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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Annual Report

MADE PURSUANT TO SECTION 204(a) OF
PUBLIC LAW 94-505

January 1, 1980 - December 31, 1980

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE INSPECTOR GENERAL

ANNUAL REPORT

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March 31, 1981

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CHAPTER I

OVERVIEW

Purpose

This report covering calendar year 1980 responds to the mandate of P.L. 94-505 requiring the Inspector General (IG) to report each year to the Secretary and the Congress on the calendar year activities of the Office of the Inspector General.

Leadership

Richard B. Lowe III, Deputy Inspector General, served as Acting Inspector General during 1980.

Organization of the Report

We have presented our 1980 accomplishments on a functional basis: Health, Income Maintenance and Assistance, Human Services and Institutions of Higher Education, and Department Administration. Each of these sections presents the accomplishments of our team of auditors, investigators and systems analysts and of our efforts to blend the skills of the several disciplines.

Staffing

At the close of 1980, the Office of the Inspector General had a total staff of 965. At the close of 1979, we had a staff of 1,240.

During 1980, we were required to transfer 275 positions to the Department of Education (ED). This was between 70 and 90 more staff than our workload data justified. Our staff further declined during the year because of the Federal Civilian Hiring Freeze imposed by President Carter on March 17, 1980. Although we have consistently insisted that increases in our staff size would be cost beneficial, we recognized that 1980 was a year of shrinking budget resources for the entire Department. Consequently, we made a number of project and staff adjustments to maximize the effectiveness of remaining staff.

The Office of the Inspector General has four organizational components:

1. Audit - On board staff of 729
2. Investigations - On board staff of 177
3. Health Care and Systems Review - On board staff of 36
4. Immediate Office of the Inspector General and Executive Management - On board staff of 23

AUDIT HIGHLIGHTS

Most of the Department's funds, with the exception of Social Security funds, are administered and spent for HHS' programs by grantees and contractors. There are well-established controls in place to assure that these monies are going for the purposes Congress intended. Audit's role:

First, to assist the Inspector General to carry out Congress' mandate to attack fraud and waste in government programs.

Next, to check what is actually happening with these monies and programs. Audit tests the controls in place to determine if they are working, and whether funds are being used properly for the purpose intended.

Ideally, an unsatisfactory situation--once identified by audit--will not recur. But this does not always happen. HHS' tens-of-thousands of grantees and contractors possess management skills ranging from excellent to marginal. A significant part of our audit effort is spent on retesting problem areas previously identified, while we continue to probe other areas for yet new problems. Because we cannot audit in a timely manner all entities receiving funds, it is important that we carefully select areas that may be specially vulnerable.

A summary of the contribution of Audit's efforts includes:

--The number of reports released: During calendar year 1980 auditors released 3,877 reports on Department activities. We also released another 1,323 reports performed for other Federal agencies under the Office of Management and Budget's (OMB) system of audit cognizance for colleges and universities.

--The extent to which the audit work of others is utilized: Of the reports processed on HHS programs, 1,132 were prepared by OIG Audit while 2,745 were done by public accountants and State auditors.

--Recommended financial adjustments: In calendar year 1980, audit reports identified some $80 million in proposed adjustments; even more meaningfully some $126.5 million in audit recommended financial adjustments were concurred with by the responsible program officials last year.

While these recoveries are sizeable and help insure adherence to the level and amount of funding established by the Congress they represent only part of the savings attributable to the auditing

function. An integral part of every audit assignment involves considering the quality of Federal oversight--and making sure that Federal regulations, procedures and policies are adequate and being followed. We often find problems at an audit site are due to conditions that Federal oversight action can correct or alleviate.

On a conservative basis, we estimate additional savings of many millions annually, as well as improved program operations, can be achieved by full implementation of the recommendations we made this past year. Examples highlighting such savings follow. These are referenced to the pages in this report where they are explained in greater detail along with the status of corrective actions.

--Identified a loophole in regulations that enabled States to charge a Federal health program for the costs of non-medically necessary housekeeping services provided certain recipients. We found that although Departmental staff had advised State officials that these services were not allowable for reimbursement, pertinent Federal regulations were not clarified, and these charges continued. In one State alone, claims for such services amounted to $1 million per month. (p. 11)

--Highlighted a situation in one State where out-of-home day care services were provided by centers having an extremely high percentage of health and safety violations. (p. 42)

--Encouraged reassessment of Federal financing of college training in a specific field for persons preparing for training-related positions with State agencies when there was little demonstrated need for these future graduates. (p. 42)

--Pointed out specific areas where improvements were needed over access to computer-stored program information and over physical access to computer tapes and the computer area. (p.34)

--Developed data relating to no-cost and low-cost measures that could be taken to conserve energy in HHS-occupied buildings. (p. 52)

--Reemphasized, through current reviews, that long-standing problems dealing with Federal payments for certain types of services by physicians remain unresolved. In one of these situations, where plans for corrective action are underway, savings to the Federal government are estimated by the office involved as being about $40 million annually. (p. 14)

--Found that States were retaining, and not crediting Federal programs for cancelled benefit checks and other collections. In some cases States retained these funds for years. As a

result, the Federal Government was needlessly incurring interest costs in the millions of dollars a year. Action was recommended and taken concerning the timely return of these funds to the Federal Government. (p. 32)

--Identified many ways in which the Social Security Trust Funds could avoid losing several million dollars annually in interest, which was occurring because Trust Fund monies were being withdrawn too far in advance of actual need. (p. 31)

Other significant financial and management findings, such as these, are shown in the remainder of this Report. Numerical information on all audit findings made during 1980 is given in the schedules contained in Appendix A of this report. This computer-generated data gives an overview of the types of problems and related costs in major HHS programs.

INVESTIGATIVE HIGHLIGHTS

This section includes a summary of Office of Investigations (OI) work accomplishments, results of matters referred to prosecutive authorities, a description of selected prosecuted cases, and an analysis of the investigative workload and comparisons with previous years.

OI has kept pace with the accomplishments of 1979 in spite of the loss of 45 positions, the transfer of 17 on board Special Agents to the newly created Department of Education and the hiring freeze on new staff.

OI is presently composed of 139 professional and 32 clerical personnel. Excluding Headquarters management and field supervisory personnel, the actual field workforce is 92 agents to conduct 917 cases and 1,085 preliminary investigations annually. This translates to nearly 22 of these matters per agent. We have about two agents per State; however, in many instances OI has utilized the resources of other Federal, State and county investigative units, e.g., FBI, Postal, INS, IRS, DEA and State and county welfare investigators, who may also have an interest in the person or entity under investigation.

OI's lack of normal law enforcement authority continues to concern us in our efforts to fully discharge our chartered responsibilities. This problem was addressed in the 1979 Inspector General's Annual Report and we are in the process of evaluating the accumulated 1980 data as the basis for a position paper.

Accomplishments

OI was responsible for 137 indictments, 145 convictions and $4.7 million in savings through recoveries, fines and restitutions for calendar year 1980. The following chart provides historical data on the number of convictions by types of case.

TYPE OF CASE	NUMBER OF CONVICTIONS CY 1977	CY 1978	CY 1979	CY 1980
Employees	9	8	16	16
Grantees/Contractors	7	22	5	20
Education	4	34	27	15
Health Care Financing*	32	34	54	30
Other (AFDC/SSI/ SSA)	-	10	49	64
TOTAL	52	108	151	145

*Includes Project Integrity Cases.

Components of HHS and other Federal agencies investigating HHS funded programs, e.g., HCFA, SSA, State Medicaid Fraud Control Units, FBI, Postal Service, etc., accounted for approximately 542 convictions and $16.9 million in savings during calendar year 1980.

CASELOAD

Historically, OI opens approximately 350 new cases annually. This past year, OI opened 353 cases and closed 289.** In addition, approximately 1,085 preliminary investigations were conducted. (There is some overlap in the above numbers because some preliminary investigations evolve into cases.)

It is estimated that during 1981 OI will conduct investigations of 2,721 matters which include both full-scale cases and preliminary inquiries. This estimated workload totals 302 work-years or a three-year workload per agent and does not include special projects.

Table 1 provides an analysis of CY 1980 caseload information.

**Includes Education cases transferred, but not Project Integrity closures.

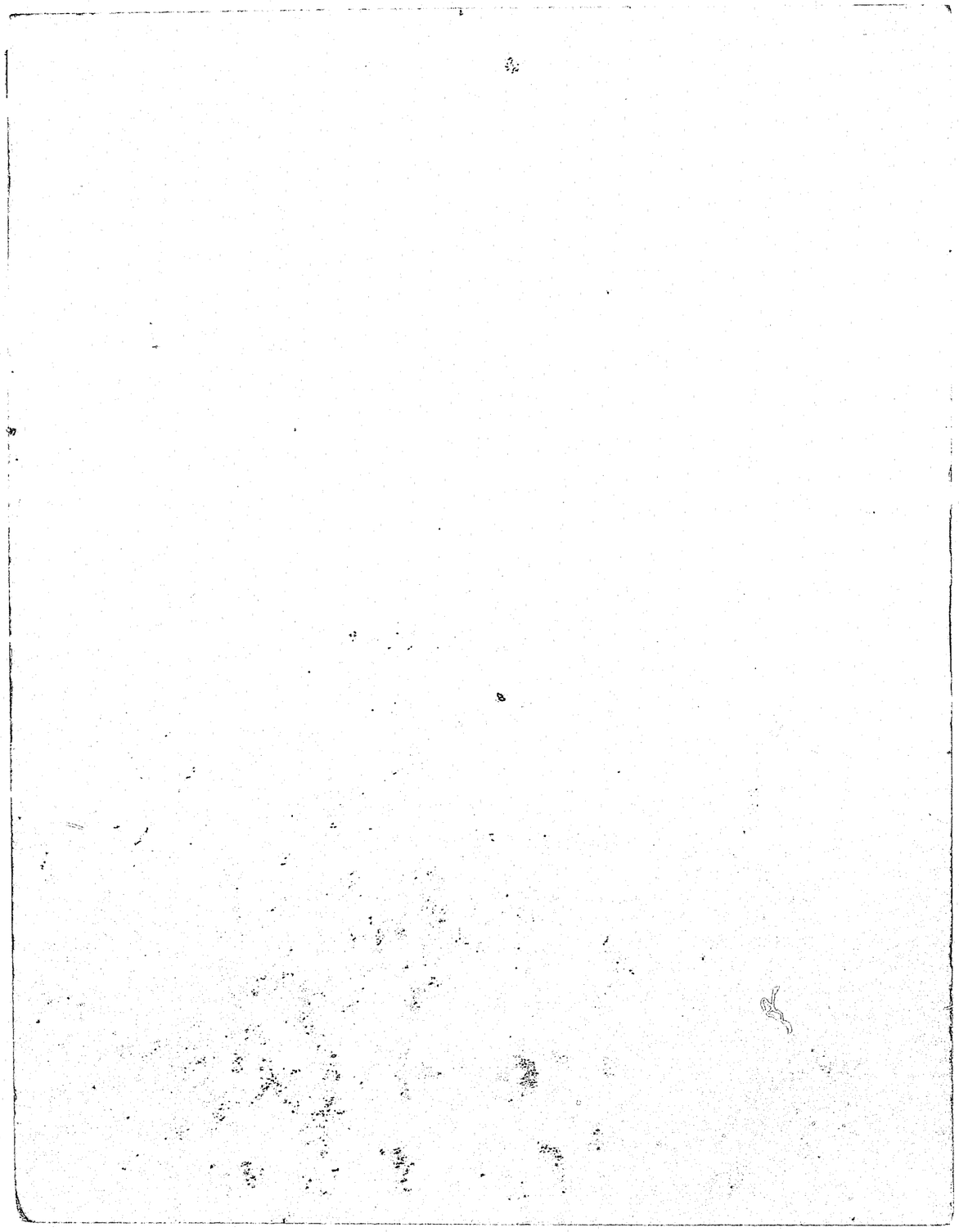
TABLE 1

OFFICE OF INVESTIGATIONS

ACTIVE AND INACTIVE CASES

CASE CATEGORY	Pending Caseload Jan. 1, 1980	Cases Opened in 1980	Yearly Caseload	Cases Disposed in 1980	Pending Caseload Dec. 31, 1981
Education	109	15	124	95*	29
Asst. Sec. for Health	46	40	86	26	60
Human Devel. Services	25	18	43	9	34
Social Security	82	109	191	43	148
Ofc. of Secretary	13	10	23	2	21
Health Care Financing	289	161	450	114	336
Sub-Totals	564	353	917	289	628
Project Integrity	227	-0-	227	170	57
TOTALS	791	353	1,144	459	685

*Includes Transfers to the Department of Education



SYSTEMS HIGHLIGHTS

A small, interdisciplinary staff of physicians, lawyers, operations researchers and program and management analysts was created to respond to anti-fraud and anti-abuse activities in health and human services programs.

The efforts of this staff tend to be directed towards cross-cutting issues, and often are accomplished in cooperation with staffs from the Office of the Secretary and Principal Operating Components. These multi-discipline activities have demonstrated the utility of this approach to detect and prevent crime and inappropriate expenditure of taxpayer funds.

Highlights of these activities include:

--A review of debt collection practices in Public Health Service loan, scholarship and award programs led to joint OIG-Assistant Secretary for Management and Budget initiatives on Department-wide debt collection practices;

--In response to a Senate Appropriations Committee suggestion that management training programs should stress fraud and waste prevention, a model training program was developed with auditors, investigators and systems staff and given to regional management staff in one Principal Operating Component; and

--An independent review of the Tuskegee Syphilis study led to the recognition that deficiencies still existed in the way the Department selected and instructed staff to serve on review panels with the result that the Secretary directed the establishment of new procedures.

Other activities performed by the staff are the analysis of proposed program regulations for potential conflict with good management practices or with anti-fraud and anti-abuse objectives. In CY 1980, about 200 regulations were reviewed.

Similarly, fraud investigations are reviewed for patterns which indicate program weaknesses. For instance, a growing number of cases involving abuses of social security numbers resulted in an audit and systems review study to explore possible ways to prevent future recurrences.

Service Delivery Assessment

Created in 1977, Service Delivery Assessments (SDAs) are short-term examinations of the Health and Human Service (HHS) programs and program-related issues. These 3 to 5-month studies provide

the Secretary with timely information about the operations and effects of programs at the local level.

SDAs seek to gain a clear understanding of how programs are currently operating. While the specific objectives of any individual SDA vary, SDAs can provide a "snapshot" of local operations, consumer and local provider perspectives, timely reporting, an "early warning" system, best operating practices, and a useful tool for program management.

Assessment findings are used internally by Department managers as an additional source of information which, when combined with other information, presents a total picture of service delivery.

Calendar year 1980 was the third full year for Service Delivery Assessment. During the year, we completed sixteen studies; that is, we prepared a written report and briefed the Secretary or Under Secretary on the findings. Six additional assessments begun in CY 1980 will be completed in early CY 1981.

