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Background Materials Relating to

OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Efforts To Combat Fraud, Waste, and Abuse

Prepared by the Staff of the

SPECIAL COMMITTEE ON AGING

John Heinz, *Chairman*

UNITED STATES SENATE

DECEMBER 1981

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., December 7, 1981.

Hon. JOHN HEINZ,
Chairman, Senate Special Committee on Aging

DEAR MR. CHAIRMAN: The enclosed background material prepared by the staff is the product of a 6-month review of the performance of the Office of Inspector General, Department of Health and Human Services. I would like to acknowledge the dedicated work of David Holton and Bill Halamandaris of the Senate Committee on Aging in preparing this report. Ed Mihalski provided support and considerable assistance.

The study focused on the activities of the Office of Inspector General, Department of Health and Human Services, in combating fraud, abuse, and waste in Department programs. Particular emphasis was placed on the 12-month period from January to December 1980.

While the staff concentrated their work on the investigative efforts of the IG, their work also included an examination of audit and health care systems review within the office. Particular attention was paid to the effectiveness of working relationships between the IG and operational units within HHS, and between the IG and units of Government, such as FBI and Justice, outside the Department. Hundreds of records, reports, and case files were analyzed. Extensive interviews were conducted with officials at the IG's Office, the Office of the Secretary, the Health Care Financing Administration, the Department of Justice, the General Accounting Office, the Department of Labor, the American Law Division and Division of Public Welfare of the Library of Congress, and others.

Two additional units within the Department have fraud and abuse control responsibilities. These include the State fraud control units, which are under the direction of the IG's Office, and certain program surveillance activities by medicare fiscal intermediaries and carriers. An examination of the activities of these units was not possible in the time allowed.

We appreciate the cooperation of the Department of Health and Human Services Inspector General, and the Health Care Financing Administration, Office of Program Validation.

Sincerely,

JOHN ROTHER, *Staff Director.*

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I. INTRODUCTION

During the period immediately preceding the enactment of Public Law 94-505 establishing the Office of Inspector General in the Department of Health, Education, and Welfare (now the Department of Health and Human Services), and the implementing regulations in 1977, committees of Congress conducted more than 70 hearings concerning fraud, abuse, waste, and the Department's ability to control these activities. (See appendix B for definition of fraud, waste, and abuse.)

These hearings demonstrated that the programs under the jurisdiction of the Department, in the words of L. H. Fountain, chairman of the House Government Operations Committee, "(P)resent an unparalleled danger of enormous loss through fraud and program abuse."

Virtually every aspect of the health programs and every provider class was implicated. Problems were found in the operation of nursing homes, prepaid health plans, boarding homes, medicaid clinics, clinical laboratories, home health agencies, pharmacies, suppliers, vendors, and others.

At that time, the loss to the Government due to these fraudulent activities was estimated at 10 percent of the total medicare and medicaid expenses—about $3 billion.[1] Subsequent estimates have placed the figure higher.

At the same time, a survey of the Department's ability to combat fraud and abuse disclosed serious deficiences in the Department's auditing and investigative procedures:

—Only 10 of the Department's 129,000 full-time employees were criminal investigators with Department-wide responsibility.

—Multiple audit and investigative units operated out of the Department without coordination or leadership.

—Auditors and investigators reported to officials responsible for the programs under review.

—Instances were found where investigators were prohibited from pursuing certain cases.

—There was an absence of meaningful data on the extent of the problem and an affirmative plan for attacking the problem.

Congress created the Office of Inspector General to address these fundamental problems of independence, duplication, inadequate resources, and to provide a remedy for the rampant abuse afflicting the programs.

Despite this mandate, most of the problems identified by Congress in 1975 remain. Problems related to abuse, fraud, and waste still plague the program. Fragmentation and duplication continue. Resources are even more limited. The Inspector General has yet to prove an effective remedy:

[1] "Fraud and Abuse Among Clinical Laboratories," S. Rept. 94-944, June 15, 1976.

—The HHS IG ranked 9 out of 11 statutory IG's in terms of questioned costs per dollar expended in 1980.
—The HHS IG ranked 13 out of the 15 statutory IG's in terms of the number of criminal investigations opened in 1980.
—Only 5 of 41 health cases referred to the Department of Justice in 1980 by the HHS IG resulted in convictions.
—There has been no apparent impact by the IG in effecting program change to prevent the recurrence of abusive or fraudulent practices.
—Jurisdictional disputes have emerged, hampering the effectiveness of the Office in its criminal investigations.
—There is no indication the Office has developed an effective comprehensive strategy for attacking the major problems facing the program.
—The HHS IG's Office is understaffed. One State, New York, has as many criminal investigators as the IG does for the Nation.

BACKGROUND

By any account, the rate of growth in expenditures for programs under the jurisdiction of the Department of Health and Human Services has been enormous. In the 6 years since enactment of the legislation creating the Office of Inspector General, the rate of growth exceeded 65 percent.

Best estimates are that the proportion of fraud, abuse, and waste in these programs has remained constant. But the medicare and medicaid programs, which are estimated to account for the majority of the total losses due to fraud, waste, and abuse,[2] have increased by 126 percent during the same period.

In 1980, the Department of Health and Human Services (HHS), spent about $195 billion. Of this total, $134.4 billion was spent by the Social Security Administration. Of the remainder, $57 billion was spent on health care—$35 billion by medicare, $13.9 billion Federal share for medicaid, and $8.1 billion for the Public Health Service.

At the time of the creation of the Office of Inspector General, there appeared a consensus that 10 percent of total medicare and medicaid expenditures—about $3 billion—was being wasted or stolen. The first annual report of the Inspector General (March 31, 1978) provided a "best estimate" that for "HEW programs involving Federal outlays in fiscal year 1977 of $136.1 billion, the incidence of fraud, abuse, and waste—at a minimum ranged between $6.3 and $7.4 billion."[2]

In recent years, there has not been an attempt to quantify the amount of waste, abuse, and fraud in programs under the Department's jurisdiction. In February of 1980, former Secretary of Health, Education, and Welfare, Patricia Harris redefined the problem, indicating she would prefer the terms "program misuse and management inefficiency." (Appendix A.)

In July of 1980, the Federal Bureau of Investigation in an appearance before the Senate Finance Committee indicated the problem was "rampant and pervasive." Spokesmen for the Department testified the most evident finding of their investigation was "that

[2] "Office of the Inspector General: Annual Report," HEW, Mar. 31, 1978.

corruption had permeated virtually every area of the medicare and medicaid health care industry."[3]

Congress has repeatedly found that the social security payment system lacks adequate safeguards. Social security card fraud schemes, payments to the dead, and fraudulent employment, welfare and other benefits to unqualified beneficiaries are said to have cost the program billions.[4]

The Inspector General's recent "Project Baltimore" matching the death tapes (recorded deaths) with social security payments has identified over 8,000 improper payments. The IG identified over $1.5 million lost in a similar fashion in improper payments under the black lung benefits program.[5]

In order to determine the amount of money lost to the Government through fraudulent acts, the General Accounting Office analyzed over 77,000 cases of fraud and other illegal activities reported by various Federal agencies between 1976 and 1979. Their May 7, 1981 report concluded the Government had lost at least $150 million through these activities and that something less than 30 percent had been recovered.[6]

In 1975, the Department had 129,000 full-time employees. Ten of these were full-time criminal investigators with Department-wide responsibilities. Other units were identified by the Department as having significant responsibility for the prevention, detection and/or investigation of fraud and program abuse; but the House Government Affairs Committee considered the list incomplete and imprecise, since there was evidence of confusion in the manner in which the units were selected and classified.[7]

According to the March 23, 1981 survey of resources, appendix B, some 43 components within HHS share with the Inspector General the responsibility of promoting efficiency and combating fraud and abuse in the Department. In addition, the Federal Bureau of Investigation has indicated an intent to target significant resources in this area.

Resources in the Department dedicated to these activities totaled 11,321 staff years at a cost of approximately $427.5 million. OIG resources accounted for 977 staff positions and $43.3 million of that total.

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[3] "Medicare and Medicaid Fraud," Senate Committee on Finance, S. Rept. No. 96-92, July 22, 1980.

[4] "$60 Million Error: Pensions to 8,000 Dead People," New York Times, Sept. 30, 1981.

[5] "Draft Inspector General's Audit of Black Lung Benefits," HHS Fact Sheet, no date.

[6] "Fraud in Government Programs: How Extensive Is It? How Can It Be Controlled?" General Accounting Office Report AFMD-81-73, Sept. 30, 1981.

[7] "Tenth Report—Department of Health, Education, and Welfare (Prevention and Detection of Fraud and Program Abuse)," House Committee on Government Operations, H. Rept. No. 94-786, Jan. 26, 1976.

II. CONGRESSIONAL HEARINGS AND FINDINGS LEADING TO THE ESTABLISHMENT OF THE OFFICE OF INSPECTOR GENERAL

The creation of the Office of Inspector General, HEW, was the culmination of intensive investigative and oversight activities. Six congressional committees were finitely involved: The Senate Special Committee on Aging, the Senate Committee on Finance, the Senate Government Operations Committee, the Senate Permanent Subcommittee on Investigations, the House Government Operations Committee, and the Oversight Subcommittee of the House Interstate and Foreign Commerce Committee.

Table 1 details these activities.

TABLE 1 DISTRIBUTION OF CONGRESSIONAL HEARINGS AND REPORTS BY YEAR 1968-1981

SCoA = Senate Committee on Aging
SGA = Senate Government Affairs
SF = Senate Finance
HCoA = House Committee on Aging
HGO = House Government Operations
HCm = House Commerce
HWM = House Ways and Means

Subject	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
General Medicare & Medicaid fraud and waste	SCoA 1							SCoA 3 HGO 2	SCoA 3 SGA 1 HCm 2 HGO 1	SCoA 2 HCm 1 HWM 3	SGA 1 HCoA 1 HWM 1		SF 1 HCoA 1	
Medicare/Medicaid administrative & reimbursement refrm		SF 2	SF 11						SF 8 SGA 1			HCm 4 SF 1	HCm 2	
Social Security improvements			SF 8 HWM 1	HWM 1	SF 3							SF 1		
Establishment of OIG									HGO 3	HGO 7	SGA 3			
State fraud units, anti-fraud									SF 2 HCm 1	HCm 3 HWM 2	SCoA 1			
HMO's (prepaid health plans)							SGA 2		SGA 2 HCm 1 HGO 1		SF 1			
Home health care								SCoA 1	SGA 3 HWM 1 HCm 1		HCoA 1	SCoA 1 SF 1		SGA 2
Hospitals (Surgery)								HCm 4					HCm 1	
Lab fraud									SCoA 2	HCm 4				
LTC/ Nursing homes			SCoA 3	SCoA 4			SCoA 2	SCoA 6 HCoA 1	SCoA 2 SGA 4 HCm 1	HCm 2	SGA 4	HCoA 1		

Senate Aging Committee Hearings

The Senate Aging Committee conducted more than 30 oversight hearings focusing on problems in the medicare and medicaid programs between 1965 and the publication of regulations establishing the IG Office in 1977. Testimony before the Senate Special Committee on Aging in 1968 cited instances of substandard care and exhorbitant profits for certain physicians and other suppliers. Subsequent oversight hearings by this committee provided a growing body of evidence of problems in the nursing home industry. The committee's examination of the trends in long-term care showed cases of facilities failing to meet quality and safety standards, patient care abuse, and fraudulent payments. The committee's review culminated in a series of reports issued in 1974 and 1975.

In September of 1975, the committee reviewed the excesses of factoring firms and the problems associated with hospitals catering to welfare patients. In October of the same year, hearings were held dealing with fraudulent and false billing practices of some home health agencies in the medicaid program. In December, the committee found widespread patient abuse and mismangement of public funds in the Nation's largest nursing home.

In February of 1976, the committee released a report on clinical laboratories, concluding that $1 out of every $5 spent on laboratory services under the medicaid program had been ripped off.

In August 1976, the committee completed an intensive review of shared health facilities (medicaid mills). Among the abuses found were unnecessary testing, kiting, blatant overutilization, ping-ponging, factoring, percentage contracts, and various forms of false billing.

Investigators found kickback arrangements to be a way of life. Pharmacists were required to pay kickbacks to physicians and nursing home operators. Purveyors of meat, linen and laundry services, produce, groceries, medical supplies, and cleaning services were found to be similarly involved.

In 1977, the committee focused for the second time on the growing tendency to dump patients from State mental hospitals into boarding homes and the related problems of abuse and theft of supplemental security income funds.

Senate Finance Committee Hearings

The first Senate Finance Committee hearing in 1969 examined a range of fraudulent and abusive practices. The hearings were held in response to preliminary HEW audit and committee staff findings of widespread abuse by recipients and providers of medicaid services coupled with a lack of effective control mechanisms both at the Federal and State levels. Actions cited included "gang visits" by physicians to nursing home patients, provision of unnecessary services, fragmentation in billing, conflict of interest situations, supplier kickback arrangements, and establishment of multiple bank account numbers making it difficult to trace Federal payments. The Finance Committee hearings provided additional documentation of these and related practices such as billing for services not rendered, and billing by supervisory physicians in teaching hospitals for services actually performed by residents and interns

without the involvement of these attending physicians. Some of these findings were restated in the Finance Committee staff report, issued on February 9, 1970. The report also contained recommendations for the establishment of a fraud and abuse unit in HEW and similar State entities. Later that month, the committee began hearings on the staff report findings. While these hearings focused on a variety of program issues, both the incidence of fraudulent actions and HEW efforts to improve administration in this area were noted. Further testimony on fraudulent activities was cited by witnesses during the committee's hearings on the "Social Security Amendments of 1970."

Between 1970 and 1976, the Senate Finance Committee held more than 30 hearings dealing with medicare and mediciad reimbursement reform, social security program improvement, and State fraud control units. Most of these hearings were held to consider legislative reforms which strengthened antifraud and abuse efforts.

Senate Permanent Subcommittee on Investigations Hearings

Beginning in 1976, the Permanent Subcommittee on Investigations detailed extensive abuse involving residential treatment centers, substandard hospitals, welfare administrators, prepaid health centers, and more than $2 billion lost in guaranteed student loans. Senator Nunn, chairman of the subcommittee, concluded, "No agency needs a system of fraud and abuse detection more than the Department of Health, Education, and Welfare. Once HEW writes a check, there is little ability on the Government's part to determine if the money is spent properly."[8]

Hearings By House Committees

Considerable evidence concerning fraudulent practices and the Department's ability to control these activities was presented to House committees.

In 1975, the Government Operations Committee, chaired by L. H. Fountain, found "extremely serious deficiencies" in the Department of Health, Education, and Welfare's auditing and investigating procedures.

Among the deficiencies cited were:

—Multiple audit or investigative units within a single agency, organized in a fragmented fashion and without effective central leadership.

—Auditors and investigators reporting to officials who were responsible for the programs under review or were devoting only a fraction of their time to audit and investigative responsibilities.

—Lack of affirmative programs to look for possible fraud or abuse.

—Instances in which investigators had been kept from looking into suspected irregularities, or ordered to discontinue ongoing investigations.

—Potential fraud situations that had not been sent to the Department of Justice for prosecution; and

[8] Congressional Record, July 20, 1976, p. 22723.

—Serious shortages of audit and investigative personnel.[9]

Specific to the Department of Health, Education, and Welfare, the Fountain committee found:

1. HEW's operations present an unparalleled danger of enormous loss through fraud and program abuse.

2. HEW officials responsible for prevention and detection of fraud and abuse have little reliable information concerning the extent of losses from such activities.

3. "HEW units charged with responsibility for prevention and detection of fraud and program abuse are not organized in a coherent pattern designed to meet the overall needs of the Department." Fraud and abuse units were found to be scattered throughout HEW in a "haphazard, fragmented and often confusing pattern."

4. Personnel of most HEW fraud and abuse units lack independence and are subject to potential conflicts of interest because they report to officials who are directly responsible for managing the programs the unit is investigating.

5. Resources devoted by HEW to prevention and detection of fraud and program abuse are ridiculously inadequate.

6. HEW, at least in part because of its fragmented organizational structures, failed to make effective use of the resources it has.

7. Serious deficiencies existed in the procedures used by HEW for the prevention and detection of fraud and program abuse.

8. Instances were found where it took as long as 5 years or more for HEW to take corrective action after deficiencies in its regulations became known.[10]

In March 1977, the Senate Aging Committee and the House Ways and Means Committee held hearings to examine alleged fraudulent medicare and medicaid billing practices by a home health agency in California. Evidence was presented concerning falsification of expense records, use of program funds for operation of unrelated businesses, and improper financial arrangements among organizations. The hearing also examined deficiencies in State and county administration of the homemaker/chore services program.

Also in March 1977, the Subcommittee on Oversight and Investigations of the House Interstate and Foreign Commerce Committee held hearings to consider allegations of various nursing home abuses, particularly in Texas and New York. Evidence was presented pertaining to deficient care, pharmaceutical kickback arrangements, and vendor kickback schemes. The subcommittee also issued a report on its survey of over 4,000 registered pharmacists; this survey disclosed that approximately 18 percent of those responding indicated knowledge or suspicion of kickback activities between pharmacists and long-term care facilities.

Later that year, the committee's Subcommittee on Health and the Environment received information on the Department's examination of payments on behalf of ineligible medicaid recipients. Approximately two-thirds of the errors were attributable to State agency actions while one-third were attributable to client errors. Total medicaid expenditures for ineligible persons were estimated at $1.2 billion in fiscal year 1977.

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[9] "Shaping the Inspector General Law," Government Accountants Journal, vol. 28, spring 1979.

[10] Reference cited in footnote 7.

III. SUMMARY OF LEGISLATION CONCERNING FRAUD, WASTE, AND ABUSE

LEGISLATIVE HISTORY-OVERVIEW

In response to the problems which has been identified in the medicare and medicaid programs, both the House Ways and Means Committee and the Senate Finance Committee included provisions in their versions of the "Social Security Amendments of 1970" designed to curtail fraudulent activities. While the 91st Congress ended before the legislation could be enacted, the provisions were again considered as part of the "Social Security Amendment of 1972." The final legislation, Public Law 92-603 contained amendments which provided sanctions for program violations and strengthened program administration.

The Senate-passed versions of both the 1970 and 1972 bills contained an amendment which provided for the establishment of an Office of Inspector General for Health Administration within HEW. This unit would have had responsibility for continuing review of medicare and medicaid in terms of effectiveness of program operations and compliance with congressional intent. This amendment was not approved by the conferees.

In response to the 1975 findings of the House Government Operations Committee, hearings were held on proposals (H.R. 15390) to establish an Office of the Inspector General as an independent entity within HEW. The committee reported H.R. 15390 on September 14, 1976.

The Senate Committee on Government Operations reported a comparable bill, H.R. 11347, on September 28, 1976. The only significant difference between the bills was that title II of the Senate measure incorporated an additional provision directing the Inspector General to establish a separate staff to handle investigations involving the medicaid, medicare, and maternal and child health programs. This measure was approved by the full Senate on September 28, 1976, and by the House on September 29, 1976; it was signed into law as Public Law 94-505 on October 15, 1976.

Legislation to strengthen penalties against program violators and expand disclosure requirements was initially considered by the Congress during 1976. The Senate approved a measure (H.R. 12961) on September 20, 1976, which contained several amendments designed to stem fraudulent practices. On the House side, hearings were conducted by the Interstate and Foreign Commerce Committee on September 22, 1976, on a number of related measures. On October 1, 1976, a modified proposal (H.R. 15810) was introduced for discussion purposes. Because of the lateness in the session, necessary congressional action could not be completed.

Consideration of antifraud and abuse legislation began early in the 95th Congress. H.R. 3 was introduced jointly by Congressmen Rostenkowski and Rogers on January 4, 1977, while a similar

measure, S. 143, was introduced by Senator Talmadge, together with 32 cosponsors on January 11, 1977.

Because this legislation affected both the medicare and medicaid programs, H.R. 3 was referred jointly to the Ways and Means and Interstate and Foreign Commerce Committees in the House. On March 3 and 7, 1977, the Health Subcommittees of these two committees held joint hearings on the bill. Witnesses focused on the need to strengthen program penalties, expand disclosure requirements, and improve State antifraud efforts; they provided specific comments and/or recommendations concerning proposed statutory changes. Major points presented during the hearings were summarized in a Ways and Means staff document issued on March 28, 1977. The Ways and Means Committee reported the bill on June 7, 1977, and the Interstate and Foreign Commerce Committee reported the measure on July 12, 1977. It was the intent of the two House committees considering the legislation to recommend very similar committee amendments when reporting the bill to the House. The Commerce Committee version included a few medicaid amendments not included in the Ways and Means version because the latter had already concluded consideration of the measure. More importantly, the two bills contained substantially different sections relating to the confidentiality of patient medical records which fostered considerable debate. The final version which passed the House on September 23, 1977, did not contain a confidentiality provision.

The Senate Finance Committee began consideration of S. 143 on August 3, 1977, and reported the measure on September 26, 1977. The Senate passed the measure, which was similar to the House-passed bill, on September 30, 1977.

Conferees for both Houses met on October 5, 1977, and resolved the differences between the House and Senate passed bills. The conference report was issued on October 11, 1977, and approved by both Houses on October 13, 1977.

Since the enactment of Public Law 95-142, the Congress has approved several provisions designed to clarify existing requirements and further strengthen antifraud and abuse activities. Public Law 96-272 the "Adoption Assistance and Child Welfare Act of 1980" included a provision, added as an amendment by Senator Schweiker during the floor debate, which pertained to the exchange of information on terminated providers.

Public Law 96-499, the "Omnibus Reconciliation Act of 1980" included five pertinent provisions: (1) An extension of the funding for State medicaid fraud and abuse control units; (2) a technical provision relating to the reporting of financial interest; (3) expansion of the exclusion of health professionals convicted of medicare and medicaid crimes to include certain groups of persons such as operators or administrators of health care facilities; (4) clarification of criminal penalties for certain medicare and medicaid related crimes; and (5) amendments designed to improve administration of the medicare home health benefit provision. The first three of these provisions were included in both the House Commerce and Ways and Means Committees' versions of H.R. 4000; the fourth provision was included in the Commerce Committee's version of H.R. 4000 and the fifth provision was included in the Ways and

Means and Commerce Committees' versions of H.R. 3990. All five were subsequently incorporated in the House-passed reconciliation measure. The Senate-passed reconciliation measure did not include these provisions, though H.R. 934, as reported by the Senate Finance Committee, had contained a provision extending funding for medicaid fraud control units.

Public Law 97-35, the "Omnibus Budget Reconciliation Act of 1981," authorized the Secretary to impose civil money penalties in the case of medicare and medicaid fraud. This provision (included in different versions in both the House and Senate passed bills) was adopted because the Government previously had no recourse, except for the collection of overpayments, in instances where fraud cases had not been brought to trial.

LEGISLATION

The following is an outline of the major antifraud and antiabuse provisions which have been enacted into law.

PUBLIC LAW 92-603, THE "SOCIAL SECURITY AMENDMENTS OF 1972"

Public Law 92-603 included several provisions which established penalties for program violations:

(A) Penalties of up to 1 year's imprisonment, $10,000 fine, or both were established for persons convicted of soliciting, offering, or accepting bribes or kickbacks; concealing events concerning a person's rights to benefits with the intent to defraud; and converting benefit payments to improper use.

(B) False reporting of a material fact as to conditions or operations of a health facility, or both, was defined as a misdemeanor and was subject to up to 6 months' imprisonment, a fine of $2,000, or both.

