Memorandum

Date JUN 8 1995

From June Gibbs Brown
Inspector General

Subject Financial Management Controls Over the National Hansen's Disease Program
(A-15-94-00026)

To Elizabeth M. James
Acting Assistant Secretary for
Management and Budget

Attached for your information is the final report which presents the Office of Inspector General's (OIG) review of financial management practices, procedures and controls over the National Hansen's Disease Program (Program) which impacted the Program's Fiscal Year (FY) 1993 budget shortfall. Our review was in response to a letter dated September 24, 1993 from the former Chairman of the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies (Subcommittee). The Chairman requested that the Department of Health and Human Services' (HHS) OIG evaluate the circumstances surrounding a late FY 1993 request the Subcommittee received from the HHS Secretary to approve a reprogramming of $1.4 million to the Program. The report contains recommendations which, if effectively implemented, can result in the strengthening of financial management controls in the Health Resources and Services Administration and the Public Health Service.

Should you wish to discuss this report, please call me or have a member of your staff contact Joseph E. Vengrin, Acting Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

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To Philip R. Lee, M.D.
Assistant Secretary for Health

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The report contains recommendations which, if effectively implemented, can result in the strengthening of financial management controls in the Health Resources and Services Administration and the Public Health Service (PHS). Comments by PHS are included in their entirety in Appendix II. In addition to noting either agreement with the intent of the OIG recommendations or concurrence with all but 1 of them, the comments include discussions of plans to take appropriate action. Summaries of agency comments and related OIG evaluations are contained within the report after the respective recommendation(s). These evaluations show the OIG continues to believe that all of its recommendations should be implemented.

We would appreciate being advised within 60 days of the status of corrective actions taken or planned on each recommendation. Should you wish to discuss this report, please call me or have a member of your staff contact Joseph E. Vengrin, Acting Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

Attachment

cc:
Elizabeth M. James
Acting Assistant Secretary for
Management and Budget

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FINANCIAL MANAGEMENT CONTROLS OVER THE NATIONAL HANSEN'S DISEASE PROGRAM

JUNE GIBBS BROWN
Inspector General

JUNE 1995
A-15-94-00026

EXECUTIVE SUMMARY

BACKGROUND

The National Hansen's Disease Program (Program) is administered by the Health Resources and Services Administration (HRSA), an agency of the Public Health Service (PHS). The annual funding level for the Program is approximately $20 million. The Program provides scientific and technical leadership in all aspects of Hansen's disease. It operates the Gillis W. Long Hansen's Disease Center (Center) in Carville, Louisiana for the care of Hansen's disease patients. The Center also accommodated low security inmates through an interagency agreement (IAG) with the Department of Justice's Bureau of Prisons (BOP).

OBJECTIVE

The objectives of this audit were to: (1) assess the financial management controls relative to events surrounding the Secretary of the Department of Health and Human Services' (HHS) request to reprogram $1.4 million to the Program; (2) determine what caused the Program's Fiscal Year (FY) 1993 budget shortfall; and (3) ascertain why HHS' reprogramming request was submitted to the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies (Subcommittee) so late in the FY.

RESULTS OF AUDIT

Financial Controls

The Program overobligated its cumulative allowance as of the end of the third quarter FY 1993. Overobligation of an allowance is an administrative violation which HHS requires to be reported to the agency head. The HRSA did not report the violation. Rather, it improperly transferred $1.4 million in obligations incurred by the Program to the National Health Service Corps (NHSC). The transfers violated HHS' requirement that an obligation be charged to the account for which it was incurred. The HRSA did not obtain clearance from departmental accounting officials before departing from this fundamental accounting principle.

Controls required by HHS, which would have prevented the transfer of the $1.4 million, were not complied with, such as the requirement that justifications for obligations be documented and that reviews be performed to verify that disbursements are being charged to the proper fund account. Such verification provides assurance that corresponding expenses and obligations were charged to the correct fund account. The HHS requires that its entities develop their own operating instruction manual for implementing the above requirements, but HRSA does not have such a manual.

Causes of Shortfall

The Program's FY 1993 budget shortfall was the result of a budget request which was too low due to responsible officials' incorrect assumption that certain expenses for payroll and the lease of a research facility in Baton Rouge, Louisiana would be offset by benefits received through an IAG with BOP. The PHS entered into the agreement without adequately

documenting its financial impact on the Program's budget and without a financial review by PHS' Office of Management, which is required by the PHS General Administration Manual. The Program further exacerbated the situation by transferring contract obligations and expenses, incurred in FY 1992, to FY 1993 in order to avoid a shortfall for FY 1992.

In October 1992, subsequent to enactment of the appropriations bill for FY 1993, HRSA officials initiated cost cutting measures. Although action taken reduced operating costs by $1 million, there still remained a shortfall of $1.4 million. The HRSA officials indicated they did not act more decisively to keep costs within the Program's $18.6 million FY 1993 budget because of proposals they had under development for additional funding via an appropriations transfer or a reprogramming.

Late Submission of Reprogramming Request

It took more than 6 months to process the reprogramming request because responsible officials had difficulty in reaching consensus on the source from which the funds were to be derived. As a result, the Secretary's reprogramming request was not submitted to the Subcommittee until after the September 1 deadline established by HHS for such requests. We noted that neither HHS nor PHS had delineated procedures for complying with this deadline.

Other Matters

It appears that either BOP owes the Program about $400,000 or the FY 1993 shortfall was actually $1.8 million, rather than the reported $1.4 million. The HRSA accounting records show that about $400,000 in obligations charged to the BOP reimbursement account in FY 1993 was not collected. A Program official told us that this amount represents medical care costs incurred on behalf of BOP inmates that, due to uncertainty over terms of the IAG with BOP, were never billed.

The Program's budget is included in an allotment with activities that are not related to Hansen's disease. Controls, at the allotment level, would be strengthened if HRSA were to keep unrelated activities separate.

The contract for a research facility lease in Baton Rouge was entered into without the required certification that funds were available. Also, the obligation for the lease was not recorded promptly.

Opportunities for financial management improvement identified in this report may be applicable to other operations serviced by HRSA's financial management system.

Recommendations

Implementation by management of the recommendations presented in this report can result in the strengthening of financial management controls in HRSA and PHS by: (1) enhancing staff awareness that justification for and review of obligations and deobligations must be documented, and that overobligations be timely reported as required by the HHS Departmental Accounting Manual; (2) spurring an assessment to determine whether PHS needs to revise its process for evaluating financial implications of IAGs; and (3) separating Hansen's disease activities from unrelated programs. Implementation of recommendation #3 could result in recovery of funds from BOP.

The PHS either concurred with most of the OIG's recommendations or agreed with their intent, and has taken or plans to take appropriate action. The OIG's evaluation of agency comments made to the recommendations is included in the report. The PHS comments are included in their entirety in Appendix II.

TABLE OF CONTENTS

ABBREVIATIONS

ASMB	Office of the Assistant Secretary for Management and Budget
BOP	Department of Justice's Bureau of Prisons
Bureau	Bureau of Primary Health Care
Center	Gillis W. Long Hansen's Disease Center
DAM	Department of Health and Human Services' Departmental Accounting Manual
DFS	Division of Fiscal Services
FY	Fiscal Year
GAO	General Accounting Office
GAM	General Administration Manual
Guidelines	Guidelines for Reprogramming Within the Department of Health and Human Services
HRSA	Health Resources and Services Administration
HHS	Department of Health and Human Services
IAG	Interagency Agreement
IHS	Indian Health Service
NHSC	National Health Service Corps
OASH	Office of the Assistant Secretary for Health
OIG	Office of Inspector General
OMB	Office of Management and Budget
PHS	Public Health Service
Program	National Hansen's Disease Program

INTRODUCTION

This report presents the results of HHS' Office of Inspector General (OIG) review of financial management controls over the National Hansen's Disease Program which impacted its FY 1993 budget shortfall. Our work was in response to a letter dated September 24, 1993 from the former Chairman of the Subcommittee who requested that the HHS-OIG evaluate the circumstances surrounding a request to the Subcommittee from the HHS Secretary to approve a reprogramming for FY 1993.

The Subcommittee staff asked OIG to answer the following questions in time for a scheduled congressional appropriations hearing in late April 1994.

- Were Program expenses deobligated and transferred to other HHS programs and, if so, was such activity proper and necessary?
- Why were Program operating costs greater than expected?
- Why were reimbursements through an IAG with the Department of Justice's BOP insufficient?
- What were the actions taken to alleviate the Program's shortfall other than reprogramming and transferring obligations to other programs?
- Why was the reprogramming request submitted to the Subcommittee so late in the FY?

In our April 6, 1994 letter to the Chairman of the Subcommittee (Appendix I), we did not include analyses of aberrations from established financial management rules. We agreed to perform additional audit work and to issue an audit report to include conclusions and recommendations to address the causes of the aberrations.

BACKGROUND

The Program is administered by the Bureau of Primary Health Care (Bureau) located in Bethesda, Maryland. The Bureau is part of HRSA, an agency of the PHS. The PHS is an operating division of HHS. The HHS' Assistant Secretary for Management and Budget (ASMB) has overall management and budget oversight for HHS. This responsibility includes coordination of budget requests with the Office of Management and Budget (OMB) and the Congress.

The PHS is required by section 320(a) of Title III of the PHS Act to provide Hansen's disease care and treatment at the Center located in Carville, Louisiana. The Center, owned by the Federal Government since 1921, employs a staff of about 300 who conduct clinical, rehabilitation, research, training, outpatient and administrative functions. This includes operating a 70 bed infirmary for inpatients, residential quarters for approximately 150 Hansen's disease patients who require assisted living care, and an outpatient clinic which

currently handles over 400 patient visits annually. The Center also contracts through 10 regional clinics across the United States to provide outpatient services to about 4,000 Hansen's disease patients.

