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Compliance With Professional Standards by the HHS Inspector General

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The Honorable Richard P. Kusserow
Inspector General
Department of Health and
Human Services

Dear Mr. Kusserow:

This report summarizes the results of our review of the Office of Inspector General's compliance with professional standards. This is the sixth in a series of reviews planned for federal inspectors general and internal audit organizations.

The report contains recommendations to you in chapters 3 and 4. Please advise us of any further actions you take in implementing these recommendations.

We are sending copies of the report to the Director, Office of Management and Budget and to the Secretary of the Department of Health and Human Services. We are also sending copies to various congressional committees and to other interested parties.

Sincerely yours,

Frederick D. Wolf
Director

Executive Summary

Purpose

Statutory offices of inspectors general play an important role in preventing and detecting fraud and abuse and in promoting economy, efficiency, and effectiveness in federal programs and operations. Because of the importance attached to their work, GAO has initiated a series of reviews to assess the quality of the work performed by inspector general organizations. This is the sixth in GAO's series of quality assessment reviews and was designed to determine whether the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) performs its work in accordance with professional standards. GAO also evaluated aspects of the OIG's inspection function and examined the support for a majority of monetary accomplishments presented in two OIG semiannual reports.

Background

GAO reviewed the OIG's adherence to 23 audit and investigation standards. The standards include the Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, the President's Council on Integrity and Efficiency (PCIE) Quality Standards for Federal Offices of Inspector General, and the PCIE Quality Standards for Investigations. GAO assessed the OIG's compliance with standards by (1) evaluating the OIG's internal controls for ensuring adherence to professional standards, (2) reviewing a sample of recently completed audits and investigations and their supporting documentation, and (3) reviewing, testing, and evaluating other evidence of OIG compliance with the standards. GAO worked with OIG officials to judgmentally choose a sample of 18 completed audits and 12 closed investigations that would fairly reflect the size and diversity of the OIG's work. The term "satisfactory compliance" is used in the report to mean that GAO found adherence to professional standards in a substantial majority of situations tested and that the nature and significance of any instances of noncompliance did not adversely affect the integrity of the OIG's work.

Results in Brief

GAO concluded that the OIG satisfactorily complied with 18 of the 23 audit and investigation standards. Prompt corrective actions have been taken to address problems GAO identified in the OIG's satisfactory compliance with three audit standards: evidence, reporting, and quality assurance; and two investigation standards: management information and screening allegations. GAO also identified some improvements which were needed to help ensure the quality and integrity of the OIG's inspection function.

The accomplishments reported in the OIG's semiannual report to the Congress and the HHS Secretary are impressive and indicate that the OIG is having a significant impact on HHS operations. However, GAO found that the OIG needs to improve the quality controls for compiling the semiannual report to ensure its accuracy and integrity. The report presentation of monetary accomplishments also needs improvement.

Principal Findings

Assessment of the Audit Function

GAO found that the OIG audit function satisfactorily complied with 9 of the 12 audit standards. However, corrective action was needed to bring the OIG into satisfactory compliance with the evidence, reporting, and quality assurance standards. GAO found that (1) auditors did not have sufficient evidence to fully support all findings and conclusions in 6 of 18 audit reports, (2) 6 audit reports did not have recommendations which flowed logically from the facts presented, (3) 7 audit reports did not accurately reflect the audits' scopes and objectives, and (4) the OIG's quality assurance program did not always provide reasonable assurance of adherence to prescribed standards, policies, and procedures for performing audits.

GAO found that eight audits did not adequately develop the causes of the underlying problems identified in the report, which contributed to the OIG's not satisfactorily complying with the evidence and reporting standards. GAO believes that not fully developing the causes of identified problems could lessen the effectiveness and utility of the OIG's work. (See chapter 2.)

Assessment of the Investigation Function

GAO found that the OIG investigation function satisfactorily complied with 9 of the 11 standards but that corrective action was needed to bring the OIG into satisfactory compliance with the information management and screening allegations standards. GAO found that data in the investigation function's management information system could not always be relied upon to produce accurate reports because the system did not accurately capture, correlate, and report data contained in the investigative case files.

In addition, GAO found that it took the OIG's hotline staff an average of 34 days to screen allegations of waste, mismanagement, fraud, and

abuse and to forward them for appropriate action. Based on prior work performed, GAO believes that allegations should be screened and forwarded within an average of 10 working days. GAO also found the OIG did not know the disposition of over 83 percent of the hotline cases sampled. (See chapter 3.)

Assessment of the Inspection Function

In the six inspection reports reviewed, GAO found that OIG inspection plans were well documented; however, improvements could be made in the areas of reporting and evidence which would enhance the accuracy and completeness of inspection reports. GAO found that (1) report recommendations in three of the six reports sampled did not flow logically from information presented in the report and (2) supporting documentation was not retained for all report statements. GAO also found that the inspection function's standards and procedures manual did not contain specific standards on the duties and responsibilities of its supervisors and that procedures for its quality assurance program were not fully implemented. (See chapter 4.)

Assessment of the OIG's Semiannual Report

GAO assessed the reported accomplishments in the two OIG semiannual reports submitted to the Congress for the periods ending September 30, 1986, and March 31, 1987. For these periods, the HHS OIG reported that $6.63 billion in monetary accomplishments resulted from its recommendations and that 1,026 criminal convictions were obtained against wrongdoers.

In the two semiannual reports, GAO found satisfactory support for 92 percent of the reported monetary accomplishments that it reviewed but did not find satisfactory support for 8 percent, or $554 million. GAO found that the controls the OIG had in place for the preparation of the semiannual report needed to be strengthened to ensure the report's accuracy and that the OIG could improve the report presentation of its monetary accomplishments. (See chapter 5.)

Recommendations

During the review, the IG took corrective actions in response to most of GAO's findings. Chapters 3 and 4 of this report contain recommendations to ensure better monitoring of the disposition of allegations and to improve the inspection function's quality assurance program.

Agency Comments

The HHS inspector general concurred with all of GAO's recommendations. He stated that the many changes made to his organization based on GAO's review will strengthen the OIG in meeting its statutory mission. He expressed concern, however, that the report does not accurately reflect the overall operation of his office and that an uninformed reader might conclude that the OIG is performing at a lower level of quality than is actually the case. In response to these concerns, GAO made a number of revisions to provide additional details and more clearly place the report's findings in perspective. GAO provides its evaluation of the OIG's specific comments in chapters 2, 3, 4, and 5 and appendix II.

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Abbreviations

AIGA	Assistant Inspector General for Audits
ASMB	Assistant Secretary for Management and Budget
CBO	Congressional Budget Office
CHC	community health center
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IG	inspector general
MMIS	Medicaid Management Information System
OA	Office of Audits
OAI	Office of Analysis and Inspections
OI	Office of Investigations
OIG	Office of Inspector General
OMB	Office of Management and Budget
PCIE	President's Council on Integrity and Efficiency
PHS	Public Health Service

Introduction

The government relies on the offices of inspectors general (OIGs) and other federal internal audit organizations to determine whether federal funds are handled properly and whether agencies are economically and efficiently achieving the purposes for which their programs were authorized and funded. In 1984, we initiated a series of "quality assessment reviews" of the OIGs' and other federal internal audit organizations' work. The first five OIG reviews were conducted at the Department of Commerce, the Department of Agriculture, the Environmental Protection Agency, the General Services Administration, and the Department of Transportation.

Our reviews were designed primarily to determine whether an OIG is performing work in compliance with generally accepted government auditing standards and other professional standards. Compliance with such standards provides users of OIG reports with greater assurance that the work was performed adequately and that the results of the work can be relied on for decision-making and oversight purposes. Noncompliance with these standards can result in unwarranted reliance on OIG reports or can cast doubts on the credibility of the OIG's efforts.

Mission and Organization of the Department of Health and Human Services' Office of Inspector General

Public Law 94-505, enacted October 15, 1976, as amended, (42 U.S.C. 3521-3527) established an OIG in the Department of Health, Education, and Welfare (subsequently renamed the Department of Health and Human Services). The President, with the advice and consent of the Senate, appoints the inspector general (IG), who directs the office, and the deputy inspector general, who serves as his principal assistant. At the Department of Health and Human Services (HHS), the IG is under the general supervision of and reports directly to the Secretary. The current IG, Richard P. Kusserow, took office on June 10, 1981.

Mission and Organization

The OIG mission is to (1) prevent and detect fraud and abuse and (2) promote economy and efficiency in the Department's programs and operations. The OIG accomplishes its mission primarily by conducting audits, investigations, and inspections of departmental activities.

The OIG carries out its mission through four major organizational units: the Office of Audit, Office of Investigations, Office of Analysis and Inspections, and the Administrative Office.

With the exception of the Administrative Office, each office is directed by an assistant inspector general. All office heads report directly to the

IG. There are eight regional inspectors general for audit, nine regional inspectors general for investigations, and eight regional inspectors general for analysis and inspections, all of whom report to the appropriate assistant inspector general. Figure 1.1 displays the OIG organization chart. As of September 30, 1987, the OIG had 1,204 staff members and a fiscal year 1987 budget of approximately $70 million with which to oversee the administration of HHS's $380 billion budget and the activities of its 124,522 employees.

Audits

The Office of Audit (OA) performs audits of HHS operations and activities. The audit activities encompass (1) health care financing issues involving both costs and patient care in the Medicare and Medicaid programs, (2) benefits and income maintenance programs of the Social Security Administration, (3) financial audit of the Social Security Trust Fund, (4) national health care and family support and social services programs, (5) design and operations audits of the Department's computer-based systems, which disperse over $300 billion annually to almost 100 million United States citizens, and (6) reviews of the management and efficiency of all HHS operations. The headquarters divisions provide technical direction and staff support for audit activities related to designated areas of HHS operations.

