

The Journal of Public Inquiry

A Publication of the Inspectors General of the United States

ARTICLES

CORE CURRICULA FOR LEADERSHIP, MANAGEMENT, AND TEAM SKILLS

Robert Emmons, Pension Benefits Guaranty Corporation
Inspector General

ROLLING OUT IG E-TRAINING

Nikki Tinsley, EPA Inspector General, and John Mullins

LEVERAGING MEDICAID DOLLARS

Dan Levinson, HHS Inspector General

NOTES

TRICARE OVERSEAS PROGRAM (TOP) FRAUD

Daniel M. Boucek, DoD Office of the Inspector General

CAPTURING EXPERTISE: KNOWLEDGE MANAGEMENT WITHIN AUDIT

Melissa McBride, DoD Office of the Inspector General

HOW BETTER TO ENSURE THAT CONTRACTORS ARE RESPONSIBLE SOURCES FOR MAJOR PROCUREMENTS

Diane H. Stetler, DoD Office of the Inspector General



Fall/Winter 2005



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In This Issue

Welcome to the Fall/Winter 2005 issue of *The Journal of Public Inquiry*. This edition is replete with articles and notes addressing a variety of timely issues that impact the Inspector General community. The topics include a wide array of Inspector General operations from health care fraud to measuring contractor performance to showcasing advances in the management of human capital. Diverse as the subject matter is, the articles share a common theme—each presents significant policy and operational challenges for decision makers.

Mr. Robert Emmons, Inspector General, Pension Benefits Guaranty Corporation, discusses “Core Curricula for Leadership, Management, and Team Skills.” The Curricula was developed jointly by the President’s Council on Integrity and Efficiency (PCIE) and the Executive Council on Integrity and Efficiency (ECIE). Mr. Emmons introduces the Curricula as a dynamic tool that can effectively and efficiently identify training opportunities that are linked to specific Inspectors General core competencies. The article also discusses the embedded evaluation system that demonstrates the Curricula’s added value as a compendium for employees, supervisors, and human capital managers. Cutting across the disciplines of the Inspector General community, the Curricula builds on the success of previous Human Resources Committee studies and enhances the professionalism of the Inspector General by advancing career development.

Ms. Nikki Tinsley, Inspector General, Environmental Protection Agency and Mr. John Mullins team up to discuss “Rolling Out OIG E-Training.” Ms. Tinsley, Chair of the Human Resource Committee, and Mr. Mullins, Advisor to the Human Resources Committee and Project Lead for Inspector General Electronic Learning (IGEL), argue that implementation of E-Learning offers many advantages over classroom training. The authors advocate that the growth of E-Learning is overcoming the traditional classroom limitations of location, time, and space. Additionally, the authors make the case that E-Learning builds organizational capacity through enhanced, cost-effective E-Learning opportunities and programs for employees. In the authors’ view, and through early use of statistics support, E-Learning is an effective tool that supports self-paced training, reflecting each employee’s unique needs and interests. Additionally, the rollout of Ms. Tinsley’s and Mr. Mullins’ E-Learning gives departments and agencies the opportunity to implement key components of the President’s Management Agenda while at the same time leveraging individual and organizational performance.

Mr. Dan Levinson, Inspector General, Department of Health and Human Services, calls our attention to key national issues impacting taxpayers—the containment of Medicaid health care costs and the effective use of precious dollars. “Leveraging Medicaid Dollars” is a national priority, and Mr. Levinson outlines the unique challenges and complexities of preserving and safeguarding Medicaid and Medicare program integrity. In *Leveraging Medicaid Dollars*, Mr. Levinson emphasizes the need to effectively collaborate in an increasingly complex operational environment. Mr. Levinson’s interagency oversight partnerships enable his agency to accomplish its mission by “ensure[ing] the best possible deployment of the nation’s health care dollars dedicated to assisting those most vulnerable and in need.” “Leveraging Medicaid Dollars” cogently demonstrates the strategic value of building and sustaining strong teams.

New to the Journal is “notes” from Capstone studies DoD employees conducted while participating in the Office of the Inspector General-sponsored Georgetown University masters degree program. The notes are abstracts of comprehensive studies examining unique policy challenges facing the IG community. The full studies discuss analysis of topical issues and offer alternatives for organizational decision-makers. The full text of the articles are at <http://www.ignet.gov/randp/jpi1.html>.

In the first Capstone study, “TRICARE Overseas Program Fraud,” Mr. Daniel Boucek substantively analyzes and discusses the identification and prevention of health care fraud. In a challenging overseas environment, Mr. Boucek, a Special Agent in Charge, Defense Criminal Investigative Service, DoD, found that policy anomalies created windows of vulnerability for fiscal exploitation. Coupled with a third world business environment, the anomalies created significant enforcement challenges. However, Mr. Boucek recommended a creative solution to build viable stakeholder partnerships. Through their mutual understanding that has led to the growth of mutual accountability, stakeholders identify fraudulent activities, improve delivery of health care services, and create positive outcomes for the American taxpayer. Drawing on 17 years of practical experience, Mr. Boucek, recommends no-nonsense policy solutions that offer incentives for stakeholders to close the fraud gap.

Ms. Melissa McBride’s Capstone study offers the results of an analysis of a looming human capital threat—loss of intellectual capital in the audit community. In “Capturing Expertise: Knowledge Management within Audit,” Ms. McBride, a Senior Contract Management Auditor, examines the audit community’s efforts to bridge the knowledge gap that departing baby boomers are creating. She argues that while existing knowledge management programs are successful, the escalating rates of employee departure coupled with progressively more complex audit requirements necessitate adaptive approaches for maintaining a competency base. In a community of practice with increasingly high performance demands, Ms. McBride lays out a proposed roadmap for successfully capturing institutional knowledge. Ms. McBride’s examinations of innovative knowledge management programs provide a foundation for her blended interdisciplinary solution.

“How to Better Ensure That Major Contractors Are Responsible Sources for Department of Defense Procurements,” will strike a responsive chord with many Inspectors General. Ms. Diane Stetler, Senior Project Manager, Audit Policy Office proposes that existing disciplinary measures fail to ensure that contractors are “responsible sources.” Her policy analysis reveals that competing interest and divergent views of stakeholders are impeding development of legislative solutions. She argues that fundamental structural changes in the business environment have negatively impacted contractor integrity and business ethics. Ms. Stetler proposes an alternative approach to the existing enforcement activities that produce undesirable outcomes. Her solution focuses on actively promoting and implementing effective contractor self-governance systems. She advocates policy changes that employ both independent certification of contractor self-governance programs and cyclical reviews by agency program managers. She concludes with the conjecture that a blended approach increases competitiveness at while strengthening the industrial base.

We know you will find this issue provocative, challenging, and thought provoking. Enjoy!

PCIE CORE CURRICULA

CORE CURRICULA FOR LEADERSHIP, MANAGEMENT, AND TEAM SKILLS

*by Bob Emmons, Inspector General, Pension Benefit Guaranty Corporation, and
John Mullins, Core Curricula Work Group Leader*

INTRODUCTION

The foundation of any organization's success depends in large part on the talents and commitment of its human resources—its people. That is particularly true in the Inspector General community, where the talents and commitment of our workforce are dedicated to improving the performance and capabilities of our Nation's Federal programs. We are in the knowledge business, and our organizations are only as capable as our people. Therefore, it is critical that OIG leaders recognize and commit to providing the workforce with the tools and resources necessary to deliver on our mission. This article tells you about the Core Curricula concept, how the concept was developed, and where you can get additional information.

WHAT IS THE CORE CURRICULA?

The Core Curricula identifies courses anyone in the IG community can attend to develop core competencies. Core competencies are more than knowledge, skills, and abilities; they are also behaviors critical to our achieving the mission. The Core Curricula provides a list of vendors and courses designed to improve leadership, management, and teamwork skills at the entry, intermediate, and advanced levels. The curricula is limited to cross-cutting competencies that apply to all professions in the IG community—occupational mastery courses specific to auditors, investigators, inspectors, and other professionals are not included.

WHAT ARE THE CORE COMPETENCIES?

The President's Council on Integrity and Efficiency (PCIE) Human Resources (HR) Committee conducted several studies that identified core competencies developing training programs for auditors, evaluators, and investigators. Based on the first study, the community adopted the core competencies identified below.

WHY DO WE NEED A CORE CURRICULA?

