



# Semiannual Report

October 1, 1992 - March 31, 1993

Office of 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
P.L. 102-486	Energy Policy Act of 1992

#### 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 5, United States Code, section 552a(i)
- Title 18, United States Code, sections on crime and criminal procedures as they pertain to OIG's oversight of departmental programs and employee misconduct
- Title 26, United States Code, section 7213
- Title 42, United States Code, sections 261, 263a(1), 274e, 290dd-3, 300w-8, 300x-8, 406, 408, 707, 1320a-7b, 1320b-10 and 1383(d), the Social Security and Public Health Service Acts

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

- Title 31, United States Code, section 3801, et seq., the Program Fraud Civil Remedies Act
- Title 42, United States Code, sections 1320a-7, 1320a-7a, 1320c-5, 1395l, 1395m, 1395u, 1395dd and 1396b

This semiannual report, submitted in accordance with the General Act of 1978, as amended, summarizes the activities of the General (OIG) of the Department of Health and Human Services ending March 31, 1993.

This has been a challenging period for OIG. We have focused our program and management vulnerabilities in such areas as Health Security Disability program and Medicaid drug costs. At the same time, demands from both statutory requirements, such as the financing provisions by the Chief Financial Officers Act, and increasingly complex issues, such as grantee indirect costs and health care provider financing, are growing mission demands come at a time of continuing resource constraints. Some major changes in the way we do business are being implemented and geographic locations to receive services. Such a posture is

- More than 20 persons have been indicted thus far nationwide for peddling confidential information, such as employment and earnings records and criminal histories, and 13 have been convicted and sentenced. (See page 46)
- An Arizona residential care home owner was excluded from the Medicare and State health programs for 20 years after being convicted of patient abuse and neglect. (See page 20)
- Thirteen persons, including hospital officials and x-ray company officers, were sentenced for their part in schemes to defraud ten New Jersey and New York hospitals of an estimated \$10 million in Medicare and private funds. (See page 19)
- A boarding house operator in New York was sentenced to 4 years in prison for stealing boarders' benefit checks. (See page 38)

#### **Identifying Systemic Management Problems:**

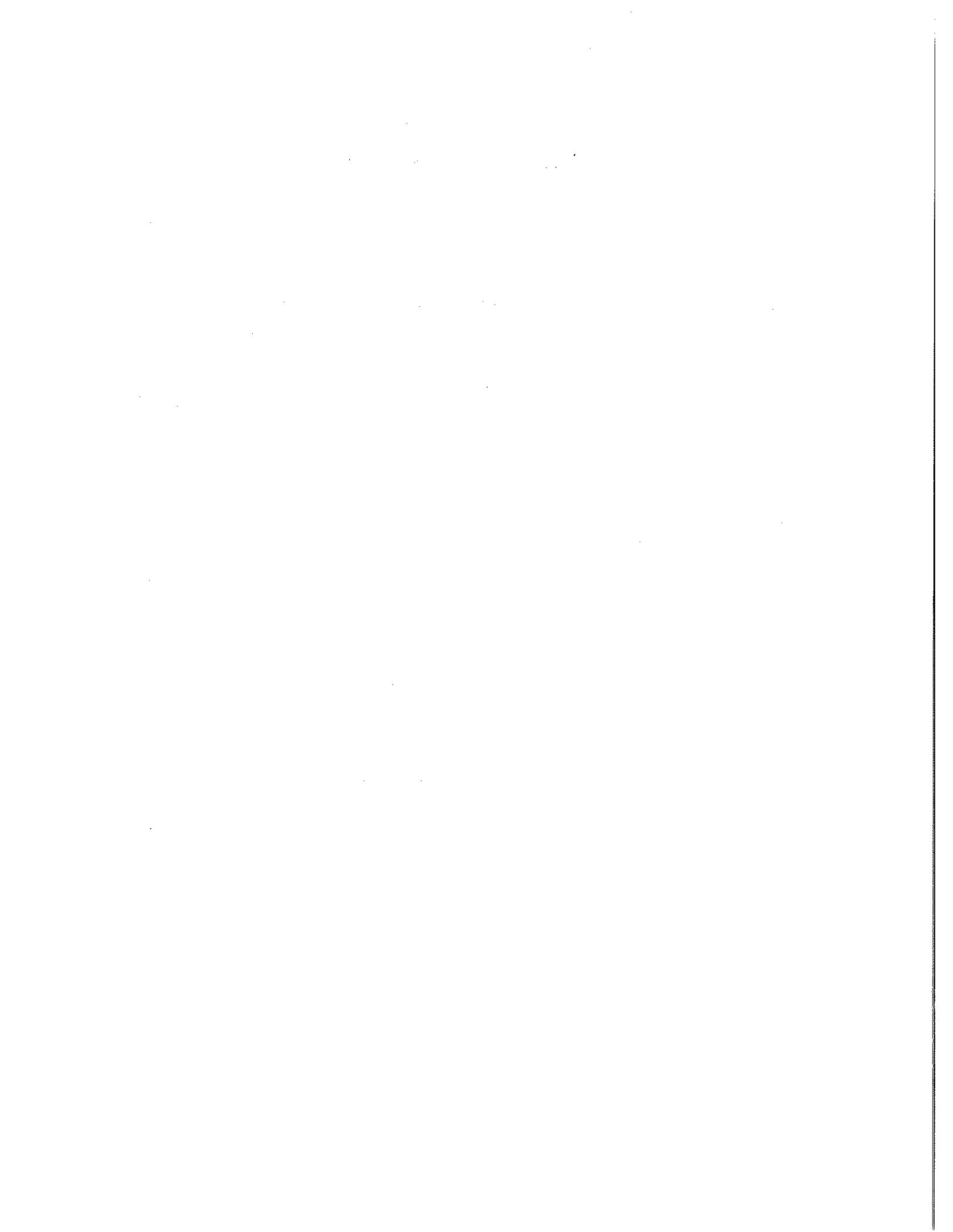
- The National Vaccine Injury Compensation Program could begin to resolve its large backlog of cases by adopting OIG recommendations for better priority case setting, process streamlining and the use of more recent scientific information for case decisions. (See page 57)
- The OIG found that 25 percent of financial institutions do not promptly refund the direct deposits of deceased Social Security beneficiaries, resulting in a loss to the SSA trust funds. (See page 45)
- The OIG recommended that the Health Care Financing Administration survey drug manufacturers to identify the various calculation methods used to develop their average manufacturers' prices (AMPs) and then provide more specific policies for calculating AMP to strengthen the Medicaid drug rebate program and reduce the rate setting burden on manufacturers. (See page 31)
- After evaluating the National Institutes of Health's (NIH) progress in eliminating the funding of research grants at levels below those recommended by the initial review groups, OIG recommended that NIH either eliminate targeted cost reductions or establish procedures to determine the impact of the reductions during the peer review process. (See page 59)

### **Promoting Improved Service Delivery:**

- Finding that federally funded community health centers were providing expanded perinatal health care services but had some serious problems to overcome, OIG called for a Department strategy to address these limitations. (See page 59)
- The OIG found that State Medicaid agencies relied on more traditional fee-for-service quality assurance standards like credentialing, utilization review and medical record review to assess the quality of care provided by Medicaid health maintenance organizations instead of health outcomes or patient satisfaction measures. (See page 30)
- In two inspections on underage users' access to tobacco, OIG concluded that underage spit tobacco use is widespread and spit tobacco laws and their enforcement are weak and ineffective. (See pages 54 and 55)

### **Developing and Assessing Performance Measures:**

- The OIG found that the Alcohol, Drug Abuse and Mental Health Administration data collection system did not provide reliable data for measuring drug abuse treatment costs. (See page 55)
- The OIG qualified its opinion on SSA's FY 1992 financial statements because an adjustment to the trust funds' balances of \$9.5 billion for revenues was not certified as required by the Social Security Act. (See page 36)
- The OIG found little evidence that Federal incentives to States have improved child support enforcement programs, and determined that States have realized increased financial benefits while the Federal Government has incurred increased costs. (See page 67)
- The OIG reported that, due to the lack of close oversight and to ineffective procedures, \$3.5 billion in overpayments under the Aid to Families with Dependent Children program were not identified and reported by States. (See page 64)



# TABLE OF CONTENTS

	PAGE
<b>Chapter I High Risk Areas and Financial Management</b>	
High Risk Areas .....	1
A. Medicare Program Data .....	1
B. Medicare Secondary Payer Program .....	2
C. Medicaid Program Data .....	3
D. Management of Indian Health Service .....	4
Financial Management .....	6
A. Federal Managers' Financial Integrity Act .....	6
B. Implementation of Chief Financial Officers Act .....	7
C. Reporting Performance Measurement .....	8
 <b>Chapter II Health Care Financing Administration</b>	
Overview of Program Area and Office of Inspector General Activities .....	11
Update on Medicare Credit Balances .....	12
Hospital General and Administrative and Employee Benefit Costs .....	12
Payments for Nonphysician Outpatient Services under the Prospective Payment System .....	13
Hospital Minimum Data Set .....	13
Medicare Secondary Payer Activities .....	14
Medicare Trust Funds: Financial Disclosure .....	14
Medicare Administrative Costs .....	15
A. Part A and Part B Costs .....	15
B. Part B Costs .....	15
Medicare Contractor's Segmented Pension Costs .....	15

	PAGE
Contractors' Unfunded Pension Costs .....	16
A. Blue Cross and Blue Shield of Texas .....	16
B. Blue Cross and Blue Shield of Michigan .....	16
Bid Proposal Audits of Peer Review Organizations .....	16
Hospital Closure: 1991 .....	17
Liver Biopsies .....	17
Fragmented Physician Claims .....	18
Diagnosis-Related Group Validation Updates .....	18
Criminal Fraud .....	19
Fraud and Abuse Sanctions .....	20
A. Patient and Program Protection Sanctions .....	20
B. Civil Monetary Penalties for False Claims .....	21
Kickbacks .....	23
Increased Application of Comparability .....	24
Exception Policy for Reimbursement of New Physicians in Medical Groups .....	25
Physicians' Costs for Chemotherapy Drugs .....	26
Cost of Dialysis-Related Drugs .....	26
Medicare Reimbursement for Epogen .....	27
Medical Necessity for Ambulance Services .....	27
Medicare Payments for Home Blood Glucose Monitors .....	28
Fraud involving Durable Medical Equipment Suppliers .....	29
Health Maintenance Organizations' Quality Assurance Standards Required by Medicaid Agencies .....	30
Medicaid Drug Policies .....	31
A. Guidance to Drug Manufacturers .....	31
B. Reimbursement for Ulcer Treatment Drugs .....	32

	PAGE
Improper State Claims for Federal Medicaid Funds .....	32
A. Enhanced Federal Financial Participation for Family Planning .....	32
B. Third Party Liability Recoveries: California .....	33
C. Prepayment Reviews: California .....	33
State Medicaid Fraud Control Units .....	34
<b>Chapter III Social Security Administration</b>	
Overview of Program Area and Office of Inspector General Activities .....	35
Audit Opinion on Social Security Administration's Fiscal Year 1992 Financial Statements .....	36
Debt Management System .....	36
Annual Earnings Test Penalty Assessments and Collections .....	37
Revoking Penalties under Good Cause Policy .....	37
Concealment of Beneficiary Status .....	38
Internal Controls over Welfare Enumeration .....	40
Fraudulent Social Security Numbers .....	40
Duplicate Payments to Attorneys .....	43
Prison Address Match .....	44
Nonresident Aliens Receiving Payment at Foreign Addresses .....	44
Financial Institution Refunds of Benefits Paid after Death .....	45
Sale of Restricted Information .....	46
Controls for Diary Actions .....	46
Computer Systems Integrity .....	46
Cost Analysis System .....	47
Tape Recordings of Social Security Appeal Hearings .....	47
Disability Work Incentives .....	48
Claimant Provision of Disability Information .....	48

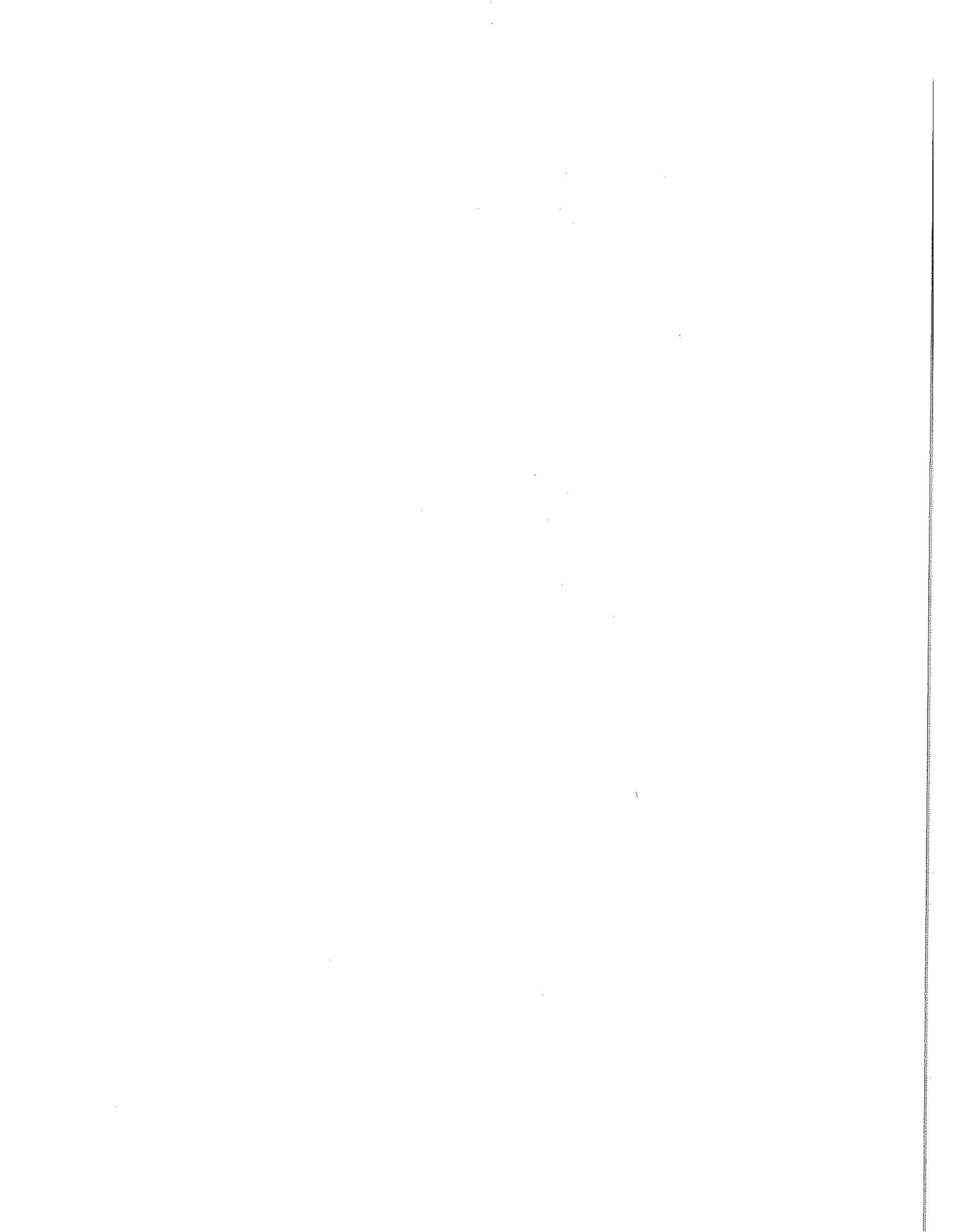
	PAGE
Field Office Processing of Disability Claim Forms .....	49
Supplemental Security Income: Presumptive Disability .....	49
Immediate and Emergency Advance Payments .....	49
Clarity of Supplemental Security Income Notices .....	50
 <b>Chapter IV Public Health Service</b>	
Overview of Program Area and Office of Inspector General Activities .....	51
Medical Device Review Process .....	52
Generic Drug Approval Process .....	52
Generic Drug Management Information System .....	53
Fraud in the Generic Drug Industry .....	53
Fraud in the Azidothymidine Program .....	54
Spit Tobacco and Youth .....	54
Youth Access to Tobacco .....	55
Measuring Drug Abuse Treatment Costs .....	55
Indian Alcohol and Substance Abuse .....	56
Indian Health Service Management and Fraud Problems .....	56
National Vaccine Injury Compensation Program .....	57
National Practitioner Data Bank .....	57
A. Reports to Hospitals .....	57
B. Administration .....	58
Selected Community Health Center Grantee Audit Findings .....	58
Perinatal Service Capacity of the Federally Funded Community Health Centers .....	59
Reductions in Proposed Budgets of Grants Awarded by the National Institutes of Health .....	59
Fraud and Abuse involving Grant Funds .....	60
National Medical Expenditure Survey .....	61

	PAGE
State Medical Boards .....	61
Public Health Service Contract Preaward Audits: Fiscal Year 1991 .....	62
 <b>Chapter V Administration for Children and Families, and Administration on Aging</b>	
Overview of Program Areas and Office of Inspector General Activities .....	63
Overpayment Recovery Process in the Aid to Families with Dependent Children Program .....	64
Welfare Fraud .....	64
Homeless Families' Access to Aid to Families with Dependent Children Benefits ...	66
Emergency Shelters for Homeless Families .....	67
Child Support Enforcement Payments: Financial and Program Implications .....	67
Health and Safety Standards at Child Care Facilities .....	68
Foster Care Maintenance Payments: Illinois .....	69
Using Community Resources for Job Opportunities and Basic Skills Program Participants .....	69
Job Opportunities and Basic Skills Program: State Maintenance of Effort .....	69
Automated Data Processing Acquisitions Not Requiring Prior Federal Approval ....	70
 <b>Chapter VI General Oversight</b>	
Introduction .....	71
Nonfederal Audits .....	71
A. Office of Inspector General's Proactive Role .....	72
B. Quality Control .....	73
Resolving Office of Inspector General Recommendations .....	74
A. Questioned Costs .....	74
B. Funds Put to Better Use .....	75

	PAGE
Legislative and Regulatory Review and Regulatory Development .....	76
A. Review Functions .....	76
B. Regulatory Development Functions .....	76
Governmental Accounting .....	76
Internal Service Funds; Connecticut .....	77
Reform of the Cost Allocation System .....	77
Controls over Contract Reporting and Contracts .....	77
Review of Department Detailees .....	78
Department's Implementation of the Lobbying Act .....	78
Employee Fraud and Misconduct .....	78
Criminal Prosecutions .....	80
Cooperation with Other Law Enforcement Agencies .....	80
<b>Appendix A - Implemented Office of Inspector General Recommendations to Put Funds to Better Use October 1992 through March 1993 .....</b>	<b>A-1</b>
<b>Appendix B - Unimplemented Office of Inspector General Recommendations to Put Funds to Better Use .....</b>	<b>B-1</b>
<b>Appendix C - Unimplemented Office of Inspector General Program and Management Improvement Recommendations ....</b>	<b>C-1</b>
<b>Appendix D - Notes to Tables I and II .....</b>	<b>D-1</b>
<b>Appendix E - Reporting Requirements of the Inspector General Act of 1978, as Amended .....</b>	<b>E-1</b>
<b>List of Acronyms .....</b>	<b>Inside back cover</b>

---

## **High Risk Areas and Financial Management**



---

## Chapter I

# HIGH RISK AREAS AND FINANCIAL MANAGEMENT

## High Risk Areas

The Department's Fiscal Year (FY) 1992 Federal Managers' Financial Integrity Act (FMFIA) report identified a total of four high risk areas. Following is a description of those areas and a brief discussion of their present status:

### A. Medicare Program Data

In 1990, the Office of Management and Budget (OMB) and the Department identified, as a high risk area, the need for more accurate and timely programmatic and financial data to better manage the national Medicare program budget. To achieve this will require the development and implementation of integrated financial and program data systems which can record and report actual program costs on a timely basis. Data must be reflected for each major benefit category and major administrative function of Medicare. This requires utilization of the Common Working File (CWF) and its reporting capabilities, and appropriate interfaces with the accounting system of the Health Care Financing Administration (HCFA).

The targeted correction date is 1993. The HCFA's strategy for providing program and financial data from the CWF is to develop a data base management system for use as a data collection repository. Data will be derived both from the data base management system and from existing systems, and new payment reports will be generated that tabulate the monthly payments charged to the major benefit and administrative functions of Medicare. The HCFA reports that it has completed three of four critical milestones and the fourth is planned for completion in FY 1993.

The following OIG reports were issued during the 6-month period ending March 31, 1993 that relate to this high risk area:

- Medicare Trust Funds: Financial Disclosure - In this report, OIG discussed the need to assure that trust fund transfers are correctly calculated and thus avoid a qualified audit opinion on the Medicare financial statements. (CIN: A-14-92-03013) (See page 14)

- Update on Medicare Credit Balances - The OIG expanded its review of hospitals' Medicare patient accounts having credit balances, which are amounts due Medicare, usually as a result of overpayment. The OIG's current report estimates that hospitals nationally owe the Medicare program \$266.4 million in uncollected overpayments. The HCFA has instituted recovery action. (CIN: A-03-92-00010) (See page 12)

Reviews which are currently in progress that pertain to this high risk area are:

- Review of HCFA's Financial Systems for Accounts Receivable
- Review of HCFA's Internal Controls and Financial Systems for Accounts Payable: Part A
- Review of HCFA's Internal Controls and Financial Systems for Accounts Payable: Part B

#### **B. Medicare Secondary Payer Program**

The OIG has estimated that the Medicare program may be paying out as much as \$1 billion a year unnecessarily because Medicare fiscal intermediaries and carriers do not always identify the primary payers, and because insurers, underwriters and third party administrators often do not pay as primary payers when they are required to do so. This problem, which was first identified as a high risk area in 1989, has been addressed through several initiatives, including proposals for legislative remedies and legal actions against noncomplying insurers.

While HCFA reported that it had completed most of the milestones in its 1992 corrective action plan, it recognizes that full achievement of additional possible savings under the Medicare secondary payer (MSP) program will require continued efforts over a number of years. The HCFA's strategy is to attack the problem in several ways: perform a data match between the Internal Revenue Service, the Social Security Administration (SSA) and Medicare files; obtain primary insurance information from beneficiaries on a prepayment basis and insert data gathered from these sources into the CWF to prevent future mistaken payments; and take actions to improve the MSP recovery activities of the Medicare contractors. One report was issued by OIG during the 6-month period ending March 31, 1993 that pertains to the high risk area of MSP:

- Review of Empire Blue Cross Blue Shield's Compliance with the MSP Legislation - This review identified the extent this Medicare contractor mistakenly paid claims as Medicare being the primary payer for individuals subject to the working aged criteria of the MSP legislation when, in fact,

Empire private lines of business should have been the primary payer for these medical services. (CIN: A-02-91-01054) (See page 14)

Reviews which are currently in progress that pertain to the high risk area of MSP are as follows:

- Second Review of Monitoring of HCFA's Implementation of the MSP Provisions Contained in the Omnibus Budget Reconciliation Acts of 1989 and 1990
- Survey of MSP Part A Retroactive Recovery Backlog at Empire Blue Cross Blue Shield
- Nationwide Review of MSP Backlog Claims for FY 1992
- Review of Travelers Insurance Company's Compliance with the MSP Legislation
- Review of Blue Cross Blue Shield of Michigan's Compliance with the MSP Legislation
- Review of Provident Insurance Company's and Its Third Party Administrator Customers' Compliance with the MSP Legislation
- Review of Blue Cross Blue Shield of Florida's Compliance with the MSP Legislation

### **C. Medicaid Program Data**

The need for better Medicaid program data was reported as a high risk area in 1991. An OMB/Department of Health and Human Services (HHS) SWAT team identified a serious need for accurate and timely programmatic and financial data to aid in managing the national Medicaid budget. This requires the development and implementation of properly integrated financial and program data systems to record actual program costs on a timely basis.

The HCFA's strategy was to establish a special HHS/OMB Management Review Task Force to analyze why Medicaid estimates have been so inaccurate; examine the deficiencies and seek corrective measures in the current Federal/State estimating process that allows discrepancies to occur; identify ways to better understand the unique policy dynamics of the program in each State; develop methods of improving Federal Medicaid tracking efforts; and evaluate the fiscal impact of future Medicaid policy changes.

The HCFA reported that most of the actions of its corrective strategy were completed during FY 1992. Cooperation between HCFA and the National Governors' Association led to legislation to resolve funding problems with voluntary contributions and provider-specific taxes. The HCFA also reported that it has completed a number of its other planned corrective actions, including the revision of State data collection instruments, the development of data systems and report tables for OMB, and the collection and processing of necessary baseline data for the profile system.

The following OIG reports were issued during the 6-month period ending March 31, 1993 that relate to this high risk area:

- Third Party Liability Recoveries: California - The OIG found that California did not accurately account in its Federal cost reports for its recoveries from third parties liable (TPL) for the cost of Medicaid services provided beneficiaries, resulting in an understatement of its TPL recoveries of \$2.3 million. (CIN: A-09-91-00127) (See page 33)
- Enhanced Federal Financial Participation for Family Planning - The OIG recommended the elimination of enhanced Federal financial participation rates provided to States for family planning services, noting that a series of reviews by HCFA and OIG identified significant internal control weaknesses and examples of flagrant and abusive billing practices which resulted in overclaims for Federal reimbursement. (CIN: A-02-91-01052) (See page 32)
- Medicaid Drug Policies: Guidance to Drug Manufacturers - The OIG found that drug manufacturers' calculations of average manufacturer's price are inconsistent due to HCFA's failure to provide adequate instructions — a problem that affects the resulting drug rebates provided to the Medicaid program by drug manufacturers. (CIN: A-06-91-00092) (See page 31)

The following review currently in progress pertains to this high risk area:

- Medicaid Financial Management Survey

#### **D. Management of Indian Health Service**

The management of the Indian Health Service (IHS) was designated as a high risk area in 1990. The IHS had not devoted sufficient resources and attention to management of its program and activities. A more responsive and efficient management had to be developed to assure quality health care in a time of growing demand and constrained resources. As a result, the development of effective management became a major priority.

In September 1992, IHS provided a status report to a joint meeting of the Department's Management Oversight Council and representatives of OMB, where it detailed its management improvement efforts and argued for a reduction of the status of the "high risk" category to "substantial improvement".

The IHS reported that it continues to make improvements in the management of the implementation of the FMFIA and key management improvement initiatives related to billing and managing third party collections, quarters construction and management, collection of rents and administration of travel. Corrected material weaknesses previously reported include improvements in the IHS scholarship and debt management program, and in the administration of equipment inventories. The IHS anticipates that its internalization of management control principles will have progressed to the point that it will petition OMB during FY 1993 for the removal from the "high risk" list.

During the 6-month period ending March 31, 1993, OIG issued the following report which pertains to the high risk area of management of IHS:

- Indian Alcohol and Substance Abuse - The OIG found that, despite a Memorandum of Agreement by the Secretaries of Interior and Health and Human Services formalizing the need for better Bureau of Indian Affairs and IHS coordination, the agreement's provisions have not been implemented. The OIG recommended that the agreement be reviewed, updated and streamlined with the goal of developing a practical plan of action. (OEI-09-92-00010) (See page 56)

In addition, OIG continues to investigate cases involving potential fraud and corruption in IHS. (See page 56)

Reviews currently in progress that relate to this high risk area are as follows:

- IHS Construction of Housing
- Review of Use of IHS Youth Alcoholism Funds
- FMFIA Segmentation Process throughout the Public Health Service
- Survey of IHS Area Office Organization
- Survey of IHS Collections from Third-Party Payers
- Survey of IHS Procurement Practices Related to Small Purchases

- Community Health Representatives: Management Issues

## **Financial Management**

Effective financial management is essential to the control of the Department's use of its resources to achieve program goals in compliance with laws and regulations. Financial management entails the organization, planning, policies and procedures designed to achieve full and reliable accountability, including performance measurement for allocated resources. In order to promote accountability and measure performance, the Congress passed the FMFIA of 1982 and the Chief Financial Officers (CFO) Act of 1990. In response, OMB promulgated implementing guidelines in the form of Circulars A-123 and A-127, and Bulletins 93-02 and 93-06.

In order to promote the efficient and effective audit of Federal funds distributed to State and local governments in the form of grants and contracts, the Congress passed the Single Audit Act of 1984. This Act was implemented by OMB through Circular A-128. In addition, OMB issued a similar directive, Circular A-133, to promote the efficient and effective audits of Federal grants and contracts distributed to other nonprofit organizations, such as universities or community health clinics.

### **A. Federal Managers' Financial Integrity Act**

Effective management control systems are a primary mechanism for preventing and detecting fraud, waste and abuse, as well as for ensuring the achievement of program goals. Since the start of the FMFIA program, OIG has been actively involved in the Department's implementation efforts. The OIG provides technical assistance to Department management in its efforts to evaluate and improve management systems and controls. In addition, OIG corroborates the effectiveness of the FMFIA process through audits, inspections and investigations that are designed to detect fraud, waste and abuse.

Management controls are reviewed as part of the FMFIA process and weaknesses are identified. Material weaknesses are identified by management as it carries out its FMFIA activities in the various operating and staff divisions, and by OIG as it performs various audits, inspections and investigations of Department programs. Material weaknesses are those management control problems of such magnitude that they may impede achievement of program mission and goals. Management control weaknesses that are reported as material are reviewed and approved or rejected by the Management Oversight Council, which oversees the Department's FMFIA program. Each year a summary of the Department's outstanding material weaknesses is reported in the Secretary's annual FMFIA report to the President and the Congress.

The Secretary's 1992 FMFIA report identified 42 material management control weaknesses that were outstanding at the end of the fiscal year. During the last 6 months, OIG recommended that the following deficiency be reported as a material weakness in FY 1993:

- Annual Earnings Test Penalty Assessments and Collections (CIN: A-13-91-00209) (See page 37)

In addition, OIG followed up on these previously reported material internal control weaknesses:

- Medical Device Approval Process (CIN: A-15-89-00065) (See page 52)
- Generic Drug Approval Process (CIN: A-15-89-00051) (See page 52)

The OIG is currently reviewing management's overall implementation of FMFIA at all operating divisions.

#### **B. Implementation of Chief Financial Officers Act**

The CFO Act of 1990 was enacted to improve the general and financial management of the Federal Government. The objectives of the CFO Act are to:

- establish more effective general and financial management practices;
- improve each agency's systems of accounting, financial management and management controls to produce reliable financial information and reduce fraud, waste and abuse of Government resources;
- produce complete, reliable, timely and consistent financial information for use by program and financial managers and the Congress in financing, managing and evaluating Federal programs;
- monitor financial execution of the budget in relation to actual expenditures including timely performance reporting; and
- develop and maintain an integrated agency accounting and financial management system, including financial reporting and management controls which provide for the systematic measurement of performance.