(C) The Secretary was authorized to suspend or terminate medicare payments to a provider found to have abused the program. Further, Federal participation was barred for medicaid payments which might subsequently be made to such a provider.

The legislation also barred so called "factoring" arrangements by prohibiting program payments to anyone other than the physician or other person who provided the service, unless such person was required as a condition of his employment to turn his fees over to his employer.

Public Law 92-603 also included several provisions designed to improve program administration. These amendments authorized increased matching funds for installation and operation of claims processing and information retrieval systems under medicaid, provided for the establishment of Professional Standards Review Organizations (PSRO's), and conformed standards for skilled nursing facilities participating in both medicare and medicaid.

PUBLIC LAW 94-505, ESTABLISHMENT OF THE OFFICE OF INSPECTOR GENERAL

Public Law 94-505 was intended to correct the problems identified by the Congress in the prevention and detection of fraudulent and abusive activities in programs administered by HEW. The

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legislation provided for the establishment of an independent Office of Inspector General (IG) for HEW. The IG and his Deputy are appointed by the President with the advice and consent of the Senate. The law specifies that these individuals shall be selected solely on the basis of integrity and demonstrated ability and without regard to political affiliation. The IG and Deputy IG may be removed by the President who is required to communicate the reasons for such removal to both Houses of Congress. Though not technically civil service employees, the IG and his Deputy are subject to restrictions against partisan political activity applicable to such individuals. The law required the IG to appoint an Assistant IG for Auditing, an Assistant IG for Investigations, and provided for the consolidation and appropriate transfer of existing audit and investigative functions.

Public Law 94-505 charged the IG with the following duties and responsibilities:

(A) Supervision, coordination, and provision of policy direction for HEW auditing and investigative activities.

(B) Recommending policies for and conducting, supervising, or coordinating other HEW activities in order to promote economy and efficiency, and to prevent and detect fraud and abuse.

(C) Recommending policies for and conducting, supervising, or coordinating relationships between the Department and other Federal agencies, State and local governmental agencies, and nongovernmental entities with respect to promoting economy and efficiency in Department programs, preventing and detecting fraud and abuse in such programs, and identifying and prosecuting participants in such fraud and abuse.

(D) Keeping the Secretary and Congress fully and currently informed, by means of required reports and otherwise, of fraud and other serious problems, abuses, and deficiencies relating to Department programs; recommending corrective action; and reporting on the progress made in implementing such corrective action.

(E) In carrying out his responsibilities, the IG is to insure effective coordination with and avoid duplication of the activities of the Comptroller General.

(F) In view of the high incidence of fraud and abuse which had been observed in medicaid and medicare, the legislation required the IG to "establish within his office an appropriate and adequate staff with specific responsibility for devoting their full time and attention to antifraud and antiabuse activities relating to the medicaid, medicare, renal disease, and maternal and child health programs. Such staff shall report to the Deputy."

(G) Public Law 94-505 required the IG to submit annual reports on the activities of the Office and quarterly reports covering problems and abuses for which the Office has made corrective action recommendations, but which in the IG's view, adequate progress has not been made. The law also required the immediate submission of reports concerning flagrant problems or abuses. The IG is authorized to make additional investigations and reports he deems necessary and to provide documents or information requested by the Congress or appropriate

congressional committees. All reports and information must be submitted to the Secretary and the Congress, or appropriate congressional committees, without further clearance or approval. The IG, insofar as is feasible, is to provide the Secretary with copies of annual and quarterly reports sufficiently in advance of their due date to Congress to give reasonable opportunity for his comments to be appended thereto.

To assist him in carrying out his responsibilities under the act, the law authorized the IG to: (1) Have access to all records, reports, audits, reviews, documents, papers, recommendations, or other material available to the Department relating to programs and operations for which he has responsibility; (2) request any necessary information or assistance from any Federal, State, or local governmental agency or unit; (3) subpena necessary information, documents, reports, answers, records, accounts, papers, and other documentary evidence (the subpena to be enforceable by order of the appropriate U.S. district court in case of contumacy or refusal to obey); (4) have direct and prompt access to the Secretary where necessary; (5) inform the Congress when a budget request for the Office has been reduced prior to submission to Congress to an extent deemed seriously detrimental; (6) select, appoint, and employ necessary staff; and (7) enter, to the extent provided for in appropriations acts, contracts and other arrangements for audits, studies, analyses, and other services with public agencies and private persons. Federal agencies are required to furnish information or assistance requested by the IG, insofar as is practicable and not in contravention of any existing statutory restriction or applicable regulations.

PUBLIC LAW 95-142, "MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS"

Public Law 95-142 included provisions designed to strengthen sanctions for program violations, expand information disclosure requirements, strengthen State fraud and abuse control activities, and otherwise strengthen program administration.

Penalty provisions

The law contained the following amendments and additions to the existing program penalty provisions:

(A) Most fraudulent acts (such as submission of false claims; solicitation, offering, or acceptance of kickbacks or bribes; and making of false statements) were redefined as felonies with penalties increased to a maximum $25,000 fine, up to 5 years' imprisonment, or both. Further, the types of financial arrangements and conduct to be classified as illegal were clarified. The penalty provisions were upgraded because the existing sanctions had not proved adequate deterrents against illegal practices by some individuals, and appeared inconsistent with existing Federal code sanctions which made similar actions punishable as felonies. Further, U.S. attorneys' offices indicated that the penalty statutes required clarification. The misdemeanor penalty provisions applicable to medicare beneficiaries or medicaid recipients convicted of defrauding the program were re-

tained; however, States were authorized to suspend, for a period not to exceed 1 year, the eligibility of medicaid recipients convicted of program fraud.

(B) The bill defined as a felony, instances where contributions are required as a condition of entry or continued stay at a hospital, skilled nursing facility, or intermediate care facility, for patients whose care is financed in whole or part by medicaid. This provision was adopted as a House floor amendment in response to a General Accounting Office (GAO) report which stated that many nursing homes had exerted various forms of pressure on families of patients to obtain contributions.

(C) The law specified that a physician would be guilty of a misdemeanor if he knowingly, willfully, and repeatedly violated his agreement not to charge a medicare patient more than the coinsurance and any deductible amount when he agrees to accept assignment of the patient's right to receive payment. The penalty for conviction would be a maximum $2,000 fine, up to 6 months' imprisonment, or both.

(D) The legislation required the Secretary to suspend from participation in medicare, for such period as he deems appropriate, a physician or other individual practitioner who has been convicted of a criminal offense related to his involvement in either medicare or medicaid. The Secretary is required to notify each medicaid agency of the suspension action and each such agency is required to suspend the individual from participation in medicaid for a period at least equal to the suspension period under medicare. The Secretary is also required to notify the appropriate State licensing authorities requesting that appropriate investigations be made and sanctions invoked in accordance with State law and policy. In his notification of the State authorities, the Secretary shall request that he and the Inspector General be kept informed of any actions taken. The Congress included these suspension provisions in response to the concern that some program violators were able to continue their program participation, often without interruption. The bill permits the Secretary, on the request of a State, to waive a practitioner's suspension under the State's medicaid program if he determines that imposition of a suspension would leave the residents of a health manpower shortage area underserved.

(E) All institutional providers of services and other agencies, institutions, and organizations are required to fulfill certain disclosure requirements as a condition of participation, certification, or recertification under medicare and medicaid. Such entities must disclose to the Department or to the appropriate State agency the name of any person who has been convicted of a criminal offense against the programs if he either: (1) Has a direct or indirect ownership or control interest of at least 5 percent in the entity; or (2) is an officer, director, agent, or managing employee. When an application contains the name of any such previously convicted individual, the Secretary or State agency can refuse to enter an agreement or refuse to contract with the entity. The Inspector General must be informed of the receipt of such applications and any action taken

on them. The Secretary or State agency may terminate any agreement or contract if the entity failed to make the required disclosure.

Disclosure provisions

Public Law 95-142 also contained the following additional requirements pertaining to information disclosure. These provisions were included because the Congress felt that information required to be provided under the previous law was often insufficient to facilitate the detection of fraudulent practices.

(A) Providers of services meeting the requirements for participation in medicare or medicaid and other individual entities (other than individual practitioners or groups of practitioners) claiming reimbursement under medicaid are required to comply with certain disclosure requirements as a condition for program participation, certification, or recertification. In addition, medicare intermediaries and carriers and medicaid fiscal agents are required to disclose specified ownership information as a condition of contract or agreement approval or renewal under these programs. Disclosing entities must supply full and complete information as to the identity of each person who: (1) Has a direct or indirect ownership interest of 5 percent or more in the entity; (2) owns (in whole or part) a 5-percent interest in any mortgage secured by the entity; (3) is an officer or director of the entity, if it is organized as a corporation; and (4) is a partner in the entity, if it is organized as a partnership. If a disclosing entity providing services under medicare or medicaid owns 5 percent or more of a subcontractor, similar ownership information must be disclosed about the subcontractor. To the extent feasible, information about a person's ownership disclosed by an entity must also include information with respect to ownership interest of the person in any other entity which is required to comply with the disclosure requirements under the bill.

(B) A provider entity must also comply with specific requests addressed to it by the Secretary or appropriate State agency for full and complete information on: (1) The ownership of any subcontractor with whom the provider has annual business transactions of more than $25,000, and (2) any significant business transactions between it and any subcontractor or between it and any wholly owned supplier.

(C) The Secretary is specifically permitted access to records of persons or institutions providing services under medicaid in the same manner provided to State medicaid agencies.

(D) A provider of services under the medicare program is required to promptly notify the Secretary of its employment of an individual who at any time during the preceding year was employed in a managerial, accounting, auditing, or similar capacity by a fiscal intermediary or carrier who serves that provider.

(E) The circumstances under which the provision of data or information would not violate the confidentiality provisions of law was expanded to include the provision of data or information by a PSRO, on the basis of its findings as to evidence of

fraud or abuse, to Federal or State agencies recognized by the Secretary as having responsibility for the identification or detection of fraud and abuse activities. Such data and information may be provided at the request of the recognized agencies at the discretion of the PSRO. Data made available to such entities may not be further disclosed except when the disclosure is made in the course of a legal, judicial, or administrative proceeding.

Provisions relating to activities of Federal and State agencies

The "Medicare-Medicaid Anti-Fraud and Abuse Amendments" contained several provisions designed to strengthen the role of governmental entities:

(A) In order to encourage States to establish effective investigative units, the legislation provided 90 percent Federal matching in fiscal years 1978–80 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units. The increased matching was subject to a quarterly limitation of the higher of $125,000 or one-quarter of 1 percent of total medicaid expenditures in such State in the previous quarter. Public Law 96–499 authorized an extension in increased funding for such entities (see discussion of that legislation).

(B) To be eligible for the increased matching rate, the State medicaid fraud control unit must be a single identifiable entity of State government which the Secretary certifies (and annually recertifies) as meeting specific requirements. Such entity must be: (1) A unit of the office of the State attorney general or of another department of State government which possesses statewide prosecuting authority; (2) if the Constitution prohibits statewide prosecuting authority, an agency with formal procedures approved by the Secretary to assure prosecution; or (3) an entity with formal procedures and a working relationship, satisfactory to the Secretary, for coordination with the State attorney general's office. Any entity is required to be separate and distinct from the State medicaid agency.

(C) The State fraud control unit must conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. The fraud and abuse control unit must have procedures for reviewing complaints of the abuse and neglect of patients by health care facilities, and, where appropriate, for acting on such complaints or for referring them to other State agencies for action. The entity is required to provide for the collection, or referral for collection, of overpayments made to health care facilities. The entity must be organized in a manner designed to promote efficiency and economy and it must employ auditors, attorneys, investigators, and other necessary personnel. The entity is further required to submit an application and annual report containing information deemed necessary by the Secretary to determine whether the entity meets these requirements. The Secretary is required to issue implementing regulations within 90 days of enactment.

(D) The legislation also contained the following amendments with respect to the activities of Federal agencies:

(1) The Comptroller General of the United States was given the power to sign and issue subpenas for the purpose of any audit, investigation, examination, analysis, review, evaluation, or other function authorized by law with respect to any program authorized under the Social Security Act. Subpenas could be issued to gain access to pertinent books, records, documents, or other information. In the case of resistance or refusal to obey a subpena, the Comptroller General is authorized to request a court order requiring compliance. Personal medical records in the possession of the GAO are not subject to subpena or discovery proceedings in a civil action.

(2) The annual report submitted by the Inspector General of HEW must include a detailed description of the cases referred by HEW to the Department of Justice, and an evaluation of the performance of the Department of Justice in the investigation and prosecution of fraud in the medicare and medicaid programs together with recommedations for improvement. After the Inspector General submits his report, the Attorney General is required to promptly report to Congress the details of the disposition of cases referred to it by HEW.

Other provisions

The legislation contained the following additional amendments relating to fraud and abuse control:

(A) The ban on "factoring" arrangements was modified to preclude the use of a power of attorney as a device for reassignment of benefits under medicare and medicaid, other than an assignment to a governmental entity or establishment, or an assignment established by or pursuant to the order of a court of competent jurisdiction. However, the law does not preclude the agent of a physician or other person furnishing services from collecting any medicare or medicaid payment on behalf of a physician, provided the compensation paid the agency for its services is unrelated (directly or indirectly) to the dollar amount of the billings or payments, and is not dependent upon the actual collection of any such payments. A major cause cited for the proliferation of factoring arrangements was the often considerable delay in payment of claims under medicaid. Therefore, the law also added a provision requiring State medicaid plans to provide for timely claims payment procedures.

(B) As a condition for participation in the medicare and medicaid programs, a skilled nursing facility must establish and maintain a system to assure the proper accounting of personal patient funds. Such system must provide for separate and discrete accounting for each patient with a complete accounting of income and expenditures so as to preclude the intermingling of other funds with patient funds. Public Law 95-292 extended this requirement to intermediate care facilities.

(C) The legislation required the Secretary to give priority to requests by Professional Standards Review Organizations (PSRO's) to review services provided in so-called "shared health facilities" (often referred to as medicaid mills) with the

highest priority being assigned to requests from PSRO's located in areas with substantial numbers of such facilities. PSRO's were to review services in terms of medical appropriateness and quality; they were not expected to be fraud detection agencies.

PUBLIC LAW 96-272, SOCIAL SECURITY ACT AMENDMENT

Public Law 96-272 included an amendment which expanded the requirements pertaining to the exchange of information on terminated or suspended providers. It requires the Secretary to notify the State medicaid agency when individual practitioners or providers are suspended or terminated under medicare for making false statements, submitting excessive bills, or furnishing services in excess of needs (but not necessarily convicted of a criminal offense). It also requires the State medicaid agency to promptly notify the Secretary whenever a provider of services or an individual is terminated, suspended, or otherwise sanctioned or prohibited from participating under medicaid. This provision was intended to assure that providers who have been earmarked for violations under either medicare or medicaid do not receive compensation for practicing under either program in any State.

PUBLIC LAW 96-499, THE "OMNIBUS RECONCILIATION ACT OF 1980"

Public Law 96-499, the "Omnibus Reconciliation Act of 1980" included four amendments which modify or clarify provisions of Public Law 95-142.

(A) This law authorizes Federal matching payments to the States for the cost of establishing and operating medicaid fraud control units at the rate of 90 percent for the initial 3-year period and 75 percent thereafter (subject to the same ceilings as under prior law).

(B) Public Law 95-142 required, as a condition of participation in medicare and medicaid, the reporting of all financial interests of 5 percent or more in any obligations secured by an entity. Public Law 96-499 amends this requirement to provide that an entity must report only those individual interests in mortgages or other obligations equal to at least $25,000, or 5 percent of its total assets.

(C) Public Law 95-142 provided that medicare and medicaid payment could be denied for goods and services furnished by a physician or other practitioner convicted of a program-related crime. Public Law 96-499 broadens the exclusion so as to apply to other categories of health professionals (e.g., operators or administrators of health facilities) and extends the exclusion to title XX of the Social Security Act (relating to social services programs). The law also clarifies that the Secretary is authorized to bar a professional who may have participated in only one program from participation in both programs.

(D) Public Law 95-142 provided that the solicitation or receipt of any remuneration in return for purchasing, leasing, or ordering any service or supply covered under medicare or medicaid constitutes a felony, punishable by a fine of up to $25,000, or 5 years imprisonment, or both. The offer of payment of kickbacks, bribes, or rebates for such purposes is also a felony, punishable to the same extent. Public Law 96-499 clarifies that such criminal penal-

ties apply only in cases where such conduct is undertaken knowingly or willfully.

(E) Public Law 96-499 also contained several provisions relating to improved administration of the medicare home health benefit. The legislation specifies that a physician certifying the need for such services may not have a significant ownership in or contractual arrangement with, the home health agency. The law also requires the Secretary, in determining the reasonable cost of home health services, to exclude amounts for any new subcontracts when such subcontract exceeds 5 years' duration or where the amount of the subcontract is based on a percentage arrangement. In the case of existing subcontracts, reimbursement is limited to reasonable amounts.

PUBLIC LAW 97-35, THE "OMNIBUS BUDGET RECONCILIATION ACT OF 1981"

Cases of potential medicare and medicaid fraud which are deemed appropriate for prosecution are forwarded by the Department of Health and Human Services (HHS) to the Department of Justice. However, for a number of reasons, many of the cases are not brought to trial. In such cases, the only recourse for the Government had been to attempt to recover the overpayments.

(A) Public Law 97-35 authorizes the Secretary of HHS to assess a civil money penalty of up to $2,000 for fraudulent claims under medicare and medicaid, and to impose an assessment of twice the amount of the fraudulent claim, in lieu of damages. Whenever the Secretary makes a final determination to impose a civil money penalty or assessment, he may bar the person (including an organization, agency, or other entity) from participation in medicare. He is also required to notify the medicaid State agency and may (expect where he approves a request by the State not to take such action) require such agency to bar the person from participation in medicaid.

(B) The law provides that the Secretary may initiate proceedings only as authorized by the Attorney General pursuant to procedures agreed upon by them. The Secretary may not make any adverse determinations until the person has been given written notice and an opportunity for a hearing with a right to be represented by counsel, to present witnesses, and to cross-examine. The law also provides for judicial review on the record if a written petition is filed within 60 days of the Secretary's determination.

(C) In determining the amount of penalty to be imposed, the Secretary is required to take into account: (1) The nature of the claims and the circumstances under which they were presented; (2) the degree of culpability, history of prior offenses, and financial condition of the person presenting the claim; and (3) such other matters as justice may require.

(D) When the Secretary's determination is final he is required to notify the appropriate State or local medical or professional organization, Professional Standards Review Organization, and State or local licensing agency.

IV. ORGANIZATION OF THE OFFICE OF INSPECTOR GENERAL

Congressional intent in creating the Office of Inspector General, HHS, was to establish an office to "conduct and supervise audits and investigations relating to programs and operations of the Department to increase their economy and efficiency and to reduce the likelihood of fraud and abuse." (Senate Committee on Government Operations, Report 94-1324.)

In addition, the IG was given specific responsibility for recommending corrective action concerning fraud and other serious problems, abuses, and deficiencies and for reporting to the Secretary and the Congress on the progress made in implementing such corrective action.

Three reporting requirements were identified—an annual report to the Secretary and Congress on the activities of the Office, quarterly reports detailing recommended corrective action on which adequate progress had not been made, and immediate reports (within 7 days) to the Secretary and appropriate congressional committees whenever the Office became aware of particularly serious or flagrant problems, abuses, or deficiencies.

To meet these responsibilities, the Office of IG is organized with three essential components: the Audit Division, the Office of Investigations, and the Office of Health Care and Systems Review. The Audit Division reflects a complete transfer of functions and personnel from the preexisting audit agency. The Office of Investigations was initially staffed with the 10 investigators of the old Office of Investigations and Security and 10 investigators from the Social Security Administration. The Office of Health Care and System Review had no existing counterpart.

Though the committee report indicates it was not Congress intent to restrict the transfer of personnel to those of the audit agency and OIS, no additional personnel or positions were transferred.

Table 2 was prepared by the HHS IG to illustrate the staff buildup of the IG and personnel sources through 1980.

TABLE 2.—HISTORY OF AUTHORIZED FULL-TIME EQUIVALENT POSITIONS, 1977–80

	Appropriated	Transfers	Total	Allocation				
				Executive management	HC and SR	Investigation	Audit	Total
Fiscal year 1977:								
1977 establishment			944			74	870	944
1977 supplemental	110		110	+16		+20	+74	+110
OIG allotment				−6	+40	+10	−44	
SSA transfer		10	10			+10		+10
Total, 1977			1,064	10	40	114	900	1,064
Fiscal year 1978: 1978 supplemental	100		100		+100		+100	
Total, 1978			1,164	10	40	214	900	1,164
Fiscal year 1979:								
1979 increase	60		60				+60	+60
HCFA transfer		20	20			+20		+20
OIG allotment				+15		−5	−10	
Total, 1979			1,244	25	40	229	950	1,244
Fiscal year 1980:								
OIG allotment				+7		−2		
Total, 1980			1,244	32	40	227	943	1,244
Transfer to Education		45				182		

A comparison of existing resources between the HHS IG and 14 other statutory IG's indicates the HHS IG is staffed at a level of one position per 203.5 million program dollars—nearly three times the workload of the agency with the next highest ratio.

The comparison, also prepared by the HHS IG, is shown in table 3.

TABLE 3.—COMPARISON OF RESOURCES AMONG DEPARTMENTAL INSPECTORS GENERAL

Department	1981,.IG staff	1980 Department outlays (in billions)	Average per position (in millions)
Agriculture	850	$24.6	$28.6
Commerce	186	3.8	20.4
CSA	54	2.2	40.7
Education	300	13.1	43.7
Energy	155	6.5	41.9
EPA	121	5.6	46.3
GSA	538	.4	.7
HHS	957	194.7	203.5
HUD	470	12.6	26.8
Interior	226	4.4	19.5
Labor	433	29.7	68.6
NASA	110	4.8	43.6
SBA	122	1.9	15.6
Transportation	443	19.0	42.9
Veterans Administration	356	21.1	59.2

V. RESOURCES DEDICATED TO THE ELIMINATION OF FRAUD, WASTE, AND ABUSE

Prior to the establishment of the Office of Inspector General, a number of HEW units were identified by the Department as having significant responsibility for the prevention, detection, and investigation of fraud and program abuse. Two of these units were located in the Office of the Secretary and had Department-wide responsibilities—the Office of Investigations and Security (OIS) and the audit agency.

The audit agency operated through a staff located in 10 regional areas at approximately 50branch offices. The agency reported 884 authorized staff positions. Staff was supplemented by the use of public accountants and State audit staffs equivalent to approximately 2,150 man-years of effort.

The audit agency's primary responsibility was the auditing of expenditures. Its role in combating fraud and abuse was secondary, confined to calling attention to possible irregularities disclosed by audits and the provision of assistance in investigations.

The Office of Investigations and Security charter called for the exercise of broad responsibility within the Department for investigations and investigative policy. However, the unit's Department-wide authority was constrained by informal agreements removing some programs—like those of the Social Security Administration—from its jurisdiction. The OIS was staffed by 10 professional investigators located at its Washington headquarters and 5 of the 10 HEW regional offices.

Two other non-SSA units had significant fraud and abuse responsibility—the Medical Services Administration's (MSA) Fraud and Abuse Surveillance Branch and the Office of Guaranteed Student Loans. In 1975 the MSA Fraud and Abuse Surveillance Branch had a staff of one. The Office of Guaranteed Student Loans carried a staff of 14.