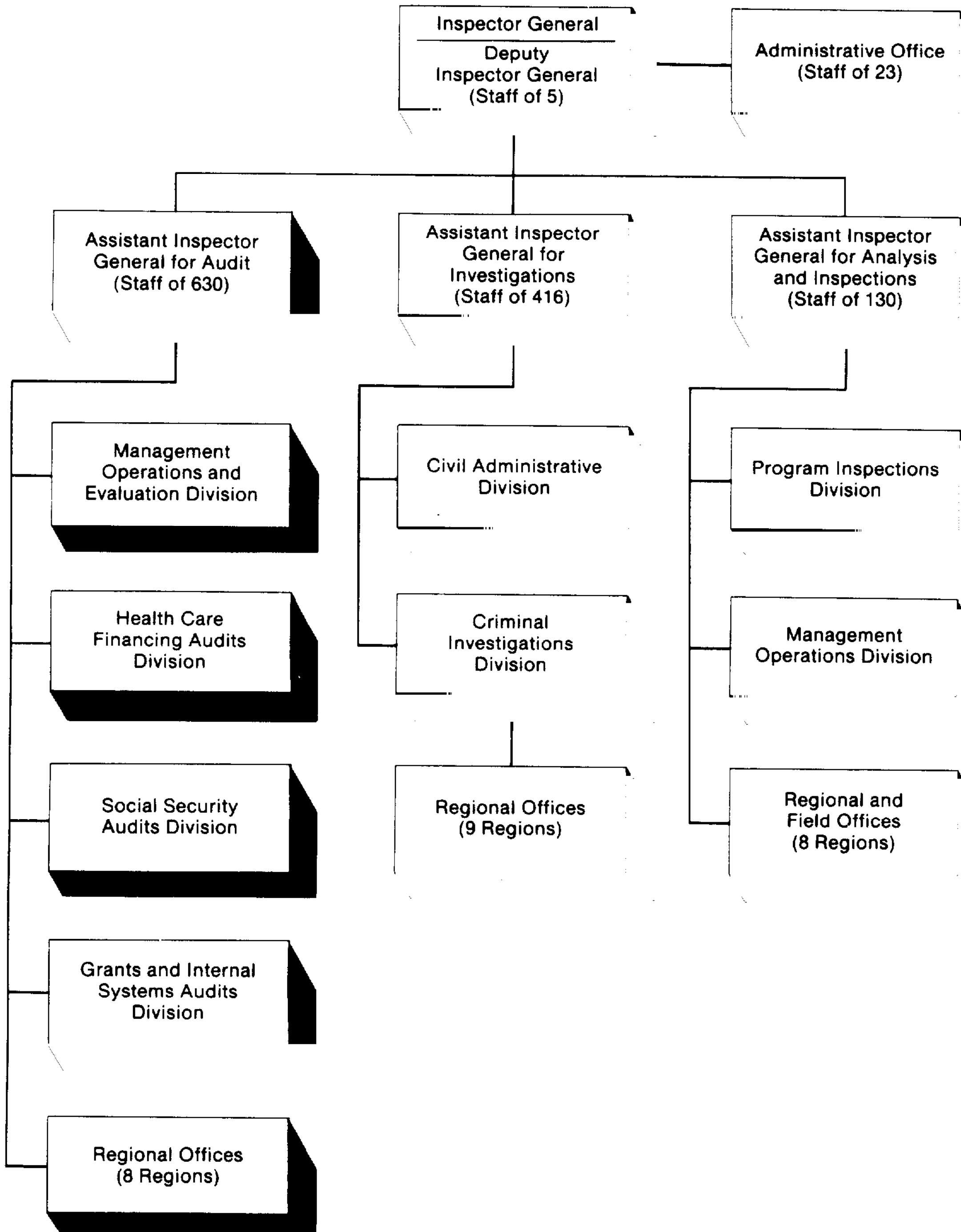
Investigations

The Office of Investigations (OI) carries out a comprehensive nationwide program for the detection and investigation of criminal, prohibited, or improper activities against HHS programs and activities by its employees, grantees, providers, physicians, or other individuals or groups. About 28 percent of OI's work is proactive, that is, work which is designed to prevent and detect unsuspected fraud in vulnerable programs and activities. The headquarters divisions mainly provide operational and technical support to the regions, identify and recommend areas for proactive work, and monitor investigative accomplishments.

Inspections

The Office of Analysis and Inspections (OAI) conducts program evaluations and policy studies of HHS programs. These evaluations and studies are national in scope and are designed to quickly review program policies and management practices in order to provide the IG with rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OAI's work covers a broad range of issues in the health care, social security, and family support

Figure 1.1: Department of Health and Human Services, Office of Inspector General Organization Chart



Source: Department of Health and Human Services, Office of Inspector General

areas. The headquarters divisions provide technical direction and staff support for the inspection activities.

Administration

The Administrative Office is the OIG's administrative support arm. Its executive officer serves as the IG's principal advisor on management and administrative activities. The Office manages and coordinates a variety of administrative functions, including resource planning and management, budgeting, personnel, training, correspondence, and records management.

Objectives, Scope, and Methodology

Our principal review objectives were to determine whether the HHS OIG was satisfactorily complying with professional standards, including (1) the Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, (2) the President's Council on Integrity and Efficiency (PCIE) Quality Standards for Federal Offices of Inspector General, (3) the PCIE Quality Standards for Investigations, and (4) the Office of Management and Budget (OMB) circular A-73, "Audit of Federal Operations and Programs."

These standards are guiding principles which must be applied with professional judgment in individual circumstances. While compliance with standards helps ensure quality work, judgments about compliance cannot be rigidly made. In the audits and investigations reviewed, we use the term "satisfactory compliance" with applicable professional standards to mean we found adherence to a standard in a substantial majority of the situations tested. We also considered the nature and significance of instances of noncompliance with a standard. Since no absolute measurement criteria exist for evaluating compliance with standards, review team members relied heavily on professional judgment.

We assessed the OIG's compliance with standards by (1) evaluating the OIG's controls, including written policies and procedures, for ensuring adherence to the standards; (2) reviewing a sample of audit and investigation reports and supporting documents for recently completed assignments; and (3) reviewing, testing, and evaluating other evidence of OIG compliance with the standards. We worked with OIG officials to choose a judgmental sample of 18 completed audits and 12 closed investigations that would fairly reflect the size and diversity of the OIG's work. We did not project our findings from the sampled audits and investigations reviewed to the universe of reports issued during our sample period. In

addition to our principal objectives, we evaluated aspects of the OIG's inspection function, semiannual report documentation, and audit resolution system.

During our review, we met periodically with the inspector general and his staff to discuss our assessment results as well as suggestions on other management practices which we thought the OIG should consider adopting. In addition, we provided the IG and his staff, including those directly involved in assignments, with a detailed briefing on our findings. As a result of our findings, the OIG took corrective actions in several areas by making revisions to its policies, and we assessed the extent to which these revisions will be adequate to help correct the identified problems. This report presents our findings in only those areas where we identified deficiencies that were of such significance as to undermine the quality of the OIG's work and to warrant corrective action by the OIG.

We obtained official agency comments on a draft of this report from the HHS inspector general. Our evaluation of these comments appears in chapters 2, 3, 4, and 5 and appendix II. Our review was performed between December 1986 and December 1987 and was conducted in accordance with generally accepted government auditing standards. Appendix I gives additional details on our objectives, scope, and methodology.

Assessment of the Audit Function

We assessed the OIG audit function's compliance with 12 professional standards, including the Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions. (See table 1.1 in appendix I for a list of the standards and their source.) The OIG audit function satisfactorily complies with the following nine standards: (1) staff qualifications, (2) independence, (3) individual job planning, (4) annual audit planning, (5) supervision, (6) legal and regulatory requirements, (7) internal controls, (8) fraud, abuse, or illegal acts, and (9) audit follow-up. Improvements are needed to bring the remaining three standards—evidence, reporting, and quality assurance—into satisfactory compliance.

Specifically, we found (1) a lack of adequate evidence to fully support all audit findings and conclusions in 6 of the 18 audits we reviewed, (2) inadequate reporting of the audit scope and/or the reporting of conclusions and recommendations which were not presented in a convincing or objective manner in 8 of the 18 audits, and (3) a lack of an effective quality assurance program.

We also found that the OIG does not receive information on the implementation status of all its nonmonetary recommendations. While this lack of information does not affect the OIG's satisfactory compliance with the above standards, we believe it is important that the OIG be aware of the status of all its significant recommendations to ensure that appropriate corrective actions are taken.

Evidence

The evidence standard requires auditors to obtain sufficient, competent, and relevant evidence to afford a reasonable basis for their judgments and conclusions regarding the organization, program, activity, or function under review. A written record of the auditors' work must be retained in the form of working papers that are complete, accurate, relevant, clear, and legible.

We found that the working papers for our sample of 18 audits were generally clear, understandable, and relevant to achieving the stated audit objectives. However, in our judgment, in 6 of the 18 audits we reviewed, the evidence used to support report findings and conclusions was not always sufficient. We did not redo any of the audits to determine the validity of the OIG findings and conclusions. However, we are concerned that the identified evidence weaknesses increase the risk that the OIG might experience problems with findings, conclusions, and recommendations resulting from its work.

In three of the six audits, no documentation existed in the working papers to support certain significant report findings. The findings were undocumented statements from agency officials and personnel upon which the OIG based report conclusions. In two of the audits, the OIG based recommendations on these undocumented statements. To illustrate, one audit concluded that officials failed to establish proper controls because agency officials stated they were unaware of the regulations requiring them to do so. As a result of this conclusion, the OIG recommended that proper controls be instituted. However, neither we nor the OIG auditors were able to find any evidence in the working papers which documented the agency officials' statements. No additional documentation to support this report conclusion was found in the working papers.

In the other three audits, we found some documented support for the reports' findings and conclusions; however, it was not adequate to support all the reports' findings and conclusions. To illustrate, in one audit the OIG estimated that $8.7 million could be saved, based on the report conclusion that ambulance claims should not be paid for end-stage renal disease patients transported from their homes to outpatient facilities for scheduled maintenance dialysis. Applicable Health Care Financing Administration (HCFA) regulations in the Medicare Carriers Manual allow for payment of ambulance services which are medically necessary. In our review of the OIG working papers from two of the five states included in the audit, we found numerous claims for end-stage renal disease patients which were made on the basis that, consistent with HCFA regulations, the ambulance services were medically necessary and allowable for payment. However, the OIG concluded that none of these claims were medically necessary and therefore should not have been paid. Since no evidence was provided to show that the HCFA regulations were not applicable, or that the ambulance services were not medically necessary for some of the claims, we believe this finding is questionable. The OIG then took all of the claims it determined were unallowable and projected nationwide savings of $8.7 million, based on a nonstatistical sample of only five states. The problem with these savings was further compounded by the OIG rounding them to $9 million in its semiannual report.

We believe many of the discrepancies which we found between report statements and working papers could have been identified by independent referencing.[1] The OIG headquarters policies effective during the period when these reports were issued required that both independent referencing and documentation of the referencing process be maintained in the report file; however, our review of OIG working papers showed these processes were not adequately performed. We found OIG reports were indexed and referenced to the working papers on a selective basis, indicating that only partial verification occurred. OIG auditors told us that referencing was often done on an informal basis, and we found little or no record of the referencing process which is required under OIG policy. We believe strict adherence to the OIG policy would have identified many of the same evidence and reporting problems as we did. As a result of our finding, the OIG clarified its policy on referencing to reemphasize the importance of the process and to specifically require that the accuracy of every figure and statement of fact be verified by an examination of the evidence in the working papers. The revised policy was issued in January 1988.

We also believe the OIG needs to provide guidance on the appropriate use of nonstatistical estimates. OIG officials told us they often use nonstatistical savings estimates to illustrate the potential magnitude of identified problems because resource limitations preclude them from expanding their audits to include statistically valid sampling. OIG auditors told us the use of these nonstatistical estimates is directly encouraged by the OIG policy of quantifying the nationwide effect of an audit recommendation whenever possible. Further, they indicated that the use of nonstatistical estimates is indirectly encouraged by OA's use of estimated savings as a measure of performance in the ratings of its regional inspectors general.

We found that the use of these nonstatistical estimates contributed to some of the problems we found with the evidence standard, as illustrated above, and also contributed to some of the reporting problems we found. If nonstatistical estimates are used to show potential magnitude, we believe their use must be closely monitored, appropriately qualified in the report, and segregated from the report's conclusions so as not to be given the same weight as actual findings. Further, such estimates should not be included in the semiannual report as an accurate measure

[1] Referencing is the process in which an experienced auditor with no involvement on an assignment compares report statements with working-paper support to ensure their accuracy.

of the OIG's work. OIG officials agreed with our concerns and issued policy guidance to clarify the use and reporting of nonstatistical estimates in February 1988.

Reporting

The reporting standard requires audit reports to be accurate, clear, concise, convincing, and objective; distributed to appropriate officials; and made available to the public. The standard also requires, in part, that audit reports include (1) statements on the audit's scope and objectives and the auditors' adherence to generally accepted government auditing standards, (2) actions recommended to correct identified problems, and (3) the agency officials' comments on the OIG's report.

We found that the OIG distributed all audit reports in our sample to the appropriate officials and made them available to the public. Also, all reports in our sample included agency comments where appropriate. However, in 8 of the 18 audits, we found the OIG did not always (1) present sufficient information in the body of the report to convince the reader that its conclusions and recommendations were valid and/or (2) fully explain the scope and objectives of each audit.

Reports Are Not Always Convincing

Report findings should be presented in a clear, objective, and convincing manner, and conclusions and recommendations must follow logically from the facts presented in order to focus the attention of responsible officials to take the appropriate corrective action. In 6 of the 18 audits, we found that some report recommendations did not follow logically from the facts presented.