Agreement With Bureau of Prisons

In November 1990, the PHS entered into an IAG with BOP as a means of offsetting Program operating costs. This agreement was developed after:

- a December 1988 HRSA strategic plan proposed relocation of all Center components from Carville to nearby Baton Rouge, Louisiana, except for provision of long term patient care. The plan contemplated economies in providing outpatient care and better access to modern medical facilities in the area.

- a 1989 study, commissioned by HRSA to evaluate options for implementing its December 1988 strategic plan, also recommended relocation of Center components to Baton Rouge. The study concluded that the Center's costs were too high and programs were not run efficiently because of excess facilities and space.

- HRSA concluded that the Center had excess medical service capacity.

The IAG stipulated that the Center provide to minimum security, elderly and medically disabled BOP inmates the following clinical and support services: (1) housing space for BOP staff and inmates; (2) inpatient infirmary bed services; (3) routine and on-call clinical, nursing and pharmacy services; (4) referral services to appropriate PHS or contract medical specialists in Baton Rouge; (5) institutional food services; and (6) hospital laundry services. It required BOP to reimburse HRSA for the cost of space and services and directed that a reimbursement schedule containing specific terms and rates be negotiated. The first reimbursement schedule, for FY 1991, was signed on January 29, 1991. The HRSA preliminary budget for FY 1993, submitted to HHS in June 1991, estimated that approximately 500 BOP inmates would reside at the Center in Carville by 1993.

In a letter dated February 13, 1992, the BOP Director gave PHS notice that BOP intended to vacate the Center because of unforeseen circumstances including: (1) concerns from initial studies that there may be hazardous wastes on-site at Carville; and (2) difficulties in construction and renovation of buildings due to Carville being declared a historic district. The HRSA officials informed us that BOP completed their move out of the Carville facility on August 6, 1994.

Lease of Research Facility

On May 1, 1991, PHS solicited a lease for laboratory space in Baton Rouge, Louisiana in order to relocate the Center's research branch. This action followed delegation of leasing authority from the General Services Administration. The relocation of the research branch partially implemented one of the 1988 strategic plan's concepts. According to the Bureau, it provided BOP with much needed additional space for its rising inmate population at Carville. A lease for a research facility on the Baton Rouge campus of Louisiana State University

(LSU) was signed on December 1, 1991. It stipulated an annual rent of about $650,000, subject to adjustments for inflation, and a lease term of 20 years beginning March 1, 1992.

FY 1993 Budget Shortfall

On October 6, 1992, the FY 1993 budget was signed into law, establishing $18.6 million as the Program's FY 1993 budget authority. This amount was $900,000 lower than the amount authorized for FY 1992. Subsequent to enactment of the appropriations bill, Program officials recognized the potential for a budget shortfall of up to $2.4 million, based upon projected FY 1993 Program operating costs of $21 million. Between November 1992 and February 1993, Program officials took action to alleviate the shortfall. Action taken, which reduced FY 1993 operating costs by $1 million, included closing a research facility, transferring personnel, deferring nonemergency equipment and supply purchases and cutting travel. The HRSA refocused its efforts for alleviating the remaining $1.4 million shortfall on proposals for obtaining additional funding for the Program.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of this audit were to: (1) assess the financial management controls relative to events surrounding the HHS Secretary's request to reprogram $1.4 million to the Program; (2) determine what caused the Program's FY 1993 budget shortfall; and (3) ascertain why HHS' reprogramming request was submitted to the Subcommittee so late in the FY.

Our review, performed from October 1993 through July 1994, included obtaining and evaluating information from HRSA and PHS Offices of Budget in Rockville, Maryland; the Bureau in Bethesda, Maryland; the Center in Carville, Louisiana; the ASMB in Washington, D.C.; PHS Region VI Office in Dallas, Texas; and BOP Headquarters in Washington, D.C.

Our audit was conducted in accordance with generally accepted government auditing standards. It included an evaluation of financial management and budgetary activities that were pertinent to the Program's FY 1993 budget shortfall. Our review of internal controls was limited to only those controls which we considered necessary to satisfy our objectives.

RESULTS OF REVIEW

We found that financial management controls relative to events surrounding HHS' request to reprogram $1.4 million to the Program were not adequate to ensure that the Program operated within its cumulative allowance. In addition, the controls were not adequate to ensure that the reprogramming request was submitted in a timely manner. As a result, the Program overobligated its cumulative allowance as of the end of the third quarter FY 1993, which financial management did not report as an administrative violation. The cause for the Program's budget shortfall was primarily due to unrealistic expectations that certain Program operating costs would be offset by benefits received from the IAG with BOP, which had been entered into without adequate review and documentation.

We also found that: (1) some costs were charged to an allowance for BOP reimbursement without being billed to BOP; (2) Program allowances were included in an allotment with unrelated programs; and (3) funds had not been certified as available before entering into a lease agreement with LSU and the related obligation was not recorded timely. Some financial management weaknesses we noted could transcend the Program to other programs for which HRSA provides accounting services.

FINANCIAL CONTROLS

The HRSA improperly deobligated $1.4 million in Program obligations, and reversed related expense and disbursement transactions, without justification or written authorization. It then transferred this activity to another HRSA program, NHSC, without the required review to assure that the appropriate fund account had been charged. The transfers were done because the Program had overobligated its allowance as of the end of the third quarter of FY 1993. Overobligation of an allowance is an administrative violation. At yearend, after reprogramming of funds to the Program was approved, the amounts were transferred back to the Program.

The HHS Departmental Accounting Manual (DAM) requires that:

- written authorization be maintained which justify obligations[1] (2-30-30-B-3);
- obligations be charged to the account for which they were incurred (chapter 2-30-30-B-4);
- as a financial management control, a certifying officer preaudit documents to assure that purchases are charged to the appropriate fund account (chapter 2-10-40-I); and
- HHS entities develop their own operating instruction manual to supplement the DAM as a measure to implement the above and other DAM requirements (chapter 0-20-00).

However, HRSA does not have its own operating instruction manual and did not obtain clearance from departmental accounting officials before departing from fundamental accounting principles as delineated in the above requirements of the DAM. The Director of HRSA's Division of Fiscal Services (DFS) noted that there are plans to develop a HRSA accounting manual following implementation of a new general ledger software package. The installation of the software is expected to be completed by March 31, 1995.

Transfer of Hansen's Disease Program Activity

The following transactions occurred in transferring $1.4 million in Program obligations, expenses and disbursements to NHSC and then back to the Program.

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[1] The General Accounting Office's Policy and Procedures Manual for Guidance of Federal Agencies, Title 7 - Fiscal Guidance, stipulates that rules for obligations also apply to deobligations (chapter 3.7-B).

- On June 30, 1993, the Center's Financial Management Office recorded transactions which deobligated $1.4 million in Program building rent and payroll expenses which had been previously obligated, incurred and paid.

- Concurrent with the deobligation, the Chief of the Bureau's Financial Management Branch (budget office), designated NHSC as the account to which the $1.4 million in Program expenses would be obligated. Bureau budget officials signed documents which authorized the obligation to NHSC. Accounting technicians within DFS recorded the obligation, expense and disbursement transactions within NHSC's account based on these signatures. The DFS officials told us that its accounting technicians are not expected to question documents which contain the necessary authorizing signatures.

- Subsequent to the initial transfer to NHSC and in accordance with the latest reprogramming proposal, additional transfers resulted in approximately $700,000 of the $1.4 million being charged to HRSA Program Management. Authorization for the necessary deobligation from NHSC was signed by the chief of the Bureau's Financial Management Branch while the corresponding obligation to HRSA Program Management was signed by the chief of HRSA's Budget Execution and Management Branch.

- On September 30, 1993, HRSA transferred the $1.4 million in obligations, expenses and disbursements back to the Program after a reprogramming of funds to the Program had been approved by the Subcommittee. The HRSA also reversed the accounting transactions which had charged Program activity to NHSC and Program Management.

The deobligation of the $1.4 million in Program expenses violated departmental and Federal accounting rules in that it was not done for a valid reason and lacked written authorization. Obligations of these amounts to other HRSA programs also violated these rules in that they too were not justified. Finally, documentation supporting the disbursements were not reviewed as required by HHS to certify that they were incurred by the fund account to which they were charged. A determination that a disbursement was made from the wrong account should trigger correction of any related expenses and obligations that may have been charged to the wrong fund account.

DEOBLIGATION

The deobligation transactions from the Program were based on verbal instructions from the Chief of the Bureau's Financial Management Branch. This was done to keep from showing that the Program had overobligated its allowance as of the end of the third quarter of FY 1993. Officials in DFS concurred that the absence of documentation for the deobligation transactions violated DAM chapter 2-30-30-B-3, which requires accounting offices to maintain written authorization to support obligations (and deobligations). Chapter 3.7-B of Title 7 of the General Accounting Office's (GAO) Policy and Procedures Manual for Guidance of Federal Agencies states that "...rules for initially obligating the appropriation also apply to any amounts deobligated."

According to GAO's "Principles of Federal Appropriations Law", deobligations, or downward adjustments of previously recorded obligations, occur for a variety of valid reasons including instances where: (1) actual costs incurred were less than estimated; (2) a project or contract was canceled; (3) the initial obligation was determined to be invalid; (4) there was a reduction of a previously recorded estimate; or (5) an error needs to be corrected. The DAM chapter 2-30-50 cites similar guidance for adjusting obligations. The above criteria does not support a deobligation to avoid overobligating an allowance.