The Social Security Administration listed four program bureaus and its Investigations Branch as fraud and abuse units—the Bureaus of Retirement and Survivors Insurance, Disability Insurance, Supplemental Security Income, and the Bureau of Health Insurance. The Bureau of Health Insurance was responsible for the medicare program. These bureaus carried a combined staff of 24,000, but only a small percentage—the program integrity personnel—worked exclusively in the fraud and abuse area.

In 1975, SSA had a total of 187 individuals working full time on fraud and program abuse activities in the four program bureaus. Nine more spent part time on this activity. An additional 13 persons were listed for the Investigations Branch of the Office of Management and Administration. The 200 full time employees for the SSA fraud and abuse units were reported as follows:[11]

[11] Reference cited in footnote 7.

TABLE 4

	Total	Baltimore	Field office
Bureau of Health Insurance	122	24	[1] 98
Bureau of Supplemental Security Income	45	15	30
Bureau of Retirement and Survivors Insurance	19	1	18
Bureau of Disability Insurance	1	1	.....
Investigations Branch	13	13	.....
Total	200	54	146

[1] These figures are based on a House Government Operations survey in April of 1975. A table furnished the committee by the Department a month later identified 157 full-time employees in the regional offices of program integrity and 9 part time. The discrepancy was explained to have resulted from the discontinuance of the regional offices of program validation and the reassignment of the staff involved to program integrity activities. With the reassignment, the number of personnel dedicated to medicare fraud and abuse activities within the Bureau of Health Insurance totaled 181.

No attempt was made by the House Government Operations Committee to quantify the other resources available within the Department in 1975 sharing responsibility for the prevention, detection, and investigation of fraud, abuse, and waste. The committee considered the list supplied by the Department to be incomplete and imprecise and indicated there was confusion in the manner in which the units were classified.

In 1980, the Inspector General's Office attempted to quantify current resources directed at controlling fraud, abuse, and waste in programs under the jurisdiction of HHS. The IG's report, dated March 23, 1981 (appendix B), lists some 43 divisions within the Department sharing this responsibility with the Inspector General.

Of the resources identified by the Fountain committee in 1975, table 4 above, 20 positions were transferred to the Inspector General in 1977. The Bureau of Health Insurance and the MSA Division of Fraud and Abuse Control were consolidated into what is now HCFA's Bureau of Quality Control. The BQC currently reports a staff of about 200.

The remaining functions specifically identified by the Fountain committee remain with the Social Security Administration. The IG found the Social Security Administration directs, 1,487 staff years ($140 million) and 464 audit years ($12.6 million) at activities designed to encourage program efficiency and prevent fraud and abuse.

The table that follows details the current resources available within HHS to combat fraud, waste, and abuse by activity.

TABLE 5

Activity	Resources available	
	Staff years	Cost (millions)
Investigations	1,689	$148.6
Audits	1,289	48.3
Management systems review	190	6.6
Fiscal review	451	14.3
Audit-related matters	224	7.0
Utilization review	42	1.5
Quality control	2,098	59.6
Other	5,338	141.6
Total	11,321	427.5

VI. PERFORMANCE OF THE INSPECTOR GENERAL—1980

There are no perfect indicators of the performance and success of an Inspector General in controlling and preventing fraud, abuse, and waste. However, a number of relative judgments are possible. With respect to audit activity, these judgments are generally based on the efficient use of audit resources, audit findings, and recoveries per dollar expended. With regard to investigations, measurements can be made based on the number of cases opened (workload), their disposition, the time interval necessary for disposition, number successfully completed and referred for prosecution, acceptance or declination of the case, indictments, convictions, sentences, restitution, and recovery.

With respect to controlling fraud, abuse, and waste, a critical measurement is based on the Office's ability to effect necessary program change to prevent a recurrence of abuses or fraudulent behavior.

AUDIT AGENCY

When the Office of Inspector General was created in 1976, all of the functions, powers, duties, assets, and personnel, of the then existing HEW audit agency were transferred to the IG. The audit agency of the Office of Inspector General has changed little since that time. The mission of the agency is "to perform comprehensive audits of all Department programs, including those conducted through grantees and contractors, in order to determine whether Department programs are operated economically and efficiently and to provide a reasonable degree of assurance that funds are expended properly and for the purpose for which appropriated." [12] Public Law 96-226 specifies that the audit activities of the Inspector General should conform to U.S. General Accounting Office standards.

In accomplishing this mission, the audit agency conducts or contracts for a variety of audits, the majority of which involve financial compliance. These audits are geared to measuring compliance with applicable rules and regulations with particular attention to the allowability of claimed costs. Over two-thirds of the reports processed on Department programs in 1980 were done by public accountants and State auditors. As a result of agency audits, some $80 million in proposed adjustments were identified in 1980.

STAFFING

Prior to the incorporation of the audit agency into the statutorily created Office of Inspector General, the agency had 884 authorized positions, with all of its professional staff accounting or business oriented. The agency staff was supplemented by the use of public

[12] Reference cited in footnote 7.

accountants and State audit staffs equaling about 2,150 staff-years of effort. The agency considered itself substantially understaffed given a workload which exceeded available resources by 566 staff-years.

As shown in table 6 below, the staff available to accomplish the mission remained about the same although unmet audit need had nearly doubled.

TABLE 6.—STAFF, WORKLOAD, AND UNMET AUDIT NEED

	Pre-IG, April 1975	March 1980	Percent increase
Audit agency staff:			
Internal	884	950	
External	2,158	2,362	
Subtotal	3,034	3,312	9
Audit workload	3,680	4,554	24
Unmet audit needs	656	1,242	89

Source: HHS IG.

FOCUS ON FRAUD AND ABUSE

The available resources are poorly targeted. First, they are not focused on changing those aspects of the programs which allow fraud, abuse, and waste to occur; second, the resources that are targeted to prevent fraud and abuse are not focused on those activities and programs that have the potential for the greatest amount of fraud, waste, and abuse; and third, these resources are inadequately integrated with the investigative efforts of the IG.

System changes.—The majority of agency audits involve financial compliance, and do not provide the evidence as to how programs are functioning and what can be done to make them better. As the newly appointed Inspector General has stated, agency auditors must rechannel some of their efforts from an audit style which focuses on external financial compliance to one which identifies needed internal management changes.

Although in 1980 the agency issued 3,877 reports on Department activities, only 9 of these were identified by IG officials as providing recommendations for significant program management changes. (See appendix C.) For the most part, audit recommendations which are characterized as program management related are recommendations for changes in accounting procedures and cost allocation methods. The audit agency operates a management information system (MIS) which captures audit recommendation data. However, the system cannot provide listings of outstanding audit findings and recommendations by program areas. Agency officials explained that the system would be modified to produce listings of program specific findings and recommendations. However, agency officials stated that audit findings and recommendations are purged from the system without verification that corrective action was actually taken by program officials.

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Potential areas.—In 1980 the audit agency planned to devote proportionately fewer resources to medicare and medicaid although those programs, (1) are estimated to account for the majority of all fraud, abuse, or waste estimated to occur in the Department, and (2) represent only 25 percent of the Department's budget.

The agency's work force is not targeted in proportion to the size of individual programs or the estimated potential for fraud, waste, and abuse.

TABLE 7.—AUDIT AGENCY WORK FORCE [1]

Major audit areas	Fiscal year 1980, percent of staff years planned	Estimated percent of fraud, abuse, and waste	Fiscal year 1980, percent of Department budget
Health services	19	65–70	25
Income maintenance and assistance	23	7–8	69
Research and human services	47	22–28	6
Internal operations	10		
Total	100	100	100

[1] Office of the Inspector General: Annual Report," HEW, Mar. 31, 1978.

OMB's system of audit cognizance is an external factor which influences the way the work force is targeted. Under this OMB policy of relying on a single audit agency to act for all agencies in auditing multiple-funded entities, the audit agency has assumed the bulk of the assignments for institutions of higher learning. In 1980, the agency planned to devote almost 17 percent of its resources to audits of higher educational institutions. These audits produce relatively small findings in relation to the amount of resources devoted to the audit effort.

Two additional areas characterized by agency officials as "low producers" are contract closings and cost proposals. The agency is required by regulation (41 CFR 350.502) to perform contract closing audits before final payment may be made on cost type contracts of $100,000 or more. The current audit backlog of HHS contracts is about 4,000 contracts worth over $4 billion. In 1980, the agency planned to devote 44 staff years of audit efforts to this area.

The agency is also responsible for performing audits of contract price proposals. HHS procurement regulations require that contracting officers determine the need for these audits. The requests for audit submitted to the agency must be handled on a timely basis to be useful to the contracting officer.

The lack of a general systematic review of all Department programs and activities aimed at assesssing the susceptibility of each to fraud, abuse, and waste—vulnerability assessments—limits the agency's ability optimally to target its audit efforts. Such assessments have not been done. agency officials claim that each audit is in itself a vulnerability assessment. However, since audits are done on selected aspects of particular programs, the agency is left without a broad assessment of the entire program.

A recent GAO report states that when all audits are considered vulnerability assessments ". . . they often produce findings and recommendations germane only to specific program operations, grantees, and other units. Generalization of these results to entire agency programs for comparison with the results of assessments of other programs would produce questionable results." [13]

Integration with investigations.—The audit agency's role in combating fraud and abuse is secondary to its basic audit function. Its antifraud effort consists of referring indications of possible fraud disclosed during an audit to the IG's Office of Investigations and providing specialized assistance in investigations.

There is no direct evidence that agency audits are planned as an effort to combat fraud and abuse or on an integrated basis with the Office of Investigations. Furthermore, the 1980 work plan allocates less that 5 percent of the agency's total direct effort to audit assistance for Federal and State investigative activities.

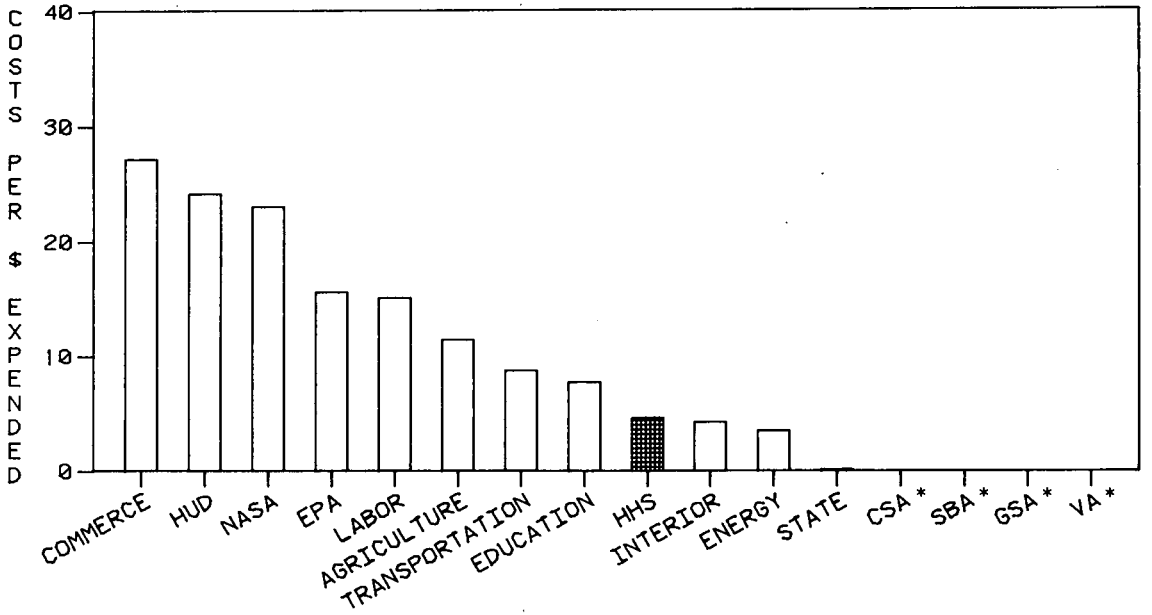
EFFECTIVENESS

Audit efforts resulted in $195 million of questioned costs which were either sustained, disallowed, or pending resolution in 1980. This amount represents a return of $4.70 for every budget dollar spent by the Inspector General that year. In comparison to 11 other IG's for which comparable data were available (Fact Book on the President's Campaign Against Waste and Fraud, July 1981), the IG's effort at HHS ranked ninth as shown in table 8.

[13] "Examination of the Effectiveness of Statutory Offices of Inspector General (AFMD-81-94)," GAO letter to Senator Harry F. Byrd, Jr., B-200598, Aug. 21, 1981.

TABLE 8

RELATIVE STANDING OF DEPARTMENTAL INSPECTORS GENERAL
QUESTIONED COSTS PER DOLLAR EXPENDED
1980-81



* Data not available.

Although almost $127 million in audit recommended financial adjustments were concurred with by the program officials, the resolution of audit findings is a problem. The backlog of unresolved audits as of the end of 1980 amounts to almost $70 million. About $39 million of that amount had been outstanding for more than 6 months—$14 million of which has been outstanding for over 2 years.

OFFICE OF INVESTIGATIONS

AUTHORITY

The Office of Investigations supervises and conducts investigations relating to programs and operations of the Department. The Office has primary jurisdiction over penalty provisions contained in title 42, USC (essentially penalties for funds involving the old-age, survivors, and disability insurance, other social security programs; medicare, and medicaid programs). In addition the Office has concurrent jurisdiction with the Federal Bureau of Investigation for violations of title 18, USC (essentially false claims, mail fraud, and conspiracy to defraud the Government statutes). Appendix D is a partial list of statutes under which medicare and medicaid fraud can be prosecuted. Administrative sanctions are listed in appendix E.

OPERATION

In medicare, the Federal Government contracts with carries and fiscal intermediaries to perform various administrative functions of the program. Carriers are required to (1) make payments for covered services on the basis of "reasonable" charges (costs in some instances) in accordance with criteria prescribed by law, (2) establish procedures and provide opportunity for fair hearings in connection with part B, (3) provide timely information and reports, and (4) maintain and afford access to records necessary to carry out the part B program. Intermediaries (1) make determinations of the reasonable costs of covered provider services, (2) make payments to providers for services rendered to beneficiaries under part A, (3) provide financial and consultative services to providers in connection with part A, (4) provide information and instructions furnished by the Health Care Financing Administration to providers, (5) make audits of provider records, and (6) help providers with utilization review procedures.

When a carrier or intermediary suspects that a particular situation involves fraud or abuse, a referral is made to HCFA's Bureau of Quality Control (BQC). After preliminary investigation by BQC, Office of Program Integrity (OPI), the case is referred to the IG's Office of Investigation (OI). According to the memorandum of understanding between the two offices (appendix F) the referral is made when a reasonable probability of criminality has been determined. The IG's Office of Investigations completes the investigation and either returns the matter to HCFA's Office of Program Integrity for administrative remedies or refers the case for prosecution.

Social Security matters are handled in a different fashion. The Office of Program Integrity (OPI), Social Security Administration (SSA), conducts criminal fraud investigations, prepares cases for presentation to the U.S. attorney, and assists in the trial prepara-

tion of beneficiary fraud cases. Referrals to OI are made when SSA's OPI has established that a Federal employee violated the law. Otherwise, based on the cases the staffs reviewed, OI only investigates social security related cases when OI is involved in a joint agency project. For example, Project Baltimore was a joint investigation by OIG, Immigration and Naturalization Service, and SSA, which focused on criminal conspiracies to obtain social security numbers for illegal aliens.

"MEDICAID FRAUD CONTROL UNITS"

Public Law 95-142 provided Federal matching funds of 90 percent for the costs incurred by States in the establishment and operation of medicaid fraud control units (MFCU's). federally sponsored, MFCU's are separate from the State agencies that administer the medicaid program. The IG is the manager and national coordinator for all MFCU's. The units receive complaints of alleged fraud and abuse, investigate and prosecute cases, and collect or refer to a State agency for collection, the program overpayments the units identify. Nearly half the Inspector General's budget was earmarked for MCFU activity.

Twenty-one States do not have federally sponsored MFCU's although some States operate similar units. In those States without units, federally sponsored or their own, medicaid fraud investigation appears to be a matter for the OI. The extent to which OI is able to address medicaid fraud in nonfraud unit States, the effectiveness of existing MFCU's, and the management provided by the Inspector General is an area which was not investigated.

PERSONNEL AND CASELOAD

After the transfer of personnel to the Department of Education in 1980, the Office of Investigations had 182 employees. Half of these were listed as field investigators. (Table 2 supra.) The other half were said to be clerical, field managers, or headquarters personnel. The location, number, and workload of field personnel is shown in table 9.

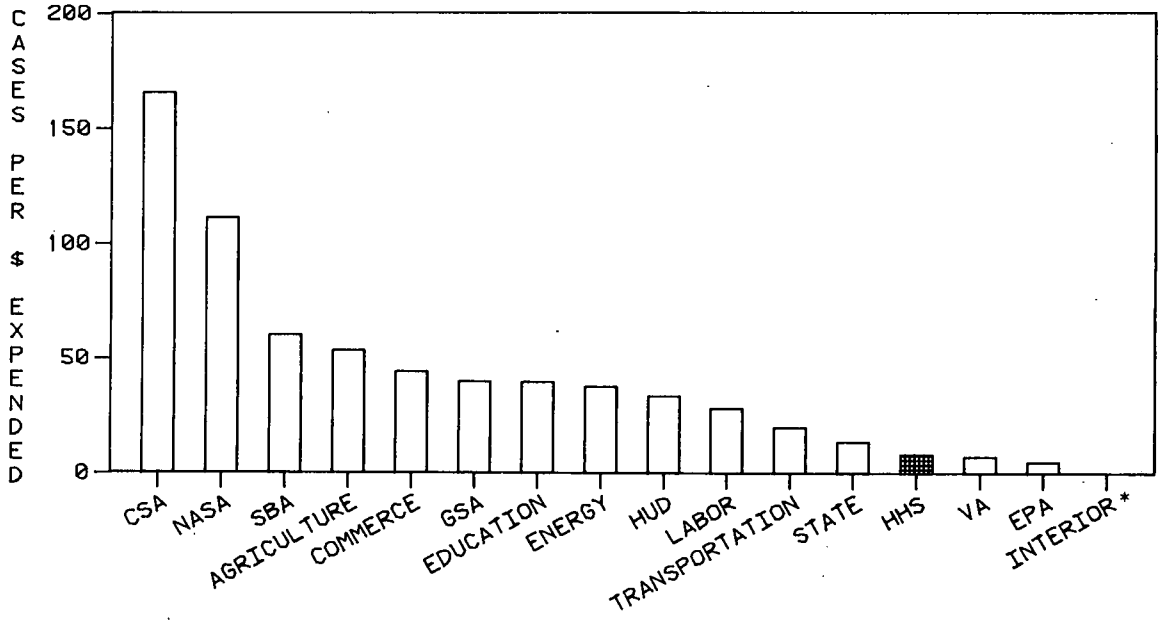
TABLE 9.—OFFICE OF THE INSPECTOR GENERAL INVESTIGATION STATISTICS

Regions	HHS dollars at risk, fiscal year 1980 (billions)	Special agents	Current open investigations (as of Sept. 30, 1980)	Anticipated new investigations by Sept. 30, 1981	Investigative closures (Oct. 1, 1980 to Sept. 30, 1981)	Anticipated open investigations on Sept. 30, 1981
I—Boston..	$11.9	7	111	320	331	100
II—New York..	26.7	10	350	464	385	429
III—Philadelphia..	24.6	16	148	262	274	136
IV—Atlanta..	31.8	19	195	295	299	191
V—Chicago..	38.2	9	164	267	221	210
VI—Dallas..	17.2	11	113	162	109	166
VII—Kansas City..	10.1	3	45	38	23	60
VIII—Denver..	4.5	3	42	62	53	51
IX—San Francisco..	23.1	10	115	248	248	115
X—Seattle..	6.1	3	40	54	53	41
Total..	194.2	91	1,323	2,172	1,996	1,499

The 1980 report of the Inspector General listed 145 convictions in that year and 353 cases opened. In comparison with the other statutory IG's, the HHS IG ranked 13th in number of cases opened in 1980 per dollar expended (table 10). Thirty-six percent of the pending cases listed were said to be 6 months old or older. Twenty-one percent were reported to be over a year old.

TABLE 10

RELATIVE STANDING OF DEPARTMENTAL INSPECTORS GENERAL
CASES OPENED PER DOLLAR EXPENDED
1980-81



* Data not available

HHS IG ranked 6th in comparison with the other statutory IG's in convictions per dollar expended. During the same period the New York State Medicaid Fraud Control Unit (formerly the Special Prosecutor for Nursing Homes) lists 305 indictments. Of these indictments there were 154 convictions, 9 dismissals, and 12 acquittals. The balance of the cases were pending.

In addition, the New York Unit reported 63 pending civil suits ($22,401,244) and 53 settled civil suits. Total recoveries in 1980 exceeded $13 million.

HEALTH CASES REFERRED TO JUSTICE

Because of the apparent concentration of fraud, abuse, and waste in the medicare and medicaid programs, Congress has expressed particular interest in the Inspector General's activities with regard to health. This interest is reflected in specific reporting requirements for health cases.

Forty-one health cases were referred to the Department of Justice by the Inspector General, Office of Investigations in 1980. (Appendix G.) Five of the forty-one cases resulted in convictions, all by plea. As shown in table 11, the longest sentence was 5 months.

TABLE 11.—1980 CONVICTIONS

Case No.	Plea	Sentence	Fine	Restitution
1	Guilty	3 yr probation		$5,592.60
2	do	[1]	[1]	[1]
3	do	31 mo probation 5 mo confinement.	$25,000	[2] 161,641.00
4	do	[1]	[1]	[1]
5	do	3 yr suspended 3 mo confinement..	5,000	10,170.77

[1] Information not readily available.
[2] Plus interest.

Thirty-one of the forty-one cases presented to Justice were declined. Three were listed as pending at the end of 1980. One of those was at trial. One case resulted in an acquittal. The resolution of one case could not be determined since it was not available for our analysis. Administrative action, civil recovery, and other sanctions were recommended by the Justice Department in 16 of the 31 cases they declined. Sanctions appear to have been made in only four of these.

Among the reasons listed by the U.S. attorneys for their declination of cases were insufficient dollar amount, lack of jury appeal, passage of time, vagueness, lack of criminal intent, lack of evidence, age and poor condition of witnesses, and lapse of the statute of limitations.

The average age of cases declined from the point the action was initiated until its presentment to, and declination by Justice, was 480 days. In one case, 1,129 days elapsed between the time the action was initiated and prosecution was declined. In one-third of the declined cases, the period between complaint and referral to

Justice exceeded 2 years. In four cases the period between complaint and declination exceeded 900 days.

Four cases were declined less than 66 calendar days from the time the initial complaint was filed. In one case only 35 calendar days had elapsed between the time the complaint was made and the case declined.

Examples of cases declined in 1980 indicate some of the problems:

—A California physician was said to have overbilled medicare by over $130,000 during 1976 and 1977. The case was referred to the Office of Program Integrity by Congressman Waxman and an investigation initiated in April of 1977. The case was declined in June of 1980 on the basis of lack of evidence. The OIG agent was not assigned until March of 1980. There is nothing in the file to indicate any action of any kind between 1978 and 1980.

—A physician was confirmed by OI to have fraudulent billings involving 43 patients. The physician had previously been indicted for the sale of controlled substances. The file indicates the complaint was initiated in September of 1979, the Office of Investigations first action in January of 1980, and a referral to Justice in November of 1980. The case reflects 22 man hours of work. It was dismissed for lack of evidence.