To illustrate, in one audit report, the OIG found that community health centers (CHC), which provide medical services to individuals in medically underserved areas, did not charge enough in fees to cover their total cost of operations and services. Based on this finding, the OIG recommended that the Public Health Service (PHS) ensure that the fees charged by CHCs more adequately cover the costs of each CHC as required by laws and regulations. However, federal laws and regulations only require that fees be designed to cover the reasonable cost of operations and that discounts be provided to individuals based on their ability to pay. Among other things, PHS grants to the centers are used to offset the difference between the costs of providing services and the revenues generated by each center. The OIG reviewed only the total costs of operating the CHCs and did not address any differences or similarities between reasonable and total costs. Therefore, the reader was not provided information in

the report to evaluate whether CHC fees recovered reasonable costs, as required by laws and regulations. Thus, the appropriateness of the OIG's recommendation is questionable, based on the information contained in the report.

We believe that not fully developing the cause of the identified problems contributed to some of the problems we found regarding the convincingness of OIG reports. We recognize that cause is often difficult to identify because several factors can contribute to an identified problem. However, when the cause is fully developed, recommendations can be designed to effectively address the problem, and thus, benefits from the audit work increase.

OIG reporting policies require that audit reports address the underlying causes for identified problems. Specifically, the discussion of cause should include: (1) specific actions or inactions by officials, (2) the functional level at which no action or improper action was taken, (3) missing or inadequate controls in the systems, and (4) management's awareness or unawareness of the weakness.

However, of the nine audits which did not satisfactorily comply with the evidence and/or reporting standards, eight audits did not adequately develop the causes of problems identified in the reports. In five of the eight audits, the report statements describing cause were based solely on auditee comments, with little or no additional work done by OIG staff to confirm or further develop the auditee's remarks. In the remaining three audits, recommendations for corrective actions were made even though the report did not have any statements regarding the cause of the problems the recommendations addressed.

As previously stated, cause can be difficult to develop; however, we believe developing underlying causes when possible and making appropriate recommendations provide greater assurance that the identified problems will be corrected. We believe that when the OIG determines the scope of each audit, the development of underlying causes should be considered, and that where practical, audits should be designed to accomplish this. In April 1988, the OIG revised its planning and reporting policies to emphasize the need for developing cause in its audit findings.

Scope and Objectives Are Not Accurately Reported

To place the auditor's work and findings in proper perspective, an audit's scope and objectives must be accurately reported. If an audit is limited in scope, the limitations must be clearly disclosed in the report.

In 7 of 18 audits, the statement of audit scope and objectives was not accurately reported. Specifically, five did not report the pertinent scope limitations on the work performed, one did not accurately state the audit objectives, and one had no scope section. In addition, two of these seven audits did not contain statements that the audit was conducted in accordance with generally accepted government auditing standards.

To illustrate, one report's scope section indicated that the audit was a review of the administrative costs claimed by a particular state for its Medicaid Management Information System (MMIS). The scope section states that the review was limited to a general determination of the allowability of these costs for federal reimbursement. However, the work reported in this audit was a review of claims from only one unit within the state, and the report scope did not disclose this limitation.

In another audit, auditors relied on the findings from an audit report prepared by the state's auditor general to support both a major audit finding and the cause of the reported problems. The OIG auditors told us they had not independently verified the auditor general's findings. Nevertheless, they included them in the report without qualifying them. We believe the use of the state auditor general's audit findings should have been reported in either the scope section or in the body of the report so the scope of the audit work performed by the OIG is not misleading.

The OIG, through its headquarters review of audit reports, found that scope sections did not always contain appropriate statements on conformance with generally accepted government auditing standards. As a result, in January 1987, the OIG issued policy guidance on the proper use of these conformance statements. The OIG's "quality assurance" program, discussed later in this chapter, revealed some of the same problems we found with the scope sections of OIG's reports. In April 1987 and January 1988, the OIG issued memos to the staff emphasizing the importance of scope sections in reports and providing examples of appropriate scope sections.

Current OIG procedures provide for both the regional audit managers and headquarters officials to review audit reports prior to their final issuance. OIG officials said they determine how well the report has been written, whether a convincing case has been presented, and whether the reports have followed OIG policies for reporting. We could not fully evaluate the thoroughness of these reviews because the reviews did not use a checklist or guidelines that we could examine. However, we believe that the results of our review of compliance with the reporting standard

are serious enough to conclude that the OIG's efforts to ensure quality reporting need improvement. OIG officials agreed that improvements could be made in the process and developed a report checklist to be used in the headquarters' review of reports. We believe the OIG policy revisions, along with the report checklist, should help ensure that the OIG is in satisfactory compliance with the reporting standard.

Also, as discussed under the evidence standard, we believe report quality would be better ensured if audit managers and supervisors followed the OIG audit policy requiring documented referencing for report statements.

Quality Assurance

The standard states that each OIG shall establish and maintain a quality assurance program. The standard defines quality assurance as an evaluative effort conducted by individuals who are external to the units under review to ensure that work performed adheres to established OIG policies and procedures, that it meets established standards of performance, and that it is carried out economically, efficiently, and effectively.

The OIG program that existed during the time of our review was not external to the units under review. It allowed each deputy regional inspector general to select members of his staff to review regional office operations and to report any problems to him. Following resolution, a copy of the report was to be sent to the Assistant Inspector General for Audits (AIGA) in Washington. Since each region was responsible for its own program and headquarters was not involved other than receiving a copy of the results, there was no assurance that the regions were evaluating all the critical areas or reviewing them in a consistent manner. Therefore, we do not believe these reviews provided the OIG reasonable assurance that the work performed adhered to audit standards and office policies and procedures.

The quality assurance reviews in the regions we visited did not find any of the evidence problems or reporting problems which we found, with the exception of problems in reporting audit scope. These reviews pointed out the need to strengthen certain policies and to make staff more aware of OIG policies and procedures. However, we believe the OIG would have greater assurance of adherence to audit standards and office policies if these reviews were performed by staff members who were external to the unit under review and who reported directly to the IG or to his representative.

In response to our findings, the Office of Audits revised its quality assurance policy in January 1988 to require that reviewers be external to the unit being evaluated and that they issue the final report directly to the Assistant Inspector General for Audits. The IG will also receive copies of the results of these reviews. We believe this program, if implemented and maintained with an adequate follow-up system to verify corrective action, should help ensure that the audit function's work satisfactorily complies with applicable auditing standards.

Lack of Information on Nonmonetary Recommendations

An audit organization's accomplishments can be measured largely by the impact of its recommendations. Feedback on whether the recommendations are valid and result in significant change can aid the organization in planning its work and in assessing whether it is achieving its full potential in improving governmental accountability and effectiveness. Such feedback can also aid in identifying instances where agency managers have not taken appropriate action on recommendations.

The OIG has a system to track all audit recommendations to a point of mutual agreement between itself and the auditee as to what corrective actions will be taken. Tracking recommendations to the point of mutual agreement complies with the Office of Management and Budget policy contained in circular A-50, "Audit Follow-Up."

The HHS follow-up official, the Assistant Secretary for Management and Budget (ASMB), is responsible for establishing a system to track findings through corrective action or implementation. The ASMB currently monitors the collection of recommended monetary recoveries and provides this information to the OIG. However, he does not always receive information on corrective actions taken for nonmonetary recommendations.

Officials from the ASMB's office told us they were confident that the status of nonmonetary recommendations was tracked by the audit liaison officials in each HHS operating division. However, we found that not all HHS operating divisions did track the status of nonmonetary recommendations. The Public Health Service and Social Security Administration do maintain systems which monitor the implementation status of nonmonetary recommendations and do provide monthly status reports to the OIG. However, the Health Care Financing Administration, where during the last six months of fiscal year 1986 the OIG conducted 58 percent of its audits, does not monitor or prepare listings on the status of unimplemented nonmonetary recommendations. At the OIG's request, the HCFA

audit liaison does determine the status of specific recommendations, usually in preparation for the semiannual report.

Officials from the Office of the ASMB told us they are working with the OIG to develop a tracking system which would track all recommendations through implementation and which would be of use to both offices. We believe the OIG should be aware of the status of all its significant recommendations through implementation in order to ensure that appropriate corrective actions are taken on identified deficiencies. Therefore, we believe the OIG should continue working with the ASMB to ensure that such a system is developed and implemented as quickly as possible.

Conclusions

The OIG satisfactorily complied with 9 of 12 professional standards in the areas we tested. However, we found corrective action was needed to bring the OIG into satisfactory compliance with the evidence, reporting, and quality assurance standards.

During our review, the OIG took corrective actions to address the problems we found with the evidence and reporting standards by revising or developing policies and procedures. While the OIG now appears to have adequate policies and procedures to ensure adherence to these standards, we believe that policies and procedures by themselves are not enough. It is important that all OIG staff members have a clear understanding of the professional standards and corresponding OIG policies and procedures and that OIG management ensure staff compliance with these auditing standards, policies, and procedures.

It is also important that the OIG have audit-quality processes which provide reasonable assurance of adherence to audit standards and OIG policies and procedures. The results of our review indicate that these processes may not always be working. Adequate audit-quality processes alert management to problems which can impact the quality and effectiveness of its work and allow management to take corrective actions. To address these concerns, the OIG revised its quality assurance program and developed a report quality checklist. We believe that the implementation of an effective quality assurance program, along with the actions the OIG is taking to strengthen its quality control processes for audits, will help the OIG satisfactorily comply with professional standards as well as make staff more aware of standards and policies and their value.

As we previously stated, we did not redo any of the audits to determine the validity of the OIG's findings, conclusions, and recommendations.

However, we believe that by not fully developing the causes of identified problems, the OIG lessens the effectiveness and impact of its work. Only by identifying and developing the cause of a problem can recommendations be designed to prevent the problem's recurrence. When cause is not developed, the appropriateness of the OIG's conclusions and recommendations may be questioned. Thus, the utility of the audit and its report is lessened.

We also found the OIG is not receiving information on the implementation of all its nonmonetary recommendations. While this does not affect the OIG's satisfactory compliance with professional standards, we believe the OIG should be aware of the status of all its significant recommendations through implementation to ensure appropriate corrective actions are taken.

Agency Comments and Our Evaluation

This chapter contains no recommendations because the IG agreed with our assessment of the audit function and took immediate corrective action on all the problems we identified. In his June 27, 1988, response to our draft report, the inspector general stated that the many changes made to his organization based on GAO's review would strengthen the OIG in meeting its statutory mission. However, he expressed concern over the public's perception of his office as a result of this report. Specifically, the IG is concerned that the report does not accurately reflect the overall operation of his office and that an uninformed reader might conclude that the OIG is performing at a lower level of quality than is actually the case. In response to these concerns, we revised our report to provide additional details and more clearly place the report's findings in perspective. The IG's specific comments and our evaluation of them are included in appendix II.

Assessment of the Investigation Function

We assessed the OIG investigation function's compliance with 11 professional standards: (1) staff qualifications, (2) independence, (3) planning, (4) due professional care, (5) directing and controlling, (6) coordination, (7) reporting, (8) preserving confidentiality, (9) screening allegations, (10) information management, and (11) quality assurance. (See table 1.2 in appendix I for the standards' sources.) The OIG investigation function satisfactorily complies with all the professional standards, except for information management and screening allegations.[1]

Specifically, we found that (1) the OIG's management information system did not accurately capture and report data contained in its investigative case files and (2) the OIG took an average of 34 days to screen the allegations in our sample. Further, the disposition status of 83 percent of these allegations was not known.

Information Management

This standard requires that the OIG store the results of investigations in a manner which allows for effective retrieval, cross-referencing, and analysis. An effective information management system enhances an OIG's ability to conduct pattern and trend analysis, fulfill its mandate of detection and prevention, and make informed judgments relative to its resource allocations and program development.

We found the OIG has a satisfactory case management system for physically storing and retrieving closed investigative files. The OIG has an automated management information system designed to facilitate the analysis of the investigative function's productivity and accomplishments as well as provide data for the IG's semiannual report. We found this system did not accurately capture, correlate, and report data contained in the investigative case files. During our review, the OIG began the process of transitioning to a new management information system.

To test the reliability and accuracy of the management information system in operation during our review, we compared the information in it to the actual investigative case files. In 44 of the 62 cases tested, the information in the automated system could not be verified in the case files. To illustrate, in 21 cases there was no documentation for the claimed savings, and in two others the savings recorded in the source documents disagreed with those contained in the automated system.