CHAPTER II

HEALTH

The Department of Health and Human Services (HHS) spent $57 billion on health care in 1980. Health financing - Medicare and Medicaid - are the major components of these health care expenditures. The programs of the Public Health Service constitute the balance of the Department's health programs. The following paragraphs provide brief descriptions of these major health programs:

Medicare, which is operated by the Federal government, covers hospitalization and medical insurance for persons aged sixty-five or disabled who are eligible for Social Security or railroad retirement benefits (and those with end stage renal disease). The program consists of two parts: Part A, Hospital Insurance, and Part B, Supplementary Medical Benefits, which covers physician's services, etc. In FY 80 the Medicare program, which is financed through trust funds, had the following expenditures: Part A-$24.3 billion; Part B-$10.7 billion.

Medicaid, which is a Federal-State operated program, provides medical services to those persons covered under the Aid to Families with Dependent Children (AFDC) program and the Supplemental Security Income (SSI) program as well as some medically needy individuals. In fiscal year 1980 Federal expenditures for Medicaid were $13.9 billion.

The Public Health Service (PHS), which administers a broad range of activities, consists of six major agencies -- the National Institutes of Health, the Food and Drug Administration, the Center for Disease Control, the Alcohol, Drug Abuse, and Mental Health Administration, the Health Resources Administration, and the Health Services Administration. In fiscal year 1980, the Public Health Service expenditures were $8.1 billion.

Due to the vast expenditures of these health care programs, the Office of the Inspector General (OIG) has committed significant time and resources in the examination of health programs. This chapter describes some of the Inspector General's significant audit activities, investigative highlights, and important management reviews and assessments completed in 1980 in the health programs.

AUDIT ACTIVITIES

In this audit area, the Inspector General has issued 748 reports recommending financial adjustments of $37.3 million. The table below presents this information by major health program areas.

Health	No. of Reports	Recommended Financial Adjustments
Medicaid	88	$16.3 million
Medicare	99	15.6
1864-1902 (health facility certification)	10	.6
PSROs	211	2.0
HMOs	18	.1
Other	322	2.7
Total	748	$37.3

The types of findings which were identified include: 1) overstated claims -- $11.8 million in Medicaid and $7.9 million in Medicare; 2) ineligible claims -- $3.8 million and $5.1 million; 3) procedural violations -- $2.3 million for Medicare and Medicaid.

During calendar year 1980, the Department's Principal Operating Components (POCs) concurred with recommended financial adjustments of $126.5 million contained in 205 reports, many of which were issued in prior years. Concurrences in the health area were the greatest at $87.2 million as follows:

Health	No. of Reports	Concurrances (in millions)
Medicaid	48	$66.9
Medicare	67	12.7
1864-1902 (health facility certification)	10	1.1
PSROs	26	.1
HMOs	1	.0
Other	53	6.4
Total	205	87.2

The following are some highlights of audit work organized by major program areas.

MEDICAID

Audits in 31 States probed selected aspects of Federal and State management systems to test their effectiveness, and to assess the degree of compliance with applicable regulations and program requirements.

Problems at the Federal Level

- Personal Care Services: An audit identified that one State has been charging housekeeping services (e.g., shopping, ironing) to the Medicaid program for certain recipients without requiring that the services be medically necessary (i.e., linked to a physician's plan of treatment). Although the Health Care Financing Administration (HCFA) regional staff had advised State officials on several occasions that these services were not allowable for reimbursement under Medicaid, pertinent Federal regulations were not clarified and these charges continued. We pointed out to HCFA that such laxness has led to substantial excess cost. Since the costs of such personal care services are usually charged to the Title XX program, a program with an annual expenditure limit, there is a strong financial incentive for States to charge such costs to Medicaid when the Title XX limit is reached. In fact, we found that the State in question had made claims of $15 million over a 15-month period for non-medically necessary housekeeping services because of this very condition.

  Because of the significance of this problem and the national potential for similar unallowable charges, we recommended that HCFA immediately revise its regulations to correct this situation and preclude recurrences. HCFA concurred and has published a Notice of Proposed Rulemaking clarifying its regulations.

- Psychiatric Care: Based on reviews in two States, we advised HCFA that the lack of clarity with respect to what constitutes "medically justifiable" services coupled with the failure to define "billable encounters" for psychiatric services could and has, in our opinion, led to abuses.

  At the selected facilities visited, psychiatric services were not limited to traditional modalities of treatment, but included a broad spectrum of services and treatment under specially-designed programs, usually provided at an off-site locale. Many of these services appeared to be of a social, recreational, or educational nature, potentially not "medically justifiable", and possibly not reimburseable under Medicaid.

Procedures at one facility visited called for billing Medicaid for psychiatric services provided patients seen in an elevator or talked to at "the stoop." Often the only documentation found in the case file to support such billings were entries such as "patient attended basketball game". . ."seen today". . . "patient seen in baking group," or. . ."patient played checkers." In each instance, Medicaid was billed at the authorized clinic rate of $54 per visit.

At the two selected clinics reviewed, billings for a 12-month period totaled over $4.5 million. We recommended that HCFA determine the extent of these problems in additional States and revise its regulations to further define covered psychiatric services. HCFA concurred and is currently surveying the extent of the problem in additional States.

Problems at the State Level

At the State level, unallowable/excessive charges to Medicaid continue primarily because State systems for monitoring and/or controlling charges were not fully effective. Our audit activity identified some $16.3 million in unallowable and/or excessive charges. Some of the more significant areas identified related to:

- Non-compliance with Federal restrictions on funding hysterectomies, or sterilizations: For two years we have reviewed States' procedures to insure that the rights of individuals were protected and that required patient consent forms were present as a condition of payment for such procedures. Audits in nine States identified improper payments of about $600,000 for which the required patient consent forms were either not obtained, or were inaccurate in some major way. More importantly, we could not determine whether the rights of the individuals were adequately protected.

- Rates paid to State intermediate care facilities for the mentally retarded (ICF/MR): Audits in two States disclosed major weaknesses resulting in substantial overpayments. Nursing home providers can be paid using:

  A retrospective system where final reimbursement rates are calculated on the basis of actual allowable costs. Since final rates cannot be calculated until after the close of the year, an interim rate is used.

  A prospective system where rates are calculated using actual costs from a preceding period, usually adjusted for inflation.

An audit of the reporting and settlement procedures under the retrospective system in one State disclosed incorrectly reported interim payments, patient days, and patient liabilities by the facilities and the State agency's fiscal agent. Unallowable costs (Federal share of $909,000) were claimed for one fiscal year. This problem was further compounded when the State subsequently changed to a prospective system. Prior cost reports on which this prospective rate was set had not been reviewed to eliminate unallowable costs, and consequently the new rate was overstated. During a 20-month period this resulted in an overclaim of about $2.6 million (Federal share). Another $398,000 in unallowable costs came about from an undetected clerical error, compounded by lack of documentation. Overall, overpayments totaled about $4 million.

In another State, an ongoing audit has shown that interim reimbursement rates established for seven State-owned facilities were not supported by the necessary cost analyses, resulting in excess reimbursement totaling about $28.3 million (Federal share $14.2 million) over a three-year period. Final audits by non-Federal auditors, although needed, had not been made to verify related costs at the State institution.

In view of the national potential for improper practices and charges, additional reviews are ongoing in other States to see if similar problems exist.

- Reimbursement claimed for services already available at no extra cost: One State claimed Federal Financial Participation (FFP) of $1.8 million for dental services provided, under fee-for-service reimbursements, to 115,000 Medicaid recipients who were already enrolled in a prepaid health plan offering such dental services. These recipients' dental needs should have been served under this prepaid health plan at no additional cost to the Medicaid program. As a result of these disclosures our audit emphasis is now being directed towards this area of gross waste in several other States with prepaid health plan arrangements.

- Other erroneous charges: An audit found that a State had improperly claimed $2.3 million in FFP for patients in five skilled nursing facilities which were institutions for the treatment of mental diseases. Federal regulations preclude FFP in the cost of care and treatment of persons under age 65 in mental institutions. As a result of this audit and preliminary surveys in other States, we believe that

numerous patients may have been transferred from State mental hospitals to nursing homes, and the cost of their care improperly charged to Medicaid. Reviews are scheduled in a number of other States to evaluate the extent of this problem.

- Recurring problems found in 1864/1902 health facility certifications: States may claim the costs they incurred in surveying and certifying facilities participating in Medicare and Medicaid. Our reviews (some of which are continuing) in five States disclosed that a recurring problem still existed: States were including costs for functions and activities relating primarily to State, not Federal, licensing activities. We identified unallowable costs of about $2.9 million.

MEDICARE

Audits have been principally directed towards examining the propriety and allowability of administrative costs claimed by Medicare's carriers and intermediaries and appraising the effectiveness of relevant HCFA policies, procedures, and regulations. Substantial amounts--$15.6 million--were found to be unallowable. Problems with Federal regulations covering certain significant aspects of the Medicare reimbursement policies were also identified. These are discussed below:

Problems at the Federal Level

- Too lenient practices followed regarding Medicare reimbursements for services provided by hospital-based physician-specialists: These specialists (pathologists, radiologists, and anesthesiologists) who practice in a hospital setting are paid by or through the hospital. While there are various facets to the manner and measures by which these specialists receive compensation, the net effect of the practices followed is that there are extreme differences in the amounts of such compensation. This finding is based on our review of 61 hospitals in two States where extreme variances were found between amounts paid such specialists in hospitals of similar size, type, and location. The most expensive were identified at those locations where physicians were compensated under "percentage of charges" arrangements with hospitals.

  Although Medicare shares in a substantial portion of these specialists' compensation, we concluded that Medicare does not have procedures in effect to control the reasonableness of program payments for the services of physician specialists who are compensated through hospital arrangements. As a

corollary, our work also disclosed that the compensation paid these physicians has increased substantially over the past few years: pathologists, up as much as 102 percent; anesthesiologists, up as much as 111 percent; and radiologists, up as much as 74 percent.

HCFA agreed with our conclusions that Medicare lacks procedures to insure that payments for services of these specialists are reasonable. They advised that plans are underway to completely revise the applicable regulations concerning hospital-based physicians. These actions could result in significant future savings. For example, one of HCFA's proposed actions would prohibit use of "percentage of charges" compensation arrangements in determining reasonable charges or reasonable costs. HCFA estimates that about $40 million per year in Federal payments could be saved if this one type of compensation arrangement could be brought under control.

- Problems continue regarding payments for physicians' services provided by teaching physicians: The OIG auditors reviewed procedures and controls used by two Medicare contractors to assure that payments for physician services provided in a teaching setting at two institutions were made in accordance with Medicare regulations and guidelines.

  Physicians who train interns and residents in teaching hospitals often maintain a regular medical practice in addition to their teaching activities; and these teaching physicians use both their private and non-private patients to provide training to interns and residents. During their training, interns and residents provide, under varying degrees of physician supervision, physician services to patients. In some cases, they actually provide essentially all of the physician services rendered to hospitalized patients.

  In 1969, Medicare issued comprehensive guidelines clarifying the conditions under which Medicare would make payments for the services of teaching physicians. These guidelines, which are still in effect, provide that claims submitted by teaching physicians on a "fee-for-service" basis must be supported by medical records which differentiate these services from those provided patients by interns and residents. These records must document that the services were furnished by the teaching physician as the patient's attending physician, or for a personal and identifiable medical service actually rendered by the physician to the patient. Interns and residents may not bill for their services as their salaries are paid by the hospital and are reimbursed as a cost of the institution.

Our findings from this current review show that services billed by teaching physicians were not always supported by required medical records or documentation. Further, the Medicare contractors audited were not reviewing these billings for compliance with Federal requirements. As a result, as much as $1.2 million in Federal funds may have been improperly claimed and paid in a relatively short span-of-time at the two institutions reviewed.

Until recently, efforts to clear up this long-standing reimbursement problem through both legislative and administrative actions had not resulted in the changes needed. P.L. 92-603 was enacted in 1972 to resolve the issue of Medicare payments for physician services in teaching hospitals (commonly known as Section 227 amendments). But in 1973, P.L. 93-233 postponed implementation of Section 227 until the matter could be studied and reported on to the Congress. Legislative postponement ended in 1978.

Opposition developed and a bill to repeal this Section was introduced in the Senate. Several months later, the Department decided the matter needed further study. After consultation with an interested professional organization, HCFA liberalized the proposed NPRM and submitted it to the Department with a background paper which delineated various options available. These included implementing Section 227 or postponing any NPRM until the Congress acted to amend or repeal this Section.

Our findings from this limited review showed that the reimbursement problem remained prevalent and action needed to be taken. On December 5, 1980, the President signed the Omnibus Reconciliation Act into law (P.L. 96-499). Section 948 of that law repealed the controversial provisions of the Section 227 amendments and replaced them with new provisions specifying the conditions under which the program will pay charges for the services of teaching physicians. These new provisions are effective with hospital cost accounting periods beginning on or after January 1, 1981. HCFA plans to draft implementing regulations by April 1981. We will continue monitoring HCFA's progress in this area.

- Delays in Implementing Incentive Rates for Renal Dialysis Defer Potential Savings: The 1972 Medicare Amendments extended coverage to practically all persons afflicted with end stage renal disease. Such coverage includes the costs of needed renal dialysis treatment and kidney transplants if medically indicated. Costs associated with renal dialysis treatment have soared to over $1 billion due mainly to:

  --The methods used to compute charges allowed by Medicare for such treatment; and

  --The increasing number of persons receiving Medicare-paid treatment as dialysis facilities became widely dispersed, and thus more readily accessible.

Currently, free-standing dialysis facilities are paid their charges for each dialysis treatment up to a set limit. Hospitals are reimbursed their costs, up to a set limit, also. This limit of $138 per treatment excludes charges for physician supervision. On an exception basis this limit may be higher.

P.L. 95-292 (June 1978) required that the Department have a system in place by the following June to (1) determine the costs incurred by renal dialysis facilities in providing treatment, and (2) have an incentive system, using prospective or target rates, to encourage more efficient service delivery. This date of June 1979 was not met.

In January 1980, we contacted HCFA about the delay in this matter, suggesting that this area needed greater attention. Since then, HCFA has made substantial progress in developing policies on the incentive rate methodology and data needed to compute the actual rates. But as of December 1980--19 months past this legislative target--the mandated systems have not been put in place by HCFA.

Our reviews of two free-standing facilities showed their costs of providing dialysis services to be substantially lower than current charge limits. Similarly, preliminary data being derived from intermediary audits of costs at a sample number of providers and free-standing facilities suggests the incentive rates may be lower than current charges and result in substantial savings when in effect.

HCFA's present schedule calls for the publication of a Notice of Proposed Rulemaking on the incentive rates and computation methodology in April 1981, and publication of the rate methodology and final incentive rates in September 1981. We are continuing to monitor HCFA's progress since delays in implementing the incentive rates defer such potential savings.

- Medicare Contractors' Administrative Costs

Audits continue to identify significant overclaims by these contractors for reimbursements of the administrative costs

charged to Medicare. These overclaims resulted for a variety of reasons; the following, for example, were disclosed during audits of 21 Medicare contractors:

$4.8 million. . .claimed by providers under common ownership for the costs of estimated future malpractice settlements. Since this reserve was not funded by contributions to a self-insurance fund--as required by regulation--it is unallowable.

$5 million. . .pertaining to taxes assessed on the contractor's commercial line of business.

$900 thousand. . .for pension costs that were either not related or not properly allocated to the Medicare program.