During the 6-month period ending March 31, 1993, OIG issued the following reports as a result of financial management audits performed under the CFO Act:

- Management Letter on the Audit of SSA's FY 1991 Financial Statements (issued November 13, 1992 to SSA's CFO)
- Audit Opinion on SSA's FY 1992 Financial Statements (See page 36)
- Medicare Trust Funds: Financial Disclosure (See page 14)

Also during this semiannual period, HHS OIG was a major participant on the President's Council on Integrity and Efficiency (PCIE) Task Force on Improved Financial Management and Implementation of the CFO Act. This task force issued its final report on implementation of the CFO Act by the PCIE community. The final report consisted of reports by the seven task force teams as follows:

- Financial Statement Audit Methodology and Policy
- Use of IG Staff Versus Independent Public Accountants
- Auditors' Assistance to Management on CFO Implementation
- Audit Reporting on Financial Management Audits
- Auditor Training for CFO Implementation
- PCIE Comments on Proposed Accounting and Auditing Standards and Reporting on the Costs and Benefits of the CFO Act to the IG Community
- Management's Overview of the Reporting Entity

In addition, the task force has developed an audit policy manual for financial statement audits of Federal entities. This manual will provide uniform guidance for adoption by the IGs responsible for conducting financial audits pursuant to the CFO Act. The manual is consistent with the audit methodology being taught at the IG Training Institute and that followed by the General Accounting Office.

Finally, in order to promote the understanding and acceptance of accountability reporting as envisioned by the CFO Act, HHS OIG has contributed extensively through seminars, presentations and training sessions on financial performance measurement reporting.

### **C. Reporting Performance Measurement**

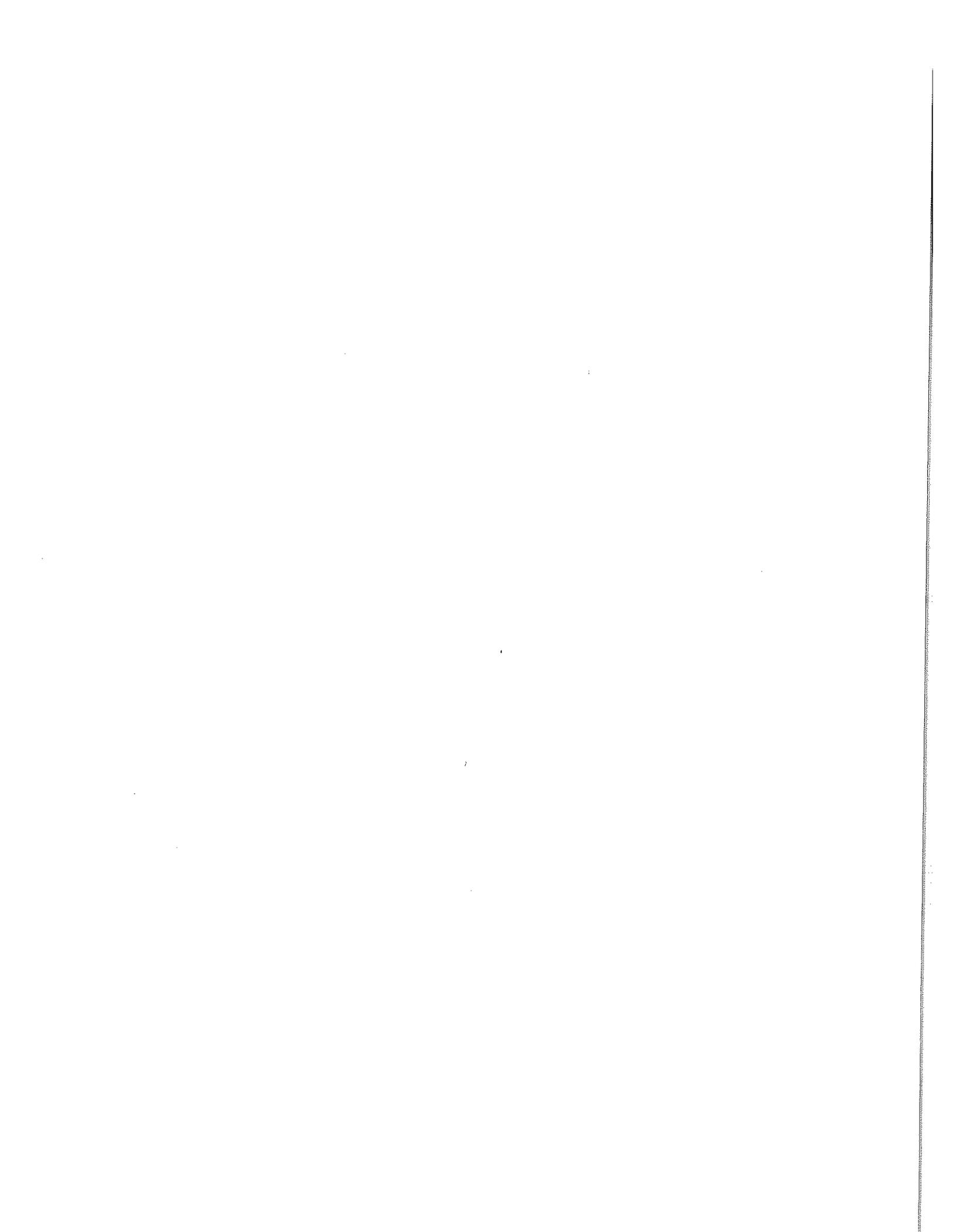
Throughout the Federal Government, there is a renewed emphasis on financial management and accountability for scarce resources. There is an increasing awareness that accountability

includes not only safeguarding of resources from waste, fraud and abuse, but, ultimately, the effective use of resources to accomplish program goals and objectives. Thus, there is an increasing focus on performance measurement as an integral part of accountability reporting.

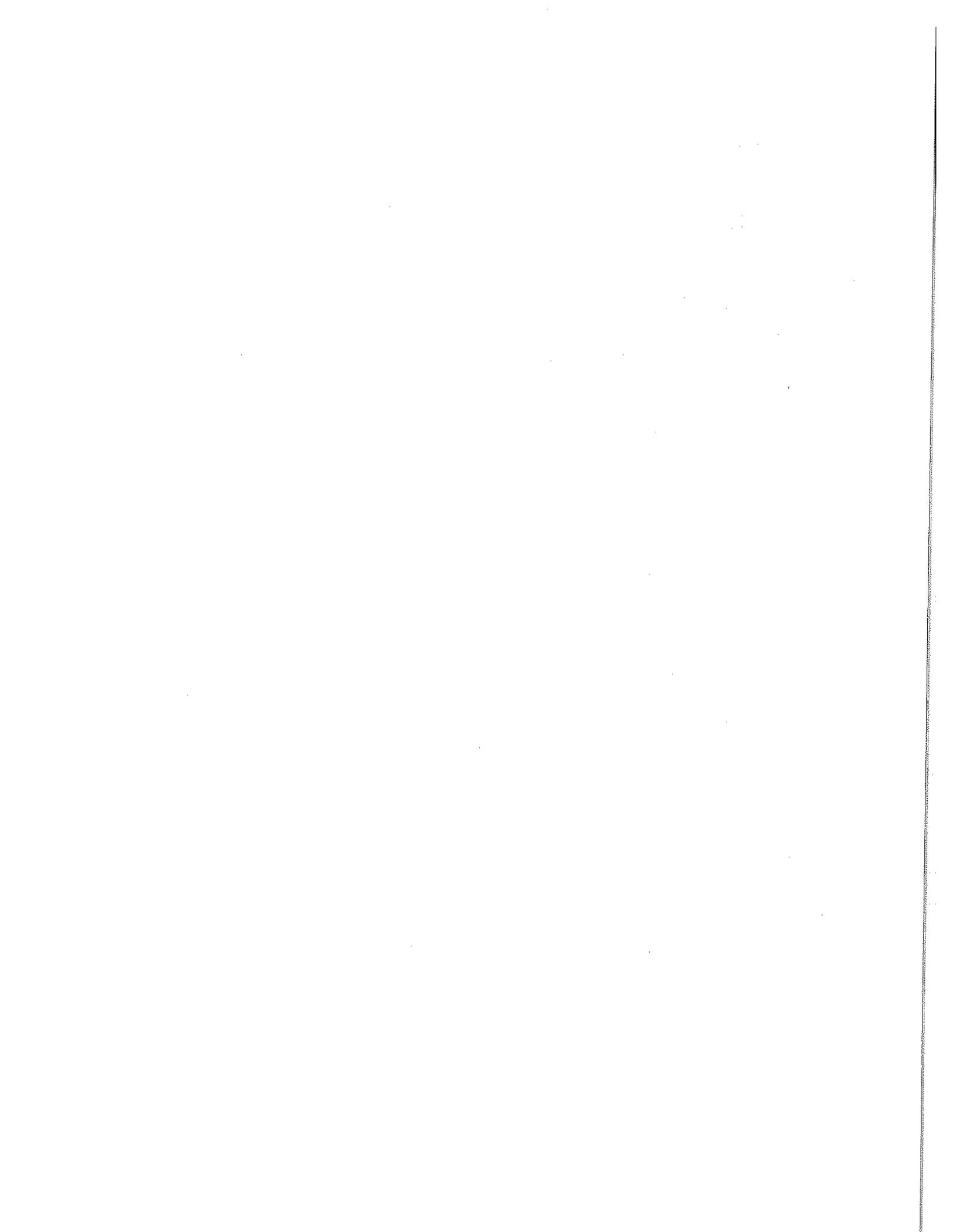
During the 6-month period ending March 31, 1993, the PCIE CFO task force team on Management's Overview of the Reporting Entity, which was led by HHS OIG, issued guidelines that define the IG role in management's overview, including performance measurement reporting. The final PCIE CFO task force report provides guidance to the PCIE community on auditors' assistance to management; audit work required and recommended on management's overview, including performance measurement, under the CFO Act; and audit reporting on management's overview. In addition, at the request of OMB, the team issued proposed standards for the development and reporting of management's financial and program performance measures and indicators.

The CFO Act requires agencies to develop and maintain financial management systems which include the systematic measurement of program performance. Under OMB guidance, this CFO accountability reporting is included as a discussion and analysis of program performance. Performance measurement reporting attempts to define the extent to which a Federal program is achieving its mission and goals, which are presented as indicators and measures. A performance indicator is an index or pointer that assesses the level of achievement of a program goal, objective, or target. Performance measures are quantitative expressions of the ratio of two performance indicators used to evaluate a program goal, such as the efficiency of an immunization program being measured by the number of inoculations provided per dollar of cost.

In order to identify OIG work in the area of performance measurement, we have tagged some items throughout the body of this semiannual report as "performance measures" with the symbol Performance Measure. In OIG's opinion, these audits, inspections and investigations offer information as to whether the programs or activities reviewed are achieving their missions and goals.



**Health Care  
Financing  
Administration**



---

## Chapter II

# HEALTH CARE FINANCING ADMINISTRATION

### Overview of Program Area and Office of Inspector General Activities

The Health Care Financing Administration (HCFA) is responsible for administering the Medicare and Medicaid programs. Medicare Part A provides hospital insurance for persons age 65 or older and for certain disabled persons. Financed by the Federal Hospital Insurance (HI) Trust Fund, Fiscal Year (FY) 1993 expenditures for Medicare Part A are expected to exceed \$82 billion. Medicare Part B (supplementary medical insurance or SMI) is an optional program which covers most of the costs of medically necessary physician and other services. Financed by participants and general revenues, FY 1993 expenditures for Medicare Part B are estimated at \$60 billion.

The Medicaid program provides grants to States for medical care for more than 30 million low-income people. Medicaid outlays have risen at a dramatic pace, causing Medicaid spending to become the fastest rising portion of both the Federal and State budgets. Federal Medicaid spending soared in FY 1992 to \$72.5 billion. Federal expenditures are expected to reach \$84 billion in 1993, a 600 percent increase since 1980. 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 or Supplemental Security Income. The Federal grant is open-ended, paying from 50 to 83 percent of the State's Medicaid expenditures, based on a calculation of the State's relative wealth.

The Office of Inspector General (OIG), over time, has devoted significant resources to monitoring and investigating the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care, improve the quality of health care and reduce the potential for fraud, waste and abuse.

Reform of the health care system has become a top policy concern of the Administration. Significant changes can be expected in the nation's patchwork health care prevention and delivery systems in the coming years. The OIG is concerned that omissions, overlaps and other problems in the current systems which make them vulnerable to fraud, waste and abuse not be replicated. In this light, OIG will continue its oversight responsibility in the following significant areas: Medicare contractor reform, Medicare as secondary payer, Medicare fraud, Medicaid drug rebates, Medicaid fraud control, administrative burdens, electronic media claims, beneficiary participation in health care decisions, managed care,

sanctions and patient protection, kickbacks, reimbursement for durable medical equipment (DME), and implementation of the Clinical Laboratory Improvement Act.

In addition, OIG will review the implementation of a fee schedule for physician services, general and administrative costs claimed by hospitals, and Medicare accounts receivable with credit balances.

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 543 successful actions against wrongdoers in these programs.

### **Update on Medicare Credit Balances**

This report updates findings reported to HCFA in 1991 regarding OIG's pilot review of Medicare beneficiary accounts with credit balances (amounts due Medicare, usually as a result of overpayment) at 11 hospitals and 1 intermediary. The HCFA had agreed with OIG's interim recommendations and instituted recovery actions. The OIG's expanded review at 76 hospitals and 9 intermediaries indicated that the conditions reported previously are national in scope. The OIG estimated that hospitals owe the Medicare program \$266.4 million. Further, OIG noted the intermediaries' failure to recover Medicare overpayments even when hospitals attempted to refund them, and the fact that some hospitals were writing off Medicare beneficiary accounts with credit balances from their accounting records and keeping the Medicare overpayments.

The OIG recommended that HCFA continue its recovery efforts as outlined in the instructions to intermediaries; require intermediaries to respond timely to hospitals' attempts to refund Medicare overpayments; and include in their hospital audits a review of Medicare beneficiary accounts with credit balances that were written off by the hospitals. The HCFA implemented the recommendations and reported that, as of September 30, 1992, about \$337.3 million in Medicare overpayments had been identified and about \$254.6 million recovered. (CIN: A-03-92-00010)

### **Hospital General and Administrative and Employee Benefit Costs**

In response to a request by the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, OIG is reviewing general and administrative (G&A) and employee benefit (EB) costs at 20 selected hospitals nationwide. The objectives of these reviews are to determine the impact of G&A and EB costs on health care expenditures, whether reported costs are allowable, reasonable and allocable to the Medicare program, and whether they relate to patient care in accordance with Medicare cost principles. During this reporting period, OIG issued reports on 12 institutions: Beth Israel Medical Center and Lenox Hill Hospital in New York; Parkway Regional Medical Center and Baptist Hospital of

Miami in Florida; Humana Hospital San Antonio in Texas; Saint Joseph Hospital in Colorado; North Kansas City Hospital in Missouri; Moss Rehabilitation Hospital, Allied Services, Inc., Albert Einstein Medical Center and Medical College of Pennsylvania in Pennsylvania; and Virginia Mason Hospital in Washington. The OIG identified unallowable costs at these institutions and recommended cost adjustments. In addition, where appropriate, OIG included a "Costs for Concern" section in the reports in response to the Subcommittee's interest in rising health care costs. These expenditures, in OIG's opinion, have questionable benefit to patient care, although they have been historically allowed by the fiscal intermediaries or the Provider Reimbursement Review Board. (CIN: A-02-92-01023; CIN: A-02-92-01022; CIN: A-04-92-02042; CIN: A-04-92-02043; CIN: A-06-92-00072; CIN: A-08-92-00555; CIN: A-07-92-00554; CIN: A-03-92-00006; CIN: A-10-92-00008; CIN: A-03-92-00008; CIN: A-03-92-00005; CIN: A-03-92-00015)

### **Payments For Nonphysician Outpatient Services under the Prospective Payment System**

The OIG issued a report indicating that, contrary to Federal regulations, hospitals under the prospective payment system (PPS) were reimbursed for nonphysician outpatient services, such as laboratory services, rendered on the day before, the day of, or during an inpatient stay. Costs of such services are included in the PPS rate. The OIG concluded that improper Medicare payments of approximately \$38.5 million were made by Medicare fiscal intermediaries to PPS hospitals in the period December 1987 through October 1990. In addition, OIG identified about \$12.9 million due beneficiaries representing the coinsurance and deductible portions of the improper charges.

The OIG recommended that HCFA continue to notify hospitals that such duplicate billings will be met with sanctions; continue monitoring intermediary compliance with PPS laws and regulations preventing separate payment for nonphysician outpatient services through a more effective Intermediary System Testing Program process; provide intermediaries with OIG's computer tapes of potential improper payments for recovery; and ensure that coinsurance and deductibles due beneficiaries are refunded. The HCFA generally concurred with the findings and recommendations and has initiated appropriate actions. (CIN: A-01-91-00511)

### **Hospital Minimum Data Set**

The Hospital Minimum Data Set (MDS) consists of the approximately 1500 data fields utilized to identify a national data base of Medicare hospital financial and statistical information. The MDS is generated from the cost report data maintained by HCFA's health care provider cost report information system (HCRIS). An OIG review found that, overall, the MDS was well maintained and managed, and that the current error rate within MDS data fields should be acceptable to most users. The review also found that internal controls for

MDS at HCFA, the HCFA data center and the fiscal intermediaries (FIs) were generally adequate.

A statistical sample of MDS showed an accuracy rate of more than 99 percent for the data elements tested. Only two FI data entry errors were responsible for the .39 percent error rate, and since most hospitals must submit their cost reports on electronic media for all cost reporting periods beginning on or after October 1, 1989, this error rate should be lower in the future. The OIG also noted errors that did not influence the overall accuracy and reliability of hospital cost report data. The OIG recommended that HCFA strengthen internal controls at FIs by requiring password security systems on all HCRIS computers. (CIN: A-07-92-00500)

### **Medicare Secondary Payer Activities**

The OIG issued a memorandum alerting HCFA to the preliminary results of a review requested on Empire Blue Cross Blue Shield. The review will identify the extent to which Empire mistakenly paid claims as primary payer for individuals subject to the working aged criteria of the Medicare secondary payer legislation when the Empire private lines of business should have been the primary payer for these medical services.

To date, computerized private side employer group health plan enrollment files, as well as applicable health plan contracts have been obtained from Empire and the reliability of the data validated. This data was matched against both the Medicare payment history files maintained by Empire as a Medicare contractor and the HCFA central office Medicare automated data retrieval system payment history files for all other Medicare contractors. Based on the results of a probe sample, OIG preliminarily estimates that the improper payments may total \$143 million. (CIN: A-02-91-01054)

### **Medicare Trust Funds: Financial Disclosure**

An OIG management advisory report alerted the Assistant Secretary for Management and Budget (ASMB) to issues that affect the preparation of full disclosure Medicare financial statements. An earlier OIG report (CIN: A-13-89-00045) identified problems in the Social Security Administration's (SSA's) wage certification procedures. An OIG review of SSA's FY 1991 financial statements showed that these issues have not been resolved and that there is an impact on the Medicare trust funds as well. The Social Security Act requires the transfer of the Medicare portion of employment payroll taxes from the general fund to the HI trust fund based on wage reports maintained by the Secretary. The OIG found that SSA performs the wage certification function but is using Internal Revenue Service (IRS) records rather than wage reports maintained by the Secretary. Further, this is inconsistent with data used to transfer other amounts, such as Medicare taxes for Government employees and refunds of overwithheld Medicare taxes. In addition, the Medicare HI and SMI trust funds contribute to the purchase of SSA's property, plant, equipment and other assets through

SSA's cost allocation process. The allocation began years ago when HCFA was part of SSA. Today, however, HCFA is a separate agency and the appropriateness of continuing to allocate SSA costs to HCFA needs to be reevaluated.

The OIG recommended a review of SSA's wage certification procedures to ensure that the transfer of funds is consistent and performed in accordance with the Act. Further, OIG proposed review of the appropriateness of SSA's policy of allocating funds from the Medicare HI and SMI trust funds to pay for a portion of its assets. The ASMB agreed with the OIG recommendations and has implemented corrective action. (CIN: A-14-92-03013)

## **Medicare Administrative Costs**

The HCFA has contracted with private insurance companies (fiscal intermediaries and carriers) to process and pay Medicare claims. The OIG reviews the allowability of costs claimed for reimbursement by these contractors.

### **A. Part A and Part B Costs**

The OIG contracted for an audit of Medicare administrative costs incurred by Health Care Service Corporation (HCSC), the Medicare Part A intermediary and Part B carrier in Illinois. The audit covered the costs claimed on HCSC's final administrative cost proposals for FYs 1987 through 1990. Of the total claimed (approximately \$114 million), auditors questioned \$1.1 million. The HCSC fully concurred with OIG's findings and recommendations on outdated statistics, miscellaneous unallowable costs, interest expenses applicable to deferred compensation and capital leases, and complementary credits. It partially concurred with findings on pension and final administrative cost proposal adjustments. In response to the draft report, HCFA generally concurred with the findings and recommendations. However, HCFA has not yet made a final management decision on this audit. (CIN: A-05-92-00108)

### **B. Part B Costs**

In a review of cost proposals for FYs 1985 through 1989 by Empire Blue Cross Blue Shield of New York, OIG determined that \$2.5 million of the \$216.6 administrative costs claimed were unallowable. The OIG recommended a downward financial adjustment of \$2.5 million. Empire Blue Cross Blue Shield agreed with the recommended adjustment of \$1.8 million relating to its assessments on insurance premiums, which are specifically unallowable under its Medicare contract. However, it disagreed with the balance of the recommended financial adjustments. (CIN: A-02-92-01028)

## **Medicare Contractor's Segmented Pension Costs**

The OIG determined that, as of January 1, 1990, Blue Cross and Blue Shield of Florida, Inc. had overstated Medicare pension assets by \$1.2 million and accumulated \$2.4 million in pension costs which are unallowable for Medicare reimbursement. The OIG recommended that the assets related to the Medicare segment of the contractor's pension plan (as of

January 1, 1990) be reduced by \$1.2 million. The contractor agreed. The OIG further recommended that the contractor separately identify \$2.4 million as being unallowable components of direct pension costs of the Medicare segment as of January 1, 1990. Also, the contractor should continue updating unallowable components of pension costs for subsequent years relating to the unfunded costs for 1986 through 1990 and provide similar treatment to any subsequent years' unfunded pension costs. (Pension costs not funded for an accounting period, plus interest related to the unfunded amounts, are unallowable components of future year pension costs.) The contractor agreed with these recommendations, except for the dollar amount. (CIN: A-07-91-00473)

## **Contractors' Unfunded Pension Costs**

### **A. Blue Cross and Blue Shield of Texas**

The OIG found that, as of April 1, 1991, Blue Cross and Blue Shield of Texas, Inc. had accumulated \$6.2 million in pension costs that are unallowable for Medicare reimbursement since the costs were unfunded. The OIG recommended that the contractor: separately identify \$6.2 million as an unallowable component of pension costs as of 1991; continue a yearly update of unallowable pension cost components related to the unfunded costs for 1988 through 1990; and identify unallowable components of pension costs for which costs of the pension plan are not funded. The contractor agreed with the calculations and criteria in the report, but expressed its intention to seek a waiver which would allow it to reassign and claim the costs in future accounting periods. In response to the draft report, HCFA agreed with the OIG findings and recommendations. However, HCFA has not yet made a final management decision on this audit. (CIN: A-07-92-00578)

### **B. Blue Cross and Blue Shield of Michigan**

In another audit, OIG determined that Blue Cross and Blue Shield of Michigan had accumulated \$2.5 million in pension costs that are unallowable for Medicare reimbursement since the costs were unfunded. The OIG recommended that the contractor separately identify \$2.5 million as an unallowable component of pension costs as of January 1, 1990; continue a yearly update of unallowable pension cost components related to the unfunded costs for 1986 through 1989; and identify unallowable components of pension costs for any subsequent years for which costs of the pension plan are not funded. The contractor stated that it would seek a waiver to permit it to reassign and claim the costs in future accounting periods. (CIN: A-07-92-00579)

## **Bid Proposal Audits of Peer Review Organizations**

The law requires that the Secretary enter into contracts with peer review organizations (PROs) to review the quality, necessity, reasonableness and appropriateness of health care provided to Medicare beneficiaries. At HCFA's request, OIG has conducted PRO bid proposal audits to be used in negotiating these contracts. The OIG reviewed HCFA's usage

of the bid proposal audits completed in FY 1990 to determine whether they were cost-effective and whether HCFA's efforts to reduce the occurrence of unsupported costs in subsequent bid proposals were adequate.

The OIG found that the audits of PRO bid proposals completed during FY 1990 resulted in savings to the Medicare PRO program of over \$33 million. This represents an extremely favorable return when compared to the cost of performing these audits. The OIG intends to continue its involvement with future PRO audits. The OIG recommended that, in future requests for proposals for PRO contract awards, HCFA include language to alert PROs to the types of unsupported costs found in OIG's bid proposal audits. Further, OIG recommended that HCFA monitor PROs subsequently contracted to ensure that corrective actions are taken as a result of procedural improvements called for in PRO bid proposal audits. The HCFA concurred with the recommendations. (CIN: A-14-91-00343)

### **Hospital Closure: 1991**

The OIG's fifth annual assessment of hospital closures and the demographics of those that closed revealed patterns similar to those previously reported. Fifty-seven general, acute-care hospitals closed in 1991, two-thirds of them rural. The average rural hospital which closed was just over a third the size of rural hospitals nationwide and had low occupancy rates. Urban hospitals which closed were less than half the size of the average urban hospital, had low occupancy rates and served more Medicaid patients than the average urban hospital (17.4 percent versus 11.7 percent).

Once again, OIG found that hospitals closed because of interrelated pressures from declining occupancy, lagging revenues and rising costs. Emergency and inpatient hospital care are available within 20 miles for most residents of communities in which hospitals closed; however, some rural residents had to travel more than 30 miles. Thirty-two of the 57 closed hospitals were being used for health-related services, including medical assistance facilities, nursing homes and clinics. (OEI-04-92-00440)

### **Liver Biopsies**

The OIG conducted a study to review the performance, coding and financing of liver biopsies paid for by the Medicare program. The OIG found that liver biopsies in which the abdomen is opened but only a needle sample is taken are not described correctly under the current common procedural terminology (CPT) coding systems. Also, 13 percent of physicians claims for liver biopsies were miscoded and 31 percent of payments to physicians should not have been made. Due to several incorrect uses of the CPT coding system for liver biopsies, nearly \$1.3 million in overpayments were made to physicians in 1986. The OIG also found that Medicare fiscal intermediaries have been generally successful in obtaining and evaluating hospitals' operative reports for each claim for open biopsies.

The OIG recommended that HCFA ensure that all payments for biopsies are made correctly by proposing revised coding structures so that all biopsies can be properly classified and ensuring that carriers adjust payment for open biopsies performed in the course of more major operations. The HCFA concurs with the recommendations. (OEI-12-88-00900)

### **Fragmented Physician Claims**

The findings in the study of liver biopsies led OIG to further examine the payment for exploratory surgery and biopsies when performed with another surgical procedure. The OIG found that physicians frequently billed for biopsies and/or explorations which were part of another surgical procedure, realizing, as a result, more than \$12 million in overpayments in 1988.

The OIG recommended that HCFA require carriers to deny or adjust payment for: "exploratory" surgery performed incidently to a procedure separately billed; biopsies performed in the course of more major surgery in the same body cavity; "separate procedures" billed with another procedure; mutually-exclusive procedures; and claims by assistants for procedures denied when billed by surgeons. The HCFA concurred with the parts of the recommendation concerning exploratory surgery, separate procedures and mutually exclusive procedures, and nonconcurred on the remainder of the recommendation. (OEI-12-88-00901)

### **Diagnosis-Related Group Validation Updates**

The Medicare program reimburses hospitals a predetermined amount of money, depending on the patient diagnosis and designation of a diagnosis-related group (DRG). The DRGs are based on the patient diagnosis, and are modified by the presence of a surgical procedure, the patient's age, the presence or absence of significant complications or other relevant criteria.

The OIG conducted follow-up reviews examining the coding accuracy for four particular DRGs. The reviews showed that all but one of these particular DRGs continue to overreimburse hospitals. The findings from these studies support a prior OIG recommendation that peer review organizations continue surveillance of hospital coding for DRG accuracy. The HCFA agrees with this recommendation. Specifically, OIG found that: billing errors for DRG 296 (nutritional and miscellaneous metabolic disorders) have not been reduced, were random in nature and caused no overreimbursement to hospitals; coding accuracy for DRG 79 (respiratory infections and inflammations) significantly improved from 1985 to 1988, but hospitals were still overreimbursed \$22.7 million; billing errors for DRG 121 (circulatory disorders with acute myocardial infarction and cardiovascular complications) were not reduced, resulting in \$28.7 million in hospital overreimbursement; and billing errors for DRG 154 (stomach, esophageal and duodenal procedures) were not reduced, resulting in hospital overreimbursement of \$41.4 million. (OEI-12-89-00195; OEI-12-89-00193; OEI-12-89-00194; OEI-12-89-00196)

## Criminal Fraud

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:

- Twenty-two persons pled guilty, of whom thirteen have been sentenced, in a series of schemes in which ten hospitals in northern New Jersey and New York were defrauded of an estimated \$10 million in Medicare and private insurer monies. Hospital officials and employees, x-ray film manufacturers' representatives, and x-ray film distributor company owners and employees participated in the conspiracy. The schemes included diversion of shipments, sale of stolen film, phony invoices, money laundering, bribery, kickbacks and no-show jobs. Sentences ranged up to 12 months in prison; and restitution, fines and special assessments ordered amounted to \$490,600.
- An audiologist was sentenced in New Hampshire to 44 months incarceration and ordered to pay a \$6,500 special assessment for filing false Medicare claims. He submitted claims to both Medicare and the Department of Labor for the same hearing tests on naval shipyard employees. He also billed for services not rendered and not referred by physicians. He billed Medicare for hearing tests on nursing home residents who had medical infirmities such as senility and Alzheimer's disease that would make the tests impossible. He advertised in newspapers and mailings "free" examinations which he then billed to Medicare. Although during the investigation he repaid Medicare \$102,557 he received as a result of fraudulent claims, he was still indicted and convicted in jury trial on 130 counts.
- A physician was sentenced to make restitution of \$425 to Medicare and \$3,000 to a Medicare carrier, ordered to perform 150 hours of community service and lose her license for a period to be determined by the Michigan licensing board. She drew blood from patients once a month and had her billing clerk file claims for comprehensive thyroid profiles. When her medical supplier refused to serve her because she was behind in payments, the drawn blood was put in the freezer. A search of her office turned up samples over 6 months old — far too old for valid testing. She also put patients in the hospital or intensive care, then billed for visits never made.

## **Fraud and Abuse Sanctions**

During this reporting period, OIG imposed 380 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 health care, conviction of program-related crimes, conviction of controlled substance manufacture or distribution, or conviction related to 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 Block Grant, and Block Grants to States for Social Services programs. Exclusions can now be imposed 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 while a disciplinary proceeding is pending before a State licensure board. Exclusion is mandatory for those convicted of program-related crimes or crimes relating to patient abuse.

The OIG reviews all factors involved in a case to determine whether an exclusion is appropriate and, if so, the proper length of the exclusion. Factors reviewed include information solicited directly from the provider and information obtained from outside sources such as courts, licensing agencies or other Federal or State programs. The following sanctions were among those imposed during this reporting period:

- A psychiatrist, another psychiatrist whose license had been revoked and an office manager in New York were each excluded for 25 years after being convicted of stealing more than \$1.3 million by billing Medicaid for over 50,000 psychotherapy sessions he did not provide.
- An Arizona residential care home owner was excluded for 20 years after being convicted of patient abuse or neglect. While under his care, patients suffered significant physical and mental harm, and two patients suffered life-threatening conditions which resulted in one of the patients having a leg amputated.
- After being convicted of raping an 83-year-old Alzheimer's patient, a New York nurse's aide was excluded for 15 years.
- A California DME salesperson was excluded for 15 years after being convicted of solicitation of unlawful Medi-Cal remuneration and attempted

submission of false Medi-Cal claims. She had previously been convicted of theft and forgery of patients' Social Security checks.