OBLIGATION

Chapter 2-30-30-B-4 of the DAM requires that obligations be charged to the account for which they were incurred. As mentioned near the beginning of this section (Financial Controls - page 4), the DAM requires that written authorization be maintained that justify obligations and deobligations. The authorization to transfer $1.4 million in Program obligations to NHSC did not contain a justification for the transfer.

DISBURSEMENT

Documentation supporting transactions which moved Program disbursements to NHSC was not reviewed by a certifying officer to assure that the appropriate fund account was being charged. Such review is required by DAM chapter 2-10-40-I. The DFS officials stated that a certifying officer did not perform a review because the transaction was completed in conjunction with an on-line payment and collection system[2] billing from the Center to NHSC. We noted, however, that Standard Form-1034 vouchers supporting the Center's rental payments to LSU did not contain the required signature by a certifying officer. These disbursements were not made via the on-line payment and collection system. Rather, they were ordinary disbursement transactions.

At a March 16, 1994 meeting, the Director, Office of Management, PHS concurred with OIG that transferring obligations from one account to another without a valid reason is wrong. This official told the PHS Management Oversight Council on March 17, 1994 that PHS is committed to notifying financial managers that such activity is not to occur again. A memorandum dated July 22, 1994 from the Director, Office of Resource Management, PHS to Agency Executive Officers states "the appropriate handling of this situation (overobligation of Program allowance) requires the adjustment in funding be made by transferring obligational authority" rather than by transferring obligations.

Implications of an Overobligation

As of the end of the third quarter FY 1993, the Program had incurred obligations which exceeded its cumulative allowance. Overobligation of an allowance is a violation of HHS

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[2] An automated system used for simultaneous on-line billing and collection of intragovernmental transactions. The system electronically transfers funds by crediting the Department of the Treasury account for the governmental agency providing services or supplies while charging the customer agency's account.

policy according to DAM chapter 2-10-80. The DAM chapter 2-10-170 stipulates that initial reports of administrative violations are to be forwarded to the agency head and may be subject to further investigation. After an investigation, a final report is to be prepared. For administrative violations, the investigator's report, addressed to the agency head, should recommend administrative discipline to be taken and amended procedures to be implemented. If applicable, DAM chapter 2-10-180 requires an explanation for why a violation was included as a finding in connection with an OIG audit and not previously discovered and reported by the agency. The HRSA, however, did not report the overobligation of allowance violation to the HRSA Administrator.

Conclusions

The HRSA violated the requirements of DAM chapter 2-30-50 as it deobligated Program expenses without a valid reason and DAM chapter 2-30-30-B-3 by not preparing a document supporting the authorization for the deobligation. The obligation of $1.4 million in Program expenses to NHSC without justification violated the requirements of DAM chapter 2-30-30-B-4, which stipulates that an obligation be charged to the account for which it was incurred.

The HRSA's practice of not requiring a certifying officer to review disbursement transactions associated with on-line payment and collection system billings violates DAM chapter 2-10-40-I. Such a review of disbursement documents would serve as a final check to assure that the appropriate fund account was being charged for the disbursement as well as the related expense and obligation. In addition, the absence of a certifying officer's signature on the vouchers (Standard Form-1034) documenting the rent disbursements to LSU gives rise to the appearance that HRSA does not adequately enforce the DAM requirement that disbursements be reviewed.

The HRSA improperly transferred $1.4 million in Program expenses to NHSC and did not report the overobligation of the Program's allowance as an administrative violation. Had HRSA enforced the DAM's requirement to report overobligations, we believe the concern that the Program was running out of funds might have been taken more seriously. If so, responsible officials may have given the reprogramming request higher priority, thus resulting in a more timely submission to the Subcommittee.

We believe that HRSA officials acted in a manner which deviated from DAM requirements. Given the violations of fundamental accounting principles and financial management controls we found, HRSA should give priority to complying with DAM chapter 0-20-00 by developing their own operating instruction manual as a supplement to the DAM. This manual should incorporate procedures which implement the above and other applicable DAM requirements and stipulate that exceptions to departmental accounting rules are allowed only when specific approval is obtained from appropriate officials.

Recommendation

1. To strengthen financial management controls within HRSA, we recommend that the Assistant Secretary for Health require that the Administrator of HRSA develop an operating instruction manual to supplement the DAM. The manual should include

specific procedures for implementing all routinely HRSA applicable DAM requirements, including the DAM requirements discussed in this report.

Agency Comments and OIG Evaluation

The PHS concurred with the intent of this recommendation, but not the specific procedures suggested. It noted that to prepare an operating manual is a viable alternative, but probably not the best option at this time because it would become obsolete in a short period of time due to the period of transition that HRSA is currently in with a multitude of changes mandated by Congress and the Department. Rather than issuing an operating instruction manual, PHS stated that HRSA's Division of Financial Management would issue a memorandum to all certifying officials reminding them to follow all relevant procedures in the DAM.

We view the planned memorandum by HRSA's Division of Financial Management as a stop-gap measure until the major portion of the HRSA transition is completed. This measure could result in an effective interim response to the recommendation if the memorandum adequately supplements the DAM procedures discussed in this report with examples of how the relevant DAM procedures are to be applied in HRSA. As is discussed in this report, the DAM requires HHS entities to develop their own supplemental operating instruction manual. In our opinion effective and efficient operation of a departmental financial management system, particularly those as large and complex as that operated by HRSA, requires an operating instruction manual to supplement the DAM. We, therefore, continue to believe that HRSA should give priority to completing such a manual as soon as practical but, in any event, no later than 6 months after HRSA's transition has been completed.

CAUSE OF THE FY 1993 BUDGET SHORTFALL

Much of the FY 1993 budget shortfall stemmed from the reduction of the Program's budget for FY 1993 to a level below the amount for FY 1992. The reduction was based upon anticipated operational savings from the IAG with BOP. Available information indicated that the anticipated savings did not materialize. We also found no evidence that the Office of the Assistant Secretary for Health's (OASH) Office of Management performed a financial review of the IAG as required by section 8-77-40-A of the PHS General Administration Manual (GAM).

Another cause of the shortfall was $300,000 in FY 1992 contract obligations which were shifted to FY 1993 due to concerns about having a shortfall for FY 1992. These shifts had not been anticipated during formulation of the budget for FY 1993 and were not supported with documentation showing the justification for the necessary transactions. Therefore, the shifts violated DAM chapter 2-30-30-B-3, which requires that written authorization be maintained which justify obligations. As was indicated in the section entitled "Financial Controls", HRSA does not have its own operating instruction manual through which it could provide specific guidance for complying with DAM requirements.

Interagency Agreement

Correspondence from PHS and HRSA officials showed the expectation of Program savings from the IAG with BOP. This expectation was also expressed by the HRSA Administrator in a September 7, 1990 memorandum to the Assistant Secretary for Health. The memorandum referred to a chart, prepared by the PHS budget office based on data provided by HRSA, which estimated that Program's FY 1993 budget authority could be reduced by about $2 million if the proposed IAG with BOP were approved--a $3 million increase in total Program obligations to be offset by reimbursement from BOP of about $5 million.

The expectation of operational savings influenced PHS budget offices as well as ASMB during their review of the Program's FY 1993 budget estimates in mid-1991. As a result, the $19 million Program budget which HHS requested as part of its FY 1993 Justifications of Budget Estimates to OMB was about $500,000 lower than the Program's FY 1992 funding level.

Our review of the circumstances surrounding the IAG with BOP found the following:

- The OASH's Office of Management, during its clearance of the IAG, did not perform a financial review of the IAG as required by chapter 8-77-40-A of the PHS-GAM.

- According to a Bureau official, the expectation that savings would result from the IAG was: (1) based on rough estimation; (2) not supported by documentation of underlying calculations, formulas and other pertinent information used; (3) overly optimistic; and (4) used to influence responsible budget officials to reduce the Program's FY 1993 budget request.

- The IAG was signed by the Assistant Secretary for Health before the terms and rates of reimbursement from BOP to PHS were negotiated.

- The IAG indicated that, should HRSA's budget become inadequate to support the payroll of the Center, BOP would accept the transfer of as many Center employees as possible. This expectation resulted in the assumption by responsible budget formulation officials that as many as one-half of the Center's 300 employees would fulfill BOP employment requirements and transfer to BOP. However, only 10 of the employees were transferred as most did not meet BOP's employment requirements.

- The Center's excess medical service capacity had been overestimated. The FY 1993 budget reduction was largely based upon the assumption that excess medical service capacity was available to provide reimbursable health care services to BOP. The Center later found that its excess capacity was more limited than first envisioned. Rather than recovering extensive amounts of personnel costs, it had to hire additional staff to provide medical services to BOP inmates.

- The Center did not develop per capita cost data in advance of the negotiations for the IAG's reimbursement schedules. Therefore, HRSA agreed to use a rate presented by BOP which was based on the costs of medical services provided to inmates at a

similar BOP facility located in Fort Worth, Texas. It was BOP's position not to reimburse the Center more for medical services than it would cost to provide them at another, similar BOP facility. According to Program officials, the rate was too low to cover higher than expected inmate medical costs. They told us BOP asserted that the per capita rate covered certain medical services and supplies provided to inmates, such as blood and urine tests, hearing aids, eye-glasses and special drugs, while the Center believed that these items should be billed to BOP separately.

- The HRSA officials anticipated that the IAG would produce enough savings[3] to cover the cost for leased space in Baton Rouge, Louisiana, which it had solicited in May 1991. Therefore, the Program's FY 1993 budget estimates did not reflect this expected cost. The lease contract, signed December 1, 1991, represented an unbudgeted cost of approximately $670,000.