$108 thousand. . .for legal fees concerning matters not related to Medicare.

$159 thousand. . .for automobile expenses which either exceeded the program's allowable mileage costs, or which were not of benefit to the program.

$1.1 million. . .for other costs, which were improperly allocated to the program.

In view of this continuing problem, we are working with HCFA to initiate a new approach to auditing contractors' administrative costs by focusing on the contractors' cost allocation systems on a prospective basis. Audit results will be used by HCFA to negotiate approved methods of allocating future contractor costs between Medicare and the contractors' other lines of business. The OIG auditors will then follow-up to make sure that the contractor is using the approved plan.

MEDICAID/MEDICARE - SPECIAL INITIATIVE

Significant weaknesses in the way claims for laboratory services were processed and monitored were revealed by a review in one State. For example, billings were made to Medicare and Medicaid: (1) at greater rates than those charged physicians for the same tests, (2) for tests not done, (3) for individual tests that were done as part of one automated test screen, and (4) for more expensive tests than physicians ordered.

Instances were also found of improper profiteering on lab work performed by subcontractors, and physicians submitting claims for lab tests performed in their own offices when such work had actually been done by outside independent labs at less cost.

Audits identified about $3.4 million in overpayments and 20 cases were referred to investigative organizations. Many recommendations were made to the State on strengthening controls over the payment for these services. One of the most important concerns awarding competitive contracts for laboratory services.

This year we are extending our review of this area to other States to see to what extent, if any, similar problems exist.

OTHER HEALTH AREAS

Health Systems Agencies

Reviews made of 18 Health Systems Agencies (HSAs)--that had received some $27 million in grant funds--disclosed numerous deficiencies in the way they allocated costs between Federal and non-Federal programs, and in the way they justified their budget estimates. Problems were noted in their internal control systems including the way in which the need for large equipment purchases was justified. Personnel costs at 10 of the 18 reviewed were either not adequately supported or appeared unreasonable.

We recommended to the Public Health Service (PHS) that they improve their monitoring of HSAs; perform more detailed cost reviews; and clarify certain financial management guidelines for these agencies. PHS has taken a number of steps towards implementing these recommendations.

Community Mental Health Centers

Grant funds are made available to Community Mental Health Centers (CMHCs) on a "deficit funding" concept. That is, funds are awarded to centers to provide the difference between estimated expenditures and projected revenue. In checking into the application of this funding arrangement we found one center where actual revenue had exceeded expenses. This center, however, had received grant funds of $260,000. Further review of records at the PHS central office showed that many grantees were also withdrawing more grant funds than were needed to cover their actual operating deficits.

OIG auditors requested that PHS act to recover the excess grant funds withdrawn by these centers. The Office of the General Counsel, however, ruled that because of the "inconsistent and incomplete manner in which the deficit funding policy has been implemented and the lack of regulations instituting the policy,

the Department is not legally required to recover excess funds. . . (and any) attempt to recover excess funds. . .would be subject to a sucessful legal challenge." We worked with PHS to develop tighter regulations aimed at correcting this situation. These regulations, issued in July 1980, should help assure that future grant funding is limited to the centers' actual operating deficits.

Hill-Burton Program

For some 30 years, PHS awarded grants totaling $4.4 billion to public and nonprofit entitites for constructing and modernizing health care facilities. Ownership and use of these facilities must continue to meet grant requirements for a period of 20 years. If not, an appropriate refund must be made to the Federal Government.

Preliminary audit work discloses that the Federal Government:

1. May not be monitoring the need for recovery action when a facility is sold or no longer being used for grant award purposes. There are between 5,000 and 7,000 facilities that fall within the 20-year restrictions discussed.

2. Lacks definitive guidelines and procedures for determining appropriate recovery. In one case, involving the sale of three hospitals, audit staff found that inappropriate obsolescence factors were used in establishing the fair market value of the facilities. The amount of dollar recovery to the Federal Government would have been substantially increased had PHS' guidelines more adequately considered the use of these factors.

Reviews are ongoing in several locations to check further into this situation.

National Cancer Institute (NCI) Contracting

We followed-up on actions to correct problems in the National Cancer Institute's contracting processes noted by a prior audit report. Our current review showed that improvements were still needed; increased attention was called for by all levels of PHS, the National Institutes of Health and NCI management to insure compliance with good contracting practices.

INVESTIGATIVE ACTIVITIES

In the investigative area, the Inspector General's office caseload continues to be dominated by health-care cases, primarily health financing. Public Law 95-142 Section 4(c) requires the Inspector General to provide Congress with an analysis of the Medicare and Medicaid cases referred to the Department of Justice. (See Appendix B for a listing of these cases.) We referred 41 cases in 1980. Total disposition totaled 82, including 15 from previous years.

Disposition of Referred Health Care Cases
As of December 31, 1980
(includes cases referred in previous years)

ADJUDICATIONS	21
Convictions	18
Indictments	1
Pending Trial	0
Nol Pros	0
Dismissed	1
Acquitted	1
PENDING DECISION	7
PROSECUTION DECLINED	54
TOTAL DISPOSITIONS	82

The Inspector General's caseload in 1980 totals 161 cases opened, 114 cases closed, and 336 cases pending. The following chart further illustrates the diversity of our investigative work.

1980 Medicaid/Medicare Caseload

Analysis of CY 1980 Medicaid/Medicare Caseload*

Provider	Cases Opened	Cases Closed	Pending
Hospitals	13	16	22
Long Term Care	9	16	25
Physicians	60	43	118
Pharmacies	6	11	9
Other Practitioners	22	21	37
DME/and other Services	21	2	54
Laboratories	3	0	14
Home Health Agencies	3	0	29
Other	24	5	28
Total	161	114	336

*Does not Include Project Integrity Cases.

The following are some highlights of our investigative activities in 1980:

MEDICARE AND MEDICAID EXAMPLES

The following case examples represent convictions received in 1980 related to the Medicaid and Medicare programs:

- A nursing home received $161,641 in excess reimbursement from January 1977 to June 1980 by misrepresenting the hours of direct patient care provided. The owner was sentenced and required to pay restitution of $183,000.

- A physician billed for lab tests that were either not conducted or were conducted by others, for hospital visits not made, and for other medical procedures not performed. From a 300 count indictment the physician was found guilty of 82. He was sentenced to two years imprisonment on each count, to run concurrently, and fined $40,000. Also a $495,000 civil suit was filed in Federal court.

- An investigation of a nursing home resulted in two counts of Medicaid fraud and restitution of $182,000 to the

Medicaid program. The owner of the nursing home submitted 39 falsified cost reports which exaggerated the number of direct care hours reported.

- A national review of 2,500 Medicaid physicians' and pharmacies' billing practices, otherwise known as Project Integrity I, is being phased out. During 1980, four convictions were obtained. Presently 53 individuals have been convicted, 433 administrative sanctions have been levied, and nearly $6.5 million has been identified for recovery.

- The owner of a large California home health agency pled no contest in September 1980 to Federal charges of false claims and statements in their submission of Medicare costs reports. This investigation, initiated in 1976, has been the subject of Congressional hearings and resulted in the 1979 conviction of an ex-financial officer of the home health agency.

- An investigation resulted in a speech therapist being sentenced to prison for three years because of false statements and other violations. This investigation showed that the individual involved charged Medicare for speech therapy to patients who were either deceased or comotose.

- An investigation of a podiatrist revealed that he was providing patients with routine foot care while billing Medicare for various types of foot surgery. He was indicted on 15 counts. The doctor pled guilty to 2 of the 15 counts.

MEDICAID FRAUD CONTROL UNITS

The State Medicaid Fraud Control Unit is a major component of States' efforts in Medicaid fraud control. The Unit's primary role is to detect and prevent fraud against the joint HHS/State Medicaid program. Thirty States have certified Units. Federal grants to these Units in 1980 totaled $25.3 million, and total expenditures (Federal and State) were $28.1 million. During calendar year 1980, the State Units' efforts resulted in 366 indictments and 196 convictions. Also at the end of 1980, there were 2,035 cases pending and under investigation.

In the 1979 Annual Report to Congress we recommended the following:

--Permit 90 percent Federal funding support of any Unit for a full three-year period from the date of initial certification of such Unit, provided that it earns annual recertification; and

--Permit continued special Federal funding support of any Unit, subject to annual recertification, after its initial three-year period of operation is completed. This could be at:

- A Federal support rate of 90 percent, or alternatively,
- A Federal support rate of 75 percent.

The Omnibus Reconciliation Act of 1980 (P.L. 96-499) provides for permanent funding at a 90 percent match for the first three years, and a 75 percent match after completion of a Unit's initial three year period. We believe the passage of this permanent funding provision is attributable to the success of these Units. The General Accounting Office (GAO) agrees with the Units' effectiveness, as reported in "Federal Funding for State Medicaid Fraud Control Units Still Needed."

OTHER HEALTH CARE

Activities in the public health portion of HHS' health care programs have not been as extensive. The three following examples illustrate the types of cases OIG has investigated in the public health programs:

- Through an investigation, we found that a Public Health Service doctor had received a kickback from an individual in return for carrying this person as an employee for one month. The doctor had also filed a false Medicaid cost report. The doctor was indicted to 22 counts of embezzlement and one count of false statements. He pled guilty to all 22 counts.
- An investigation revealed that a psychiatrist submitted claims for services not rendered and for services provided by his medical secretary. He received about $22,000 fraudulently. His sentence was three years probation and restitution of $25,547.
- An investigation revealed that a dentist had submitted false claims to a Public Health Service grantee for work not performed which totaled $14,910. He was sentenced after entering a guilty plea.

ASSESSMENTS AND REVIEWS

In addition to the traditional audit and investigative work, the Inspector General's office performs numerous reviews and assessments. The reviews concentrate on problems from a systems and

management perspective, while the assessments examine issues from the service delivery level.

MEDICAID AND MEDICARE

The following are highlights of work involving issues related to the Medicaid and Medicare programs:

Hospitals

During 1980 we were involved in a number of activities designed to identify and control fraud, abuse, inefficiency, and waste in hospitals. For example, the Inspector General's office participated in the funding and monitoring of a contract with the New York State Special Prosecutor's Office. The contract required New York to conduct investigative audits in 50 hospitals. As a result of these investigations, the Special Prosecutor's Office prepared both audit and investigative manuals. New York's experiences indicated the need for further in-depth penetration of problem areas brought to light during these investigations. Such areas included the handling of gifts and contracts by hospitals and the propriety of methods for computing Medicare and Medicaid cost allocations. In addition, under this contract, New York conducted a series of training sessions for State and Federal investigative staffs.

Another example of our hospital activities is our participation in the Illinois Hospital Audit Project. The purpose of this project was to test the adequacy of existing hospital audit guides and procedures and design any new and improved guides. The areas selected for study were: payments to hospital-based physicians, the recovery of third-party liabilities, the handling of gifts and grants, and the allocation of charges to Medicare patients.

Assessments of Service Delivery

We assessed the extent of and reasons why patients on Medicare and/or Medicaid remain in hospitals beyond their need for acute care. Our findings confirmed that a substantial number of patients are kept in hospitals only because nursing home placements cannot be arranged. The "backed-up" patients are poor, old, and highly dependent. They are refered to as "heavy care" patients -- those requiring extensive staff-time and attention. We also found that hospitals have little incentive to move these heavy care patients into nursing homes.

An assessment of the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the Maternal and Child Health (MCH) programs focused on how and why poor children use or do not use these programs and to what extent they promote

continuing, comprehensive health care. Our findings showed that most Medicaid children are getting some preventive health care checkups whether or not they participate in EPSDT, but these are often irregular. Obstacles to health service include the inaccessability of resources, crisis-oriented lifestyles, the ineligibility of many poor, the programs' (EPSDT and MCH) failure to accept the exam components or tests of the other, and little tracking or follow-up with clients.

We assessed beneficiaries' experience with the accessibility, utilization, and effects of Medicare carriers' communication with clients. We found that the vast majority of beneficiaries are substantially uninformed about the provision of the Medicare Part B program and their individual rights.

In an assessment of the End Stage Renal Disease Program, we examined patients experiences with end stage renal disease, including the patients' role in decisions concerning their method of treatment and selection of service provider. The assessment found that, largely because of the influence of their nephrologist (kidney specialist), most clients dialyze at a facility and seldom switch to home dialysis or undergo a kidney transplant. There is currently no trend toward significantly greater client interest in home dialysis or kidney transplant or other means of self care. Clients who dialyze in facilities have considerable concern over the high rates of staff turnover while those who dialyze at home have family stress. Regarding employment, only about one-fourth of those working full-time at the time of kidney failure continue to work.

OTHER HEALTH PROGRAMS

Most of our work in the Public Health programs have been assessments. Two major reviews, however, were also conducted last year. The debt collection review of five scholarship and research programs within the Public Health Service is included in the Department Administration Chapter of this report. The other review is described below, along with several assessments.

Indian Health

Through a review conducted at headquarters and a number of reservation sites of the Indian Health Service (IHS), we found that IHS suffers from a number of management deficiencies such as inadequate resources, poor internal communication, insufficient policy guidance, a lack of priorities, and a lack of coordination of Indian Affairs within the Department.

The majority of our recommendations deal with the necessity for IHS to re-establish certain critical centralized management policies, particularly those dealing with tribal contract awards, uniform procedures in approving and verifying contract health care, and establishing a national forward planning process for both resource allocation and information systems development. In addition, we have recommended that headquarters develop national standards for a wide range of local management tasks and hold field managers accountable for their performance in those areas.

Health Maintenance Organizations

We assessed Health Maintenance Organizations (HMOs) to determine how the executive staffs of local HMOs perceived HHS' efforts to promote the establishment and growth of HMOs. Their perceptions included: HHS' efforts in HMO development is disorganized and poorly managed; compliance activities need to focus on early identification and technical assistance to HMOs before a crisis occurs; and community health centers perceive a bias on the part of HHS' HMO office against their conversion to HMOs and likewise report ambivalence, fostered by HMO, regarding the enrollment of the poor and elderly in HMOs.

Tuskegee Syphilis Study

An independent review of the Tuskegee Syphilis Study was conducted to determine: (1) the background of recently discovered documents in the National Archives; (2) whether there was any evidence that any Federal personnel intentionally withheld or concealed materials; (3) whether, and for how long, black males with syphilis who were part of the study were lied to about their treatment and were denied available treatment; and (4) what was the role in such deceit and mistreatment of persons within the U.S. Public Health Service.

Our review found that documents in the National Archives were placed there in 1942 and were available shortly thereafter. The 1972 Ad Hoc Committee was unaware that these documents existed. We also found that no evidence existed implying that any Federal employee intentionally withheld or concealed the documents. This review further found that the subjects of this 1930's study were intentionally misled about the nature of the study and the risks associated with their involvement. It appeared that this continued until 1972.

The Inspector General concluded that there are serious deficiencies in the way in which the Department selects and instructs staff to serve on panels such as the one in 1972. The current process had made the Department vulnerable to charges of conflict of interest

and suppression of data. The Secretary of HHS instructed the Department to establish procedures to insure that: (1) investigative panels which are charged with the responsibility of studying a given agency not be assigned staff from the same agency; and (2) staff selected would be experienced in fact-finding techniques.