Traditionally, our training programs have been devoted to occupational mastery, which are the transfer of technical skills unique to a specific profession. Increasingly, our employees need training in cross-cutting competencies, such as creativity, vision,

Table 1. Core Competencies for IG Community

Leadership	Management
Constitution	Stewardship
Vision	Accountability
Political Skills	Customer Service
Influencing/Negotiation with External Groups	Financial Management
Globalization and Cultural Awareness	Human Capital
Entrepreneurship/Business Practices	Technology Management
Continual Learning	Project Management
Results Orientation	
Resilience	Decisiveness
Leading People	Strategic Thinking
Integrity	Systems Thinking
Team Skills	Occupational Mastery
Creativity	Agency/Mission Knowledge
Team Problem Solving	Audit Standards and Practices
Coaching	Criminal Laws and Procedures
Conflict Resolution	Evaluation Methods and Techniques
Integration	Oral Communication
Time Management	Written Communication
Group Facilitation	Administrative Law and Procedures
Team Development	Information Technology Tools

and strategic thinking. For that reason, the HR Committee chartered a working group that would identify and evaluate courses focusing on the cross-cutting competencies (leadership, management, and team skills).

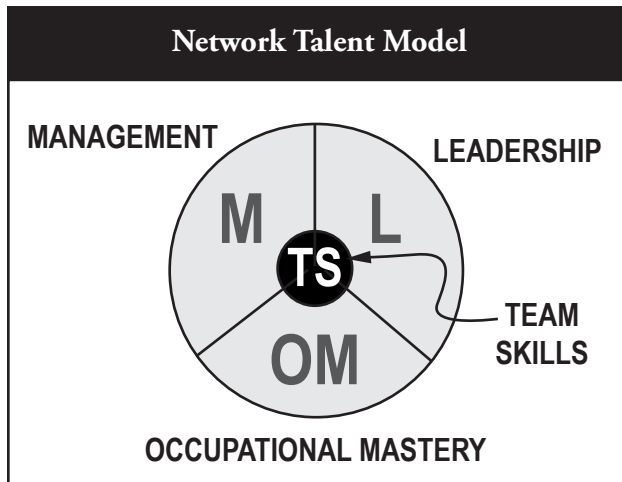
The need for Core Curricula is best illustrated by the Network Talent Model, which is applicable to everyone in the community. The Network Talent Model is displayed below in Figure 1.

No matter your career field, you possess

occupation-specific competencies needed to accomplish your occupation. However, your success also depends on your proficiency in the three cross-cutting competencies of leadership, management, and teamwork.

HOW DO I PROGRESS?

The skill level for each of the core competencies changes as you progress. For example, at the entry



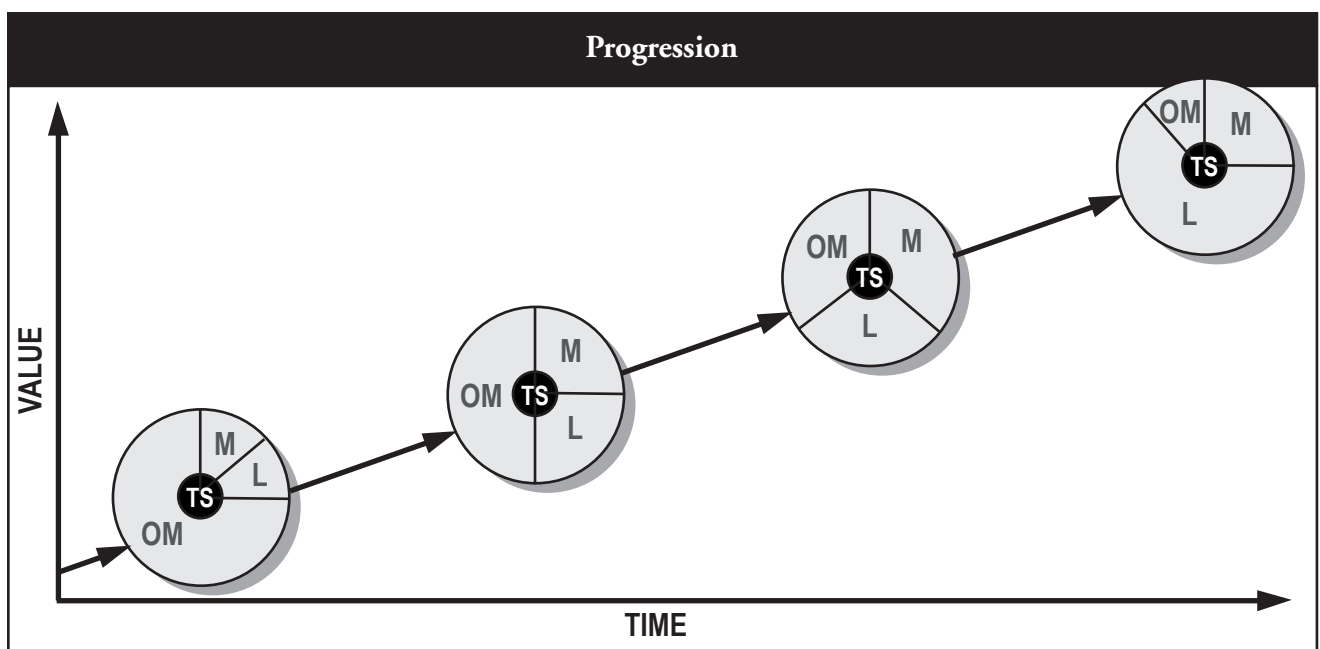
level position, the focus is on building and mastering technical skills and knowledge. The model would reflect the higher proportion of technical skills development. As individuals advance to the next level, they will be expected to learn and demonstrate increased leadership, management, and team skills in performance and execution of projects and to ensure technical proficiency. At the journeyman level, staff are expected to be proportionally developed and performing the full range of leadership, management, and team skills, as well as be technically proficient in their area of specialization. In other words, one will not reach the journeyman level in their discipline framework (grades and steps) unless the appropriate leadership,

management, and team skills are developed and demonstrated in work. The illustration below demonstrates the progression.

HOW WERE COURSES SELECTED FOR THE CORE CURRICULA?

Because hundreds of sources for training exist, the work group narrowed the initial number of vendors included in the curricula to a small number of providers. Using the collective judgment of the team, we selected vendors recognized for providing high-quality training in the areas of leadership, management, and team skills. We selected the following vendors for inclusion in the Core Curricula:

- USDA Graduate School
- Brookings Institute
- Federal Executive Institute
- OPM Management Development Centers
- Institute of Internal Auditors
- Management Concepts
- Performance Institute
- Association of Government Accountants
- Potomac Forum, Ltd.
- Harvard–John F. Kennedy School of Government Senior Executive Fellow Program
- Inspector General Management Institute



After evaluating courses each vendor provided, the work group selected 100 courses for inclusion in the Core Curricula. The curricula can be found on the IGSNet Web site under the reports and periodicals tab. The courses are identified by general competency area and by level (entry, intermediate, and advance) to help you find the best course for your needs. The vendor, course title, learning objectives, competencies, cost, and length are included for each course.

In the future, we plan to include information on more courses and gather data on the quality of the courses. The work group developed an evaluation system for collecting feedback when you complete a course. The evaluation will ask you to evaluate the course's effectiveness as well as the value and relevance to the IG community. The HR Committee will periodically review the survey results to update the curricula evaluate the quality training. The Training Evaluation Survey can be accessed at <http://www.ignet.gov/evals/>.

CONCLUSION

The Core Curricula should be used as a tool for identifying courses that address training needs for cross-cutting competencies. When developing individual development plans for leadership, management, and team skills, you and your supervisor should consider the courses in curricula. Please contact your Human Resources or Training Director or go to IGSNet and acquire your own personal copy of the Core Curricula. In closing, we want to thank the Core Curricula Work Group for their leadership, dedication, and hard work that is evident in their product. The HR Committee will continue to look to them for guidance in the future as we continue to expand and improve the curricula.

CORE CURRICULA WORK GROUP

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THE IGEL PILOT

E-LEARNING IN THE INSPECTORS GENERAL COMMUNITY—THE IGEL PILOT

by Nikki Tinsley, Inspector General, Environmental Protection Agency and Chair of the Human Resources Committee, and John Mullins, Advisor to the Human Resources Committee and Project Lead for IGEL.

“The illiterate of the 21st Century will not be those who cannot read and write, but those who cannot learn, unlearn and relearn.”
- Alvin Toffler, futurist and author

Toffler’s quote is more true today than at any time in history. As agents of positive change, Inspector General (IG) offices struggle to position themselves to help their departments and agencies continually improve. How can IG offices embrace and commit to the continuous learning required for helping their departments and agencies improve programs and operations, increase Government integrity, thwart crime, build relationships across levels of Government while providing innovative solutions to complex problems? One strategy is E-Learning. The IG community’s E-Learning (IGEL) pilot provides staff with access to a broad range of curricula, information, and performance enhancement tools in a “just in time” and “any place” learning and work environment.