Chapter 8-77 of the HHS-GAM establishes departmental policy for the management and use of agency agreements while the chapter 8-77 of the PHS-GAM, to be used in conjunction with the HHS-GAM, establishes administrative guidelines for the preparation and management of agency agreements initiated or sponsored within PHS. Our review of this guidance found the following:

- Although section 8-77-60-B of the PHS-GAM requires that proposed IAGs be forwarded to OASH's Office of Management with pertinent information, including funding and accounting information, it does not provide direction for the development of such financial information, such as detailed instructions for preparing and presenting an analysis which validates the financial and budgetary impact of a proposed IAG.

- The PHS-GAM, section 8-77-60-C requires that copies of all IAGs be maintained, but does not specify maintenance of documentation associated with the preparation of IAGs, such as evidence of OASH's Office of Management financial review and clearance.

- There is no requirement which prohibits IAGs from being submitted for signature until the parties to the IAG have negotiated specific reimbursement terms.

Shift of Obligations from FY 1992 to FY 1993

At the end of FY 1992, Program officials deobligated $300,000 in unliquidated obligations for six contracts and, using FY 1993 funding authority, subsequently obligated the same amount on October 1, 1992. We were told the shift was made to avert a possible funding

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[3] In addition to savings expected from the interagency agreement with BOP, the Director of HRSA's Division of Financial Management stated that PHS expected savings from the elimination of the 25 percent "hazardous pay" differential received by two-thirds of the Center's civil service staff (approximately $1.5 million per year). Although the elimination of the pay differential had previously only been informally discussed, the FY 1993 budget was formulated under the assumption that the necessary legislation would be enacted prior to FY 1993. The legislation was not actually proposed until it became part of a legislative package which HRSA forwarded to PHS in May 1993.

shortfall for FY 1992. Neither this explanation nor any other explanation was documented for these transactions. The departmental requirement to document such accounting transactions was discussed in the section entitled "Financial Controls" (see page 4).

The FY 1992 obligational authority remaining for these contracts was insufficient to pay all the contractor invoices for services received in FY 1992. Therefore, a portion of contract services received by the Program in FY 1992 were charged to and paid by FY 1993 authority. The DAM, chapter 2-30-30-B-4, requires that an obligation be charged to the FY in which it was incurred.

Conclusions

The apparent failure of the IAG with BOP to produce the expected benefits contributed to the Program's budget shortfall for FY 1993. It was not prudent to enter into the IAG before the terms and rates of reimbursement had been negotiated. The lack of sufficient evaluation and analysis of the issues surrounding the proposed IAG with BOP adversely impacted HRSA's ability to accurately estimate the expected financial benefits to be derived from the IAG with BOP. This resulted with HRSA, and ultimately PHS and ASMB, relying on assumptions in estimating the expected savings to be derived from the IAG.

Had OASH performed a financial review of the IAG with BOP, it is possible that the expectation of operational savings from the IAG would have been more accurately assessed. In our opinion, PHS needs to strengthen its guidance on IAGs. The PHS' system for the management and use of its IAGs does not adequately provide instruction for the (1) development of information which presents the financial impact of IAGs which is sound and can be validated, and (2) retention and maintenance of pertinent information as prescribed by HHS-GAM chapter 8-77-40. The PHS should require that its agencies maintain evidence that financial reviews by the OASH Office of Management have been requested and performed, including documentation supporting the review of detailed calculations, analysis and underlying assumptions associated with revenue and cost estimates.

In addition, the obligation and payment of expenses incurred in FY 1992 using FY 1993 budget authority violated the requirements of DAM chapter 2-30-30-B-4, which stipulates that an obligation be charged to the FY in which it was incurred. Implementation of our first recommendation should include procedures to address this DAM requirement.

Recommendation

2. We recommend that the Assistant Secretary for Health revise the PHS-GAM to include procedures for: (a) processing future IAGs for signature only after the parties to the IAG have negotiated specific reimbursement terms; (b) preparing documentation to support revenue and cost estimates of the financial and budgetary impact of IAGs, including detailed calculations, analysis and underlying assumptions; (c) preparing documentation to support OASH's Office of Management performance of a financial review of a proposed IAG, as required by the PHS-GAM chapter 8-77-60-B-4 and that such evidence be maintained in a central location, as required by the HHS-GAM chapter 8-77-40; and (d) processing IAGs only after OASH's Office

of Management has performed a financial review of an IAG during its clearance of the IAG.

Agency Comments and OIG Evaluation

The PHS concurred with the intent of this recommendation, but not all of the specific procedures suggested. It agreed that future IAGs should not be signed until after all of the parties have negotiated specific reimbursement terms and stated it would ensure that: (1) the IAGs include as comprehensive analysis and calculation as may be required under the circumstances, (2) the files contain sufficient documentation in support of the work performed, and (3) the IAGs have been reviewed and approved by the appropriate parties. However, it did not state how it would ensure this and did not address our recommendation that the PHS GAM be revised. We continue to believe that PHS should revise the GAM to include procedures necessary for guidance and to effectuate communication with PHS staff regarding proper controls over processing and developing IAGs.

LATE SUBMISSION OF REPROGRAMMING REQUEST

It took 6 months for responsible officials to reach consensus on the best source of funds from which to reprogram in order to alleviate the Program's $1.4 million shortfall. Various proposals were developed and reviewed during this period, which we summarized as follows:

- In late February 1993, the Administrator of HRSA requested that the Acting Assistant Secretary for Health approve an appropriations transfer from HRSA's Health Professions Construction Grant Program to the Program. In a letter dated March 30, 1993, the Acting Assistant Secretary for Health denied the appropriations transfer because program authorization for the unused construction appropriation would have required congressional approval.

- In April 1993, the HRSA Administrator submitted a request to the Acting Assistant Secretary for Health which identified six HRSA primary care programs[4] as the source for possible reprogramming.

- In a May 10, 1993 memorandum, the Acting Assistant Secretary for Health expressed concerns regarding the use of funds from primary care programs which were part of the President's investment initiative. Nevertheless, a May 24, 1993 memorandum from the Acting Assistant Secretary for Health to the Acting ASMB recommended that HHS request congressional approval of a reprogramming of funds from the six primary care programs to the Program. During June 1993, ASMB interacted with HRSA officials to obtain information on the Program's spending plan, expenditures and unobligated balances, the effect of the shortfall on the IAG with BOP, steps

[4] Community Health Centers, Migrant Health Centers, Health Care for the Homeless, National Health Service Corps, National Health Service Corps Recruitment and Ryan White Title IIIb.

already taken to alleviate the shortfall, and options considered by HRSA to eliminate the shortfall.

- In July 1993, ASMB communicated to OMB its intent to reprogram funds from six primary care programs to the Program. The OMB requested additional information from HRSA including alternative sources from which to reprogram.

- In early August 1993, HRSA proposed using Health Services for Residents of Public Housing primary care funds as an alternative source for the reprogramming. The OMB, which was sent the proposal, questioned its validity, especially since it involved the shifting of grantee award start dates in order to shorten the FY 1993 grant period and reduce the need for funds in FY 1993. The OMB referred to a 1992 GAO report[5] which found PHS' practice of funding grants for less than 12 months was generally inconsistent with agency policy.

- On September 10, 1993, HRSA proposed reprogramming to the Hansen's Disease Program, $700,000 from HRSA's NHSC and another $700,000 from HRSA's Program Management activity. These funds became available after cost-saving measures were implemented by HRSA program officials. The PHS forwarded the proposal to the HHS/ASMB, which requested OMB concurrence.

- On September 13, 1993, OMB responded that, based upon a review of the revised proposal, discussions with HHS staff, and the approaching end of the FY, they would not object to the revised reprogramming.

- The Secretary sent a letter dated September 17, 1993 to the Chairman of the Subcommittee requesting the reprogramming of $1.4 million to the Program. A letter dated September 24, 1993 from the Chairman approved the reprogramming request.

In April 1993, ASMB released a document entitled "Guidelines for Reprogramming Within the Department of Health and Human Services" (Guidelines). According to an ASMB official, the Guidelines represent departmental policy and include a requirement that reprogramming requests be forwarded to Congress no later than September 1 of a given FY. However, a July 7, 1993 note to agency financial management officers from the Director, Division of PHS Budget states that the Guidelines were developed in response to Appropriation Committee concerns that HHS had taken reprogramming action without obtaining Committee approval and that "...it is essential to take the necessary steps to ensure that these guidelines are followed."

Although the Guidelines define reprogramming and provide the requirements and procedures for submitting requests to Congress, they do not include procedures for review and approval of reprogramming proposals preceding submission to the Deputy Assistant Secretary for Budget. In addition, PHS has not implemented procedures to comply with the Guidelines.

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[5] *Community Health Centers: Administration of Grant Awards Needs Strengthening* (March 18, 1992, GAO/HRD-92-51).

The PHS budget officers indicated that implementation of specific procedures for review and approval of reprogramming proposals would not improve the reprogramming process. They noted that each case is unique, most reprogramming requests are already processed in a timely manner, and for difficult reprogramming proposals, such as the one for the Program, management would override the Guidelines in order to reach consensus.

Conclusions

Since the reprogramming request was not submitted to the Subcommittee until September 17, 1993, it did not follow departmental policy that reprogramming requests be forwarded to Congress no later than September 1 of a given FY. Had the Guidelines included procedures and deadline dates for receiving, reviewing and approving reprogramming proposals at the agency level and within ASMB, then responsible officials, , who had interacted during the months of June and July of 1993, may have been more committed to resolving outstanding questions and concerns which had delayed the reprogramming proposal. However, PHS officials questioned whether development of such procedures would improve the reprogramming review and approval process. In our opinion, ASMB and PHS should assess its processes for reviewing and approving reprogramming requests to determine what might be done to better assure that requests are timely submitted.