—A Colorado laboratory was accused of overbilling. A complaint was filed against the company twice—once in July of 1977 and again in March of 1978. In both cases the source of complaint was a tip from an employee that fraudulent tests were being performed. The case was referred to the Office of Investigations a year and a half after the initial complaint. It was nearly 3 years before the matter was presented to the U.S. attorney. The case was declined due to a problem with the statute of limitations.

—A podiatrist was accused of misrepresenting services and false billing. The initial complaint was made in March of 1980. The case was referred to OIG in April, and Justice in June. The podiatrist was convicted on two counts of false billing. He was sentenced to 3 years probation and ordered to repay $6,000.

—A physician associated with a skilled nursing facility was accused of embezzling funds from the SNF and accepting kickbacks. The investigation was initiated by a complaint to OIG in November of 1979. OIG's investigation began in December of 1979, and was completed in January of 1980. The case was declined because the total loss could not be calculated.

SSA CASES

The Social Security Administration utilizes some 8,426 staff years ($322.1 million) or about 10 percent of its total staffing resources to combat fraud, waste, and abuse. Of that total, 1,487 staff years ($140 million) were devoted to investigations. Over 464 staff years ($12.6 million) was spent on audits or audit-related matters.

The Social Security Administration initiated 10,760 cases of program fraud in 1980. There were very few referrals to the Office of Investigations; those that were referred involved mostly employee fraud. Some 873 cases were referred from SSA regional offices to

local U.S. attorneys with a recommendation for prosecution. Of these, 283 resulted in convictions (approximately 30 percent).

The case review indicates that these cases were easier to prosecute for the basic reason that social security cases tended to be simpler and more straightforward. They involved less effort and little investigatory activity other than verification.

Health Care and Systems Review

The third basic function of the Inspector General's Office is to prevent the recurrence of fraudulent and abusive practice by effecting program change. Within the HHS IG, this mission is assigned to the Office of Health Care and Systems Review (HCSR). HCSR has a staff of 40.

HCSR pursues its mission in three ways:

(1) Audit findings are reviewed for program implications. When program implications are identified, HCSR transmits their recommendation for change to the appropriate operating component.

(2) As of November 1980, investigators are required to file a management implications report (MIR) at the conclusion of each investigation. The purpose of the MIR is to identify program changes which would prevent the similar fraud from occurring in future—in short—program vulnerability.

(3) In addition, HCSR undertakes reviews, called service delivery assessments (SDA's), to determine the effectiveness of programs under the Department's jurisdiction.

MIR's

HCSR records indicate 81 management implications reports were filed in 1980. As of July 27, 1981, seven of these were said to be active. Fourteen were pending. The remainder were classified as inactive. HCSR staff explained most of the early MIR's were of questionable value and did not contain findings with program implications.

However, the promise of the program was demonstrated in the emergence, from a MIR filed late last year, of Project Baltimore, focusing on the timeliness of SSA termination of payments to the deceased. Office of Investigations staff indicate they are in the process of revising the process and clarifying the procedure for filing of MIR's by investigators.

AUDIT

Audit findings with program implications are referred directly to the principal operating division within the Department responsible for the program. To the extent HCSR identifies the need to revise operating procedures based on audit findings, the findings are consolidated for tracking.

Two general problems were identified with this procedure. Most of the findings were audit specific. The corrective action suggested related to the specific program and agency reviewed. There appeared to be little interest in determining the systemic implications involved. Second, there were indications—denied by the Audit Division—that Audit would not share its findings with HCSR.

Nine audit findings with program implications were identified by HCSR (appendix C). The impact, if any, of these recommendations on program operations could not be determined. The appropriate program components have been asked to evaluate and respond.

SERVICE DELIVERY ASSESSMENTS

Service delivery assessments are described as "analogous to investigative reporting," the SDA's are conducted by a small group of in-house staff, and "generally consist of focused discussions with consumers and service providers." (Appendix H is an executive summary of the service delivery assessment process.)

Each topic is either identified or approved by the Secretary or Under Secretary before the study begins.

In 1980, nine SDA's were undertaken: Low-income energy assistance program, community health centers, health and social services to public housing residents, title XX program, medicare part B beneficiary services, national health service corps, availability of physician services to medicaid beneficiaries, end stage renal disease program, and restricted patient admittance to nursing homes.

Results of the assessments are said to be "used internally by Department managers as an additional source of information, which, when combined with other information, presents a total picture of service delivery." There is no apparent record of program change as a result of this activity.

In addition to SDA's, HCSR develops letter reports and memoranda to advise program officials of problem areas. In 1980, 21 of these memoranda and letters related to health; 16 others were identified. (Appendix I.)

In general, other than the liberty of raising the question of what action a program component may have taken based on a particular recommendation, the HCSR has no way of tracking the IG's recommendations or assessing impact. Provisions, of law require a quarterly report to Congress of significant recommendations not implemented. To this point, the quarterly reports have been silent on this issue.

Bureau of Quality Control

HCFA's Bureau of Quality Control reflects the consolidation of the BHI program integrity staff, the MSA Division of Fraud and Abuse Control.

In 1976, during the debate on the creation of the Inspector General, HEW nearly doubled the number of staff said to be dedicated to controlling medicare fraud, abuse, and waste by phasing out regional program validation activities and reassigning those involved to program integrity activities. In 1978, with the creation of the IG and the assignment of responsibility for criminal investigations to that Office, the program validation concept was resurrected.

The Bureau of Quality Control currently reports some 200 staff members dedicated to validation and integrity activities throughout the country. Staff are said to be roughly equally divided between the two activities. Program integrity staff are responsible for investigating cases, teaching, and monitoring medicare carriers and

intermediaries. Program validation staff are involved in identifying providers who are abusing the program, testing program policies, and reviewing contractor procedures.

Through fiscal year 1980, the Bureau of Quality Control estimates savings of $145,037,618 from validation activities. (Appendix J.) The savings are said to be the result of overpayment recoveries, corrected operational deficiencies on the part of medicare contractors and State medicaid agencies, and recommended policy changes. All but $40 million of the estimated savings are said to be attributable to changes in policies or operational deficiencies.

JURISDICTIONAL DISPUTES

In practice, the division between validation and integrity activities is almost indistinguishable. This confusion and the conflict it has created between personnel of the Inspector General, Office of Investigations, and those of the Bureau of Quality Control, HCFA, retards the ability of the Department to control fraudulent and abusive acts.

The committees have obtained documents from several OPI regions questioning the effectiveness of the Office of Investigations. At the same time documents were obtained detailing serious problems encountered by the Office of Investigations in obtaining the cooperation of OPI personnel.

Copies of these documents are appended at K and L. With regard to allegations against the Office of Investigations (appendix K) they indicate:

—Many more cases were presented to Justice and declined than the Inspector General acknowledges;
—the IG has inflated his conviction rate by taking credit for OPI cases;
—cases were improperly presented to the U.S. attorneys;
—cases were presented without adequate development or expansion of the sample (one case was said to have been presented 4 days after it was received by OI); and
—failure to coordinate activity so that administrative sanctions, civil recovery, and suspension of payments could be effectuated.

The General Accounting Office, in a 1980 letter report to the Senate Finance Committee, confirmed that in 1979, the IG took credit for some cases it did not investigate.[14]

The examples below illustrate some of these problems:

Two Government employees found to have filed false claims in excess of $2,500 in 1979, were allowed to resign rather than face prosecution. The regional OPI was critical of the result and the fact that there had been no apparent attempt to expand the universe to fully document the extent of the problem.

In a second 1979 case, an anesthesiologist was said to have billed for services to two or more patients at the same time. The declination was said to be based on the limited dollar amount involved—less than $2,000. OPI was critical of the development of the case. Records of the physician show the receipt of over $8,000 in assigned

[14] "Validation of the Health Care Related Convictions Attributed to the Office of Investigations of the Department of Health and Human Services (HRD-81-34)," letter to Jay Constantine, U.S. Senate Committee on Finance, B-201407, Dec. 5, 1980.

medicare payments and about $64,000 in unassigned payments in the period in question. No attempt had been made to expand the case. Mail fraud statutes had not been considered. Ultimately, the case was again presented to the U.S. attorney—this time by OPI—and accepted on the basis of mail fraud.

The third example demonstrates the confusion and conflict between the two offices. This 1980 case involved a medical equipment supplier's violation of the kickback statutes. The supplier attempted to induce medicare beneficiaries to purchase or lease equipment by offering to provide other items at no extra charge. According to the regional Office of Program Integrity, the special agent in charge, Office of Investigations, closed the case based on a judgment "there was no criminal violation."

Six months later, based on an opinion from HHS General Counsel that "the language . . . is most clear, and the described practice, if conducted, would fall squarely within the prohibition of the statute," the case was returned to the Office of Investigations.

The cover letter on the referral indicated concern for precedent and impact on the field if the practice were allowed to go unchallenged. The OPI indicated there were no apparent administrative sanctions to effectively deal with the problem.

The Office of Investigations expressed its appreciation for the opinion of General Counsel but disagreed. There has been no further action on the case.

At the end of 1980, the Regional Administrator of HCFA, region IV, summarized the existing situtation in a letter (appendix M) to the Administrator of HCFA, which stated in part:

> Since 1976, with the exception of cases handled to completion by OPI, there have been no criminal convictions involving medicare in south Florida. Our past experience with the area (some 21 criminal convictions obtained by OPI in the 1976–78 period) and the continuation of the same kinds of potential criminal activity reflected in the cases OPI now refers to the Office of Investigations lead us to believe that a major problem continues to exist in terms of medicare fraud in that area.
>
> This lack of criminal convictions has had further effects, the Regional Administrator continued. Due to the large number of initial complaints of potential fraud and abuse we received from medicare beneficiaries through Social Security offices in south Florida, the Social Security Administration years ago set up a special unit in the Miami Beach district office to which all Social Security offices in the area referred initial complaints. This special unit, staffed with as many as six field representatives, screened these complaints and referred on to OPI only those which had good potential as fraud cases. The volume of complaints has now fallen to the point that the unit was disbanded several months ago. We believe this drop in the number of complaints is directly attributable to the lack of criminal convictions and the attendant publicity such convictions receive in the media.

With regard to the Office of Program Integrity (appendix L), the Office of Investigations documents alleged that:

—The Office of Program Integrity does not refer all criminal cases to OI;
—OPI has repeatedly refused to assist and support the OI in the development of cases;
—there has been a significant decrease in the number of cases referred to OI and the dollar amount involved; and
—OPI emphasizes civil actions at the expense of criminal actions.

One example provided, documents six requests for assistance from the OI to the regional Bureau of Quality Control. Each time assistance was refused.

The case was initiated by a carrier early in 1981. In July, after referral from OPI to the Office of Investigations, representatives of the two divisions met to discuss the case. Allegations concerned a laboratory's use of a double price list and the filing of false claims.

In August of that year, the Office of Investigations wrote the Regional Administrator of the Bureau and requested assistance in reviewing subpenaed records. The U.S. attorney's office had accepted the case and requested the review.

In September, the Regional Administrator, BQC responded: "Our entire staff is engaged in intensive fiscal year-end activities relating to our primary responsibilities." Support for validation of the records in question could not be provided until after October 15, 1981.

In October the assistant U.S. attorney involved with the case requested priority consideration. The regional Office of Investigations renewed its request for assistance.

The regional office BQC responded: "The type of assistance we contemplated was more advisory than participatory." The response went on to say the type of work requested seemed "clerical in nature, and does not appear to be an appropriate assignment for one of our program analysts."

In November, the special agent in charge, OI, in transmitting the history to his supervisor, said it was "a typical example of relationships with this office much to the detriment of the agency's mission. The audit director and I will take no further action to attempt to secure services of HCFA Quality Control Division based on their refusal to assist the OIG and the U.S. attorney's office."

Case Study

The following example indicated the impact of the HCFA OPI/OI jurisdictional dispute and its consequences.

On August 12, 1976, the Bureau of Health Insurance initiated an investigation of a Florida home health agency. It was alleged the brother and sister who ran the agency had conspired to defraud the Government. Among the charges questioned were salaries to the sister, as administrator, of $60,000; and $38,000, to the brother, as associate director; fraudulent travel and telephone expenses; billing medicare for first-class travel for themselves and others; maid service for the administrator; billing medicare for personal legal fees; and making loans to themselves and others out of agency funds. The complaint that initiated the investigation was said to flow out of Senator Chiles' Subcommittee on Federal Spending Practices investigation of problems in the home health program.

Investigation of the agency was conducted under the direction of the U.S. attorney's office and a Federal grand jury. Through the early part of 1977, BHI directed a Blue Cross audit of the agency's records. The Office of Investigations joined the investigative team in January of 1977.

After preparing an inventory of investigative activities previously undertaken, the Office of Investigations assumed the responsibility of directing the investigation. Subpenas were issued. Witnesses interviewed were reinterviewed. Due to the length of the investigation, findings were presented to several grand juries.

In August of 1979, Deputy Inspector General Richard Lowe appeared before the Senate Aging Committee, then chaired by Senator Chiles, to address problems in home health care. Mr. Lowe indicated the IG's Office had launched a 3-pronged attack. These efforts, Mr. Lowe candidly admitted, had been accelerated by the imminence of the hearing.

The first prong was said to be the deployment of significant resources in cooperation with the Department of Justice to come to grips with the most meritorious cases in Florida. Nearly 30 agencies were said to be involved in the investigative initiative. Mr. Lowe promised to supervise personally the progress of the investigation.

Internal documents obtained from the regional office of Program Integrity indicate the "significant resources" never materialized. Despite the presence, involvement, and "lead" of the Office of Investigations, the Department of Justice continued to rely heavily on the program integrity staff.

In April of 1977, the Justice Department attorney in charge of the case called the regional program integrity office to insist on the continued involvement of a program integrity auditor. The attorney is said to have threatened that if the auditor were not made available, she would recommend that Justice drop the case, citing noncooperation of HEW as the reason.

Two years later, in March of 1979, the Program Integrity auditor was still involved in the case. Conflict between this auditor and OI personnel had grown to the extent that the two entities quarreled publicly as to the source of a recent press leak. The OI, special agent in charge, threatened the auditor with investigation and the assistant U.S. attorney on the case was forced to mediate.

On April 2, 1980, 4 years after the investigation commenced, the grand jury indicted the brother and sister on charges of conspiracy and filing of false statements.

In November, on request of the U.S. attorney, the indictments were dismissed. Civil recovery was suggested by the U.S. attorney, but no recovery has been made.

Following the dismissal of the suit, the U.S. attorney wrote the Department to discuss the "numerous difficulties we encountered with medicare regulations relating to funding. This resulted, not only in the great length of the investigation," the U.S. attorney reported, "but ultimately in my decision to request that the indictment be dismissed."

The regulations were criticized as being so vague, "Administrators need only back up their questionable activities by stating the regulations allow them to conduct those activities. There is pres-

ently little incentive to hide what superficially would appear to be illegal financial and other activities, since regulations permit them."

The U.S. attorney proposed tightening regulations to require the board of directors be unrelated to the administrators; prohibit leasing of expensive automobiles for personal use, limit travel to that necessary to conduct the agency's activities; limit personal expenses, fringe benefits, vacations, and sick leave; control the use of consulting contracts; forbid passing of personal expenses through agency account, prohibit the use of agency resources for private benefit; and prohibit the payment of attorney fees in criminal prosecution.

At the same time, as a result of the 1979 Aging Committee hearing, the Bureau of Quality Control, Office of Program Validation conducted a review of 24 home health agencies in four States. The findings and recommendations were nearly identical; yet, other than point of origin, the efforts were unrelated. The Health Care and Systems Review unit of IG has consolidated the validation findings with those generated internally. But the HCSR has not been able to track the recommendations or assure their implementation.

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VII. LEGAL ISSUES

Part of the confusion surrounding the operation of the Office of Inspector General, HHS, revolves around Congress intent in creating the Office. Among the issues apparent are questions of autonomy of operation, resources, law enforcement powers, jurisdiction, and independence.

A review of these issues by the American Law Division of the Library of Congress (appendix N) indicates congressional intent to delegate broad authority for the IG to monitor both auditing and investigative activities of the agency. The legislation itself, however, seems to contain inherent obstacles to the exercise of such broad authority.

The record is confusing and inconsistent. Committee reports on both sides of Congress indicate concern for the fragmentation of existing resources, the lack of independence of existing HEW units, and the need to prevent evident conflicts of interest as well as centralize existing resources.

But the issue of independence is reflected in the law establishing the Inspector General only in the way the IG is selected (Presidential appointment and ratification of the Senate) and in concurrent reporting requirements.

As for the question of resources, only two of the existing agencies at the time of the IG's creation were specifically transferred. The transfer of additional resources though contemplated was not mandated.

This confusion is reflected in the disharmony between the Office of Program Integrity, HCFA and the IG's Office of Investigations and in growing jurisdictional disputes with other Federal agencies. Appended at O are 10 memoranda of understanding between HCFA OPI and IG OI in a period of 4 years. The problems continue. Appended at P and Q are copies of transmittals from the Federal Bureau of Investigation and the Attorney General addressing jurisdictional issues.

VIII. CONCLUSIONS

The problems Congress attempted to address with the creation of the Inspector General, HHS, remain. The criticisms of the 1975 Fountain committee are as accurate now as then.

1. Multiple audit or investigative units exist within the Department, organized in a fragmented fashion, without effective central leadership.

A March 1981 survey indicates there are more than 40 divisions consisting of 11,331 staff years within the Department of Health and Human Services attempting to combat fraud, abuse, and waste.

—There is no effective, centralized leadership for this activity. Authority, focus, and relationship of these entities with the Inspector General varies from division to division.

—In one case, relations between the IG and a program division (the Bureau of Quality Control, Office of Program Integrity) are so confused 10 memorandas of understanding have been attempted in a period of 4 years.

—Like agencies are treated differently in their relationship to the IG. BQC, OPI staff are not considered criminal investigators. Their role is confined to administrative sanctions and receiving, processing, and referring all criminal cases to OI. SSA, OPI personnel are explicitly considered criminal investigators and only refer those cases relating to SSA employee misconduct to the IG.

2. Auditors and investigators report to officials who are responsible for the programs under review or are devoting only a fraction of their time to audit and investigative responsibilities.

Fraud, abuse, and waste prevention and detection units remain scattered throughout the Department in a haphazard, fragmented, or often confusing pattern.

—Less than 10 percent of the total resources dedicated to controlling fraud, abuse, and waste (977 of 11,321 staff years) are under the control of the Inspector General.

—HCFA reports nearly 20 percent of its resources (946 staff years of 4,685) are dedicated to control abuse and waste. Fraud investigations are no longer the responsibility of HCFA, that responsibility having been transferred to the IG in 1977. Of HCFA's 946 staff years directed at abuse and waste, 256 staff years are in quality control and 178 staff years in audit activities.

—The Social Security Administration currently utilizes about 8,426 staff years to combat fraud, abuse, and waste.

3. There is a lack of affirmative programs to look for possible fraud and abuse.

—Other than computer matching activities, there has not been a serious focused effort to find and eliminate fraudulent activities.

—Targeting of activities based on programs at greatest risk has been absent. Though audit and investigative personnel expressed an awareness of areas offering strong potential for recoveries or investigation, this awareness was not reflected in work plans.

—Neither the IG nor any other division of the Department have demonstrated the ability to attack and control organized efforts to defraud the programs, or major, intrastate activities.

—In October of 1978, the House Committee on Aging received evidence of the involvement of organized crime elements in programs under the Department's jusisdiction in 35 of 50 States. There was no indication of any involvement by the IG in attempting to control these activities.

4. Serious shortages of audit and investigative personnel exist.

—A comparison of existing resources between the HHS IG and 14 other statutory IG's indicates the HHS IG is staffed at a level of one position per 203.5 million program dollars—nearly three times the workload of the IG with the next highest ratio.

—The audit agency is staffed below its 1975 level. Estimated essential workload exceeds the current staff capacity by nearly 40 percent.

—The Office of Investigations is staffed too low to permit proper development of cases referred to OPI, let alone the initiation of proactive investigations. One State fraud unit, New York, has more field investigators than the IG does for the entire Nation. (Statements from U.S. attorneys supporting the IG's need for more investigators are appended at R).

5. HHS, at least in part because of its fragmented organizational structure, has failed to make effective use of the resources it has.

—The creation of the Office of Inspector General has not simplified or consolidated the Department's fraud, abuse, and waste control efforts.

—The continuation of program efficiency and integrity efforts, essentially unchanged since 1975, has extended the time necessary to bring a case to conclusion and created jurisdictional disputes, duplication and inefficiency.

—In some instances, the conflict resulting from these jurisdictional disputes has damaged the Department's overall fraud control effort and caused the loss of good cases.

—Largely because of the failure to commit adequate resources and the continuation of the preexisting fragmented organizational structure, the IG's office has been ineffective.

—In comparison with the other 15 statutory Inspector Generals, the HHS IG ranked third from last in the number of cases opened in 1980 per dollar expended.

—The HHS IG ranked second from last out of the 11 statutory IG's with comparable data in dollars recovered per dollar expended in 1980.
—Thirty-one of the forty-one health cases presented to the Department of Justice in 1980 by the IG were declined. Three were listed as pending. One was at trial. One resulted in an acquital. One case was not available for analysis.
—Only 5 of the 41 cases referred to the Department of Justice in 1980 resulted in convictions. The longest sentence ordered was 5 months. During the same time, the New York State medicaid fraud unit listed 305 indictments, 154 convictions, 9 dismissals and 12 acquitals. The balance were said to be pending.

6. *Instances were found where it took protracted periods of time for HEW (HHS) to take corrective action after deficiences in its regulations became known.*

—The backlog of outstanding unresolved HHS audits, as of the end of 1980, amounted to almost $70 million. About $39 million of that amount had been outstanding for more than 6 months. $14 million had been outstanding for over 2 years.
—Thirty-six percent of the criminal cases said to be pending at the end of 1980 were 6 months old or older. Twenty-one percent were reported to be over a year old.
—Although the IG's Office of Health Care and Systems Review has targetted resources at effecting necessary program change, these activities are rudamentary. In general, other than the liberty of raising the question of what action a program division may have taken based on a particular recommendation of the IG's office, the HCSR has no way of tracking the recommendation or assuring implementation.
—Provisions of law requiring a quarterly report to Congress of significant recommendations for systems change not implemented have been ignored.

Despite the presence of many capable and dedicated investigators, auditors, and management personnel, the Inspector General's Office has not performed as Congress anticipated in 1976.

The essential elements necessary to the fulfillment of that potential are the unification under the IG's leadership of the Department's efforts to control fraud, waste, and abuse; targeting of resources; and the elimination of jurisdictional disputes.

CONGRESSIONAL BIBLIOGRAPHY

This section provides a bibliography of major congressional documents on Medicare and Medicaid fraud and abuse. The documents are organized chronologically by committee.