BACKGROUND

E-Learning is not new—it has a surprisingly long history. With its beginnings during the 1970s, many computer programmers got their first lessons on green-screen machines.¹ During the next stage of development—1980 through 1990—satellite-based video training, commonly called distance learning, brought together large gatherings with multiple speakers from around the world. Global companies such as FedEx and Xerox participated in such events as a way of providing information and communicating key directions to their staff across the globe. During that same period, PC-based training began by way of the CD ROM.² Programs such as DOS and Windows were among the first products in that format. The first generation of Web-based training or the virtual classroom, what we now commonly understand as E-Learning, began in 1998.³ Current trends in E-Learning emphasize blended learning experiences incorporating the Web, video, audio, and simulations. IGEL builds from best practices, offering the IG community state-of-the-art E-Learning opportunities. E-Learning is also advocated through the President’s Management Agenda.

¹ *E-Learning: Evolution, Best Practices and Future Solutions*, Jack J. Phillip and Christine Pope, ASTD 2001.

² *How Did We Get Here?* Josh Bersin, Jossey-Bass, 2004.

³ *Ibid.*

THE IGEL APPROACH

Work on the IGEL pilot began in April 2005 when an E-Learning Steering Group that represented the community met to develop guidance and support for 35 participating IG offices. The Steering Group met for the first time in late April. IGEL was launched in July. With the assistance of subject matter experts, the Steering Group developed learning programs for each key occupation within the community.

The staff at participating IG offices were asked to test a learning program based on their specific occupations or their areas of operations. When the IGEL pilot ends in April 2006, the Steering Group will report to the PCIE/ECIE the effectiveness of E-Learning as a way of increasing the skill levels of the community, reduce overall training hour costs, increase actual training hours and training opportunities, while supporting developing core skills and training experiences consistent with the community's core competencies.

THE POWER OF E-LEARNING

We are already learning that E-Learning has many advantages over classroom training including:

- Broader reach. E-Learning has no boundaries. E-Learning does not have travel restrictions, scheduling concerns, or restrictions on classroom size.
- Consistency across the organization. With E-Learning, delivery is consistent. Customization of content can be designed into the course or blended learning can be conducted to bring a fresh touch or feel consistent with specific user requirements. However, the strength of E-Learning is in the consistent delivery of learning across an organization.
- More choice. We have more than 2,000 courses available to the community. Students can take courses when they feel the need or when they desire greater skill proficiency. Staff can and are encouraged to go where their interests take them. Tomorrow's work will need different sets

of skills than we have today. IGEL provides a rich curricula for IG staff to explore.

- Training on demand. Training is available when the user wants or needs it. IGEL is available 24 hours a day, 7 days a week. You do not need to be on line to take IGEL courses. Courses can be downloaded to the student's laptop and the course taken on an airplane, at the beach, or wherever students find themselves. Upon reconnection with the Web site, course work is updated into the student's individual folder.
- Self-paced training. For too long, students were locked into the pace of the classroom instructor or the slowest student. No longer; E-Learning is self-paced. You can go as fast or as slow as necessary. In our pilot, students are encouraged to take the course test first. If they pass, they receive credit without having to take the course. Self-paced training can accelerate the learning process and ensure a level of proficiency that we expect within the IG community.
- Training that reflects employee needs and interests. While the Steering Group established expectations around specific occupations and core competencies, NO restrictions on the overall curricula exist. Staff can take as many courses as they want.
- Custom content. The IG community is the first in the Federal Government to have access to "Dialogue." Dialogue is a virtual classroom application that lets us provide custom content to our community. We are pleased to announce that the Number 2 course is a course our Investigative Academy developed—"Flying Armed." For participating agencies, investigators no longer need to schedule, travel, and pay for the course. The course is available through Dialogue. As a virtual classroom application, Dialogue is a powerful tool and provides IG investigators with a solution to their training challenges.
- Performance enhancement tools. IGEL provides access to Books 24x7 Referenceware. With more than 7,000 titles, the reference library promises to be of immense value. Books 24x7 comes with a powerful search engine that identifies books,

chapters, and pages that can be read, copied, and pasted into our work products. With Books 24x7, offices can reduce the need to purchase books. Instead, staff can peruse hundreds of books or a few on a specific issue or problem, or search for best practices to support findings and recommendations, or both. Such functionality has the potential to significantly increase staff research capabilities.

EARLY PILOT PERFORMANCE

The IGEL pilot is receiving strong support and activity in the community. At the end of August, IG staff had accessed more than 2,000 courses. The top three courses included Blood-Borne Pathogens, Flying Armed, and Building Relationships to Get Results. Staff also made extensive use of Books 24x7, having read more than 4,600 pages on line. The top three books assessed were “Project Management Tool Kit,” “100 Tip and Techniques for Getting the Job Done Right,” and “175 Ways to Get More Done in Less Time.”

The Human Resources Committee and I are encouraged with early performance statistics and the promise of the IGEL pilot. When users were asked to respond to whether the course content was useful, 85 percent responded strongly agree. On a similar track, when asked whether the subject matter could be applied to their work, 84 percent of the respondents strongly agreed.

CONCLUSION

How does the IG community posture itself to continually improve? How do IG leaders assist IG staff embrace and commit to the continuous learning required to work with their departments and agencies to improve programs and operations, to increase Government integrity, to thwart crime, to build relationships across Government lines, and to provide innovative solutions to complex problems? E-Learning may prove to be part of the strategy. While not a silver bullet, the strategy could prove to be a component of our comprehensive

workforce capability development program. The Human Resources Committee encourages pilot participants to log on to IGEL at <http://igel.skillport.com>

I want to express my thanks to the IGEL Steering Group whose names are listed below. Their dedication, insight, and sense of community are evident in this E-Learning pilot.

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LEVERAGING MEDICAID DOLLARS

LEVERAGING PARTNERSHIPS TO MAXIMIZE THE MEDICAID DOLLAR

by Daniel R. Levinson, Inspector General, Department of Health and Human Services

Rising health care costs and the critical need to maximize health care dollars are key national concerns. The Department of Health and Human Services (HHS) administers two of the largest Government health care programs, Medicare and Medicaid, making those matters of paramount importance to the HHS Office of Inspector General (OIG). One major responsibility for the OIG is ensuring that Federal payments for Medicaid are accurate and appropriate.

Complexity is generally inherent in health care program administration, and Medicaid is no exception. Because it is structured as a Federal-state partnership, Medicaid presents special challenges for ensuring appropriate and effective use of funds. Accordingly, collaboration between a number of Federal and state partners is more than desirable—it is essential. We, therefore, place a premium on information sharing and strategic coordination across jurisdictional boundaries.

This article outlines the challenges of identifying and addressing improper payments and fraud in the Medicaid program. It also describes the roles of OIG and a number of our partners in contributing to a coordinated strategy for ensuring Medicaid integrity. Although the Medicaid program is unique in some administrative respects, we hope that by sharing how we rely on Federal-state partnerships to oversee Medicaid, useful insights may be gained for those responsible for other government program oversight activities where multiple authorities are involved.

THE MEDICAID PROGRAM

Medicaid is the largest government health insurance program in the United States and provides a vital safety net for millions of low-income Americans. Jointly funded by the Federal Government and the states, the Federal share of Medicaid outlays in fiscal year (FY) 2004 exceeded \$176 billion and is expected to exceed \$192 billion in FY 2006. In FY 2004, Medicaid covered 43.7 million federally eligible children and adults, and the number of federally eligible enrollees is expected to exceed 46 million in FY 2006.¹

At the Federal level, the Centers for Medicare and Medicaid Services (CMS) administer the Medicaid program. The Federal Government pays a share of each state's Medicaid program costs, known as the Federal Medical Assistance Percentage (FMAP). The FMAP ranges by state from 50 to 83 percent and is determined annually based on

¹ *Centers for Medicare and Medicaid Services FY2006 Budget in Brief.*

each state's average per capita income level. With certain exceptions, Federal payments to states for medical assistance have no set limit. Rather, the Federal Government matches (at FMAP rates) each state's outlay for covered items and services and also matches, at the appropriate administrative rate (typically 50 percent), the necessary and proper administrative costs.

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis or may have managed care arrangements. Within federally imposed upper limits and specific restrictions, states have broad discretion in determining the payment methodology and payment rate for services.

IMPROPER PAYMENTS AND FRAUD IN MEDICAID

Because Medicaid is a matching program, improper payments by states to providers cause corresponding improper Federal payments. However, the Federal Government does not routinely examine individual provider claims, and therefore inappropriate claims by states for a Federal share are not always easily identified. Controlling

the cost of Medicaid and maximizing the Medicaid dollar involves identifying and resolving improper and fraudulent payments and strengthening the integrity of the program through our audits, program evaluations, investigations, and use of statutory authorities to sanction providers who have engaged in fraud.

TYPES OF IMPROPER PAYMENTS

While some improper payments are fraudulent, our sense is that the majority of providers are honest in their billings for Medicaid reimbursement. However, improper payments may arise because of clerical errors, misinterpretations of rules, or poor record keeping. Improper payments include both overpayments and underpayments and are generally adjusted or collected administratively. Common categories of improper payments are detailed in Table 1.