OTHER MATTERS

In conducting this audit we noted that: (1) certain costs were charged to an allowance for BOP reimbursement without being billed to BOP; (2) Program allowances were included in an allotment with unrelated programs; and (3) funds had not been certified as available before entering into a lease agreement with LSU and the related obligation was not recorded timely. We also noted weaknesses disclosed in previous audits which indicate that weaknesses disclosed in this report could be applicable to other programs for which HRSA provides accounting services.

Unbilled Costs

The Center collected only $4.5 million of the $4.9 million it had obligated on behalf of BOP, according to a September 30, 1993 status of funds report of the Center's reimbursement allowance (#3-21044). Center officials explained that the $400,000 difference is attributable to unbilled costs for certain medical services provided to inmates. The officials added that BOP believed the services were covered by the IAG's per capita medical services rate, while the Center had thought they were not covered and should be billed separately to BOP.

Conclusion

The HRSA should determine whether the $400,000 charged to the Program's reimbursement allowance, but not billed to BOP, represents a legitimate receivable, and take action to collect all amounts due. Amounts charged to the reimbursement allowance that are not legitimate receivables should have been charged to the Program's allowance. Inappropriate charges to the reimbursement allowance would have resulted in the understatement of the Program's FY 1993 budget shortfall.

Recommendation

3. We recommend that the Assistant Secretary for Health require that HRSA determine whether any additional amounts are due to the Program for services provided to BOP inmates and take appropriate action to collect such amounts.

Agency Comments and OIG Evaluation

The PHS concurred with this recommendation. It stated that HRSA's Bureau of Primary Health Care has verified that $400,000 had not been billed to BOP, directed Program officials to initiate billing action, and had billed BOP.

Unrelated Allowances Within the Same Allotment

According to the Director of HRSA's Division of Financial Management, the deobligation of $1.4 million in Program expenses (see section entitled "Financial Controls" - page 4) was necessary to preserve the integrity of the Bureau's funding for non-Hansen's disease activities. Had the deobligation not occurred, the Program would have used available funding within the applicable administrative division of funds established for budget control (allotment #21000).

Allotment #21000 not only authorizes allowances for care and treatment of Hansen's disease patients, but also includes allowances for two reimbursement programs which do not support Hansen's disease activities. The reimbursement programs are the Federal Occupational Health and National Oceanic and Atmospheric Administration. A HRSA official stated that there is no practical reason for including Federal Occupational Health and National Oceanic and Atmospheric Administration reimbursements in the same allotment as the Hansen's disease activities and surmised that they were put together in the first place because they were not similar to the other programs which the Bureau administers. According to a PHS official, HRSA's Beneficiary Medical Program, which operated the National Oceanic and Atmospheric Administration reimbursement program, had recently been transferred to OASH. A HRSA budget official noted that the National Oceanic and Atmospheric Administration reimbursement program allowance currently remains within HRSA allotment #21000.

Conclusion

Had the $1.4 million in Program expenses not been deobligated, the overobligation of the Program's allowance at the end of the third quarter FY 1993 would have required the use of available obligational authority from non-Hansen's disease activities within the same allotment as the Program. Such funds are not intended for the purposes of supporting the Program. For this reason we believe that budget controls would be strengthened if Federal Occupational Health reimbursements were placed into a separate HRSA allotment and National Oceanic and Atmospheric Administration reimbursements moved to an OASH allotment.

Recommendation

4. We recommend that the Assistant Secretary for Health require that the Administrator of HRSA separate Hansen's disease activities from the other allowances currently within HRSA allotment #21000 and include the allowance for National Oceanic and Atmospheric Administration reimbursements with other OASH programs.

Agency Comments and OIG Evaluation

The PHS concurred with this recommendation. It stated that Hansen's disease activities were placed in a separate account at the start of FY 1995, that a separate OASH allotment had been set up for the National Oceanic and Atmospheric Administration reimbursement, and that OASH now bills directly for this reimbursement.

Certification of Funds Availability and Recording of Lease

We noted that there is no indication on the LSU lease agreement as to whether a certification of funds availability had been made prior to the lease being signed on December 1, 1991. Chapter 2-30-30-B-2 of the DAM requires that certification of funds availability be indicated on an obligation document (a lease agreement is an obligation document). According to the contracting officer, the lease was executed based upon a letter from the Center's director to the contracting officer which included a prevalidation of funds availability for future lease costs. On February 14, 1992, 2½ months after the lease was signed, the Center's financial management officer certified the availability of funds for the LSU lease.

In addition, the obligation of the estimated FY 1992 LSU lease cost was not recorded until February 21, 1992. Chapter 2-30-30-B-1 of the DAM states that valid obligations should be recorded promptly as they are incurred, and chapter 2-30-30-E-2 states that obligations for amounts due under leases should be recorded when the lease agreement is consummated.

We did not evaluate this matter further since it was outside the scope of our audit. However, we believe HRSA should assess the implications of our observation and take corrective action where necessary.

Related Weaknesses Noted in Other Programs

We noted weaknesses disclosed in previous audits which indicate that weaknesses disclosed in this report could be applicable to other programs for which HRSA provides accounting services.

In a report entitled "Audit of Youth Alcoholism Program Funds Expended by the Phoenix Area Office Under Public Law 99-570" (A-09-91-00142, dated March 19, 1992), OIG reported that loose accounting controls had allowed the undetected transfer of Indian Health Service (IHS) contract health services costs to the Youth Alcoholism Program without approval. *This compares to our finding that HRSA had transferred $1.4 million in Hansen's Disease Program obligations, expenses and disbursements to other HRSA programs.* In

FY 1993, IHS reported that it had strengthened its controls to assure that funds and expenditures are used for their stipulated purposes.

In a letter dated March 31, 1994 to PHS' Service and Supply Fund officials on an audit of the FY 1993 financial statements of this fund, an independent public accounting firm under contract with OIG, disclosed that transactions can be recorded directly into HRSA's Health Accounting System without supervisory approval. *In comparison, we found in this review that HRSA had not followed HHS' requirement to review disbursement transactions before they were recorded.*

The HRSA officials, in commenting on a discussion draft, stated that the weaknesses disclosed in the two audits noted above were not related to the unique issues and problems found during our review of the financial controls over the Hansen's Disease Program. We subsequently revised the report to clarify the relationship.

Conclusion

We believe that our findings applicable to routine accounting and budgetary transactions are not unique to circumstances which arose due to the IAG. Therefore, these findings as well as those disclosed in prior audits indicate that weaknesses transcend the financial management of the Program and could impact other programs for which HRSA provides accounting services.

Recommendation

5. We recommend that the Assistant Secretary for Health evaluate the financial transaction weaknesses identified in this report to determine their applicability to all operations serviced by HRSA's financial management system.

Agency Comments and OIG Evaluation

The PHS did not concur with this recommendation. It did not believe a special evaluation as recommended is warranted at this time because (1) no material weaknesses have been identified in recent years from financial audits and ad hoc internal reviews and (2) by mid-summer a FY 1995 financial statements audit of the HRSA appropriation will begin. The PHS stated that HRSA will take appropriate corrective action should these audits and reviews disclose significant problems.

The PHS believed that our reference to the disclosure, from the audit of the PHS Service and Supply Fund FY 1993 financial statements, that transactions could be recorded directly into HRSA's Health Accounting System without supervisory approval could be misconstrued in that it addresses only one small area of the audit and not the entire scope. The PHS believed it worth noting that the auditors did not identify any material internal control weaknesses and, in fact, expressed an unqualified opinion on the financial statements, thus supporting the integrity of the accounting system. Nevertheless, PHS stated that it had reemphasized to accounting personnel the need to review disbursement transactions before they are recorded.

We believe the report provides enough information for the intended purpose of conveying two examples of instances disclosed in other audits that appear similar to two disclosed in this audit. The PHS, in asserting that the audit of the FY 1993 financial statements of the PHS Service and Supply Fund supported the integrity of HRSA's accounting system did not note that:

- the audit of the FY 1993 financial statements was the third annual audit of this fund and that all three audits disclosed internal control deficiencies, some of which were considered by the previous auditors to be material weaknesses. Auditors of the FY 1993 statements reported that the weaknesses had been substantially corrected but reported weaknesses considered to be significant.[6]

- auditors, while able to express an unqualified opinion on the PHS Service and Supply Fund's statement of financial position as of September 30, 1993, were unable to express an opinion on the statements of operations and changes in net position, cash flows and of budget and actual expenses for the year then ended. This was because, in the prior year, auditors were unable to express an opinion on the Fund's financial statements as of September 30, 1992.

While we applaud HRSA for improvements in providing financial management services for the PHS Service and Supply Fund, we do not believe that audits of financial statements for only one of many entities serviced by HRSA supports the integrity of HRSA's entire accounting system, even if all of the audits disclosed no significant weaknesses in internal controls and produced unqualified opinions on all of the financial statements. An unqualified opinion pertains to the reasonableness and adequacy of information presented in the financial statements and not the system of internal controls.

We do not believe that PHS should wait for the results of the FY 1995 audits to determine whether weaknesses noted in this audit report are widespread. Management, in carrying out its responsibility for operating effective management control systems, should always consider the broader implications of internal control weaknesses identified in audit reports or through any other medium. While audits are designed to detect internal control weaknesses, fraud, waste and abuse, prompt detection is not guaranteed. In our opinion the best way to deter fraud, waste and

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[6] The significant internal control deficiencies were disclosed in the audit report as "reportable conditions." Reportable conditions involve matters relating to significant deficiencies in the design or operation of the internal control structure which, in the auditors' judgment, could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in financial reports.

abuse is for management to continuously work to improve on the effectiveness and efficiency of their internal controls.