A. Senate Documents

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APPENDIX

APPENDIX A

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

: All Executive Staff

DATE: February 8, 1980

REFER TO: SAX

OM : Herbert R. Doggette, Jr.
Deputy Commissioner (Operations)

BJECT: Program Misuse and Management Inefficiency--INFORMATION

In a recent meeting, Secretary Harris informed us that in the future, rather than using the phrase, "fraud, abuse, and waste," she would prefer "program misuse and management inefficiency." I agree that the Secretary's terminology more accurately reflects what we are measuring and working to eliminate. The change is effective immediately; please see that is is effected in your areas of responsibility.

cc:
OC
OGC

OC # 0393

APPENDIX B

SURVEY OF RESOURCES WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AIMED AT REDUCING FRAUD, ABUSE AND WASTE

Prepared by: Office of Inspector General
Health Care and Systems Review
March 23, 1981

Purpose

This survey updates a previous one completed in August 1977 which responded to a question from a Congressional questionnaire to the Inspector General on the total resources (staff and dollars) available to promote economy and efficiency and/or combat fraud and abuse in the Department. The Office of Inspector General (OIG) committed itself to resurvey the Department's resources once the reorganization from HEW to HHS was accomplished.

Background

The terms fraud, abuse, or waste (inefficiency) were not redefined from those used in the original survey. This survey did, however, attempt to encompass a much broader look at the available resources to combat fraud, abuse and waste (FAW). Its intent was to include all activities involved in combating FAW beyond "post-audit" activities.

The following definitions were used:

- Fraud: the obtaining of something of value through willful misrepresentation.
- Abuse: covers a wide variety of program violations and improper practices not involving fraud.
- Waste (inefficiency): consists of any and all actions and or lack of actions leading to the unwise use of Federal programs, funds or resources, resulting in costs incurred without the receipt of full and reasonable benefits.

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All Principal Operating Components (POC) including components of the Office of the Secretary and Offices of Principal Regional Officials were asked to re-survey their operations and provide us with the total resources (staff and dollars) engaged in combating FAW. The request also called for a brief narrative or functional statement of duties performed for each component identified in the survey.

Summary of Survey

The total figures provided represent on-board strength at the time of the survey (October/November 1980). The survey disclosed that exclusive of the OIG, 10,344 staff years at a cost of $384.211 million are expended toward combating fraud, abuse and waste in the DHHS. The OIG on-board total resources as of November 1980 were 977 ($43.320 million) for a Departmental total of 11,321 staff years at a cost of approximately $427.527 million.

The survey data was reviewed to insure each POC's adherence to the general guidance provided by the OIG. We independently canvassed two major POC's to determine the accuracy and consistency of the data. For the most part, the responding and responsible components for this review were the respective Office of Management and Budget in each POC. HCFA, SSA and OHDS' data were all compiled by the Management and Budget staffs. PHS took a different approach and allowed each component within that POC to respond to the OIG request. For this reason it is conceivable that there may be some incon-

sistency in the PHS data with respect to both staffing and costs.

As previously indicated this review took a much broader look at fraud, abuse and waste activities than did the previous survey which concerned itself mostly with "post audit" functions. This report therefore reflects a greater increase in the efforts currently being expended by HHS in the following areas:

... fraud and abuse investigations;

... audits of State and local governments, nonprofit organizations, insurance companies, and internal HHS activities;

... other audit-related matters and/or reviews, e.g., monitoring of implementation of audit recommendations, field examination and compliance reviews by certain program staff, etc.;

... program integrity activities;

... management surveys and related activities dedicated to resolving specific programs or operational and organizational problems; and

... quality control reviews of the various programs.

These survey data do not reflect resources available in the Office for Civil Rights or the Center for Disease Control. Both of these components did not respond to the OIG request.

The following schedules represent each POC's efforts aimed at combating fraud, abuse and waste.

Office of the Secretary - 1205 Staff Years $50.639 Million

The Office of the Secretary has four components (including the Office of Inspector General) with resources available to combat fraud and abuse and/or promote economy and efficiency in HHS programs. They are a) the Office of Inspector General (OIG) 977 Staff Years $43 Million, b) the Assistant Secretary for Management and Budget (ASMB) 85 staff years $3.0 million, and c) the Assistant Secretary for Personnel Administration (ASPA).

General Description of Activities

	Resources Available	
	Staff Years	Cost (Millions)
Investigations	181.0	$ 7.958 1/
Audits	742.0	32.897 2/
Management Systems Review	72.0	2.799 3/
Fiscal Review	135.0	4.370
Audit-Related Matters	17.0	.640 4/
Utilization Review	9.0	.228
Other	49.0	1.744 5/
Total	1205.0	$50.639

1/ Investigations (180.7 Staff Years $7.958 Million) - The OIG has the majority of investigations represented here. They are located within the Office of Assistant Inspector General for Investigations (175 Staff Years $7.759 Million). This office provides leadership, policy direction, planning, coordination

and management of the HHS OIG investigative program, conducts investigation of cases of alleged fraud and abuse in programs and operations administered or financed by the Department, including allegations against Department contractors, grantees, or other entities or individuals funded, supported or employed by the Department.

ASPA (5.7 Staff Years $.19 Million) - The Division of Personnel Investigations assess allegations, conducts investigations, and makes recommendations for disposition in merit systems and non-criminal standards-of-conduct cases. It also established and maintains an internal employee security program.

2/ Audits (742.0 Staff Years $32.897 Million)-- The Office of Assistant Inspector General for Auditing's major duties include: 1) audit service to all management levels within the Department through the conduct of comprehensive audits which include examinations of the Department, and its grantees and contractors; 2) developing policies, procedures, standards and criteria relating to audit activities at all levels within the Department; 3) determining when audits can be best carried out by organizations outside HHS, preparing guidelines for conduct of such audits and reviewing adequacy of reports prepared by others for HHS; and 4) conducting follow-up audits and special analyses to determine propriety of action taken by top management on previous audit findings and recommendations.

3/ Management Systems Review (72.1 Staff Years $2.799)

a. Assistant Inspector General for Health Care and Systems Review (HCSR) - 36.0 Staff Years $1.596 Million - HCSR reviews management by the Department of its programs, giving particular attention to management information systems, quality control systems and program integrity. The HCSR provides analysis and systems development necessary to keep the Secretary and Congress fully informed about problems and deficiencies relating to the administration of Department programs and 2) develops and recommends policies for the conduct, direction or management of interdepartmental, interagency, interstate and international activities relating to promotion of economy and efficiency in the prevention and detection of fraud and abuse in all Departmental programs.

b. Assistant Secretary for Management and Budget (ASMB) - 32.5 Staff Years $1,120 Million - The ASMB administers the Operation Management Systems (OMS) which involves the periodic reviews of operating component's progress against major operational plans and objectives; 2) studies the use of consultant contracts to detect government waste and abuse; 3) conducts a number of reviews of program activities with respect to fraud and waste; 4) conduct reviews of conference management with OS; other activities

in this category include assisting programs in identifying operating problems and appropriate corrective actions in order to improve the efficiency of daily operations.

4/ Audit-Related Matters - 16.5 Staff Years $.640 Million-

a. ASMB, Office of Grant and Contract Financial Management- Resolves audit findings involving system deficiencies and cost disallowances of grantee/contractor organizations which "cut across" POC or Federal agency lines. Develops policies and procedures on audit resolution and cost determination related to grants and contracts.

5/ Other - 49.2 Staff Years $1.747 Million

a. ASPA - 3 Staff Years $.104 Million - Activities involve program evaluation, coordination or evaluation with the Office of Personnel Management and the development of evaluation techniques and guidance to principal operating components and service to personnel offices.

b. OIG (Executive Management) - 24 Staff Years $1.064 Million- Responsible for supervision, coordination, and direction of investigative, audit and HCSR functions in HHS. The IG's responsibilities and duties are to promote economy and efficiency in the administration of and prevention and detection of fraud and abuse in HHS programs.

c. Offices of Principal Regional Officials - 22.2 Staff Years $.579 Million - In this category are functions and duties which encompass the Division of Cost Allocations, Regional Offices Facilities, Engineering and Construction and the Division of Administrative Services activities. Functions involve claims review for contractors and space management; relating to news media in reference to fraud and abuse activities; reviewing and checking of plans and specifications, bids, change orders, construction, and payments.

Social Security Administration (SSA) - 8426 Staff Years $322.1 Million

SSA's data, abstracted from a report on fraud and abuse prevention and detection, submitted to the Subcommittee on Social Security of the House Ways and Means Committee, represents approximately 10 percent of their total staffing resources. The total resources identified here include the audit resources of the Office of Child Support Enforcement (OCSE). SSA's budget provides for some specific activities aimed at assuring the integrity of SSA - administered programs. For example, the fiscal year 1981 budget provides about 2500 staff years and $70 million for the Office of Assessment.

General Description of Activities

	Resources Available	
	Staff Years	Cost (Millions)
Investigations	1487	$ 140.0 1/
Audits/Audit-Related Matters	464	12.6 2/
Quality Control Reviews	1794	50.0 3/
Management Systems Reviews	50	1.5 4/
Other	4631	118.0 5/
Total	8426	322.1

1/ Investigations - - (1487 Staff Years $140 Million)

a. Continuing disability investigations involve 1272 Federal staff years and a total of $134 million for Federal and State involvement. These investigations help insure that disability insurance and SSI disability beneficiaries continue to meet statutory requirements.

b. External Fraud -- SSA investigates a large number of potential external fraud cases each year. In the year ending September 30, 1980 over 11,000 potential fraud cases were identified for investigation. 215 staff years ($6 million) were identified which involve investigations and program integrity activities.

Among these activities are the development, by the program integrity staff, of anti-fraud policies and procedures and investigation of cases of suspected external fraud and abuse. District office staff-years involved in these activities number approximately 133.

Internal fraud investigation involving Federal employees are usually not conducted by SSA, but by the Office of Inspector General.

2/ Audit (464 Staff Years $12.6 Million)

a. OCSE - (137 Staff Years $5.0 Million) - The Audit Division of OCSE develops plans, schedules and standards for State

Child Support Enforcement audits as required by law and conducts annual audits and other audits of State OCSE programs.

b. Office of Assessment (OA) - Division of Administrative Integrity-Internal SSA fiscal and systems security audits are conducted by this division both at the local and national levels. Fiscal audits include

- o time and leave practices;
- o cash collections;
- o petty cash and imprest funds; and
- o contractual operations.

Systems Security audits include

- o SSI form-8080 turnaround time;
- o pre-effectiveness audits of District Office Imput (DODI); and
- o pre-and post-award audits of SSA Data Acquisition and Response System (DARS).

Aimed at internal or employee fraud and abuse activities are some 240 staff years ($5.9 million) for internal security in the district offices. Among other things, SSA is testing procedures which will require the use of a personal identification number for field staff to gain access to the computer systems. This will allow SSA to establish an audit trail for all payment transactions.

Furthermore, future audits of the Social Security Trust Fund are proposed. There is a feeling that existing HHS Audit Agency activities do not serve SSA's needs and that there is very little coordination between the Audit Agency and SSA.

3/ Quality Control Reviews - (1794 Staff Years $50.0 Million)
Quality Control functions of the Old Age Survivors Disability Insurance (OASDI) and SSI quality assurance systems are largely maintained by the Office of Assessment. These systems provide information on the amount and causes of incorrect payments and help formulate appropriate corrective action plans.

4/ Management Systems Review - (50 Staff Years $1.5 Million)
Efforts expended in this area include systems security officers in headquarters and regional offices to help insure that security is integrated into the management processes of SSA. These efforts are specifically aimed at internal or employee fraud.

5/ Other - (4631 Staff Years $118.0 Million)
In this category efforts are devoted for SSI redeterminations. The redetermination process verifies continued eligibility and accuracy of payment amounts. The majority of resources for this effort are located in SSA district offices. These redeterminations are major SSA activities which have a fraud deterrent and detection effort.

HEALTH CARE FINANCING ADMINISTRATION

GLOSSARY OF PROGRAM TERMINOLOGY

1. An Aberrant Cost Study is a type of program validation review performed on specific health providers reimbursed on a cost-related basis. Such a study is initiated when statistical patterns indicate the need for onsite independent review of pertinent cost centers.

2. The Annual Contractor Evaluation Report (ACER) is a formal appraisal of an individual contractor's operations. Its preparation involves the synthesis of information from a variety of sources including onsite reviews.

3. The Annual State Evaluation Report (ASER) is a formal evaluation of each Medicaid State Agency's performance based on the State Assessment and other reviews.

4. Carriers are public or private organizations under contract to administer Medicare Part B (Supplementary Medical Insurance).

5. The Contractor Performance Evaluation Program (CPEP) provides for an annual onsite appraisal of each medicare contractor. This appraisal involves Medicare Part A and/or Part B reviews in a number of core areas.

6. The Cost Report Evaluation Program (CREP) is designed to measure the quality of the intermediaries' action in reviewing, adjusting, and settling hospital cost reports.

7. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a program included in a 1967 amendment to the Medicaid law requiring states to insure the provision of periodic screening, diagnosis, and treatment to eligible children.

8. EPSDT Quality Control (QC) reviews are conducted on State EPSDT programs to insure conformance with regulatory provisions.

9. Intermediaries are public or private organizations under contract to administer Medicare Part A (Hospital Insurance).

10. The Medicaid Quality Control (MQC) Program provides for federal re-reviews of a subsample of state MQC reviews in the areas of Medicaid eligibility determinations, claims processing, and third-party liability.

11. The Medicare Part B Quality Control Program provides for federal re-reviews of a subsample of carrier Part B Quality Assurance Reviews.

12. The Professional Standards Review Organization (PSRO) Program provides for a system of peer review under Title XIB of the Social Security Act. Each Professional Standards Review Organization (PSRO) is administered and controlled by local physicians who evaluate the necessity and quality of medical care delivered within their area under the Medicare, Medicaid, and Maternal and Child Health programs.

13. PSRO Assessments evaluate the effectiveness of PSRO performance.

14. A Program Implementation Review is performed at States, Medicare contractors, or individual health providers when there are indications of unreasonable Medicare or Medicaid reimbursements resulting from potential or perceived weaknesses in Medicaid and Medicare program policy or operations.

15. State Assessments are onsite reviews of the performance of Medicaid State Agencies in a number of core areas, e.g., claims processing, third party liability, eligibility determinations, reimbursement/financial management, utilization control, and EPSDT.

16. A Systematic Abuse Review is conducted on non-institutional providers, i.e., those reimbursed on a charge or fee-related basis, when there are indications that inappropriate payments have been made.

17. Utilization Control Reviews evaluate the effectiveness of State utilization surveys in which samples of individual patient files are selected for intensive analysis. These surveys are required under Medicaid for those facilities that do not accept PSRO decisions as binding.

Health Care Financing Administration (HCFA) 946.0 Staff Years-$30.612 Million

HCFA's original submission revealed a total of 844.3 staff years ($19.730 million) devoted to combating fraud, abuse and waste. HCFA reorganized in 1979 creating five major components which now show an increase of 102.1 staff years devoted to combating abuse and waste. HCFA's response was limited to abuse and waste (inefficiency) since they are no longer responsible for conducting fraud investigations. The survey data represent 20% of HFCA's total resources of approximately 4685 staff years.

General Description of Activities

	Resources Available	
	Staff Years	Cost (Millions)
Audits	44.0	$ 1.40 1/
Quality Control Review	256.0	8.196 2/
Utilization Reviews	8.0	.320 3/
Fiscal Reviews	80.0	2.56 4/
Audit-Related Matters	178.0	5.71 5/
Management Systems Reviews	10.0	.576 6/
Other	370.0	11.85 7/
	946.0	$ 30.612

1/ Audits (44 Staff Years $1.40 Million) - The Office of Program Validation maintains audit activities in 3 areas. They are a) program implementation reviews, b) aberrant cost studies and c) systematic abuse reviews. All three activities

follow audit protocols in looking at "operations" and "policies". The Group Health Plans Operations Staff, Bureau of Program Operations, also maintains audit of cost reports of group health plans.

2/ Quality Control (QC) (256 Staff Years $.196 Million) - HCFA has a Bureau of Quality Control which maintains the Mediciad QC Program, EPSDT QC programs, Utilization Control Review programs and the Part A and B Quality Assurance programs. Regional offices also provide support in the Mediciad Quality Control (MQC) program, including federal re-reviews of State MQC reviews, analysis and summary of State MQC statistical reports; and Medicare Quality Control including providers cost report evaluation program (CREP) and Part B Quality Control sampling.

3/ Utilization Review (8 Staff Years $.320 Million) - The Bureau of Program Policy's Utilization Effectiveness Branch reviews Medicaid State Plan changes; makes Utilization Review Policy, and reviews Utilization Screens of Medicare contractors.

4/ Fiscal Review (80 Staff Years $2.56 Million) - Efforts are expended both at HCFA headquarters and field officials in conducting and analyses of providers, groups of providers or industry segments to identify aberrant benefit expenditures patterns. HCFA also reviews reimbursement performance of

contractors and state agencies, including interregional coordination and evaluation activities; develops and administers systems for recovery of overpayments and reviews budget estimates from state agencies (SA) and contractors. Other fiscal activities include reviews of cost effectiveness and accounting aspects of contractors and state agency ADP systems proposals; reviews of contractor and administrative costs; and reviews of states' claims for Federal Financial Participation (FFP) in Medicaid programs.

5/ Audit-Related Matters (178 Staff Years $5.71 Million)

The following HCFA components are involved in audit-related activities.

a. Office of Financial Analysis - Acts as control point for review and resolution of GAO and HHS-AA audits.

b. Division of Financial Analysis performs oversight of Medicare/Medicaid audit resolutions; conducts audit liaison for Bureau of Program Operations;

c. Office of Direct Reimbursement Technical support staff-coordinate audits of direct-dealing providers.

d. HCFA Regional Offices - Office or Program Validation staff conduct aberrant cost studies, program implementation reviews, systematic abuse reviews and sanction activities. The headquarters staff for these same activities maintain audit functions following audit protocols.

6/ Management Systems Reviews (10 Staff Years $.576 Million - The Office of Management Services maintains the Department's Operation Management System (OMS) which monitors a number of savings initiatives.

7/ Other (370.2 Staff Years $11.85 Million) - Captured in this designation are all other on-going program functions which work toward promoting economy and efficiency such as:

a. Division of Performance Evaluation (15 Staff Years - $.480 Million) performs evaluation of contractors and State agencies; maintains ACER, CPEP, and state assessment programs; maintains oversight of regional office evaluation of contractor and state agencies performance.

b. Division of Operations analyzes and evaluates nationwide operating problems in Medicare and Medicaid problems; including fixed price contracts.

c. Division of Systems Review and Evaluation reviews contractor and state agency automated systems; evaluates claims processing systems; and reviews request for increased FFP and EDP changes and upgrades.

d. Corrective Actions Projects Division directs technical assistance to State agencies or contractors for management/systems improvement to reduce erroneous payments.

e. Division of Health Care Cost Containment established and maintains limits on cost of hospitals, home health agencies and skilled nursing facilities.

f. Regional offices -

- performance of PSRO assessments
- conduct of CPEP reviews; preparation of ACERS; other contractor performance evaluations;
- performance of state assessments, reviews of State plans and amendments; resolution of compliance issues; other state agency evaluations.

Office of Human Development Services (OHDS) - 397 Staff Years
14.195 Million

The Office of Human Development Services concentrate its major effort to combat fraud, abuse and waste in three functional areas; fiscal reviews, management/other reviews and audit or audit-related activities.

General Description of Activities

	Resources Available	
	Staff Years	Cost (Millions)
Audit/Audit Related	33.0	$ 1.155 1/
Fiscal Review	145.0	5.040 2/
Management/Other Reviews	219.0	8.0 3/
Total	397.0	14.195

1/ Office of Management Services/Division of Grant and Contracts Management maintains extensive follow-up procedures on audit findings in the Head Start and Native American programs, also current regulations mandate annual program/financial management audits for these same two program areas. OHDS anticipates to strengthen on-going audit resolution activities and inaugurate a joint Head Start/Community Services Administration audit process.

2/ Office of Fiscal Operations (OFO) - Financial management (grants management) specialists conduct extensive reviews of the fiscal operations of grantees to assess their adherence

to prescribed Federal, Departmental and OHDS policies and procedures. These reviews are most often independent of program reviews and oriented toward providing technical assistance to grantees in the area of financial management procedures. These reviews are most often independent of program reviews and oriented toward providing technical assistance to grantees in the area of financial management. In-depth cost analyses are also conducted on HDS contracts.

3/ This category involves all those programmatic activities such as those conducted by the Office of Program Coordination and Review (OPCR) and program administrative functions within the Administration for Children, Youth and Families, Administration on Aging, Administration for Developmental Disabilities, Administration for Native Americans and Work Incentive Program both in headquarters and field. Mandated by OHDS internal policy, program specialists conduct periodic on-site visits to grantees to ensure program and policy directives are followed and that grantees are in compliance with legislative requirements, etc.

Public Health Service (PHS) 347.0 Staff Years $9.981 Million

The Public Health Service responded to our survey with individual agency response with coordinating effort by their Office of Management and Budget. The Center for Disease Control was the only PHS unit which failed to provide any data for this report.

General Description of Activities

	Resources Available	
	Staff Years	Cost (Millions)
Audits/Audit-Related Matters	35.0	.861 1/
Investigations	21.0	.632 2/
Fiscal Reviews	91.0	2.328
Quality Control Review	47.5	1.408
Utilization Reviews	25.0	.983
Management Systems Review	58.0	1.756
Program Integrity	17.0	.427
Other	52.0	1.587
Total	347.0	9.981

1/ Audits/Audit-Related Matters (34.4 Staff Years $.861 Million)

Health Services Administration (HSA)

a. Office of Fiscal Services - (7.0 Staff Years $.153 Million)
Conducts audits of Imprest Fund Cashiers; audits and examinations of vouchers and other documents to ensure proper charges and receipts for direct loans and interest subsidy

payments; and also maintains audit report resolutions activities.

b. Indian Health Service - (4.5 Staff Years $.080 Million)- Audits are conducted in conjunction with the Office of Fiscal Services. Other activities include implementation of new budgeting and cost accounting systems.

c. Bureau of Community Health Services (BCHS) - BCHS has no auditors as such, but they have initiated a requirement that all BCHS supported projects will have an annual CPA audit. Even though this is contrary to established DHHS policy, which does not permit annual audits, BCHS believes this is necessary for adequate monitoring and control.

Health Resources Administration (HRA)

a. Division of Grants and Procurement Management Cost Advisory Board (1.9 Staff Years $.047 Million) - This staff of professional accountants performs financial and general business management reviews of grantee and contractor organizations when there is evidence or substantial reason to suspect that agency funds are being used improperly or inefficiently. The results of these reviews are reported to the requesting office, higher echelon agency officials, or HHS' Office of Inspector General.

Office of the Assistant Secretary for Health (OASH)

a. Division of Material Management, ASC/OM - (2 Staff years $.043 Million) audit-related activities involve audits resolution, review of contractor's invoices and vouchers

to determine allowability and allocability of contractor's cost billings.

b. Cost and Audit Management Branch (CAMB), DGC/ORM/OM (3 Staff Years $.154 Million) - Responsible for 1) developing and implementing policies and procedures for an effective management and use of audit reports of PHS contracts and grant awards; and 2) monitoring audit resolution and audit recommendations implementation activities through an audit follow-up system.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

a. National Institute of Mental Health (NIMH), St. Elizabeth's Hospital (SEH) (2.5 Staff Years $.065 Million) - Audit activities are maintained by the Office of Special Audits, an "internal Inspector General for SEH".

Food and Drug Administration (FDA)

a. Policy Management Staff, Office of Management and Operations, Office of the Commissioner - conducts audits of program operations to assure program integrity in conjunction with investigations of internal programs.

PHS Regions

There is some regional audit activity in the Division of Health Services Delivery/Clinical Consultation Branch, which includes audits of medical and dental records, nursing, nutrition and pharmacy services.