CHAPTER III

INCOME MAINTENANCE AND ASSISTANCE

The Department's income maintenance and assistance programs include the Social Security Retirement, Survivors and Disability Insurance (RSDI) programs and the cash assistance programs of Supplemental Security Income (SSI) and Aid to Families with Dependent Children (AFDC). These programs are under the management of the Social Security Administration (SSA), which administers the RSDI and SSI programs directly through its national field office network and oversees the AFDC program administration by the States.

The social security insurance programs, authorized under Title II of the Social Security Act, provide over $115.5 billion annually to 35.3 million retired and disabled workers and their families and the families of deceased workers. The Social Security Administration's operation and management of these programs and their related activities has been a major focus of the Office of the Inspector General (OIG) in 1980. A growing concern has been the increase since 1978 of fraud and abuse in the area of social security numbers. As a result, the OIG committed significant resources to a study of the social security number process and to increased investigative activities in this area.

The Department's cash assistance and related programs, provided under the Social Security Act, cost about $14 billion for 1980. The primary cash assistance programs, SSI and AFDC, involve Federal/State partnerships, either through State supplementation of Federal benefits (SSI) or Federal financial participation (AFDC). Accordingly, the OIG concentrated in 1980 on State claims and administrative practices in addition to welfare fraud investigations and assessments of service delivery problems in SSI and the new Low Income Energy Assistance Program.

AUDIT ACTIVITIES

Among the 90 audits completed in income maintenance programs in 1980, we recommended $17 million in financial adjustments, identified needed improvements in controls over data processing facilities and files, found States retaining Federal funds from cancelled benefit checks, and recommended improvements in trust fund withdrawals and disbursements. The following are highlights of our 1980 audit accomplishments in this area.

INSURANCE PROGRAMS

In 1980, our audit activities in SSA's Retirement, Survivors and Disability Insurance program operations and administrative practices concentrated on SSA's data processing security controls, various aspects of disability operations, and trust fund financial practices. We also initiated a major project which will examine the accuracy and validity of all types of payments made under SSA's Title II programs.

Medical Reevaluations in Disability Insurance

Under the Social Security Disability Insurance Program, benefits are paid to individuals with disabling medical conditions which have lasted--or are expected to last--12 months or longer, or will result in death. Since not all disabling conditions are permanent, SSA needs to reevaluate those beneficiaries periodically for possible medical recovery or rehabilitation.

Audit's tentative findings show that at least 10,000 medical reevaluations, which should have been made under current regulations for these individuals, had not been made. At our request, SSA reevaluated a sample of these cases. Based on this sample, we estimated some 4,100 were ineligible resulting in erroneous payments of $18 million. Further work showed that SSA's master beneficiary records contained incomplete information as to which recipients should be reevaluated. Pending necessary corrective action on the part of SSA, substantial erroneous payments will continue to be made annually.

State Agency Reimbursement for Disability Determinations

State agencies, under agreements with the Department, carry out the disability determination process for both the Title II (DI) and Title XVI (SSI) programs. The State agencies' primary function is to develop medical, vocational and other evidence and to determine if a disability exists. The costs incurred for performing these functions, totaling $270 million annually, are reimbursed by the Federal Government.

We contracted with various CPA firms to validate the propriety and allowability of State reimbursement claims in 20 States. Problems were found in the way States computed indirect cost, withdrew funds under the letter-of-credit system, and claimed reimbursement for space. As a result, auditors questioned the allowability of about $600,000 in State charges.

SSA's Critical Case Payment System

SSA's Immediate Payment Critical Case (IMPACC) System is designed to expedite benefit payments which have been delayed in processing and have resulted in severe beneficiary hardship. Through April 1980, IMPACC payments totaled $573 million--$345 million applicable to disability beneficiaries. Our audit of the system focused on controls over disability IMPACC transactions and on payments with characteristics indicating high probability for error or fraud. Although our review revealed no specific instances of fraud or abuse, we found internal controls were such that improper IMPACC payments could be initiated by a single employee with little chance for detection. Additionally, we found that SSA has not effectively used its supervisory or post-payment quality appraisal reviews to identify potential employee fraud situations. Improved physical safeguards also were needed over computer terminals to prevent unauthorized equipment access and operation. Appropriate recommendations were made to correct these problems.

Trust Fund Withdrawals

SSA is responsible for authorizing withdrawals from the Trust Funds to pay monthly benefits under the RSDI programs. Auditors found that for a selected three-month period, reviewed Trust Fund withdrawals exceeded actual Treasury disbursements to program recipients by an average of about $53 million. Trust Fund interest could be increased by an estimated $4.5 million annually if SSA would estimate cash needs using more current payment data. SSA generally agreed with our findings and has taken a number of steps to better estimate amounts needed to be withdrawn.

SSA Funds Transferred to the Railroad Retirement Board

The Railroad Retirement Board (RRB) is responsible for paying benefits to persons eligible for RSDI payments under both the Social Security and Railroad Retirement Acts. SSA sends benefit data and transfer funds ($21 million monthly) to RRB for approximately 100,000 persons receiving these combined payments.

We found that controls over the transfer of funds and beneficiary payment data were not effective. As a result, beneficiary payment record discrepancies valued at $123 million and involving 540,000 records had accumulated as of February 1979. This total increased by about $10 million each month in calendar year 1979.

Our recommendations to SSA call for establishing and coordinating procedures with the RRB to identify and correct record discrepancies and to reconcile monthly fund transfers and disbursements.

Special Initiative

As a major audit initiative this year, we are making a system-wide review of the accuracy and propriety of a sample of payments made under the Social Security's Retirement, Survivors, and Disability Insurance programs (RSDI). This will entail a comprehensive redevelopment of the cases selected. This project's approach will be unique in that the payments to be sampled will be selected from end-of-line sources: Treasury's records of payments made. Redevelopment of the sample cases will be extensive, even entailing face-to-face visits with beneficiaries in their homes. Audit tests will seek to identify possible fraudulent and incorrect payments, to identify situations where payment processing controls can be improved, and to create ancillary data concerning the processing, delivering, cashing, and clearing of RSDI payments for use in evaluating delivery system efficiency and service to the public. We will also be able to probe for possible fraud occurring outside SSA's operations.

PUBLIC ASSISTANCE PROGRAMS

Of the 49 audits performed in the public assistance programs, we recommended $13.8 million in financial adjustments, primarily in the area of administrative costs. We also continued our audits of States' practices in these programs, and our highlights in these areas follow:

Cancelled Benefit Checks

One of the more significant audit findings in the public assistance programs involves States not crediting Federal programs for cancelled benefit checks and other collections. In previous years, we identified five States where credits totaling $23 million were not made to Federal programs. Reviews made during 1980 in a number of other States have identified an additional $8.3 million due the Federal Government. In some cases States have retained these funds for years.

Our reviews disclosed that this situation was attributable, at least in part, to a lack of Federal regulations requiring States to return the Federal portion of uncashed benefit check within a specified time period. As a result, the Federal Government was needlessly losing interest charges running in the millions of dollars per year. Subsequent to our reviews, SSA officials advised us that a Notice of Proposed Rulemaking would be published requiring the timely return of the Federal portion of uncashed benefit checks and other credits.

We also found States' claims for Administrative costs and foster care payments significantly overstated:

Administrative Costs

During the calendar year, auditors questioned the allowability of substantial amounts claimed by States. The most pervasive problem involved States not following their approved cost allocation plans when claiming Federal financial participation. For example, ongoing reviews in one State found the administrative cost claim was overstated by $11.3 million. In another State, claims included $7.4 million in charges not benefiting Federal programs, $6.5 million in charges not based on the agency's approved cost allocation plan, and $2 million in administrative costs for providing services to ineligible recipients. Final reports issued identified similar problems and recommended financial adjustments totaling $10.2 million.

Foster Care

To be eligible for Federal financial participation under the Foster Care Program, the children for whom the State claims such assistance must be receiving or be eligible for AFDC assistance, be removed from their home under a court order, and be placed in a private nonprofit or public institution or private home. Audits in five States (some completed, others ongoing) identified improper payments of $24.4 million because these conditions were not met. In one State alone, we found that payments of $18.9 million (over a four year period) did not qualify for reimbursement.

SUPPLEMENTAL SECURITY INCOME (SSI)

SSI provides cash assistance to needy aged, blind, and disabled persons. SSI, which was implemented in 1974 to replace State-administered programs, is funded by general revenues. In 1980 over 3.6 million persons received about $5.7 billion in Federal SSI benefits. SSA also administers the SSI supplementation payments for 26 States and the District of Columbia. Our audit highlights, which concern these supplementation programs follow:

- Under provisions for mandatory supplementation to the SSI program, States are reimbursed for certain administrative costs for furnishing recipient data to SSA. Our review of approximately $24 million in administrative costs claimed by 14 States disclosed about $2.6 million in unallowable charges. The bulk of these involved costs for activities benefiting only State programs.

- A more significant finding from audit of State claims under SSI, however, involves a $97 million reduction in Federal liability. This came about because of an error made by the State in determining the correct "adjusted payment level" (APL). To determine Federal/State liability of cases transferred from State-operated assistance programs (Titles I, X, XIV, and XVI of the Social Security Act) to the SSI program, an APL rate is computed. This rate represents what an SSI recipient would have received under the transferred program for January 1972. The rate is applied to each SSI recipient's account to determine base liability. For the two year period ended June 30, 1976, the State proposed an APL rate of $201.25 per case. Using statistical sampling techniques, we found that the rate was overstated by about $10 per case (due to inclusions of wrong factors and other errors).

ADMINISTRATION OF INCOME MAINTENANCE AND ASSISTANCE PROGRAMS

Payments for Repairs and Maintenance of SSA Facilities

The General Services Administration (GSA) will not take action on requested repair and improvement work until it bills and receives full payment for its estimated costs. Auditors explored the ramifications of this policy as it impacted on SSA's Trust Funds. From an analysis of 39 projects (fiscal years 1975-78), audit concluded that SSA's Trust Funds lost about $450,000 in interest on monies transferred to GSA in advance of actual need.

In discussing this matter with GSA representatives, we were told that a waiver of the advance payment requirement would be considered based on a demonstration of adverse effect on the Trust Funds. A more acceptable method, in our opinion, would be for SSA to pay for such projects on the basis of percentage of work completed. SSA is currently working with GSA to obtain a waiver.

SSA Computer Files and Data Processing Facilities

SSA maintains computer records of earnings and benefit payments for millions of wage earners and beneficiaries. We examined how well this information was being protected from accidental or intentional manipulation or disclosure. We found that access to this data (by using data terminals or other such means) appeared relatively unrestricted -- and this created a security problem.

We also reviewed SSA's controls over data processing facilities, computers, and computer record files. Our principal findings:

--SSA freely issued badges allowing access to the computer area to programmers, food vendors, maintenance staff and others and did not revoke badges upon the retirement or relocation of personnel. SSA had not developed standards specifying the level of access and procedures for the guidance of security personnel. Lastly, personnel entering the secure area were not subjected to security investigation, or made aware of the provisions of the Privacy Act of 1974.

--SSA did not adequately safeguard computer tapes. SSA uses an automated tape library control system. Those which SSA receives from outside sources--such as contractors, State agencies, and others--are controlled by a manual system. Neither of these systems adequately accounted for the movement of tapes in or out of the ADP secure area. Tapes held outside the secure area were not afforded an adequate level of protection against theft, loss, misuse, or environmental hazards. Because of these security problems, the privacy and integrity of the information recorded on these tapes--which includes confidential data on annual wages and SSA benefit payments--could be compromised.

SSA has concurred with our recommendations for upgrading ADP facility access controls and securing tapes and has initiated corrective actions.

INVESTIGATIVE ACTIVITIES

In 1980, 109 cases were opened relating to income maintenance programs and activities in SSA. In addition, the Inspector General initiated and continued several special projects to detect fraud and abuse or facilitate investigations in the income maintenance programs. Many of these projects involve the use of computer scanning techniques to reveal multiple case situations, fraudulent eligibility information or unstated income. All involve active participation and coordination with other Federal, State and local counterparts.

Project Baltimore

This ongoing project is a joint investigation by OIG, Immigration and Naturalization Service (INS), and SSA focussing on criminal conspiracies to obtain social security numbers (SSNs) for illegal aliens. The project began in 1978 after a joint investigation by OIG and INS culminated in the convictions of nine individuals, including an SSA employee who admitted to receiving $25,000

in bribes to fraudulently process SSN applications. Presently, over 100 similar conspiracies have been identified and are in varying stages of investigation around the country. During 1980, the Inspector General, Commissioner of SSA and Commissioner of INS signed a memorandum of accord providing for the computerization of evidence in these cases.

To date the project has produced over 50 criminal convictions including that of four SSA employees. Sentences have ranged from probation to four years imprisonment and fines up to $10,000 for such crimes as bribery; mail fraud; visa fraud; the concealment, harboring or shielding of illegal aliens; submission of false INS documents; and forgery of official seals. In addition to the indictments obtained, the efforts of this project led to deportation proceedings for over 600 illegal aliens.

Project Match

This national computerized program was designed to identify Federal employees who are fraudulently receiving State welfare benefits and recipients who are fraudulently receiving welfare benefits simultaneously from more than one State. In addition to OIG, SSA personnel, Postal Service, FBI and State welfare investigators have figured prominently in these investigations; and during 1980 approximately 50 cases have been referred for prosecution by OIG and others. For example, the FBI indicted 29 Federal employees and 10 county employees in the Philadelphia, Pennsylvania area. As an example of the results received from these efforts, an OIG initiative in North Carolina resulted in 12 convictions, fines of $1,600 and restitutions of $34,391.

Project Sacramento

This is a single State (California) pilot project assisting county prosecutions of welfare defrauders. The majority of cases involve fraudulent use of multiple social security benefits and SSI payments in addition to AFDC payments. Previously, the counties routinely requested verifications, extracts, and copies of checks through SSA. Because this process took many months or years, the counties often abandoned investigations.

By agreement between OIG, the Fraud Prevention Bureau, California Department of Social Services and all 52 county investigative units, all such requests are now routed directly to OIG's Sacramento sub-office. The sub-office processes verifications and SSI extracts in one week and returns SSA extracts in six to eight weeks and certified photocopies of checks in fourteen weeks. Since October 1, 1980, this office has handled 114 inquiries and has submitted five prosecutive reports to district attorneys, resulting in three indictments and two pending indictments.

Project Missing Kids

This pilot project in a single State (Connecticut) involves a computer match of children receiving AFDC benefits against Medicaid benefit tapes, school attendance records and vital statistics records. The purpose is to corroborate indications that some recipients may be reporting nonexistent children on applications for Federal benefits. In October 1980, a couple were indicted and the husband held on $100,000 bail for fraudulently receiving over $60,000 in benefits. The case has been publicized as the largest welfare fraud in Connecticut's history.

Case Sample

The following are examples of our investigative cases and the convictions and sentences that resulted in the income maintenance programs:

- A joint OIG and INS investigation of a Connecticut travel agency resulted in numerous convictions for activities related to providing social security cards to illegal aliens. For example, in November 1980, one subject was convicted of falsely certifying documents submitted to INS and received a one-year suspended sentence, two-years probation and a $1,000 fine.