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We would appreciate being advised within 60 days of the status of corrective actions taken or planned on each recommendation. Should you wish to discuss this report, please call me or have a member of your staff contact Joseph E. Vengrin, Acting Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

APPENDIX I

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 6 1994

The Honorable David R. Obey
Chairman, Committee on
Appropriations
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

In a letter dated September 24, 1993, the late William H. Natcher, Chairman, Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies (Subcommittee) requested that the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) evaluate circumstances surrounding a request to the Subcommittee from the HHS Secretary to approve a reprogramming for Fiscal Year (FY) 1993 of $1.4 million to the National Hansen's Disease Program (Program), operated by the Health Resources and Services Administration (HRSA), an agency of the Public Health Service (PHS) within HHS.

The focus of the Subcommittee's concern, as discussed with Ms. Susan Quantius and other Subcommittee staff, revolved around questions of: whether Program obligations were transferred to other HRSA programs and whether these transfers were proper and necessary; why Program operating costs were greater than expected and why reimbursements through an interagency agreement with the Department of Justice's Bureau of Prisons (BOP)[1] were not sufficient; and what actions were taken to alleviate the Program's shortfall other than reprogramming and transferring obligations to other programs; and why the reprogramming request was submitted to the Subcommittee so late in the fiscal year. Our detailed responses to the Subcommittee's questions are set forth in the enclosure to this letter.

Transfer of Program Obligations

The Hansen's Disease Program obligations were improperly transferred to other HRSA program activities. Program officials stated that the original deobligation of Program funds was effected to prevent exceeding funding available for the third quarter. The obligations were transferred back to the Program after the Subcommittee approved the reprogramming request.

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1 The agreement allows for the sharing of the Program's Carville, Louisiana facility with minimum security BOP inmates so such inmates may receive certain clinical and support services from the Public Health Service on a reimbursable basis. It was expected to provide a means for offsetting Program costs.

Why Additional Funds Were Needed

The transfers were prompted by a shortfall in Program funds. This was due to a number of factors including:

- o lease costs of approximately $670,000 for the Gillis W. Long Hansen's Disease Center's research branch on the Baton Rouge campus of Louisiana State University were not identified when formulating the Program's FY 1993 budget.
- o PHS and HRSA officials misjudged the level of resources available to provide services to BOP, and mistakenly believed that certain Program personnel could be financed by reimbursements or transferred to BOP;
- o expenditures planned for Program contract services were unrealistically low;
- o contract obligations totaling $300,000 were shifted from FY 1992 to FY 1993 to avoid a shortfall for FY 1992; and
- o a reimbursement rate which HRSA negotiated with BOP did not appear to cover all costs for medical services.

Actions to Alleviate Shortfall Other Than Obligation Transfers and Reprogramming

The Program officials took various actions during FY 1993 in an effort to alleviate the shortfall, which originally was projected at $2.4 million. These actions, however, resulted in FY 1993 savings of only about $1 million.

The Program officials knew as early as the Spring of 1991 that expenditures would exceed appropriation levels. However, they did not develop an operational plan to hold expenditures to these levels because they assumed they would receive a supplemental appropriation or reprogramming authority.

Why the Reprogramming Request Was Submitted So Late

It took more than 6 months for the responsible officials to reach consensus on the best source of funds to alleviate the Program shortfall. A number of options were developed such as a proposal in February 1993 to transfer unused funds from a Health Professions Construction Grant Program. This proposal was rejected because congressional approval would have been required. The next proposal involved reprogramming funds from six primary care programs.[2] These funding deliberations continued until early September 1993, when HHS requested the Office of Management and Budget (OMB) to concur with its proposal to

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[2] Community Health Centers, Migrant Health Centers, Health Care for the Homeless, National Health Service Corps, National Health Service Corps Recruitment and Ryan White Title IIIb.

reprogram to the Hansen's Disease Program $700,000 from HRSA's National Health Service Corps and another $700,000 from HRSA's Program Management activity.

On September 13, 1993, OMB concurred with the reprogramming request. At the same time, OMB suggested that a full review of the Program be undertaken, that a material weakness in the Program be designated under the provisions of the Federal Managers' Financial Integrity Act, and that the HHS Inspector General be asked to assess the financial management capabilities of the Program.

We found no evidence that a review had been undertaken as recommended by OMB. As far as designating the Program a material weakness, Program officials stated that as a result of staff reductions, downsizing of certain operations and congressional increases for FY 1994, they did not expect to experience a shortfall for FY 1994. The OIG was brought into this matter on October 4, 1993, when it received Mr. Natcher's request to review issues surrounding the $1.4 million reprogramming request.

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We hope that this information is responsive to the Subcommittee's request. Should you have any questions please call me or have your staff contact Michael R. Hill, Assistant Inspector General for Public Health Service Audits, at (301) 443-3583.

Sincerely yours,

June Gibbs Brown
Inspector General

Enclosure

Office of Inspector General Response to Questions Concerning a Reprogramming Request for the National Hansen's Disease Program

The following are questions the Committee on Appropriations, Subcommittee on Labor, Health and Human Services, Education and Related Agencies (Subcommittee) staff communicated to the Office of Inspector General (OIG) and our responses. The questions stem from the September 17, 1993 proposal by the Secretary of Health and Human Services (HHS) to Congressman William Natcher, Chairman of the Subcommittee, to reprogram $1.4 million to the National Hansen's Disease Program (Program). According to the Secretary's request, additional funds were needed to cover the shortfall that resulted from reimbursements from the Department of Justice's Bureau of Prisons (BOP) being lower than expected, and the Program's operating costs being higher than expected.

PROGRAM AND ORGANIZATION

The Program is administered by the Bureau of Primary Health Care (Bureau) located in Bethesda, Maryland. The Bureau is part of the Health Resources and Services Administration (HRSA), an agency of the Public Health Service (PHS), which in turn is an operating division of HHS. The HHS' Assistant Secretary for Management and Budget (ASMB) has overall management and budget oversight for HHS. This responsibility includes coordination of budget requests with the Office of Management and Budget (OMB) and the Congress.

The Gillis W. Long Hansen's Disease Center (Center) is a major activity of the Program. The Center, owned by the Federal Government since 1921, employs a staff of about 300 who conduct clinical, rehabilitation, research, training, outpatient and administrative functions. This includes operating a 70 bed infirmary for inpatients, residential quarters for approximately 150 Hansen's disease patients who require assisted living care, and an outpatient clinic which currently handles over 400 patient visits annually. The Center also contracts through 10 regional clinics across the United States to provide outpatient services to about 4,000 Hansen's disease patients.

AGREEMENT WITH BUREAU OF PRISONS

In November 1990, the PHS entered into an interagency reimbursable agreement with BOP as a means of offsetting Program operating costs. This agreement was entered into after:

- a December 1988 HRSA strategic plan proposed relocation of all Center components from Carville to nearby Baton Rouge, Louisiana, except for provision of long term

patient care. The plan contemplated benefits in providing specialized patient training and research services at an urban site with access to a modern biomedical complex.

- a 1989 consultant's study which evaluated options for implementing its December 1988 strategic plan, also recommended relocation of Center components to Baton Rouge. The study concluded that the Center's costs were too high and programs were not run efficiently because of excess facilities and space.

- HRSA concluded that the Center had excess medical service capacity.

The agreement stipulates that the Center will provide to minimum security, elderly and medically disabled BOP inmates the following clinical and support services: (1) housing space for BOP staff and inmates; (2) inpatient infirmary bed services; (3) routine and on-call clinical, nursing and pharmacy services; (4) referral services to appropriate PHS or contract medical specialists in Baton Rouge; (5) institutional food services; and (6) hospital laundry services. The services are provided at the Program's Center in Carville, Louisiana.

The agreement requires BOP to reimburse PHS for the cost of space and services and directed that a reimbursement schedule containing specific terms and rates be negotiated. The first reimbursement schedule, for Fiscal Year (FY) 1991, was signed on January 29, 1991. The HRSA preliminary budget for FY 1993, submitted to HHS in June 1991, estimated that approximately 500 BOP inmates would reside at Carville by 1993. In a letter dated February 13, 1992, the BOP Director gave PHS notice that it intends to vacate the Center during FY 1995 because of unforeseen circumstances including: (1) concerns from initial studies that there may be hazardous wastes on-site at Carville and (2) difficulties in construction and renovation of buildings due to Carville being declared a historic district.

SUBCOMMITTEE QUESTIONS AND RESPONSES

Question 1

Were obligations of the National Hansen's Disease Program transferred to other HRSA programs, were such transfers proper, and were they necessary?

Response 1

On June 30, 1993, the Bureau deobligated $1.4 million in Program obligations for payroll and building rent and recorded those obligations in HRSA's National Health Service Corps (NHSC), a separate program activity within the HRSA appropriation. In August 1993, the HRSA budget office informed the Bureau that HRSA's Program Management activity was under budget and would have excess funds. In early September, the Bureau authorized accounting transactions to deobligate approximately $700,000 in NHSC obligations -- previously shifted from the Program -- and reobligate that amount in Program Management. On September 24, 1993, Congressman Natcher approved an agency reprogramming request

to provide $1.4 million in additional funds to the Program. On September 30, 1993, HRSA officials reversed the above described shifts, thereby restoring all obligations to the Program. Had the $1.4 million of Program obligations not been reversed, they would have remained as overcharges against two other HRSA program activities, NHSC and HRSA Program Management. A corresponding understatement would have existed for the Program for FY 1993.