- Based on his Virginia conviction and sentencing for mail fraud involving private insurance companies, a physician was excluded from participation in the Medicare and State health care programs for 15 years. The physician, who specialized in infertility, carried out a bogus pregnancy scheme in which he tricked patients into believing they were pregnant when they were not and later told them they had miscarried and the fetus had been reabsorbed. He also artificially inseminated patients with his own sperm, which resulted in the birth of numerous children.

Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request a review by the Departmental Appeals Board. If he is still dissatisfied after this review, he may take his case to District Court.

#### **B. Civil Monetary Penalties for False Claims**

Under the civil monetary penalty (CMP) authorities enacted by the Congress, OIG may impose penalties, assessments and, in certain cases, exclusions against health care providers who submit false or improper claims to the Medicare and State health care programs. The CMP law, therefore, allows recoupment of some of the monies lost through illegitimate claims, but it also protects health care providers by affording them due process rights similar to those available in the administrative sanction process. Many providers, however, elect to settle their cases prior to litigation. The OIG recouped approximately \$17.3 million through CMP settlements and hearing decisions during this period, of which the following are examples:

- A major blood testing laboratory headquartered in California agreed to pay \$100 million in settlement for defrauding Medicare by manipulating doctors into ordering medically unnecessary tests. The settlement, which was obtained with the cooperation of most of the State Medicaid officials, is the largest ever reached between the Government and a provider in a health care case. The laboratory also will pay a criminal fine of \$1 million and reimburse State Medicaid agencies approximately \$10 million for their losses attributable to its criminal conduct. The agreement settled claims that the laboratory added high density lipoprotein cholesterol tests and iron storage tests to the series of blood tests doctors order most because it is highly informative and relatively low cost (Medicare pays a flat fee for any work-up of 19 or more tests in the series). By 1989, the laboratory was performing about 7 million of the series a year. The two extra tests,

however, were not really part of the series run, and were billed separately to Medicare regardless of whether the doctors had ordered them. These tests were fraudulently billed at a substantially higher rate than the doctors were charged.

- As part of a global settlement, a South Carolina ophthalmologist who owned and operated a free-standing surgery clinic in Charleston pled guilty to charges related to Medicare/Medicaid fraud. Investigation of a complaint that he was billing for endothelial cell tests he had not performed turned up some 400 tests for which there was no documentation. In fact, he did not even have equipment to do the test at his downtown satellite office. When he became aware of the investigation, the ophthalmologist ordered a lens to attach to his "slit lamp" and told employees to show it to the investigators if they asked to see the equipment. He agreed to pay the Department \$569,475 in the settlement.
- A Nevada plastic surgeon entered an agreement to pay \$100,000 for improper submittals of Medicare and Medicaid claims. The claims were for surgical services which had been upcoded and fragmented, with the result that he was overpaid \$36,580.
- An ALJ upheld a CMP and assessment proposed by OIG against a New York optometrist. The optometrist had been excluded from the Medicare and Medicaid programs after a State conviction, but duped his partner into billing Medicare for services he himself performed. Investigation preparatory to the ALJ hearing showed that he had also been convicted of mail fraud. In addition, it was found that his optometry license had been suspended but he had continued to practice. During the proceedings, he was transferring his assets to his wife. The ALJ imposed penalties of \$56,000 and assessments of \$3,885 for causing claims to be filed during his exclusions.
- Upon appeal, a New York doctor acquired heavier penalties and assessments as well as a longer exclusion period. In 1987, the doctor was convicted of Medicare fraud for submitting claims for nerve blocks and office visits when acupuncture was actually performed. After a lengthy CMP hearing, the ALJ imposed a penalty of \$140,000, an assessment of \$45,000 and an exclusion of 7 years, which both the doctor and OIG appealed. The Departmental Appeals Board remanded the matter back to the ALJ, who imposed a penalty of \$345,000, an assessment of \$70,000 and a 10-year exclusion.

- In Ohio, an x-ray company signed a settlement providing for immediate payment of \$245,000 to cover civil damages for false Medicare/Medicaid claims for the corporation only. Several owners of the corporation still face possible liability. Two owners, a husband and wife who managed the corporation, caused it to bill for services not performed. The corporation also billed mileage charges for transporting equipment which actually represented delivery of film to physician offices. The most serious scheme was the billing of Medicare for Bucki views, which are special chest x-rays for large persons. The average x-ray service in the area performed 8 of these views for every 100 patients, but this company billed 155 per 100. The technicians admitted never taking Bucki views, merely overexposed x-rays which they called Bucki views. Criminal charges are pending against three persons, and the civil liabilities of several persons are being reviewed.
- A Maryland ophthalmologist and his surgery center agreed to pay \$750,000 in settlement of false Medicare billings. The ophthalmologist billed Medicare for laser surgery when all he performed was post-operative suture removal, a procedure typically included in the global fee for eye surgery. He averaged Medicare billings of more than \$1.5 million a year in 1989 and 1990.
- A Pennsylvania hospital billed Medicare for ambulance services for which it was not entitled to reimbursement. The hospital billed as if it had transported patients and provided advanced life support services, when in fact it provided technicians for advanced life support but the actual transport was performed by another company. The hospital agreed to pay \$374,430 in civil penalties and restitution. As part of the settlement agreement, the hospital agreed to set up a training program for employees to insure that Medicare is billed properly in the future.
- A Massachusetts physician repeatedly billed Medicare for serial tonometry procedures along with claims for routine eye exams. It was determined that he was in fact performing simple tonometry, which is part of the routine eye exam. In order to resolve his CMP liability, the ophthalmologist agreed to pay \$250,000 in restitution and civil penalties.

## **Kickbacks**

Many businesses engage in referrals to meet the needs of customers or clients for expertise, services or items which are not part of their own regular operations or products. The medical profession relies heavily upon referrals because of the myriad specialties and technologies associated with health care. If referrals of Medicare or Medicaid patients are

made in exchange for anything of value, however, both the giver and receiver may violate the Federal anti-kickback statute. They also may directly or indirectly increase Medicare/Medicaid costs.

Over the years, some 500 convictions, judgments and settlements have been obtained as a result of OIG investigations of violations of the anti-kickback statute. The following convictions for kickbacks were reported during this period:

- In Tennessee, a former State Commissioner on Aging and his former business partner were convicted of kickbacks, false statements and claims, money laundering and obstruction. The former commissioner, who had been an unsuccessful gubernatorial candidate, was sentenced to 57 months in jail for defrauding Medicare and Medicaid through a chain of home health agencies he owned. He was also ordered to pay more than \$5.8 million in restitution, and banned from applying for credit, liquidating anything of value over \$1,000 without court permission, or working at anything paid by Medicare or Medicaid funds. The judge ordered confiscation of his \$190,000 home, bank accounts and life insurance policy. His former business partner was sentenced to 51 months in prison and ordered to pay restitution of more than \$3.6 million. He too was banned from work involving Medicare and Medicaid funds. The former commissioner made it appear that he sold his home health agencies, then set up a company which contracted to "manage" them. He owned durable medical supply companies which sold equipment to the agencies at 100 percent markup.
- A former purchasing agent for a health insurance company in Wisconsin was sentenced to 4 months incarceration and 3 years probation, fined \$10,000, and ordered to pay restitution and special assessment of \$146,300 for accepting kickbacks. In the course of investigating allegations that a telemarketing firm was pressuring a hospital employee to accept "premiums" in return for ordering its supplies, the purchasing agent was discovered to have accepted kickbacks from the firm. Further investigation showed that he also accepted kickbacks from another New York company in return for large purchases of computer-related supplies that either were not delivered or were priced at grossly inflated markups.

### **Increased Application of Comparability**

Medicare payment for physician services was changed, effective January 1, 1992, from a reasonable charge basis to a fee schedule amount. When computing the payment base under the fee schedule, HCFA was required to take into account the old payment rules, including comparability as it was implemented under that system. The Medicare comparability

provision provides that the reasonable charge for a service may not exceed the established charge for non-Medicare policyholders of a carrier for a comparable service under comparable circumstances.

An OIG review showed limited carrier implementation of the comparability provision. The OIG estimated that by applying the comparability provision to 12 high-dollar volume procedures, Medicare and its beneficiaries would have saved \$3.9 million for 1986 and \$38 million for 1990. These higher payments will continue under the fee schedule because HCFA was not required to consider potential payment reductions associated with the increased application of the comparability provision when computing the payment base.

Annual adjustments to the fee schedule payments are made through the Medicare volume performance standard rates of increase. The OIG recommended that HCFA consider the \$38 million savings when updating payments under the fee schedule and, if necessary, seek legislative authority to consider measurements of comparability as part of the Medicare volume performance standard rates of increase. In response to the draft report, HCFA disagreed with the findings and recommendation. However, HCFA has not yet responded to the final report. (CIN: A-05-92-00100)

### **Exception Policy for Reimbursement of New Physicians in Medical Groups**

Since 1975, various Medicare cost restraints have been imposed on physicians' charges, some of which do not apply to physicians in their first year of practice. As a result, reimbursement for a given service rendered by first-year physicians sometimes exceeded that of established physicians. To remedy this, the Congress provided that, effective April 1, 1988, first-year physicians' customary charges be limited to 80 percent of the prevailing charges of established physicians in the same localities. The law was subsequently amended to cover physicians and other health care practitioners in their second, third and fourth years of practice by providing limits of 85, 90 and 95 percent, respectively.

The HCFA reasoned that, since new physicians did not have unique national identification numbers, the carriers would be unable to identify and apply the limits to new physicians who practice in group settings. Accordingly, it provided an exception that allowed carriers to use the Medicare group customary charges rather than applying the percentage limits to new physicians in a group. The OIG determined that the HCFA exception policy was not warranted and that, by excluding many new physicians, intended savings may not have been realized. The OIG concluded that there were other alternatives that HCFA should have considered in order to comply with the law.

The HCFA removed the exception policy when the physician fee schedule was implemented on January 1, 1992. In addition, it reduced the fee schedule payment amounts to reflect the

effect of the exception policy. As a result, OIG determined that appropriate action has now been taken and that no further recommendations are necessary. (CIN: A-09-91-00097)

### **Physicians' Costs for Chemotherapy Drugs**

At HCFA's request, OIG conducted a review to provide information on physician costs for 13 high dollar volume chemotherapy drugs paid for under the Medicare program. The OIG found that, for the physicians surveyed, the drugs may be purchased at amounts below the established average wholesale price (AWP) and that AWP is not a reliable indicator of the cost of a drug to physicians. Also, OIG determined that the costs of wasted and spoiled drugs, spilled drugs, storage of drugs and bad debt costs (arising from unpaid 20 percent coinsurance) were minimal and should not have a great impact on providing the drug.

The OIG believes that, in gathering invoice prices as part of the carrier surveys required by regulation, HCFA should consider the source physicians use to obtain drugs. The survey results should be adjusted to the lowest price available in the marketplace when physicians indicate purchases at higher prices from pharmacies and wholesalers for drugs that could have been bought directly from manufacturers at lower prices. The OIG recommended that HCFA define reimbursement policy to encourage physicians to purchase drugs using the most economical means available. The HCFA should also establish uniform survey criteria to be used by carriers to determine estimated acquisition costs (EAC) and set uniform policy for carriers' evaluation of drug inventory, waste and spoilage costs. In addition, HCFA should revise its coding and reimbursement systems to pay for drugs based on the dosage actually administered. The HCFA has requested that OIG expand its review to obtain more information and continue to explore alternative sources of pricing information for chemotherapy drugs. (CIN: A-02-91-01049)

### **Cost of Dialysis-Related Drugs**

The HCFA utilizes a prospective method of payment for dialysis services under which it establishes a per treatment composite rate to reimburse independent renal dialysis facilities and hospital-based facilities. The composite rate is a comprehensive payment for all services related to dialysis treatment except for physicians' patient care services, blood, and certain drug and laboratory services that are separately billable.

The OIG conducted an audit at HCFA's request to review its proposal to change the methodology for reimbursing separately billable drugs. Subsequently, HCFA published final regulations effective January 1, 1992 setting reimbursement for separately billable drugs at the lower of the EAC (derived by the carrier from surveys of the actual invoice price paid for the drug) or the AWP.

The OIG found that dialysis facilities purchase separately billable drugs for significantly less than the AWP, and concluded that HCFA's instructing the Medicare fiscal intermediaries

(FIs) to set the reimbursement limit at the EAC rather than the AWP for selected drugs appears to be a reasonable method for controlling Medicare program expenditures. The OIG recommended that HCFA: provide the necessary guidance to the Medicare FIs to ensure timely implementation of the EAC provision of the new Medicare drug regulations; encourage providers to purchase their drugs from the most economical source; and consider a methodology for folding the costs of all separately billable drugs into the composite rate. The HCFA agreed with the first two recommendations, and agreed in principle with the last recommendation, but needs additional data before proceeding with its implementation. (CIN: A-01-91-00526)

## **Medicare Reimbursement for Epogen**

In June 1989, the Food and Drug Administration approved Amgen Inc.'s product licensing application to manufacture the drug Epogen (EPO). Amgen manufactures and markets EPO directly for dialysis patients in the United States, for which Amgen has exclusive market rights under the Orphan Drug Act provisions. The Medicare program, through reimbursement to dialysis facilities, is the primary payer for this drug since approximately 90 percent of the EPO market are Medicare beneficiaries.

As part of the Omnibus Budget Reconciliation Act of 1990, the Congress amended the payment methodology for EPO to one based on units actually administered and set the rate of reimbursement for 1991 at \$11 per 1,000 units. An OIG management advisory review found that, for a selection of dialysis facilities, the cost of EPO was between \$10 and \$10.10 per 1,000 units administered, approximately \$1 less than the Medicare reimbursement rate. In addition, some facilities also received year-end manufacturer rebates (2 to 8 percent of the purchase price) or free EPO, depending on the volume purchased. The OIG recommended that HCFA consider reducing the reimbursement rate not to exceed \$10.10 per 1,000 units administered and enter in negotiations with Amgen to determine a rate which takes into consideration manufacturer rebates. In response to the draft report, HCFA stated that it would consider OIG's findings when calculating the future payment rate of EPO. The HCFA has not yet responded to the final report. (CIN: A-01-92-00506)

## **Medical Necessity for Ambulance Services**

Medicare carriers are permitted by HCFA to pay separate reimbursement rates for basic life support (BLS) and advanced life support (ALS) ambulances. Although the Carriers Manual requires the use of an ALS ambulance for the supplier to obtain reimbursement at the ALS rate, it does not require the provision of ALS level services.

The OIG found that, from 1986 to 1989, the number of trips in ALS ambulances increased by 131 percent while the number in BLS ambulances increased by only 14 percent. Further, allowed charges for base rate ALS and BLS ambulance services increased by \$72 million from 1988 to 1989, of which \$53 million (or 73 percent) was attributable to increased

utilization of ALS ambulances. The OIG believes that the increase in ALS utilization is due, in large part, to policies which base payment on the mode of transportation rather than the medical necessity for the level of service. The OIG estimates that nearly \$16 million would be saved annually if payment were based on the medical need of the beneficiary (\$12.76 million program savings and \$3.19 beneficiary savings).

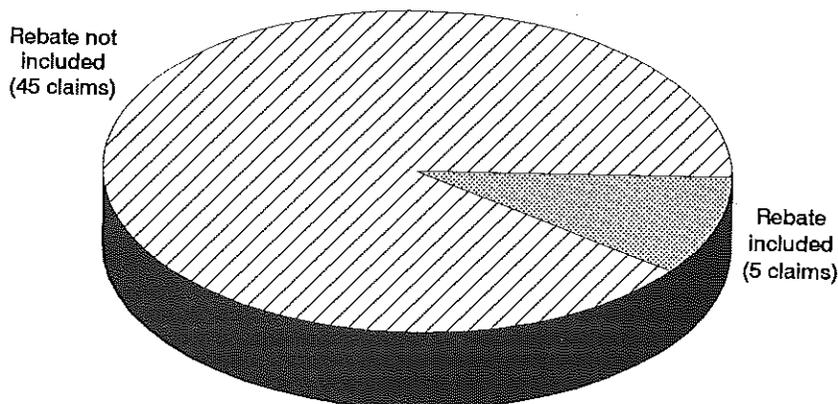
The OIG recommended that HCFA: modify its policies to allow payment for nonemergency ALS service only when medically necessary at that level of service; instruct carriers to institute controls to ensure that payment is based on the medical need of the beneficiary; and closely monitor carrier compliance. The HCFA generally concurred with the recommendations and has agreed to take corrective actions. (CIN: A-01-91-00513)

### Medicare Payments for Home Blood Glucose Monitors

The OIG conducted a review to determine if Medicare claims for blood glucose monitors were being reduced by manufacturers' rebates and to evaluate the Medicare fee schedules for monitors.

The OIG concluded that excessive Medicare payments were made for monitors because claims were not adjusted to reflect manufacturers' rebates. In a review of 80 claims paid by two Medicare carriers in two States in 1991, OIG found that 50 monitors had rebates available at the time of purchase. As shown below, the majority of the claims were not adjusted to reflect manufacturers' rebates.

#### REVIEW OF CLAIMS WITH REBATES AVAILABLE



In addition, OIG found that payment limits in fee schedules established for monitors were too high. Although monitors could be purchased for about \$50, Medicare fee schedule limits ranged from \$144 to \$211.

The anti-kickback statute prohibits rebates where the discount is not accurately reported to Medicare or Medicaid. While the statute provides for criminal penalties in some instances, criminal prosecution may not be realistic or appropriate. Therefore, legislation providing for civil monetary penalties is needed to ensure that discounts are properly reported. The OIG offered to work with HCFA to promote and design the framework for such a legislative initiative. In addition, OIG recommended that HCFA: work with carriers to identify rebate programs for possible violations of the anti-kickback statute; ensure that Medicare payments for monitors are net of any available rebate; continue efforts seeking legislation to allow carriers to apply inherent reasonableness to the fee schedule amounts; and require manufacturers to identify rebates paid to customers and recover any overpayments for claims filed for benefit payments. In response to the draft report, HCFA provided comments that were in agreement with or generally responsive to the first three recommendations. The HCFA nonconcurred with the fourth, citing factors such as cost and difficulty in administration. (CIN: A-09-92-00034)

### **Fraud involving Durable Medical Equipment Suppliers**

The successful actions against fraud in the DME industry during this 6-month period were the result of investigations begun before HCFA published new regulations last year. These regulations addressed reimbursement problems that recurred over the years, especially carrier shopping and telemarketing. The specification of claims processing jurisdiction by four regional jurisdictions should resolve many of these problems. In the meantime, the following successful actions were accomplished during this reporting period:

- The owner of a DME company in Ohio was sentenced for billing Medicare for seat lift chairs never delivered. Noting that he delivered more than 1,000 chairs before running into "cash flow problems," the judge placed him on probation for 5 years, on the condition that he serve 2 months electronically monitored home confinement within the first 2 years. He must also make restitution of more than \$18,650. He solicited orders through a telemarketing firm, collecting \$300 to \$600 from each of some 40 beneficiaries, many of whom were disabled, but never ordered the chairs.
- In Arkansas, a DME company was ordered to pay restitution of \$52,000 and a fine of \$50,000 for billing Medicare and Medicaid for services never provided. The company owners were each sentenced to 1 year in prison, with the final 4 months to be served in a pre-release program, and fined \$20,000 each. Two of the owners' children and employees were permitted

to enter pre-trial diversion agreements that they would not engage in business involving Medicare and Medicaid for 3 years. The case was part of an earlier nationwide project investigating fraud in the DME industry.

## Health Maintenance Organizations' Quality Assurance Standards Required by Medicaid Agencies

Performance Measure

The extent to which a health maintenance organization (HMO) can control utilization and costs may mean the difference between its financial success and failure. Consequently, the incentives for these providers to limit services makes quality assurance (QA) an essential component of managed care programs. Realizing this, Medicaid agencies mandate their contracting HMOs to perform certain QA functions to ensure that Medicaid recipients receive appropriate and good quality care.

The OIG conducted an inspection to describe HMO QA standards and the methods used by State Medicaid agencies to monitor compliance with them, interviewing all 25 Medicaid agencies that contract with HMOs to provide medical care. The Medicaid agencies use structural, process and outcome QA standards to monitor contractor HMOs as illustrated below.

Structural Standards	Number of Medicaid Agencies	Process Standards	Number of Medicaid Agencies	Outcome Standards	Number of Medicaid Agencies
Patient education programs	25	Credentialing	21	Complaint grievance procedures*	25
Access to care*	25	Individual patient care data	16	Patient satisfaction surveys	8
Written QA plan	23	Utilization review	13	Health outcome monitoring and evaluation	6
		Medical record review	12		
		Reporting physician quality problem terminations	7		
		Clinical practice guidelines	6		
		Physician management	3		

\*Federal law mandates this standard

The OIG found that all Medicaid agencies use some form of structural standards. They have carried over fee-for-service process standards to their HMO programs, and they rely on complaint standards more than patient satisfaction surveys and health outcome reviews to ensure quality. (OEI-05-92-00110)

## **Medicaid Drug Policies**

The Omnibus Budget Reconciliation Act (OBRA) 1990 required that manufacturers provide rebates to States for drug purchases made by Medicaid recipients. The OIG conducted a series of studies dealing with manufacturers' drug pricing policies since passage of the Medicaid drug rebate legislation. The OIG is also reviewing other aspects of Medicaid drug reimbursement policy, including State payment for drugs in excess of manufacturers' recommended dosages.

### **A. Guidance to Drug Manufacturers**

Drug manufacturers are required to provide a listing to HCFA of all covered outpatient drugs and the average manufacturer price (AMP) for each of the drugs for a base period. Then, on a quarterly basis, the manufacturers report the AMP and the best price for each of the drugs to HCFA. The HCFA calculates a unit rebate amount for each drug based on this data and the applicable consumer price index (urban). The unit rebate amounts are provided by HCFA to the States to be used to calculate the actual rebate amounts owed by each manufacturer.

In one study, OIG reviewed the AMP and best price calculation policies of four major U.S. drug manufacturers. The OIG found that best price determinations were acceptable, but that manufacturers' calculations of AMP were inconsistent due to HCFA's failure to provide them with adequate instructions on acceptable calculation methods. The calculation method used affects the AMPs, the accuracy of pricing information provided to HCFA and the resulting rebates. Further, OIG found major differences in the manufacturers' policies on OIG's right of access to company records and the length of time for which records relating to drug rebates are retained.

The OIG recommended that HCFA: survey drug manufacturers to identify the various calculation methods being used to develop the AMP, and provide more specific policies for calculating AMP to protect the interests of the Government and be most equitable and least burdensome to the manufacturers. The OIG also recommended that HCFA establish records access and retention requirements for the manufacturers. The HCFA stated that the drug rebate law and the rebate agreements have already established a methodology for computing AMP. The OIG believes that the law and rebate agreements define AMP only in broad terms and that the variations disclosed at the manufacturers illustrate the need for further instructions. The HCFA concurred in part with the recommendation for OIG and other oversight authorities to have unrestricted access to manufacturers' records, but stated that it

must consider the confidentiality provisions of the manufacturers. The OIG believes that current law and OIG policy protect the rights of the manufacturers. The HCFA agreed with the 3-year record retention period recommended in the OIG report. (CIN: A-06-91-00092)

### **B. Reimbursement for Ulcer Treatment Drugs**

The OBRA 1990 required State Medicaid agencies to operate drug use review (DUR) programs on an ongoing basis to assess actual patient use against predetermined standards, one of which is the manufacturers' recommended dosages. Because ulcer treatment drugs are among the most commonly prescribed Medicaid drugs, OIG is performing a review at eight randomly selected States to quantify the potential cost savings available nationwide to the Medicaid program by limiting the reimbursements for these drugs to the manufacturers' dosages.

Reviews in Illinois, Minnesota and Indiana disclosed potential savings for Calendar Year 1990 of \$5.82 million (Federal share \$2.1 million), \$2.03 million (Federal share \$1.01 million), and \$2.12 million (Federal share \$1.35 million) respectively, had the States limited payment for six ulcer treatment drugs to the amount needed to pay for the manufacturers' recommended dosages. The OIG recommended that the States establish procedures to limit the payment for these ulcer treatment drugs to the manufacturers' recommended dosages and that HCFA take an active role in encouraging the States to implement the recommendation. Illinois stated that the report had merit and advised that it was actively involved in the development of a DUR program that would include a prospective review of ulcer treatment drugs. Minnesota indicated that it would take the recommendation under advisement and review it with the State Drug Utilization and Review Board. Indiana advised that the State would give due consideration to OIG's recommendations during future program enhancement efforts. The HCFA, however, disagreed with the OIG recommendation and questioned the use of the manufacturers' recommended dosage as a national guideline. (CIN: A-06-92-00008; CIN: A-06-92-00005; CIN: A-06-92-00007)

## **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 costs of care and treatment only when certain criteria are met.

### **A. Enhanced Federal Financial Participation for Family Planning**

The OIG issued a management advisory report urging HCFA to update and reintroduce a previously developed legislative proposal to eliminate the enhanced Federal financial participation (FFP) rate provided to States under the Medicaid program for family planning services. States have been reimbursed at the enhanced rate of 90 percent for such services since 1972. While the higher FFP rate was originally needed to "jump-start" the program, family planning services are now a well recognized, established and operating part of State

Medicaid programs. The 90 percent enhanced rate is costly, unjustified, and may act as a disincentive to the States' design and maintenance of adequate internal controls. A series of reviews by HCFA and OIG have noted significant internal control weaknesses, and the reports contain examples of flagrant and abusive billing practices which have resulted in overclaims for Federal reimbursement.

The OIG estimates that the Federal Government would save approximately \$80 million annually if the enhanced rate were eliminated and believes that the proposal, if enacted, would represent a positive step toward the containment of escalating Medicaid program costs at the Federal level. The HCFA believes that it would be premature to submit a legislative proposal until it can be evaluated within the context of the new Administration's health care reform agenda. (CIN: A-02-91-01052)

#### **B. Third Party Liability Recoveries: California**

The OIG conducted a review to determine if the Medicaid amounts reported by California to the Federal Government as third party liability (TPL) recoveries for the period July 1, 1988 through March 31, 1991 were supported by subsidiary records. The OIG determined that California understated its TPL recoveries by \$2.3 million (Federal share \$1.1 million) and that the State did not maintain complete records reconciling reported amounts to the subsidiary records. Since recoveries serve as credits which reduce net expenditures, the State effectively overclaimed Federal funds for the Medicaid program by not reporting the \$2.3 million in recoveries.

The OIG recommended that the State refund the \$1.1 million to the Federal Government. Further, OIG proposed that California establish internal controls to ensure that documentation is retained to support reported TPL recoveries and that recoveries are accurately accounted for on Federal reports. The State concurred and agreed to repay the \$1.1 million. It also indicated that it had implemented the recommended internal controls to prevent future errors. (CIN: A-09-91-00127)

#### **C. Prepayment Reviews: California**

The OIG conducted an audit to determine if prepayment reviews performed by California were adequate to assure that claims for seven Los Angeles County hospitals were for covered items or services provided to eligible Medicaid recipients, and were based on actual, rather than estimated expenditures. Federal law and regulations, as well as the California Medicaid State plan, require that the State conduct prepayment reviews of hospital claims before making payments. The OIG audit disclosed that the State did not perform the required prepayment reviews but, instead, estimated how much of the hospitals' claims were allowable based on nonstatistical samples. Although there was evidence that the State's estimates may have overstated the allowability of the hospitals' claims, the extent of any such overstatement could not be determined.

Because the State's claim was not based on a valid statistical sample, OIG was unable to express an opinion on the allowability of the Medicaid claim for \$1.022 billion (Federal share \$340 million) for hospital services covering the period January 1, 1980 through October 31, 1983. If HCFA agrees that California's claim was not valid, it will then need to negotiate an equitable settlement with the State. The data gathered in OIG's audit may provide HCFA with a starting point in negotiating an equitable settlement. The HCFA has not yet made a final management decision on this audit. (CIN: A-09-90-00095)

## **State Medicaid Fraud Control Units**

Medicaid health care provider payments currently exceed \$76 billion annually, representing a 422 percent increase over the \$18 billion 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.

Forty-one 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 1993, OIG administered \$24.7 million in grants to the MFCUs. The MFCUs reported 306 convictions and \$12.2 million in fines, restitutions and overpayments collected for the period July 1, 1992 through December 31, 1992.

**Social Security  
Administration**



---

## Chapter III

# SOCIAL SECURITY ADMINISTRATION

### Overview of Program Area and Office of Inspector General Activities

Nearly sixty 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 Old Age and Survivors Insurance (OASI) program, and the Disability Insurance program, added in 1956, are popularly called Social Security. In Fiscal Year (FY) 1993, the Social Security Administration (SSA) expects to pay over \$295 billion in cash benefits to more than 41 million beneficiaries. The program is financed almost entirely through payroll taxes paid by employees, their employers and the self-employed. Benefits are distributed to retirees and disabled persons, their spouses and dependent children, and certain surviving family members 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 1993, SSA expects to pay SSI benefits in excess of \$23 billion to over 5 million recipients. This amount includes more than \$3 billion reimbursed by the States.

The Office of Inspector General (OIG) reviews all aspects of SSA's programs and operations, including: disability insurance benefits, information resource management, program integrity and efficiency, quality of service, representative payees and SSI benefits. The OIG is also providing oversight to SSA's financial management by auditing SSA's financial statements, examining internal controls and reporting on the status of debt management activities.

Fraud and abuse in Social Security programs have historically been based on two types of deception: concealment of a recipient's status and/or the use of false Social Security numbers (SSNs) in order to receive benefits. Over the past few years, the misuse of SSNs has grown far beyond mere benefits fraud to include a wide range of "con" games and hard crime. Moreover, during this reporting period successful prosecutive actions were taken against several persons involved in the sale of confidential information available by using

SSNs to gain access to employment earnings records. The extraordinary increase in Social Security fraud, particularly SSN fraud, comes at a particularly difficult time for OIG because of diminishing resources.

## **Audit Opinion on Social Security Administration's Fiscal Year 1992 Financial Statements**

The OIG issued its opinion on SSA's financial statements for the fiscal year ended September 30, 1992. This represents the sixth consecutive year OIG has audited SSA's financial statements and the second year such audits were required by the Chief Financial Officers (CFO) Act of 1990. The audit was completed and the opinion letter issued well ahead of the date required by the CFO Act in order that the financial statements and results of operations could be made available to congressional budget committees early in the appropriations process.