Region IX's Division of Alcohol, Drug Abuse and Mental Health programs conducts special quick asssments/audits of grantees.

2/ Investigation - 20.7 Staff Years $4.632 Million

a. Food and Drug Administration (FDA) - (18 Staff Years $.540 Million) - The Policy Management Staff, Office of Management and Operations, conducts investigation of internal programs and audits program operation to assure program integrity; establishes policy and procedures for ADP security; and reviews all appointments for compliance with conflict of interest regulations.

b. Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)- OM, Division of Personnel Management (.3 Staff Years $.008 Million) - Investigates DHHS hotline and conflict of interest cases.

c. Health Services Administration (HSA) -

(1) Bureau of Medical Services (1 Staff Year $.025 Million)- The Bureau is not an investigative body, however, it does respond to investigations, conducted by others including the Inspector General's "hotline" cases.

(2) Office of Contracts and Grants (OGC) (1 Staff Year $.038 Million) - In carrying out overview and surveillance responsibilities the staff pursues through informal investigations, matters brought to its attention or identified in the course of its normal activities that

require or warrant fuller assessment. Matters deemed important to agency management are brought to the attention of the Administrator, his staff or the DHHS Inspector General.

d. Office of Assistant Secretary for Health (OASH) - Cost and Audit Management Branch (CAMB) DGC/ORM/OM - (.4 Staff Years $.021 Million) - CAMB is responsible for monitoring the resolution of Office of Investigation's (OI) reports forwarded to them by the Assistant Inspector General for Investigations. CAMB reviews the reports to determine what administrative actions should be pursued, and acts as a liaison between the involved PHS agencies and OI. The investigations involve primarily fraud and program abuse, although instances of waste have been documented by the investigations.

e. National Institutes of Health (NIH), Office of Administration, Division of Management Survey and Review - (12 Staff Years $.455 Million) - This office investigates specific problem areas at the request of top management. This staff also provides advice and assistance to OD staff and operating officials on management problems.

SCHEDULE OF RESOURCES WITHIN HHS AIMED
AT REDUCING FRAUD, ABUSE AND WASTE

	OS		SSA		HCFA		OHDS		PHS	
	Staff Years	Cost (In Millions)	Staff Years	Cost (In Millions)	Staff Years	Cost (In Millions)	Staff Years	Cost (In Millions)	Staff Years	Cost (In Millions)
Audit-Related Matters	17.0	$ .640			178.0	$ 5.710	2.0	$ .074	27.0	$ .588
Fiscal review	135.0	4.370			80.0	2.56	145.0	5.040	91.0	2.328
nagement Review	72.0	2.799	50.0	$ 1.500	10.0	.576			58.0	1.756
Utilization Review	9.0	.228			8.0	.320			25.0	.983
Quality Control			1794.0	50.0	256.0	8.196			48.0	1.408
Program Integrity									17.0	.427
Other	49.0	1.747	4631.0	118.0	370.0	11.850	219.0	8.0	52.0	1.587
Audit	742.0	32.897	464.0	12.600	44.0	1.400	31.0	1.081	8.0	.272
Investigation	181.0	7.958	1487.0	140.00					21.0	.632
Subtotal	1205.0	$ 50.639	8426.0	$322.100	946.0	$ 30.612	397.0	$ 14.195	347.0	$9.981
Total	11321	$427.527								

APPENDIX C

OFFICE OF INSPECTOR GENERAL -- DHHS
HEALTH CARE AND SYSTEMS REVIEW
HCSR INDENTIFIED RECOMMENDATIONS FOR PROGRAM CHANGE

	Audit number	Date	Agency	Subject
A.		2-4-80	OHDS	Runaway Youth Follow-up, memo to Manuel Caballo Deputy Assistant Secretary
B.		6-25-80	SSA	Assessment of Problems found in the computer process of SS Enumeration System (attached to letter to Ted Murchek from Sheila Brand)
C.		8-22-80	GC	Memo to General Counsel re: Cost Disclosure Requirement.
1.	13-02608	3-31-80	SSA	Review of proceduers for Reimbursing GSA from non-recurring reimbursable work authorizations
2.	15-00200	6-13-80	HCFA	Management of Personal Care Services Authorized under Title XIX
3.	15-90250	6-30-80	SSA	Report on State Practices in refunding the Federal Portion of Recovered Over-payments
4.	06-02001	8-80	HCFA	Report on Need for More Restrictive Policy & Procedures Covering Medicare Reimbursement for Medical Services by Hos-pital-Based Physicians
5.	13-12614	10-15-80	SSA	Report on Review of Title II Benefit Payment Withdrawls & Disbursement by SSA
6.	12-13087	10-23-80	OS	Review of Cash Management Practices DFAFS
7.	04-03001	11-3-80	HCFA	Report on Review of the Implementation of the Requirements for Teaching Physicians to Qualify for Reimbursement Under Medicare and Medicaid
8.	12-13076	12-1-80	DHHS	Review of Internal Controls Overpayment of Overtime
9.	12-13105	12-2-80	ASMB	Reduction in Energy Use by HHS

APPENDIX D

A Partial List of Statutes Under Which Medicare/Medicaid Fraud Could Be Prosecuted

STATUTE	CAPTION	MEDICARE/MEDICAID CASES	MAXIMUM PENALTY FINE	JAIL
1. 18 U.S.C. § 285 (1970)	Taking or using papers relating to claims.		$5,000	5 yrs.
2. 18 U.S.C. § 286 (1970)	Conspiracy to defraud the Government with respect to claims.		$10,000	10 yrs.
3. 18 U.S.C. § 287 (1970)	False, fictitious or fraudulent claims.	United States v. Catena, 500 F.2d 1319 (3d Cir. 1974), *cert. denied*, 419 U.S. 1017.	$10,000	5 yrs.
4. 18 U.S.C. § 371 (1970)	Conspiracy to commit offense or to defraud United States.	United States v. Radetsky, 535 F.2d 556 (10th Cir. 1976), *cert. denied*, 429 U.S. 820 (1976).	$10,000	5 yrs.
5. 18 U.S.C. § 495 (1976)	Contracts, deeds and powers of attorney [forgery].		$1,000	10 yrs.
6. 18 U.S.C. § 1001 (1976)	Statements or entries generally.	United States v. Gordon, 548 F.2d [illegible] (8th Cir. 1977). United States v. Radetsky (cited above) United States v. Sisson, 523 F.2d 771 (5th Cir. 1975), *cert. denied*, 429 U.S. 817 (1976).	$10,000	5 yrs.

		United States v. Mekjian, 505 F.2d 1320 (5th Cir. 1975). United States v. Peterson, 488 F.2d 645 (5th Cir. 1974), *cert. denied*, 419 U.S. 828. United States v. Matanky, 482 F.2d 1319 (9th Cir. 1973), *cert. denied*, 414 U.S. 1039. United States v. Carey, 475 F.2d 1019 (9th Cir. 1973). United States v. Kraude, 467 F.2d 37 (9th Cir. 1972). United States v. Blazewicz, 459 F.2d 442 (6th Cir. 1972). United States v. Katz, 455 F.2d 496 (5th Cir. 1972), *cert. denied*, 408 U.S. 923. United States v. Chakmakis, 449 F.2d 315 (5th Cir. 1971).		
7. 18 U.S.C. § 1002 (1976)	Possession of false papers to defraud United States.	United States v. Radetsky (cited above).	$10,000	5 yrs.
8. 18 U.S.C. § 1341 (Supp. I 1977)	Frauds and swindles [mail fraud].		$1,000	5 yrs.
9. 18 U.S.C. § 1961 (Supp. I 1977)	Definitions [Racketeer Influenced and Corrupt Organizations].		$25,000	20 yrs.

STATUTE	CAPTION	MEDICARE/MEDICAID CASES	MAXIMUM PENALTY FINE	JAIL
10. 18 U.S.C. § 2071 (1970)	Concealment, removal, or mutilation generally.		$2,000	3 yrs.
11. 26 U.S.C. § 162(c)(3) (Supp. I 1977)	Trade or Business Expense Kickbacks, Rebates and Bribes under Medicare and Medicaid.			
12. 26 U.S.C. § 7201 (1970)	Attempt to evade or defeat tax.	United States v. Smith (cited above).	$10,000	5 yrs.
13. 31 U.S.C. § 231 (1976)	Liability of persons making false claims.	United States v. Peterson, 508 F.2d 45 (5th Cir. 1975), *cert. denied*, 423 U.S. 830.	Forfeit $2,000; plus double damages; plus costs of suit.	
		United States v. Long's Drugs, Inc., 411 F.Supp. 1144 (S.D. Cal. 1976).		
		United States v. Zulli, [1976] 3 Medicare/Medicaid (CCH) ¶ 28,085.		
14. 31 U.S.C. § 232 (1976)	Liability of persons making false claims; suits; procedure.	United States v. Long's Drugs (cited above).		
15. 42 U.S.C. § 406 (Supp. IV 1974)	Representation of claimants before Secretary.		$500	1 yr.
16. 42 U.S.C. § 408 (Supp. IV 1974)	Penalties [for fraud under the federal Old-Age, Survivors,	United States v. Radetsky (cited above).	$1,000	1 yr.

		and Disability Insurance Subchapter of the Social Security Act].	United States v. Holt, 529 F.2d 981 (4th Cir. 1975). United States v. Cacioppo, 517 F.2d 22 (8th Cir. 1975). United States v. Zulli (cited above).		
17.	42 U.S.C. § 1307 (Supp. IV 1974)	Penalty for fraud [for false representations under Chapter 7 of 42 U.S.C.A.-Social Security].		$1,000	1 yr.
18.	42 U.S.C. § 1395nn (Supp. IV 1974)	Offenses and Penalties [for fraud under Title XVIII-Medicare].	United States v. Gordon (cited above). United States v. Rousseau, 534 F.2d 584 (5th Cir. 1976). United States v. Holt (cited above).	$25,000 ~~$10,000~~	5 ~~1 yrs~~
19.	42 U.S.C. § 1396h (Supp. IV 1974)	Offenses and Penalties [for fraud under Title XIX-Medicaid].	United States v. Long's Drugs (cited above). United States v. Long's Drugs (cited above).	25,000 ~~$10,000~~	5 ~~1 yrs~~

NOTE: 18 U.S.C. § 1 (1970) defines a felony as any offense punishable by imprisonment for a term exceeding one year.

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APPENDIX E

ADMINISTRATIVE SANCTIONS

I. Employee Misconduct

A. PROSCRIBED CONDUCT BY DHHS EMPLOYEES

Generally: Conduct of DHHS employees is regulated by rules from a variety of sources. Foremost among these are OPM regulations (5 CFR Part 735) directing each agency to issue standards of conduct covering its own employees (and detailing certain offenses which must, at a minimum, be proscribed by the agency) and the DHHS Standards of Conduct issued under this directive (45 CFR Part 73). In addition, various statutes carrying criminal penalties or requiring mandatory administrative action impose limits on employee conduct. Finally, miscellaneous OPM regulations and executive orders further circumscribe federal employee responsibilities and conduct. Each of the above regulations, statutes and executive orders is discussed individually below.

OPM DIRECTIVES AND DHHS STANDARDS OF CONDUCT:

The DHHS Standards of Conduct reflect prohibitions and requirements imposed by criminal and civil laws of the United States. The list of proscribed offenses contained in the Departmental Standards is comprehensive, but is expressly not exhaustive. The Standards specify that violation of any provisions contained therein may be cause for administrative disciplinary action in addition to any other penalty prescribed by law. Disciplinary actions available to each supervisor are outlined in the next section of this paper.

The specific activities prohibited by the Standards of Conduct are as follows:

1. Gifts, Entertainment Favors: An employee may not accept or solicit contributions, gifts or anything of monetary value from anyone who conducts or is seeking to conduct business with the agency. In addition, an employee may neither solicit nor make contributions for gifts to an official supervisor, nor may a supervisor accept such gifts. Violation of the statute governing gifts to supervisors may subject the employee to criminal penalties under 5 U.S.C. 7351. (Of course, there are exceptions for birthday gifts, farewell gifts, and the like). Upon conviction, the statute mandates removal from the federal service. In addition, 5 U.S.C. 7342 and the Standards prescribed circumstances in which an employee may accept gratuities from foreign governments which would otherwise be prohibited by Article I, section 9 of the United States Constitution.

2. Outside Activities: Generally, an employee is prohibited from engaging in outside activities which are incompatible with the full discharge of his official duties. Such activities include acceptance of fees or compensation where acceptance creates an actual or apparent conflict of interest. However, employees are encouraged to engage in teaching, lecturing, writing and the like where the activity is undertaken in a personal capacity, on the employee's own time, and in conformance with the requirements governing advance approval.

Certain criminal statutes also prohibit specific outside activities by federal employees:

- o Acceptance of compensation for services as a federal employee from a source other than the U.S. Government may subject the employee to a $5,000 fine and/or one year's imprisonment (18 U.S.C. 209).

- o Prohibition against an employee representing another in prosecuting claims against the Government which imposes a maximum penalty of $10,000, two years' imprisonment or both (18 U.S.C. 205).

- o Prohibition against an employee's receiving compensation for representing another in prosecuting claims, contracts, rulings, etc. which imposes a maximum penalty of $10,000 and two years' imprisonment, and removal (18 U.S.C. 203).

3. Financial Interests: An employee or any member of his immediate family is prohibited from having financial interests which conflict or appear to conflict with the employee's official Government duties. Participation by the employee in any matter in which he, his family, or any organization with which he is affiliated has a financial interest may subject the employee to criminal penalties under 18 U.S.C. 208. Finally, an employee may not engage in any financial transaction in which he is relying primarily on information obtained through Government employment.

As a corollary to the above prohibitions, certain employees are required to report substantial financial interests under the DHHS Standards. Also, the Departmental Ethics Counselor may waive the financial interest provisions as to certain holdings.

The procedures for resolving any conflicts within the financial provisions are enumerated at 45 CFR 73.735-904. Possible methods to be employed by the Department in the event of violation of the financial interest provisions are:

a. Disqualification from participation in the matter;

b. Change of assignment;

c. Waiver;

d. Mandating that the employee hold the funds in trust;

e. Requiring divestiture of the interest;

f. Termination of the employee.

4. Use of Government Funds: Employees may not improperly use travel, payroll or other vouchers on which Government payment is based. In addition, an employee may not fail to account for funds which are entrusted to him. Violation of any of the above may subject the employee to criminal penalties under 18 U.S.C. 508 and 18 U.S.C. 643 (counterfeiting transportation requests and failure to account for public money, respectively).

5. Use of Goverment Property: Employees may not use or approve the use of government property for other than official purposes. In addition to this general proscription, there is a specific statutory prohibition against private use of government vehicles, at 31 U.S.C. 638(a). Under that statute, willful unauthorized use of a government vehicle imposes a mandatory suspension of at least one month, with provison for a longer supsension or removal from office if circumstances warrant.

6. Misuse of Information: (a) Classified Information: An employee may not release classified information to anyone other than an authorized recipient. Unlawful release of classified information carries criminal penalties under 18 U.S.C. 789.

(b) Confidential Information: Unauthorized release of confidential financial information in the hands of the government (for example, trade secrets of corporations) violates the provisions of 18 U.S.C. 1905, which imposes a maximum penalty of $1,000 fine, one year's imprisonment and removal.

(c) Privacy Act: Section (i) of the Privacy Act imposes criminal penalties for willfully disclosing information subject to the Act. (5 U.S.C. 552a(i)).

(d) Unauthorized Use of Documents: There is a general statutory prohibition against using documents relating to official duties in an unauthorized manner. The penalty is five years' imprisonment or $5,000 or both (18 U.S.C. 285).

7. Indebtedness: Employees are required to pay just financial obligations in a proper and timely fashion. Failure to do so, which reflects badly on the Government, or causes an official to devote substantial amounts of time to dealing with the employee's creditors may result in a disciplinary action against the employee.

8. Gambling, Betting and Lotteries: An employee is barred from engaging in gambling (including lotteries) while on Government-owned or leased property. In addition, employees may not solicit contributions or engage in commercial soliciting and vending, except as provided for in 45 CFR 73.735-305.

9. Engaging in Riots or Civil Disorders: Persons convicted of participating in a riot or civil disorder may not be hired or continue employment in the federal service (5 U.S.C. 7313). Information regarding such a conviction is to be referred directly to the Director of Policy and Evaluation at OPM, who will direct the agency to remove the employee.

10. Political Activities of Employees: There are detailed regulations and statutes governing just what political activity may be engaged in by federal employees, both on and off government property. Although these proscriptions are too numerous to recite here, some, such as using one's official position to influence an election, or making illegal political contributions, carry a maximum penalty of removal (5 U.S.C. 7323-7325). There are criminal penalties applicable as well.

11. Other Prohibitions: In addition to the above specific prohibitions, the Standards of Conduct generally proscribe conduct which might result in, or create the appearance of:

a. Using public office for private gain;

b. According any person preferential treatment;

c. Impeding government efficiency:

d. Losing impartiality;

e. Rendering a Government decision outside official channels; or

f. Affecting adversely on the integrity of the government.

The Standards of Conduct expressly provide that violation of any of the above provisions may be cause for disciplinary action. The official responsible for determining if and what action should be taken should consider the objectives of the law: to deter similar offenses and maintain high standards of conduct. The various disciplinary actions available are discussed later.

MISCELLANEOUS STATUTORY PROSCRIPTIONS

In addition to those prohibitions enumerated in the Standards of Conduct (and related statutory requirements), there are a variety of statutes which bear on employee conduct. These are briefly summarized below.

1. Bribery: Prohibition against bribery of a public official carrying a maximum penalty of $20,000 (or three times the value of the bribe), and 15 years' imprisonment and removal. (18 U.S.C. 201).

2. Acceptance or Solicitation to Position: Prohibition against acceptance or solicitation to obtain public office, with a penalty of $1,000, one year's imprisonment or both. (18 U.S.C. 211).

3. Lobbying: Prohibition against lobbying with appropriated funds, with a maximum penalty of $500, one year's imprisonment and removal. (18 U.S.C. 1913).

4. Disloyalty and Striking: Prohibition against disloyalty and striking, carrying a maximum penalty of $1,000 and one year and one day's imprisonment and removal. (5 U.S.C. 7311, 18 U.S.C. 1918).

5. Communist Organization Membership: Prohibition against employment of a member of a Communist organization carrying a maximum penalty of $10,000 ten years' imprisonment and removal. (50 U.S.C. 784).

6. Intoxicants: Prohibition against habitual use of alcohol to excess, which imposes a maximum penalty of removal. (5 U.S.C. 7352). (OPM regulations and Internal DHHS instructions require that the agency provide an opportunity for the employee to seek rehabilitation before disciplinary action is taken.)

7. Franking Privilege: Misuse of franking privilege imposes a maximum penalty of $300 fine. (18 U.S.C. 1719).

8. Deceit in Personnel Action: Prohibition against deceit in examination or personnel action, carrying a maximum penalty of $1,000 and one year's imprisonment. (18 U.S.C. 1917).

9. Fraud, False Statements: Prohibition against fraud and false statements which imposes a maximum penalty of $10,000 and five years' imprisonment. (18 U.S.C. 1001).

10. Destruction of Public Documents: Prohibition against mutilating or destroying public records, carrying a maximum penalty of $2,000, ten years' imprisonment and removal. (18 U.S.C. 2971).

11. Embezzlement and Theft: Prohibition against embezzlement and theft of Government money, property or records, with a penalty of $10,000, ten years' imprisonment, or both, (18 U.S.C. 641).

12. Wrongful Conversion: Prohibition against wrongfully converting property, with a penalty of fine equalling the amount embezzled, imprisonment for up to ten years or both. (18 U.S.C. 654).

13. Foreign Agents Registration Act: Prohibition against an employee acting as an agent of a foreign principal registered under the Foreign Agents Registration Act. (18 U.S.C. 219).

MISCELLANEOUS NON-STATUTORY PROSCRIPTIONS

In addition to prohibitions on conduct which are imposed by statute there are others arising from executive orders, and miscellaneous OPM rules and regulations. Some of these are:

1. Misconduct Generally: OPM regulations prohibit criminal, infamous, dishonest, immoral or notoriously disgraceful conduct. (5 CFR 731.202(b)). OPM may use this as a basis to instruct an agency to summarily remove an employee during that employee's probationary period. In addition, OPM may disqualify an employee on the basis of:

a. Intentional false statements,

b. Refusal to furnish testimony,

c. Abuse of narcotics and controlled substances,

d. Reasonable doubt as to the employee's loyalty, or

e. Any statutory disqualification.

2. Unauthorized Absence: An agency may, under Chapter 751 of the Federal Personnel Manual, take disciplinary action against employees who abuse the rules governing leave.

3. Executive Order 11222: as amended, prescribes general standards of ethical conduct for government officers and employees. Most of the pertinent provisions of this Order have been reproduced in the DHHS Standards of Conduct.

4. Executive Order 10577: amended the civil service rules so as to prohibit an employee from influencing anyone to withdraw from competing for a position in the federal service.

The above statutes, regulations, manual provisions and executive orders are by no means an exhaustive reference for potential misconduct warranting administrative action against an employee. However, they do include all of the prosciptions contained in the major compilations of regulation of employee conduct.

B. ADMINISTRATIVE SANCTIONS AVAILABLE

There are a number of disciplinary actions available to a supervisor in the event of employee misconduct. They include admonishment, reprimand, reassignment, suspension, demotion, removal and forced leave. Among these, suspension, demotion and removal are "adverse actions" requiring that the agency accord the employee specified procedural safeguards. It should be noted that these procedural safeguards are not applicable when adverse action is taken against an employee in the excepted service. Brief explanations of each disciplinary action, and the accompanying procedural requirements follow.

1. Admonishment (Written or Oral): Admonishment is an informal disciplinary action, in which a supervisor, either orally or in writing, dicusses a given problem with the employee. No record of the admonishment may be placed in the employee's Official Personnel Folder. It may, however, be used to help support a more severe administrative action at a later date.

2. Official Reprimand: Although an Official Reprimand is not an adverse action within the meaning of relevant OPM regulations, it is more severe than a mere admonishment, so the employee is afforded an opportunity to respond. The procedure is basically as follows. A Notice of Proposal to Reprimand (detailing the grounds for the action) is sent by a supervisor to the employee. The employee then has 15 days to submit a reply to the allegations. The decision whether to reprimand should be made, in writing, within 15 days of receipt of the employee's response. The employee does not have a right of appeal of an Official Reprimand. However, he or she may file a grievance under the internal Departmental grievance procedures outlined in HHS Personnel instruction 771. Also, if the Official Reprimand is later used as a basis for a future adverse action, it is then reviewable. Finally, the Official Reprimand becomes a part of the employee's Official Personnel Folder for two years from the date of issuance, at which time it is expunged.

3. Suspension for 14 Days or Less: All suspensions are adverse actions, but the length of time the employee is placed in a status without duties or pay determines the procedural rights to which he is entitled. If the suspension is for 14 days or less, then the employee must receive advance written notice, be granted a reasonable time to respond orally and/or in writing, and be given the right to have a representative present if desired. In addition, the employee may file an internal grievance concerning any final decision to suspend. However, he has no right of appeal outside the Department. Finally, the decision to suspend becomes a permanent part of the employee's Official Personnel Folder.