- Two subjects (one an SSA employee) pled guilty to charges of bribery and conspiracy related to selling social security cards to illegal aliens. The SSA employee was sentenced to two years imprisonment and three years probation. The other subject was sentenced to three years imprisonment (suspended) and five years probation and fined $300.

- An audit survey reflected that an individual was receiving AFDC payments in three States. Investigation disclosed that the subject had illegally received $12,000 in benefits. The subject was indicted and pled guilty to one count of mail fraud. In February 1980, the court imposed restitution of $800.

- Another investigation revealed that an individual had received AFDC payments and food stamps by falsely claiming unemployment from 1975 through 1978. In September 1980, a four count Federal indictment was returned, and the subject pled guilty to all counts. In December 1980, the subject received two years suspended sentence and two years probation.

- Our investigation of an SSA claims representative disclosed that the SSA employee had intentionally overpaid SSI recipients, forced the recipients to refund, and then diverted the funds to her own use. The employee was indicted on ten counts and in May was found guilty of one count each of embezzlement and theft of government property. She was sentenced to three years probation and fined $500.

- Another investigation revealed that an SSA employee had falsified documents to obtain SSI payments for her mother. In September 1980, the subject pled guilty and was subsequently sentenced to three years probation and ordered to restitute $6,959.

REVIEW AND ASSESSMENT ACTIVITIES

In addition to the traditional audit and investigative activities, the Office of the Inspector General (OIG) initiates special studies that either cross-cut program areas, integrate the audit and investigative disciplines with overall systems and management analysis, or assess the problems and perspectives of clients and front-line service providers. Highlights of these special studies in the income maintenance area follow:

Review of the Social Security Number (SSN) Issuance System

Alarmed by the rapid increase in SSN fraud cases since 1978, the Inspector General initiated a study of the Social Security Administration's (SSA) SSN issuance system. We performed the review between January and September 1980, using two target cities with high alien populations--New York City and Washington, D. C. The review, which combined traditional audit techniques with management review and computer analysis methods, examined the management practices and internal controls in SSA's field offices, the validity of SSN application data, the vulnerabilities and deterrent/detection capabilities of the computer system and the trends in issuance of SSNs to aliens not authorized to work.

The major findings of the review follow:

- While U.S. citizens may use SSNs for any purpose for which an SSN is needed, SSA issues two types of SSNs to aliens: (1) work-related numbers for those aliens authorized to work by the Immigration and Naturalization Service, and (2) nonwork numbers to those aliens who do not have work authorization but need the SSNs for other purposes (e.g., driver's license). In the two cities reviewed, we found that almost half of all persons of all ages obtaining work-related social security numbers were aliens. Of these work-related social security numbers issued to aliens, 20 percent were issued erroneously either to illegal aliens or to visiting aliens not authorized to work. In addition, at least 24 percent of the numbers issued to aliens for nonwork purposes are indeed being used for work.

- Although the social security number area is increasingly more vulnerable to fraud and misuse, it is an area that both through perception and design does not receive a proportionate share of SSA field office time and resources.

- There is no national fraud awareness nor effective central office guidance to the field on how to control fraud and misuse. In the void, Regional and field offices are setting up ad hoc procedures to deal with the problems.

- SSA's evidence certification process lacks controls, supervision, and document training resulting in erroneous issuance of social security numbers.

- Because of the lack of case control and effective reconciliation, field office involvement can be totally bypassed and fraudulent numbers issued with no systematic method of detection.

- Because the telecommunication system lacks effective access controls, personal accountability, and a password system, all enumeration activity which employs the telecommunication system is vulnerable to compromise.

- Although illegal aliens are known to have paid over $100 for a blank social security number card, controls over the printing, distribution, and storage of blank social security number cards were found to be totally ineffective.

- SSA has not provided its district offices with clear instructions for issuing SSNs to aliens without work authorization nor instituted any deterrents to the abuse of these numbers.

We recommended numerous improvements in internal controls to SSA and advised that priority be given to training programs in document verification, fraud control guidelines, quality assurance programs, case control and reconciliation procedures and risk assessment of the future expanded telecommunications process.

Information and Referral Services for Supplemental Security Income (SSI)

We examined the extent and manner in which SSA provides information about other programs and services available to SSI recipients. The assessment found that SSI clients seldom expect information and referral services from SSA offices or even know that the offices provide them. SSA office managers accord low priority to information and referral as they concentrate on meeting the processing time and accuracy goals upon which their performance is measured. Consequently, current information and referral are typically done in a quick, perfunctory manner. The Commissioner of Social Security has prepared a complete workplan to address the problems identified by this assessment.

Low Income Energy Assistance Program

In 1979, the Congress created a $1.6 billion Low Income Energy Assistance Program (LIEAP) to help poor people meet increased energy costs in the winter. In 1980 we assessed this program to provide early warnings of problems in the implementation of the LIEAP and to identify major issues for future program consideration.

The assessment findings showed that the flexibility allowed by the program, combined with other individual State efforts, resulted in each State having its own distinctive program. Categorical programs (i.e., Special Energy Allowance/SSI) were relatively easy and inexpensive to administer but were criticized for not targeting aid to fuel bills. Conversely, application programs were more costly to administer, but effectively targeted broad segments of the eligible population.

During the conduct of this assessment, findings were given continuously to the Under Secretary and the responsible program officials. By doing so, many early problems in program operations were corrected.

CHAPTER IV

HUMAN SERVICES AND INSTITUTIONS OF HIGHER EDUCATION

The Department of Health and Human Services administers a wide range of human services programs directed towards special populations including: children, youth, older Americans, the developmentally disabled and Native Americans. This Chapter will cite problems and deficiencies in these programs which were uncovered as a result of audits, investigations and assessments carried out by the Office of the Inspector General (OIG). Recommendations to correct identified problems, training for human services headquarters and regional staff to assist in fraud and abuse detection and prevention, and an assessment of Office of Civil Rights (OCR) activities related to human services activities are also included. In addition, results of audit cognizance over higher educational institutions and concluding educational investigative cases are also described.

AUDIT ACTIVITIES

TITLE XX HUMAN SERVICES PROGRAMS

Title XX of the Social Security Act is the Department's largest human services program and a primary funding source for State social services. States are reimbursed 100 percent for child day care services up to $200 million, 90 percent for family planning services and 75 percent of costs to provide other social services to low income individuals and their families. The Federal allotment for FY 1980 was $2.7 billion.

Twenty-five audits were conducted in CY 1980 which recommended financial adjustment of $3.2 million. Overstated claims by States accounted for the bulk of these adjustments.

States' Claims

Ongoing audits have identified significant problems regarding States' claims:

- States claim costs which are not covered...

  One case relates to a State's claim of $42 million for social services provided mentally retarded residents in six State-owned and operated training centers. The problem here is that Federal regulations do not allow financial participation in cases where services are provided by the facility and are intrinsic to the purpose of the facility.

- States claim costs for facilities which do not meet Federal requirements...

  In the other case, State non-compliance with a requirement that out-of-home day care services meet Federal Interagency Day Care Requirements as a condition for Federal financial participation could become the basis for a very substantial audit recommended disallowance. During the 4½ year period covered by our audit this State claimed reimbursement for about $90 million (Federal share) for day care services furnished Title XX-eligible children. Our preliminary findings show that about 87 percent of the day care centers reviewed in this State had health and safety violations. While we are expanding our work to include a more detailed study of these centers, it appears that a significant portion of the State's claim may be inappropriate for Federal matching.

TITLE XX TRAINING

Title XX also provides Federal support for personnel training and retraining directly related to the provision of social services under Title XX. States may provide grants to higher educational institutions for both short- and long-term training, direct financial assistance to students enrolled in these training programs and to support in-service training. In FY 1980, $95 million (including $20 million for prior claims) was expended for Title XX training.

During this past year we developed further information on a situation discussed in our prior Annual Report, released March 31, 1980. It concerns the fact that States may claim Federal reimbursement for the costs of training individuals who are preparing for employment with the State to work on or with the Title XX program. Our prior report noted we were finding that very few of these graduates ended up working for the State. There were simply more graduates than jobs. An example was shown of one State which had spent $12.7 million for curriculum grants and $1.4 million for direct financial assistance to 698 students. Only 51 graduates in this group had been employed by the State.

Demand for persons in social services and related vocational fields appears to be declining. Thus, providing financial assistance to induce college students to accept employment with State Title XX agencies may not be economically justifiable or of critical importance. It might be noted, also, that prospective students have other readily available sources of financial assistance for educational purposes, if needed. Projected nationwide, we

believe such assistance costs could total as much as $9 million annually. Our work further disclosed that States have not established effective procedures to recover financial assistance paid (and claimed as Title XX training costs) individuals who had defaulted by not honoring their employment commitments.

We have discussed this situation with responsible Office of Human Development Services (OHDS) staff. While regulations have not been changed, OHDS advises they will consider strengthening regulatory language concerning recoupment of funds provided individuals defaulting on their employment commitment. They also agreed to study the possibility of total exclusion of any assistance to persons preparing for employment with the State agency. Thus, while actions have been taken, or are being considered, the identified problems still exist.

HEAD START PROGRAM AND NATIVE AMERICANS PROGRAM

Head Start provides educational, health, nutritional and social services to preschoolers. In addition, contracts are awarded for evaluation, research and demonstration projects as well as technical assistance. In FY 1980, $737 million of Federal funds were expended.

The Native Americans program provides financial assistance grants to Native American groups to promote economic and social self-sufficiency. In addition, through contracts, grants and interagency agreements, financial support is given to related technical assistance and research, demonstration and evaluation activities. In FY 1980, $34.8 million of Federal funds was spent to support this program.

Most audits of Head Start and Native Americans program grants are made by non-Federal auditors (usually public accounting firms) who follow our guidelines in making these reviews. However, Federal audits are made when serious management deficiencies have been disclosed through these "non-Federal" audits, or as part of multi-region program reviews. During calendar year 1980, we reviewed and issued 1,577 reports by non-Federal auditors concerning these programs.

These reports cited 4,569 deficiencies in grant administration, such as problems with accounting, internal controls and record-keeping practices. These were reported to the Office of Human Development Services who is responsible for administration of these programs. Our reports also recommended the need for $12.7 million in financial adjustments.

Single Audit Responsibility

In addition, a cooperative project was undertaken to improve the quality of audit coverage afforded community action agencies who receive Federal funding under many grants (most from the Community Services Administration (CSA), but also Head Start). This project required working with the Office of Management and Budget (OMB) and several other Federal agencies to establish a single audit responsibility for these community action agencies. Under this concept one Federal audit agency now has responsibility for all Federal audit work at a particular community action agency.

INSTITUTIONS OF HIGHER EDUCATION AND NON-PROFIT ORGANIZATIONS

Colleges and universities receive an estimated $7 billion annually from the Federal government for such purposes as research, evaluation, training and demonstration, as well as student financial assistance. Through an Office of Management and Budget-administered system of audit cognizance, the Department of Health and Human Services (HHS) is responsible for providing audit coverage at 98 percent of the 2,500 colleges receiving Federal grants and contracts.

During CY 1980, 856 audits of colleges, universities and non-profit organizations resulted in recommended financial adjustments of $7.7 million. In addition, there were $29.8 million in costs for which we could not render an opinion on their validity.

Continuing problems in validating costs charged to government grants and contracts by a number of colleges and universities include:

- Costs which are charged or transferred to Federal projects without the support needed to insure they are valid charges;
- Costs which have the necessary support but are inappropriate or otherwise in error and, therefore, should not have been charged; and
- Costs for salaries and wages which have been charged based upon budget estimates instead of data showing actual time and effort, as required.

Reducing Problems in Validating Costs

Work is proceeding on ways in which the scope of problems in validating costs can be reduced. Wherever feasible, extended audit procedures continue to be used. Under this concept, when needed supporting documentation is incomplete or missing, alternative methods are used to substantiate the reasonableness and allowability of the charges that have been made. Employees are interviewed; records are reconstructed; and other techniques are employed.

While beneficial in some cases, this procedure does have limitations. Individuals most familiar with a particular Federal project may have problems recalling specific time and effort spent on particular projects. Also, some cases regularly occur in which the affected individuals no longer work for the institution. The process of reconstructing records, of course, becomes more difficult as time passes.

One new concept which appears to offer promise is known as 'on-line auditing.' Under this approach, expenditure transactions and supporting documentation are validated, on site, as they occur. The institution, using its own internal audit staff--or a public accounting firm--validates the accuracy of such costs using statistical sampling techniques. Auditors have final approval of the sampling and audit process and periodically validate the audit results.

On-line auditing is currently operating at three large universities that are responsible for administering over $75 million in government funds. Implementation of this procedure is planned at other universities. It should be noted, however, that the ultimate success of this approach requires the full cooperation of the institutions involved.

INVESTIGATIVE ACTIVITIES

In CY 1980, 18 cases were opened relating to human services programs and 9 cases were closed. At the end of the calendar year 34 cases were pending. Special initiatives, such as one dealing with the Native Americans Program, were undertaken in an effort to prevent fraud and abuse.

Native Americans Program Initiatives

A financial audit of a single reservation questioned over $.5 million of expenditures. An inadequate financial management system and the lack of documentation made it impossible to track the receipt and expenditure of Federal funds. A survey of six other Federal agencies indicated similar problems at other reservations.

Uncoordinated and individual audits by the various Federal agencies negated a true evaluation of the reservation's total financial condition as funds could be shifted from program to program to mislead any single audit.

The Office of the Inspector General investigators coalesced the several funding Federal agencies and it was agreed that a joint audit would be performed. We promoted the concept of an overall Federal program monitor and, in agreement with the Department of Interior, the Tribal Chairman and Council and the other Federal agencies, a monitor is in place. The monitor is responsible for the receipt and expenditure of Federal funds and the training of reservation members in fiscal management and accountability.

In CY 1980, 15 cases were opened relating to Federal programs occurring at educational institutions and 95 were closed. At the end of CY 1980, 29 cases of this type were pending.

With the creation of the Department of Education in May 1980, responsibility for fraud and abuse efforts related to educational programs was transferred from the Department of Health and Human Services (DHHS). However, investigative efforts at the near completion stage were retained.

Concluding Educational Cases

Following are examples of concluding educational investigative cases:

- An investigation of a proprietary school owner operating 13 schools in Texas and 1 in Atlanta (from 1971 to 1975) was initiated by the Office of the Inspector General investigators (Atlanta) in 1974. Joint efforts by investigators and FBI agents, Departmental auditors and the Texas State Attorney General's office required extensive funds-flow tracing of the converted grant funds and a detailed review of student files, government default files and lender records to establish the fraudulent claims and wrongful conversion.

  The subject was convicted in November 1980 after a four-week jury trial in Dallas, Texas, on 37 criminal counts. This included 24 counts of false claims, 12 counts of conversion of Federal grant funds and 1 count of conspiracy to defraud the U. S. Government. He was sentenced in December 1980 to serve five years followed by five years probation, a fine of $350,000 and restitution of $400,000. Earlier, the Texas Attorney General's Office, assisted by this investigation, had obtained a judgment against the subject in the amount of $927,000.