The OIG opinion was again qualified because of an adjustment to be made to trust fund balances of about \$9.5 billion for revenues not certified in accordance with the Social Security Act. The OIG was also unable to satisfy itself as to the collectibility or the fair presentation of receivables reported in the amount of approximately \$2.7 billion as they were based on accounting systems not in conformance with required accounting standards. The OIG was able, however, to satisfy itself as to the valuation of the equipment in the financial statements for FY 1992 as SSA satisfactorily completed the reconciliation of its physical inventory with its accounting records. (CIN: A-13-93-00406)

## **Debt Management System**

The debt management system (DMS) has been under development at SSA since 1988. It is being designed to control, account for and facilitate timely recovery of all programmatic debts due SSA. Implementation of DMS is occurring in a series of incremental software releases which will continue for the next several years. At the Commissioner's request, OIG has participated as part of the project team in an oversight role.

The current review showed that DMS objectives scheduled for completion during the audit period were successfully implemented. However, two critical issues which have not been addressed must be resolved in order to successfully complete the implementation of DMS. The two issues are the integration of DMS software with the rest of the Retirement, Survivors and Disability Insurance program post-entitlement framework, and the development of DMS software for the SSI program debt collection activities. (CIN: A-13-92-00225)

## **Annual Earnings Test Penalty Assessments and Collections**

The Social Security Act provides that beneficiaries who report their earnings to SSA after a specified deadline are subject to a penalty. The OIG concluded that SSA's controls over the penalty assessment and collection process do not assure that penalties are properly accounted for and controlled. As a result, SSA: has not classified at least \$277 million in penalties as accounts receivable for Tax Years 1985 through 1989; is not currently honoring 30,000 beneficiary requests for installment withholding of \$20 million in penalties; and is not pursuing collection of \$1.2 million in penalty assessments from 2,700 beneficiaries who are receiving benefits on another Social Security record. In addition, OIG determined that SSA's programmatic software incorrectly assesses penalties for some beneficiaries who are exempt from penalty assessments, resulting in incorrect assessment of 18,900 penalties valued at \$7.7 million.

The OIG recommended that SSA: implement accounting controls which establish penalty assessments as an accounts receivable and maintain historical record of them; establish a controlled alert to prevent the full withholding of a penalty when a beneficiary has requested installment withholding of a penalty; ensure that penalties are collected from beneficiaries who become entitled to benefits on another Social Security record; modify its programmatic software to prevent erroneous penalty assessments for beneficiaries whose initial month of entitlement has been changed to the following year; and take corrective action to repay beneficiaries who were incorrectly assessed penalties. Further, OIG proposed that the weaknesses identified be reported to the President and the Congress under the Federal Managers' Financial Integrity Act (FMFIA). The SSA agreed with the recommendations, but did not agree that the weaknesses should be reported under FMFIA. (CIN: A-13-91-00209)

## **Revoking Penalties under Good Cause Policy**

The OIG reviewed program service center, teleservice center and field office adherence to procedures for revoking penalties in accordance with SSA's good cause policy. Under this policy, penalties may be revoked for such reasons as serious illness, inability to obtain records and conditions beyond the beneficiary's control.

The SSA revoked 41,990 penalties totaling an estimated \$23.3 million for Tax Year 1988. The OIG found that an estimated \$5.6 million in penalties was revoked based on incorrect decisions by SSA personnel, and case folders for an estimated \$7.2 million in penalty revocations did not contain sufficient documentation for OIG to determine whether revocations were correct. The OIG recommended that SSA increase training to ensure that employees authorized to revoke penalties under the good cause policy are properly interpreting and applying policy and procedural requirements. Further, SSA should provide for independent and/or supervisory review of penalty revocation decisions before finally authorizing such transactions and entering the results into an automated system. The SSA

agreed with the first recommendation and established two initiatives. It concurred with the idea of the second recommendation, but did not agree to implementation. The SSA will, on a sample basis, evaluate the results of training efforts designed to reduce incorrect revocations. If sample data does not improve performance, SSA will revisit the issue. (CIN: A-13-91-00208)

## **Concealment of Beneficiary Status**

The SSA has several lines of defense against individuals' continuing to receive benefits after they are no longer eligible. Recipients of OASI benefits and SSI benefits, as well as representative payees for these beneficiaries, are required to periodically confirm beneficiary status. Moreover, to some extent as a result of OIG projects, SSA has instituted computer program matches to spot those no longer eligible, such as matches of beneficiary rolls against State death and Federal incarceration records as well as earnings records. Some of the violations are based on deceptive use of SSNs, as discussed later. Others, however, are based merely on concealment of marriage, death or other circumstances of the beneficiaries, as indicated in the following cases.

- A woman who at one time ran as many as five boarding houses in New York was sentenced to 4 years in prison and 3 years supervised probation, fined \$20,200 and ordered to repay \$22,000 to SSA. The woman used a bank account she set up in South Carolina in the name of a deceased former boarder, as well as an account in New York, to launder stolen and forged benefits checks intended for her boarders. Most of her boarders were former mental patients, many of whom had been reinstitutionalized.
- A former social worker at a New York hospital was sentenced to 15 months in prison and 2 years probation for theft of Government property. While arranging for care of personal matters for certain elderly hospital patients, she had their Social Security checks sent to the hospital. She then diverted them to her personal bank account. She was ordered to repay \$6,814 to the Government and to undergo a substance abuse program.
- In Louisiana, a woman had her probation revoked and a 5-year prison sentence imposed. In 1988, she had received a suspended 6-month prison sentence and 5 years probation for claiming, as representative payee, that her brother lived at home when he was in prison. She has since been charged with victimizing four elderly people, using one woman's personal checks to get between \$6,000 and \$8,000 for herself, obtaining power of attorney from the four to get money from their safety deposit boxes and bank accounts, and directing their mail to her house in order to get their Social Security checks and bank statements. One victim signed over her house for \$500.

- A woman who concealed her sight recovery to continue to receive disability benefits was sentenced to 15 months in prison. She was also fined \$2,000 and ordered to repay \$5,382 to SSA, pay \$855 in court costs and perform 250 hours of community service. She had received some \$20,000 in benefits since 1979 because of statutory blindness. She failed to report to SSA that her vision had improved, that she was working and driving a vehicle, and that she was generally functioning as a fully sighted person.
- A New Jersey State corrections officer was sentenced to 1 year in prison and ordered to pay restitution of \$134,355 in Social Security overpayments. He applied for and began to receive disability benefits in 1978 for a heart condition. He worked for at least the last 10 years, including a stint as a disciplinarian at a school for children, as well as serving as a prison guard.
- A Pennsylvania woman who was convicted of converting to her own use Social Security checks issued to her disabled adult stepdaughter was sentenced to 15 months incarceration and 3 years supervised probation. The stepdaughter married in 1973, but SSA was not notified and the checks continued. The woman was ordered to pay restitution of \$3,370, a fine of \$3,000 and a special assessment of \$50.
- In New York, a man was sentenced for embezzlement of surviving child insurance benefits intended for his daughter. After his wife died in 1980, the man essentially abandoned his daughter, who was cared for by family friends. When the friends applied for legal custody of the child in 1988 and sought to become her representative payee, they discovered that her father, who had contributed less than \$100 to the child's well-being and almost never visited her, had been representative payee since 1980. His plea agreement requires that he make restitution of \$21,580 to his daughter.
- A Texas woman was sentenced to 5 years probation and ordered to pay restitution of \$39,200 to SSA. Nine days after she filed to be made representative payee for her mother, the mother died. She continued to accept and negotiate the checks, later initiating their direct deposit. She made withdrawals from the account through an automatic teller machine and admitted she used the money for her own benefit.
- A woman was sentenced in Missouri to 2 years probation for disability benefits fraud. In the early 1980's, two children were taken away from her by the State and adopted by relatives of her disabled husband. Two subsequent children were also taken away, but she filed for and obtained benefits for herself and these two on the basis of her husband's disability.

An SSA employee who lived in the same building reported she had never seen the children there when she learned the woman was receiving the benefits. The woman collected about \$19,650.

- A Pennsylvania man was sentenced to 4 months home confinement with an electronic device, 5 years probation, \$1,000 fine and \$13,850 in restitution. His mother died in February 1989 and he continued to withdraw SSI funds from her account.
- An Oklahoma woman was ordered to make restitution of \$15,000 and pay a \$100 special assessment for claiming benefits because her daughter was living in the household when the child's stepfather died in 1977. Investigation showed that the stepfather was unemployed and separated from the woman at the time of his death. Moreover, the child had lived with her grandmother since birth, the mother had provided no support, and the State had terminated parental rights.

### **Internal Controls over Welfare Enumeration**

The OIG evaluated SSA's oversight of the welfare enumeration process in States which have an agreement with SSA to process SSN applications for welfare recipients. The OIG found that SSA worked with the States to design an adequate system of application processing, document review and supervisory review, and that SSA's procedures for reviewing and accepting applications were adequate. However, one-third of the SSN applications reviewed, which were submitted through State welfare agencies, contained procedural errors. The OIG recommended that SSA strengthen internal controls related to periodic reviews of State welfare enumeration procedures, notify State welfare agencies of errors detected, and provide accurate and timely notification of assigned SSNs to State welfare agencies. The SSA agreed and has initiated corrective actions. (CIN: A-01-92-02005)

### **Fraudulent Social Security Numbers**

One of OIG's most important responsibilities is protection of the SSN enumeration system. In addition to misuse of SSNs to obtain undeserved program benefits, attempts to compromise the application process are relatively common, as shown in the following examples:

- A former claims development clerk in a New York SSA office and her fiancé were sentenced for selling SSN cards to undocumented aliens. The fiancé solicited sales, selling cards for as much as \$500 each, and the clerk prepared and entered the applications. The clerk was sentenced to 1 month of electronically monitored home confinement, for which she was to pay \$6 a day. The fiancé pled for mercy because he had entered a drug treatment

program after his arrest and was now drug free and employed. Both were sentenced to 5 years supervised probation, and each ordered to pay a \$50 assessment.

- A man was sentenced in New York to 6 months home detention and 5 years probation for bribing an OIG agent who posed as a corrupt SSA employee. The man, a law student who worked for a law firm, had approached an SSA security guard looking for someone who would issue Social Security cards for workers at a construction company he claimed to represent. The man paid the undercover agent \$100 for the cards, promising additional money. He also introduced a foreign national to the agent who paid \$320 for two cards. The man was also fined \$2,550. The foreign national was sentenced earlier to 6 months in prison and fined \$5,000.
- A man and his friend attempted to bribe a security guard at a Social Security office in New York. The guard immediately notified the office manager who in turn called agents of the local OIG. The agents responded at once and were able to have the two men arrested at the office. The two pled guilty to bribery and were sentenced to 6 months supervised probation. They also were ordered to pay a fine and special assessment of \$300 each.

While false SSNs are often used to obtain Federal benefits, their most common use is to create false identities in a wide range of crimes, from con men operating credit card scams to murderers trying to conceal their identity. During this period, convictions in cases worked by OIG in which use of false SSNs was a major factor involved more than \$6.5 million in court-ordered fines, restitutions and recoveries. The actual cost of the use of false SSNs is certain to amount to billions of dollars, most of it being borne by taxpayers in higher prices in the marketplace. The following cases are examples of the fraudulent use of SSNs which did not involve a loss to the trust funds:

- In Texas, two men and a woman were sentenced for an equity scheme in which fraudulent credit information and SSNs were used on mortgage applications for 150 homes. The three assumed mortgages, rented the homes, collected the rent and made no payments. As a result, the Departments of Housing and Urban Development and of Veteran Affairs had to foreclose on the original mortgage holders, losing an estimated \$4 million. The two men were ordered to pay total restitution and fines of \$512,880 and serve several months in jail. The woman was sentenced to 5 years probation, but ordered to pay \$1.18 million in restitution.
- A man was sentenced in New York to a year and a day in jail for supplying false information, including fictitious SSNs, to obtain financial aid and

student loans. The man had previously been arrested for masquerading as a doctor, a lawyer and a stockbroker when applying for bank loans. He used a seeing eye dog and told people that all he could see was shadows. When he was arrested in April 1992, however, he was able to read the warrant and other documents without his glasses. He was ordered to make restitution of over \$14,360.

- When a State Department employee returned from a 5-year overseas tour of duty, he found his credit rating had been destroyed by his father. After his father had accrued a debt of \$10,000 under his own name, address and SSN, he began using his son's. After accruing a sizable debt under his son's identity, he used his deceased father's and even fictitious ones to obtain credit on which he defaulted. The son reported the father, who was convicted and sentenced to 4 months incarceration and 4 months in a community treatment center. He was also ordered to repay \$62,513 to his creditors.
- A man was sentenced to 60 days incarceration, 3 years probation and 120 hours of community service for his part in an international scheme involving false SSNs and stolen or forged money orders. The man was arrested in Wisconsin while attempting to open a business checking account using a false SSN. At the time he had a forged \$44,000 cashier's check similar to one that has been negotiated more than 50 times in the United States and Europe for an estimated loss of more than \$2 million. He claimed to have received the check from someone in Nigeria who owed him money. He was also ordered to pay a \$1,500 fine and a \$50 special assessment, and to surrender the forged check.
- A Pennsylvania man pled guilty to seven of eleven counts of tax fraud, bank fraud and misuse of SSNs. He kited checks on personal accounts established under false SSNs and accounts set up for his two clothing businesses, and obtained loans on which he defaulted. He also used false SSNs on income tax returns. He was sentenced to 2 years in prison and 3 years supervised probation, and ordered to pay restitution of \$495,362 and a special assessment of \$350. He also must pay any back taxes, penalty and interest the Internal Revenue Service may determine that he owes.
- A man was sentenced in Colorado to 4 years deferred judgment for theft involving use of false SSNs. Using the names and SSNs of two other persons, he filed insurance claims against two companies for the theft of diamond jewelry which did not exist. Investigation showed that the jewelry appraisals were forged and the company that supposedly made them did not

exist. Upon his arrest, he refused to identify himself. A fingerprint and background check showed that he had been a licensed stock broker, but had lost his license because of unauthorized purchase of stock. He was ordered to repay \$12,200 to the one insurance company that had paid his jewelry theft claim.

As reported in an earlier semiannual report, a joint Federal, State and local project begun in Ohio in 1991, which targeted the use of fraudulent SSNs to obtain legitimate identification documents (IDs), primarily State driver's licenses and ID cards, resulted in major system improvements. A second phase of the project targeted an interstate ring of individuals who lived by using false IDs, including SSNs, to pass forged and stolen checks. They also used stolen credit cards and returned for refunds items they obtained illegally. Four of these individuals have been arrested and pled guilty, including the ringleader, and two of them were sentenced to jail. Local police credited their arrests with a considerable drop in the types of crime they committed. A third phase in this project now underway is targeting the sellers of IDs used to cash stolen and forged checks. The continuing success of the project is expected to lower considerably the popularity of Ohio as a place to obtain fraudulent IDs.

Although SSN fraud is becoming a major problem, OIG investigative resources are declining. The OIG therefore has been forced to develop criteria for limiting its involvement in SSN cases, in order to focus its limited budget resources more directly on the protection of the Department's programs and trust funds. The use of SSNs in the commission of non-Department-related crimes, however, is a continuing concern in that it threatens the reliability of the SSA enumeration system.

### **Duplicate Payments to Attorneys**

The OIG reviewed SSA's controls over duplicate payments to attorneys who represented applicants in their efforts to obtain Social Security disability benefits. (The payments are handled by SSA as part of the award of benefits.) The OIG found that procedures are inadequate to prevent duplicate payments and that there is currently no control for detecting duplicate payments. As a result of these weaknesses, OIG estimates that SSA issued 315 duplicate payments totaling over \$562,000 to attorneys during Calendar Year 1991. As of March 1992, the attorneys had returned an estimated 60 duplicate payments worth approximately \$180,000 to SSA.

The OIG recommended that SSA: document a procedure instructing employees to look up attorney fee payments that may have previously been recorded; modify the automated system with a control to detect duplicate payments to attorneys; review all potential duplicates identified by OIG and begin recovery procedures where appropriate; and periodically identify and review cases that contain two or more identical attorney fee payments to determine if duplicate payments have been made. The SSA concurred and will initiate action to address the problems noted. (CIN: A-13-92-00219)

## **Prison Address Match**

The OIG conducted an inspection to determine the effectiveness of an ongoing match of correctional facility addresses against SSA payment records to identify incarcerated felons who are receiving Social Security and/or SSI benefits. Since 1983, the law provides for the suspension of Social Security benefits to individuals convicted and incarcerated for felony offenses.

The OIG had previously identified inmates who had used aliases and false or multiple SSNs to conceal their identities. Where such inmates were receiving Social Security benefits, SSA was unaware of their convictions and incarcerations. In the current sample, OIG identified only about \$47,000 in overpayments over a 10-year period to 18 confined felons. In these cases, SSA had already suspended payments to the individuals. However, OIG did note the lack of a unique suspense code to identify beneficiaries suspended due to confinement for a felony conviction. The SSA agreed to develop such a code and is planning modifications to its procedures and systems. (OEI-07-91-00370)

## **Nonresident Aliens Receiving Payment at Foreign Addresses**

The Social Security Act provides that noncitizen auxiliary beneficiaries (spouse and/or dependent children of the primary beneficiary) who are outside the United States for 6 consecutive calendar months will not be paid benefits beginning with the seventh month of absence. Benefit payments are suspended until the noncitizen beneficiary returns to the United States and resides there for a full calendar month. Noncitizen auxiliaries may be exempt from this provision if they have resided in the United States for at least 5 years during which they were the spouse or child of the primary beneficiary.

In a review of payments made to 6,368 noncitizen auxiliaries residing in Mexico, the Dominican Republic and the Philippines, OIG found that an estimated 828 were incorrect. In addition, an estimated 1,083 payments were either based on weak evidence of periods of United States' residency or were inadequately documented. The OIG estimates that the annualized incorrect and questionable payments amounted to \$1.9 million and \$2.1 million, respectively, for 1990.

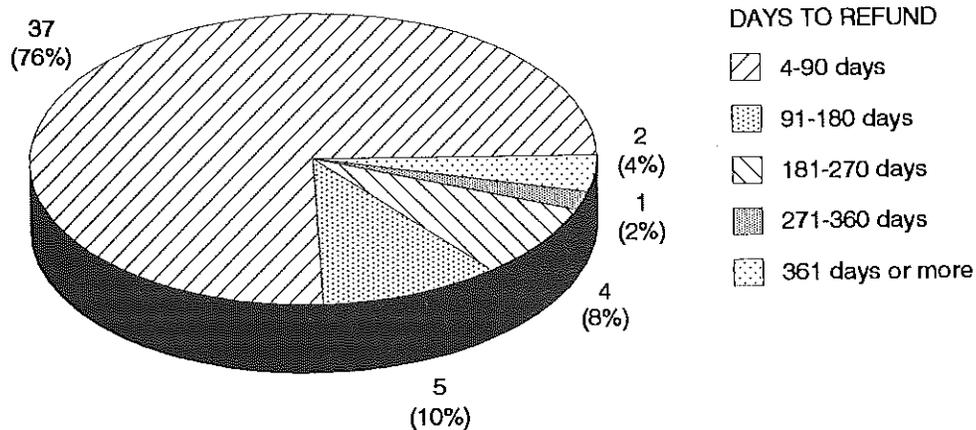
The OIG recommended that SSA issue a program circular reminding employees of the correct processing procedures for foreign payments to individuals subject to the alien nonpayment provisions and the importance of correct status coding. In addition, SSA should perform a follow-up review of foreign payments in the three subject countries and revise its procedures regarding the type of evidence required to substantiate periods of residency in the United States. The SSA agreed to issue a program circular and perform a follow-up review. However, SSA did not agree to revise its policies and procedures regarding evidence requirements, but will review the recommendation again after it conducts the follow-up review. (CIN: A-05-91-00090)

## Financial Institution Refunds of Benefits Paid after Death

An increasingly popular method for paying Social Security benefits is direct deposit, under which the Department of the Treasury transmits payments to banks through automated clearing houses. Post-death direct deposit payments continue until SSA becomes aware of a beneficiary's death or the bank refunds the payment. Treasury's instructions to banks state that direct deposit payments must be refunded immediately, but no later than 3 business days, if the bank becomes aware of the death of a beneficiary or if an account has been closed. Remittances received by Treasury are to be deposited on a daily basis.

In a review of Social Security cases involving deceased beneficiaries with direct deposit during Calendar Year 1988, OIG found that banks made timely refund of the direct deposits in 153 of 202 cases (76 percent). However, in the remaining 49 cases, 32 banks held funds more than 3 days after they had knowledge of death or had closed an account.

### DELINQUENT REFUNDS (49 Cases)



Based on this data, OIG estimates that the trust funds are suffering an annual loss of \$540,000 in interest income. The OIG also found that Treasury does not deposit refunded Social Security payments timely, resulting in additional annual trust fund losses of \$222,000. In furtherance of SSA's ongoing negotiations to improve delivery and reclamation of direct deposit payments, OIG recommended that SSA work with the National Automated Clearing House Association to develop early indicators of death and with Treasury to minimize late deposits of refunded direct deposit payments. The SSA concurred. (OEI-07-89-01670)

## **Sale of Restricted Information**

As a result of a nationwide investigation by OIG and other Federal law enforcement agencies, over 20 persons have been indicted thus far for peddling restricted information such as SSA employment and earnings records, and National Crime Information Center criminal histories. Thirteen persons have been convicted thus far, including eight information brokers, four former SSA employees and a former OIG official. The former SSA employee and OIG official were sentenced to home probation, and all but one of the brokers were sentenced to probation plus forfeiture of all illegal gains. The sentences were based on Federal guidelines. One broker, however, received an upward departure from Federal sentencing guidelines after making arrogant statements on a national television show. He was sentenced to 14 months in prison as well as forfeiture of illegal gains.

The leniency of Federal sentencing guidelines in comparison to the seriousness of these crimes is of grave concern to OIG, and the House Subcommittee on Social Security of the Committee on Ways and Means has expressed interest in stiffer penalties.

## **Controls for Diary Actions**

The OIG performed a follow-up review to a prior audit which found that, for a number of reasons, SSA diaries were not acted on promptly. Diaries are controls over unfinished claims actions and serve as reminders that action needs to be taken at a future time. The OIG had previously recommended that SSA incorporate standards requiring prompt processing into managers' performance plans, remind managers of the importance of prompt processing and perform internal control evaluations after the proposed automated diary system is implemented. In its follow-up review, OIG found that SSA had issued reminders to managers of the importance of prompt processing, but that it continued to disagree that prompt processing of diary actions needed to be specifically identified in managers' performance plans. Also, while SSA stated that it had plans to evaluate the automated system once it was operational, implementation has been delayed until sometime in 1993 or possibly 1994. In the future, OIG plans to evaluate the automated system and its controls, and to determine whether, in fact, SSA is holding managers accountable. (CIN: A-13-92-00227)

## **Computer Systems Integrity**

The OIG performed a follow-up audit of computer system software controls at SSA. This and an earlier audit were performed as the Department's contribution to a multi-agency effort for the President's Council on Integrity and Efficiency/Computer Systems Integrity Project. The original audit found that, although SSA effectively used many of the internal controls available in its operating systems, significant weaknesses existed in procedures and controls which could have placed the operating systems and all applications run through them at risk. The follow-up review disclosed that SSA has considerably improved security over systems software. Improvements have been made in all areas originally reviewed, and

all previous recommendations except two have been resolved. The SSA should address the two areas where further improvement is needed: the formalization of procedures for evaluating and applying available fixes for identified systems software problems, and securing supervisor calls that still present risks. (Supervisor calls are the mechanism used to link application programs running on a computer system to that computer's own operating system.) The SSA concurred and has initiated corrective actions. (CIN: A-13-91-00211)

### **Cost Analysis System**

An OIG report concluded that SSA's costs analysis system, used to allocate SSA's administrative costs among the programs it administers, was not always in conformance with prescribed internal control standards or accounting principles and standards. Possible inequities arise by using benefits paid by each of the trust funds as a base to allocate administrative costs, including the cost of intake processing for the Medicare program. Such inequities will be exacerbated by the projected growth in health care benefit payments in relation to the benefit payments of other programs administered by SSA, and will result in an increasingly disproportionate share of administrative costs being borne by the Health Care Financing Administration and the Medicare trust funds.

The OIG recommended the establishment of a task group to reevaluate the use of benefit payments as an allocation base. The use of benefit payment outlays as one of the bases for allocating joint product administrative costs (activities shared by more than one program) does not result in equitable distribution of those costs because there is no direct relationship between benefit payments and administrative efforts related to the programs. The SSA welcomed the exploration of acceptable alternatives and has already participated in meetings of the recommended task group. (CIN: A-13-89-00039)

### **Tape Recordings of Social Security Appeal Hearings**

The OIG conducted a review to determine whether SSA has adequate controls in place to ensure that audio cassette tapes needed in connection with appealed hearings decisions can be located. When tapes in these cases are lost, hearings must be redone, resulting in unnecessary costs and delays, as well as inconvenience to claimants.

Since new procedures were put into effect in 1988, SSA has issued nine memorandums to employees reminding them of the need to comply with the instructions. Despite this, in Calendar Year 1991, 17 percent of the requested tapes could not be located and were subsequently certified as lost. The responsibility for the missing tapes rests with the hearings offices (HOs) where the administrative hearings are held. Some offices continue to misroute tapes, improperly remove tapes from case files and delay in mailing tapes to the Office of Hearings and Appeals (OHA) headquarters. In contrast, OIG found that the operations of the Docket and Files Branch and the Computer Cassette Library (CCL) at

OHA headquarters, and the Office of Disability and International Operations (ODIO) were basically effective and in accordance with SSA instructions.

The OIG recommended several minor procedural refinements to procedures at CCL and ODIO. Also, OIG recommended that SSA establish a system to monitor HO compliance with established procedures for the disposition of tapes of disability hearings. This should enable SSA to identify HOs which repeatedly violate procedures and to take management action. The SSA generally agreed with the recommendations. (CIN: A-03-92-02604)

## **Disability Work Incentives**

The OIG found that SSA's work incentives are not sufficient to encourage unskilled beneficiaries to work full time (earn over \$500 per month) after a 9-month trial work period (TWP) and forgo disability payments. Approximately 76 percent of the beneficiaries who completed a TWP remained jobless or underemployed and dependent on disability benefits. Beneficiaries with low earnings or those who left work for reasons other than disability earned enough each month to stop disability payments, but took home less than the amount of their benefit payments. It was, therefore, financially attractive for them to continue receiving disability payments. Profitability was the most important factor in the beneficiary's work-or-not-work decision. Also, trial work earnings significantly influenced the beneficiary's work-or-not-work decision because they might be used to increase benefit payments, making it more competitive with net earnings. For example, earnings from trial work periods might replace lower earnings from previous years in calculating the amount of the disability payment, making the latter more competitive with earnings from the TWPs.

The OIG recommended that SSA provide subsequent TWPs for low-earning beneficiaries who have completed 9 trial work months within the last 5 years. This additional incentive would protect benefit payments while enabling low-earning beneficiaries to take advantage of employment opportunities as they occur. Additionally, SSA should defer payment increases based on trial work earnings to ensure that wages rise faster than benefit payments. In response to the draft report, SSA agreed to explore modifications to the TWP provisions and pursue development of possible legislative enhancements. The SSA did not concur with the recommendation to defer payment increases. (CIN: A-13-92-00223)

## **Claimant Provision of Disability Information**

Performance Measure

To manage growing SSA workloads with downsized staff, SSA began to replace the traditional claimant face-to-face interview with self-help claims, wherein the claimant completes all or parts of the disability claim forms. The OIG found that disability claim forms are difficult for many claimants to complete without assistance. The OIG recommended that SSA simplify the disability claim forms which claimants are asked to complete, and develop a more specific claimant screening guide and additional instructions

to improve the quality of self-help disability claim forms. The SSA is in the process of reviewing and commenting on the final report. (OEI-06-91-00480)

## **Field Office Processing of Disability Claim Forms**

Performance Measure

The SSA field offices are responsible for ensuring the accurate and full completion of a number of forms that provide essential information used by disability determination services (DDSs) to develop other aspects of the disability claim. To correct persistent problems with disability claim form accuracy and completeness, OIG recommended that SSA: reaffirm field office management responsibility for assuring that accurate and complete disability report forms are sent to DDS; establish clear management accountability for assuring that all necessary information is obtained at the time an individual applies for disability benefits; and provide field office management with and ongoing assessment of the accuracy and completeness of disability forms sent to DDS. The SSA is in the process of reviewing and commenting on the final report. (OEI-06-91-00481)

## **Supplemental Security Income: Presumptive Disability**

Performance Measure

This OIG inspection revealed that, overall, the presumptive disability process appears to be working as the Congress intended when it enacted the SSI program in 1972. Most State DDS agencies make presumptive disability decisions early in the process. The Federal dollars lost from presumptive disability reversals are relatively minor. However, OIG did find problems with high reversal rates in some State DDS agencies and payments effective with the wrong date. The OIG recommended that SSA highlight presumptive disability reversal rates in management information reports on State DDS agencies' performance. Further, OIG recommended that SSA issue a reminder to field offices and State DDS agencies that SSI presumptive disability payments are to begin no earlier than the month of the presumptive disability decision. (OEI-07-89-01650)

## **Immediate and Emergency Advance Payments**

The SSA issues immediate payments or emergency advance payments (IP/EAP) to SSI recipients who are in dire need. These payments are an advance of SSI benefits and should be recovered in total from the recipient's next benefit payment. The OIG determined that SSA did not recover 9.8 percent of these payments. This was due to a poorly designed system which has insufficient controls to ensure that IP/EAPs are recorded on the supplemental security record (SSR) and system limitations which impede recovery of payments that are recorded on the SSR. The OIG recommended interim measures for field office management to ensure that payments are recorded and recovered, and proposed system modifications to strengthen controls and correct limitations. In response to the draft report, SSA generally concurred. (CIN: A-05-91-00094)

## Clarity of Supplemental Security Income Notices

Performance Measure

The OIG conducted an inspection to determine if SSA's automated notices to SSI recipients are clear, understandable, appropriate to the audience and in accordance with SSA's notice standards. In July 1989, SSA published a revised notice standards handbook covering notice format and type style, reading level, wording, and sentence and paragraph length. While these standards have improved overall notice readability, annual Social Security client satisfaction studies conducted by OIG between 1987 and 1991 show that additional improvement is needed.

The OIG found that the SSI notices reviewed met the notice standards for reading level and sentence length. However, some other aspects of the notices continued to be difficult to understand, particularly in the Notice of Award.

