid Use and notes that educational efforts would have to be coordinated across Departments.

OIG Recommendation	Status
<p>Integrity of Medical Evidence in Disability Determinations: The SSA should reemphasize its requirement that Disability Determination Services (DDSs) conduct an annual security evaluation and forward copies of their security profiles to the applicable regional security offices and disability program branches. (OAI-03-88-00670)</p>	<p>The SSA has developed the indicated procedural guidelines to implement the OIG recommendations. These guidelines are to be implemented in conjunction with the consultative examination/medical evidence of record regulations scheduled for publication in FY 1991.</p>
<p>Integrity of Medical Evidence in Disability Determinations: The DDS quality assurance procedures should include a sample check of physician reimbursements against the files containing the evidence for which payment was made. (OEI-03-88-00670)</p>	<p>The SSA is developing procedural guidelines which will require DDSs to conduct sample checks by its quality assurance units to compare medical evidence payment vouchers with the medical evidence in the file.</p>
<p>False Evidence Submitted to Obtain an SSN: The SSA should systematically identify all original SSN applications from U.S. born applicants over age 24 and require a second level review of such applications. (OEI unnumbered management advisory report, October 1987)</p>	<p>The SSA is conducting a nationwide study of selected Social Security number (SSN) applications to validate the results of an earlier regional study before committing to a more intense review of selected high risk cases.</p>
<p>Extent of SSN Discrepancies: The SSA should revise regulations establishing the routine use of SSN verification to those financial entities which are required to report interest and dividend income to IRS. (OAI-06-89-01120)</p>	<p>The SSA deferred a decision until it completes an evaluation of its entire disclosure policy in light of the Supreme Court Reporters Committee decision.</p>
<p>Recovery of RSDI Overpayments through Income Tax Refund Offset: The SSA should determine the SSNs of the overpaid former auxiliary beneficiaries for whom SSNs are unknown. (OEI-12-91-00610)</p>	<p>The SSA agrees that having the SSNs of all auxiliary beneficiaries would facilitate debt collection. Now that SSA has the legislative authority to recoup overpayments through tax refund offset, it will include an automated data processing plan for locating the missing SSNs in its refund offset work plan.</p>
<p>Social Security Payments for Vocational Rehabilitation: The SSA should require the States to establish a formal mechanism to screen and enroll those SSA clients who show the greatest potential for successful rehabilitation. (OAI-07-89-00950)</p>	<p>The SSA is contacting all States to urge that more effective screening and referral mechanisms be put into place, and is requiring regional office tracking and reporting of State implementation plans.</p>
<p>Reclamation of Incorrect Electronic Fund Transfer Payments: The SSA should implement an accounts receivable system to account for incorrect payments, improve reclamation procedures and work with Treasury to clarify respective functions. (CIN: A-01-87-02003)</p>	<p>The SSA implemented an accounts receivable system and OIG has issued a report to the Secretary requesting that the Board of Trustees for the trust funds attempt to get SSA and Treasury to resolve problem areas.</p>
<p>Improvements Needed in Processing Controls for RSDI Diary Actions: The SSA should emphasize to staff the importance of completing diared actions, incorporate standards into managers' merit pay plans and perform internal control reviews after the proposed automated diary system is completed. (CIN: A-13-88-00024)</p>	<p>The SSA has issued regular reminders regarding prompt processing; rejected OIG's proposal to include items in merit pay plans; and incorporated plans to evaluate the effectiveness of the new system.</p>