TYPES OF FRAUDULENT ACTIVITIES

Some improper billings and related practices are also determined fraudulent. Fraudulent behavior may arise when enrollment procedures for providers

Table 1. Types of Improper Payments

Unsupported Services	Providers must maintain sufficient records to justify diagnoses, admissions, treatments, and continued care. When the records are insufficient or missing, claims reviewers cannot determine whether services billed were actually provided to beneficiaries, the extent of the services, or their medical necessity.
Medically Unnecessary Services	The medical record documentation leads an informed claims reviewer to conclude that the medical services or products received were not medically necessary.
Incorrect Coding	Standard coding systems are generally used to bill state Medicaid programs for services provided. In a coding review, medical reviewers determine whether the documentation submitted by providers supports a lower or higher reimbursement code than was actually submitted.
Noncovered Costs or Services	Some costs or services Medicaid will not reimburse because they do not meet the state's Medicaid reimbursement rules and regulations.
Third-Party Liability	Medicaid inappropriately pays claims, and is generally not reimbursed, for beneficiaries who have other sources of payment, such as private insurance.

Table 2. Types of Fraudulent Activities

Billing for Services Not Provided	One of the most common types of fraud. Examples include a provider who knowingly bills Medicaid for a treatment or procedure that was not actually performed, such as blood tests when no samples were drawn or x-rays that were not taken.
False Cost Reports	A nursing home owner or hospital administrator may intentionally include inappropriate expenses not related to patient care on cost reports submitted to Medicaid.
Illegal Remunerations (Kickbacks)	One health care provider may conspire with another to share in the monetary reimbursement the provider receives in exchange for the referral of patients. Kickbacks can include cash or other items of value. The practice results in encouraging performance of unnecessary tests and services designed to generate additional income to both the referring source and the provider.

are inadequate, internal controls are deficient, payment rates are excessive (inviting fraudulent and abusive behavior), or when especially vulnerable beneficiaries can be exploited easily. The types of fraudulent schemes we see in the Medicaid program in many ways mirror those in Medicare and are likely relevant to Federal health care programs in other Departments. Table 2 describes three categories of fraudulent activities.

**ENSURING MEDICAID INTEGRITY:
FEDERAL AND STATE PARTNERS**

The responsibility for detecting improper payments and investigating and prosecuting fraud and abuse in the Medicaid program is shared between the Federal and state governments. At the Federal level, OIG, CMS, and Federal law enforcement agencies (including the Department of Justice) collaborate to ensure Medicaid integrity and to investigate and prosecute fraud. Our state-level partners include state Medicaid agencies, state Medicaid Fraud Control Units, state auditors, and state attorneys general. Each of those Federal and state partners makes critical contributions toward protecting and maximizing the Medicaid dollar. Table 3 (on the next page) briefly describes some of the responsibilities of the partners and a few examples of their activities to ensure Medicaid integrity.

OFFICE OF INSPECTOR GENERAL

The OIG conducts a variety of activities that promote the economy, efficiency, and effectiveness of Medicaid. Activities include investigations and litigation of fraud and wrongdoing, audits of Medicaid payments, evaluations of the management and effectiveness Medicaid programs, and provision of legal guidance. These activities result in criminal convictions, settlements, recovery of misspent funds, savings through funds put to better use, and improved program operations.

**IDENTIFYING AND PURSUING IMPROPER
PAYMENTS AND FRAUD**

One significant OIG role in Medicaid integrity is identifying and pursuing improper payments and fraud. Improper or fraudulent payments result in a substantial drain on state and Federal funds. Therefore, our office conducts a large number of Medicaid audits on our own initiative or at the request of CMS, the Department, or Congress. Intended to identify improper payments, these audits not only reveal questionable billings, but sometimes expose fraud, program management deficiencies, or weaknesses and loopholes in program rules. When we question Medicaid payments, we notify CMS of our findings. If CMS

Table 3. Federal and state Partners in Ensuring Medicaid Integrity

PARTNER	RESPONSIBILITIES	EXAMPLES OF RELATED ACTIVITIES
Federal:		
OIG	Promote economy, efficiency, and effectiveness of Medicaid through the elimination of fraud, waste, and abuse Oversee Medicaid Fraud Control Units	<ul style="list-style-type: none"> • Audit and evaluate Medicaid payments and administration • Investigate Medicaid fraud • Provide legal guidance • Refer and assist in Federal fraud cases
CMS	Administer Medicaid (Federal level) Oversee state Medicaid agencies	<ul style="list-style-type: none"> • Oversee and assist states' program integrity efforts • Lead Medicaid Alliance for Program Safeguards • Develop Medicaid error rate
DoJ	Enforce Federal laws (related to Medicaid fraud)	<ul style="list-style-type: none"> • Investigate and prosecute Federal Medicaid fraud cases
State:		
State Medicaid Agencies	Administer Medicaid (state level)	<ul style="list-style-type: none"> • Conduct pre- and post-payment screens • Detect aberrant billing • Identify and refer potential fraud cases
Medicaid Fraud Control Units	Investigate and prosecute Medicaid provider fraud, administration fraud, and patient abuse and neglect	<ul style="list-style-type: none"> • Investigate fraud and abuse referrals • Prosecute identified fraud and patient abuse/neglect • Pursue civil litigation
State Auditors	Ensure efficient and effective management of public funds (including Medicaid funds)	<ul style="list-style-type: none"> • Audit internal controls and systems operations of state Medicaid programs
State Attorneys General	Enforce state laws (related to Medicaid fraud)	<ul style="list-style-type: none"> • Prosecute state Medicaid fraud cases

agrees the questioned payments were improper, it recovers the Federal share from the states.

If we find possible fraud, our criminal investigators review the matter and determine whether to open an investigation. Our auditors may also assist in the ongoing criminal investigations being conducted by our office or other law enforcement agencies. OIG, along with the Department of Justice and other law enforcement agencies, has achieved major successes in using the False Claims Act, and in particular its *qui tam*² provisions, in pursuing fraud in both the Medicare

and Medicaid programs. Many of these cases have been brought against pharmaceutical companies and have resulted in unprecedented civil and criminal monetary penalties.

OVERSEEING THE STATE MEDICAID FRAUD CONTROL UNITS

Since 1979, OIG has been responsible for management and oversight of the state Medicaid Fraud Control Units (the units) grant program. The purpose of the Medicaid Fraud Control Units

² The *qui tam* provisions allow whistleblowers to bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The False Claims Act imposes civil liability on any person or entity who submits a false or fraudulent claim for payment to the United States Government. The whistleblower, or relator, may share in any later recoveries, whether ordered by a court or as the result of a settlement.

is to investigate and prosecute Medicaid provider fraud, patient abuse or neglect, and fraud in the administration of the program. (The activities of the units are described in more detail later in this article.) OIG responsibilities include monitoring the units' overall performance and productivity and certifying the units, in accordance with performance standards developed jointly by OIG and the units themselves. We maintain ongoing communication with individual state units and the National Association of Medicaid Fraud Control units related to the interpretation of program regulations and other policy issues.

Oversight responsibilities afford OIG an opportunity to coordinate effectively with the units. Our office, the Medicaid Fraud Control Units, and other law enforcement agencies work closely on fraud cases and other activities, and these partnerships have greatly enhanced the OIG's ability for carrying out its mission. In FY 2004, the OIG conducted joint investigations with the units of 314 criminal cases and 91 civil cases and achieved 64 convictions.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

As the Federal administrator of Medicaid, CMS plays a crucial role in ensuring Medicaid program integrity. To that end, in 1996 the agency established a program integrity group specifically to address fraud and abuse issues within the Medicaid and Medicare programs. That group conducts and oversees many projects intended to reduce program fraud. CMS is also leading development of a methodology for measuring Medicaid program error rates. Another effort, called the Medi-Medi pilot, compares Medicare and Medicaid billing data to identify aberrant provider billings, such as situations in which both programs are billed for the same items and services.

CMS also leads the Medicaid Alliance for Program Safeguards, which is a national intergovernmental initiative for reducing Medicaid

fraud and abuse. Partners in that alliance include OIG, state Medicaid programs, state Program Integrity Units, state Medicaid Fraud Control Units, the Federal Bureau of Investigation, and the Department of Justice. Accomplishments include presenting intergovernmental executive seminars and issuing a comprehensive plan for program integrity, guidelines for addressing fraud and abuse in Medicaid managed care, and a resource guide of state fraud and abuse systems. Among other activities, the Alliance is conducting a series of program integrity reviews at state Medicaid agencies designed to help states strengthen their program integrity operations to prevent, identify, and resolve improper and fraudulent Medicaid payments.