[1]During our review, the Office of Analysis and Inspections was responsible for the activities associated with the screening allegations standard. Near the end of our review, these activities were transferred to the Office of Investigations.

The Assistant Inspector General for Investigations told us he was aware of this system's limitations and, as a result, did not generally accept the reports it generated without consulting his regional inspectors general for manual verification. The unreliability of these reports not only affected management's ability to accurately analyze this function's accomplishments, but also impacted the accuracy of the OIG's semiannual reports, as we discuss later in chapter 5.

The OIG began implementing a new information management system in early 1987 and expects it to be fully operational in the summer of 1988. The system is being implemented gradually, with each function being tested concurrently against the old system.

Screening Allegations

This standard requires that the OIG establish and maintain a well-publicized system for receiving, controlling, and screening allegations of waste, mismanagement, fraud, and abuse received from agency employees and other interested persons. It also requires this system, which should be fully documented, to ensure that each allegation is promptly screened and that an appropriate disposition is determined for each allegation.

In 1979, the OIG established a fraud hotline and a post office box to receive allegations and it currently publicizes the operation with posters, bulletins, IG publications, and a listing in the Department's telephone directory. The Office of Investigations was responsible for this function until March 1986, when it was transferred to the Office of Analysis and Inspections.

Based on prior work performed, we believe that allegations should be screened and forwarded for appropriate action within an average of 10 working days. In a judgmental sample of 47 allegations[2] from the HHS hotline, we found it took an average of 34 days for the OIG to screen the allegations. Over half of these allegations were screened twice, once by the OAI staff and a second time by OI staff. For those allegations receiving two screenings, we found it took an average of 36 days to transfer the allegations from OAI to OI for the second screening, and an average of 10 days for OI to screen and refer the cases.

[2]The sample was based on a 3-month period, July 1, 1986, through September 30, 1986. During this period, HHS received 461 allegations. We selected every 10th case for our sample of 47.

Most of the allegations received were of a criminal nature, and none of the OAI staff operating the hotline had investigative field experience. Therefore, after the OAI staff screened incoming fraud allegations, those identified as substantive were forwarded to OI investigators for a second screening and for a determination as to which allegations should be pursued.

Of the 47 sampled allegations, we found that 8 were administratively closed and the OIG did not know the disposition of the remaining 39 cases. In an earlier report,[3] we found that the final disposition of approximately 375 cases referred over an 8-year period by GAO to the HHS hotline were unknown because the hotline could not locate the files. Though the disposition of 39 cases in our sample was unknown, we did find files for all the cases sampled during this review.

OIG policies require the hotline to monitor all allegations of fraud, waste, or abuse involving HHS until the allegations are closed. The OIG has established detailed monitoring procedures for allegations, including time frames for follow-up. We found that the procedures were not being followed in the cases where the disposition was not known.

Prior to our review, the OIG had conducted an assessment of its hotline operations. Based on our observations and the OIG's own assessment, OIG officials agreed with our concerns regarding the delays in screening allegations. To correct this problem, the hotline operation was transferred back to OI in November 1987. During our review, the hotline staff was beginning to monitor the status of screened allegations with an automated tracking system, including the organization receiving the referral, the date referred, and the status of its disposition. During our review, we observed that OIG staff had difficulty in obtaining information from this system to respond to our questions; however, we recognize the system was not fully operational. A date for its completion was not known.

Conclusions and Recommendation

The OIG satisfactorily complied with 9 of the 11 professional standards tested; however, corrective action is needed to bring the OIG into satisfactory compliance with the information management and screening allegations standards.

Currently, the OIG is implementing a new information management system to provide accurate data on its investigation function's productivity

[3] Fraud Hotline: 8-Year GAO Fraud Hotline Summary (GAO/OGC/OSI/87-1FS, April 8, 1987).

and accomplishments. The old and new systems will operate concurrently until the desired levels of accuracy and reliability are achieved. If implemented properly, the new information management system should help bring the OIG into satisfactory compliance with the information management standard.

The OIG recognizes the problems we found with the prompt screening of allegations and the tracking of their disposition. The OIG transferred the hotline operation back to OI to eliminate delays in screening and is developing an automated system to monitor actions taken on each allegation, in accordance with established OIG policies and procedures. We believe the OIG is taking corrective action regarding the problems with its hotline operation. However, we do not know whether the system being developed to monitor allegations will ensure adherence to the OIG's own policies and procedures or the screening allegation standard.

Therefore, we recommend that the inspector general evaluate whether this system will ensure compliance with the screening allegation standard and the OIG's own policies and procedures or that he develop an alternative approach which will.

Agency Comments and Our Evaluation

In his June 27, 1988, response to our draft report, the inspector general agreed with our recommendation. He believes the operation of the hotline has improved since its transfer back to the Office of Investigations, and he will continue to evaluate how well the current operation is complying with the screening allegation standard. Due to the magnitude of the problem which the OIG was having in monitoring the status of its allegations—the disposition of 83 percent of its allegations was unknown—we support the OIG's continued examination of its hotline operations to ensure full compliance with its own policies and procedures and the screening allegation standard. The IG's specific comments and our evaluation of them are included in appendix II.

Assessment of the Inspection Function

In addition to the audit and investigation functions, the HHS OIG, as well as many of the other statutory offices of inspectors general, has established an inspection function. Inspections vary widely across the IG community and result in different types of reports, addressing issues that range from economy and efficiency to technical and complex issues which deal with major policy issues. At HHS, inspections are studies of HHS programs and are designed to quickly review program policies and management practices to provide the IG with rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

We reviewed six HHS inspections and found improvements could be made in the reporting and evidence areas which would better ensure accurate and complete work products. We also found that improvements could be made to the inspection function's standards and procedures and quality assurance program which would help ensure the quality and integrity of its work.

Inspection Function at HHS

The Office of Analysis and Inspections was organized in April 1985 to consolidate program evaluation functions that were being performed by other OIG organizations. Program inspections are designed to be independent, objective studies of HHS programs. They are designed to review, as quickly as possible, program policies and management practices and to provide the IG with rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

The IG considers these inspections to be preventive in nature. While audits and investigations are frequently based on a suspected or known problem, inspections attempt to identify potential problems before they occur. Inspections may result in the initiation of a full-scale audit or investigation, but unlike an audit survey which can also lead to an audit or investigation, inspections have findings and conclusions. Inspections also contain recommendations which may require changes in legislation or regulations to achieve the desired improvement in program operations. Monetary benefits associated with some of these recommendations are also reported in the IG's semiannual report.

At HHS, program inspections are generally to be completed in 3 to 5 months. According to the IG, inspections can be performed more quickly because they study and comment on management operations in situations where the rigor required by audit standards is not critical. Reports resulting from program inspections are short, rarely exceeding 20 pages,

and are generally targeted to the managers of the programs or activities under review. Inspections are performed on such diverse topics as organ transplants, medical licensure and discipline, and smokeless tobacco.

There are no agreed upon professional standards for conducting inspections. Most IGs with inspection functions do not believe it is wise to require all inspections to adhere to a specific set of standards. They feel that those IGs who wish to follow specific standards should be allowed to do so, but this decision should be at the discretion of each IG. In a September 1984 report, the President's Council on Integrity and Efficiency, whose membership includes the statutory IGs, took the position that the inspection function is separate and distinct from audits and investigations, and that inspections do not have to adhere to a specific set of standards such as the generally accepted government auditing standards. The Council concluded that IGs who wish to develop standards should devise them broadly enough to fit the individual circumstance of each inspection.

In September 1986, after several years' experience in conducting inspections, the HHS OIG implemented written standards and procedures[1] for this function. These standards and procedures discuss OIG requirements for inspection planning, documentation of report observations and recommendations, and the convincingness and objectivity of inspection reports.

The HHS OIG inspection standards were not in effect during the entire period that our review sample covered, April 1, 1986, through September 30, 1986. Therefore, we limited our review of six inspection reports to only determining for each inspection whether individual assignment plans were properly designed to achieve their stated objectives; whether working papers contained documentation for inspection report observations and recommendations; and whether reports adequately described the work planned, results achieved, and conclusions reached. These are critical areas which the OIG incorporated in the new inspection standards, and OIG officials agreed with our use of these areas to assess the six inspections. We also reviewed the OIG's newly developed standards and procedures for inspections and the quality assurance program for inspections.

[1]Office of Inspector General's National Program Inspections Standards, Procedures and Methodology Manual, September, 1986.

Sampled Inspections

Overall, we found that the OIG's inspections plans were well documented; however, improvements could be made in the reporting and evidence areas which would help enhance the accuracy and completeness of the OIG's work products.

Basis for Recommendations Is Not Always Reported

In three of the six cases, we found recommendations which did not flow logically from the information presented in the body of the report. To illustrate, one report addressed the adequacy of state medical boards' licensing policies and practices with respect to graduates of foreign medical schools and the boards' policies and procedures for sharing information on incompetent or disciplined physicians. Neither the report nor the working papers discuss the issue of funding for the educational costs of students in foreign medical schools; however, the report contained three recommendations regarding the payment of federal assistance to foreign medical students for direct and indirect medical educational costs.

In March 1988, the OIG instituted a report review process to improve the quality of its inspection reports. This review process is designed to ensure that inspection reports comply with OIG and departmental policies and procedures, report statements are clear and valid, and a direct correlation exists between the report's findings, conclusions, and recommendations. A checklist will be used to document the review process. This process, if implemented as designed, should assist in identifying and correcting the types of problems discussed above.

Documentation of Evidence Was Not Complete

We were also unable to locate documentary support for some of the report statements we tested; however, we found no indication that what had been reported was inaccurate. The policies and procedures in place during the period under review required neither the retention of supporting working papers nor the indexing of report statements to supporting working papers. Therefore, not all of the working papers were retained for the reports we reviewed, and none of the reports were indexed to the working papers. However, the OAI staff did selectively index the reports before we began our review.

Working papers provide a link between field work and the final report and should contain support for the report's findings, judgments, and conclusions regarding the organization, program, activity, or function under review. This type of support helps to ensure the quality of the work and the utility of the report. OIG officials agreed with our concerns and had already incorporated in their standards and procedures a

requirement to retain all documentary support in the form of working papers. In addition, the OIG is developing a uniform working paper file system to be incorporated into the inspection function's standards and procedures.

Inspection Standards and Procedures

In our review of the OIG's National Program Inspections Standards, Procedures and Methodology Manual, we did not find standards on the responsibilities of supervisors. During our review, regional management and often headquarters staff were closely involved in the design and execution of the inspections and in the drafting and processing of each final report. This was in large part due to the relatively small staffs (usually 8 to 12 individuals) assigned to the regional offices. However, the OIG is currently increasing staff resources in the inspection function. As both the regional offices and headquarters staff expand, standards on supervisory duties and responsibilities would help ensure the accuracy and integrity of the work performed. Therefore, we believe the OIG should clearly define in its standards and procedures what is expected of each supervisor. OIG officials agreed with our concerns and in April 1988, issued supervisory standards which clearly defined the duties and responsibilities of its supervisors.

Quality Assurance Program

In January 1987, the OIG established a quality assurance program to ensure the effectiveness of its inspection function's operations and staff compliance with its policies and procedures. The office has conducted quality assurance reviews in all its regions and plans to review each region on a yearly basis. The reviews are conducted by the Assistant and Deputy Assistant Inspectors General for OAI and a program analyst from headquarters. Checklists were developed for conducting these reviews—one each for standards, procedures, and internal controls. OIG officials told us that all areas in the procedures and internal controls checklists were reviewed in fiscal year 1987, but the standards checklist was not administered.

For fiscal year 1988, the OIG will continue to use the procedures and internal controls checklist but will use the report review checklist discussed previously and a working paper review guide in place of the standards checklist. Both of these reviews will be administered by a unit external to the one conducting the work. These reviews will address areas such as the adequacy and sufficiency of evidence, working paper preparation, and report findings and conclusions, areas which are critical to the integrity of the OIG's work. We believe that the inspection

function's quality assurance program is comprehensive, and if it is implemented appropriately, will help ensure the effectiveness of operations and the staff's compliance with policies and procedures.