The standard for imposing a suspension for 14 days or less is statutorily set at 5 U.S.C. 7503(a), which reads, in part, ". . .an employee may be suspended for 14 days or less for such cause as will promote the efficiency of the service (including discourteous conduct to the public. . ."). The Federal Personnel Manual Chapter 752 elaborates only slightly on this general standard. It states that a cause for disciplinary action is a "recognizable offense against the employer-employee relationship." Further, the decision to suspend may not be based on any of the prohibited reasons outlined at 5 U.S.C. 2302 (discrimination, reprisal for whistleblowing or exercise of any right by the employee, etc.).

4. Removal, Suspension for 15 Days or more, Reduction in Grade or Pay: Before imposing one of these severe sanctions, an employee must be afforded the following procedural protections: detailed notice of the proposed action (at least 30 days unless there is an emergency), an opportunity to respond orally and in writing to a designated official of the agency, representation by anyone of the employee's choosing, and an agency decision based solely on reasons specified in the notice. The employee also has the right to appeal the final determination to the Merit Systems Protection Board (MSPB), or to file a grievance under a negotiated grievance procedure.

The statutory standard for imposition of the above penalties is, again, a broad one. Section 7513 of title 5 of the U.S. Code permits such action "only for such cause as will promote the efficiency of the service." Decisions by the MSPB have made clear that there must be some nexus between the employee's performance or off-duty conduct and the agency's ability to discharge it duties/responsibilities, in order for a suspension to be upheld. (There is an exception, in that the agency may take into account an employee's conviction of a crime.) In addition, there are certain statutes, enumerated above, which mandate the removal of an employee for conviction of certain crimes. Otherwise, the decision whether to take such adverse action is left to the manager or supervisor.

5. Forced Leave: Under certain circumstances, the agency may force an employee to take leave. Generally, the agency may do so in an emergency situation constituting an immediate threat to Government property or to the well-being of the employee, his fellow workers or to the public; and when the agency has not had an opportunity to appraise the situation and decide whether to initiate suspension or removal action. In such circumstances, 5 CFR 752.404(d)(3) authorizes the agency to place the employee in an administrative leave status. This provision may not be used during an investigation of the employee for wrongdoing (prior to a final decision to suspend or remove). In that instance, an agency must observe the appropriate procedural safeguards governing suspensions.

II. DEBARMENT AND SUSPENSION:

The major methods available to the Department for guarding against misconduct by outside entities doing business with DHHS are debarment and suspension. "Debarment" is defined as an exclusion from Government contracting and subcontracting for a reasonable, specified period of time. "Suspension" is defined as a temporary disqualification from Government contracting and subcontracting for a temporary period of time because a concern is suspected of engaging in criminal, fraudulent or seriously improper conduct. It is important to note that these actions are designed to protect the interests of the Government, and are not intended for use as penalties or punishment. Generally, the Federal Procurement Regulations and DHHS regulations promulgated thereunder, outline the causes and procedures for debarment and suspension of contractors. In addition, DHHS has issued regulations authorizing debarment and suspension of recipients of financial assistance (grantees) from the Department. As a practical matter, although the above procedures for excluding contractors and grantees have been in effect for several years, there have been extremely few actions initiated under them. Recognizing that this problem existed throughout the executive branch, the Office of Management and Budget has recently circulated proposed procedures for debarment which would apply government-wide. Each of the above regulatory schemes is discussed individually below.

Debarment and Suspension of Contractors

Debarment: Current Federal Procurement Regulations at 41 CFR 1-1.600, et seq, set forth the cause for debarment, as well as the procedures to be followed. The Departmental regulations governing such debarments (41 CFR 31.6) do not deviate significantly from the FPR requirement. In short, a contractor may be debarred for the following:

1. Conviction of a criminal offense incident to a contract;

2. Conviction of embezzlement, theft, bribery, forgery, falsification or destruction of documents, or any other offense indicating a lack of business integrity;

3. Conviction under the Antitrust statutes;

4. Serious violation of provisions of a previous contract;

5. Any other cause affecting responsibility as a Government contractor of serious enough nature as may be determined by the head of the agency to warrant debarment; or

6. Debarment by any other agency.

Debarments operate to exclude the contractor from contracting with any office of the Department. Although no ceiling is imposed by the regulations on the duration of the exclusion, a debarment must be for a reasonable, definite period of time, commensurate with the seriousness of the offense, generally not to exceed three years.

Within the Department, decisions to debar are made by the Director, Office of Procurement and Materiel Management of the Office of the Assistant Secretary for Administration and Management. That office also provides contractors with a detailed notice of proposed debarment, and an opportunity for a full hearing prior to exclusion. Therefore, any information which suggests cause for debarment of a given contractor or subcontractor should be referred, together with a documented file of the case, to the above Director.

Suspension of Contractors: A suspension is a disqualification from contracting for a temporary period of time when a firm is suspected of engaging in criminal, fraudulent or seriously improper conduct. The suspicion of wrongful conduct must be based "upon adequate evidence." The Federal Procurement Regulations require that in determining whether adequate evidence exists, the following should be considered:

a. Amount of credible evidence of contractor's failures available;

b. Any corroborating evidence of important allegations;

c. Examination of basic documents such as contracts, correspondence, etc.

Cause sufficient for suspension of a contractor parallels that for debarment. Therefore, if there is a suspicion, upon adequate evidence, of conduct by a contractor constituting a cause for debarment, the agency may suspend. In addition, suspension by one agency may be used to support sudpension by another.

The duration of any suspension must be a temporary period pending the completion of an investigation, and any legal proceedings that may ensue. In no event may a suspension last for more than 18 months, unless prosecution has been initiated during that time period.

Both suspension and debarment serve to disqualify the contractor, and in some cases, its affiliates, from contracting with any part of the Department for the duration of the action.

Debarment and Suspension of Grantees

Debarment: In 1980, DHHS implemented regulations authorizing the debarment and suspension of individuals and institutions from eligibility to receive grants or financial assistance under

departmental discretionary programs. (45 CFR Part 76). The grounds for debarring or suspending a grantee are similar to those listed in the Federal Procurement Regulations pertaining to contractors. Again, such debarments are not intended to be punitive, but rather are intended to protect the interests of the Government.

Final decisional authority as to whether to debar a given grantee rests with the Secretary, and has not been delegated. Hearings, if requested, are conducted by a Hearing Officer, but the ultimate decision is in the hands of the Secretary. Therefore, any referrals for possible debarment or suspension of a grantee should be sent to the Office of the Secretary.

The regulations place no ceiling on the duration of debarment, but again, advise that the duration should be commensurate with the seriousness of the grantee's offense. Also, a debarment of a grantee operates to exclude that institution from direct receipt of grant funds, as well as contracts, subcontracts or subgrants under any form of financial assistance awarded by DHHS. Therefore, an entity contracting with an HHS grantee may be debarred.

Suspension of Grantees: The standard required to institute suspension of grantees is a general one--where the Secretary believes reasonable grounds for debarment exist (or there is an outstanding indictment for one of the enumerated criminal offenses) and immediate action is necessary in order to protect the interests of the Government, the Secretary may order a suspension. The maximum duration of the suspension varies depending on the grounds for the suspension. Generally, however, debarment proceedings should be commenced within six months. If a suspension is based on a criminal indictment, it may continue until completion of the criminal proceedings (or 18 months). Again, suspensions bar entities from receiving direct grant funds, subgrants or contracts with DHHS grantees.

Proposed OMB Regulations

On July 16, 1981, OMB circulated for comment proposed regulations governing debarment and suspension of contractors. The most notable feature of these regulations is that a debarment or suspension imposed by any one agency in the Executive Branch would operate to exclude the debarred individual or institution from contracting with all executive agencies. In addition, the regulations would impose uniform procedures for initiating debarments and suspensions.

III. PROGRAM SPECIFIC AND MISCELLANEOUS ADMINISTRATIVE SANCTIONS

Various programs within the Department may take specific administrative action in the event of employee misconduct, or wrongdoing by a participant in the program. For example, fraud against the Medicare, Medicaid or Title XX programs may result in suspension from any or all of those programs. In a similar vein, wrongdoing in the context of a particular grant or contract may result in suspension from that grant, or termination of the contract. Finally, failure to follow the rules for release of documents under the Freedom of Information process may result in sanctions against the employee. Each of these is discussed below.

1. Medicare, Medicaid, Title XX (Grants to States for Social Services): Section 1128 of the Social Security Act provides for exclusion of certain individuals convicted of related crimes from participation in Medicare, Medicaid or Title XX programs. When the Secretary determines that an individual has been convicted of a crime related to any of the above programs, the perpetrator of the crime will be automatically barred from Medicare. In addition, the Secretary will notify state agencies of the conviction, and require that the agency bar the same individual from Title XX and Medicaid. The Department will also notify appropriate state licensing agencies, requesting that they both investigate the individual or institution, and keep the Department apprised of any action taken.

2. Medicare, Only: Section 1862(d) of the Social Security Act precludes payments for any services provided by one who has submitted false statements, bills for unnecessary services, or bills substantially in excess of customary charges to Medicare. Determinations made pursuant to this section are transmitted to state agencies participating in Medicaid.

3. General Rights of the Government with regard to Grants: In addition to debarment and suspension of grantees, the Government has a number of lesser administrative actions available to it in the event of wrongdoing by a grantee, or mistake by the Government. Although each arises from a substantial body of case law, I will just mention them here. The Government has a right:

a. To enforce terms and conditions of grants by:

1. Termination of the contract for the convenience of the Government;

2. Termination of the contract for default by the contractor;

3. Deletion of work required of the contractor by a Change Order;

4. The Government may order a contractor to suspend or delay work under a contract (may be used to prohibit the contractor from incurring additional costs while under investigation);

5. Government may recover under any bond posted by the contractor.

b. Remedies Based Primarily on Common Law:

1. Withholding payment and set-off (if funds are erroneously paid);

2. Recission and cancellation of the contract (if a contract is obtained by bribery, or award is tainted by conflict of interest, the contract may be avoided by the Government).

5. Freedom of Information Act: The Act provides for disciplinary action against individuals who arbitrarily or capriciously withhold requested documents under the Act. (5 U.S.C. 552a(4)(F)). A prerequisite to such an action is that a court orders production of wrongfully withheld documents, finds that there is cause to believe that the agency acted abitrarily and capriciously, and instructs the MSPB to investigate. The MSPB and not the agency initiates disciplinary action under this section.

APPENDIX F

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : Office of Investigations Staff
Office of Program Integrity Staff

DATE: September 14, 1978

FROM : Inspector General
Assistant Administrator for Program Integrity

SUBJECT: Revised OI/OPI Operating Statement

During the summer of 1977, with the establishment of the Office of the Inspector General and the Health Care Financing Administration, it became clear that in the area of criminal fraud investigations, both the Office of Investigations of the Inspector General's Staff and the Office of Program Integrity, HCFA, had been carrying out many similar functions.

In order to more clearly define roles and responsibilities during this period of change, an operating statement was signed by the Inspector General and the Acting Assistant Administrator of Program Integrity.

As the two organizations have implemented their respective functions, it has become necessary to more fully define the respective roles. Therefore, we have prepared and signed a new operating statement reflecting our revised responsibilities. This new operating statement supersedes the August 24, 1977 operating statement for OI and OPI.

In establishing the new procedures, we recognize there will be an interim period during which cases presently being worked by OPI must be handled in one of the following ways:

1. Cases already referred to U. S. Attorneys by OPI will be completed by OPI.

2. Cases undergoing active field investigation by OPI will go to OI or stay with OPI depending on the extent of developmental work already done by OPI. OPI will complete those cases where continued OPI work will result in the most effective handling of the case. This could be for a variety of reasons including the extent of work completed,

special knowledge or expertise on the part of OPI staff involved, and the extent of informal contact which has already occurred with U. S. Attorney. The final decision on these cases should be reached jointly by OI/OPI Regional Staffs. In the event that a joint decision cannot be reached, the case should be referred to OI/OPI Central Offices for a decision.

3. Cases where sufficient preliminary review has established clearly that a case of potential fraud exists will be referred to OI.

We believe that this transition can be accomplished smoothly and that these interim procedures will enable us to handle all cases now being worked by OPI efficiently, so that the transfer of fraud cases to OI can be achieved as rapidly as possible.

The attached Memorandum of Understanding will be effective October 1, 1978.

Thomas D. Morris
Inspector General

Don E. Nicholson
Assistant Administrator for
Program Integrity

Attachment

OPERATING STATEMENT

OFFICE OF INSPECTOR GENERAL/OFFICE OF INVESTIGATIONS

HEALTH CARE FINANCING ADMINISTRATION/
OFFICE OF PROGRAM INTEGRITY
MEDICARE-MEDICAID FRAUD

I. Introduction

This statement sets out guidelines for a cooperative effort to control Medicare/Medicaid fraud by the Office of the Inspector General's Office of Investigations (OI) and the Health Care Financing Administration's Program Integrity Staff (OPI). By law and regulation, the Inspector General has the responsibility to supervise, coordinate and provide direction for investigations relating to all the Department of Health, Education, and Welfare (HEW) programs. To meet this responsibility, the IG's Office of Investigations is staffed by professionally qualified criminal investigators who are responsible for all departmental criminal investigations. The Health Care Financing Administration's (HCFA) Program Integrity Staff brings to this effort professional staff with extensive program knowledge who have demonstrated a strong capability and experience in developing and investigating cases of Medicare and Medicaid fraud and abuse. These guidelines are based on the principle that, recognizing the Inspector General's responsibility, the effective control of Medicare/Medicaid fraud can only take place through the most effective use of the strengths and skills of both staffs.

II. Preliminary Review

OPI will perform a preliminary review on complaints which it receives and on other information regarding aberrant practices which it identifies or receives.

A. Fraud

At the point in the preliminary review where OPI staff have sufficient information to believe a strong potential for fraud warranting full-scale investigation exists, the case will be referred to OI and all additional developmental work will be performed by OI.

The referral will consist of OPI preparing a Medicaid/Medicare Fraud Report and transmitting this to OI with a narrative summary of all OPI activity and information on the case and the complete case file. The narrative summary will include a listing of all administrative actions taken or anticipated by HCFA.

OPI will immediately refer to OI any case where a Medicare or Medicaid fraud complaint has been received on a matter which is currently under a full-scale Medicare or Medicaid investigation by OI, any other Federal investigative agency or by the State.

Within 45 days of referral, OI will inform OPI regionally whether they intend to schedule the case for investigation; and, if not, will return the case to OPI for appropriate civil or administrative action (see Section VII C).

Those cases investigated by OI where a decision by the U. S. Attorney is made to prosecute or not to prosecute criminally, at the option of OI, will be 1) pursued civilly by OI (either false claims or common law recovery), 2) pursued civilly by OI with participation and assistance of OPI as appropriate, or 3) returned to OPI for administrative or civil action. Where the case material was obtained by an investigative grand jury, OI will be responsible for facilitating OPI access to the case material consistent with applicable law.

OPI will assume responsibility for civil fraud action on all cases where it is the decision of the U. S. Attorney to pursue civil negotiation rather than prosecution of the civil suit. In those instances where civil suit is filed and a civil prosecution in court is contemplated or where criminal and civil prosecution are simultaneously undertaken, OI may, at its option, retain responsibility for the civil case but will involve OPI in any pre-sentencing negotiation which involves the settlement of the civil suit.

B. Non-Fraud Cases

Those situations where aberrant practice exists

but which do not present potential for fraud will be developed by OPI for administrative action.

III. Contacts with Other Offices and Organizations

A. In view of their ongoing relationship with Medicare contractors, Medicaid State agencies and fiscal agents, and Social Security offices, OPI will inform these organizations, upon learning that OI has accepted a matter for criminal investigation, except in those cases where such notification would in any way compromise the investigation, that they may be contacted by OI for information to support their investigation. All other contacts on individual fraud cases (with exception of those covered in item B) will be made by OI.

It is further understood that there may be occasions when OI will need direct contact with the agencies and entities mentioned in this paragraph, at the very onset of an inquiry. Where appropriate, OI will advise OPI of such contacts. OPI will utilize its relationship with these agencies and entities to educate them to this possibility. OI will apprise OPI of any problems in obtaining information from contractors and States.

B. With respect to withholding of payments in criminal cases, particularly where Grand Jury action has not begun, OPI will decide the appropriateness of the withholding action and will instruct contractors and advise State agencies. At the time of referral to the U. S. Attorney or earlier if at all possible, OI will provide OPI access to case file information consistent with applicable law, necessary to justify the withholding action and the estimated dollar amount overpaid.

Upon indictment and disposition in any Medicare or Medicaid case, OI will follow the requirements in the Medicaid/Medicare Fraud Reporting System and will immediately notify OPI and furnish OPI with copies of the judgment so that HCFA can take appropriate suspension or termination action. In addition, in the case of a physician or other practitioner, OI, consistent with applicable law,

will provide OPI with all information necessary to determine the length of the suspension.

C. Continuing contacts with Medicaid State agencies and fraud control units and contractors for monitoring and management purposes will be maintained by OPI.

D. Contact with the FBI, Postal Inspector (except in forgery cases covered in Section V.C. of this paper) and other investigative agencies on matters under criminal or potential criminal investigation will be made by OI. OI may ask OPI to provide programmatic assistance to investigative agencies.

E. OI will consult with OPI on any restitution of funds agreement reached in plea bargaining or the probationary determination process.

F. OPI will expeditiously notify OI of any suspension from participation in the Federal Health Care Programs, of any payment withheld, and of any termination of a provider agreement, in any case that was investigated by OI or has been scheduled for investigation by OI, in any case that has been referred by OI to another agency for investigation, Federal or State, or in any task force effort where OI had either an investigative or a monitoring role.

G. If access to records is denied during any initial review, OI should be immediately contacted. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendants should be deferred to OI.

IV. State Medicaid Fraud Control Units

OPI will be the lead agency responsible for the certification, recertification, and funding of the State Medicaid Fraud Control Units. OI will participate in the certification and annual recertification process by reviewing and determining the adequacy of the investigative capacity of the units and will provide input to OPI's certification/recertification report. OPI will review and determine the adequacy of the administrative aspects of the units and their relationship with the Medicaid State agencies.

V. Special Categories of Cases

A. Primary responsibility for investigation and referral to U. S. Attorneys of beneficiary/recipient fraud cases will rest with OPI unless there is an indication of a conspiracy with a third party such as an employee of the paying agent or a medical provider in which instance the case will be the responsibility of OI.

B. OPI will refer to OI without any preliminary investigation all allegations involving the possibility of a crime by (1) a Federal employee, (2) a contractor or State agency employee, or (3) organized and recognized major criminal elements.

C. OPI will refer forgery cases to the Postal Inspectors or appropriate local authorities.

D. OPI will handle cases involving assignment violations and will refer cases involving potential prosecutions to OI for additional investigation and submission to a U. S. Attorney.

E. With respect to complaints involving a practitioner, OPI will conduct its normal initial review. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendants should be deferred to OI.

F. In cases involving supplier fraud, OPI will conduct its initial review process which will include the analysis of supplier records, laboratory records, etc.

G. With regard to institutional fraud, including fraud in the certification process, because of case complexities and the various kinds of fraud perpetrated, it is not possible to formulate the type of case to be referred. OPI will have the responsibility, based on initial development, to document the facts of a case which warrant a recommendation for a full-field investigation by OI. However, OPI will advise and periodically brief OI on the institutional case workload in which the potential for fraud may exist.

H. OI will be immediately notified of any allegation or

information concerning kickbacks or rebates coming to the attention of OPI. OI will then assume the responsibility for that phase of the investigation.

VI. Reporting

Upon referral of a case to OI, OPI will prepare a Medicaid/Medicare Fraud Report and will send a copy of it to OI. OI cases which have not been referred by OPI should be reported to OPI annotating the Medicaid/Medicare Fraud Report accordingly; likewise, when OI is informed that another investigative body has a Medicare or Medicaid case, it should prepare a Fraud Report and transmit it to OPI. Subsequently, OI will send OPI an update of the Fraud Report at the time of presentation to an Assistant U. S. Attorney, indictment, and disposition. At any point where a full investigative or prosecutorial action is concluded, OI will update the Fraud Report and transmit it to OPI. Simultaneous with the acceptance of a case by OI, OPI will prepare a Medicaid/Medicare Fraud Report and send it to the Medicaid State agency and, where appropriate, the State Medicaid Fraud Unit, under the procedures of the Data Exchange Agreement. When OPI receives a Medicaid/Medicare Fraud Report from a State under the Data Exchange Agreement, a copy will be forwarded to OI.

VII. Administration

A. In some cases, it may be necessary for OPI staff to assist OI on a specific case. These situations should be rare, and OPI participation will be requested for a specific case or related group or cases in a formal memorandum for the record. Such requests will require CO/OPI clearance. Wherever possible, staff and time considerations should be estimated.

B. Case referrals mentioned in this memorandum will generally be made at the regional level.

C. Issues on general questions of approach and policy and issues on specific cases between OI and OPI should be resolved locally. Issues that cannot be resolved locally should be submitted to OI and OPI central office components for resolution. This includes disputes between OI/OPI Staff on

whether a case should be investigated for fraud or handled administratively.

D. This statement supersedes all previous OI/OPI agreements on the matter of Medicare/Medicaid fraud development. It remains in effect until it is itself superseded or specifically withdrawn.

9/13/78
Thomas D. Morris
Inspector General

9/13/78
Donald E. Nicholson
Assistant Administrator
for Program Integrity

REFERRAL TO OFFICE OF INVESTIGATIONS

Practitioner Fraud

There are a number of steps to be considered before referring a case involving practitioner fraud to the Office of Investigations (OI) for investigation. The initial review process should consider the following items:

A. earnings level

B. practitioner pattern

C. number of patients

D. prior complaints

If, upon completing this analysis a decision is made to close the case, a detailed check of Medicaid statistics should be initiated to determine if a similar situation exists. If the screening clearly reflects that additional fraud development is not necessary, then screening consideration should be given to abuse (e.g., consultation with contractor/State agency medical staff, PSRO, medical society, etc.

Where a decision is made to continue developing the fraud case, telephone or mail contact should be made with 20 beneficiaries. As a rule of thumb, if 4 or more strong discrepancies are documented, the case should be referred to OI.

In every instance where there is an alleged discrepancy, personal contact with the beneficiary should be made and a statement outlining the facts surrounding the discrepancy taken.

If the preliminary review does not indicate referral to OI is warranted, the case should be sent to the carrier for resolution or the practitioner contacted personally for any explanation. In either instance, an overpayment should be established.

Institutional Fraud

With regard to institutional fraud, including fraud in the certificatic process, because of case complexities and the various kinds of fraud perpetrated, it is not possible to formulize the type of case to be referred. OPI will have the responsibility based on initial development to document the facts of a case which warrant a recommendation for a full field investigation by OI. However, OPI will advise and periodically brief OI of the institutional case workload in which the potential for fraud may exist.

Supplier Fraud

The initial review process will apply as in practitioner fraud cases, except that OPI may need, during the initial review, supplier records, laboratory records, etc., rather than contacting beneficiaries.

Kickbacks or Rebates

Similarly, kickback situations will require an investigative strategy which should involve the examination of multiple records as well as preliminary contacts with informers before referral to OI. Consulta

with OI in these cases is critical at the earliest possible stage in the process.

General

If access to records is denied during any initial review, OI should be immediately contacted. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendents should be deferred to OI.