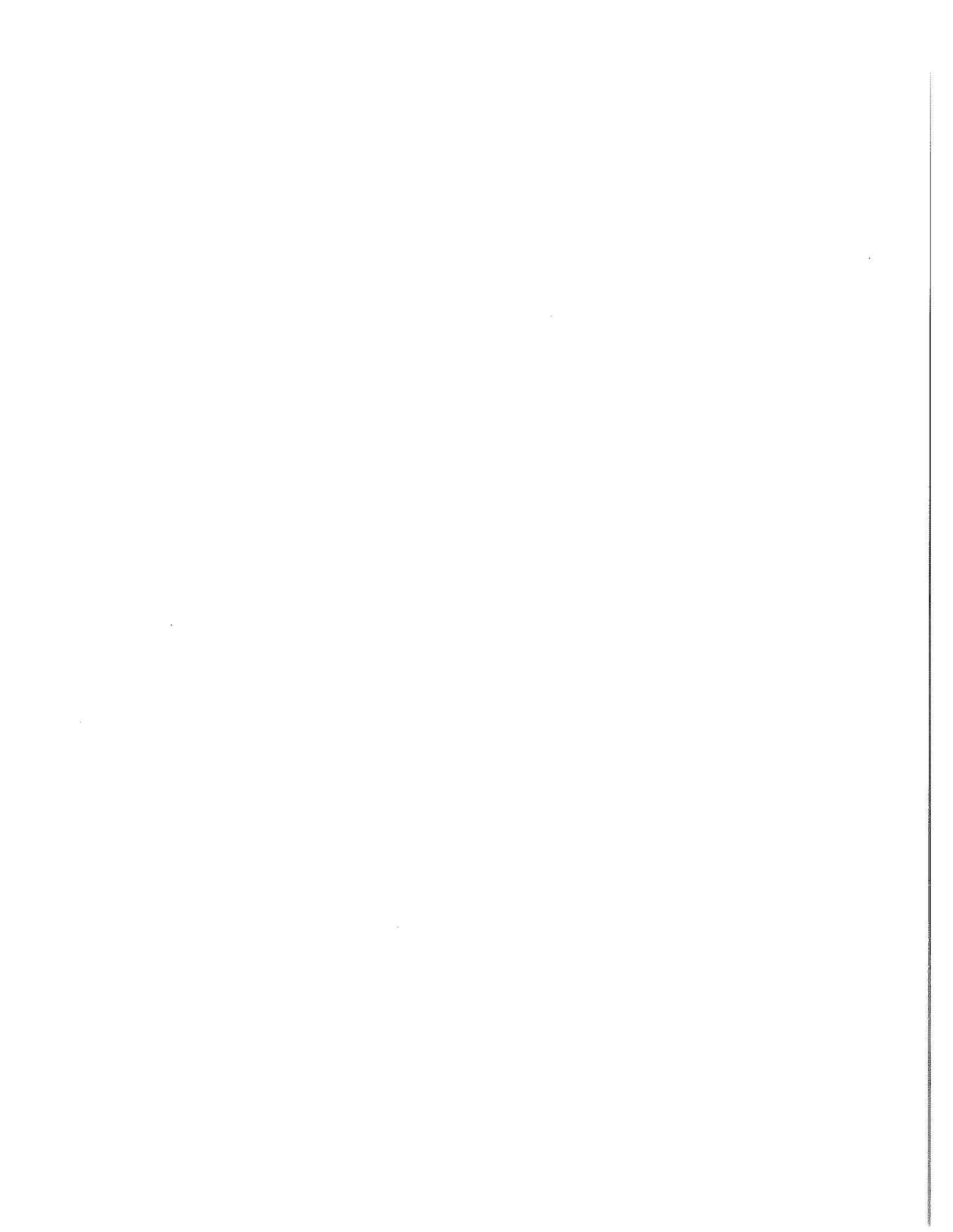
<b>ACCURACY OF ALL RESPONDENTS TO SSI NOTICE ELEMENTS</b>				
<b>Notice</b>	<b>Main Message</b>	<b>Required Actions*</b>	<b>Optional Actions</b>	<b>Appeals Information</b>
Award	91%	44%	34%	79%
Change	91%	88%	75%	83%
Important information	83%	89%	57%	91%
Planned action	90%	94%	71%	81%
<b>COMPOSITE TOTAL</b>	<b>89%</b>	<b>78%</b>	<b>59%</b>	<b>83%</b>

\*Required actions include reporting responsibilities as conveyed in the notices.

The OIG also found that notices did not describe the effect of known or estimated income beyond the current computer system operating month. Further, SSA has no ongoing process for reviewing SSI notices.

The SSA has taken several steps to improve the quality of its notices. In order to further enhance that quality, OIG recommended that SSA apply the 1989 notice standards in all automated notices; reexamine the Notice of Award to determine alternative methods for communicating required and optional actions; revise the SSI computer system to allow the issuance of notices which accurately reflect future payments based upon known or estimated earned and unearned income; and establish quality assurance processes to periodically monitor the readability of notices. The SSA generally agreed with the findings and recommendations. (OEI-07-90-2460; OEI-07-90-02461)

# **Public Health Service**



---

## Chapter IV

# PUBLIC HEALTH SERVICE

### Overview of Program Area and Office of Inspector General 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, cosmetics and medical devices; Centers for Disease Control and Prevention, 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, to address issues related to Superfund toxic waste sites; the Agency for Health Care Policy and Research, 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; and the Substance Abuse and Mental Health Services Administration, previously the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), to assist States in refining and expanding treatment and prevention services. The PHS will spend more than \$19.4 billion in Fiscal Year (FY) 1993.

In the past 5 years, the Office of Inspector General (OIG) has significantly increased its oversight of PHS programs and activities. The OIG has concentrated on a variety of issues such as biomedical research funding, substance abuse, Indian health services, drug approval processes and community health center programs. The OIG has also looked at the regulation of drugs, foods and devices, and explored the potential for improving these activities through user fees. The OIG has conducted audits of colleges and universities which annually receive substantial funding from the Department. The OIG continues to examine several PHS-wide policies and procedures to determine whether proper controls are in place to guard against fraud, waste and abuse. These activities include property management, travel approval, preaward and recipient capability audits, and evaluation of PHS' information resource management activities. This oversight work has provided valuable suggestions to program managers for strengthening the integrity of PHS policies and procedures.

## **Medical Device Review Process**

The OIG conducted a follow-up review to assess FDA's progress in implementing the recommendations in a 1989 OIG report (CIN: A-15-89-00065) on the medical device 510(k) review process. The 510(k) process refers to the section of the Food, Drug, and Cosmetic Act that requires medical device manufacturers to submit notification to FDA prior to marketing a medical device. This follow-up review was conducted in response to a request from the Subcommittee on Oversight and Investigations, House Committee on Energy and Commerce. The Subcommittee was concerned that, despite the development of a corrective action plan by FDA, conditions identified in OIG's earlier report had not substantially changed. The OIG determined that FDA had made progress in implementing corrective actions in its 510(k) program, but more needs to be done to fully address the weaknesses disclosed in the earlier OIG report, weaknesses, which when taken as a whole, were material in nature. Specifically, FDA had not: fully implemented a method to detect possible manipulation of the review process; ensured compliance with the "first-in, first-reviewed" policy; required full documentation of 510(k) decisions; fully implemented alternate actions to augment the 510(k) review process by examining, for example, the product sample; implemented a quality control review system focused on the scientific aspects of the 510(k) review; and fully implemented controls over access to personnel and offices. The PHS generally concurred with OIG's recommendations. (CIN: A-03-92-00605)

## **Generic Drug Approval Process**

The OIG conducted a follow-up review to assess FDA's progress in implementing the recommendations in a 1989 OIG report (CIN: A-15-89-00051) on vulnerabilities in the generic drug approval process. For the past 3 years, the absence of adequate internal controls in the generic drug approval process has been reported as a material weakness under the provisions of the Federal Managers' Financial Integrity Act. The Office of Management and Budget (OMB), which had designated the generic drug approval process as a high risk area from 1989 through 1991, deleted it from the high risk list in the President's FY 1993 budget, concluding that all major corrections had been completed.

In its current review, OIG found that FDA has not taken sufficient action to correct this material weakness. The OIG determined that FDA needs to: modify the method by which generic drug applications are assigned to reviewers to remove any opportunity for showing partiality or favoritism; revise its "first-in, first-reviewed" policy for generic drugs because the current policy may allow for the unequal treatment of drug firms' applications; develop comprehensive guidelines to assure that generic drug applications are reviewed in a uniform and consistent manner; and establish a quality control review system outside the Office of Generic Drugs to ensure the propriety of individual generic drug application reviews and the integrity of the review process. The PHS concurred with the recommendations. Since full implementation of actions is underway and not expected to be completed until some future

date, OIG believes that this issue should continue to be reported as a material internal control weakness. (CIN: A-15-91-00025)

## **Generic Drug Management Information System**

In a 1990 report, OIG made recommendations on how the generic drug management information system (MIS) could be better used by FDA to improve management and oversight of the generic drug review and approval process. In a follow-up review, OIG found that, although FDA has taken some actions to implement the recommendations in the earlier report, more needs to be done.

The OIG determined that the generic drug MIS still does not track important events in elapsed days throughout the entire application review process, and does not provide the reasons for variances in the times needed by FDA to approve applications for the same drug products submitted by different firms. In addition, FDA's alternative method for maintaining data on generic drug application deficiencies, a one-time study, does not provide the means to continuously analyze how the drug industry can improve the quality of applications. The OIG also determined that, with one exception, the MIS data on assignments were accurate and up to date, and the MIS was used as a primary tool to estimate the staffing needs for reviewing applications. The OIG made several recommendations to further improve the generic drug MIS. The PHS generally concurred in principle with the recommendations, but disagreed with the specific measures proposed by OIG for improving the generic drug MIS. (CIN: A-15-91-00026)

## **Fraud in the Generic Drug Industry**

Much of the evidence of the material weakness in FDA's generic drug approval process was the result of a series of investigations which uncovered rampant fraud and corruption. These investigations are now winding down. During this reporting period a man who was the former president, co-founder and chief executive officer of one of the nation's biggest generic drug companies was sentenced for obstruction of justice, wire fraud and submitting false data to FDA, as was the company's former vice president of operations. The former president was sentenced to 5 years in prison without parole and fined \$1.25 million. The former vice president was sentenced to 3 years without parole and fined \$100,000.

These sentencings brought to eight the number of convictions for this generic drug company alone. The judge was particularly harsh in his comments to the former president. He characterized his criminal activity as more excessive than anyone involved in the some 40 generic drug cases and defendants he had had in court. He called him one of the few principals who had caused the decline of the generic drug industry in this country, saying that his company made more money from the illegal activity than all the others combined, and that there was never any apparent concern for the public's health and welfare.

## Fraud in the Azidothymidine Program

A Texas pharmacy and its owner were sentenced for defrauding the Federal azidothymidine (AZT) program of more than \$600,000. The owner was sentenced to 5 years and 4 months imprisonment, and ordered to pay a \$750 special assessment fee. She was also ordered to divest herself of the pharmacy and serve 3 years supervised release, during which she cannot be employed as a pharmacist or own or have any equity interest in a pharmacy. The pharmacy was sentenced to 5 years probation, fined \$1 million and ordered to pay a \$3,000 special assessment fee. The owner and the company were ordered to jointly pay \$581,700 in restitution, \$100,000 immediately. The pharmacy participated in a program in which it could obtain AZT from pharmaceutical firms for eligible acquired immune deficiency syndrome patients and the State would reimburse the firms with PHS grant funds. After the State discovered the pharmacy had ordered AZT for deceased individuals, an investigation showed it had over-ordered from the program and used the federally funded AZT to fill private and insurance paid prescriptions. The pharmacy was the largest recipient of the federally funded drug in the Dallas area, receiving about \$1.4 million worth of AZT.

## Spit Tobacco and Youth

Performance Measure

In a follow-up inspection requested by the Surgeon General, OIG found that underage use of spit tobacco (snuff and chewing tobacco) persists as a national problem with potentially serious health consequences.

The OIG concluded that underage spit tobacco use is high, widespread and begun early. A 1990 and 1991 school-based survey in 22 select States showed that nearly 20 percent of males in grades 9 through 12 were current users of spit tobacco. Among white males, an even higher percentage use spit tobacco.

PERCENT USE DURING PRECEDING 30 DAYS				
Grades 9 to 12*				
Year	Males		Females	
	White	Total	White	Total
1990	23.9%	19.1%	1.5%	1.4%
1991	23.6%	19.2%	1.4%	1.3%

\*Students surveyed: 1990-11,631  
1991-12,272

The OIG found that underage users are seriously endangering their health as spit tobacco contains cancer-causing and addictive substances. Perceived social support from fathers, other male relatives and friends is the most influential reason youth first try spit tobacco, and the connection to baseball and product placement in stores further enhance acceptability of use. Moreover, spit tobacco laws and their enforcement are weak and ineffective. The OIG concluded that the responsibility for addressing the problem rests with many groups at the national, State and local levels. The OIG proposed that responsible groups: promote community awareness and action; support improved State and local tobacco control; seek the support and involvement of health care providers and organized athletics; and reexamine national tobacco control and access policy and coordinate a plan for deterring youth use of spit tobacco. (OEI-06-92-00500)

## **Youth Access to Tobacco**

A 1990 inspection by OIG found that 45 States had laws prohibiting the sale of cigarettes to minors, but that States were not enforcing their laws. The report provided information for development by the Department of a model law recommended for adoption by States or localities to prevent the sale of tobacco products to minors. The ADAMHA Reorganization Act of 1992 requires States to ban the sale and distribution of tobacco products to anyone under the age of 18 by October 1, 1994 and to enforce their laws "in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to underage youths."

In a current review, OIG found that, although most States prohibit the sale of tobacco to minors, their failure to enforce their laws would place them out of compliance with the new Federal law. Despite the lack of State efforts, some localities are demonstrating that enforcement is possible. Vending machine restrictions are the most common initiative; twenty-one States and the District of Columbia have passed laws that restrict vending machines.

The OIG suggested that the States: designate an enforcing agency, ban vending machines, enact provisions of the model law, educate communities and vendors, post signs and conduct "sting" operations. The Department should provide technical assistance to the States, monitor State activities, collect base line data, develop criteria and conduct research on effective enforcement models. (OEI-02-91-00880)

## **Measuring Drug Abuse Treatment Costs**

Performance Measure

Federal legislation passed in 1988 increased ADAMHA's data collection requirements and States' block grant reporting requirements. The agency is required to develop uniform criteria for collecting drug abuse treatment cost data to support research on the comparable costs and efficacy of different treatment models. The ADAMHA has three major sources for data collection on drug abuse treatment: the State Alcohol and Drug Abuse Profile, the

National Drug Abuse and Alcoholism Treatment Unit Survey and the Drug Abuse Services Research Survey.

An OIG study found that ADAMHA's data collection system does not provide reliable data for measuring drug abuse treatment costs. The three major sources of data on drug abuse treatment were flawed in their cost reporting and limited the completeness, accuracy and relevancy of cost data. Additionally, existing cost data understates costs and funding data does not relate to services provided. The OIG recommended that ADAMHA aggressively continue to build a system for measuring drug abuse treatment costs, and, as a condition of grant award, require that drug abuse treatment research and demonstration grantees who perform clinical effectiveness studies use Federal standards for collecting treatment cost data. (OEI-04-91-00430)

## **Indian Alcohol and Substance Abuse**

Performance Measure

At the request of the Senate Select Committee on Indian Affairs, OIG conducted an inspection to assess IHS's coordination of alcohol and substance abuse programs. The Congress enacted the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 to provide a coordinated and comprehensive attack on Indian alcohol and substance abuse by Indian youth. As required by the law, the Secretaries of Interior and of Health and Human Services entered into a memorandum of agreement (MOA) to coordinate resources.

The OIG found that IHS and the Bureau of Indian Affairs (BIA) have not achieved the level of coordination envisioned by the Congress. Major provisions of the MOA remain incomplete. These include periodic reviews of the MOA, the organizational master action plan, tribal action plans and local action plans, and tribal comprehensive reports. A number of barriers inhibit effective coordination. These barriers include differing missions, differing headquarters staff structures, high staff turnover, and lack of full-time BIA area alcohol and substance abuse coordinators. The OIG recommended that IHS and BIA review, update and streamline their MOA with the goal of developing a practical plan of action. The PHS agreed with the OIG recommendation and indicated actions it has taken or plans to take to address the specific issues. (OEI-09-92-00010)

## **Indian Health Service Management and Fraud Problems**

Three years ago, IHS was declared a high risk area. The OIG has been working with IHS management to solve some of the problems which make its programs vulnerable to fraud. (See page 4 for a discussion of IHS management actions in response to the high risk.) Nonetheless, some problems seem to recur, such as internal financial mismanagement, procurement improprieties, travel fraud and reprisals for exposing fraud, waste and abuse. Tribal embezzlement allegations continue to increase. In Wisconsin, for example, a bookkeeper for a tribal health department was convicted for taking \$1,900 from an

IHS-funded project to buy a motorcycle. Less than 3 years earlier, his predecessor was sentenced to a year in prison for embezzling nearly \$63,000 in IHS funds.

Some of IHS's responses to OIG referrals of complaints and investigative results continue to be slow. No administrative action has been reported on investigative results referred 3 years ago concerning mismanagement and misconduct of high-level officials and employees at one area office. Further, no official response has been received on two OIG-referred Early Alert Reports (EARs) on potential material weaknesses. These EARs, which were issued in 1991, warned of weaknesses involving Buy Indian contracts and conflicts of interest in contract health care.

## **National Vaccine Injury Compensation Program**

Performance Measure

The Vaccine Injury Compensation Program (VICP) is a Federal "no-fault" system to streamline the compensation process to persons who have suffered injuries due to certain vaccines. The VICP involves three government entities: PHS, the Department of Justice (DOJ) and the United States Court of Claims. In a recent study, OIG found that VICP is currently struggling to handle a large, unanticipated influx of retrospective compensation cases. At the current production level, it will take approximately seven years to complete all of the retrospective cases. However, once a case is assigned, case processing is efficient. Further, OIG found that a significant portion of PHS medical review recommendations to not compensate are overturned by the Claims Court. Potential reasons identified for the high reversal rate include differing opinions on corroborating evidence and various interpretations of the vaccine injury table by the parties involved.

To correct these problems, OIG recommended that PHS work with DOJ and the Claims Court to: inventory and set priorities for the backlog and improve estimates of future resource needs; further streamline the process; support revision and updating of the vaccine injury table; improve contact with petitioners and their attorneys; and emphasize using annuities to pay the awards. The PHS generally concurred with the recommendations, and has restated its willingness to continue working with DOJ and the Claims Court to resolve retrospective cases as quickly as possible, while applying improved skills and techniques to maintain the efficient processing of prospective cases. The PHS has already taken a number of actions to address the OIG recommendations. (OEI-02-91-01460)

## **National Practitioner Data Bank**

### **A. Reports to Hospitals**

Since September 1, 1990, the National Practitioner Data Bank has received and maintained records of malpractice payments and adverse actions taken by hospitals, other health care entities, licensing boards and professional societies against licensed health care practitioners. It provides hospitals and other health care entities with information relating to the

professional competence and conduct of physicians, dentists and other health care practitioners.

The OIG found that most data bank reports were useful to hospitals, but that these reports rarely led hospitals to make privileging decisions they would not have made without the reports, even when the reports provided information that hospitals did not already know. The findings indicated that the usefulness and impact of the data bank information are strongly affected by the timeliness of the reports. The OIG recommended that PHS seek to reduce further the time between query and response and make this a high priority in its next contract for operation of the data bank, and that the Joint Commission for Accreditation of Health Care Organizations establish guidelines on how quickly hospitals should query the data bank after receiving applications for privileges. (OEI-01-90-00520)

### **B. Administration**

The OIG conducted a review of the administration of the National Practitioner Data Bank in response to OMB concerns that HRSA was unable to contain the costs of the data bank's contractor to budgeted levels. The OMB's concerns involved the appropriateness of the contract, the allowability of reimbursed costs, the reasonableness of HRSA's contract monitoring and the adequacy of HRSA's financial management controls.

The OIG noted that HRSA has improved its contract administration and is aware that the data bank still needs improvement. However, the report discusses three long-standing and significant deficiencies: the need for technological modernization of operations; inadequate contractor controls over the processing of checks and monitoring of money owed related to user fees; and the need to expand the scope of the data bank to include all licensed health care practitioners as well as health care entities such as hospitals per the requirements of section 5 of the Medicare and Medicaid Patient and Program Protection Act of 1987.

The OIG made specific recommendations for HRSA to develop an improved, expanded data bank which will provide efficient service to users and satisfy legislative requirements. The HRSA concurred with the recommendations and indicated that corrective action will be taken. (CIN: A-09-91-00150)

### **Selected Community Health Center Grantee Audit Findings**

The OIG prepared a management advisory report to alert PHS to the magnitude of noncompliance issues and internal control weaknesses identified in audit reports on the community health center (CHC) program. In a review of 212 nonfederal audit reports pertaining to 171 of the 520 CHC grantees, OIG found that: 46 percent had inadequate internal control systems; 50 percent had inadequate accounting records and procedures; 36 percent had inadequate patient revenue systems; 20 percent had cash management practices that did not protect Federal funds and preclude excessive interest cost to the Federal

Government; and 27 percent prepared inaccurate or untimely financial status reports and Federal cash transaction reports.

The OIG recommended that HRSA strengthen its monitoring procedures to improve CHC's accountability; revise the program monitoring guide to include internal control systems, accounting records and procedures, patient revenue systems, cash management practices and other deficiencies noted in nonfederal audit reports; provide greater emphasis on the guide through training workshops for regional staff, emphasizing areas identified as problems by the nonfederal audit reports; and consider using model systems and techniques in the workshops to improve CHC accountability. The PHS concurred and indicated that corrective action will be taken. (CIN: A-07-92-00518)

### **Perinatal Service Capacity of the Federally Funded Community Health Centers**

Performance Measure

The CHCs play an important role in reducing infant mortality by delivering comprehensive perinatal care to high-risk women in medically underserved areas across the nation. In a study examining the service capacity of CHCs, OIG found that between 1988 and 1990 CHCs significantly increased: the number of prenatal caseloads; the range of medical and health promotional services; the range of ancillary services, such as home visiting and transportation; and total center revenues. Despite capacity increases, demand for perinatal services has continued to grow, and many center clients do not receive the optimal coordinated package of care in a timely fashion. The centers identified several major constraints seriously limiting their capacity to provide care: staffing shortages; the high cost of medical malpractice insurance; ineffective ties between centers and the Medicaid program; and inadequate coordination of perinatal services in the community.

The OIG recommended that PHS, the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE) develop and implement a plan of action to address these constraints. The PHS and ASPE concurred with OIG's recommendation and proposed steps to implement it. The HCFA did not concur with the recommendation, stating that action is already being taken by the Department in the areas identified. (OEI-01-90-02330; OEI-01-90-02331; OEI-01-90-02332)

### **Reductions in Proposed Budgets of Grants Awarded by the National Institutes of Health**

Performance Measure

In response to a congressional request, OIG conducted a review of selected grants awarded during the period October 1, 1990 through June 30, 1991 to evaluate NIH's progress in eliminating "downward negotiations" of research grant awards. The NIH defines "downward negotiations" as the practice of its Institutes, Centers and Divisions to fund research grants at a level below that recommended by initial review groups (IRGs). Since

the process does not involve negotiations, OIG believes that downward adjustment is a more accurate term.

The OIG found that, contrary to congressional intent, NIH continued downward adjustments on new and competing research grants awarded during the first 9 months of FY 1991. In OIG's opinion, there is a risk that cuts not based on cost analysis or the merits of the grant proposal could result in revisions in research objectives or scope of work, raising the possibility that the level of research effort approved by IRGs is not the same level of research effort underway by principal investigators. This risk is exacerbated by NIH's lack of detailed financial expenditure data on grant awards. The Department recognized this as a material internal control weakness, but did not receive approval from OMB to require grantees to report this information.

The OIG reviewed NIH's plan for managing costs which was prepared in response to congressional concerns. While the plan calls for improved cost analysis of grant proposals, it does not specifically prohibit downward adjustments, or more importantly, cuts to achieve targeted cost reductions. The OIG recommended that NIH either eliminate targeted cost reductions or, if this is not immediately feasible, establish procedures to obtain input on the potential impact of targeted budget reductions on grant proposals from IRGs and/or advisory councils and boards during peer review. The PHS stated that, while reductions in budgets for grant awards should be based on scientific and financial evaluation and assessment of the proposals, targeted budget reductions could not be completely eliminated as long as NIH was required by the Congress to make a specified number of grant awards. (CIN: A-03-91-03002)

## **Fraud and Abuse involving Grant Funds**

The OIG is responsible for investigating cases involving embezzlement or misuse of funds in organizations which receive a major portion of their support from PHS grants. The following convictions were obtained during this period:

- A large midwestern university entered into a settlement agreement to pay \$2.8 million and furnish another \$300,000 of computer time at no cost, for overcharging Federal users. The university used two different computer systems for which it charged one rate for university-related users and a higher rate for Federal users. The Government also recovered an additional \$250,000 in computer time when rates were reduced to meet Federal regulation requirements.
- The former chief pharmacist of a clinic in Oklahoma was sentenced to 78 months in prison after conviction on 45 counts related to embezzlement, misuse of Government funds and drug diversion. In the 15 months preceding his retirement in March 1991, the pharmacist ordered 135,000

valium and 6,700 dilaudid tablets, although the pharmacy dispensed neither drug. He was ordered to pay \$2,250 as a special assessment and to make restitution of \$35,040 to the clinic, which is supported by PHS grant funds.

- The principal investigator for an NIH grant at a California university agreed to a \$53,000 settlement under the Program Fraud Civil Remedies Act. The investigator, who managed the salaries for employees working under the grant, padded the time sheets of one of the employees and forged his signature on the resulting checks. The scam was uncovered when the employee got a wage and tax statement for \$10,000 more than he actually received.

## **National Medical Expenditure Survey**

The National Medical Expenditure Survey (NMES) is a major data collection and research program undertaken approximately every 10 years. It provides data on health care utilization costs, sources of payment and insurance coverage of the Nation's population. The OIG reviewed the responsiveness of the NMES to the needs of Federal officials engaged in health care programs, and budget and legislative activities. The OIG determined that respondents are generally satisfied with NMES products and the services of the Agency for Health Care Policy and Research, which include establishing priorities for serving Federal users, and responding promptly to data requests. Nevertheless, there is some concern about the age of the data and questions about strategic planning efforts, the budget process and the functioning of a NMES work group. The OIG made several recommendations to PHS, ASPE and the Assistant Secretary for Management and Budget (ASMB) addressing these concerns. (OEI-02-92-00350)

## **State Medical Boards**

State medical boards provide a vital front line protection for the millions of people who receive medical care, including those in the Medicare and Medicaid programs. They determine whether or not a physician meets the minimum necessary qualifications to practice medicine. The OIG summarized promising approaches that State medical boards have taken or are considering taking to help pursue quality-of-care cases. These approaches fall into five major areas that parallel the process for addressing quality-of-care cases: identification, investigation, negotiation/prosecution, intervention and prevention.

A second OIG report provided management information from prior OIG work related to States' physician quality assurance efforts, along with other proposals and reports outlining how the Federal Government might improve the quality assurance efforts of State medical boards. This report identified four issues to consider: the difficulty State medical boards have in pursuing quality-of-care cases; the absence of State medical boards' proactive quality assessment and assurance after initial licensure examinations; the difficulties of

performance assessment; and the effects of inadequate funding. (OEI-01-93-00020; OEI-01-92-00050)

### **Public Health Service Contract Preaward Audits: Fiscal Year 1991**

The OIG summarized contract preaward audits it had completed for various PHS operating divisions during FY 1991. A preaward audit determines the reasonableness, allowability and allocability of costs proposed by the tentative contractor. In addition, it may assess the adequacy of the tentative contractor's accounting and administrative systems. In FY 1991, PHS awarded 6,568 cost reimbursable contracts for about \$1.5 billion.

The OIG found that, of the total \$332 million in proposals reviewed, a majority contained overstated and unsupported projected costs totaling approximately \$85 million. For those preaward reports resolved, PHS continues to sustain a significant amount of the findings of overstated or otherwise unreasonable costs. Where proposals were eventually awarded, PHS concurred in approximately \$4.8 million of recommended audit adjustments, and reduced funding by about \$12.6 million because of costs set aside (as undocumented). Further, for proposals reviewed by OIG which were not funded by PHS, there were \$8 million in audit adjustments and about \$45 million in costs set aside. The remaining \$15 million in questionable proposed charges were justified by additional documentation or other evidence of allowability or reasonableness. The OIG concluded that the preaward review process resulted in significant savings to PHS and that it would continue to perform such audits in the future. (CIN: A-02-92-02518)

**Administration  
for Children  
and Families,  
and Administration  
on Aging**



---

## Chapter V

# ADMINISTRATION FOR CHILDREN AND FAMILIES, AND ADMINISTRATION ON AGING

### Overview of Program Areas and Office of Inspector General Activities

The Administration for Children and Families (ACF) provides direction and funding for State-administered programs designed to promote stability, economic security, responsibility and self-support for the Nation's families. Expenditures for the ACF programs are expected to total \$26.4 billion for Fiscal Year (FY) 1993. The major programs include: Aid to Families with Dependent Children, Child Support Enforcement, Child Care, Job Opportunities and Basic Skills (JOBS) training, Head Start, Foster Care and Adoption Assistance and Refugee Resettlement.

The Office of Inspector General (OIG) reviews the cost-effectiveness of the various social service and assistance programs, including determining whether authorized services are rendered to eligible recipients at the lowest cost. The OIG identifies opportunities to improve Federal and State management over delivery of program services and monitor the implementation of the Family Support Act of 1988, which provides for a comprehensive restructuring of the welfare system to reduce long-term dependency on welfare programs.

Further, OIG reviews the Department's programs that serve children, and has issued several reports in this area. Overall, OIG has found that there are significant barriers to the effective coordination and implementation of these programs, including Head Start, Foster Care and Adoption Assistance, and the Child Support Enforcement programs. Although the Department has made changes and appears to be on the right course, improvements are needed to better target these services to the needs of children. The OIG reports have focused on ways to increase the efficient use of the program dollar, and how to better coordinate program implementation between the Federal and State/local governments.

Federal funding of the Administration on Aging (AoA), which reports directly to the Secretary, is about \$900 million annually. The AoA awards grants to States for establishment of comprehensive community-based systems that assist the elderly in maintaining their independence (and in remaining in their homes) as long as possible. The assistance is targeted to the socially and economically disadvantaged especially the

low-income minority elderly, and includes supportive services, nutrition services, education and training, low-cost transportation and housing, and health services.

Earlier OIG reviews identified material management control weaknesses in AoA's awarding and monitoring of discretionary grants, and the need to protect the reversionary interest of the Federal Government in multipurpose senior centers. The Department is taking action to correct these problems. More recently, OIG reported opportunities for program improvements to target the neediest for services, expand available financial resources, upgrade data collection and reporting, and enhance program oversight.

### **Overpayment Recovery Process in the Aid to Families with Dependent Children Program**

Performance Measure

The OIG found that ACF's policies and procedures are too general, and do not provide State and local agencies with specific, uniform procedures to use for each phase of the Aid to Families with Dependent Children (AFDC) overpayment recovery process. The OIG believes that specific regulations are essential to achieving the level of accountability ACF needs from State and local agencies to facilitate performance measurement and program monitoring.

The OIG had previously reported that, as of 1989, there had been up to \$3.5 billion in potential overpayments which had not been identified and reported by State agencies. Since that time, the backlog of potential overpayments has not been reduced. According to its own quality control data, ACF estimates that State and local agencies continued to make \$1 billion in additional AFDC overpayments annually. Considering the magnitude of the problem, OIG believes that the need for intensified program oversight to protect Federal program interests is essential. The OIG reported this area as a material management control weakness in the spring 1992 semiannual report.