Senior PHS officials concurred that transferring obligations from one account to another without a valid reason is wrong. They plan to issue a memorandum to PHS employees on this matter.

During our review, Program officials stated that the original deobligation of Program funds was effected to prevent exceeding funds available in their third quarter allotment.[1] Subsequently, Program officials have commented that they were actually only concerned about exceeding an allowance. The distinction is significant for purposes of the Antideficiency Act.

The Antideficiency Act provides that no Federal official may make or authorize an obligation or expenditure in excess of the amount made available through apportionment or certain administrative subdivisions of those apportionments. Under OMB Circular A-34, overobligation of an allotment or a suballotment also violates the Antideficiency Act. Exceeding an allowance is not a violation, unless (1) agency regulations so stipulate (HHS guidance does not), or (2) in exceeding the allowance, the agency also exceeds an allotment or suballotment.

Our review did not include a determination of whether third quarter obligations for this allotment would have exceeded the amount authorized had the $1.4 million transfer not occurred. A thorough audit of the entire allotment including reimbursements would have been necessary to make such a determination, which was not possible within the time frame of the Subcommittee's request. As agreed to by Subcommittee staff, our review was limited to specific questions relating to the Program.

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[1] The allotment (#3-21000) authorizes: obligations of the National Hansen's Disease Program's appropriation and activity related to reimbursements; obligation of an appropriation for payments to Hawaii for Hansen's Disease care and treatment; and activities related to reimbursements from the Federal Employee Occupational Health Program and the National Oceanic and Atmospheric Administration.

Question 2

Why were operating costs greater than expected and why were reimbursements from BOP less than expected?

Response 2

Operating Costs

Operating costs were greater than expected for the following reasons:

- o lease costs of approximately $670,000 for the Center's research branch on the Baton Rouge campus of Louisiana State University were not identified when formulating the Program's FY 1993 budget.

  The Bureau was aware of a solicitation for leased space at the time it developed the Program's preliminary FY 1993 budget, but assumed that the lease costs would be offset by operational savings expected due to the interagency agreement with BOP. Much of the space occupied by BOP had been vacant but a portion was being occupied by the research branch, which was relocated due to the need for a modern facility and in order to satisfy the needs of BOP's increasing inmate population.

- o the budget anticipated that the Center would be able to transfer about one half of its approximately 300 employees to BOP but only 10 were transferred.

  The PHS preliminary budget submission to HHS for FY 1993 indicated that the Program's full-time equivalent level would decrease from 300 to 150. According to a HRSA official, the decrease was based upon the expectation that approximately 150 full-time equivalents would be transferred to BOP to reduce the Center's operating costs, if needed. The agreement stipulated that "...should PHS' budget become inadequate to support the Center's payroll, BOP will accept the transfer of as many Center employees as possible." However, only 10 of the employees were transferred. Most others failed to meet BOP employment requirements. The PHS officials stated that they were aware of these requirements but had hoped that BOP would make exceptions for those who had significant lengths of service with the Federal Government.

- o the Center's excess medical service capacity was overestimated.

  A major part of the FY 1993 budget reduction was based on the assumption that the Center had sufficient excess medical service capacity to provide the majority of medical services needed for BOP inmates. However, the Center had less excess capacity than was assumed and, therefore, did not attain the expected benefits from BOP. Rather than recovering extensive amounts of program costs for this assumed excess capacity, the Center found that it had to hire additional staff to provide much

of the medical services to BOP inmates. While the personnel costs for the additional staff were passed through to BOP, the Program did not benefit since it incurred a dollar in additional costs for each dollar it recovered.

- o contracts including those with community health centers and hospitals throughout the country which provide medical services to Hansen's disease outpatients, exceeded the $2,869,540 initially budgeted by $1,528,651.

  The Center officials explained that the amount initially budgeted for these contracts was unrealistically low since the comparable FY 1992 actual costs were $3.9 million. They explained that the low figure was used to make planned expenditures equal the $18.62 million appropriated for FY 1993.

- o to avoid a FY 1992 shortfall, $300,000 in contract obligations were shifted from FY 1992 to FY 1993.

  Accounting records at the Center showed that FY 1993 obligations under these contracts were increased by the amount deobligated for FY 1992. Personnel at the Center explained that the shifted obligations actually were for services provided in FY 1992, that they were shifted to avoid a shortfall for FY 1992, and that this contributed to the shortfall for FY 1993.

Reimbursements

During budget formulation in FY 1991, HRSA overestimated the amount that BOP reimbursements would reduce Program costs for FY 1993.[2] During negotiations with BOP, HRSA agreed to use a BOP-provided per capita rate. The BOP stated that their rate was based on the costs of medical services provided to inmates at a similar BOP facility located in Fort Worth, Texas. The BOP officials were not willing to reimburse the Center more for medical services than it would cost to provide them at a similar BOP facility. The HRSA officials explained that their accounting system cannot determine the cost of services provided to BOP inmates, but believed that the per capita rate for FY 1993 did not produce enough reimbursement to cover costs to the Center for services provided. The HRSA officials indicated they are planning to establish a new cost accounting system for the Center.

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[2] The estimated and actual amounts of FY 1993 reimbursement from BOP was $2.250 and $4.876 million, according to the HRSA Justification of Appropriation Estimates for the Committee on Appropriations for FYs 1993 and 1995 respectively. Although actual reimbursement was much greater than estimated, as was previously indicated, the amount offsetting Program costs was less than expected. A major portion of the reimbursement was due to additional costs for medical services provided to BOP inmates by staff specifically hired for such purpose or by nonfederal providers. These additional costs are termed "pass-through" costs. The pass-through activity results in only a "wash" as it increases Program revenues and expenses by equal amounts.

The Bureau realized in early 1991, during development of the FY 1993 appropriation request, that the interagency agreement with BOP would not produce the operational savings originally expected. This was communicated to PHS, which requested that the Bureau provide documentation to support its opinion. The PHS officials indicated that the Bureau's response was inadequate in that it only provided a copy of the interagency agreement and the initial reimbursement schedule.

According to PHS and ASMB officials, HRSA had been very convincing when it proposed the concept of providing services to BOP inmates during the development of the initial interagency agreement. Therefore, despite the opinion of the Bureau that operational savings may have been previously overestimated, PHS and ASMB continued to support the operational savings concept during their review of the Program's budget. Therefore, the Program's preliminary FY 1993 budget estimate of $21 million was lowered to $19 million to reflect expectations of $2 million in operational savings to result from the interagency agreement with BOP.

There was no indication that HRSA conducted a formal evaluation or analysis preceding the agreement in order to determine the potential benefits, problems and issues which would likely occur as a result of the presence of BOP inmates on the Carville campus. A formal study would likely have provided the negotiators with data which could have been used during the negotiations.

Question 3

What actions were taken to alleviate the shortfall other than reprogramming and transferring obligations to other programs?

Response 3

The Center took several actions to alleviate the shortfall, which it had projected at $2.4 million at the beginning of FY 1993. Actions taken include closing a research facility, transferring personnel, deferring non-emergency equipment and supply purchases, and cutting travel.

As indicated earlier, the Center knew in the Spring of 1991, after its review of BOP's reimbursement schedules, that the interagency agreement with BOP would not generate the hoped for operational savings. However, operational plans developed by Program officials did not assure that expenditures were held to the amount appropriated because they assumed that they would receive a supplemental appropriation or reprogramming authority that they planned to request. The officials did not seek approval for reductions in force or furloughs, canceling contracts or eliminating Program activities prior to enactment of the appropriation

law. Subsequent to enactment of the appropriations bill in October 1992, Program officials acted to alleviate the shortfall.

- In November 1992, the Center closed its research laboratory in San Francisco, California, established a policy of not filling any open positions, deferred non-emergency equipment purchases and cut travel to a bare minimum.

- At a February 10, 1993 meeting, a revised spending plan was provided to the HRSA Administrator. This plan proposed various options for resolving the remaining shortfall in case neither a supplemental nor a reprogramming of funds was approved. These options included terminating certain temporary employees; transferring two commissioned officers to other HRSA programs; discontinuing the diabetic foot program, the patient employment contract, and patient rations programs; postponing supply purchases; canceling 5 of the 10 regional service contracts; and furloughing all nonclinical staff for 26 days. The Administrator, however, approved only the transfer of the commissioned officers and postponement of supply purchases. Combined with the actions taken in November 1992, Program officials had generated FY 1993 savings of approximately $1 million.

- On April 2, 1993, the Bureau director sent a memorandum to the HRSA Administrator to formally request approval for furloughing all nonmedical civil service employees for about 75 days. The Bureau did not receive a written response but was informed that the request would not be approved. Although the Bureau continued to implement cost savings strategies, its emphasis shifted to obtaining authority to reprogram funds.

- In the fourth quarter of FY 1993, the Center terminated 16 temporary employees whose annual appointments came up for renewal. This action resulted in minimal FY 1993 savings because it came so late in the FY.

Question 4

Why was the reprogramming request submitted to the Subcommittee so late in the fiscal year?

Response 4

The request was submitted so late in the FY because responsible officials were unable to reach consensus on where to obtain the needed funds. The following is a list of important events from the initial reprogramming proposal to final approval.

- In late February 1993, the Administrator of HRSA requested that the Acting Assistant Secretary for Health (ASH) approve an appropriations transfer from HRSA's Health

Professions Construction Grant Program to the Program. In a letter dated March 30, 1993, the ASH denied the appropriations transfer because program authorization for the unused construction appropriation would have required congressional approval.