OIG Recommendation	Status
<p>Suspended Payments Need to be Resolved Timely: The SSA should, in direct deposit cases where the beneficiary is placed in suspense status, institute stronger controls to ensure that timely action is taken to resolve these suspensions so that SSA can either terminate or reinstate payments. (CIN: A-13-89-00027)</p>	<p>The SSA agreed to proceed with policy and procedural changes.</p>
<p>Modernized Claims System Needs Controls to Compensate for Lack of Separation of Duties: The SSA needs to implement controls in the modernized claims system since employees are authorized to take, develop, adjudicate and effect payment on a claim without any independent review or compensating controls. (CIN: A-13-89-00025)</p>	<p>The SSA generally agreed and has proposed corrective action.</p>
<p>Undeliverable Notices Need to be Better Controlled: The SSA needs better controls to make the undeliverable notice process an effective tool for detecting unreported deaths. (CIN: A-13-88-00035)</p>	<p>The SSA agreed to make improvements.</p>
<p>Representative Payee Procedures: The SSA should review accountability reports to identify high risk cases and verify the information reported, and should also verify a random number of reports. (CIN: A-07-90-00266)</p>	<p>The SSA performed a study to determine high risk representative payees and developed plans to perform other verifications as additional resources permit.</p>
<p>Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should ensure that field offices comply with instructions for processing death alerts and issue monthly reports to management on cases pending over 60 days for beneficiaries in current pay. (CIN: A-09-90-00044)</p>	<p>The SSA agreed to remind field offices of procedures and to more closely monitor compliance. A systems capability to have on-line information is under consideration.</p>
<p>Improved Controls Necessary in Field Office Processing of Death Alerts: The SSA should provide for a separation of duties in death alert processing at field offices since staff are also involved in other claims data. (CIN: A-09-90-00044)</p>	<p>The SSA generally agreed to improve controls.</p>
<p>Equipment Inventory: The SSA should perform a physical inventory of all equipment, make necessary adjustments to the accounting records and establish better controls over the disposition of equipment. (CIN: A-13-87-00035)</p>	<p>The SSA has developed a control system and reported that it should be implemented in December 1992. Procedures to control equipment disposition have been established.</p>
<p>Further Improvements Necessary to "800" Telephone System: The SSA should decrease the number and size of telephone centers, make better use of technology and back-up agents to increase handling capacity and accuracy, and initiate a pilot to determine whether the telephone centers could become full service centers. (CIN: A-09-90-00071)</p>	<p>The SSA agreed to consider OIG's recommendations.</p>

OIG Recommendation	Status
<p>Employee Relocation Services: The SSA needs to improve its management of employee relocations so that they are done in a more economical and efficient manner. (CIN: A-13-89-00018)</p>	The SSA agreed to review certain noted weaknesses.
<p>Certification of Wages Subsequent to 1977: The SSA should base its certification of wages on the combination of the amount of wages recorded in the individual's earnings and suspense records, and an estimate of the amount of wages that may eventually be added to those records at some future date. (CIN: A-13-89-00045)</p>	The SSA is considering OIG's recommendation, as well as the views of the General Accounting Office (GAO) and an independent accounting firm.
<p>Review of HCFA's Cost Allocation System for FY 1988: The Assistant Secretary for Management and Budget (ASMB) should provide HCFA with guidance on how to refine its cost allocation system and periodically monitor the system to ensure that it is being properly implemented and maintained. The HCFA should establish a system to document actual central office staff activities; distribute administrative costs to the trust funds and the general fund on the basis of actual employee activity; and identify costs contained in the administrative cost pool as either direct or indirect. (CIN: A-04-89-02036)</p>	The HCFA and ASMB agreed with the recommendation. The cost allocation system has been revised and is being tested.
<p>Follow-up to GAO Audit of the Medicare Healthchoice Demonstration Project: The HCFA should establish a divisionwide policy for data release using the Data Release User Guide developed by the Bureau of Data Management and Strategy (BDMS) as a model; require Privacy Act coordinators within each component to adhere to this policy; and designate BDMS as the focal point for the continued development of data release policies and procedures. These policies and procedures should be fully coordinated with HCFA's Privacy Act officer. (CIN: A-14-90-02048)</p>	The HCFA originally concurred with GAO's recommendation and developed a "Data Release User Guide." However, HCFA has not yet issued the guide as divisionwide policy.
<p>Follow-up to GAO Audit on Use of Medicaid Data to Monitor Controlled Substance Diversion: The HCFA should work with the Department of Justice (DOJ) to identify ways in which the Medicaid management information system (MMIS) controlled substance data can be used by regulatory, licensing and law enforcement agencies. It should also make information obtained from OIG's computer program for MMIS controlled substances data available through DOJ to law enforcement, regulatory and licensing agencies outside the Medicaid program. (CIN: A-14-90-02047)</p>	The HCFA has developed a corrective action plan and implementation is underway.

OIG Recommendation**Status**

Regulation of Hemoperfusion Medical Devices:

The FDA should take action to remedy deficiencies noted in a review of the premarket notification submissions made by two competing companies. (CIN: A-15-90-00043)

The Center for Devices and Radiological Health has instituted a procedure to acknowledge receipt of complaints within 10 days. It plans to implement an automated system in FY 1991 to allow acknowledgment of complaints within 72 hours of their being logged in, and to implement a mechanism to formally account for the number and disposition of photocopies made of a corporation's premarket submission documents.

IHS Contracting Practices:

The IHS should implement post-award monitoring of contract compliance and document all contract compliance evaluations; establish post-award monitoring performance standards for all project officers; establish a process to ensure that project officers are provided with evaluations and data on a contractor's performance; and establish a process for the review and approval of public vouchers by the project officer. (CIN: A-06-89-00066)

The Oklahoma City Area Office concurred with all of OIG's proposals. It plans to continue efforts to improve the use of measurable criteria by providing additional training; amend current contract reporting requirements; and initiate a requirement that project officers submit a periodic assessment of contract activities.