The OIG recommended that ACF review its control procedures in each of the four phases of the overpayment recovery process: timely processing of potential overpayments; collecting overpayment amounts due from current and former recipients; determining when it is not cost-effective to continue recovery efforts; and reporting accurate data on overpayment recovery activities in each State. Also, OIG proposed that ACF take several actions requiring State and local agencies to apply uniform procedures in the recovery of overpayments from current and former AFDC recipients. The ACF generally agreed with the findings and recommendations, and stated that it has initiated a corrective action plan to address the problems identified in the report. (CIN: A-01-92-02506)

### **Welfare Fraud**

Welfare assistance provided under the AFDC, Medicaid, Food Stamp and general assistance programs is based on State determinations of eligibility. As a result, welfare fraud is usually

perpetrated by providing false information 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's compensation rolls or income tax returns. The following actions resulted from OIG investigations, many of which were worked jointly with agencies responsible for administering the programs on the State and local levels:

- A woman was sentenced to 18 months in the Massachusetts house of corrections (committed for 30 days) and ordered to make restitution of \$51,000 that she was overpaid in benefits from the AFDC program. From May 1989 to May 1992, she concealed Social Security benefits and wages she and her husband received, in order to obtain the AFDC benefits.
- In Ohio, 14 persons were sentenced as a result of investigations by a county welfare fraud task force in which OIG participated. A total of \$67,567 was ordered in fines, restitutions and assessments, \$40,035 of which is to be returned to the AFDC program.
- A Tennessee woman who had received AFDC benefits since 1974 for her four-person household failed to report that she went to work in 1986. She was sentenced to 4 months of prison and 4 years probation, and ordered to make restitution of \$4,720.
- A Minnesota man was convicted of welfare fraud, assault and terrorist threats related to using at least six names and even more Social Security numbers (SSNs). His sentence of 24 months confinement was stayed, and he served 6 months in a county work house. However, he violated parole thereafter and was sent to serve the full 24 months in prison. The man had defrauded the welfare system of \$10,490.

In two instances local social service employees used their positions to manipulate welfare records to cause checks to be issued illegally, from which they received a portion:

- In Louisiana two sisters who were welfare case workers were convicted for accepting fees from welfare recipients to manipulate State AFDC computer records to add fictitious dependents to their files. A third sister was also convicted for being part of the scheme. Two were sentenced to 40 months in prison and the third to 3 years. Total restitution and fines ordered from the three amounted to more than \$130,800. A recipient who testified against the caseworkers was given 3 years probation and ordered to repay \$1,730.

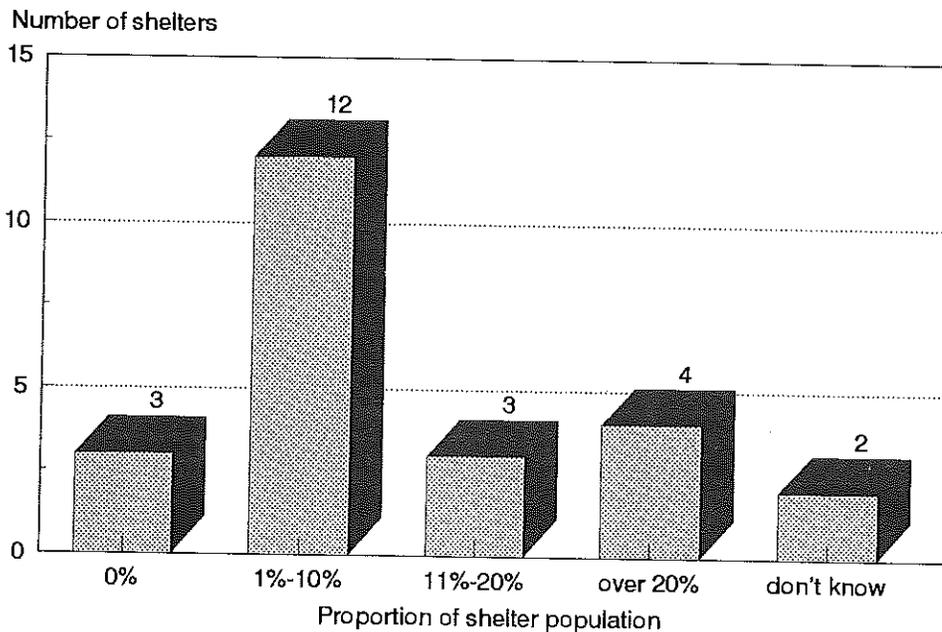
- In San Diego County in California, the last 18 of 20 defendants were sentenced during this period for a scheme in which as much as \$1 million may have been embezzled from the AFDC program. Five employees of the county department of social services established phony files under false SSNs, causing checks to be issued to friends, relatives and acquaintances. Almost all of the defendants were given prison time, one as much as 7 years, and total fines and restitutions ordered amounted to more than \$158,800.

## Homeless Families' Access to Aid to Families with Dependent Children Benefits

Performance Measure

At the request of the Assistant Secretary for Planning and Evaluation (ASPE), OIG began to examine the question of how well homeless families access Federal mainstream programs such as AFDC. Homeless families are estimated to compose approximately 30 percent of the homeless population. The assumption for the study was that many homeless families were not accessing AFDC and that the application processing time was a hindrance to AFDC access. The OIG found that most homeless families were already on AFDC. For the 31 percent who were not receiving AFDC, there were reasons such as employment of a parent or receipt of other income. As illustrated by the following chart, very few residents in the 24 shelters contacted were first time applicants to AFDC.

**FIRST TIME APPLICANTS TO AFDC  
(AS A PROPORTION OF TOTAL SHELTER POPULATION)**



Sixty percent of shelter officials said that first time applicants did not have problems with waiting for their first AFDC checks because the shelters took care of their basic needs. Of the nine shelter officials who cited problems, three said it was because their shelters could not provide for residents' basic needs until the checks arrived, and another three said it was because the maximum length of stay in their shelters was too short to apply for and receive benefits. (OEI-05-91-00061)

## **Emergency Shelters for Homeless Families**

Performance Measure

Also at ASPE's request, OIG performed an inspection to assess the quality of living conditions and services in emergency shelters for homeless families. Overall, OIG found that the shelters visited were effectively providing important services to homeless families. Most shelters were clean, and shelter security and safety were not significant problems for most residents. However, 20 percent of families said that they were concerned for their safety. The shelters provided or made arrangements for a variety of services, but only 25 percent had access to day care for their residents. Two-thirds of the shelters denied admittance to older males, causing family separations in some cases. Federal dollars accounted for 18 percent of funding sources for the sampled shelters; most shelters were funded through donations and other sources.

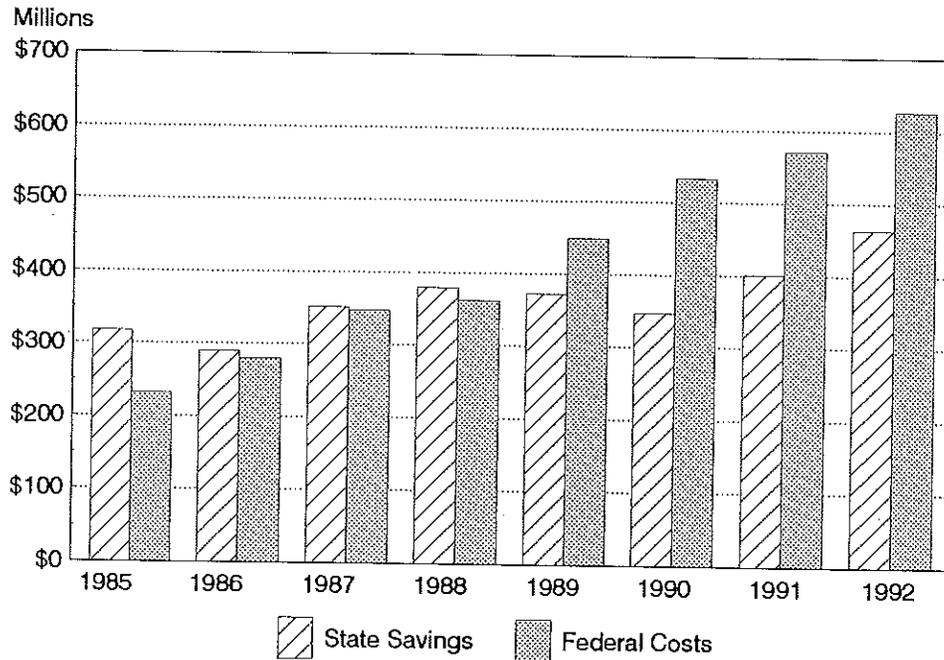
The OIG recommended that State and local officials, shelter operators, homeless program coordinators and others wishing to improve shelters for homeless families should focus on: ensuring cleanliness and security where they are lacking; arranging for day care to be provided to families with children who are attempting to find work while living in a shelter; and developing policies and effective practices to prevent family separations due to restricting admission of older males. (OEI-07-91-00400)

## **Child Support Enforcement Payments: Financial and Program Implications**

Performance Measure

The OIG conducted a review to determine if changes in Federal incentives and/or cost sharing should be made to the Federal funding levels for the Child Support Enforcement (CSE) program. The OIG found that the States have realized an increasing amount of financial benefits from the CSE program while the Federal Government has incurred increasing costs, as illustrated by the following chart.

## STATE SAVINGS AND FEDERAL COSTS Fiscal Years 1985-1992



The OIG also found little evidence that incentives have improved program performance. The OIG recommended various options for legislative changes to increase the financial involvement of States, thereby encouraging them to be more concerned about the effectiveness and efficiency of their CSE programs. The OIG believes that the realization of State savings from incentive payments contradicts the legislative intent of using the States' cost matching requirement as a motivator to encourage them to operate an effective and efficient program. Moreover, it is OIG's opinion that incentive payments should only be made to reward exceptionally good performance. The overall performance of States has been rated "poor" in a recent congressional report card. The ACF agreed that CSE program improvements were needed, but thought that this should be achieved by restructuring the incentives formula to link incentives with performance. (CIN: A-09-91-00147)

### Health and Safety Standards at Child Care Facilities

As part of its ongoing State reviews of health and safety standards at child care facilities that receive Federal funds, OIG continues to find health and safety problems that cause serious concern. The OIG issued an early alert to ACF on its review in one State which found violations ranging from record discrepancies to fire code violations and unsanitary conditions. The OIG recommended that the State build in additional controls and safeguards to assure compliance with all State regulations and codes. (CIN: A-12-92-00044)

## **Foster Care Maintenance Payments: Illinois**

The Foster Care program provides funds to pay for foster care when a child eligible for AFDC benefits is removed from the home as a result of a voluntary placement agreement or a judicial determination. For the period October 1, 1988 through September 30, 1990, Illinois claimed about \$106 million for reimbursement of foster care maintenance assistance costs. The Federal financial participation in this amount was about \$53 million. The OIG determined that approximately \$5 million was improperly claimed by the State for unlicensed facilities, or incomplete judicial determinations or missing case files. The OIG recommended that Illinois strengthen its controls to ensure that all foster care payments are made in accordance with Federal regulations, and that the State make a financial adjustment of \$5 million for the ineligible claims. The State did not concur in 21 of the 37 payments questioned, but ACF agreed with the findings and recommendations. (CIN: A-05-92-00075)

## **Using Community Resources for Job Opportunities and Basic Skills Program Participants**

Performance Measure

The OIG conducted a survey to identify and describe promising practices in using community resources for educating and training JOBS training program participants. The reputedly successful program practices were relatively straightforward, and many of them could easily be adopted by other jurisdictions. The JOBS administrators surveyed deemed cooperation among Federal, State and community agencies to be vitally important for successful JOBS programs. One community program that served an estimated 200 teen parents returned 129 drop-outs to school, using resources from two Federal, two State and two county programs. The cooperating agencies provided funds, facilities, equipment, instructors, tutors, counselors, and support services such as child care and transportation. The JOBS administrators in two other communities partly relied on the resources of private corporations, business associations and volunteers. These resources included computer hardware and software, internships, special loans, and volunteer instructors, tutors and consultants. This added real life work experiences to the training. Seven communities cited particularly promising techniques for providing child care, transportation and other support services, without which many AFDC recipients would not participate in the JOBS program. (OEI-04-90-00341)

## **Job Opportunities and Basic Skills Program: State Maintenance of Effort**

The OIG conducted an audit of the maintenance of effort provisions for the Job Opportunities and Basic Skills (JOBS) program in three States: Arkansas, Ohio and Oklahoma. The principal objective of the reviews was to determine if the States were complying with the JOBS maintenance of effort (MOE) provisions which require them to maintain a certain level of funding for JOBS. The OIG found that all three States reviewed met the MOE requirement of maintaining the FY 1986 level of expenditures for FY 1990.

However, Oklahoma incorrectly computed the FY 1986 baseline costs. Oklahoma claimed unallowable costs and excessive Federal financial participation (FFP) in excess of \$388,000 (Federal share) for the JOBS program. Further, Oklahoma was unable to ensure that JOBS funds were not used for services otherwise available on a nonreimbursable basis. As a result, \$213,900 (\$146,000 Federal share) was set aside for awarding agency resolution. The OIG also found that ACF's current policy regarding the treatment of child care costs when computing the FY 1986 baseline year is in conflict with the JOBS regulations and is unfair to the States in that child care costs are excluded from base year costs.

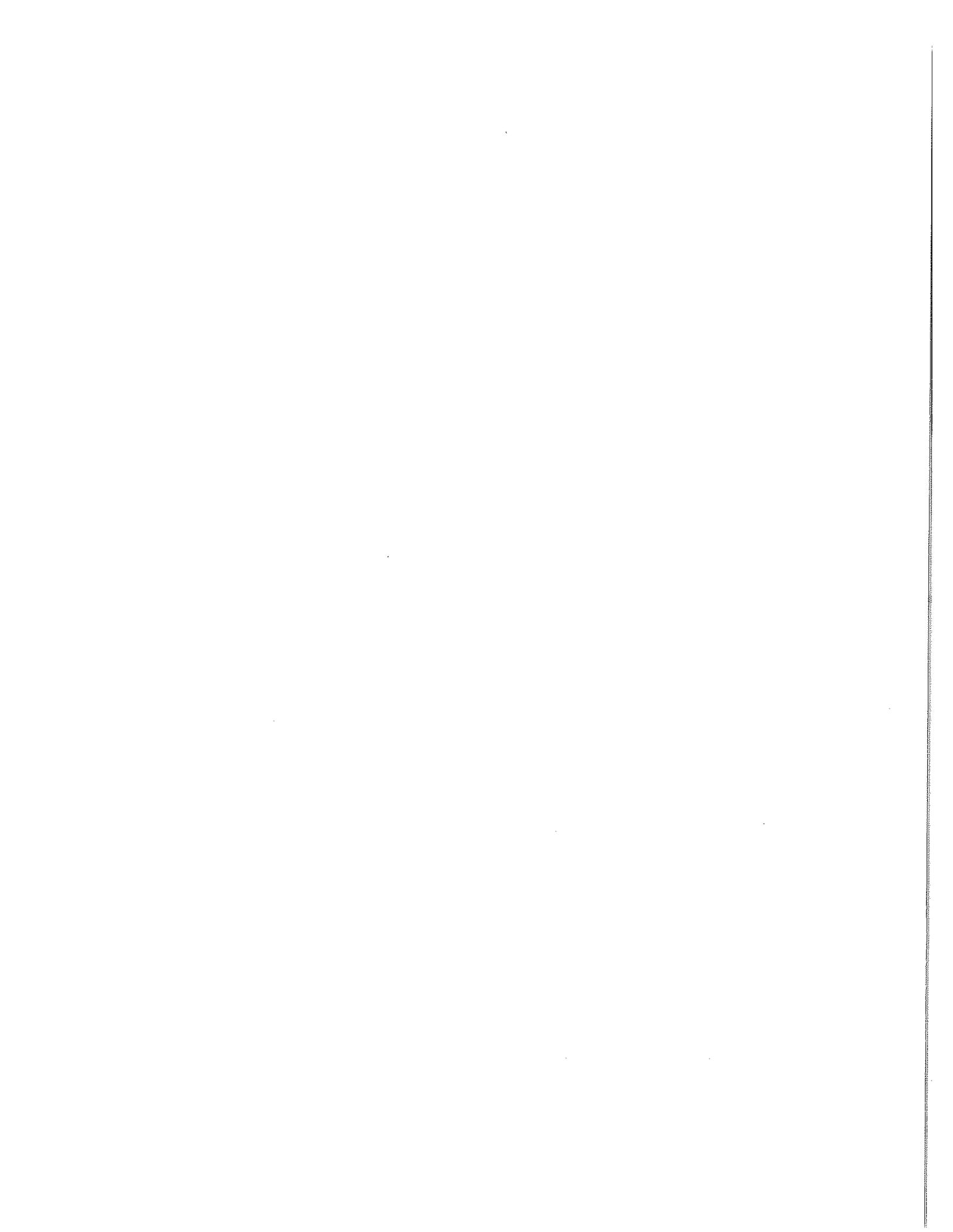
The OIG recommended that ACF revise the policy to treat child care costs consistently in the base year and current year. Oklahoma agreed to correct the procedural deficiencies noted and to make a financial adjustment for the unallowable costs and excessive FFP claimed for the JOBS program. Also, OIG recommended that ACF determine the allowability of the \$146,000 set aside. The OIG further recommended that ACF revise its policy to allow States to consider child care costs in both base year and current year expenditures. (CIN: A-06-92-00002)

### **Automated Data Processing Acquisitions Not Requiring Prior Federal Approval**

The OIG conducted surveys in Florida and North Carolina to assess State procedures to centrally control automated data processing (ADP) acquisitions not requiring prior Federal approval. The OIG found that the instructions in the Department's action transmittal for centrally controlling ADP projects and expenditures were not clear and did not specify an effective date for implementation of the guidelines. Also, the format for reporting ADP expenditures was not adequate for purposes of monitoring by ACF. Despite the lack of centralized approval for federally-funded acquisitions, OIG did not find any indication that duplicative purchases were made or that major procurements had been segmented to circumvent the Federal requirement for prior written approval.

The OIG recommended that the action transmittal be revised to clarify that central reviews are required, specify an effective date and prescribe an improved reporting format for ADP related costs that includes separate line entries for the different types of ADP costs. The ACF agreed with the findings and recommendations and has initiated actions to address the conditions observed. (CIN: A-04-92-00031)

## **General Oversight**



---

## CHAPTER VI

# GENERAL OVERSIGHT

### Introduction

This chapter addresses the Office of Inspector General's (OIG's) departmental management and Governmentwide oversight responsibilities other than financial management (which is discussed in Chapter 1). The Office of the Secretary (OS) will spend \$153 million in Fiscal Year (FY) 1993 to provide overall direction for departmental activities as well as common services such as personnel, accounting and payroll to the individual operating divisions. Central to these activities is the development of the Department of Health and Human Services' (HHS') budget and its execution, as well as the related activities of establishing and monitoring departmental policy for debt collection, cash management, payment of HHS grants and contracts and procurements. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

The OIG has oversight responsibility for all staff division activities at the departmental level. Another major responsibility flows from the Office of Management and Budget's (OMB's) assignment to OIG to audit the majority of the Federal funds awarded to the major research schools, 104 State and local government cost allocation plans, and separate indirect cost plans of about 1,000 State agencies and local governments. In addition, OIG oversees the work of nonfederal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations.

The OIG's FY 1993 work in departmental management and Governmentwide oversight focuses principally on financial management and managers' accountability for resources entrusted (discussed in Chapter 1), standards of conduct and ethics, and Governmentwide audit oversight, including recommending necessary revisions to OMB guidance.

### Nonfederal Audits

The OMB Circulars A-128 and A-133 establish the audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under the Circulars, these entities are required to have an annual organizationwide audit which includes all Federal money they receive.

These annual audits are conducted by nonfederal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In FY 1992, OIG's National External Audit Review Center (located in Kansas City) reviewed almost 3,300 reports that covered over \$681 billion in audited costs. Federal dollars covered by these audits totaled \$104 billion, about \$54 billion of which was HHS money.

The OIG's oversight of the nonfederal audit activity not only provides Department managers with assurances about the management of Federal programs, but also identifies any significant areas of internal control weakness, noncompliance and questioned costs that require formal resolution by Federal officials.

#### **A. Office of Inspector General's Proactive Role**

The OIG has taken the following steps in the nonfederal area to ensure adequate coverage of the Department's programs and provide for greater utilization of the data provided:

- Through evaluation and summarization of reported data, OIG is able to provide both basic audit coverage and analyses of trends that could indicate systemic problems within HHS' programs. These systemic problems are brought to the attention of departmental management to improve program administration.
- To ensure audit quality, OIG maintains a quality control program (discussed below) and has taken steps to ensure that adequate guidance is available to the nonfederal auditor.
- As a further enhancement of audit quality, OIG provides technical assistance to grantees and the auditing profession through its toll free number and through training. During the past 6 months, training was provided to State certified public accountant societies, State auditor staff and the Association of Government Accountants on Circulars A-128 and A-133 issues.
- The OIG also has been heavily involved in the development of the President's Council on Integrity and Efficiency study on the Single Audit Act and the American Institute of Certified Public Accountants audit and accounting guide for audits of not-for-profits receiving Federal awards.

## B. Quality Control

In order to rely on the work of the nonfederal auditors, OIG maintains a quality control review process which assesses the quality of the nonfederal reports received and the audit work that supports selected reports.

Uniform procedures are used to review nonfederal audit reports to determine compliance with Federal audit requirements and Government auditing standards. During this reporting period, OIG reviewed and processed 1,549 nonfederal audit reports. The following table summarizes those results:

Reports issued without changes or with minor changes	968
Reports issued with major changes	510
Reports with significant inadequacies	<u>71</u>
Total audit reports processed	1,549

During the review period, nine audits were referred to State officials and professional organizations for appropriate action. Several other referrals are pending. The OIG referrals of inadequate audit work can result in significant disciplinary action against the accounting firms involved.

The 1,549 audit reports discussed above included recommendations for HHS cost recoveries totaling \$24.8 million as well as many for improving management operations. In addition, areas were identified for follow-up by OIG auditors.

## Resolving Office of Inspector General 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 <sup>1</sup>	412	\$419,082	\$26,044
B. Which were issued during the reporting period <sup>2</sup>	<u>319</u>	<u>\$459,207</u>	<u>\$12,910</u>
Subtotals (A + B)	731	\$878,289	\$38,954
Less:			
C. For which a management decision was made during the reporting period <sup>3</sup> :	304	\$214,577	\$17,622
(i) dollar value of disallowed costs		\$164,950	\$5,226
(ii) dollar value of costs not disallowed		\$49,627	\$12,396
D. For which no management decision had been made by the end of the reporting period	427	\$663,712	\$21,332
E. Reports for which no management decision was made within 6 months of issuance <sup>4</sup>	74	\$170,101	\$9,079
See Appendix D for footnotes.			

**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		
	<u>Number</u>	<u>Dollar Value</u> (in thousands)
A. For which no management decision had been made by the commencement of the reporting period <sup>1</sup>	92	\$2,252,395
B. Which were issued during the reporting period <sup>2</sup>	<u>58</u>	<u>\$448,635</u>
Subtotals (A + B)	150	\$2,701,030
Less:		
C. For which a management decision was made during the reporting period:		
(i) dollar value of recommendations that were agreed to by management <sup>3</sup>		
(a) based on proposed management action	63	\$535,987
(b) based on proposed legislative action	<u>0</u>	<u>\$0</u>
Subtotals (a+b)	63	\$535,987
(ii) dollar value of recommendations that were not agreed to by management	<u>15</u>	<u>\$251,222</u>
Subtotals (i + ii)	78	\$787,209
D. For which no management decision had been made by the end of the reporting period <sup>4</sup>	72	\$1,913,821
See Appendix D for footnotes.		

## **Legislative and Regulatory Review and Regulatory Development**

### **A. Review Functions**

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. During this reporting period, OIG reviewed 58 of the Department's regulations under development and no departmental legislative proposals. While the lack of legislative proposals is unusual, OIG expects this activity to increase in the next reporting period.

In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigative and legislative 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.

### **B. Regulatory Development Functions**

The OIG also develops regulations for civil money penalty (CMP) and exclusion authorities which the Inspector General administers. During this reporting period, OIG developed and published a final rule that established new safe harbor provisions to provide protection for certain health care plans, such as health maintenance organizations and preferred provider organizations, that offer incentives to enrollees or that enter into negotiated price reduction agreements with contract health care providers. These safe harbors set forth specific standards and guidelines that, if met, will result in particular managed care arrangements being protected from criminal prosecution or civil sanctions under the anti-kickback statute. During this same period, OIG also developed and published a final rule implementing the exclusion and civil monetary penalty provisions established through the Medicare and Medicaid Patient and Program Protection Act of 1987.

The OIG continues its development of several regulations related to the safe harbor provisions under the Medicare and State health care programs' anti-kickback statute, and various rulemaking efforts related to expanding and revising its CMP and peer review organization sanctions authorities.

## **Governmental Accounting**

Each year, State and local government entities receive over \$104 billion in Federal grant funds. It is estimated that Federal agencies pay at least \$6 billion and possibly as much as \$20 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.

### **Internal Service Funds: Connecticut**

During this reporting period, OIG contracted (with a certified public accountant firm) for a review of Connecticut's internal service funds (self-supporting, revolving funds that charge users for common activities, such as data processing, motor pools, etc.) to determine if they had accumulated unnecessary surpluses due to excessive rates used to charge Federal programs and included unallowable costs such as interest expense in the rates. The review found that, as of June 30, 1990, the State's internal service funds had accumulated a reserve balance totaling \$30.5 million in excessive retained earnings. The State disagreed, stating that profits were offset against future indirect costs.

However, OIG could only verify that the State made an adjustment for \$9.7 million against future indirect costs. Accordingly, OIG recommended that the State adjust the remaining \$8.1 million (\$1.62 million Federal share) of the excessive retained earnings in its internal service funds for the 5-year period covered by the audit. For the \$12.7 million in retained earnings generated prior to the audit period, OIG recommended that the Department's Division of Cost Allocation (DCA) negotiate a settlement of the Federal share. The OIG also recommended that, during the review and approval stage of the cost allocation plan, DCA ensure that the State has made the appropriate adjustments to its internal service fund operations. (CIN: A-01-92-02504)

### **Reform of the Cost Allocation System**

Performance Measure

The OIG is reissuing its report that summarizes the results of a study covering cost allocation plans for 35 States to provide a better understanding of the process and systems State and local governments have in place to annually allocate approximately \$20 billion of direct and indirect costs to Federal programs, and to recommend opportunities for reform. This report, which incorporates comments from all relevant Federal financial management agencies, is being sent to members of the State and local government community for review. The report presents for OMB consideration a range of options for reforming the allocation process. Ideally, consideration should be given to developing a new system to benefit both the States and the Federal Government by reducing administrative burdens and costs. (CIN: A-12-92-00014)

### **Controls over Contract Reporting and Contracts**

The law requires OIG to provide an annual report to the Congress on the accuracy and completeness of data provided to the Federal Procurement Data System (FPDS), and the Department's progress in implementing controls over contracts for advisory and assistance services (CAAS). In a review of Administration for Children and Families (ACF) contract actions during FY 1991, OIG found that about 90 percent of the 69 new contract actions had

coding errors or omissions that caused the contract information to be omitted from the data transmitted by the Department to FPDS. Three of 27 contracts reviewed in detail should have been classified as CAAS but were not, and 16 contract actions on 11 contracts were not classified as to whether services were CAAS or not. The contract files for 3 of 15 CAAS contract actions did not have the documents and/or approvals required by the Department. As a result of these conditions, the Department understated ACF's FY 1991 overall new contracting activity of \$18.3 million by \$15.6 million in FPDS. In addition, due to ACF's coding errors, the Department was unable to provide complete contract data to the Internal Revenue Service required for administering the tax code.

The OIG recommended that ACF institute stronger management controls over CAAS contract actions, obtain training for responsible staff and correct errors in data for ultimate submission to FPDS. The ACF concurred and has initiated corrective action. (CIN: A-12-92-00032)

### **Review of Department Detailees**

In its annual report to the Congress, OIG reported on Department employees detailed to congressional committees and offices in FY 1992. The OIG report to the House and Senate Appropriations Committees indicated the grade, position and office of each person detailed from HHS. (CIN: A-17-93-00024)

### **Department's Implementation of the Lobbying Act**

Performance Measure

The OIG released its third annual evaluation of the Department's implementation of the Lobbying Act. The OIG determined that the Department has implemented the necessary procedures to carry out the Act's requirements. While OIG found no indications that the Department was not in compliance with the Act, it did indicate strong reservations concerning the adequacy of the reported disclosures. Further, although departmental officials were aware of the Act's requirements, OIG found uncertainty about the application of the law to specific lobbying activity. The OIG recommended that the Congress consider strengthening the Act by requiring disclosure certifications and agency reports. (CIN: A-17-92-00016)

### **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 official of the National Cancer Institute in Maryland was sentenced for unlawfully supplementing his income and giving false

information on his outside income. He was sentenced to 3 years incarceration, with all but 2 months suspended and to be served in a community services facility. While serving as deputy director of the tumor cell biology laboratory headed by a prominent human immunodeficiency virus researcher, the official accepted \$25,000 from a private biological research firm as payment for virological testing research. He then claimed on a Government financial disclosure statement that he merely consulted and lectured for fees not exceeding \$4,500 per year. Earlier, another senior officer in the same laboratory pled guilty to accepting illegal gratuities and conflict of interest.

- Two Social Security Administration (SSA) employees in Maryland entered a settlement agreement under the Program Fraud Civil Remedies Act (PFCRA) after submitting inflated claims for taxi and limousine fares while on a training trip. They submitted claims for more than double the actual amount of the fares, and supplied no receipts. Both were suspended without pay by SSA for 14 days, and both refunded the amount of their cash advances that exceeded the allowable reimbursement. Under the PFCRA agreement, each will also pay \$716. This action was the first use of PFCRA authorities in a case involving travel fraud by employees against the Department.
- In North Dakota, an Indian Health Service (IHS) employee was sentenced for stealing and cashing another employee's travel reimbursement check. The guilty employee was an administrative secretary, whose duties included filing travel vouchers and orders and serving as custodian for Government-issued Diners Club cards. She was sentenced to 2 years probation and ordered to pay restitution of \$440, plus a \$50 assessment, for the check theft. The OIG also referred her case to IHS for disciplinary action because of misuse of a Diners Club card.
- A former SSA employee in Alabama was sentenced to 2 years incarceration and fined \$25,000 for soliciting a bribe. The employee demanded and accepted \$2,000 in exchange for performing her official duties in processing an applicant's claim for Supplemental Security Income payments. She also demanded another \$1,300 to generate remaining payments due.
- A former claims development clerk in a Dallas SSA office was placed on a pre-trial diversion program for 18 months for using a false Social Security number (SSN) she obtained by abusing her position. The clerk filled out an application for a duplicate card in the name and number of a relative, signing her own name as reviewer. She copied and altered a fellow

worker's pay slips to show she was making more money than she actually made, and using them and the relative's SSN card, applied for credit.