We also reviewed the fiscal year 1987 quality assurance reports and found that the OIG, in addition to not using the standards checklist, did not address most of the areas included in the procedures and internal controls checklists. The reports did not fully explain what was reviewed, discussing instead only those areas where problems were identified, such as job planning, training needs, time and attendance, and office procurement. We believe the quality assurance reports should detail the extent of the review and give at least some assurance that all weaknesses identified are discussed in the report.

Our review of the OIG's quality assurance program also disclosed a lack of procedures for routine follow-up to determine whether quality assurance report recommendations are implemented. OIG officials told us that implementation of fiscal year 1987's recommendations for procedures and internal control problems will be examined during the fiscal year 1988 quality assurance reviews at each regional office. We believe the OIG should formally incorporate this annual follow-up as part of its quality assurance program to better ensure that corrective action is taken.

Conclusions and Recommendations

From our review of the six sampled cases, we found that OIG inspection plans were well documented. However, we found areas where improvements could be made in the reporting of the work and the retention of supporting documentation for the work. The OIG had already taken corrective action in both these areas by adopting standards and procedures which deal specifically with reporting and the retention of supporting documentation. Further, it has instituted a report review process to help ensure the completeness and usefulness of its work products.

From our review of the inspection function's new standards and procedures, we found that the responsibilities of supervisors were not clearly defined. Specific policy guidance on the roles of supervisors would help ensure the accuracy and integrity of the work performed. The OIG took corrective action to address this problem by issuing supervisory standards which detailed the duties and responsibilities of its supervisors.

We also found that the quality assurance program designed for inspections is comprehensive. However, we found the quality assurance

reports did not fully explain the extent of each review or provide assurance that all identified weaknesses were discussed. In addition, the program does not include a formal requirement for follow-up on recommendations from previous reviews.

To help ensure an effective quality assurance program in the inspection function, we recommend that the inspector general:

- require all quality assurance reports to clearly state the scope of each review and include a statement that all identified weaknesses are discussed; and
- require formal procedures to be developed for following up on quality assurance report recommendations to ensure that corrective action has been taken.

Agency Comments and Our Evaluation

In his June 27, 1988, response to our draft report, the inspector general agreed to take appropriate actions to implement our recommendations. In future quality assurance reports, statements will be included addressing the scope of the reviews and providing assurance that all identified weaknesses are discussed. In his comments, the IG states that current OIG procedures require follow-up on quality assurance report recommendations; however, we did not find such procedures in the OIG policy and procedures manual. Though OIG officials told us they intend each quality assurance review to follow up on prior year recommendations, we believe that to ensure that this is a continued requirement of the program, follow-up procedures need to be formalized. The IG's specific comments and our evaluation of them are included in appendix II.

Assessment of the OIG's Semiannual Report

One of the most significant responsibilities of any inspector general is keeping the agency head and the Congress fully and currently informed about problems and the actions being taken to correct them. One way in which OIGS report the results of their activities is through semiannual reports to their agency heads and the Congress. At HHS, we reviewed the documentation for and presentation of information in semiannual reports for the periods ending September 30, 1986, and March 31, 1987. For these periods, the HHS IG reported that $6.63 billion in monetary accomplishments had been realized as a result of OIG recommendations and that 1,026 criminal convictions were obtained against wrongdoers.

We believe the accomplishments reported in the HHS semiannual reports indicate the OIG is having a significant impact on HHS operations. However, we did not find satisfactory support for approximately $554 million, or about 8 percent, of the reported monetary accomplishments in the two semiannual reports we reviewed. In addition, we found that the controls the OIG had in place for the preparation of the semiannual report needed to be strengthened. We also found that the OIG could improve its report presentation of monetary accomplishments. The IG agreed with our concerns and has initiated changes which we believe will help to improve his reports.

HHS OIG's Semiannual Report

The HHS IG submits semiannual reports to the Congress pursuant to Public Law 94-505, as amended (42 U.S.C. 3542). The reports contain (1) an executive overview of OIG accomplishments; (2) brief narratives on selected audits, investigations, and inspections; (3) information on the OIG's nonfederal audit, audit resolution, and debt collection activities; and (4) appendixes detailing the monetary impact of the OIG's work. The OIG places a great deal of emphasis on its semiannual report and states in its guidelines for preparing the report that it is "probably the most important document the OIG releases."

OIG policies state that savings are to be reported in the semiannual report only after definitive action to effect the savings has taken place. For example, in cases of recommendations pertaining to legislation, the law must already have been passed and signed by the President, and in the cases of recommendations pertaining to changes in or issuance of new regulations, a final regulation must have been published before savings are reported. OIG policies also state that independent, outside estimates, such as Congressional Budget Office (CBO) estimates, should be obtained and used in the report when available. The HHS OIG believes that independent estimates are "more neutral and creditable."

Of the $6.63 billion in the two semiannual reports we reviewed, about $6.55 billion was claimed as a result of recommendations in audit and inspection reports, with the remaining $80 million attributed to fines, restitutions, and recoveries resulting from OIG investigations. About $5.81 billion of the $6.55 billion from audit and inspection reports was based on 5-year estimates provided by the CBO as legislative savings, and approximately $740 million was based on the OIG's own estimates, generally covering a 1-year period.

As part of our review, we examined the documentation for those audit and inspection reports in which the savings reported were $1 million or greater. This accounted for all of the $5.81 billion in savings based on CBO estimates and about $700 million of the $740 million based on OIG estimates. We were not, however, able to assess the accuracy of the investigative data for the 1,026 reported convictions and could only test about $30 million of the Office of Investigations' reported $80 million in monetary accomplishments, because OI did not retain supporting documentation for its input to the semiannual report and could not recreate the support due to problems with its management information system. (See chapter 3 for a more detailed discussion of these problems.)

Monetary Accomplishments Were Not Always Satisfactorily Supported

We did not find satisfactory support for about $554 million of monetary accomplishments reported in the two semiannual reports we reviewed. However, this does not mean that monetary benefits may not have resulted from the recommendations associated with the reported $554 million. We found problems with both the OIG's use of CBO estimates and its own projections.

CBO Estimates

The OIG attributed about $5.81 billion in savings resulting from OIG audit and inspection recommendations to calculations made by the CBO. We found that about $86 million in savings from two inspection reports were not satisfactorily supported by the referenced CBO estimate.

In the first report, the OIG reported that $405 million in savings resulted from its recommendation to lower Medicare reimbursement for standby anesthesia. We found that while legislation was passed to lower the Medicare reimbursement, the OIG's support for the savings was not a CBO estimate as reported, but a HCFA estimate. The CBO estimated that the

savings resulting from lowering the Medicare reimbursement would be $360 million over a 5-year period.

In the second report, the OIG reported that $41 million in savings resulted from its recommendation to limit Medicare funding for direct medical education expenses for foreign medical school graduates to residents who have passed the Foreign Medical Graduate Examination. Again, we found that legislation was passed implementing the OIG's recommendation and that the OIG's support for the savings was not a CBO estimate, as reported but an estimate from HCFA. CBO determined that no savings were associated with this legislation and reported this to the Congress in its analysis of the bill. CBO officials told us that the change in legislation had no budgetary impact, because the change merely legislated a requirement that the American Medical Association had already imposed on all accredited teaching hospitals.

OIG Estimates

We also examined the documentation for $700 million of the reported $740 million in monetary accomplishments based on OIG estimates. We did not find satisfactory support for $468 million, or about 67 percent, of the OIG's estimates we reviewed, because of the OIG's use of nonstatistical estimates as savings.

For example, in one audit a nonstatistical sample was used to project a savings of $450 million if 19 states would transfer an existing management information system into their states instead of each state designing and developing its own system. The projected savings was based on the savings achieved by two states and represents the maximum benefit which could be obtained by the transfer. There was no evidence presented to show that these two states were representative of the other 19, and in fact, the report shows that the savings would vary based on an individual state's ability to adapt the system to its needs. OIG officials agreed with our concerns. Subsequent to our review, the OIG found that 4 of the 19 states cited in the report had not participated in the transfer program, but that an additional 7 states not included in the original 19 had participated. Though the exact amount of savings resulting from this audit is not known, OIG officials believe the savings will be close to the amount reported.

We discussed another example of the OIG's use of nonstatistical estimates as savings in the semiannual report in chapter 2. In this case the OIG projected a nationwide savings of $8.7 million, based on the questionable finding that no ambulance claims should be paid for end-stage

renal disease patients. The $8.7 million in savings was based on a nonstatistical sample of only five states and was reported in the semiannual report as a $9.0 million monetary accomplishment.

Controls Over the Semiannual Report Need to Be Strengthened

Some of the problems we found with the support for dollar figures in the semiannual reports were due, in part, to the OIG's process for preparing them. Each organizational unit compiled its accomplishment data and forwarded it to the OAI for assembly. No one from outside the operations units independently verified the information or ensured that all reporting criteria had been met. The OIG did send drafts of the semiannual reports to HHS operating and staff divisions for their comments before issuance; however, we do not believe this procedure replaces the need for adequate controls within the OIG itself.

As discussed in the previous chapters, we found problems in all three organizational units which impact the accuracy of the semiannual report: the use of nonstatistical estimates in the audit function, the lack of retaining documentation in the inspections functions, and the lack of a reliable information system in the investigation function. Considering these problems, we believe it is important for the OIG to have an independent verification of the dollar figures reported as monetary accomplishments in its semiannual reports.

The IG shares our concerns. He assured us that independent verification of all data will be performed and provided us documentation of the process that will be used. He has also transferred the responsibility for the semiannual report's preparation to the Administrative Office. This process was fully operational for the first semiannual report in fiscal year 1988. We believe these changes, as well as the corrective actions taken by each of the individual operational groups that are discussed in previous chapters, should help to ensure that satisfactory support exists for monetary accomplishments included in the semiannual reports.

Presentation of Monetary Accomplishments

During our review, the OIG was in the process of revising the presentation of its monetary accomplishments and is continuing to make revisions in subsequent reports in order to make its presentation more accurate. We suggested some additional revisions which we believe would help make the OIG's report presentation more accurate and understandable. Our major concern was with the OIG's report presentation of management commitments.

In 1984, we issued a report[1] stating that it is misleading to portray management commitments, such as disallowed costs, as savings because these commitments are only an interim point in the audit resolution process. Savings occur only when funds are recovered or withheld from the auditee. When costs have been disallowed by management, they may later be allowed when the auditee provides additional documented support that convinces the program official to allow the cost or when the program official's decision is overturned on a legal appeal. In the report, we recommended that OMB establish standard definitions for reporting audit resolution data, such as savings and questioned costs, to the Congress. The Senate and the House of Representatives have passed separate bills which support standardized reporting by the IGs.[2] Both bills contain provisions which not only require the IGs to report the same types of accomplishments in their semiannual reports, but also provide standard definitions for accomplishments. These definitions are consistent with those found in our 1984 report, as discussed above.

In both semiannual reports we evaluated during this review, savings and management commitments such as "disallowed costs" were combined together in one appendix, titled "Analysis of Cost Savings" in the first report and "Programmatic Recoveries and Cost Savings" in the second report. Though the appendixes made some distinction between types of accomplishments, the distinction between savings and management commitments was not clear. We also found that on the first page of both reports in the executive overview, the OIG stated that billions "in settlements, fines, restitutions, recoveries, and savings were realized" as a result of OIG recommendations; however, the executive overviews did not specify that the dollar figures reported also included management commitments. Not making a clear distinction between management commitments and savings throughout the report could imply that there is no difference. Such an implication is misleading to the reader because some of the recommendations agreed to by management may not be implemented, and thus the savings will not materialize.

From the approximately $700 million we reviewed of the reported $740 million based on OIG estimates in the two reports, we found $8.8 million of management commitments in these appendixes which were not implemented because either additional documentation was provided

[1] Audits of Federal Programs: Reasons For the Disparity Between Costs Questioned By Auditors and Amounts Agencies Disallow (GAO/AFMD-84-57), August 8, 1984.