- A preliminary investigation of the student loan office of a small college in Dallas, Texas was begun in early 1974 after an audit indicated irregularities in that office. After determining fraud indicia and consulting with the U. S. Attorney, it was agreed that, because of the lack

of investigative resources (two agents were assigned to the thirteen States of Regions IV and VI), the case would be referred to the FBI. This joint OIG investigative/FBI effort resulted in seventeen employees of the college being convicted for various Federal violations. This led to an exhaustive audit of Federal funds granted to the college over a five-year period and ultimately led to the indictment and conviction in 1980 of the former President, Vice President and Business Manager of the college for unlawful conversion of Federal funds.

- An ongoing three-year OIG/State investigation in Massachusetts of the defrauding of Federal/State vocational education funds has, to date, resulted in 17 convictions as well as fines and restitutions amounting to $399,000.

- OIG investigators reviewed the fiscal records of the owner of three beauty schools in California for civil trial under the False Claims Act. A United States Magistrate awarded the U. S. Government $1,240,000 and an additional $54,645 was recovered.

These cases have been transferred to the Department of Education, Office of the Inspector General.

REVIEW AND ASSESSMENT ACTIVITIES

Migrant and Seasonal Farmworkers Services

The purpose of this assessment was to examine the conditions under which farmworkers live and work; their experiences in obtaining health, education, and social services; and the extent to which HHS programs are serving this part of our population.

The assessment found that the migrant farmworkers population is rapidly becoming composed of Hispanics of Mexican heritage. The conditions under which they live and work are worsening. Accomplishments of HHS' special migrant programs have brought a better way of life to many farmworkers, yet vast numbers remain underserved or neglected.

The Secretary directed a number of actions including an initiative to insure eligible migrants are enrolled in Federal service programs and an effort to encourage the private sector to establish migrant day care programs.

Health and Social Services to Public Housing Residents

This assessment examined the delivery of HHS health and social services to public housing residents. The assessment findings

revealed that crime, both the reality and the fear, hinders service delivery, since many residents are afraid to leave the projects and some providers are afraid to enter. Although most health and social services are provided in or near projects, most residents are still unaware of the available services. Poor transportation and limited service quality make some services in effect unavailable.

The Secretary used the findings of this report in managing a Departmental operational objective on this subject.

Indochinese Refugees Assessment

With the increased resettlement of Indochinese Refugees in the U. S., the Secretary directed a management review and service delivery assessment to determine how the refugees are doing, how useful the voluntary agency resettlement efforts and HHS' current programs are, how well the "system" works and whether current programs can absorb large numbers of new refugees.

Most refugees were found to live in marginal circumstances: they speak little English, are trapped in the secondary job market or on welfare, and live in overcrowded, ghetto-like housing. Refugees have many needs which are not sufficiently met by the private sector or by HHS services, and there are significant State differences in the type and extent of services. The demand for English training far surpasses all other service needs. Health screening is rare, dental care spotty, and housing and transportation are major problems.

Numerous actions were taken by the Secretary to strengthen the program including: (1) an HHS Office of Refugee Resettlement, with a significantly increased staff, was created as the Department's focal point for all refugee matters, (2) HHS' proposed budget for FY 1980 earmarked a minimum $54 million for English language training--more than double the amount in Fiscal Year 1979, (3) the Secretary assigned a team of Public Health Service physicians to strengthen the health screening of U. S. bound refugees, and (4) special project funds were devoted to the creation or strengthening of community-based organizations to help refugees by coordinating multi-agency programs.

Civil Rights Enforcement

Activities assessed include those in health and human development programs with respect to complaint processing and referrals, compliance reviews, pre-grant reviews, training and technical assistance.

Because of past Office of Civil Rights (OCR) emphasis on compliance and enforcement activities in education, this assessment found the health and human development programs had been neglec-

ted. A lack of outreach, an indifferent public information program, and weak external coordination and technical assistance practices caused confusion about the OCR role. The OCR field staff criticized Headquarters OCR for sluggish policy development and dissemination, and delays in clearance of Letters of Findings for compliance reviews and complaint investigations.

The findings of this SDA were used by the Under Secretary to help direct a Departmental Task Force to improve the performance of programs with regard to civil rights.

Office of Human Development Services Staff Training

A Senate Appropriations Committee report accompanying the Supplemental Appropriations Bill for FY 1980 stated: "At the very least the Committee believes that management training programs within the Federal government should stress to managers at all levels the absolute importance of reducing and preventing fraud and waste."

In response to the Senate Appropriations Committee's suggestion a training program was developed. Investigators, auditors and systems analysts worked as a training team to increase the awareness and ability of regional Office of Human Development Services staff to minimize fraud, abuse and waste in program operations. Case examples from investigative and audit reports were used to illustrate vulnerabilities or "what went wrong" in the present systems and what corrective actions could be taken.

CHAPTER V

DEPARTMENT ADMINISTRATION

The Office of the Inspector General has taken a strong and continuing interest in improving the efficiency of Departmental management capabilities as well as eliminating fraud and abuse.

Audits, investigations, reviews and special initiatives were undertaken in these broad areas of Departmental management: contracts and grants, debt collection, regulations review, property and energy-related activities, and employee-related issues. This Chapter illustrates activities within each of these areas by providing descriptions of specific projects.

AUDIT ACTIVITIES

CONTRACT AND GRANT ACTIVITIES

Audit attention was devoted to evaluating the effectiveness of Departmental procurement planning. . .whether competition has been obtained. . .the adequacy of sole source procurement controls and. . .the use of price and cost analysis where warranted. Particular attention was given to reviewing consultant service contracts because of a prior Audit Agency report disclosing serious deficiencies in the contracting processes.

Our findings: about $100 million is spent annually on contracts to obtain technical assistance and evaluation services. Prior reviews have shown problems with this type of contract. In our ongoing audit, we are testing the adequacy of controls over the planning, approval, contracting, and reporting process. We are also checking on other contracts to determine whether any contained consultant service arrangements which circumvented the classification and reporting process, and whether the reliability of contracting data reported to the Federal Procurement Data System and the Congress was accurate.

Our tentative findings have shown that information reported to the Congress and internally within HHS on these contracts is not reliable. For example, we found at least $10 million in contracts were not properly classified as consultant services although they met all criteria. In addition, there were at least $1 million in other contracts which were

excluded from reporting in part because of ambiguities in the definition of consultant services. Although these errors did not cause the expenditure ceiling imposed by the Congress to be exceeded, the potential exists that the ceiling could be surpassed if there are other unidentified contracts which were misclassified.

We believe that improvements are needed in the administration and accountability of these contracts and in definitions of services to be provided to assure that they are properly classified and reported.

Improved Surveillance Needed Over Grantee Cash Withdrawals

An audit of the Department's Office of Federal Assistance Financing Systems (DFAFS) was conducted to determine whether proper controls were in place to prevent excess cash disbursements. DFAFS is the fiscal intermediary between HHS agencies awarding grants and contracts and the recipients of these funds. Current disbursements average about $31 billion annually.

In checking on the effectiveness of DFAFS procedures and recipients' accounting systems in limiting cash withdrawals to immediate needs, two problems surfaced:

- The recipients of these funds were drawing down more than their immediate needs--contrary to Federal requirements. For example, two recipients were found to have earned interest of about $900,000 by investing Federal funds that were in excess of their current needs.

- Although Federal monitoring of grantee withdrawals had been stepped-up, inadequate staffing precluded cyclical visits to grantee contractor sites to look into their cash management practices.

DFAFS agreed with our findings and advised that action would be taken to assign higher priority toward aligning cash withdrawals to larger recipients' accounts; to develop an automated recipient "dunning" letter process; to identify accounts with excess cash; to implement a pilot electronic fund transfer project for more timely transfer of funds; and to increase site visits to the extent feasible.

DEBT COLLECTION ACTIVITIES

Problems in Controlling and Monitoring Collection of Audit Disallowances

HHS' Principal Operating Components (POCs) are required to control and monitor the collection of sustained audit recommended disallowances. We reviewed systems in place at three components within the Department. At one, only $221,000 was properly recorded in its accounting records as receivable--of some 35 disallowances totalling $45.4 million (outstanding at the time of our review). Similarly, we found that the other two components omitted recording $32.3 million in disallowances and had not forwarded the necessary documents to its finance office for recording disallowances as receivables . . .accounts receivable were not being aged to identify delinquent accounts. . .followup actions on delinquent accounts were not being initiated. . .and reliable quarterly status reports were not being submitted to the Department as required.

Actions have been taken or initiated to correct these problems.

PROPERTY AND ENERGY RELATED ACTIVITIES

Controls Over Personal Property

Within the Washington metropolitan area, the Assistant Secretary for Management and Budget (ASMB) is responsible for surveillance and administration of the Department's inventory of personal property (currently valued at $140 million) and for developing and implementing adequate controls over Departmental acquisitions, storage and disposition of furniture.

Although ASMB established Department-wide policies for the management of personal property, these policies often were ignored. As a result, office items were needlessly purchased, inventory figures were not reliable and new, serviceable, and repairable items were not utilized but continued to be stored. We have estimated about $1 million could have been saved by filling furniture requirements from available stock and reducing storage facilities, thus accommodating only standby emergency levels. ASMB concurred with our findings and recommendations. They have initiated a number of steps to improve the management of personal property.

Energy Conservation in HHS Occupied Buildings

An audit identified many low or no cost measures that could be taken by the Department to minimize energy consumption. Some can be taken by all Department employees; others require specialized assistance of HHS or GSA building maintenance personnel. For example, auditors estimate that annual energy savings of about $800,000 could be saved by such measures as using lower wattage light bulbs and turning off individual heating/cooling units after working hours. Additional annual

savings of $930,000 could be achieved if funding were provided for retrofit projects such as installing heat recovery systems and using double glazing on windows.

EMPLOYEE-RELATED ISSUES

Payment of Employee Overtime

Auditors reviewed some $478,000 in overtime payments made to 146 employees in the Washington, D.C. area over a 10-month period. We found a number of instances where written overtime request and approval documents were either not used, or were not prepared in advance to insure that about $134,000 in overtime was justified and authorized. Similarly, time sheets and Administrative Time and Leave Records were not properly documented to support overtime payments of $123,000.

Similar conditions were previously reported by the Audit Agency and the General Accounting Office. The Assistant Secretary for Personnel Administration concurred with our findings and recommendations and has taken or initiated corrective action. At Secretary Schweiker's direction, we will re-survey this area.

INVESTIGATIVE ACTIVITIES

During CY 1980, 20 convictions for grantee and contractor fraud and 16 convictions of HHS employee fraud were obtained.

The Office of the Inspector General maintains a Hotline for individuals to anonymously report suspected cases of fraud and abuse. Trends and patterns of types of reported fraud and abuse, referral locations and dispositions of referrals are included in this Chapter.

Investigative activities also include special initiatives which seek to identify efficient means to detect those who defraud the Federal Government. One CY 1980 initiative, a joint HHS-Labor Department project, is described.

INSPECTOR GENERAL'S HOTLINE

The management responsibility for the OIG Hotline was placed with the Office of Investigations in May of 1980. This was done to effect a more timely and coordinated response to incoming Hotline calls. A panel composed of Office of Investigations, Audit and OIG management meet periodically to review, evaluate and assign Hotline referrals to the proper entities within and outside of HHS.

Following is a summary of Hotline complaints:

- Hotline Totals

  During CY 1980, the Hotline has received a total of 1,573 complaints, including:

  1,010 OIG Hotline calls
  96 OIG Hotline correspondence
  114 GAO Hotline referrals to OIG
  353 GAO Hotline referrals directly to the Social Security Administration

The General Accounting Office (GAO) complaints involve allegations such as welfare and disability fraud and programmatic abuses. All other complaints regarding employees and mismanagement are referred to the OIG Hotline Office.

The number of non-substantive complaints received has greatly decreased since a secretarial memorandum was distributed to all Department of Health and Human Services employees redefining the objectives of the Hotline.

- GAO Complaints

  Total cases referred to HHS 114

  Of this 114, 19 are closed and 95 pending. This figure does not include the direct referrals to the Social Security Administration from GAO. Complaints have been referred as follows:

		Pending
SSA	10	6
HCFA	39	39
AA/OI	9	3
OHDS	22	22
PHS	30	25
OS	3	--
OCR	1	--
TOTAL	114	95

Trends and Patterns

Disability/welfare fraud	14
Waste/mismanagement	22
Grants/contracts	29
Medicare/Medicaid fraud	30
Time/attendance/travel	6
Other	13
TOTAL	114

SUMMARY OF OIG HOTLINE CALLS AND DISPOSITIONS
BY MAJOR DEPARTMENT COMPONENT
AS OF DECEMBER 31, 1980

ACTION	AA/OI	PHS	SSA	OHD	HCFA	OS	OCR	TOTALS
Closed after necessary action	12	69	87	-0-	13	15	3	199
Under Review awaiting final determination	20	1	21	10	4	2	-0-	58
Hold, awaiting further information	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Totals	32	70	108	10	17	17	3	257

SUMMARY OF OIG HOTLINE CORRESPONDENCE AND DISPOSITION
BY MAJOR DEPARTMENT COMPONENT
AS OF DECEMBER 31, 1980

ACTION	AA/OI	PHS	SSA	OHD	HCFA	OS	OCR	TOTALS
Closed after necessary action	4	8	7	-0-	-0-	4	2	25
Under review awaiting final determination	-0-	10	11	-0-	-0-	-0-	-0-	21
Hold, awaiting further information	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
Totals	4	18	18	-0-	-0-	4	2	46

Complaints Made by Government Employees and Private Citizens:

Private citizens	98
Government employees	16
TOTAL	114

PROJECT FECA (FEDERAL EMPLOYEES COMPENSATION ACT)

Project FECA is an on-going investigation designed to identify beneficiaries of the Federal Employees Compensation Act who are concealing employment while receiving compensation benefits. The Office of Investigations is coordinating reviews of files of possible violators with six other Federal agencies in cooperation with the U.S. Department of Labor. During CY 1980, the project was conducted on a pilot basis in the Atlanta region. Five cases have been opened thus far.

REVIEW AND ASSESSMENT ACTIVITIES

Year-End Spending

The Office of Inspector General was asked to examine the effect of a Secretarial policy aimed at reducing hasty year-end spending on contracts. Agency programs that do not plan their support activities find that as the end of a fiscal year approaches they have unspent money that will be returned to the U.S. Treasury if they do not act to award it.

In the past, a significant amount of the year's contracting activity occurred in the last quarter. For example, 64 percent of HHS' total procurement budget was obligated in the fourth quarter of 1978. In FY 1980, agencies were required to spread their contract-making evenly throughout the year. The scheduling improvement resulted in FY 1980 fourth quarter awards being just under 30 percent.

Cost Disclosure for Consultant Contracts

All consultant contracts are required to contain cost disclosures. This measure was intended to facilitate review of consultant services contracts. We conducted a review of the Department's consultant services contracts which revealed that 98 percent of consultant service contracts from the most recent year for which complete files were available were not in compliance with the requirements.

Based on our review, we made a number of recommendations to correct the problem. Corrective action is under way.

Debt Collection Practices in Selected Public Health Service Loan Scholarship and Award Programs

A review was made of the payback provisions for selected Public Health (PHS) student loan, award and scholarship programs, as well as the Department's current claims and collections process to recoup debts owed to these programs.