- In April 1993, the HRSA Administrator submitted a request to the Acting ASH which identified six HRSA primary care programs[3] as the source for possible reprogramming.

- In a May 10, 1993 memorandum, the Acting ASH expressed concerns regarding use of funds from some of the six primary care programs. Nevertheless, a May 24, 1993 memorandum from the Acting ASH to the Acting ASMB recommended that HHS request congressional approval of a reprogramming of funds from the six primary care programs to the Program. During June 1993, ASMB interacted with HRSA officials to obtain information on the Program's expenditures, spending plan, unobligated balances, the effect on the shortfall of the reimbursable agreement with BOP, the steps already taken to alleviate the shortfall, and options considered by HRSA to eliminate the shortfall.

- In July 1993, ASMB communicated to OMB its intent to reprogram funds from six primary care programs to the Program. The OMB requested additional information from HRSA including alternative sources from which to reprogram.

- In early August 1993, HRSA proposed using Health Services for Residents of Public Housing primary care funds as an alternative source for the reprogramming. The OMB, which was sent the proposal, questioned its validity, especially since it involved the shifting of grantee award start dates in order to shorten the FY 1993 grant period and reduce the need for funds in FY 1993. The OMB referred to a 1992 General Accounting Office report[4] which found that PHS' practice of funding grants for less than 12 months was generally inconsistent with Agency policy.

- On September 10, 1993, HRSA proposed reprogramming to the Hansen's Disease Program, $700,000 from HRSA's NHSC and another $700,000 from HRSA's Program Management activity. The PHS forwarded the proposal to the HHS/ASMB, which requested OMB concurrence.

- On September 13, 1993, OMB responded that, based upon a review of the revised proposal, discussions with HHS staff, and the approaching end of the FY, they would

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[3] Community Health Centers, Migrant Health Centers, Health Care for the Homeless, National Health Service Corps, National Health Service Corps Recruitment and Ryan White Title IIIb.

[4] *Community Health Centers: Administration of Grant Awards Needs Strengthening* (March 18, 1992, GAO/HRD-92-51).

not object to the revised reprogramming. The OMB concurred with ASMB that steps should be taken by HHS to improve the financial management capabilities of the Program, and suggested the following:

- undertake a full review. As part of the FY 1995 Budget review process, OMB recommended an in-depth review of PHS plans for the Program both in FYs 1994 and 1995. To initiate this review, OMB suggested that supplemental materials accompanying the FY 1995 budget submission include additional documentation. The OMB provided a list of the additional supplemental materials needed.

- designate a material weakness. The OMB noted that HHS may wish to consider designating the Program a material weakness under provisions of the Federal Managers' Financial Integrity Act.

- seek the advice of the Inspector General. To ensure that corrective action is taken quickly, the OMB advised that HHS/ASMB may want to ask the Inspector General to assess the financial management capabilities of the Program.

- We found no evidence that a review had been undertaken as recommended by OMB. As far as designating the Program a material weakness, Program officials stated that as a result of staff reductions, downsizing of certain operations and congressional increases for FY 1994, it does not expect to experience a shortfall for FY 1994. The officials said they did not receive the OMB suggestion in sufficient time to provide the additional documentation with the FY 1995 budget submission. The OIG was brought into this matter on October 4, 1993, when it received Congressman Natcher's request to review issues surrounding the $1.4 million reprogramming request.

o The Secretary sent a September 17, 1993 letter to Congressman William Natcher, Chairman of the Subcommittee requesting the reprogramming of $1.4 million to the Program. We also note that this reprogramming action did not adhere to HHS guidelines which state that "No reprogrammings will be forwarded to the Congress after September 1 of a given fiscal year." A letter dated September 24, 1993 from Congressman Natcher approved the reprogramming request.

APPENDIX II

6451

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date APR 10 1995

From Deputy Assistant Secretary for Health (Management and Budget)

Subject Office of Inspector General (OIG) Draft Report "Financial Management Controls Over the National Hansen's Disease Program," A-15-94-00026

To Inspector General, OS

Attached are the Public Health Service comments on the subject OIG report. We concur with most of the report's recommendations, or their intent, and have taken or will take actions to implement them. In any instance where we do not concur with a recommendation, our comments provide the rationale for our nonconcurrence.

Anthony L. Itteilag

Attachment

IG	✓
SAIG	
PDIG	✓
DIG-AS	✓
DIG-EI	
DIG-OI	
AIG-CFAA	
AIG-MP	
OGC/IG	✓
EXSEC	✓
DATE SENT	4/11

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1995 APR 11 A 11:03
OFFICE OF INSPECTOR GENERAL

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT "FINANCIAL MANAGEMENT CONTROLS OVER THE NATIONAL HANSEN'S DISEASE PROGRAM," A-15-94-00026

OIG Recommendation

We recommend that the Assistant Secretary for Health:

1. Require that the Administrator of the Health Resources and Services Administration (HRSA) develop an operating instruction manual to supplement the Departmental Accounting Manual (DAM). The manual should include specific procedures for implementing all routinely HRSA applicable DAM requirements, including the DAM requirements discussed in this [OIG] report.

PHS Comment

We concur with the intent of this recommendation, but not the specific procedures suggested. To prepare an operating manual is a viable alternative, but probably not the best option at this time. The HRSA is currently in a period of transition with a multitude of changes mandated by Congress and the Department (e.g., the National Performance Review, the closure of the regional procurement and finance offices) as well as changes in accounting systems (e.g., PHS Financial Management System, the Standard General Ledger and Travel Management System) which emphasize trends in electronic rather than paper processing. Therefore, we believe that the development of an operations manual would not be prudent use of resources at this time since it would become obsolete in a short period of time.

Another way to accomplish the objective of this recommendation is through guidance and instructions. The HRSA's Division of Financial Management will issue a memorandum in April 1995 to all certifying officials reminding them to follow all relevant procedures in the DAM.

OIG Recommendation

2. Revise the PHS General Administration Manual (GAM) to include procedures for: (a) processing future interagency agreements (IAG) for signature only after the parties of the IAG have negotiated the specific terms; (b) preparing documentation to support revenue and cost estimates of the financial and budgetary impact of IAGs, including detailed calculations, analysis and underlying assumptions; (c) preparing documentation to support OASH's Office of Management performance of a financial review of a proposed IAG, as required by the PHS GAM chapter 8-77-60-B-4 and that such evidence be maintained

in a central location, as required by the HHS GAM chapter 8-77-40; and (d) processing all IAGs only after OASH's Office of Management has performed a financial review of an IAG during its clearance of the IAG.

PHS Comment

We agree with the intent of this recommendation, but not all of the specific procedures suggested. We agree with the OIG that future IAGs should not be signed until all of the parties have negotiated specific reimbursement terms. However, we believe that most IAGs do not require "... detailed calculations, analysis and underlying assumptions, ..." We believe that the level of calculation and analysis should not exceed that which is necessary to ensure that estimates in a given IAG are reasonable and accurate. Therefore, we will ensure that the IAGs include as comprehensive an analysis and calculation as may be required under the circumstances, the files contain sufficient documentation in support of the work performed, and the IAGs have been reviewed and approved by the appropriate parties.

OIG Recommendation

* 3. [This recommendation is directed to the Assistant Secretary for Management and Budget].

OIG Recommendation

* 4. Require that HRSA determine whether any additional amounts are due to the Program [National Hansen's Disease Program] for services provided to BOP [Bureau of Prisons] inmates and take appropriate action to collect such amounts.

PHS Comment

We concur. The HRSA's Bureau of Primary Health Care (BPHC) has verified that $400,000 had not been billed to BOP. The BPHC directed Program officials to initiate billing action. The BPHC billed BOP on February 9, 1995.

OIG Recommendation

* 5. Require that the Administrator of HRSA separate Hansen's disease activities from the other allowances currently within HRSA allotment #21000 and include the allowance for National Oceanic and Atmospheric Administration (NOAA) reimbursements with other OASH programs.

*OIG NOTE: Draft report recommendation #3 was deleted. Draft report recommendation #s 4 to 6 are shown in the final report as #s 3 to 5.

PHS Comment

We concur. Hansen's disease activities were placed in a separate account at the start of Fiscal Year (FY) 1995. In addition, at the start of FY 1995 a separate OASH allotment and CAN (common accounting number) were set up for the NOAA reimbursement. The OASH now bills NOAA directly for these reimbursements.

OIG Recommendation

* 6. Evaluate the financial transaction weaknesses identified in this report to determine their applicability to all operations serviced by HRSA's financial management system.

PHS Comment

We do not believe that a special evaluation, as recommended here, is warranted at this time. The HRSA and its financial customers are continually undergoing audits and reviews such as the audits of the PHS Service and Supply Fund and various ad hoc internal reviews, e.g., those required by the Federal Managers' Financial Integrity Act. There have been no material weaknesses identified from these audits and reviews in recent years.

In addition, by mid-summer a FY 1995 financial statements audit of the HRSA appropriation will begin. This will be conducted by independent auditors under contract with the OIG.

However, should the audits and reviews cited above disclose any significant problems or weaknesses, HRSA will take appropriate corrective action.

The OIG report references certain findings concerning the audit of the PHS Service and Supply Fund FY 1993 financial statements which disclosed that transactions could be recorded directly into HRSA's Health Accounting System without supervisory approval. We believe that this reference could be misconstrued in that it addresses only one small area of the audit and not its entire scope. We believe that it is worth noting that the auditors did not identify any material internal control weakness and, in fact, expressed an unqualified opinion on the financial statements, thus supporting the integrity of the accounting system. Nonetheless, we have reemphasized to accounting personnel the need to review disbursement transactions before they are recorded.

*OIG NOTE: See the OIG note on the previous page.