STATE MEDICAID AGENCIES

Each of the state Medicaid agencies is required to have a program integrity unit or other office that conducts preliminary investigations of suspected fraud and refers cases to the state's Medicaid Fraud Control Unit or other appropriate law enforcement officials for a full investigation. In addition, each of the state Medicaid agencies has a data system, called the Surveillance and Utilization Review Subsystem, which is a part of the state's Medicaid Management Information System. In smaller states, surveillance units may also operate the program integrity units, conducting preliminary reviews of Medicaid fraud or abuse and referring appropriate cases for a full investigation. In all states, the surveillance data system applies automated post-payment screens to Medicaid claims to identify aberrant billing patterns that may indicate fraud or provider abuse. When potential fraud cases are detected, the state agency refers the cases to the state's Medicaid Fraud Control Units.

STATE MEDICAID FRAUD CONTROL UNITS

As discussed, OIG oversees the state Medicaid Fraud Control Units grant program, whose purpose

is to investigate and prosecute Medicaid fraud and patient abuse or neglect. The Units are part of the state attorney general's office or other state agency that is separate and distinct from the Medicaid state agency.

Over the years, the units' efforts resulted in hundreds of millions of dollars in recoveries and thousands of convictions. Recoveries include settlements or court-ordered restitution, fines, and penalties. In addition to financial fraud, the Units also investigate patient abuse and neglect in Medicaid-funded facilities. Those cases are critical to the provision of high quality and appropriate care, especially for our nation's frail elderly.

One area of increasing activity by the Medicaid Fraud Control Units is in civil litigation. Under a 1999 policy interpretation by our office, the Units are expected to investigate any potential criminal violations first and must then consider if there is a civil fraud case. The amount of civil recoveries by the Medicaid Fraud Control Units has been increasing since 1999, and at least two states have designated special sub-units to develop civil fraud cases. Civil fraud cases may be pursued under state laws, including false claims acts in those states that have such laws, or under the Federal Civil False Claims Act, which has been a longstanding and powerful tool in the fight against health care fraud and abuse. Under the False Claims Act, the Department of Justice may pursue False Claims Act penalties and damages. Under our own administrative sanction authorities, OIG may pursue civil monetary penalties and exclusion of providers for violations of health care laws.

Communication with numerous partners is critical to the mission of the Medicaid Fraud Control Units. In addition to referrals from state Medicaid agencies, the Units receive leads from other sources, including other state and Federal law enforcement agencies, whistleblowers, beneficiaries, concerned citizens, the press, and legislative bodies. If a matter that comes to the attention of a Medicaid Fraud Control Unit is determined to be an improper payment that does not warrant a fraud investigation, the matter is

referred to the state Medicaid agency to pursue recovery of the improperly paid amount.

STATE AUDITORS

OIG has initiated a number of partnerships with state auditors. Several years ago, OIG began an initiative to work more closely with state auditors in reviewing the Medicaid program. A partnership plan was created to provide broader coverage of the Medicaid program by partnering with state auditors, state Medicaid agencies, and state internal audit groups. The level of involvement of each partner is flexible and can vary depending on specific situations and available resources. In one instance, the OIG role may entail the sharing of our methodology and experience in examining similar Medicare issues. In other cases, we may join together with state teams to audit suspected problems.

The partnership approach provides broader coverage of the Medicaid program and maximizes the impact of scarce audit resources by both the Federal and state audit sectors. To date, the joint efforts have been developed in 25 states. Completed reports identified \$263 million in Federal and state savings and included recommendations for improvement in internal controls and computer systems operations.

IMPROVING THE MEDICAID PROGRAM

The shared goal of each partner is to bring about program improvements that help reduce the cost of providing necessary services to Medicaid beneficiaries to maximize the Medicaid dollar. In addition to identifying misspent funds, OIG also strives to find ways that will improve and strengthen the program. Many of our reviews determine whether the Medicaid program is managed properly and pays a fair price in the health care marketplace.

Over the years, in collaboration with our partners, our work has addressed numerous vulnerabilities in the Medicaid program. Below are two of the

most notable issues that we believe still merit attention and require corrective action that could significantly benefit the Medicaid program.

USE OF INTERGOVERNMENTAL TRANSFERS UNDER UPPER PAYMENT LIMIT RULES

OIG audited enhanced payments made to local public hospitals and nursing facilities under upper payment limit rules in several states and found that billions of Medicaid dollars were, in effect, at risk of being diverted from their intended purpose. Enhanced payments are the difference between the state's reimbursement amount and the upper payment limit (that is, maximum amounts paid to certain providers under Medicare rules).

Medicaid funds are at risk when states use intergovernmental transfers to disproportionately shift the cost of Medicaid to the Federal Government, contrary to Federal and state cost-sharing principles. Intergovernmental transfers are transfers of non-Federal public funds between the state and/or local public Medicaid providers and the state Medicaid agency. States divert funds from an intended purpose by making an intergovernmental transfer after drawing down the Federal share of the benefit. Financial consequences include an inappropriate decline in the state share of Medicaid payments and corresponding increase in the Federal taxpayers' share. The increased Federal Medicaid funding derived from these transfers becomes commingled in general revenue accounts and can be used for purposes unrelated to Medicaid.

Of our Federal and state partners, CMS has been involved most in addressing such vulnerability. In accordance with our early work, CMS made regulatory improvements that would effectively reduce the funds that states can gain through these transfer mechanisms. To improve national consistency in Medicaid reimbursement policy, CMS also created the National Institutional Reimbursement Team, responsible for reviewing institutional reimbursement state plan amendments, providing technical assistance to the states, and developing Medicaid institutional

reimbursement regulations and policy. CMS worked with states to halt the inappropriate use of intergovernmental transfers. According to CMS, the agency identified 33 states using inappropriate intergovernmental transfers, and 26 of the 33 states have since halted the practice.

Additional changes are needed, however, to curb ongoing abuses. Recent OIG work at individual nursing facilities demonstrates that states still divert enhanced funding needed by poorly functioning facilities to other purposes, with negative implications for quality of care. OIG believes that CMS should continue to work with states on this issue. In addition, inappropriate financing mechanisms should be permanently eliminated by law or regulation.

PRESCRIPTION DRUG REIMBURSEMENT

Nearly a decade of OIG work on Medicaid drug reimbursement leads to one conclusion—Medicaid pays too much for prescription drugs. The crux of the issue is that while states must reasonably reimburse pharmacies for prescription drugs, they often lack access to accurate pricing data that is necessary to do so. Because of that, states rely on published prices, such as average wholesale price, when determining Medicaid reimbursement. We have found that the published prices states use for estimating pharmacy acquisition costs are substantially higher than prices pharmacies actually pay for drugs.

The goal of our work is to ensure that Medicaid's prescription drug programs reimburse pharmacies at a fair price that reasonably reflects actual acquisition costs. We have offered a variety of options that would improve states' programs, which would lead to substantial savings. Those options include making more accurate pricing data available to states. Specifically, we recommended that Medicaid base reimbursement on prices calculated from actual sales transactions rather than the published prices currently being used.

In accordance with our findings, state Medicaid agencies made changes in their reimbursement

amounts and methods, but more improvements are needed. The Administration and Congress expressed interest in reforming Medicaid drug reimbursement and using sales-based prices.

In addition to our evaluations and audits, OIG partnered with the Department of Justice, Medicaid Fraud Control Units, and state attorneys general to pursue cases against drug manufacturers related to illegal pricing or fraudulent price reporting. For example, in 2004, Schering Plough Corporation agreed to pay almost \$345.5 million as part of a global settlement with the Government and entered a 5-year corporate integrity agreement with OIG. As part of the settlement, Schering-Plough agreed to pay almost \$293 million to resolve its civil and administrative liabilities in connection with illegal and fraudulent pricing under the Medicaid drug rebate program.

CONCLUSION

Protecting the integrity of Medicaid is one of the top priorities for the OIG, and our success is

largely dependent on the ability to work effectively with a number of state and Federal partners. The HHS OIG will continue to devote its energies to auditing and evaluating the Medicaid program to identify payment issues and errors, recover improper payments, improve the program, and, when necessary, pursue appropriate law enforcement actions to recover funds paid to fraudulent providers.

We continually look for ways to build on our collaboration with CMS, state Medicaid agencies and auditors, the state Medicaid Fraud Control Units, the Department of Justice, as well as other intergovernmental enforcement agencies to identify and resolve fraud and abuse. Developing and leveraging such partnerships significantly increases our collective ability to maximize the Medicaid dollar, helping ensure the best possible deployment of the Nation's health care dollars are dedicated toward assisting those most vulnerable and in need.