Early into the review, we found that each of these programs--except for the student loans--were begun in the mid-seventies and are just beginning to feel the surge of individual debtors whose debts are coming due, and who are either unable or unwilling to meet their obligations. With high interest rates and major financial commitments having been made to meet the rising costs of tuition, we felt that debts owed to the Federal government for these programs could become quite significant in the not too distant future.

Finally, we looked briefly into the student loan programs and found that procedures did not exist to provide adequate management oversight or control of problem schools, nor an assessment of the debt collection practices in place at the school level.

We made recommendations as follows:

- Develop Departmental policies and procedures for debt collection for the Public Health Service (PHS) programs in general, and the targeted programs in particular;
- Explore additional service options for the National Health Service Corps and the Indian Health Service Corps scholarship programs so as to prevent and reduce future defaults;
- Develop necessary debt collection practices for the student loan programs as appropriate.

All recommendations were concurred with by the Public Health Service and are now in varying stages of implementation. A related report--the Debt Collection Project--was prepared by the Assistant Secretary for Management and Budget for the President's Management Improvement Council. It incorporated the OIG recommendations on debt management activities for PHS as well as the Department. The OIG is working closely with ASMB to develop and implement debt management activities across the Department's programs.

Regulations Review

Review of Departmental regulations is an important function of the Office of the Inspector General. During CY 1980, nearly

200 proposed and final regulations were reviewed. Particular attention is given to insuring that regulations are:

- Consistent with the OIG's mandate to reduce program vulnerabilities to fraud, abuse or waste; and
- Possess standards to insure accountability, enforcement capability, and compatibility with related Departmental programs.

In addition to the review of proposed and final regulations, we often assist in the developmental phase. This helps to insure initial attention is paid to eliminating vulnerabilities to fraud and abuse.

Computerized Multiple Fraud Detection Systems (CFAD)

The Office of Inspector General developed the CFAD System in 1978 to explore and detect fraud and abuse in publicly financed benefit payment programs. This system was successfully applied to student financial assistance recipients. Now it will be used to identify individuals or entities using false identities to receive public assistance through a fiscal intermediary.

Files of individuals receiving Aid to Families with Dependent Children (AFDC) benefits or Medicaid benefits will be analyzed under computer scans by participating States. Some States and municipalities are now conducting similar pilot projects in AFDC and Medicaid programs. For example, the State of New York is verifying non-issued Social Security numbers within their recipient population. The Social Security Administration recently funded a proposal from the Sacramento County Department of Public Welfare in California to explore and develop for its own use a computerized system to detect and prevent multiple aid fraud.

Management Oversight Review (MOR)

A MOR Program review of the Bureau of Hearing and Appeals (BHA), of the Social Security Administration (SSA), has been completed at the request of BHA. Some of the significant findings requiring action for management improvement were:

- The lack of positive management action in identifying and correcting administrative deficiencies;
- The organizational structure of Hearing Offices appeared artificial and often counterproductive; and

- The inconsistent application of rules and regulations within the organizational units of the Hearing Office.

As a result of this review, corrective action is under way.

APPENDIX A

AUDIT REPORTS ISSUED ON HHS PROGRAMS

CALENDAR YEAR 1980

AUDIT AREA	AUDIT AGENCY REVIEWS		NON-FEDERAL REVIEWS		TOTAL REVIEWS	
HEALTH	NO. OF REPORTS	RECOMMENDED FINANCIAL ADJUSTMENTS MILLIONS	NO. OF REPORTS	RECOMMENDED FINANCIAL ADJUSTMENTS MILLIONS	NO. OF REPORTS	RECOMMENDED FINANCIAL ADJUSTMENTS MILLIONS
Medicaid	74	$ 14.7	14	$ 1.6	88	$ 16.3
Medicare	55	10.9	44	4.7	99	15.6
1864-1902 State Cert. of Health Facilities	5	.6	5	-0-	10	.6
Professional Standards Review Organizations	42	.7	169	1.3	211	2.0
Health Maintenance Organizations	7	.1	11	-0-	18	.1
OTHER	54	2.0	268	.7	322	2.7
AREA TOTAL	237	29.0	511	8.3	748	37.3
INCOME MAINTENANCE AND ASSISTANCE						
Public Assistance	34	11.5	15	2.3	49	13.8
SSI	11	2.5	9	.1	20	2.6
TITLE II	8	.4	13	.2	21	.6
AREA TOTAL	53	14.4	37	2.6	90	17.0
HUMAN SERVICES AND INSTITUTIONS OF HIGHER EDUCATION						
Colleges and Non-Profit Organizations	493	5.7	363	2.0	856	7.7
Head Start	7	-0-	1,365	11.6	1,372	11.6
TITLE XX	21	3.2	4	-0-	25	3.2
Aging	7	.1	33	-0-	40	.1
Native Americans	4	.1	212	1.0	216	1.1
AREA TOTAL	532	9.1	1,977	14.6	2,509	23.7
HHS ADMINISTRATION						
Grants and Contracts	26	.4	19	.1	45	.5
Administration	70	.1	6	-0-	76	.1
Other	214	.9	195	.2	409	1.1
AREA TOTAL	310	1.4	220	.3	530	1.7
TOTAL	1,132	$ 53.9	2,745	$ 25.8	3,877	$ 79.7

ACCEPTANCE OF AUDIT ADJUSTMENTS ON
HHS PROGRAMS - CALENDAR YEAR 1980

AUDIT AREA	AUDIT AGENCY REPORTS		NON-FEDERAL AUDITS		TOTAL REVIEWS	
HEALTH	NO. OF REPORTS	CONCURRENCES MILLIONS	NO. OF REPORTS	CONCURRENCES MILLIONS	NO. OF REPORTS	CONCURRENCES MILLIONS
Medicaid	44	65.8	4	1.1	48	66.9
Medicare	58	11.5	9	1.2	67	12.7
1864-1902 State Cert. of Hlth. Facs.	8	1.1	2		10	1.1
Prof. Standards Review Organizations	4		22	.1	26	.1
Health Maintenance Organizations	1		0		1	
Other	44	6.3	9	.1	53	6.4
Area Total	159	84.7	46	2.5	205	87.2
INCOME MAINTENANCE AND ASSISTANCE						
Public Assistance	38	18.8	0	0	38	18.8
SSI	9	.8	1	.1	10	.9
Title II	5	.4	3	.9	8	1.3
Area Total	52	20.0	4	1.0	56	21.0
HUMAN SERVICES AND INSTITUTIONS OF HIGHER EDUCATION						
Colleges and Non-Profit Orgs.	118	6.2	19	.1	137	6.3
Head Start	2	0	300	4.9	302	4.9
Title XX	15	3.1	1	.2	16	3.3
Native Americans	2	.0	78	.5	80	.5
Area Total	137	9.3	398	5.7	535	15.0
HHS ADMINISTRATION						
Grants	21	.7	2	.2	23	.9
Administration	3	.0	0	.1	3	.9
Other	50	2.0	13	.3	63	1.5
Area Total	74	2.7	15	.6	89	3.3
TOTAL	422	116.7	463	9.8	885	126.5

TOTAL AUDIT REVIEWS - CY 1980

H E A L T H P R O G R A M S

Type of Finding	MEDICAID		MEDICARE		1864-1902		PSROs		HMOs		OTHER		TOTAL	
	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)
Regulatory, Policy or Procedural Violation	13	$ .1	46	$ 2.2	4	$	86	$ .1	5	$	55	$ .1	209	$ 2.5
Overstated Claims	33	11.8	88	7.9	6	.5	52	.8	1	.1	36	.3	216	21.4
Ineligible Claims	18	3.8	114	5.1	1	.1	52	.7	4		50	1.7	239	11.4
Unsupported Claims	9	.4	29	.3	5		33	.3	4		36	.4	116	1.4
Accounting/Record Keeping Deficiencies	11	(.2)	23		3		111	.1	6		206		360	(.1)
Internal Control Deficiencies	23	.1	12		4		107		7		164		317	.1
Administrative Deficiencies	50	.1	22	.1	9		49		3		104	.1	237	.3
Overhead Rate Studies	1	.2	2				3				2		8	.2
Matching Fund Requirements not Met	1										9	.1	10	.1
Claims Processing Deficiencies	18		8		1		7				19		53	
Total	177	$16.3	344	$15.6	33	$ .6	500	$ 2.0	30	$ .1	681	$ 2.7	1765	$37.3

AUDIT AGENCY REVIEWS - CY 1980

HEALTH PROGRAMS

Type of Finding	MEDICAID		MEDICARE		1864-1902		PSROs		HMOs		OTHER		TOTAL	
	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)
Regulatory, Policy or Procedural Violation	10	$ .1	17	$ 1.2	1	$	8	$	2	$	12	$	50	$ 1.3
Overstated Claims	26	11.0	48	6.7	3	.5	22	.5	1	.1	19	.1	119	18.9
Ineligible Claims	16	3.2	46	2.8	1	.1	17	.1			21	1.4	101	7.6
Unsupported Claims	8	.4	12	.1			12	.1	1		6	.4	39	1.0
Accounting/Record Keeping Deficiencies	8	(.2)	10				2		1		6		27	(.2)
Internal Control Deficiencies	19	.1	3		1		3		1		4		31	.1
Administrative Deficiencies	38	.1	15	.1	2		2		1		4	.1	62	.3
Overhead Rate Studies							2				1		3	
Matching Fund Requirements not Met	1												1	
Claims Processing Deficiencies	13		3								3		19	
TOTAL	139	$14.7	154	$10.9	8	$ .6	68	$ .7	7	$ .1	76	$ 2.0	452	$29.0

NON-FEDERAL REVIEWS - CY 1980

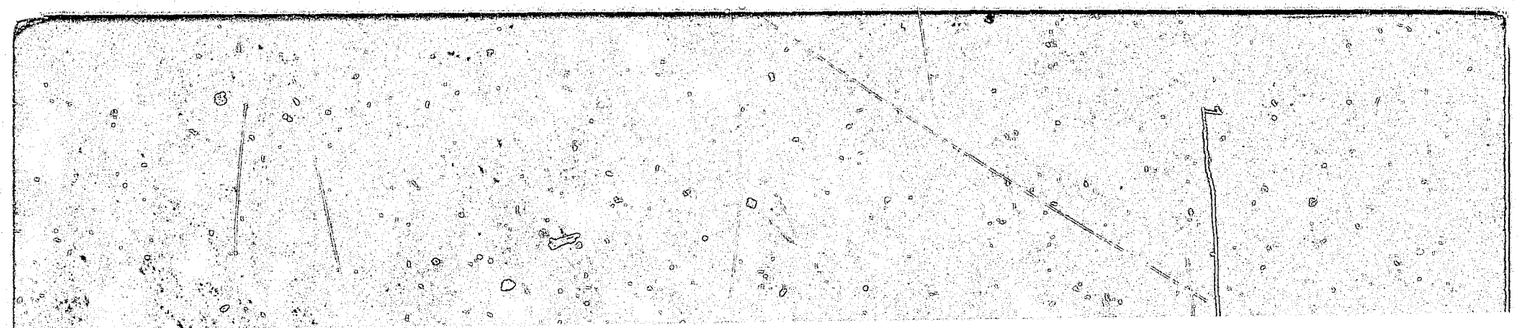
H E A L T H P R O G R A M S

Type of Finding	MEDICAID No. of Findings	MEDICAID Amt. (Millions)	MEDICARE No. of Findings	MEDICARE Amt. (Millions)	1864-1902 No. of Findings	1864-1902 Amt. (Millions)	PSROs No. of Findings	PSROs Amt. (Millions)	HMOs No. of Findings	HMOs Amt. (Millions)	OTHER No. of Findings	OTHER Amt. (Millions)	TOTAL No. of Findings	TOTAL Amt. (Millions)
Regulatory, Policy or Procedural Violation	3	$	29	$ 1.0	3	$ -0-	78	$ .1	3	$ -0-	43	$ .1	159	$ 1.2
Overstated Claims	7	.8	40	1.2	3		30	.3			17	.2	97	2.5
Ineligible Claims	2	.6	68	2.3			35	.6	4		29	.3	138	3.8
Unsupported Claims	1		17	.2	5		21	.2	3		30		77	.4
Accounting/Record Keeping Deficiencies	3		13		3		109	.1	5		200		333	.1
Internal Control Deficiencies	4		9		3		104		6		160		286	
Administrative Deficiencies	12		7		7		47		2		100		175	
Overhead Rate Studies	1	.2	2				1				1		5	.2
Matching Fund Requirements not Met											9	.1	9	.1
Claims Processing Deficiencies	5		5		1		7				16		34	
Total	38	$ 1.6	190	$ 4.7	25	$ -0-	432	$ 1.3	23	$ -0-	605	$ .7	1313	$ 8.3

TOTAL AUDIT REVIEWS - CY 1980

INCOME MAINTENANCE AND ASSISTANCE PROGRAMS

TYPE OF FINDING	PUBLIC ASSISTANCE															
	Administrative Cost		Assistance Payments		Child Welfare		SSI		TITLE II		TOTAL	
	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)
Regulatory, Policy or Procedural Violation	11	$ .6	6	$ .3	1	$ -0-		$	10	$	28	$ .9
Overstated Claims	31	3.6	11	3.1	3		17	.2	18	.2	80	7.1
Ineligible Claims	10	6.0	8	.2	3		10	2.4	3		34	8.6
Unsupported Claims	1		2		1		8		4	.1	16	.1
Accounting/Record Keeping Deficiencies	5		1				4		16		26	
Internal Control Deficiencies	6		7		4		1		11		29	
Administrative Deficiencies	6		11		3				9		29	
Overhead Rate Studies	1				1		2		2	.3	6	.3
Matching Fund Requirements not Met												
Claims Processing Deficiencies			1		1				2		4	
TOTAL	71	$ 10.2	47	$ 3.6	17	$ -0-	42	$ 2.6	75	$ .6	252	$ 17.0



AUDIT AGENCY REVIEWS - CY 1980

INCOME MAINTENANCE AND ASSISTANCE PROGRAMS

	PUBLIC ASSISTANCE													
	Administrative Cost		Assistance Payments		Child Welfare		SSI		TITLE II		TOTAL	
TYPE OF FINDING	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)
Regulatory, Policy or Procedural Violation	3	$ .2	5	$ .3		$ -0-		$	3	$	11	$ .5
Overstated Claims	25	2.8	9	3.1			6	.1	8	.1	48	6.1
Ineligible Claims	8	4.9	8	.2			7	2.4			23	7.5
Unsupported Claims			2				3		1		6	
Accounting/Record Keeping Deficiencies	3		1				2		1		7	
Internal Control Deficiencies	2		5				1		3		11	
Administrative Deficiencies	4		5						7		16	
Overhead Rate Studies									1	.3	1	.3
Matching Fund Requirements not Met												
Claims Processing Deficiencies			1						1		2	
TOTAL	45	$ 7.9	36	$ 3.6		$ -0-	19	$ 2.5	25	$ .4	125	$ 14.4