Contract Pre-Award Audits for FY 1989:

The PHS should assess the need for OIG to examine a greater number of the proposals being awarded by all PHS agencies. (CIN: A-02-90-02505)

The OASH indicated full concurrence with the need for a greater number of pre-award audits.

Commissioned Corps Identification Cards:

The OASH should immediately perform a review of internal controls over the issuance of Commissioned Corps identification cards. (CIN: A-15-91-00010)

The PHS has scheduled the internal control reviews of card issuance for FY 1993.

APPENDIX C

IMPLEMENTED OIG RECOMMENDATIONS TO PUT FUNDS TO BETTER USE OCTOBER 1990 THROUGH MARCH 1991

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 period amounted to \$2,639.8 million.

OIG Recommendation	Status	Savings in Millions
Administering the Medicare Secondary Payer Program:		
The HCFA's legislative proposal to require insurance companies, underwriters and third party administrators to periodically submit Employer Group Health Plan (EGHP) coverage data directly to HCFA should be revised and resubmitted for FY 1991. Also, supplemental actions should be taken to identify EGHP insurers of Medicare beneficiaries through collateral sources of information. (CIN: A-09-89-00100; OAI-07-86-00091; OAI-07086-00017; OAI-07-88-00092; OEI-07-90-00764)	Section 6202 of OBRA 1989 enabled HCFA to obtain information from SSA, IRS and individual employers. Section 4203 of OBRA 1990 extended secondary payer provisions until 1995.	\$800
State Legalization Impact Assistance Grant Appropriation:		
The FY 1991 appropriation for the State Legalization Impact Assistance Grant (SLIAG) should be reduced by \$500 million. (OEI-07-90-02260)	The FY 1991 Labor, HHS, Education Appropriations Act reduced the FY 1991 SLIAG appropriation by \$566.8 million.	566.8
Raise and Index the Medicare Part B Deductible:		
The Medicare Part B deductible should be raised to \$100 and indexed. (ACN: 09-52043)	Section 4302 of OBRA 1990 increased the Part B deductible to \$100 beginning in 1991.	350
Laboratory Reimbursements:		
The HCFA should take advantage of the economies of scale present in the laboratory industry by making reductions to the fee schedule amounts. (OAI-02-89-01910; CIN: A-09-89-00031)	Section 6111(a) of OBRA 1989 established a ceiling on fee schedule payments at 93 percent of the median for a particular test in a particular laboratory setting, beginning January 1, 1990. Section 4154 of OBRA 1990 lowered that ceiling to 88 percent of the median effective January 1, 1991, and limited the annual fee schedule increase for clinical laboratory tests to 2 percent for 1991, 1992 and 1993.	220





ACRONYMS

ACYF	Administration on Children, Youth and Families
AFDC	Aid to Families with Dependent Children
ALJ	administrative law judge
ASC	ambulatory surgical center
ASMB	Assistant Secretary for Management and Budget
ASPA	Assistant Secretary for Public Affairs
ASPE	Assistant Secretary for Planning and Evaluation
ASPER	Assistant Secretary for Personnel Administration
CDC	Centers for Disease Control
CFO	Chief Financial Officers
CMP	civil monetary penalty
CPCP	Comprehensive Perinatal Care program
DD/EFT	direct deposit/electronic fund transfer
DDS	disability determination service
DME	durable medical equipment
EGHP	employer group health plan
ESRD	end stage renal disease
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
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
HDS	Office of Human Development Services
HEAL	Health Education Assistance Loan
HIV	human immunodeficiency virus
IHS	Indian Health Service
ILP	Independent Living program
IOL	intraocular lens
IPL	independent physiological laboratory
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
LRI	laboratory roll-in
MAC	monitored anesthesia care
MFCU	Medicaid fraud control unit
MMIS	Medicaid management information system
MSP	Medicare secondary payer
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health
OBRA	Omnibus Budget Reconciliation Act
OCSE	Office of Child Support Enforcement
OMB	Office of Management and Budget
OPD	hospital outpatient department
OPM	Office of Personnel Management
OS	Office of the Secretary
PCIE	President's Council on Integrity and Efficiency
PHS	Public Health Service
PPS	prospective payment system
PRO	peer review organization
RET	retirement earnings test
RRC	rural referral center
RSDI	Retirement, Survivors and Disability Insurance
SLIAG	State Legalization Impact Assistance Grants
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
UC	unemployment compensation
VE	Value Engineering
WCF	Working Capital Fund

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