TRICARE OVERSEAS PROGRAM

TRICARE OVERSEAS PROGRAM (TOP) FRAUD¹

by Daniel M. Boucek, Special Agent in Charge, Defense Criminal Investigative Service, DoD

Since late 1999, the Defense Criminal Investigative Service (DCIS), the investigative arm of the Department of Defense (DoD) Office of Inspector General (OIG), along with the United States Attorney's Office in Madison, Wisconsin, pursued answers to a predicament outside their immediate responsibility. The problem, which has existed for several years, is TRICARE Overseas Program (TOP) fraud. TRICARE is the DoD-managed healthcare program for active duty military, active duty service families, retirees and their families, and other beneficiaries.²

A DoD Hotline complaint alleging TOP fraud in the Philippines initiated DCIS involvement in 1996. DCIS continues to investigate the fraud and presents cases to the United States Attorney's Office for prosecution. TOP fraud is, however, unique from the typical healthcare fraud that occurs in the United States. The problem is not simply the fraud but that the TRICARE Management Activity (TMA)³ claims they have done all they can administratively. TMA determined that the only answer to their fraud dilemma was to call upon the OIG for more investigators. No matter how many investigators are thrown into the mix, little effect on the real problem will occur until TMA takes action. The real problem is the need for administrative program changes that will make existence of TOP fraud difficult.

The historical claims data exposed a startling trend that should have provided an early clue for TMA that something was seriously wrong with TOP in the Philippines. TOP figures revealed a spike in total claims from \$1.6 million (1,506 claims) paid in 1996 when the first DCIS case was initiated to \$64.2 million in 2003 (157,894 claims).

Upon review of TRICARE claims data, DCIS and the United States Attorney's Office determined one reason for the spike in claims was a single corporation that made up a significant portion (83 percent in fiscal year 2002, or \$45.8 million) of the overall TOP expenditures for the Philippines. The investigation disclosed that the corporation billed TRICARE for services not rendered and for grossly inflating TRICARE claims. An analysis of the claims from the corporation revealed that the claims were, on average, inflated by approximately 300 percent.

¹ This article is a synopsis of a May 6, 2005, paper submitted as a requirement for the Georgetown University Executive Masters in Policy Management sponsored by the Department of Defense Office of Inspector General.

² Department of Defense, "The TRICARE Overseas Program Fact Sheet," (Aurora, Colorado: TRICARE Management Activity, January 31, 2002).

³ TRICARE Management Activity is the organization responsible for managing the TRICARE program

DCIS and the United States Attorney's Office looked for the root cause of the fraud. They learned that engaging in TOP fraud in the Philippines as well as other locations around the world is easy because of the open-ended policy for processing and paying TOP claims.⁴ The initial lack of controls TMA had for overseas activities put their program in a vulnerable position. The policy stems from the TRICARE desire that eligible beneficiaries receive quality healthcare anywhere around the globe. As a result, the TRICARE program has foregone some of the traditional checks and balances found in administration of stateside claims. The unintended consequence of such a policy decision was a 21-fold increase in TRICARE costs for the Philippines since 1998.

After months of focusing on the criminal aspects of the TOP problem, the United States Attorney's Office and DCIS became concerned that TMA placed too much emphasis on criminal prosecution as a way of resolving the TOP problem in the Philippines. Although TMA knew of the extensive fraud in the Philippines, all appearances were that they were operating in a business-as-usual mode. The data show they did not take the increase in expenditures seriously. If they had been serious about their fiscal outlay in the Philippines, TMA would have immediately taken corrective measures. To address the issues, the United States Attorney's Office and DCIS established a working group made up of TMA and other related players. The United States Attorney's Office and DCIS believed that involvement from the beginning was a vital factor in identifying potential policy issues that contributed to the TOP problem. Michael Munger writes that, "In general, there is only one way to ensure that politicians and bureaucrats are more likely to favor, or at least not oppose, a policy" and that is to "Get them involved from the beginning."⁵

At the first working group, Peggy Lautenschlager,

the United States Attorney for the Western District of Wisconsin, stated that TMA must take administrative action, as well as implement appropriate program controls that would make abusing the TRICARE program more difficult. Lautenschlager and other Assistant United States Attorneys have repeatedly reported that without such controls, TOP fraud will continue into the future at the expense of the taxpayer—regardless of on-going prosecutorial actions.

Because of the magnitude of TOP fraud, a Management Control Deficiency Report, which addressed a number of TOP fraud issues in the Philippines, was issued to the Assistant Secretary of Defense for Health Affairs in May 2001. Eventually, TRICARE followed the public bureaucracies, as described in *Politics and Public Policy*, by making some incremental changes to TOP as both the Management Control Deficiency Report and working group meetings recommended.⁶

As a result of the deficiency report and because efforts encouraging TMA to make the needed changes seemed at an impasse, DCIS requested audit assistance from its own OIG. DCIS, the United States Attorney's Office, and the Defense OIG Office of Auditing (Audit) believe a number of viable policy options are available that will resolve the problem of TOP fraud in the Philippines and elsewhere. With the audit in progress, the audit team seeks to identify options of mutual concern for DoD. The audit will contain an overview of TOP as well as a discussion of the environment in which the fraud occurred. While in progress, Audit and DCIS will reach out to TMA in areas of mutual interest. TMA and the DoD OIG would like to see an end to the TOP fraud, which is the single most important goal shared by all involved.

Working with TMA over the years has revealed that the organization is no different than most large bureaucracies of the U.S. Government. TMA has a unique culture. As James Wilson discusses

⁴ *Department of Defense, Chapter 12, TRICARE/CHAMPUS Policy Manual 6010.54-M, August 1, 2002.*

⁵ *Michael C. Munger, Analyzing Policy, (New York: W.W. Norton & Company, 2000), pp. 14-15.*

⁶ *Donald C. Baumer, William T. Gormley, and Carl E. Van Horn, Politics and Public Policy, 3rd ed. (Washington, DC: CQ Press, 2001), pp. 101-102.*

in Bureaucracy, “Organizational cultures consist of those enduring differences among systems of coordinated action that lead those systems to respond in different ways to the same stimuli.” He adds that when organizations are criticized, some will hunker down and others will conduct a searching self-examination.⁷ However, by focusing on mutual interests rather than positions, the TOP problem will be overcome.

Several alternatives to the status quo were developed. The result of the analysis was a recommendation for an incremental policy change that would lead to development of a provider network and curtail much of the fraud committed within TOP, reduce healthcare costs, and identify qualified and trustworthy providers.

Some of the changes are simple, while others are more complex. Examples of issues the audit team is reviewing include supplemental insurance plans, third party billing, legislative changes to sanction beneficiaries, cap coverage and adequacy, increased use of medical reviews on claims outside the continental United States, and creation of a network. The culture and bureaucracy within TMA were taken into consideration when selecting alternative courses.

During the years TOP has existed, TMA has been cautious about making changes. With that in mind, the recommendation is for incremental changes leading to a network of certified providers. Using a provider network automatically puts in place controls that do not exist under TOP as it exists today. Most importantly, the costs for services will be regulated. The new policy would likely mirror, to the extent possible, existing healthcare programs in the United States. One option for TMA consideration may include a partnership with Blue Cross Philippines, which has a network of approved providers operating under a reasonable cost schedule. As with any change, however, resistance exists, but with immediate

positive measurable outcomes the change will be more palatable to TMA and encouraging to the DoD OIG as well as the American taxpayer.

TMA has already implemented several recommendations the working group discussed or the audit team addressed. Some of the more significant actions, such as not paying the claims of the corporation alluded to earlier in this report, appear to have made an impact on the flow of American tax dollars to fraudulent providers. Now is not, however, the time for TMA to rest on their laurels, but instead they should draw upon what they have learned from this unique situation as well as implement additional controls and move toward a provider network.

DCIS has had some success in routing several of the TOP criminal elements in the Philippines. Since the initial complaint in 1996, 37 individuals have been indicted, including 7 physicians. Of those individuals indicted, 16 pled guilty in Federal Court to conspiring to file false medical claims and mail fraud. Total restitution to date is more than \$1.8 million. In spite of the success, the fraud continues to grow and evolve as the players learn how to use and abuse the TRICARE program.

In “Politics and Public Policy” the authors appropriately propose that major changes in bureaucratic behavior, such as the actions called for in this report, are more difficult to implement. The authors suggest that institutional settings matter and they matter in somewhat predictable ways with different levels of government having their own special opportunities or pitfalls.⁸ This is true in this project.

Public policy is a course of action or inaction authorities choose to address a given issue or an interrelated set of issues. It is the hope of DCIS, the United States Attorney’s Office, and the DoD OIG audit team that TMA will choose to take the policy course of action as recommended in this project.

⁷ James Q Wilson, *Bureaucracy: What Government Agencies Do and Why They Do It*, (Basic Books, Inc., 1989), p. 93.

⁸ Donald C. Baumer, William T. Gormley, and Carl E. Van Horn, *Politics and Public Policy*, 3rd ed. (Washington, DC: CQ Press, 2001), pp. 22-23.