NON-FEDERAL REVIEWS - CY 1980

INCOME MAINTENANCE & ASSISTANCE PROGRAMS

TYPE OF FINDING	PUBLIC ASSISTANCE								SSI		TITLE II		TOTAL	
	Administrative Cost		Assistance Payments		Child Welfare									
	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)			No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)
Regulatory, Policy or Procedural Violation	8	$ .4	1	$ -0-	1	$ -0-				$	7	$	17	$ .4
Overstated Claims	6	.8	2		3				11	.1	10	.1	32	1.0
Ineligible Claims	2	1.1			3				3		3		11	1.1
Unsupported Claims	1				1				5		3	.1	10	.1
Accounting/Record Keeping Deficiencies	2								2		15		19	
Internal Control Deficiencies	4		2		4						8		18	
Administrative	2		6		3						2		13	
Overhead Rate Studies	1				1				2		1		5	
Matching Fund Requirements not Met														
Claims Processing Deficiencies					1						1		2	
TOTAL	26	$ 2.3	11	$ -0-	17	$ -0-			23	$ .1	50	$ .2	127	$ 2.6

TOTAL AUDIT REVIEWS - CY 1980

HUMAN SERVICES AND INSTITUTIONS OF HIGHER EDUCATION

TYPE OF FINDING	Research Training & Development		Head Start		Title XX		Aging		Native American		Total	
	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)
Regulatory, Policy or Procedural Violation	83	$ 1.3	678	$ 2.3	8	$ .1	14	$	95	$ .2	878	$ 3.9
Overstated Claims	199	2.6	264	2.2	8	2.2	3	.1	46	.2	520	7.3
Ineligible Claims	186	1.8	360	3.5	5	.9	4		79	.3	634	6.5
Unsupported Claims	111	1.2	138	.4	1		5		47	.2	302	1.8
Accounting/Record Keeping Deficiencies	102	.2	1141	.3	2		28		180		1453	.5
Internal Control Deficiencies	73	.1	544	.2	6		15		110		748	.3
Administrative Deficiencies	40		471	.4	15		23		53		602	.4
Overhead Rate Studies	14	.2	11	.1					2		27	.3
Matching Fund Requirements not Met	5	.3	235	2.1			4		28	.2	272	2.6
Claims Processing Deficiencies	12		72	.1	1		4		15		104	.1
Total	825	$ 7.7	3914	$11.6	46	$ 3.2	100	$ .1	655	$ 1.1	5540	$23.7

AUDIT AGENCY REVIEWS - CY 1980

HUMAN SERVICES AND INSTITUTIONS

OF HIGHER EDUCATION

TYPE OF FINDING	Research Training & Development		Head Start		Title XX		Aging		Native American		Total	
	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)
Regulatory, Policy or Procedural Violation	44	$ .8	1	$ -0-	8	$ .1	5	$	2	$	60	$ .9
Overstated Claims	168	2.1			8	2.2	3	.1	2	.1	181	4.5
Ineligible Claims	144	1.6			5	.9	1				150	2.5
Unsupported Claims	80	.6					3		1		84	.6
Accounting/Record Keeping Deficiencies	24	.2	2		2		3		2		33	.2
Internal Control Deficiencies	13	.1			4		2		1		20	.1
Administrative Deficiencies	10				8		1		1		20	
Overhead Rate Studies	6	.1									6	.1
Matching Fund Requirements not Met	3	.2									3	.2
Claims Processing Deficiencies	3						1				4	
Total	495	$ 5.7	3	$ -0-	35	$ 3.2	19	$ .1	9	$ .1	561	$ 9.1

NON-FEDERAL REVIEWS - CY 1980

HUMAN SERVICES AND INSTITUTIONS OF HIGHER EDUCATION

TYPE OF FINDING	Research Training & Development		Head Start		Title XX		Aging		Native American		Total	
	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)	No. of Findings	Amt. lions)
Regulatory, Policy or Procedural Violation	39	$ .5	677	$ 2.2		$ -0-	9	$ -0-	93	$ .2	818	$ 2.9
Overstated Claims	31	.5	264	2.2					44	.1	339	2.8
Ineligible Claims	42	.2	360	3.5			3		79	.3	484	4.0
Unsupported Claims	31	.6	138	.4	1		2		46	.2	218	1.2
Accounting/Record Keeping Deficiencies	78		1139	.3			25		178		1420	.3
Internal Control Deficiencies	60		544	.2	2		13		109		728	.2
Administrative Deficiencies	30		471	.4	7		22		52		582	.4
Overhead Rate Studies	8	.1	11	.1					2		21	.2
Matching Fund Requirements not Met	2	.1	235	2.1			4		28	.2	269	2.4
Claims Processing Deficiencies	9		72	.2	1		3		15		100	.2
Total	330	$ 2.0	3911	$11.6	11	$ -0-	81	$ -0-	646	$ 1.0	4979	$14.6

CONTINUED

1 OF 2

TOTAL AUDIT REVIEWS - CY 1980

H H S A D M I N I S T R A T I O N

TYPE OF FINDING	Grants and Contracts No. of Findings	Grants and Contracts Amt. (Millions)	Admin. No. of Findings	Admin. Amt. (Millions)	Other No. of Findings	Other Amt. (Millions)	Total No. of Findings	Total Amt. (Millions)
Regulatory, Policy or Procedural Violation	15	$ .1	11	$	65	$ .1	91	$ .2
Overstated Claims	11	.1	3	.1	5	.8	19	1.0
Ineligible Claims	12	.3			12	.2	24	.5
Unsupported Claims	4		2		3		9	
Accounting/Record Keeping Deficiencies	15		6		24		45	
Internal Control Deficiencies	6		16		29		51	
Administrative Deficiencies	14		21		30		65	
Overhead Rate Studies	1				9		10	
Matching Fund Requirements not Met	1				3		4	
Claims Processing Deficiencies	6		3		55		64	
Total	85	$ .5	62	$ .1	235	$ 1.1	382	$ 1.7

AUDIT AGENCY REVIEWS - CY 1980

H H S A D M I N I S T R A T I O N

TYPE OF FINDING	Grants and Contracts		Admin.		Other		Total	
	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)	No. of Findings	Amt. (Millions)
Regulatory, Policy or Procedural Violation	7	$	11	$	55	$	73	$
Overstated Claims	11	.1	3	.1	4	.8	18	1.0
Ineligible Claims	8	.3			9	.1	17	.4
Unsupported Claims	3		2		1		6	
Accounting/Record Keeping Deficiencies	3		6		8		17	
Internal Control Deficiencies	3		15		8		26	
Administrative Deficiencies	10		20		18		48	
Overhead Rate Studies					8		8	
Matching Fund Requirements not Met					2		2	
Claims Processing Deficiencies	3		3		1		7	
Total	48	$ .4	60	$ .1	114	$ .9	222	$ 1.4

NON-FEDERAL REVIEWS - CY 1980

H H S A D M I N I S T R A T I O N

TYPE OF FINDING	Grants and Contracts No. of Findings	Grants and Contracts Amt. (Millions)	Admin. No. of Findings	Admin. Amt. (Millions)	Other No. of Findings	Other Amt. (Millions)	Total No. of Findings	Total Amt. (Millions)
Regulatory, Policy or Procedural Violation	8	$ .1		$ -0-	10	$ .1	18	$ .2
Overstated Claims					1		1	
Ineligible Claims	4				3	.1	7	.1
Unsupported Claims	1				2		3	
Accounting/Record Keeping Deficiencies	12				16		28	
Internal Control Deficiencies	3		1		21		25	
Administrative Deficiencies	4		1		12		17	
Overhead Rate Studies	1				1		2	
Matching Fund Requirements not Met	1				1		2	
Claims Processing Deficiencies	3				54		57	
Total	37	$ .1	2	$ -0-	121	$ .2	160	$ .3

A

APPENDIX B

OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
1	CN	DPM	Billing for services not rendered.	7/80			7/80	Closed
2	CN	AMB	Billing for services not rendered.	4/80			4/80	Closed
3	MA	MD	Billing for services not rendered.	11/80			11/80	Closed
4	CN	AMB	Billing for services not rendered.	5/80			5/80	Closed
5	NJ	MD	Billing for services not rendered.	2/80			2/80	Closed
6	S-NY	MD	Billing for services not rendered.	1/80			1/80	Closed
7	E-NY	MD	Duplicate billings.	10/80			10/80	Closed
8	S-NY	DPM	Billing for services not rendered.	3/80			3/80	Closed
9	NJ	SNF	Kickbacks.	2/80				Pending Decision
10	W-NY	POD	Billing for services not	5/80			5/80	Closed
11	E-NY	MD	Billing for services not	8/80				Pending Decision
12	WDC	MD	Billing for services not	5/80			5/80	Closed
13	EPA	AMB	Billing for services not	4/80			4/80	Closed
14	MPA	PHAR	Billing for drugs not supplied.	4/80			4/80	Closed

OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
15	S-FL	MD	Billing for services not rendered.	10/80			10/80	Closed
16	S-FL	DPM	Billing for services not rendered.	10/80			10/80	Closed
17	M-NC	MD	Misreprenting services.	9/80			9/80	Pending Civil
18	E-TN	HHA	False cost reporting.	3/80			4/80	Closed
19	M-TN	SNF	False cost reporting.	7/80				Pending Decision
20	N-IL	AMB	Billing for services not	2/80				Pending Decision
21	N-IN	MD	False claims.	11/80			11/80	Closed
22	N-IL	DPM	Billing for services not rendered.	5/80	10/80	12/80		Closed
23	CO	AMB	False claims.	12/80			12/80	Closed
24	W-OK	SNF	False cost reporting.	4/80			4/80	Closed
25	W-OK	SNF	False cost reporting.	3/80	9/80	9/80		Closed
26	E-AK	DME	Kickbacks.	6/80			6/80	Administrative
27	E-MO	SNF	Perjury.	1/80	10/80*		10/80	Pending Civil
28	NE	HOSP	False claims.	5/80			8/80	Closed

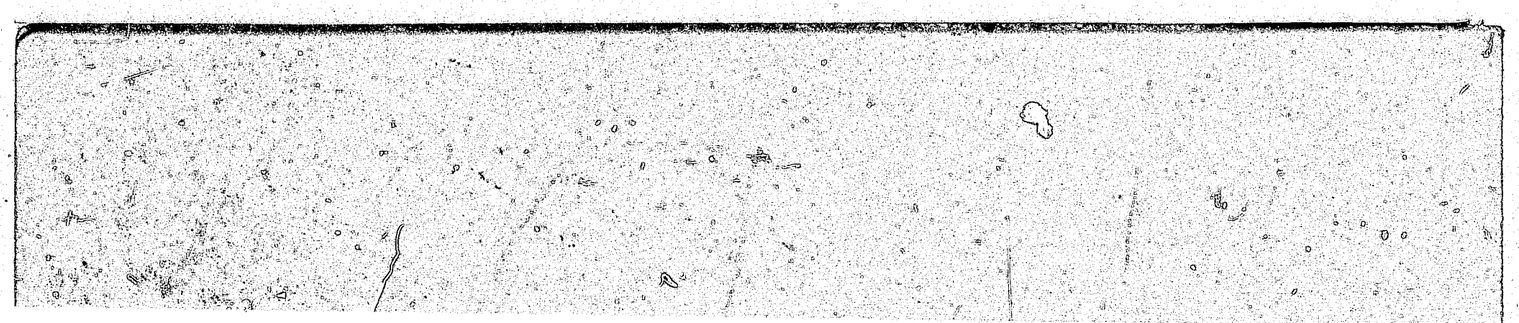
OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
29	CO	LAB	Billing for services not rendered.	3/80			3/80	Closed
30	UT	MD	Billing for services not rendered.	4/80			4/80	Closed
31	CO	POD	Billing for services not rendered.	4/80			4/80	Closed
32	CO	DPM	False claims.	4/80			4/80	Closed
33	SD	MD	Billing for services not rendered.	7/80			7/80	Closed
34	CO	MD	Billing for services not rendered.	4/80	6/80	8/80		Closed
35	CO	DPM	Billing for services not rendered.	4/80			5/80	Closed
36	MT	HOSP	Billing for services not rendered.	4/80			4/80	Closed
37	C-CA	LAB	Billing for services not rendered.	6/80			7/80	Closed
38	C-CA	DME	Billing for services not rendered.	8/80			8/80	Closed
39	W-WA	MD	Billing for services not rendered.	7/80			7/80	Closed
40	E-WA	SNF	Billing for services not rendered.	1/80			1/80	Closed
41	W-WA	AMB	Billing for services not rendered.	4/80			4/80	State Conviction (10/80)

Office of Program Integrity (HCFA)
Cases Referred to the U.S. Attorneys
Calendar Year 1980

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
1	Massachusetts	BENE	False claims.	1/80				Pending Decision
2	Masachusetts	LAB	False claims.	1/80				Pending Decision
3	Massachusetts	LAB	False claims.	1/80				Pending Decision
4	Connecticut	POD	False claims.	3/80				Pending Decision
5	Newark, NJ	CLINIC	Duplicate billing.	1/4/80			1/4/80	
6	Newark, NJ	MDS	Billing for services not rendered.	2/21/80			2/21/80	
7	New York	AMB	Billing for services not rendered. Misrepresenting services.	6/5/80			6/5/80	
8	New York	DME	Billing for services not rendered.	5/17/80			5/17/80	
9	New York	AMB	Misrepresenting services.	5/27/80			5/27/80	
10	New York	POD	Billing for services not rendered.	4/11/80			4/11/80	
11	New York	MD	Billing for serivces not rendered.	1/31/80			1/31/80	
12	New York	MD	Billing for services not rendered.	11/21/80			11/21/80	
13	New York	AMB	Duplicate billing.	9/29/80			9/29/80	
14	New York	DME	Billing for services not rendered.	9/29/80			9/29/80	



Office of Program Integrity (HCFA)
Cases Referred to the U.S. Attorneys
Calendar Year 1980

Case #	Judicial District	Class	Nature of Offense	Date Referred to U.S. Attorney	Date of Indictment	Date of Conviction	Date of Declination	Status Pending Further Investigation
15	New York	AMB	Misrepresenting services.	9/2/80			9/2/80	
16	New York N-District	MD	Billing for services not rendered.	5/15/80			5/15/80	
17	New York W-District	DME	Billing for services not rendered.	2/1/80			2/1/80	
18	New York W-District	MD	Billing for services not rendered.	2/28/80			2/28/80	
19	Newark, NJ	MD	Misrepresenting services.	5/22/80			5/22/80	
20	Newark, NJ	MD	Billing for services not rendered.	5/22/80			5/22/80	
21	Tennessee	HOSP	False claims.	1/31/80			1/31/80	
22	S. Georgia	AMB	False claims.	6/27/80				Pending Decision
23	Georgia	BEN	False claims.	5/29/80				Pending Decision
24	S. Alabama	BENE	False claims.	12/16/80				Pending Decision
25	S. Alabama	BENE	False claims.	12/16/80				Pending Decision
26	N. Florida	BENE	False calims.	1/24/80			6/25/80	
27	Nebraska	HOSP	Duplicate billing.	5/27/80			8/19/80	
28	Kansas	DO	Misrepresenting services.	7/29/80			7/29/80	
29	E-Washington	MD	False claims.	2/12/80				Pending Decision

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END