[2] The Senate passed S. 908 on February 2, 1988. The House of Representatives passed H.R. 4054 and its version of S. 908 on July 26, 1988.

by the auditee or management reconsidered its position. We found an additional $56 million in reported accomplishments that is currently under appeal with the Department's Grants Appeals Board.

The OIG agreed with our concerns and has made several revisions to the report's presentation based on our review. In future reports, management commitments and savings will be reported in separate appendixes, and to ensure there is no misinterpretation of the report, the OIG is adding management commitments to the list of accomplishments reported in its executive overview. In addition, the OIG will no longer use the term "realized" when reporting the results of its work, because this term could be interpreted by some to mean that all the monetary accomplishments have been collected, when in reality some of them have not or may never be.

The OIG, on its own initiative, has made additional changes to its report's presentation to provide the reader with a better understanding of the results of its work. These changes include presenting tables displaying departmental receivables, collections, and write-offs by HHS operating divisions, as well as the audit disallowances included in the accounts receivable. The OIG is also expanding the report section dealing with the results of the Department's financial integrity work. We believe these changes will further improve the presentation of the OIG's accomplishments and the reader's understanding of them.

Conclusions

About $5.81 billion of the OIG's reported $6.63 billion in monetary accomplishments in the two semiannual reports we reviewed was cited as an estimate provided by the CBO. It is OIG policy to report independent, outside estimates, such as CBO estimates, in the semiannual report when available. We believe the OIG's use of independent estimates, if carefully verified and documented, does provide the reader with a more objective number.

The OIG needed an effective quality control process for compiling the semiannual report to help ensure the accuracy and supportability of monetary accomplishments reported. During our review, the IG took steps to improve the quality control process for the semiannual report by developing procedures for an independent verification of all the data included in the report. He also has assigned the responsibility for the report's preparation to the Administrative Office.

The semiannual report should present accomplishments in a clear and understandable manner in order to fully inform the Congress of the type and timing of accomplishments being claimed. During the course of our review, the IG was revising its report presentation and took additional steps based on our review to improve the presentation of monetary accomplishments in the semiannual report. We believe these actions have improved the report's presentation and will provide the reader with a better understanding of the OIG's work.

Agency Comments and Our Evaluation

This chapter contains no recommendations because the IG agreed with our assessment of the semiannual report and took immediate corrective action on all the problems we identified. The IG's comments on our draft report and our evaluation of them are included in appendix II.

Additional Details on Our Objectives, Scope, and Methodology

Our principal review objectives were to determine whether the HHS OIG performs its work in accordance with professional standards. Our approach involved evaluating the OIG's controls, including written policies and procedures, to ensure adherence to the standards; reviewing a sample of reports and working paper files for recently completed assignments; and reviewing, testing, and evaluating other evidence of OIG compliance with the standards.

In addition to our principal review objectives, we also evaluated the OIG's inspection function, the documentation for and presentation of information in the IG's semiannual reports to the Congress, the OIG's system for tracking management's implementation of audit recommendations, and the scope of the OIG's audit coverage.

We measured the OIG audit function against generally accepted government auditing standards, which are contained in the Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions, revised in 1981. We also used PCIE quality standards[1] for evaluating annual audit planning and the audit function's quality assurance program. In addition, we evaluated the OIG's annual audit planning against OMB circular A-73, "Audit of Federal Operations and Programs." We measured the OIG investigation function against the PCIE Quality Standards for Federal Offices of Inspector General and the PCIE Quality Standards for Investigations for use in conjunction with the quality standards. During our review, we used the term "standard" to refer to either an individual standard or, in some cases, to a combination of similar standards or OMB policy directives. (See tables I.1 and I.2 for a summary of the standards used to assess the audit and investigation standards.)

We assessed compliance on a standard-by-standard basis for the OIG audit and investigation function. We did not necessarily test every area of every standard. Accordingly, we cannot be certain that our review disclosed all reportable conditions in the OIG's operations; however, all reportable conditions that came to our attention are discussed in the report. We did not redo any of the audits or investigations and thus cannot conclude whether any OIG reports contained invalid findings, conclusions, or recommendations.

[1] PCIE Quality Standards for Federal Offices of Inspector General are advisory standards which were formulated and adopted by those inspectors general who are members of the PCIE.

Our review approach for this report is essentially the same one we used in our earlier "quality assessment reviews" of the OIGs at the departments of Commerce, Agriculture, Transportation, and the Environmental Protection Agency, and the General Services Administration.[2] In developing the approach for the first of our five reviews, we discussed the review methodology and criteria with the various statutory inspectors general, who generally agreed with our approach. In addition, we requested comments on our review guidelines from the inspectors general, the American Institute of Certified Public Accountants, selected state auditors, intergovernmental audit forums, and public accounting firms. Most respondents felt that the guidelines were very thorough and comprehensive. (For a more detailed discussion on how we developed our review approach, refer to our report on the Commerce OIG.)

As in our earlier reviews, we selected a sample of audits and investigations to review. For the audit sample, we obtained an OIG-generated listing of 350 audit reports issued between April 1, 1986, and September 30, 1986. We verified the list's accuracy by tracing our selected reports to the actual reports maintained in OIG files. We then identified the audits conducted by each regional office and headquarters audit division. For the Boston, Chicago, and New York regional offices, we categorized the audits as large (over 400 staff days), medium (200-400 staff days), and small (less than 200 staff days); determined the number and type of program areas addressed (health care financing, social security, family support, etc.) of the audits for review; and selected, judgmentally, 17 audits to examine. We also selected one Federal Managers' Financial Integrity Act audit from the Grants and Internal Systems headquarters division to review. We evaluated each

[2] Compliance With Professional Standards by the Commerce Inspector General (GAO/AFMD-85-57, August 12, 1985).

Inspectors General: Compliance With Professional Standards by the Agriculture Inspector General (GAO/AFMD-86-41, September 30, 1986).

Inspectors General: Compliance With Professional Standards by the Transportation Inspector General (GAO/AFMD-87-28, August 10, 1987).

Inspectors General: Compliance With Professional Standards by the EPA Inspector General (GAO/AFMD-86-43, September 30, 1986).

Inspectors General: Compliance With Professional Standards by the GSA Inspector General (GAO/AFMD-87-22, July 20, 1987).

selected audit against key areas[3] of the audit standards shown in table I.1.

Table I.1: Standards Used for Assessing the OIG Audit Function

Categories	Comptroller General audit standards[a]	Other standards
Staff qualifications	Qualifications	
Independence	Independence Scope impairments	
Individual job planning	Planning	
Annual audit planning	No standard	Planning[b,c]
Supervision	Supervision Due professional care	
Legal and regulatory requirements	Legal and regulatory requirements	
Internal controls	Internal controls Auditing computer-based systems Due professional care	
Evidence	Evidence Working papers Due professional care	
Fraud, abuse, and illegal acts	Fraud, abuse, and illegal acts	
Reporting	Reporting	
Audit follow-up	Due professional care	
Quality assurance	No standard	Quality assurance[c]

[a]Comptroller General's Standards for Audit of Governmental Organizations, Programs, Activities, and Functions.

[b]OMB circular A-73, "Audit of Federal Operations and Programs."

[c]PCIE Quality Standards for Federal Offices of Inspector General.

For the investigation sample, we obtained an OIG-generated listing of 1,416 investigation cases closed between April 1, 1986, and September 30, 1986. We verified the list's accuracy by comparing it to reported closings submitted by regional offices for the review period. We then identified the cases completed by each regional office; determined the type of investigation (benefits fraud, false applications, social security account fraud, kickbacks, etc.) and the amounts recovered in savings, fines, and restitutions in the cases for review; and selected, judgmentally, 12 cases to examine from the Chicago, New York, and Philadelphia regional offices. We evaluated each selected investigation against key areas of the investigation standards shown in table I.2.

[3]A specific requirement contained in a professional standard, such as requiring sufficient evidence to support report statements—that is evidence which is factual, adequate, and convincing enough to lead others to the same conclusion as the auditor.

Table I.2: Standards Used for Assessing the OIG Investigation Function

Categories	PCIE quality standards[a]	PCIE investigation standards[b]
Staff qualifications	Assuring staff qualifications	Qualifications
Independence	Maintaining independence	Independence
Planning	Planning	Planning
Due professional care	No standard	Due professional care Execution
Directing and controlling	Directing and controlling	No standard
Coordination	Coordinating	No standard
Reporting	Reporting	Reporting
Preserving confidentiality	Preserving confidentiality	No standard
Screening allegations	Receiving, controlling, and screening allegations	Information management
Information management	No standard	Information management
Quality assurance	Maintaining quality assurance	No standard

[a]PCIE Quality Standards for Federal Offices of Inspector General.

[b]PCIE Quality Professional Standards for Investigations.

To evaluate the inspection function, we reviewed a sample of inspection reports, the OIG's newly developed standards and procedures, and its quality assurance program. For the inspections sample, we obtained an OIG-generated list of 11 inspection reports issued between April 1, 1986, and September 30, 1986. We verified the list's accuracy by comparing it to actual reports maintained in OIG files. We then identified the reports completed by each regional office; determined the program area addressed; and selected, judgmentally, six cases to review from the Boston, Chicago, and San Francisco regional offices. We evaluated each selected inspection against practices we consider critical in ensuring the quality and integrity of the inspection function's work.

Our review involved detailed work at OIG (1) headquarters in Washington, D.C., (2) regional offices for audit in Boston, Chicago, and New York, (3) regional offices for investigations in Chicago, New York, and Philadelphia, and (4) regional offices for analysis and inspections in Boston, Chicago, and San Francisco.

Comments From the Department of Health and Human Services

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

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Mr. Frederick D. Wolf
Director, Accounting and Financial
Management Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Wolf:

We appreciate the opportunity to comment on your draft report, "Inspectors General: Compliance with Professional Standards by the HHS Inspector General."

See comment 1.

We are very pleased that GAO was able to review our reported statistical results for a full 12-month period and validate $5.98 billion (92 percent) in monetary accomplishments. We are also pleased that GAO was able to report that the OIG "...is having a significant impact on HHS operations." With regard to the 8 percent of monetary accomplishments where some reservation was expressed, 80 percent of that figure ($450 million) related to one report, wherein GAO observed "Though the exact amount of savings resulting from this audit is not known, OIG officials believe the (actual) savings will be close to the amount reported." Thus only 2 percent of the total is still in dispute. Regardless of the merit of the disputed amounts, we believe action was warranted. We took the recommended steps to further strengthen controls over the reporting process.

See comment 2.

We also appreciate GAO observing that "The HHS OIG believes that independent estimates are more neutral and creditable." There is further reference that:

> "OIG policies state that savings are to be reported...only after definitive action to effect savings have taken place. For example, in cases of recommendations pertaining to legislation, the law must already have been passed and signed by the President, and in the cases of recommendations pertaining to changes in or issuance of new regulations, a final regulation must have been published before savings are reported. OIG policies also state that independent, outside estimates, such as Congressional Budget Office (CBO) estimates, should be obtained and used in the report when available."

Although these policies are more restrictive and conservative than is permitted under PCIE standards, we believe that they more accurately reflect accomplishments. We take GAO's emphasis of this point as reassurance that they believe this is a preferable method of reporting.

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See comment 2.

We also are pleased that as a result of your work GAO found OIG in full compliance with 82 percent of the investigative standards and 75 percent of the audit standards. On balance, GAO noted that "Corrective action was needed..." to be in full compliance. Although the materiality of deficiencies noted is very limited, we believe that any deficiency no matter how minor should be eliminated and we therefore concurred in all GAO recommendations and took immediate corrective action. In all cases, we cleared our corrective actions with GAO audit staff to ensure that actions taken were full and complete.

See comment 3.