CAPTURING EXPERTISE

CAPTURING EXPERTISE: KNOWLEDGE MANAGEMENT WITHIN AUDIT¹

by Melissa M. McBride, Senior Contract Audit Manager, Auditing, DoD Office of the Inspector General

Close to 40 percent of eligible personnel in the Department of Defense (DoD) Office of Inspector General for Auditing (commonly referred to as Audit) will likely retire within the next 5 years, taking with them knowledge and experience that will be hard to replace. Despite that level of change and drain on institutional knowledge, senior audit managers expect that younger, less-experienced employees will maintain high levels of efficiency and effectiveness within the organization. What is necessary to close the retirement gap is an active knowledge management (KM) program.

Although no one definition exists, the term *knowledge management* generally refers to a process through which organizations “find, select, distill, and present information in a way that improves an employee’s comprehension in a specific area.” Through consistent implementation of KM activities, organizations become more focused on acquiring, storing, and most importantly, using institutional knowledge of strategic planning, problem solving, and decision-making.

OPTIONS AVAILABLE

Several options for improving KM are available for Audit to consider: (1) continue current KM practices, which have been well received and with which employees are familiar; (2) cease formal KM activities (and rely on informal knowledge transfer), which would allow Audit to reallocate resources currently focused on KM to other goals; or (3) improve and/or expand current KM activities, which would increase chances of a successful outcome and signal management’s full scale commitment to KM objectives. (See the table following the article for information that summarizes the strengths and weaknesses of each option.)

CONTINUING THE CURRENT PROGRAM

The KM activities Audit initiated during the late 1990s were well received. To enhance individual career development and help build a network of professionals within the organization, Audit established a Mentoring Program in 1997. More recently, Audit began brown bag lunch sessions, during which managers discuss or provide employees with anecdotal and benchmarking information. Senior management and

¹ Graduate School of Business, University of Texas at Austin, “KM Answers to Frequently Asked Questions About Knowledge Management” (February 1998). Retrieved November 1, 2004, from www.mcombs.utexas.edu/kman/answers.htm.

voluntary participation of employees at all levels indicate a desire among Audit employees to foster KM throughout the organization. In addition, employee surveys conducted after each activity indicate that the activities have been beneficial and successful at providing good networking opportunities for employees.

However, an ad hoc KM program such as the one that is currently operational may not be the most efficient and effective way to capture and codify organizational knowledge of retiring employees. No overarching strategic plan exists that focuses activities on specific business processes and incorporate a phased approach for implementing KM. Furthermore, the KM activities are not embedded into everyday activities of employees and are less likely to be successful. Therefore, continuing the KM program as it exists may not benefit Audit's core operations.

ELIMINATING FORMAL KM PROGRAM/ RELYING ON INFORMAL KM

The nature of the team environment throughout Audit inherently helps facilitate KM. Employees work as a team on a daily basis, identifying audit issues, developing findings, and drafting reports. Because of the information sharing that already occurs on a regular basis through team interaction, additional efforts for capturing and retaining institutional knowledge may not be necessary. Historically, Audit has worked as a fluent organization, providing timely responses to Congress and publishing reports that impact DoD operations. Reallocating resources targeted for KM could help Audit achieve other organizational goals and provide better service for DoD.

Case studies have shown, however, that KM can substantially help increase the knowledge retention in an organization. While knowledge is inherently shared through Audit's team environment, stopping formal KM activities and relying on everyday information knowledge transfer does not provide a consistent avenue for Audit to fully capture, codify, and retain institutional knowledge.

EXPANDING THE CURRENT PROGRAM

By building and improving upon the existing KM program, Audit can incorporate successful past KM activities while also identifying where to focus future KM efforts. Case studies show that implementing a structured, formal KM program significantly increases the likelihood of successfully capturing and codifying institutional knowledge. Because Audit's formal KM program is still in its infancy, the time is opportune for Audit to create a strategic program that encompasses lessons learned from past KM activities as well as characteristics of successful KM programs from public and private organizations.

CHARACTERISTICS OF A SUCCESSFUL KM PROGRAM

Analysis of case studies from the public and private sectors suggest important lessons about the characteristics of successful KM programs.

Senior management support and coordination is crucial not only for securing the necessary budget and resources to develop and implement a knowledge management program, but as the first step in gaining employee support. Coordination with senior management during development and implementation of a KM program is critical to ensure that the program meets the needs and expectations of senior management.

Linking the knowledge management strategy to the organizational mission and goals ensures that KM supports these objectives and demonstrates the importance of KM to agency operations. The KM strategy should provide a clear objective that specifically identifies the organizational business processes to which KM will be tied, and should create a clear, tangible picture relating KM to these processes.

Phased implementation can provide an environment where management and employees can observe results, and where the most effective KM efforts can be easily identified. The KM strategy should not be a grand strategy of how to change

organizational business processes overnight; rather, the strategy should focus on achieving an overall objective in an incremental, phased fashion.

Embedding KM practices into everyday activities increases the potential benefits of KM by reducing the likelihood that employees will view KM as a duty peripheral to the organization's main business. Incremental KM should focus on pursuit of KM activities as extensions of current activities, without focusing on the KM aspect. Successful KM embedding will result in employees not recognizing activities as KM practices, but as a part of what they do on a routine basis.

Monitoring the success of KM activities is also crucial. Studies show that organizations can generate support for the program by providing anecdotal evidence of successful KM activities. The ultimate measure of success for a KM program is when employees stop using the term KM because KM has become part of their everyday activities.

HOW AUDIT CAN BUILD A MORE EFFECTIVE KM PROGRAM

Based on the analysis of Audit's three options to the characteristics of successful KM programs, I recommend that Audit expand its current KM program. To implement this option and build a more successful KM program, Audit should begin with the following steps.

1. Establish a position within the Audit Follow-up and Technical Support Directorate responsible for developing a strategic KM program, managing KM efforts, and measuring results. That individual would be the focal point for KM efforts, and would work closely with management to understand and incorporate their KM expectations.

2. Develop a strategic plan and a phased implementation approach in collaboration with senior management and employees at all levels of the organization. The KM strategic plan should be based on management view of the Audit mission as well as the objectives for KM within Audit, and should draw a clear connection between them.

3. Embed KM practices into the normal

activities of employees. Employees, specifically Project Managers and Program Directors, should create desk manuals that outline their duties and responsibilities, ensuring a smooth transition for incoming employees. Additionally, incorporating KM into manager's performance plans will help ensure managers focus on KM as an everyday activity. Incorporating such initiatives, as well as continually expanding KM activities, will benefit the entire Audit organization.

4. Focusing initial efforts on a particular Audit function will make the results of KM activities become easily apparent and encourage more support for the program. Team Leaders, Project Managers, and Program Directors have expressed in the past that there is a substantial learning curve to become accustomed to when promoted. Therefore, to ensure a smoother transition into management positions and help facilitate knowledge sharing throughout the organization, Audit should focus initial KM efforts on those individuals newly promoted into these positions. Subsequently, Audit should conduct a knowledge audit that will identify knowledge the organization has, what it needs, and how the knowledge will benefit the organization.

5. To the extent possible, measure the results of KM activities, which will ensure the program is meeting its goals, and then report the results of the program to management and audit personnel. Audit should continue to administer employee surveys to gain feedback on KM efforts and their impact on everyday activities.

CONCLUSION

Experience gaps within Audit are increasing because of retiring senior and middle managers. Despite the turnover, less-experienced employees are expected to maintain certain levels of efficiency and product quality. By appointing an individual who will develop and implement a strategic KM program and focusing KM efforts on specific employees or business processes, Audit will be able to embed KM activities within the everyday job

of employees. Furthermore, focusing initial efforts will produce results that are more likely to be visible to management and employees. Implementing and monitoring a KM program should help Audit

continue functioning efficiently and effectively while providing employees the knowledge needed to do their jobs.