## **Criminal Prosecutions**

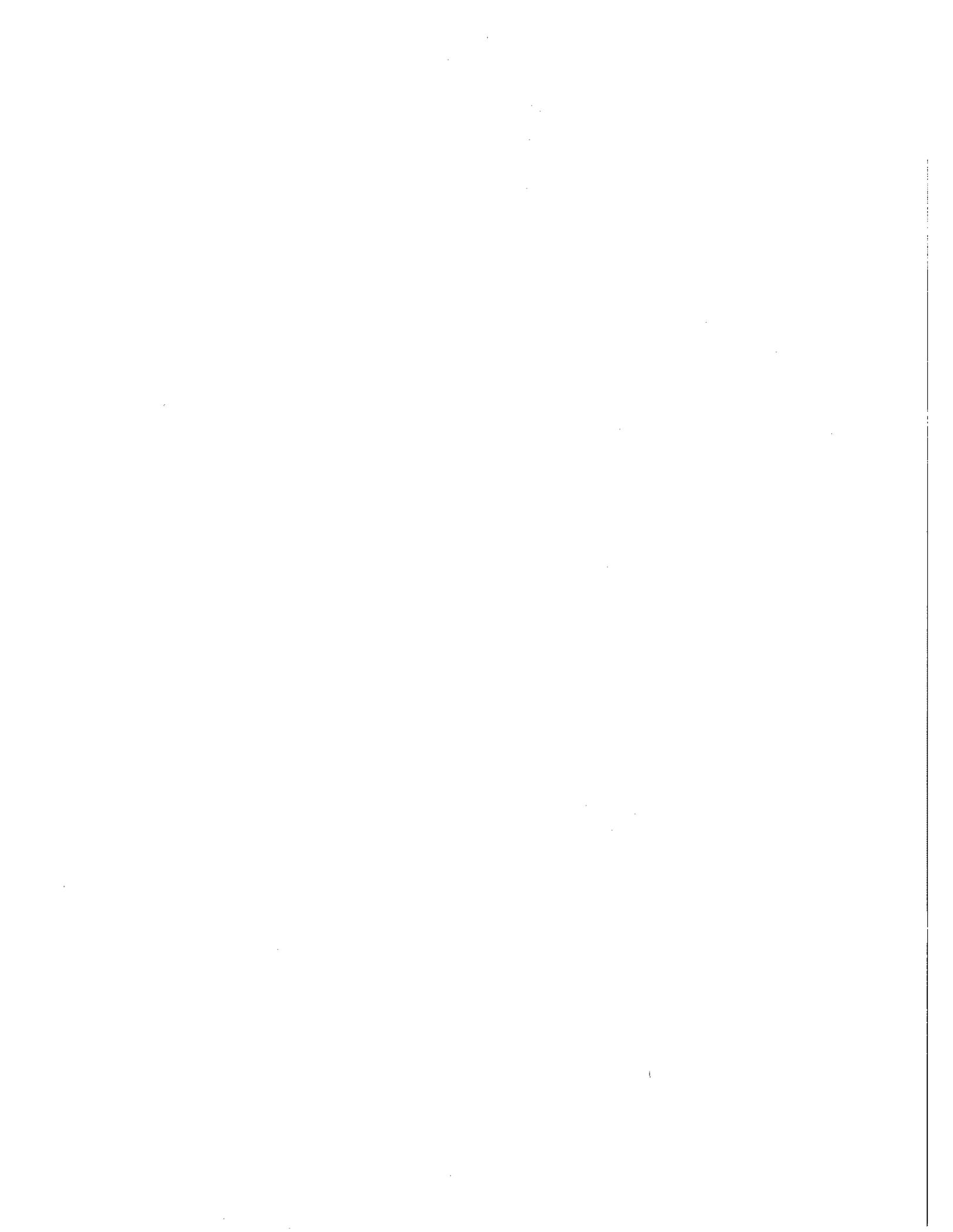
During this semiannual reporting period, OIG investigations resulted in 763 successful criminal actions. Also during this period, 750 cases were presented for prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors in 659 cases.

The number of convictions in this period has declined from previous reporting periods. Resource constraints in OIG have resulted in fewer criminal investigators and a growing backlog of cases. In keeping with our commitment to the highest priorities, OIG is reducing investigative coverage in some geographic and program areas. Existing staff are being concentrated in States with the most HHS program dollars and being deployed to work on the most serious program violations.

## **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 SSNs in a broad range of illegal activities, including bank and credit card fraud, 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 these cases in which OIG participates result in monetary fines, recoveries, restitution or savings for the other agencies. During this period, the monies accruing from these cases amounted to approximately \$10.5 million for other public or private entities.

## **Appendices**



## APPENDIX A

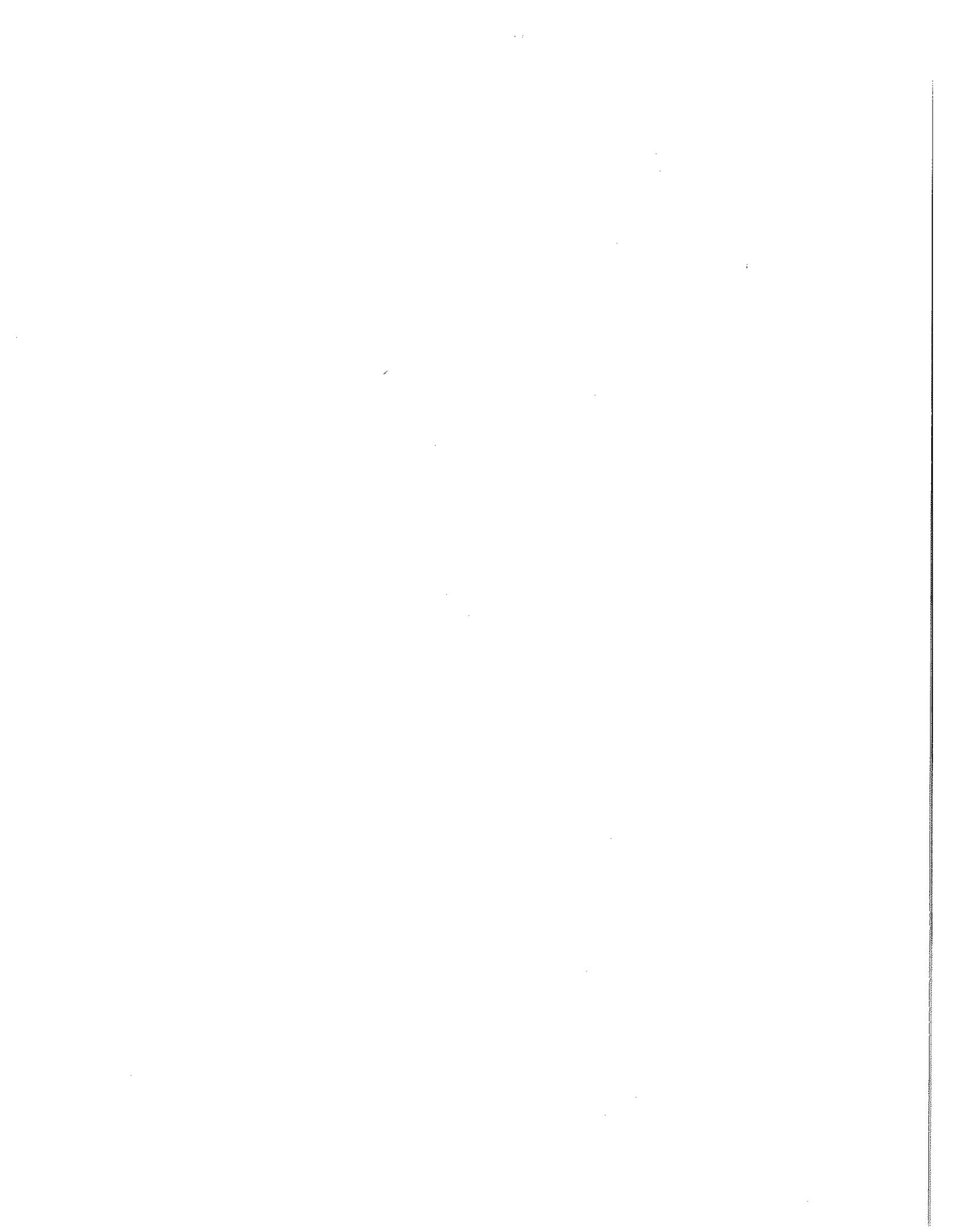
### Implemented Office of Inspector General Recommendations to Put Funds to Better Use October 1992 through March 1993

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 \$2,468.2 million.

OIG Recommendation	Status	Savings in Millions
<b>Capital-Related Costs of Inpatient Hospital Services:</b>		
Discontinue inappropriate Medicare prospective payment system (PPS) payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4001 of the Omnibus Budget Reconciliation Act (OBRA) 1990 provides for a 10 percent reduction for capital-related payments attributable to portions of cost reporting periods or discharges occurring from October 1, 1991 and ending September 30, 1995.	\$760
<b>Raise and Index the Medicare Part B Deductible:</b>		
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. However, OBRA 1990 did not subject the deductible to indexing.	560
<b>Reimbursement for Outpatient Facility Services:</b>		
The Health Care Financing Administration (HCFA) should limit outpatient department (OPD) facility fees and beneficiary charges to the applicable ambulatory surgical center (ASC) rate or reduce payments for OPD services to bring them in line with ASC payments. (OAI-85-IX-00046; CIN: A-14-89-00221)	Section 4151(b) of OBRA 1990 reduced payments for hospital outpatient services paid on a reasonable cost basis, and section 4151(c)(1)(a) modified the blending formula for payments for ambulatory surgical procedures performed in OPDs. However, the disparity between OPD and ASC payments still exists.	340
<b>Capital-Related Costs of Outpatient Hospital Services:</b>		
Discontinue inappropriate Medicare PPS payments for hospital costs. (ACN: 14-52083; ACN: 09-52020)	Section 4151(a) of OBRA 1990 reduces payments for outpatient capital by 15 percent for portions of cost reporting periods in Fiscal Year (FY) 1991 and by 10 percent in FYs 1992 through 1995.	295

OIG Recommendation	Status	Savings in Millions
<b>Coronary Artery Bypass Graft Surgery and Cataract Surgery:</b>	Section 6104 of OBRA 1989 required a further reduction from those imposed in OBRA 1987 in the Medicare reimbursement rates for CABG surgery and for cataract implant surgery effective April 1, 1990.	\$195.5
The HCFA should place special limitations on reasonable charges for the primary surgeon's fee for coronary artery bypass graft (CABG) surgery, and should consider consolidating payments for primary surgeons, assistant surgeons and anesthesiologists. The HCFA should periodically assess the changes in surgical procedures and technology, and mandate adjustments to Medicare reimbursement. (OAI-09-86-00076; OAI-85-IX-00046)		
<b>Continuous Ambulatory Peritoneal Dialysis Supplies:</b>	Section 6230 of OBRA 1989 reduced payments for supplies to no more than the amounts paid under a single composite rate to an ESRD facility, beginning February 1, 1990.	135
The HCFA should limit payment allowances to suppliers who deal directly with end stage renal disease (ESRD) patients to amounts allowable under a single composite rate to an ESRD facility. (CIN: A-09-87-00108)		
<b>Child Support Enforcement for Non-Aid to Families with Dependent Children Clients:</b>	The Administration for Children and Families has encouraged the States to begin periodic review of all child support cases, and where appropriate, establish new orders or modify existing ones. Many States have taken the recommended action with positive results.	111.4
States should perform systematic review of all child support cases, including those from sources other than the Aid to Families with Dependent Children program, targeting those where absent parents earn more than \$10,000 annually, and establish new or modify existing child support orders. (OAI-05-88-00340)		
<b>Hospital Patient Transfers:</b>	The HCFA has implemented the recommended computer edits to prevent future overpayments of this nature.	36
The HCFA should recover Medicare claims erroneously reported and paid as discharges for patients who were actually transferred to other prospective payment system hospitals and implement computer edits to prevent further overpayments. (CIN: A-06-89-00021)		
<b>Coordinate Third Party Liability Information:</b>	The OCSE amended its Program Results Audit Guide to reflect the medical support regulations and has penalized negligent States.	32
The Office of Child Support Enforcement (OCSE) should enforce current regulations regarding medical support by amending its Program Results Audit Guide and applying penalties to States found negligent in applying those regulations. (OAI-07-88-00860)		
<b>Zip Code Software:</b>	The SSA began using the 9 digit zip code for Supplemental Security Income benefit checks in November 1990 and for Retirement, Survivors and Disability Insurance benefit checks in March 1991.	2
The Social Security Administration (SSA) should acquire commercial zip code software to help ensure accurate address information and quicker mail delivery. (CIN: A-13-87-02656)		

OIG Recommendation	Status	Savings in Millions
<b>Improper Cashing of Replacement Checks:</b> The SSA should establish automated controls over double check negotiation cases. (CIN: A-13-86-62635)	The SSA has established automated controls as part of its debt management system.	\$1.3



## APPENDIX B

### Unimplemented Office of Inspector General 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
<b>Medicare Secondary Payer: Definition Expansion Savings</b> Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries without limitation. If legislation requiring Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986, is not enacted, seek legislation making Medicare the secondary payer for all retirees of exempt State and local agencies. (CIN: A-09-88-00072; CIN: A-10-86-62016)	While the Omnibus Budget Reconciliation Act (OBRA) of 1990 extended the ESRD provision from 12 to 18 months, OIG continues to believe that legislative action is appropriate. In the 102nd Congress, H.R. 11 (as passed by the Senate) continued a provision to extend the MSP ESRD provision from 18 to 24 months. However, this provision was not enacted. The proposal to include under Medicare all State and local government employees hired before April 1, 1986 has been included in previous presidential budgets. Although this proposal was not enacted, OIG continues to advocate this legislation. As an alternative, the Health Care Financing Administration (HCFA) could seek legislation making Medicare the secondary payer for retirees of exempt State and local agencies.	\$2,070
<b>Close Loopholes Affecting the Federal Insurance Contribution Act Wage Base:</b> Require that salary reduction agreements established under Internal Revenue Code cafeteria plans be included in the definition of wages for Federal Insurance Contribution Act (FICA) purposes. (CIN: A-05-86-62602)	Although the Social Security Administration (SSA) generally supported expansion of the FICA wage base, it did not believe that it was appropriate to seek legislation at this time. The HCFA said that it will give the proposal further consideration should the Administration decide to examine ways to expand the tax base.	1,247
<b>Reducing Federal Financial Participation:</b> The Administration for Children and Families (ACF) should consult with the Congress on modifications to the Federal Medical Assistance Percentages formula which would result in distributions of Federal funds that would more closely reflect per-capita-income relationships. (CIN: A-06-90-00056)	The ACF did not agree with the recommendation.	1,100

OIG Recommendation	Status	Savings in Millions
<p><b>Laboratory Roll-In:</b> Fees for laboratory services should be included in Medicare recognized charges for physician office visits. (OEI-05-89-89150; OEI-05-89-89151)</p>	<p>The HCFA disagreed with the recommendation. The OIG continues to believe that it should be implemented.</p>	<p>\$1,100</p>
<p><b>Indirect Medical Education:</b> 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-07-88-00111)</p>	<p>The OIG continues to recommend that HCFA reduce the indirect medical education adjustment factor to the level supported by empirical data.</p>	<p>1,045</p>
<p><b>Medicare Secondary Payer: Retroactive Recoveries</b> The HCFA should ensure that contractors' resources are sufficient and instruct contractors to recover improper primary payments; ensure that contractors take sufficient action to preclude the loss of backlogged MSP cases (claims where contractors are more than one quarter behind in sending a demand letter) because the recovery period lapsed; implement financial management systems to ensure all overpayments are accurately recorded; and pursue alternative strategies such as contingency contracts, demonstration and incentive programs, or fund collection activities from recovery proceeds. (CIN: A-01-90-00509; CIN: A-01-91-00525; CIN: A-04-91-02004; CIN: A-04-92-02037; CIN: A-04-92-02057; OEI-07-89-01683)</p>	<p>During Fiscal Year (FY) 1992, HCFA provided the contractors an additional \$20 million in administrative funding to reduce the MSP backlog, but the backlog continues. The HCFA has also developed an MSP overpayment tracking system. However, it is not considered a financial management system. In addition, the Department submitted an FY 1994 legislative proposal to establish a payment safeguards revolving fund to provide smoother and more certain funding levels which could result in more consistent and efficient contractor MSP operations. The HCFA submitted a legislative proposal that would establish a cost recovery fund for carriers.</p>	<p>961.6</p>
<p><b>Medicare Secondary Payer: Prospective Savings</b> The HCFA should revise the justification for an FY 1990 legislative proposal, which would require insurance companies, underwriters and third-party administrators to periodically submit employer group health policy (EGHP) coverage data directly to HCFA, and resubmit it for FY 1994; require that employers report EGHP coverage on the Wage and Tax Statement (W-2); revise all Medicare claims forms to require a positive or negative response pertaining to other health insurance coverage; request that SSA maintain beneficiary spousal information in its master beneficiary record system for use by HCFA; establish a national data bank system containing primary insurance information; assure compliance with all carrier first claim development procedures and collect health insurance information for disabled beneficiaries during the required disability waiting period. (CIN: A-09-89-00100; CIN: A-09-91-00103; OEI-07-90-00760; OEI-07-90-00763)</p>	<p>The HCFA is considering these recommendations and supports the establishment of a national clearinghouse of health insurance information as an alternative, and has taken some measures to prevent mistaken Medicare payments, such as: the initial enrollment questionnaire, the Common Working File and the implementation of the Internal Revenue Service (IRS)/HCFA/SSA data match project. However, implementation plans and policies have not been developed and corrective action has not been implemented on some of OIG's recommendations.</p>	<p>900</p>

OIG Recommendation	Status	Savings in Millions
<p><b>Reduce Hospital Capital Costs:</b> Seek legislative authority to continue mandated reductions in capital payments beyond FY 1995. The HCFA should determine the extent of the capital reductions that are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (CIN: A-09-91-00070)</p>	<p>The HCFA did not agree that there were inappropriate cost elements in payment rates, but agreed that there is some validity concerning OIG's position on excess capacity. The HCFA did not agree to seek legislation at this time.</p>	\$800
<p><b>Clinical Laboratory Tests:</b> 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)</p>	<p>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. The President's FY 1993 budget and legislative program contained a proposal to reduce the cap for reimbursing clinical laboratory tests to 76 percent of the median of all fee schedules. However, the proposal was not enacted.</p>	426
<p><b>Modify Payment Policy for Medicare Bad Debts:</b> Seek legislative authority to modify bad debt payment policy. (CIN: A-14-90-00339)</p>	<p>The HCFA plans no further action on this report.</p>	400
<p><b>Limit Federal Participation in States' Costs for Administering the Foster Care Program:</b> The ACF should limit Federal participation in the States' administrative costs for the Foster Care program. (CIN: A-07-90-00274)</p>	<p>The President's FY 1993 budget includes a legislative proposal to change the financing of State child welfare activities by creating and funding a new comprehensive child welfare services capped entitlement program. Under the proposal, each State will be required to maintain current efforts and previous levels of expenditures, and provide a match of 25 percent of funding, as opposed to the 50 percent match currently required for administrative costs.</p>	247
<p><b>Lodging Compensation:</b> Include permanent lodging compensation for FICA coverage. (CIN: A-09-90-00050)</p>	<p>The SSA did not support the recommendation since it results in different Social Security and IRS treatment of the value of employer-supplied lodging and the IRS indicated the proposal could be difficult to administer. The OIG pointed out that other similar provisions are currently being administered.</p>	221

OIG Recommendation	Status	Savings in Millions
<p><b>Hospital Admissions:</b> 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; CIN: A-05-92-00006)</p>	<p>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. However, HCFA agreed that it may be appropriate to modify policy to encourage hospitals to treat cases involving observation after outpatient services as outpatient rather than inpatient cases, since it is not anticipated that these patients will require additional procedures. The HCFA intensified peer review organization (PRO) review of short-stay admissions as a first step in dealing with the problem, and has modified both the intermediary and hospital manuals in an effort to minimize the problem of inappropriate admissions. However, OIG's follow-up report indicated that problems still exist with intermediary instructions pertaining to inappropriate admissions, and that the instructions have not significantly reduced the volume of 1-day admissions on a national basis. The volume of 1-day admissions has increased approximately 150 percent over 1985 levels.</p>	\$210
<p><b>Institute and Collect User Fees for Food and Drug Administration Regulations:</b> 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; CIN: A-12-88-00004)</p>	<p>Various legislative proposals are being considered which would result in the expansion of user fees across FDA functions.</p>	200
<p><b>Adjust Physician Fee Schedule Payments Based on Site of Service Differentials:</b> Seek legislative authority to expand the reimbursement limitation to physician services provided in additional settings and to expand the definition of services routinely performed in physicians' offices to include a high volume criterion. (CIN: A-05-92-00007)</p>	<p>The HCFA does not concur with OIG's high volume criterion, stating that expense component of physician payments is statutorily defined. The HCFA is evaluating payments under the physician fee schedule to determine if adjustments should be made for services furnished in additional settings.</p>	176.9
<p><b>Expand Mandatory Tip Reporting Requirements:</b> 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)</p>	<p>The SSA believes that any changes are within the jurisdiction of IRS and IRS has not supported the proposal.</p>	134

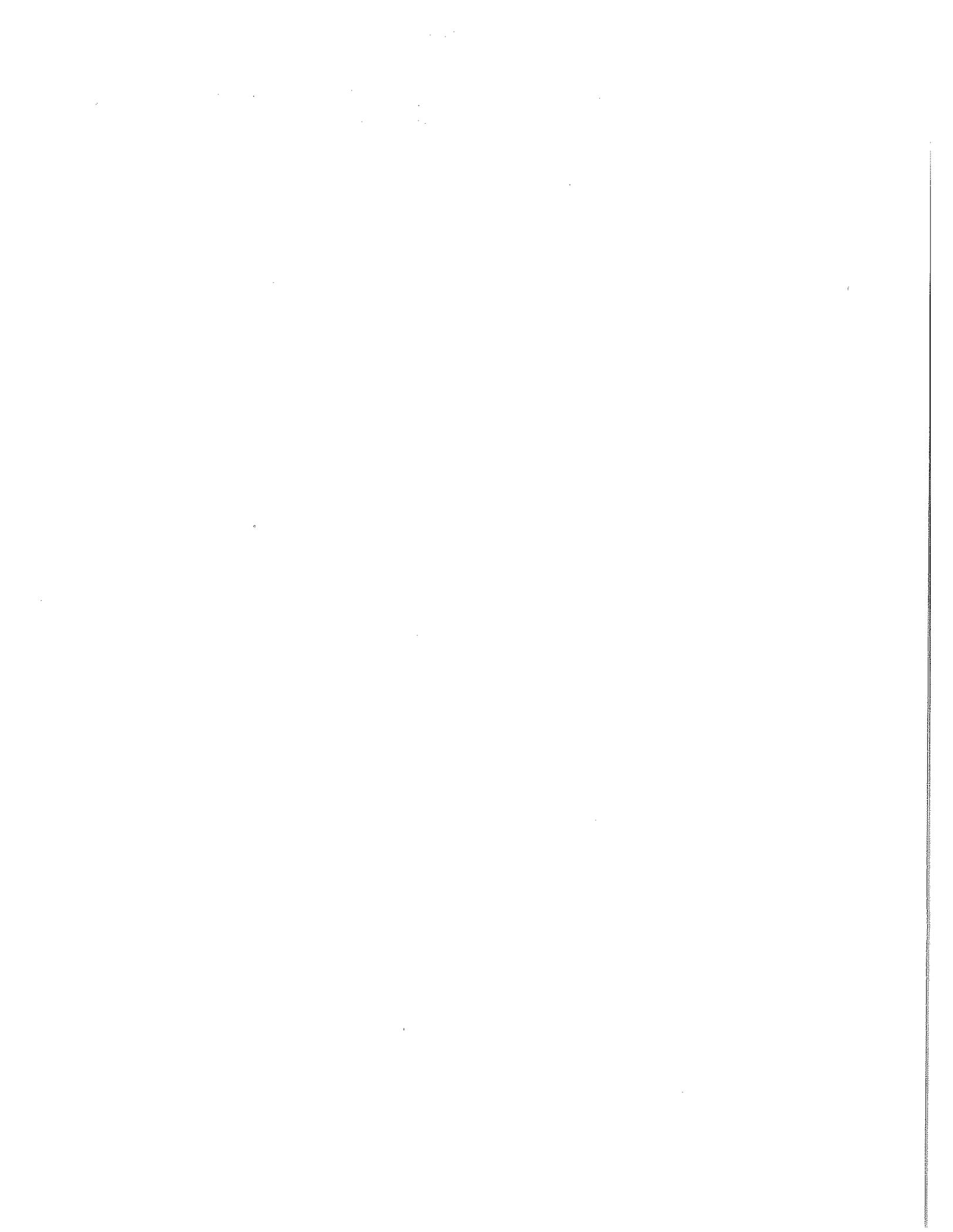
OIG Recommendation	Status	Savings in Millions
<p><b>Recover Value Lost to the Trust Funds from Past Due Debts:</b>            Institute a policy change to allow recovery for each delinquent overpayment at the higher of the interest income lost to the trust funds or the value lost to the trust funds due to inflation. (OAI-03-88-00680)</p>	<p>The SSA disagrees with the proposed method of recovery in the absence of a clear legislative mandate. The OIG remains convinced that the recommendation is appropriate.</p>	\$112
<p><b>Outpatient Surgery - Cataract Quality of Care Costs and Unnecessary Endoscopies:</b>            The HCFA should reduce the incidence of payments for medically unnecessary and poor quality cataract surgeries, upper gastrointestinal endoscopies and colonoscopies through a combination of efforts by PROs and carriers, including targeted review of certain providers. (OEI-09-88-01005; OEI-09-88-01006)</p>	<p>Contingent upon the approval of the fourth scope of work, PROs will review a 5 percent sample of certain outpatient surgeries in ambulatory surgical centers for medical necessity and quality of care.</p>	106.1
<p><b>Accelerate Federal Grantees' Deposits of Payroll Taxes:</b>            Require recipients of Federal funds to deposit payroll taxes on the same day Federal funds are drawn down to meet payroll needs. (CIN: A-12-88-00110)</p>	<p>The recommendations are being considered by the Office of Management and Budget (OMB) in its initiative to develop cost containment proposals. Corrective action is pending implementation of the Cash Management Reform Act.</p>	103.4
<p><b>Reduce Payments for Intraocular Lenses:</b>            Medicare should pay a flat \$150 for all intraocular lenses (IOLs). (OEI-07-89-01664)</p>	<p>The HCFA is currently prohibited by law from reducing the IOL reimbursement rate below the \$200 cap until 1993. House Resolution 21, if passed, would extend the ban for several more years.</p>	100
<p><b>Disallow Interest Charges on Unfunded Liabilities of Government Pension Plans:</b>            The OMB should revise Circular A-87 limiting Federal sharing of actuarially determined pension costs, including amortization of unfunded liabilities, to situations where the State and local governmental unit is funding such cost through an actuarially sound plan. Interest cost caused by late funding should not be allowed. (CIN: A-09-87-00031)</p>	<p>Because of the sensitivity and financial impact of the proposed changes on the State and local governmental entities, OMB has expended considerable effort working with State and local interest groups prior to issuance as a draft proposed rule change. The OIG continues to recommend that OMB clarify the rule relating to pensions by finalizing revisions to Circular A-87.</p>	100
<p><b>Reduce Medicare Payments for Hospital Outpatient Department Services:</b>            Establish a legislative initiative to reduce the current payments for services in outpatient departments to bring them more in line with ambulatory service center approval payments. (CIN: A-14-89-00221)</p>	<p>The HCFA developed a legislative proposal which was contained in the FY 1992 President's budget. However, the proposal was not passed and HCFA believes that such a proposal will not be passed in the future. The OIG continues to believe that its recommendation is valid.</p>	90

OIG Recommendation	Status	Savings in Millions
<p><b>Recover Federal Share of Excess Reserves in Self-Insurance Funds:</b>  The OMB should revise Circular A-87 to tighten standards for charging of self-insurance funds to Federal programs and improve reporting by the States on fund operations, condition and funds flow. (CIN: A-04-90-00018; CIN: A-05-88-00082; CIN: A-02-88-02010; CIN: A-04-88-00061; CIN: A-03-91-01450; CIN: A-04-90-00019; CIN: A-04-91-00023; CIN: A-04-88-00060; CIN: A-04-90-00020; CIN: A-10-86-86-60450; CIN: A-03-91-14562; CIN: A-03-92-00603; CIN: A-04-91-00024)</p>	<p>The OMB has developed changes to OMB cost principles that will tighten the standards and improve reporting on self-insurance funds. The OMB will seek and consider public comments before finalizing revisions to Circular A-87. The OIG continues to recommend that OMB clarify all rules on self-insurance funds by finalizing revisions to Circular A-87 cost principles.</p>	\$76
<p><b>Conventional Eye Wear:</b>  Exclude conventional eye wear from Medicare coverage for beneficiaries receiving IOL implants. (CIN: A-04-88-02039)</p>	<p>The OBRA 1990 limits coverage to one pair of eyeglasses following cataract surgery with an IOL implant. The OIG continues to recommend that HCFA seek legislation to exclude all conventional eyeglasses following certain cataract surgery.</p>	72
<p><b>Disallow State Sales Tax Charged to Federal Programs:</b>  The OMB should review Circular A-87 to disallow payment of self-assessed State sales tax charged to Federal programs. (CIN: A-04-87-00040)</p>	<p>The OMB has developed a change to OMB Circular A-87 cost principles that will disallow payment of self-assessed sales and similar taxes as an allowable cost to Federal programs. The OMB will seek public comments and make changes as appropriate. The OIG continues to recommend that OMB clarify the rules relating to charging of State sales taxes by finalizing revisions to Circular A-87.</p>	54
<p><b>Inpatient Psychiatric Care Limits:</b>  New limits should be developed to deal with the high cost and changing utilization patterns of inpatient psychiatric services. (CIN: A-06-86-62045)</p>	<p>There is no legislative proposal addressing this issue in HCFA's FY 1994 legislative package.</p>	47.6
<p><b>Recover Medicare Payments Made for Beneficiaries Eligible for Other Government Health Insurance:</b>  Recoup part of unauthorized Medicare payments made on behalf of the Uniformed Services Treatment Program members. (CIN: A-14-90-00325)</p>	<p>The HCFA agreed to the recommendation. The OIG will verify the amount claimed by HCFA.</p>	40
<p><b>First Month of Eligibility:</b>  The SSA should submit a legislative proposal establishing a consistent definition of eligibility for age-based retirement and survivor payments. (OEI-12-89-01260)</p>	<p>The SSA did not agree with the recommendation and thought that it should be supported with a stronger rationale.</p>	40