We believe, however, that the tone of the report does not accurately reflect the overall operation of our office nor put in proper perspective the true sense of our accomplishments. Despite GAO's assessment of our accomplishments, the report seems out of balance and appears to convey what we believe to be an unintended view of the Office of Inspector General. As a result, an uninformed reader might conclude that the Office of Inspector General is performing at a lower level of quality than is actually the case. An examination of the report shows no evidence that GAO's findings are as significant as they might appear.

See comment 4.

For example, the report concludes that the audit function does not adequately comply with the standards of evidence. We disagree with what we believe to be an overgeneralized conclusion. The GAO leaves the impression that six reports with evidence deficiencies from two of our eight offices are typical of the more than 600 audit reports we issue annually nationwide. Further, deficiencies cited in three of the six reports as "...a lack of adequate evidence..." are on close reading merely nonmaterial technical deviations from standards of evidence. In any event, none of the reports GAO cites contained deficiencies significant enough to warrant amendment of the reports. In fact, five of the six reports in question were found convincing and concurred in by auditee and Department officials, with corrective actions already taken. Action on the sixth, calling for major program change, is under advisement.

Our comments on GAO's recommendations as well as a discussion of our specific concerns are enclosed. We believe that our comments, including those contained in this transmittal, should be appended in their entirety.

As we indicated at the outset of this engagement, it was our hope that a fresh, independent examination by GAO would give us added insights for improving our operations. The formal recommendations and informal observations by GAO audit staff have

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enabled us to make many changes that will strengthen us in meeting our statutory mission. For that, both the OIG as an organization and I personally, am grateful. Thank you.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

COMMENTS OF THE OFFICE OF INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT "INSPECTORS GENERAL: COMPLIANCE WITH PROFESSIONAL STANDARDS BY THE HHS INSPECTOR GENERAL"

General Comments

We appreciate the opportunity to provide comments on this draft report. We are concerned, however, that to a large extent the report is lacking in balance and proper perspective of the operation of the Office of Inspector General.

See comment 5.

With respect to the audit function, GAO gives the impression that the overall deficiencies noted in 8 reports (of the 18 reviewed) are typical of the more than 600 audit reports issued by the OIG annually. Further, the extent and significance of deficiencies cited by GAO are misleading and inconsistent with the standards themselves. For example, deficiencies cited in three reports as "...lack of adequate evidence..." were merely technical deviations from standards of evidence, and not a significant departure from those standards. In any event, no report contained deficiencies significant enough to warrant additional work or amendment. Were the deficiencies material, audit standards would dictate further action. In our opinion, the GAO risks credibility by projecting the relatively insignificant results of a very limited review to a broad generalization of the entire organization.

We do consider GAO's recommendations, many of which were made during the course of their review, as positive, helpful steps in improving OIG operations. We concurred with all recommendations and most are already in place. These include:

- o Development of an audit report review checklist to help evaluate and ensure that reports are in compliance with all reporting standards.
- o Revision of audit policy on quality assurance reviews to require that reviewers be external to the unit being evaluated and that the final report be issued directly to the Assistant Inspector General for Audit.
- o Development of a new information management system to provide more accurate data on the productivity and accomplishments of the Office of Investigations (OI).
- o Adoption of standards and procedures for inspections which deal specifically with supervisory responsibilities and the maintenance of supporting documentation.

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o Implementation of procedures for an independent verification of data to be included in the semiannual report, and changes to the report's presentation to provide the reader with a more in-depth understanding of the OIG's accomplishments.

Our comments on GAO's remaining recommendations follow.

GAO Recommendation

". . . that the inspector general evaluate whether this system [automated system to monitor action taken on allegations] will ensure compliance with the screening allegation standard and the OIG's own polices and procedures or that he develop an alternative approach which will."

OIG Response

See comment 6.

We agree with the GAO recommendation that we evaluate whether existing operations and procedures for the OIG hotline will ensure compliance with the standard for screening allegations as well as OIG policies and procedures. Although the hotline has been under the supervision of the Office of Investigations only for a short period, we believe that there is a vast improvement in its operation. We will continue to evaluate how well current operations comply with screening standards.

GAO Recommendation

". . . that the inspector general require all quality assurance reports to clearly state the scope of each review and include a statement that all identified weaknesses are discussed."

OIG Response

See comment 7.

We concur with this recommendation and will add these statements to future reports. With respect to past reports, we believe that participants in the process knew the full scope of those reviews. The instruments used were shared with regional office staff prior to entrance conferences as described in the scope of the review. Exit conferences were also held to discuss all weaknesses discovered.

GAO Recommendation

". . . that the inspector general require procedures to be developed for following up on quality assurance report recommendations to ensure that corrective action has been taken."

2

OIG Response

See comment 7.

Our current procedures require this; we will, however, determine whether further clarification is needed. At the completion of each quality assurance review the Assistant Inspector General (AIG) or Deputy AIG transmits the report to the appropriate office identifying specific weaknesses. The transmittal correspondence requires the office manager (i.e., the Regional Inspector General) to respond within 30 days with a corrective action plan. Those actions are corroborated by periodic follow-up reviews.

Specific Concerns

Our specific concerns follow. As will be seen, GAO's findings deal more with form rather than substance. The reports in question were generally concurred in by auditee and Department officials and corrective action taken.

Chapter 2 - Assessment of the Audit Function

1. GAO states:

> "In three of the six audits, no documentation existed in the working papers to support certain significant report findings. The findings were undocumented statements from agency officials and personnel upon which the OIG based report conclusions. In two of the audits the OIG based recommendations on these undocumented statements."

See comment 8.

OIG: GAO erroneously gives the reader the impression that there was no documentation to support the finding and conclusion, rather than that there was no documentation to support statements in the report attributable to auditee officials. In the three reports discussed by GAO, there is an implication that all findings and conclusions were invalid simply because there was an absence of documentation in the working papers supporting statements in the report attributable to auditee officials.

GAO is correct in stating that a document was not in the file at the time of their review. However, they are incorrect in stating that we did not have evidence to support these statements at the time they were made.

3

In sending a copy of our draft report to auditees for comment, we specifically request that auditees comment on the accuracy of the report presentation. When no comments to this effect are received, we believe it reasonable to conclude that the report presentation was accurate.

2. GAO states:

"In the other three audits, we found some documented support for the reports' findings and conclusions; however, it was not adequate to support all the reports' findings and conclusions."

See comment 9.

OIG: The illustration starting on page 21 pertains to an OIG report on the use of ambulances by ESRD patients to obtain dialysis services at hospitals. GAO disagreed with 8 (GAO says "numerous") claims that OIG concluded were questionable as to medical necessity. In reality, GAO disagreed with the sample results, and the nonstatistical projection of those results to the universe (and the inclusion of that projection in the OIG semiannual report). GAO sampled from 200 of the 300 claims reviewed by OIG and disagreed with 8 of them. This does not impact the adequacy of supporting documentation to the extent GAO is suggesting. It is the projection to the universe that GAO objects to, not that we found questionable a number of claims for which medical necessity did not appear to exist. The use of nonstatistical sampling is permissible under generally accepted auditing standards, and in some instances and under the right conditions, is preferable to statistical sampling. The GAO has not demonstrated that the use of nonstatistical sampling has made the OIG findings invalid. The thrust of our conclusion was: Should Medicare be paying for ambulance usage by any patient who merely requires regularly scheduled routine maintenance dialysis treatments provided in an outpatient setting of a hospital?

3. GAO states:

"However, we are concerned that the identified evidence weaknesses increase the risk that the OIG might experience problems with findings, conclusions, and recommendations resulting from its work."

4

See comments 4 and 5.

OIG: As indicated previously, none of the reports that GAO reviewed contained deficiencies serious enough to warrant the amendment or retraction of the report. The reports in question were generally concurred in by auditee and Department officials and corrective action taken.

4. GAO states:

> " . . . in 8 of the 18 audits, we found the OIG did not always (1) present sufficient information in the body of the report to convince the reader that its conclusions and recommendations were valid and/or (2) fully explain the scope and objectives of each audit."

See comment 10.

OIG: In six of the eight reports, agency officials were persuaded by the report findings to take appropriate corrective action. The remaining two reports called for major program change; corrective action is still pending.

5. GAO states:

> "Thus, the appropriateness of the OIG's recommendation is questionable, based on the information contained in the report."

See comment 10.

OIG: By letter dated April 18, 1986, PHS concurred with our findings and recommendations and issued policy guidance to the regional health administrators regarding adjusting and discounting fee charges; setting schedules of fees; billing and collection procedures; as well as other billing and collection practice areas where guidance was deemed appropriate. Program savings are being documented as a result of PHS' actions taken in a manner consistent with our findings and recommendations.

6. GAO states:

> "To illustrate, one report's scope section indicated that the audit was a review of the administrative costs claimed by a particular state for its Medicaid Management Information System. The scope section states that the review was limited to a general determination of the allowability of these costs for federal reimbursement. However, the work reported on in this audit was a review of claims from only one unit within the state, and the report scope did not disclose this limitation."

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See comment 11.

OIG: As brought out clearly in the OIG report, the unit in question performed one of several functions for which the State agency's Bureau of Medicaid Services was responsible. It is this bureau (and only this bureau) that operates the mechanized claims processing and information retrieval system, and therefore its costs to operate the MMIS qualify for 75 percent enhanced Federal sharing.

Other functions performed by the bureau do not qualify for enhanced sharing, e.g., third party liability determinations. Accordingly, our report recommended that costs associated with other functions of the bureau (e.g., third party liability determinations) be paid at the 50 percent rate and not the 75 percent enhanced rate.

7. GAO states:

> "The standard states that each OIG shall establish and maintain a quality assurance program."

See comment 12.

OIG: There was no such standard at the time of the GAO review. This was brought to GAO's attention at the exit conference. They were not able to produce such a standard. They only referred to PCIE guidance that encourages such a program. It is particularly disappointing to see GAO, who is charged with development of the standards, to abuse and misuse the term.

The 1981 revision of GAGAS did not require or even encourage implementation of a quality assurance program. The AICPA Professional Standards, AU 161, states that a firm of independent auditors should establish quality control practices and procedures. The word "firm" is defined in the AICPA's statements on quality control as a "...proprietorship, partnership or professional corporation engaged in the practice of public accounting..." The 1981 revision of GAGAS stated that the AICPA professional standards only apply to audits performed to express opinions on the fairness of financial statement presentation.

The GAO did not have adequate criteria to state that there was a quality assurance standard applicable to the OIG. GAO's recommendation regarding this issue was appropriate but this matter is not a compliance issue.

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Therefore, the subject statement in the draft report should be revised to state: "The OIG should improve its quality control function to obtain greater assurance of adherence to audit standards."

Chapter 3 - Assessment of the Investigation Function

1. GAO states:

> "OIG officials agreed with our observations and concerns regarding the delays in screening allegations. To correct this problem, the hotline operation was transferred back to OI in November 1987."

See comment 13.

OIG: We believe the second sentence should read, "To correct this problem, the OAI conducted a full study of hotline operations resulting in the development of a model manual, new operating procedures and a transfer of the function to OI where greater continuity could be maintained." This revised statement recognizes that we had identified several problems with the hotline process and prepared new operational procedures to rectify them, as opposed to saying the only change made was the organizational placement. Our manual was selected by the PCIE as a model for all IGs to review.

2. GAO states:

> "...corrective action is needed to bring the OIG into satisfactory compliance with the information management and screening allegations standards."

See comment 2.

OIG: We accept GAO's conclusions with regard to the Management Information System (MIS) of the Office of Investigations. We had, in fact, reached similar conclusions by 1984, and by July of that year had issued a Statement of Work to obtain contract support in the design, development, and implementation of a Case Management System (now known as CIMS) to replace the MIS. We were aware of the price such a commitment would exact in both time and money. We felt strongly, however, that a comprehensive, irrefutable data system was necessary to carry out the mission of the OIG. To ensure such a system we instituted a policy of verifying all Office of Investigations statistics on a monthly basis. We are gratified that GAO has acknowledged and affirmed our efforts to correct and improve our system.