Table 1. Summary of the Three Policy Options Presented in this Paper, Their Associated Strengths, Weaknesses, and Obstacles to Policy Implementation

	Summary of Policy Option	Strengths	Weaknesses	Obstacles to Implementation
1) Continue Current KM Practices	Continue current KM practices, including the Mentoring Program, brown-bag lunches and knowledge management website to transfer knowledge.	<ul style="list-style-type: none"> • Support from senior management, Audit managers. • Voluntary participation by auditors. • Website contains KM info and is accessible to all employees. 	<ul style="list-style-type: none"> • May not be the most effective means of capturing/ codifying knowledge. • No targeted business process or group of employees. • Not part of employees' everyday activities. • Website has not been updated. 	<ul style="list-style-type: none"> • Monitoring results and benefits from these efforts is difficult. • No actual visible results of KM to date; though employee survey feedback is positive.
2) Cease Formal KM Activities and Rely on Informal KM Activities	Cease formal KM activities and rely on informal KM activities.	<ul style="list-style-type: none"> • Audit functions efficiently and effectively with informal KM. • Resources would be freed for other purposes. • Specialized knowledge is required for audit projects so there is no value added by sharing outside the Audit team. 	<ul style="list-style-type: none"> • Continued risk that institutional knowledge may be lost. 	<ul style="list-style-type: none"> • Recent emphasis on KM throughout the Federal government. • Support for KM from management.
3) Improve/ Expand Current KM Activities into Strategically Focused KM Activities	Establish a position responsible for developing and implementing a KM program that is characterized by a detailed strategic plan, a phased implementation approach and activities focused on specific personnel and business processes.	<ul style="list-style-type: none"> • Opportunity to develop and implement a program with all of the characteristics of a successful KM program. • Program is new and changes can be made relatively easily. • Audit is hospitable location for successful KM. 	<ul style="list-style-type: none"> • Development/ implementation can take time, money, and senior level commitment. Management may hesitate to make the investment. 	<ul style="list-style-type: none"> • Difficult to monitor and measure successes and failures of activities.

RESPONSIBLE SOURCES

HOW TO BETTER ENSURE MAJOR CONTRACTORS ARE RESPONSIBLE SOURCES FOR DEPARTMENT OF DEFENSE (DOD) PROCUREMENTS¹

by Diane H. Stetler, Senior Project Manager, Audit Policy and Oversight, DoD Office of the Inspector General

The Department of Defense (DoD) is facing a potential procurement crisis. Statistics indicate that in fiscal year 2003 DoD awarded 31.8 percent of its contracts (worth approximately \$66.4 billion) to five corporations. The current procurement environment may limit the measures that DoD can take without endangering successful completion of a contract. On the other hand, it also emphasizes the importance of having contractors consistently conduct business in an ethical manner.

DoD is required by law—section 2305(b)(3), title 10, United States Code [(10 U.S.C. 2305(b)(3)] —to award contracts only to “responsible sources.” Additionally, 41 U.S.C. 403(7) and Federal Acquisition Regulation Subpart 9.1, “Responsible Prospective Contractors,” list several criteria the Government uses to determine whether a contractor is a “responsible source,” including a “satisfactory record of integrity and business ethics.”

DoD, other Federal agencies, and outside organizations have undertaken numerous approaches designed to encourage contractors to be honest and trustworthy. Anecdotal evidence suggests that current approaches have not sufficiently motivated large DoD contractors to consistently act responsibly for a long time. Varying opinions by the numerous stakeholders as to the appropriate implementation of the requirements further complicates the issue.

STAKEHOLDERS IN CORPORATE RESPONSIBILITY

Stakeholders—including DoD Components, Congress, public interest groups such as the Project on Government Oversight (POGO), DoD contractors, and related industry organizations—have differing views of how corporate responsibility is assessed and ensured. DoD organizations include the Office of the Under Secretary of Defense (Acquisition, Technology, and Logistics), the procurement and suspension/debarment officials from the Defense Logistics Agency; the Department of the Army, the Department of the Navy, the Department of the Air Force, and other DoD Components; the Defense Contract Management Agency; and the Defense Contract Audit Agency.

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Because of the number and variety of stakeholders and key players, their competing interests further complicate effective implementation of a solution.

POLICY AND APPROACHES

With a limited number of large DoD contractors, suspension or debarment has become an ineffective remedy. DoD approaches to encouraging ethical contractor behavior can be characterized in one of three categories—proactive, oversight/monitoring, or reactive/punitive. However, new approaches that take into account the changed procurement environment are needed to ensure that large contractors actively promote and implement an effective self-governance system.

The proactive approach for ensuring responsible sources includes the Defense Acquisition Regulations Supplement (DFARS) Subpart 203.70, “Contractor Standards of Conduct.” The supplement lists seven elements encompassing an effective contractor ethics program. Cyclical internal control system reviews that the Defense Contract Audit Agency performs of a contractor’s overall control environment are a DoD monitoring or oversight measure. To increase emphasis on corporate self-governance, larger DoD contractors established, in 1986, the Defense Industry Initiative on Business Ethics and Conduct (DII). The majority of top 10 DoD contractors are DII signatories. Reactive or punitive approaches include suspension, debarment, or a settlement agreement, which FAR Subpart 9.4, “Debarment, Suspension, and Ineligibility” establishes. Additionally, the Federal Organizational Sentencing Guidelines allow for reduced fines when an organization has established an ethics program. However, new approaches that take into account the changed procurement environment are needed to ensure that large DoD contractors actively promote and implement an effective self-governance system.

ALTERNATIVE SOLUTIONS

Three alternatives were considered as a potential solution.

- Comprehensive reviews of contractor self-governance systems that are performed on a cyclical basis,
- Consideration, when negotiating a fee or profit, of the effectiveness of a contractor’s self-governance system, and
- Identification and development of new sources, especially when a sole source contractor is considered for suspension, debarment, or an administrative agreement, as advanced by POGO.

The criteria used in evaluating the merits of the proposed alternatives include the cost impact of implementation for DoD and contractors, ease of implementation, and likelihood of positive versus negative outcomes.

SUMMARY ANALYSIS

To compare the various alternatives with one another, each criterion was assigned an overall rating summarizing potential impact. Using established criteria, the table below summarizes evaluation of the alternatives. The cost impact for each alternative is rated as high, medium, or low. Cost impact includes both DoD and contractor costs. A high rating indicates that DoD or DoD contractors incur substantial costs, taking into account offsetting costs, to implement the alternative. A low rating indicates that costs are manageable.

Ease of implementation is rated as high, medium, or low with low indicating that implementation is difficult because of complications such as major revision of existing regulations, significant DoD or contractor resistance to implementation, or a lengthy time period occurring prior to implementation. Conversely, a high rating indicates implementation

as being relatively straightforward or meeting only minor DoD or contractor resistance.

Overall outcome is rated as positive, negative, or neutral. A positive rating indicates that, in general, the positive affects or results will substantially outweigh any potential negative results. A neutral rating for the criteria indicates that potential positive outcomes are neutralized by potential negative results. The overall outcome is rated as negative when the negative results greatly outweigh the potential positive outcomes from the alternative.

Criteria	Cyclical Review	Criteria	Adjusted
Cost Impact	Medium/High	Medium	High
Ease of Implementation	Medium	Low	Medium/Low
Overall Outcome	Positive	Negative	Neutral

For the first alternative—comprehensive reviews of contractor self-governance systems that are performed on a cyclical basis—the major impediments are resource constraints for DoD and contractor opposition to what they view as additional and intrusive oversight. The main impediment to implementing the second alternative is that DoD as well as contractors might view it as further complicating a procurement process that is already complex enough without a corresponding advantage. For the third alternative, the major impediments include opposition from large contractors and their professional organizations, an inability of DoD officials to advance and implement revised procurement policies because of resource constraints, and DoD nonrecognition of the lack of competition as a significant issue. However, a major impediment to implementation of any alternative approach is a failure of both DoD and large contractors to recognize that improvements

are needed to regain and maintain other interested parties' confidence when DoD continues to do business with contractors who have ethical lapses.

RECOMMENDED APPROACH

A cyclical review of the contractor's self-governance system is the best overall solution because such a review can expand on existing reviews while still offering flexibility in implementation. Cyclical reviews also provide contracting officers and suspension and debarment officials information that will enable them to better perform their duties.

To be fully successful, top-level DoD officials must support the program. DoD should use lessons learned from previous implementation of similar programs such as the Contractor Risk Assessment Guide that solicited contractor participation in a voluntary joint DoD/contractor program. DoD, an external independent entity, or a combination of various entities including the contractor could perform the cyclical reviews depending on DoD established criteria. However, DoD should perform the first test reviews to identify any deficiencies in the review program and make the appropriate adjustments.

CONCLUSION

Ethical lapses at companies such as Enron, MCI/WorldCom, Boeing, Arthur Anderson, and other high-profile companies emphasize the importance of self-governance programs. DoD also must act to restore public trust in the concept of present responsibility and educate stakeholders regarding implementation. Contractors must realize that Sarbanes-Oxley signals that both the public and DoD expect a higher level of ethical conduct from companies and that things are not business as usual. For instance, the Air Force reached a comprehensive settlement agreement with Boeing

because the company failed to comply with a prior administrative agreement implementing “present responsibility.” Boeing spent more than \$30 million to reinvigorate an ethics program that the Ethical Leadership Group report labeled as “...above average for Fortune 100 companies, with room for improvement given the changed environment of 2003.” Further, Boeing has reimbursed the

Air Force \$1.9 million for investigative costs and the administrative agreement could cost Boeing as much as \$1.6 million each year. As Arthur Andersen and Boeing have discovered, even if POGO and the public do not agree, the penalty for unethical lapses can be severe for more than just those individuals directly involved in the activity.