OIG Recommendation	Status	Savings in Millions
<p><b>Monitored Anesthesia</b> The HCFA should study the appropriateness of paying the same amount for monitored anesthesia care and general anesthesia in view of the fact that other insurers are more restrictive than Medicare. (OEI-02-89-00050)</p>	The HCFA does not concur with this recommendation.	\$28
<p><b>Overpayments to SSI Recipients:</b> Nursing homes should be required to report to SSA admissions of SSI recipients within 1 day after they are admitted. (CIN: A-07-91-00376)</p>	The SSA generally concurred but believed that HCFA should develop and issue regulations. The HCFA did not concur.	22
<p><b>Limit Period of Emergency Assistance to 30 Days:</b> Revise current emergency assistance regulations to limit benefits to one period of 30 consecutive days or less in 12 consecutive months. (CIN: A-01-87-02301)</p>	The ACF concurred with the recommendation. In lieu of a regulatory change, draft legislation was sent to the Congress in February 1992 proposing a statutory change. The 102nd Congress did not act on this legislation prior to adjournment.	22
<p><b>Further Reduce Medicare's End-Stage Renal Disease Rates:</b> Reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (CIN: A-14-90-00215)</p>	The HCFA agreed that ESRD facilities have become more efficient in their operations and that the composite payment rate should reflect the costs of outpatient maintenance dialysis treatment in an efficiently operated renal facility. However, the OBRA 1990 prohibited HCFA from changing the ESRD composite rates. The HCFA should seek legislation to reduce payment rates to reflect the current market value.	22
<p><b>Develop Cost Standards for Disability Determination Services:</b> The SSA should adopt the reimbursement method for laboratory fees used by Medicare for use by the disability determination services (DDSs). (OAI-06-88-00820)</p>	A new draft notice of proposed rulemaking has been developed which would apply Medicare laboratory fee schedules for use by DDSs. The SSA deferred action however, until gaining a year's experience using the new consultative examination regulation which was published in the Federal Register on August 1, 1991. The SSA continues to evaluate its experience in using the new regulation.	15.3
<p><b>Low Income Home Energy Assistance Program - Duplication of Benefits:</b> The ACF should continue its effort to seek a change in the Low Income Home Energy Assistance Program (LIHEAP) statute that will explicitly allow States to consider other home energy assistance received by applicants before LIHEAP grants are made. (CIN: A-04-90-00005)</p>	The ACF agreed and submitted a legislative proposal. The ACF is planning to resubmit the proposal as part of its FY 1994 legislative package.	14.4

OIG Recommendation	Status	Savings in Millions
<p><b>Establish Mandatory Prepayment Edit Screens for Medicare and Medicaid:</b> The HCFA should move swiftly with the process of establishing mandatory prepayment edit screens for the Medicare and Medicaid programs. (CIN: A-03-91-00019)</p>	<p>The HCFA believes that the OIG approach does not consider the carriers' responsibility to establish Medicare coverage and payment policy when there is no national HCFA policy. The OIG disagrees. Good internal control procedures would require basic edit checks to ensure that the procedure codes are not manipulated.</p>	\$12.9
<p><b>Unreported Workers' Compensation:</b> The SSA should expedite current negotiations and consider expansion of information exchange agreements with several States. A pilot exchange should be conducted to determine the most efficient method of obtaining workers' compensation (WC) information. If the pilot proves to be cost-effective, SSA should seek legislation to require States to identify WC recipients. (OEI-06-89-00900)</p>	<p>The SSA is negotiating with a State for a pilot WC information exchange agreement to determine the efficacy of legislation to require States to provide SSA with WC information.</p>	11.7
<p><b>Revise Criteria for Waiving Overpayments:</b> The SSA should pursue a regulatory or statutory change in waiver criteria to eliminate waivers for persons under age 59 so that it could pursue collection when and if the individual developed an ability to repay. (CIN: A-05-90-00034)</p>	<p>The SSA disagreed with OIG's recommendation.</p>	9
<p><b>Collect Nonresident Alien Taxes:</b> 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 automated data processing plan now includes a project to address this issue.</p>	7.7
<p><b>Recover Grant Funds Awarded for the Construction of Community Mental Health Centers:</b> The Substance Abuse and Mental Health Services Administration (SAMHSA) should initiate recovery action on grants awarded in excess of \$6.8 million (Federal share for 13 grants) from 9 grantees not providing essential and below-cost or free services, and determine whether an additional \$235,000 plus interest can be recovered from one grantee. (CIN: A-05-91-00050)</p>	<p>The SAMHSA is scheduling visits to all community mental health center grantees over the next several years to determine if grantees are complying with waiver conditions and are now providing all essential services.</p>	7

OIG Recommendation	Status	Savings in Millions
<p><b>Recover Supplemental Security Income Benefits through Income Tax Refund Offset:</b> Take administrative action to recover certain Supplemental Security Income (SSI) overpayments through income tax refunds. (OAI-12-86-00065)</p>	<p>The SSA has implemented tax refund offset to recover Retirement, Survivors and Disability Insurance overpayments. In consideration of the potential for a relatively small collection of delinquent debt and other priority demands for available resources, SSA has postponed implementation of tax refund offset for SSI debt until 1995.</p>	\$6
<p><b>Reduce Unneeded Health Care under Urban Indian Health Programs:</b> Promptly implement procedures to comply with legislative requirements regarding annual evaluations of individual urban Indian health projects, and the evaluation of ongoing and future proposals for direct health care services for urban Indians. Eliminate or reduce direct health care services provided in areas where the services duplicate services already accessible in the community and where the extent of Indian utilization does not support the need for Indian Health Service (IHS) services. (CIN: A-09-86-63001)</p>	<p>The Public Health service concurs but has not completed corrective action. The IHS will be developing an instructional manual during the fourth quarter of FY 1993 that will be used to assess the need for direct care services in urban areas where there may be duplication or low utilization.</p>	5.6
<p><b>New Cards for New Brides:</b> The SSA should actively pursue the acquisition of computerized marriage records from States having this capability. (OEI-06-90-00820)</p>	<p>The SSA agreed with this concept, but will study quantitative and cost issues before agreeing to implement.</p>	5.5
<p><b>Refund Undocumented Training Costs:</b> New York State should refund to the Federal Government over \$4.2 million of the training costs claimed and over \$450,000 of the administrative costs claimed. (CIN: A-02-91-02002)</p>	<p>The Department's Division of Cost Allocation (DCA) concurred with all of OIG's findings and has requested a response from the State as to their position. The DCA, in addition to seeking recovery of funds, needs to reemphasize to the State that its system must be changed to prevent such events from recurring.</p>	4.7



## APPENDIX C

# Unimplemented Office of Inspector General Program and Management Improvement Recommendations

This schedule represents recent Office of Inspector General (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
<p><b>Kidney Acquisition Cost:</b> The Health Care Financing Administration (HCFA) should support demonstration projects incorporating kidney transplantation and acquisition under a diagnosis-related group (DRG). (OEI-01-88-01331)</p>	<p>The HCFA has agreed to consider a DRG demonstration for Fiscal Year (FY) 1995.</p>
<p><b>Medicare Carrier Assessment of New Technologies:</b> 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)</p>	<p>The HCFA indicated that it recognized the problems with the carrier assessment of new technologies and had taken steps to correct the problems. The OIG plans to conduct a follow-up study to determine if effective actions have been completed.</p>
<p><b>Coping With Twin Disasters - Department of Health and Human Services Response to Hurricane Hugo and the Loma Prieta Earthquake:</b> 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)</p>	<p>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.</p>
<p><b>Coping With Twin Disasters - HHS Response to Hurricane Hugo and the Loma Prieta Earthquake:</b> 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)</p>	<p>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.</p>
<p><b>False Evidence Submitted to Obtain a Social Security Number:</b> The Social Security Administration (SSA) should systematically identify all original Social Security number (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 has decided to implement a manual control process to verify the evidence submitted for U.S.-born applicants age 18 and older rather than implement the OIG recommended automated alert.</p>

---

**OIG Recommendation****Status**

---

**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)

The SSA is reviewing the entire area of vocational rehabilitation referral, and has established a task force with the Rehabilitation Services Administration to jointly develop a framework for better screening mechanisms and a more effective referral process.

---

**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)

The SSA agreed to proceed with policy and procedural changes.

---

**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)

The SSA generally agreed and has proposed corrective action.

---

**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)

The SSA performed a study to determine high risk representative payees and developed plans to perform other verifications as additional resources permit.

---

**Further Improvements Necessary to 800 Telephone System:**

The SSA should decrease the number and increase the 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)

The SSA has referred the issue of the number and size of the telephone centers to a work group for evaluation. It has included evaluation of technological improvements in its service delivery plans and has expanded use of back-up units in its program service centers. The SSA did not support the concept of full service centers for the 800 number system.

---

**Review of HCFA's Cost Allocation System for Fiscal Year 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)

The HCFA and ASMB agreed with the recommendation. The cost allocation system has been revised and is being tested.

---

**Project Clean Data:**

The SSA should develop, maintain and widely disseminate a software package for detecting invalid SSNs patterned after Project Clean Data. (OEI-12-90-02360)

The SSA agrees with the objective but believes greater use of the enumeration verification system would be more effective. The SSA will conduct a pilot test in FY 1993 to assess employer interest and use.

OIG Recommendation	Status
<p><b>Drug Addicts and Alcoholics:</b> The SSA should work with PHS and HCFA to develop clearer definitions for drug addiction and alcoholism status, treatment and successful rehabilitation. (OEI-02-90-00950)</p>	<p>The SSA agreed that significant improvements are needed in this process and has convened a work group to improve the definitions of drug addiction and alcoholism status, treatment and successful rehabilitation. The SSA has also formed an intercomponent steering committee to address concerns relative to the drug addiction and alcoholism program.</p>
<p><b>Delayed Notices of Planned Action:</b> Because of the potential cost implications of field office failure to maximize opportunities for overpayment avoidance by using manual notices of planned action in the Supplemental Security Income (SSI) program, OIG recommended that SSA initiate a review to determine the extent of the problem. (OEI-04-90-02160)</p>	<p>The SSA had already planned a comprehensive review of the same subject. The OIG will defer its actions until after the results of SSA's studies are compiled.</p>
<p><b>Carrier Maintenance of Provider Numbers:</b> The HCFA should establish adequate safeguards for detection of abusive providers. (OEI-06-89-00870)</p>	<p>The HCFA is taking steps to address the problems identified in the report, which OIG will monitor.</p>
<p><b>Independent Physiological Laboratories:</b> The HCFA should increase its monitoring of independent physiological laboratories (IPLs), including determining what testing is appropriate in IPLs, and establishing a regulatory or certification program to promote stronger quality assurance in IPLs. (OEI-03-88-01400)</p>	<p>Although it will not pursue the actions outlined in the recommendations, HCFA is studying data from Medicare carriers and its regional offices to determine if it is necessary to regulate or set standards for these laboratories.</p>
<p><b>Certified Wages:</b> The SSA should take prompt action to certify wages for tax years after 1978 by using as a basis its own wage records or seeking legislation to change the basis. (CIN: A-13-91-00210)</p>	<p>The SSA sought the views of the General Accounting Office, which provided options for consideration. The SSA plans to resolve this issue quickly.</p>
<p><b>Improvements Needed in Processing Delayed Claims:</b> The SSA should follow procedures and better utilize its claims control system to prevent claims from remaining in delayed status for unreasonable periods. (CIN: A-06-88-00037)</p>	<p>The SSA generally agreed and stated that changes have been made or are in the process of being made.</p>
<p><b>Better Controls Would Help Post More Earnings to Wage-Earners' Accounts:</b> The OIG made 29 recommendations which, if implemented, should substantially improve SSA's capability for correcting name and SSN errors for reported earnings. (CIN: A-13-89-00040)</p>	<p>The SSA agreed with most of the recommendations. It has started to implement some of these as well as other recommendations made by its own work group convened to explore wage reporting problems.</p>
<p><b>Debt Management:</b> The SSA should expedite the development and implementation of its new debt management system. (CIN: A-13-91-00210)</p>	<p>The SSA agreed. It has made considerable progress with phased implementation.</p>
<p><b>Work Incentives for Disabled SSI Recipients:</b> The Commissioner of SSA should take the lead in organizing efforts to identify and study ways to encourage employers to hire severely disabled workers. (OEI-09-90-00020)</p>	<p>The SSA believes that coordination of agency efforts is a good idea, but that it should not assume the lead for such a Governmentwide effort. However, SSA has initiated several pilots to test different approaches to encourage the disabled workers to return to work.</p>

**National Practitioner Data Bank - Controls over Authorized Agents:**

The PHS should revise Data Bank forms and procedures in order to strengthen controls over authorized agents. (OEI-12-90-00530)

The PHS has prepared, in draft form, revised guidelines for dealing with authorized agents.

**Summarization of Head Start Grantee Audit Findings:**

The Administration for Children and Families (ACF) should increase training and technical assistance to grantees; strengthen procedures regarding grantee monitoring and use of interest bearing accounts, and refunding interest income; implement the new audit requirement for nonprofit organizations administering Federal programs; develop procedures to detect grantees with interfund transfers; reevaluate procedures to ensure that excess cash is not drawn; and obtain evidence that excess balances are collaterally secured when awarding grants. The ACF should also reemphasize that the nonfederal match is properly documented and met; require evidence of current licensing or compliance with all of the facility standards; and emphasize use of sales tax exemptions and timely deposits of tax refunds. (CIN: A-07-91-00425)

The ACF is in general agreement with the recommendations.

**Child Support Enforcement Payments - Financial and Program Implications:**

The ACF should consider the following options for legislative changes: limit the payments of incentives to a State's cost; eliminate incentive payments to performing States; and reduce the Federal matching rate in child support enforcement costs to 50 percent to increase States' financial participation in the program. (CIN: A-09-91-00147)

The ACF agreed that there is a need to modify the incentive formula. However, it had concerns about the viability of the recommended options to reduce Federal costs.

**Review of Short Term Goals of the Common Working File:**

The HCFA should conduct an analysis to determine the optimum number and alignment of host sectors. The results of this analysis should be structured to permit organizations other than Medicare contractors to offer bids, allow offerors to bid on multiple sectors, and serve as the basis for the complete recompetition of all the current common working file (CWF) host contracts in a timely and effective manner. (CIN: A-14-91-02531)

The HCFA agrees that the award of multiple sectors to a single host could be advantageous and has employed a contractor to perform a study to identify the optimum number and alignment of host sectors. However, HCFA disagrees that the CWF host scope of work is severable from the carrier's scope of work, and that organizations other than Medicare contractors should be permitted to process Medicare claims.

**Review of Short Term Goals of the Common Working File:**

The HCFA should delay the migration of the CWF system to the Federal Telecommunications System (FTS) 2000 until cost-effectiveness, and technical and other issues are resolved in an efficient and effective manner. (CIN: A-14-91-02531)

The HCFA agreed with this recommendation and indicated that it had selected a contractor to analyze potential approaches for migrating CWF to FTS 2000.

---

**OIG Recommendation****Status**

---

**Review of Short Term Goals of the Common Working File:**

The HCFA should implement improvements to the current system, including requiring all CWF hosts to migrate to International Business Machines Corporation Information Network (IIN) now; increasing the proportion of non-prime usage of IIN to the maximum practical extent; and remaining as an on-line batch process while retaining the current hybrid system design. (CIN: A-14-91-02531)

The HCFA has developed a corrective action plan and implementation is underway.

---

**Review of Medicare Bill and Claim Processing - Opportunities for Long Term Improvement:**

The HCFA should initiate a strategic planning effort to determine the feasibility of further streamlining Medicare operations through standardization, consolidation and system integration. Further, HCFA should include the initiative in its information resources management (IRM) strategic plan submission to the Department. (CIN: A-14-91-02532)

The HCFA was largely in agreement with the recommendations and believes that in several instances it has already taken corrective actions.

---

**Review of HCFA's Implementation of the Project to Redesign Information Systems Management:**

The HCFA should include in its IRM plan a discussion of how it intends to assign duties of sufficient scope to, and maintain the independence of, its principal IRM official (PIO). Also, ASMB should review HCFA's implementation of recently issued departmental IRM policy, particularly with respect to assignment of PIO duties. (CIN: A-14-91-02533)

The HCFA disagrees because it believes that the duties of the senior IRM official in HCFA are properly assigned within HCFA's organizational structure. The ASMB has issued several IRM policies to improve the planning and management controls of departmental operating division IRM programs.

---

**Property Management:**

The SSA should complete the reconciliation of its accounting records with the results of its physical inventory and adjust the records as needed, and remedy practices contributing to not being able to locate property during a physical inventory. (CIN: A-13-91-00206)

The SSA generally agreed and will pursue corrective actions.

---

**Supplemental Security Income Accounts Payable:**

The SSA needs to document the programmatic problems in the SSI accounts payable system, document the causes and integrate the solution into a systemic plan. An accurate accounts payable balance is necessary to ensure proper payments and financial statements. (CIN: A-13-91-00206)

The SSA agreed to initiate the recommended actions.

---

**Security of Manually Issued Social Security Number Cards:**

Improvements are needed in the security, control and accountability of SSN cards issued manually outside the automated system. There is a need for more management control and involvement. (CIN: A-13-91-00204)

The SSA generally agreed and is pursuing corrective actions.

---

**OIG Recommendation**

---

**Status**

---

**Telecommunications Management:**

The SSA should test new telecommunications technology after first identifying those functions where it can have the most impact on reducing costs and improving service. It also needs to monitor procurement and perform a needs assessment regarding video services. (CIN: A-09-91-00105)

The SSA concurred and will continue to work on a sound network strategy and an evaluation of emerging technology. It will focus on optimum utilization in a cost-effective manner.

---

**Central Computing Strategy:**

The SSA's data systems are highly centralized and need to be protected against down-time or catastrophic failure. (CIN: A-13-89-00041)

The SSA has been evaluating and proceeding with distributed data processing alternatives, and evaluating its back-up and recovery strategy.

---

**Death Match Operation:**

Although the death match operation has improved SSA processing of death records, enhancements would increase its utility and hence lead to more accurate payments. (CIN: A-13-90-00046)

The SSA has agreed to address the OIG recommendations in planned systems modification projects.

## APPENDIX D

### Notes to Tables I and II

---

**Table I**

---

<sup>1</sup> The opening balance was adjusted to reflect a downward revaluation of recommendations in the amount of \$187.1 million.

<sup>2</sup> Included in the reports issued during the period are questioned costs totaling \$60,919 and management decisions to disallow costs of \$64,719 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

<sup>3</sup> During the period, revisions to previously reported management decisions included:

CIN: A-05-86-60150	Indiana Department of Public Welfare: A settlement reduced previously disallowed costs by \$35.4 million.
CIN: A-02-88-02018	Review of Capital Leases in New York State: \$10.1 million in disallowed costs were subsequently allowed based on additional information provided by the State.
CIN: A-02-89-00001	Review of Administrative Costs, New York Disability Determination Program: \$3.8 in disallowed costs were subsequently allowed based on additional information provided by the State.

Not detailed are additional revisions to previously reported decisions totaling \$1.76 million.

<sup>4</sup> Audits on which a management decision had not been made within 6 months of issuance of the report:

A. Resolution of the following reports will be through the departmental conflict resolution process:

CIN: A-07-90-00262	Review of Asset Reversions from Pension Plan Terminations Occurring after the Implementation of the Prospective Payment System, May 1990, \$92,000,000
CIN: A-07-89-00134	Medicare is Losing Millions of Dollars from Terminations of Pension Plans, January 1990, \$27,600,000

B. Due to administrative delays, many of which were beyond management's control, resolution of the following audits was not completed within 6 months of issuance; however, based upon discussions with management officials responsible for those audits, resolution of these outstanding recommendations is expected before the end of the next semiannual reporting period:

CIN: A-12-91-00018	Cash Management by State Child Support Agencies, August 1991, \$13,200,000 (Related recommendation of \$13,800,000 on Table II)
CIN: A-05-91-00050	Community Mental Health Construction Grant - Phase I, October 1991, \$6,823,979 (Related recommendation of \$235,000 on Table II)
CIN: A-03-89-00046	Maryland BC/BS Administrative Costs - FY 85-88 - Part B, September 1991, \$5,996,278
CIN: A-05-92-00026	Associated Insurance Company - Medicare Administrative Costs, February 1992, \$2,530,409
CIN: A-02-91-01006	Blue Shield of Western New York Medicare Administrative Costs, September 1991, \$2,379,239
CIN: A-09-89-00162	MSP Nationwide Employer Review, July 1992, \$2,218,824
CIN: A-05-90-00090	Blue Cross Blue Shield - Administrative Costs Contract Audit, November 1990, \$1,825,677

CIN: A-03-92-19733 State of Maryland, August 1992, \$1,505,462

CIN: A-03-90-00053 Blue Cross of Virginia Administrative Costs, August 1992, \$1,487,212

CIN: A-03-90-00051 Maryland BC/BS Administrative Cost-Part A - FY 85-88, August 1991, \$1,438,414

CIN: A-06-92-00024 Arkansas Child Care and Support Services, August 1992, \$1,401,782

CIN: A-08-92-00508 Credits and Collections - Colorado, June 1992, \$1,121,830

CIN: A-05-91-00136 Community Mutual Insurance Company - Administrative Costs, August 1992, \$720,668

CIN: A-06-92-00017 Indian Health Service - Creek Contract Closeout Report, May 1992, \$468,217

CIN: A-03-92-03313 Greater Philadelphia Health Action - 330/329, July 1992, \$462,011

CIN: A-05-92-20107 Lorain County Community Action Agency Inc., August 1992, \$416,123

CIN: A-03-92-17153 Virginia Department for the Rights of the Disabled, January 1992, \$323,006

CIN: A-09-92-00063 Blue Cross of California - Administrative Costs, March 1992, \$310,665

CIN: A-03-91-02005 Blue Cross of National Capital Area, August 1992, \$296,218

CIN: A-05-91-05017 Indiana Department of Human Services, October 1990, \$292,920

CIN: A-03-92-20250 Virginia Department for the Rights of the Disabled, August 1992, \$261,095

CIN: A-05-92-16405 Indiana Department of Human Services, October 1991, \$255,524

CIN: A-03-92-20033 State of Delaware, August 1992, \$247,609

CIN: A-05-91-00064 Nationwide Administrative Costs Contract Audit, October 1991, \$211,422

CIN: A-10-92-00005 WPS Administrative Cost Audit, February 1992, \$179,891

CIN: A-06-92-15903 State of Texas, May 1992, \$160,197

CIN: A-09-92-00093 Blue Cross - Arizona - Administrative Costs, August 1992, \$129,518

CIN: A-02-91-01021 Cooperativa Medicare Administrative Costs, September 1991, \$118,682

CIN: A-09-92-06592 Inter-Tribal Council of California, Inc., August 1992, \$107,446

CIN: A-08-92-16320 State of Colorado, June 1992, \$102,303

CIN: A-04-92-19779 Poarch Band of Creek Indians, August 1992, \$95,871

CIN: A-01-92-16709 State of Rhode Island and Providence Plantations, August 1992, \$77,171

CIN: A-06-92-17478 Santo Domingo Pueblo, January 1992, \$74,803

CIN: A-03-91-02002 Delaware Blue Cross Administrative Costs, October 1991, \$66,858

CIN: A-01-92-18535 State of New Hampshire, May 1992, \$62,478

CIN: A-03-91-16232 Unisys Inc., September 1991, \$61,754

CIN: A-06-92-19887 Central Tribes of the Shawnee Area Inc., July 1992, \$57,944

CIN: A-08-92-16564 State of South Dakota, April 1992, \$55,424

CIN: A-03-92-19994 Lynchburg Community Action Group Inc., August 1992, \$46,735

CIN: A-05-92-20076 Lac Courte Oreilles Tribal Council, August 1992, \$37,102

CIN: A-10-92-06767 Spokane Tribe of Indians, August 1992, \$30,670

CIN: A-07-91-14263 State of Missouri, April 1991, \$25,431

CIN: A-07-92-17150 Iowa Protection & Advocacy Services Inc., January 1992, \$22,960

CIN: A-05-92-20639 Indiana Department of Public Welfare, August 1992, \$21,330

CIN: A-04-90-04009 Laboratory Animal Breeders, July 1990, \$21,274 (Related recommendation of \$224,668 on Table II)

CIN: A-09-91-05313 American Samoa Government, April 1991, \$14,504

CIN: A-02-92-16983 State of New Jersey, August 1992, \$13,500

CIN: A-06-92-16588 State of Oklahoma, August 1992, \$12,274

CIN: A-03-92-17538 State of West Virginia, June 1992, \$9,890

CIN: A-04-91-05172 State of Florida, December 1991, \$7,712

CIN: A-06-92-18040 State of Oklahoma, August 1992, \$6,771

CIN: A-06-92-19355 Albuquerque-Bernalillo County Economic Opportunity, June 1992, \$5,763

CIN: A-06-91-00034 Audit of Collection & Credit Activities at Texas Department of Human Services, January 1992, \$5,081

CIN: A-08-92-17463 Oglala Sioux Tribe, January 1992, \$3,677

CIN: A-03-92-16787 State of West Virginia, June 1992, \$3,547

CIN: A-10-92-00002 WPS Termination Costs, January 1992, \$3,380

CIN: A-08-91-00484 Review of Account Controls & Expenditure Billings IHS, August 1992, \$2,380 (Related recommendation of \$2,130,035 on Table II)

CIN: A-08-92-20308 Indian Health Board of Billings Inc., August 1992, \$1,618

CIN: A-03-91-14545 Commonwealth of Pennsylvania, December 1990, \$1,584

CIN: A-05-92-16914 West Central Wisconsin Community Action Agency Inc., December 1991, \$1,165

C. Reports in litigation:

CIN: A-01-90-00509 Medicare Secondary Payer Review - Aetna, February 1992, \$1,471,233 (Related recommendation of \$12,100,000 outstanding on Table II)

CIN: A-04-91-04050 United Schools of America Contract (283870012), July 1991, \$169,448

D. Reports that have subsequently been resolved:

CIN: A-10-92-06767 Spokane Tribe of Indians, August 1992, \$288,241

CIN: A-04-91-04067 Review Appropriateness of HRSA's Non-Competition Award, May 1992, \$274,697

CIN: A-08-92-20014 Pueblo Community Health Center, August 1992, \$120,065

CIN: A-04-92-20152 Nash-Edgecombe Economic Development Inc., August 1992, \$117,745

CIN: A-06-91-00106 Review of Recharge Center Billing Rates Tulane University, May 1992, \$117,462

CIN: A-07-92-19830 Northwest Nebraska Community Action Council, July 1992, \$61,085

CIN: A-08-92-20286	Salish & Kootenai Housing Authority, August 1992, \$18,581
CIN: A-10-92-06712	Council of Athabaskan Tribal Governments, August 1992, \$9,506
CIN: A-02-92-20604	Rincon Rural Health Initiative Program Inc., September 1992, \$7,657
CIN: A-10-92-06668	Yupit Nation, August 1992, \$1,929

---

**Table II**

---

<sup>1</sup> The opening balance was adjusted to reflect a downward revaluation of recommendations in the amount of \$289.6 million.

---

<sup>2</sup> Included are funds put to better use recommendations totaling \$259,018 and sustained management decisions totaling \$606,639 attributable to audits performed by the Defense Contract Audit Agency under a reimbursement agreement.

---

<sup>3</sup> The Health Care Financing Administration agrees with the recommendations in OIG's report OEI-07-89-01683, but does not agree with the estimated savings of \$361 million.

---

The Social Security Administration agrees with the recommendations in OIG's report OEI-07-89-01650, but does not agree with the estimated savings of \$4.3 million.

---

<sup>4</sup> Management decisions have not been made within 6 months of issuance on 10 reports. Discussions with management are ongoing and it is expected that the following reports will be resolved during the next semiannual reporting period:

CIN: A-06-91-00048	Non-AFDC Application & User Fees for Child Support Enforcement Services, July 1992, \$385,000,000
CIN: A-05-92-00006	One Day Admissions, January 1992, \$233,000,000
OEI-09-88-01006	Outpatient Surgery: Unnecessary Endoscopy, August 1991, \$54,800,000
OEI-06-90-00180	Emergency Room Use by Medicaid Recipients, March 1992, \$39,500,000
CIN: A-03-90-00201	Medicaid Limits on Payment for Drugs, September 1991, \$35,000,000
OEI-07-90-00911	Medicaid Credit Balances in Skilled Nursing Facilities, July 1992, \$18,000,000
OEI-12-88-00901	September 1992, Fragmented Billings for Biopsies and Laparotomies, \$12,000,000
CIN: A-04-91-00001	Review of Regional Administrative Support Center's Procedures for Recording, Maintaining and Reconciling Sustained Audit Disallowances, March 1992, \$1,544,849
CIN: A-09-91-05300	Kass Management Services, Inc., April 1991, \$79,829
CIN: A-09-90-07111	Yomba Shoshone Tribe, January 1990, \$12,832

## APPENDIX E

### Reporting Requirements of the Inspector General Act of 1978, as Amended

The specific reporting requirements of the Inspector General Act of 1978, as amended, are listed below with reference to the page in the semiannual report on which each of them is addressed. Where there is no data to report under a particular requirement, this is indicated as "none." A complete listing of Office of Inspector General audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

<b>Section of the Act</b>	<b>Requirement</b>	<b>Page</b>
Section 4(a)(2)	Review of legislation and regulations	76
Section 5(a)(1)	Significant problems, abuses and deficiencies	throughout
Section 5(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	throughout
Section 5(a)(3)	Prior significant recommendations on which corrective action has not been completed	appendices B and C
Section 5(a)(4)	Matters referred to prosecutive authorities	80
Section 5(a)(5)	Summary of instances where information was refused	none
Section 5(a)(6)	List of audit reports	under separate cover
Section 5(a)(7)	Summary of significant reports	throughout
Section 5(a)(8)	Statistical table I - reports with questioned costs	74
Section 5(a)(9)	Statistical table II - reports with recommendations that funds be put to better use	75
Section 5(a)(10)	Summary of previous audit reports without management decisions	appendix D
Section 5(a)(11)	Description and explanation of revised management decisions	appendix D
Section 5(a)(12)	Management decisions with which the Inspector General is in disagreement	none



## ACRONYMS

ACF	Administration for Children and Families
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ADP	automated data processing
AFDC	Aid to Families with Dependent Children
AMP	average manufacturer price
ALJ	administrative law judge
AoA	Administration on Aging
ASMB	Assistant Secretary for Management and Budget
ASPE	Assistant Secretary for Planning and Evaluation
BIA	Bureau of Indian Affairs
CAAS	contract advisory and assistance services
CDC	Centers for Disease Control and Prevention
CFO	Chief Financial Officers
CHC	community health center
CMP	civil monetary penalty
CSE	child support enforcement
CWF	common working file
DCA	Division of Cost Allocation
DDS	disability determination service
DME	durable medical equipment
DMS	debt management system
DOJ	Department of Justice
DRG	diagnosis-related group
DUR	drug utilization review
EGHP	employer group health plan
ESRD	end stage renal disease
FDA	Food and Drug Administration
FFP	Federal financial participation
FI	fiscal intermediary
FMFIA	Federal Managers' Financial Integrity Act
FPDS	Federal Procurement Data Systems
FY	fiscal year
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IOL	intraocular lens
IRM	information resources management
IRS	Internal Revenue Service
JOBS	Job Opportunity and Basic Skills
LIHEAP	Low Income Home Energy Assistance Program
MFCU	Medicaid fraud control unit
MSP	Medicare secondary payer
NIH	National Institutes of Health
OASH	Office of the Assistant Secretary for Health
OASI	Old Age and Survivors Insurance
OBRA	Omnibus Budget Reconciliation Act
OHA	Office of Hearings and Appeals
OMB	Office of Management and Budget
OPD	outpatient department
PCIE	President's Council on Integrity and Efficiency
PFCRA	Program Fraud Civil Remedies Act
PHS	Public Health Service
PPS	prospective payment system
PRO	peer review organization
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	supplementary medical insurance
SSA	Social Security Administration
SSI	Supplemental Security Income
SSN	Social Security number
TWP	trial work period
VICP	vaccine injury compensation program
WC	workers' compensation

**DEPARTMENT OF  
HEALTH AND HUMAN SERVICES**

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