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We informed GAO at the onset of their review that complete files of all evidence and statistics related to a case were maintained in the field. The GAO's review of our headquarters' files identified the need for us to enhance the data in these files. We have since decided that the files should also contain related statistical documentation, to assist in the monthly verification process. This action should further strengthen the reliability of our information reporting.

Chapter 4 - Assessment of the Inspection Function

1. GAO states:

> "The Office of Analysis and Inspections was organized in May 1985..."

See comment 14.

OIG: OAI was organized in April 1985.

2. GAO states:

> "There are no agreed upon professional standards for conducting inspections."

See comment 15.

OIG: In this paragraph, GAO relies heavily on a PCIE report in September 1984 which said that "inspections do not have to adhere to a specific set of standards such as the generally accepted Government auditing standards." At the time of the PCIE report and even today several Inspectors General have an inspections function, but the mission and methods of those units differ.

As the PCIE report states, "Inspections vary widely in terms of their objectives, approach (i.e., targets), scope and depth of coverage, duration, level of staffing, and adherence to standards." Our inspection activity performs timely program and management analysis. Others may review the efficiency of agency installations, etc. Because of these differences in function, the IG's decided it was highly inappropriate to develop a common set of standards. Instead, as GAO correctly points out, each IG was left to develop his or her own standards. We believe it is important for GAO to report the differences in functions as the primary reason for not having common standards and emphasize that the HHS-OIG has developed policies, procedures, and standards governing the inspection function within our own organization.

3. GAO states:

> "Neither the report [Medical Licensure and Discipline] nor the working papers discuss the issue of funding for the educational costs of students in foreign medical schools; however, the report contained three recommendations regarding the payment of federal assistance to foreign medical students for direct and indirect medical educational costs."

See comment 16.

OIG: Only one of the recommendations addresses the issue of funding for educational costs of students in foreign medical schools. The basis for that recommendation is stated in the report and in the rationale statement following the recommendation. The other two recommendations speak to the issue of Medicare reimbursement to U.S. hospitals for the direct and indirect medical education costs associated with foreign medical graduate residents. The basis for these recommendations can be found in the report and the rationale statements following the recommendations. It should be further noted that the report discusses the fact that the IG's recommendations were discussed by a departmental work group created by the Secretary himself in response to our formal verbal presentation to him. Consensus was reached on the appropriateness of and support for these recommendations.

Chapter 5 - Assessment of the OIG's Semiannual Report

1. GAO states:

> "We did not find satisfactory support for about $554 million of monetary accomplishments reported in the two semiannual reports we reviewed."

See comment 1.

OIG: Although we are pleased that GAO ratified that over 90 percent of our monetary accomplishments are being supported satisfactorily, we believe the characterization above is misleading in that $450 million (80 percent) in savings are in fact materializing.

2. GAO states:

> "We found that about $86 million in savings from two inspection reports were not satisfactorily supported by the referenced CBO estimate."

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See comment 17.

OIG: We believe this statement is only partially correct and implies a significance that is not warranted. The $86 million in question refers to savings attributed to two inspection reports. The first deals with our study on anesthesia services. The disagreement centers on the difference between our projected savings of $405 million and CBO's estimate of $360 million. We agree that the OIG attributed the $405 million to CBO when in fact the estimate was based on HCFA figures. As we explained to GAO staff, a mistake (i.e. the inadvertent deletion of a footnote referencing the HCFA source) in the preparation of the semiannual report led to this. While we accept responsibility for this mistake, we believe the GAO report unintentionally implies the higher savings figures are not supportable. This is clearly not the case. We supplied GAO with our support for the estimate in the form of a HCFA regulatory impact statement which provides full background and evidence for the calculations. That HCFA statement was published in the Federal Register/Volume 51, No. 158/Friday, August 15, 1986. We believe that fairness requires that GAO present this information to avoid the reader reaching an important conclusion which was not intended by GAO--that the savings figure is not supportable.

The second report GAO referenced in the $86 million figure concerned our inspection on Medical Licensure and Discipline. On page 59, GAO states that "...the OIG's support for the savings was not a CBO estimate, as reported, but an estimate from HCFA. CBO determined that no savings were associated with this legislation...the change merely legislated a requirement that the American Medical Association (AMA) had already imposed on all accredited teaching hospitals."

As we told GAO staff, we received a $41 million savings estimate from both CBO and HCFA. The CBO provided us its estimate on August 12, 1986. We independently obtained the same total savings estimate from HCFA. We were unsuccessful in our efforts to have GAO identify the CBO official they quote as saying there were no savings as the "...change merely legislated a requirement that the American Medical Association had already imposed on all accredited teaching hospitals." Had we been able to discuss this matter with CBO staff, we would have been able to clarify that the AMA may

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recommend that hospitals adopt certain policies, but cannot impose requirements on them. Only law or regulations can do that. As the administrator for the Medicare program, the HCFA understands this principle and correctly attributed the $41 million in savings to the IG recommended change. We, therefore, believe the GAO, is in error and should delete this finding.

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The following are GAO's comments on the Health and Human Services Inspector General's letter dated June 27, 1988.

GAO Comments

1. The purpose of our review was not to validate monetary accomplishments. Instead, we determined whether sufficient documentation existed to support examples of dollar savings of $1 million or greater reported in two of the OIG's semiannual reports. We did not verify the accuracy of the supporting documentation other than for those monetary accomplishments discussed under "Evidence" in chapter 2 and under "Information Management" in chapter 3. With respect to the $450 million, the OIG did not have satisfactory supporting documentation for including this savings estimate in the semiannual report at the time it was published. Subsequent events suggest that some savings will be achieved; however, the exact amount is not known.

2. No change to the report is necessary.

3. This review is the sixth in a series of quality assessment reviews designed to determine whether OIGs are performing their work in conformance with professional standards. Our report states that the OIG is in compliance with 18 of the 23 professional standards we tested and provides details on only those deficiencies that are of such significance as to undermine the quality of the OIG's work and to warrant corrective action by the OIG to eliminate the circumstances allowing those deficiencies to occur. The OIG's reported accomplishments were not reviewed as indicators of compliance with professional standards but were reviewed to determine the OIG's impact on HHS operations. While we believe the OIG has a significant impact on HHS operations, this was not used as criteria for assessing the OIG's compliance with standards.

4. In selecting our audit sample, we worked with OIG officials to choose a sample of 18 audits from the 350 issued during our 6-month sample period which would fairly reflect the size and diversity of the OIG's audit efforts. Our review of the supporting working papers showed the evidence used to support major findings and conclusions was not sufficient in 6 of the 18 audits. Irrespective of whether the auditee agrees to take corrective action, we do not believe that insufficient evidence is either nonmaterial or a technical deviation. Our review disclosed weaknesses in the OIG's quality controls for ensuring satisfactory compliance with auditing standards on evidence. The OIG agreed with our findings concerning its audit function and took immediate corrective action to improve its audit quality. (See chapter 2.)

5. Our review found audit quality problems in 9 of the 18 reports we reviewed. These nine audits were presented to the IG as indicators of conditions needing corrective action. We did not project our findings from the 18 audits reviewed to the universe of 350 reports issued during our 6-month sample period. Professional auditing standards require that report statements and dollar savings figures be accurate, reported fairly, and supported by appropriate documentation. Our report demonstrates the significance of our findings.

6. The HHS IG response is discussed under "Agency Comments and Our Evaluation" in chapter 3.

7. The HHS IG response is discussed under "Agency Comments and Our Evaluation" in chapter 4.

8. In the three audits in question, undocumented statements by unidentified agency officials and personnel were the basis for report conclusions and the corresponding recommendations in two reports. Obtaining auditee comments on draft reports does not exempt OIG auditors from gathering and/or retaining sufficient and competent evidence in their working papers to support report conclusions and recommendations.

9. The OIG did not have adequate evidence to support either the report conclusion or the $8.7 million in projected savings. The OIG concluded that due to fraud and the lack of documented medical necessity, none of the claims it reviewed should be paid. Our review of 150 of 200 claims in the working papers found that only 46 claims were applicable to end-stage renal disease patients and that 13 of the 46 had documentation showing specific medical necessity and proper reason for payment. We believe this to be a significant oversight by the OIG.

10. The convincingness of a report's recommendations is dependent upon the recommendations flowing logically from the evidence set forth in the report. For the reports in question, we were not convinced that some of the OIG recommendations, if implemented, would correct the identified problems. The basis for the recommendations were either not addressed in the report or were dependent on undocumented and/or uncorroborated testimonial evidence. Auditee agreement is not necessarily a reliable indicator of whether auditors followed auditing standards in their work.

11. The scope section of this report does not limit the review to only the third party liability unit's claims for enhanced administrative cost reimbursement, but rather infers this is a review of these claims for the entire MMIS system. The scope section also does not indicate that this report is one of several reports resulting from an OIG review of the allowability of claims for enhanced Medicare reimbursement. Since the report's recommendations are directed only at the third party liability unit, the reader may conclude, incorrectly, that this was the only unit submitting improper claims.

12. The PCIE Quality Standards for Federal Offices of Inspector General were adopted by the PCIE, which includes all of the statutory inspectors general. These standards were first adopted by the PCIE as interim standards in April 1985 and in final form in January 1986. This document includes a specific standard on quality assurance. We have assessed OIGs' compliance with this standard in our previous quality assessment reviews and have found it has been accepted throughout the IG community. An effective quality assurance program is necessary to ensure that work performed adheres to established OIG policies and procedures, meets established standards of performance, and is carried out economically, efficiently, and effectively. Due to the nature of the problems we found in the audit function, we believe the IG will benefit greatly from an effective quality assurance program.

13. The only formal studies of the OIG hotline operations were conducted before we began our review of the hotline. These studies were (1) a review of complaint processing released in April 1986 and (2) a sample review of hotline complaints referred to OI from December 1 through December 15, 1986, released in February 1987. The hotline procedures manual was under development throughout the course of our review and, as of August 1, 1988, has not been issued. We did not find any evidence that the manual was adopted by the PCIE as a model. However, the PCIE did use the draft manual in conjunction with other OIG hotline manuals to compile for publication a list of the type of procedures needed for an effective hotline operation. The report is amended to reflect the OIG assessment of the hotline operations.

14. Report changed to reflect April 1985 date.

15. No change to the report is necessary. The report recognizes the fact that inspection functions vary across the IG community.

16. Our work showed that the recommendations in question do not flow logically from the evidence presented in the body of the report. The report does not develop the issues of either federal funding or Medicare reimbursement for the medical education costs of foreign medical school students and graduates, yet the report contains recommendations addressing these issues. The fact that meetings among top HHS, OIG, and auditee officials produced agreement on certain recommendations does not exempt the final report from establishing a clear link between the corrective action recommended and the problem area addressed. OIG inspection procedures issued after our sample period require that all recommendations flow logically from the information presented in the report.

17. No change to the report is necessary. During our review, we tested to see if the OIG had satisfactory evidentiary support for its monetary accomplishments. OIG policy states that independent outside estimates, such as CBO estimates, should be obtained and used when available. In both these cases, CBO estimates were available but not used by the OIG. Instead, HCFA estimates were used but attributed to CBO. We found no explanation in the semiannual reports or the reports' backup documentation which provided the OIG's rationale for deciding that HCFA estimates were more appropriate than CBO's in these cases. Because it is OIG policy to use CBO estimates when available, it would seem that a justification for the use of HCFA estimates would be provided in these cases. We did not review the reliability of the HCFA estimates and thus we cannot attest to their validity.

In the second report discussed, which deals with medical licensure and discipline, the OIG states that CBO as well as HCFA provided it with the $41 million savings estimate. The OIG provided us with testimonial evidence in the form of a one paragraph memo stating that CBO personnel confirmed a $41 million savings estimate by telephone on August 12, 1986. However, the OIG did not provide CBO documentation to support any change in CBO's position. We contacted CBO's Deputy Assistant Director for Income Security and Health, whose group was responsible for the finding that no savings in Medicare outlays would result from enactment of this legislation, and he told us that the original CBO finding had not changed.

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