APPENDIX G

OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

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

OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

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

OFFICE OF INVESTIGATIONS

HEALTH CARE CASES REFERRED TO DOJ IN CY-80

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

APPENDIX H

OFFICE OF INSPECTOR GENERAL -- DHHS

HEALTH CARE AND SYSTEMS REVIEW

SERVICE DELIVERY ASSESSMENTS

(CONTENTS) *

*Source: OIG-HHS

A. EXECUTIVE SUMMARY

A major responsibility of the Inspector General is to provide the Secretary with an independent assessment of the effectiveness of program operations. Service Delivery Assessment (SDA) is one of the important tools the Inspector General uses to do this. Created in 1977, SDAs are short-term examinations of Health and Human Service (HHS) programs and program related issues. These 3 to 5 month studies provide the Secretary with timely information about the operations and effects of programs at the local level.

SDAs are not pure research, compliance reviews, audits, program monitoring, or traditional program evaluation. Rather, they are a new form of program evaluation more analogous to investigative reporting. Designed and conducted by a small group of in-house staff, SDAs generally consist of focussed discussions with consumers and service providers, and observation at local service programs. They seek to gain a clear understanding of how programs are currently operating. Assessment results and recommendations are used internally by Department managers as an additional source of information which, when combined with other information, presents a total picture of service delivery.

Because of the high interest and importance of these topics, the Secretary/Under Secretary personally identify or approve each SDA topic. While the specific objectives of any individual SDA vary, SDAs can provide a "snapshot" of local operations, consumer and local provider perspectives, timely reporting, an "early warning" system, best operating practices, and a useful tool for program management.

The Inspector General serves as the functional manger for SDA, with the Principal Regional Officials (PROs) responsible for performing the studies. A small core staff (between 3-5 individuals) are assigned to each of the 10 Regional Offices of Service Delivery Assessment. These Regional Offices of SDA are under the direct supervision of the PRO.

To date, SDA teams have visited over 1,100 local sites and have spoken with over 12,000 consumers, local service providers, and others involved in service delivery. The resulting SDA reports are short (i.e. 15 pages) and written in clear, understandable style. These written reports precede an oral briefing for the Secretary and top program managers. In the last three years, the Secretary and Under Secretary have received over 30 SDA briefings and reports about how various HHS programs are functioning at the local delivery level. The information obtained by SDAs helps the Secretary address program problems, thus making HHS programs more efficient and responsive to the people they serve.

B. SUMMARIES -- 1980 SDA's

1. LOW INCOME ENERGY ASSISTANCE PROGRAM (LIEAP)

The purpose of this SDA was to provide early warnings of problems in the implementation of the LIEAP and to identify major issues for future program consideration.

The assessment findings showed that:

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

2. COMMUNITY HEALTH CENTERS

The purpose of this assessment was to determine how clients perceive the quality, accessibility and responsiveness of Community Health Centers (CHCs).

The assessment findings showed that:

- In spite of some problems and limitations, the centers appear to be relatively efficient and sensitive primary health care agencies with high client satisfaction.
- Training, technical assistance and monitoring by HHS Regional Offices were inadequate.
- CHC's face a dilemma in their efforts to reach the most needy clients, while at the same time moving toward greater financial self-sufficiency. It affects the aggresiveness of their outreach, the services provided, the size of staff and the use of sliding fee scales.

3. HEALTH AND SOCIAL SERVICES TO PUBLIC HOUSING RESIDENTS

This SDA examined the delivery of health and social services to public housing residents.

The assessment findings showed that:

- Crime, both the reality and the fear, hinders service delivery, since many residents are afraid to leave the projects and some providers are afraid to enter.
- Although most health and social services are provided in or near projects, most residents are unaware of the available services. Poor transportation and limited service quantity make some services in effect unavailable.
- The Public Housing Urban Initiatives Program has had little or no impact on health and social services to residents.

4. TITLE XX (SOCIAL SERVICES) PROGRAM

This SDA examined the Title XX program with attention given to resource allocation at the State level, the local social service delivery system, purchase of services, client experiences, and service coordination.

The assessment findings showed that:

- Since almost all states are at their funding ceiling, resource allocation is based on tradition with little ability to respond to new service needs.
- Purchase of service (contracts) is increasingly the States' preferred method of providing services, however, little real competition exists in awarding contracts, and there is little monitoring of services.
- The working poor are being squeezed out of Title XX services as States lower income eligibility to stretch Title XX dollars.

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5. MEDICARE PART B BENEFICIARY SERVICES

This assessment focussed on the beneficiary's experience with the accessibility, utilization and effects of the Medicare carrier's communication (beneficiary services) with clients. Part B of Medicare covers medical (physician) services and equipment.

The assessment findings showed that:

- The vast majority of beneficiaries are substantially uninformed about the provisions of the Medicare Part B program and their individual rights.
- Only about one-third of the beneficiaries ever use beneficiary services, but the number of service requests is increasing.
- Beneficiaries have an almost blind respect for the Medicare Program and are reluctant to challenge whatever payment they receive. When they do request a review of their claim, they win 60% of the time.

6. NATIONAL HEALTH SERVICE CORPS (NHSC)

This assessment examines the experiences of designated Health Manpower Shortage Areas (HMSAs) in receiving health care through the NHCS, the impact on local health care for those manpower shortage areas without corps assignees, and the characteristics and conditions in areas which have been unable to recruit or retain corps staff.

The assessment findings showed that:

- The Corps is producing local health care systems through small government investments.
- Distribution inequities exist in many of the most needy areas without Corps assignees.
- Mid-level corps staff (i.e., nurse practitioners) are more adaptable to remote areas than physicians.
- Health shortage areas prefer voluntary over scholarship recruits.

7. AVAILABILITY OF PHYSICIAN SERVICES TO MEDICAID BENEFICIARIES

The primary purpose of this study was to assess whether Medicaid clients have adequate access to physicians' services.

The assessment findings showed that:

- Most Medicaid clients, but not all, are able to see a physician when needed. Twenty-four percent say few or no doctors in their area accept Medicaid.
- Almost all physicians limit the size of their Medicaid caseload, citing inadequate reimbursement, excessive and confusing paperwork, reimbursement delays and undesirable client characteristics as reasons.
- Hospital emergency rooms, largely because of their 24-hour accessability, are providing an increasing amount of primary care for Medicaid clients.

8. END STAGE RENAL DISEASE PROGRAM

This SDA examines patient experiences with end stage renal disease, including the patients' role in decisions concerning their method of treatment and selection of service provider.

The assessment findings showed that:

- Largely because of the influence of their nephrologist (kidney specialist), most clients dialyze at a facility and seldom switch to home dialysis or undergo a kidney transplant.
- There is no trend toward significantly greater client interest in home dialysis or kidney transplant or other means of self care.
- Clients who dialyze in facilities have considerable concern over the high rates of staff turnover while those who dialyze at home often note family stress.
- Only about one-fourth of those working full-time at the time of kidney failure continue to work.

9. RESTRICTED PATIENT ADMITTANCE TO NURSING HOMES

This assessment describes the extent of and reasons for patients remaining in hospitals beyond their need for acute care.

The assessment findings showed that:

- A substantial number of patients are kept in hospitals only because nursing home placements cannot be arranged.
- Backed-up patients are poor, old, and highly dependent. Hospitals and nursing homes universally define these patients as "heavy care", meaning that they require extensive staff time and attention.
- Hospitals, physicians, nursing homes, patients, and patients' families have little incentive to move these heavy care patients into nursing homes.

APPENDIX I

OFFICE OF INSPECTOR GENERAL -DHHS-

REPORTS PREPARED BY HEALTH CARE AND SYSTEMS REVIEW (HCSR)

HEALTH

1. Review of NIH Contracts with Organizations that Employ Current or Former HEW Employees or Consultants -- November 11, 1978

2. Medicaid Report -- February 1979

3. Review of Cosmetic Surgery Performed at Public Health Service Hospitals

4. Supplementary Review of NIDA Contract with John A. Whysner Associates, Inc. -- August 14, 1979

5. FDA 79-151-243/259, PCBs in Valentine Candies and Boxes

6. Report on Heart Murmur Instructional Materials Projects, NMAC Contract Action

7. A Report on the Management of the Indian Health Service -- January 1981

8. Office of the Inspector General Study of Debt Collection Practices in Selected Public Health Service Loan, Scholarship and Award Programs

9. A Surveillance and Utilization Review Subsystem Perspective for the Eighties -- Ocotber 1, 1980*

10. Surveillance and Utilization Review (SUR) System Project (Draft excerpt for Annual Report -- Not Dated)

11. Surveillance and Utilization Review System Project (OIG Brief Status Report - September 1980)

12. Alternatives to the MMIS General Systems Design (GDS) -- (Executive Summary -- November 10, 1980)*

13. Alternatives to the General Systems Designs (MMIS) -- September 30, 1980*

14. Suggested Initiative to Act upon Findings of the GAO Report and our OIG Survey Team Re the Need to Strengthen Medicaid Management information Systems --- November 29, 1978 (Memo w/ attachments to HCFA Administrator from the Inspector General)

15. OIG Audit Agnecy Report -- Minnesota -- Audit of Medicaid Management Information System (MMIS) -- (ACN: 05-00200) --- May 13, 1980 (Cover Memo w/o attachment from Audit Inspector General to HCFA Administrator)

16. Alternatives to the Nedicaid Management Information System (MMIS) General Systems Design (GSD) --- (Draft excerpt for Annual Report -- Not Dated)

* In cooperation with HCFA

17. Report on the Tuskegee Syphilis Study (with attachments) --- December 9, 1980

18. National Cancer Institute (NCI) Contracting Operations (Memo w/attachment to the Secretary froj the Inspector General) --- May 1, 1978

19. Abstract -- Review of National Cancer Institute Contracting Operations Performed by the Office of the Inspector General (Abstract of Suporting Recommendations) -- Not Dated

20. Report on Follow-up Review -- Contracting Operations --- National Cancer Institute --- Not Dated

21. Response to the OIG Audit Agnecy Follow-up Review of NCI Contracting Operations (Memo w/attachments to OIG Audit Agency from Deputy Assistant Secretary for Grants and Procurement) --- February 3, 1981

NON-HEALTH (Other)

1. Report of Recommended Improvements in the Administration of the Aid to Families with Dependent Children Program -- June 1, 1978

2. Systems Security at SSA -- September 22, 1978

3. Backup and Recovery of the Automated Data Processing System for the Guaranteed Student Loan Program (GSLP) -- February 14, 1979

4. Fraudulent Manipulation of the SSI and RSDI Computerized Disability Determination and Payment Process -- April 2, 1979

5. SSA's Action Plan on Systems Security

6. Management Review of Title XX Social Services

7. Analysis of Program Operations and Grant and Contract Processes of the Runaway Youth Program -- October 19, 1979

8. Management Review of the Indochinese Refugee Assistance Program -- September 24, 1979

9. Status Report on the Management Problems in the Office of Indian Education -- March 27, 1980

10. Cover Letter and Two Reports to Mssrs. Murcheck and Schutzman of SSA on: (1) Description of ALPHIDENT Computer Program Logic and Data Flow and (2) Assessment of Problems Found in the Computer Process of the Social Security Enumeration System -- June 25, 1980

11. Debt Collection Practices in Selected Public Health Service Loan, Scholarship, and Award Programs -- June 30, 1980

12. Outline and Draft Report on SSA's Enumeration System -- July 28, 1980

13. Cost Disclosure Requirement of Consultant Services Contracts -- August 22, 1980

14. A Review of the Social Security Administration Social Security Number Issuance System -- February 1, 1981

15. Draft Report of Recommended Improvements in the Management of Foster Care Services -- February 12, 1981

16. HDS Seminar -- Joint Participation -- HDS/OIG Staff -- March 1981

APPENDIX J

Bureau of Quality Control

PROGRAM VALIDATION

OVERVIEW OF 1980 RESULTS

AND

PLANS FOR 1981

NOVEMBER 1980

INTRODUCTION

Program validation was initiated during FY 1979. Fiscal year 1980 was the first full year of operation. There are three primary purposes underlying our validation activity which are to: (1) determine appropriateness of Medicare contractor and Medicaid State agency reimbursement and postpayment review systems; (2) identify problems with regard to specific providers which may be indicative of potential fraud, abuse, or waste and provide recommendations necessary to correct those problems; and (3) examine selected policies or operational procedures where the potential for inappropriate program expenditures is suspected. Our validation reviews take on three different forms which we call:

- Systematic Abuse Reviews which focus on providers reimbursed on a reasonable charge or fee related basis;
- Aberrant Cost Studies which focus on providers reimbursed on a cost or cost related basis;
- Program Implementation Reviews which may or may not focus on a particular provider type but which is designed and conducted primarily to examine the appropriateness of existing policies as opposed to discovering problem providers or deficiencies in individual States or contractors operations.

HIGHLIGHTED RESULTS TO DATE

OPV began with FY '80 producing quarterly reports reflecting for each quarter statistical results and highlighting some of the more significant validation activities. These reports have been widely circulated within HCFA and have been furnished the regional offices. Beginning with FY '81, we are going to start sending quarterly report information to contractors and State Medicaid agencies not only on our validation activity, but on "best practice" information we become aware of through regional participation in CPEPs and State assessments. We are in the process now of compiling an "OPV Annual Report" which will be completed by December 15, 1980 and will include a major section on validation.

The attached selected charts (1-4) provide a level of statistical detail on our validation activity through FY '80. A brief summary follows:

Reviews Completed - To date we have conducted 245 reviews where reports have been prepared in draft or final. The central office has produced 33 such reports while the regions have produced 212. For FY '80 our work plans called for 185 reviews to be conducted with reports produced in draft. Nationally 195 reports were produced with five regions and central office over target, two regions on target, and three regions under target. The projected and completed numbers for 1980 by type of reviews are as follows:

	Projected	Completed	Net Result
SARs	46	50	+4
ACSs	82	89	+7
PIRs	57	56	-1
Total	185	195	+10

Dollar Results - Through FY 1980 based on both final reports and drafts we are reporting estimated savings of $145,037,618. These dollars are a combination of:

—overpayments identified specific to individual providers;

—operational deficiencies on the part of State Medicaid agencies and Medicare contractors which when corrected will result in program savings;

—recommended policy changes which if accepted will result in program savings.

To date we have not structured our feedback and reporting system to break dollar amounts into specific categories. We are developing these instructions now and beginning with FY '81, we will report dollars by category. Our best estimates are that approximately $40 million of the above relate to specific provider practices with the remainder attributable to changes in policies or noted operational deficiencies.

Recommendations to Other Bureaus

To date we have processed 41 recommendations to other Bureaus. Of those 12 have been accepted and of this number 5 have resulted in some form of implementation (e.g., revised instructions to contractors, revised regulations, etc.). Two of the recommendations have not been accepted and 27 are still pending. The numbers of recommendations by Bureau and status are as follows:

	Total Forwarded	Total Accepted	Total Rejected	Still Pending
BPP	27	10	2	15
BPO	10	1	0	9
HSQB	3	0	0	3
BSS	1	1	0	0
Total	41	12	2	27

Some of the more significant of these recommendations include:

1. Physician Reimbursement for Lab Services

   The Atlanta Regional Office conducted a review of independent laboratory services which identified a loophole in the reimbursement for laboratory tests which allows physicians to bill the Medicare program and receive reimbursement which exceeds the cost charged for performing the test by the independent laboratory. Restricting physician's reimbursement to the amount charged by the laboratory will result in a savings of over $3 million per year. OPV has been working with policy to implement this policy change. Final action is expected in February 1981.

2. ODR Reimbursement Under PIP

   The Dallas Regional Office conducted a review at Doctors Hospital. They discovered that the Office of Direct Reimbursement (BSS) had paid $[illegible],000 in erroneous PIP payments to the hospital after the

date that the hospital had transferred to another intermediary. BSS has implemented corrective action through a computer override which will prevent PIP payments to institutions after termination by BSS. The overpaid amounts have been recovered.

3. Reductions in Hospital Lengths of Stay

The Chicago Regional Office with the cooperation of the regional office of the Health Standards and Quality Bureau conducted a study of providers which exceeded the national average for the length of stay. Through onsite reviews by the OPI regional office and the 39 local PSROs, program savings through a reduced average length of stay by the subject providers have exceeded $7 million. OPV is now working with HSQB to extend the study to a nationwide project.

Selected FY '80 Reviews Highlighted

The level of effort, scope, and results related to each validation obviously varies considerably. Several of the 245 done to date have had a low yield or produced no results at all. On the other hand many have been quite significant, a few of which are articulated below.

Home Health Agency Reviews - Reviews were conducted on 24 HHAs in 4 States and Puerto Rico. The review on the Puerto Rico HHA revealed enormous problems which translated to estimated overpayments of $7.3 million. For the remaining 23 HHAs review results indicated program overpayments of over $1.2 million which averaged $60,000 per agency. As an adjunct to our HHA validation project, we have produced cost and utilization data ranking HHAs and intermediaries where statistics indicate a need for focused audit or management attention. This data has been forwarded to the Regional Administrators and an action plan detailing regional response has been requested by December 31, 1980.

Nursing Home Rate Reviews - We have initiated a national review which will eventually include three regions and CO staff to examine State Medicaid agency rate setting processes and reimbursement methodologies, we have conducted preliminary reviews in Kentucky, Wisconsin, and Ohio and produced a report comparing the three States' different systems. During the course of our preliminary survey work, we have already identified $4.5 million in savings in Ohio as a result of an error in establishing reimbursement ceilings and $2.8 million in Wisconsin as a result of paying a separate 10 percent add-on charge for claims handling by nursing homes the costs of which are already part of the nursing homes cost reimbursement and for other nonallowable costs based on reviews of 8 nursing homes in Wisconsin. We also determined that $9.5 million in payments to nursing homes in Ohio is advanced because all homes are reimbursed at the maximum allowable per diem rate for general and administrative costs. Many nursing homes will not attain the maximum level so that retroactive adjustments will have to be made. This could result in at least three inequities to the Federal Government: (1) foregoing interest on excess funds advanced to nursing homes; (2) potential loss of funds advanced where nursing homes go out of business or otherwise leave the programs; and (3) encouraging nursing homes that have already been paid at rates exceeding their costs to incur greater costs so they don't have to refund monies.

ESRD Survey - We conducted reviews on three ESRD freestanding facilities to gain base line information to use as a basis for conducting a national review in FY '81. Extensive review in this area will be performed through the combined efforts of the central office and seven regions. Based on the preliminary report we have already issued, we have estimated that as much as $48.5 million could be saved if needed changes in reimbursement policy were made.

Comprehensive Health Centers - Estimated savings of over $5.5 million are attributable to review performed on three CHCs in Illinois. Those savings are primarily attributable to State practices in areas of auditing, program monitoring, and cost reporting requirements.

Psychiatric Study - Extensive use was made of PSRO staff in conducting medical necessity reviews on individual psychiatrists identified through a validation review conducted by New York. Thirty-nine psychiatrists were selected for the review. In addition to extensive overutilization noted with several of the psychiatrists under review, four of the physicians were referred for criminal investigation. Policy recommendations to modify existing reimbursement procedures were made and deficiencies were noted in carrier processing procedures which are being corrected.

PLANS FOR FY '81

Numbers and Types of Reviews

Some of our '81 activity will be an extension of what has been initiated in FY '80. Examples include further reviews related to the ESRD and nursing home rate review studies. Nationally, we intend to conduct fewer reviews during FY '81 (155) than planned for FY '80 (185). The 155 may be even further reduced as regions reexamine their priorities and workload initiatives under reorganization. The reduced numbers are necessary for a variety of reasons but are primarily attributable to the fact that we have a number of draft reports in the pipeline that require work to get the reports in final and ensure that recommendations are adhered to.

Attached are charts which were published in our FY '81 audit plan which details by type of review and by region and central office our planned activity. The 155 intended reviews breakdown as follows:

	SARs	ACS	PIRs	Total
Central Office	6	18	6	30
Regional Offices	27	46	52	125
Total	33	64	58	155

The text of the annual audit plan provides limited detail on the specific plans of each region and the central office. Pages 2 and 3 identify 14 areas considered of priority importance. We are estimating salary and expense costs associated with conducting validation reviews to be approximately $5 million and estimate that at least $25 million in potential program savings or overpayments will be identified through our review activity. Attached (Chart 8) is a statement of our savings initiative as prepared for our OMS submission.

Validation Support Activities

With 1 1/2 years of operating experience behind us, it is time we focused more staff attention on some of the ancillary activities necessary to improve and perfect our validation techniques. These activities have not been ignored, but have often received short shrift because of the necessities of conducting the reviews and drafting the reports called for specifically by work plans. Some of the more significant of these activities are enumerated below.

1. Training - During FY '80 we conducted two training sessions; one for our nurses and the other oriented toward those performing the accounting/fiscal auditing aspects of reviews. We are forming a CO/RO training committee to help in the formulation of our entire training program for the fiscal year, but right now, we are anticipating three training sessions specific to validation:

   —Team Leader Training - January

   --Auditor Training - February

   —Medical Review Training - May

2. Manual Instructions - Most of the written instructions needed for the validation process have been developed. However, they have been released in various forms and some need to be modified and updated. We are asking our Regional PI Director from New York to come in for at least 3 days during the week of November 17 to help us to bring this project to the final stages of completion.

3. Monitoring RO Performance - We have always assumed a central office responsibility for reviewing regionally prepared draft validation reports. This will continue and where we determine it appropriate we will go onsite to the RO in conjunction with a formal RO assessment program carried out in another part of OPV. During FY '81 we will prepare at least one assessment report for each RO to feedback to the PI Director and the Regional Administrator the CO impression of each ROs performance. Also, in FY '81 we will develop a detailed evaluation system to provide benchmarks and to evaluate both CO and RO validation activities against those benchmarks. This evaluating guide will include standards for quantity, quality and timeliness for use beginning with FY '82. Finally, we have developed "boilerplate" language for RA and PID use in formulating their FY '81 work plans which is included as Attachment IX on the list of attachments.

4. Research - We have recognized a need to develop more structured approaches in conducting research. We intend to undertake approximately 16 research projects through the use of central office staff and will request at least 2 research projects per region. We are developing a structure for calling on the assistance of our sister offices in the Bureau in meeting our research goals and have already developed a four page form for use in recommending multiregional reviews based on research results.

5. Reporting and Cataloging Validation Results - As mentioned earlier we have been preparing quarterly statistical and highlight reports. These reports will continue and we are exploring the use of a computerized management reporting system to accommodate our reporting needs and also to assist in research. We also intend to begin reporting validation highlights and results to contractors and States on a quarterly basis and provide more structure to our publicity efforts by issuing at least four press reports during the fiscal year based on validation findings.

SUMMARY

Fiscal year 1980 was a very successful year. We met our numerical targets and demonstrated a very positive cost/benefit ratio. The validation concept is becoming more understood and accepted by States and contractors. We are soliciting them as partners and they are accepting. We have received complimentary reactions to a number of our review efforts and have attached two such examples (Attachments X and XI).

We still need to do a better job particularly with HCFA top management and BPO in providing feedback on validation processes and results. Perhaps consideration should be given to quarterly briefings following the issuance of our highlight reports. We also need a better system of categorizing our dollar findings which we are accommodating with our instructions rewrite. Other needed improvements include:

1. greater capacity to select program areas and providers for review based on uses of data which suggest aberrancies;

2. improved uses of the computer to provide tighter target areas once providers or program areas are selected;

3. coordination between QC Programs' CREP activity and the ACS portion of our validation activity;

4. better communication between ourselves and other HCFA components in considering the value of recommendations flowing from validation review findings.

While there is room for improvement in these and other areas, we are pleased with our progress. We believe that program validation does now and should continue to play a vital role in searching out ways to conserve program dollars by pointing up program inequities and inefficiencies characterized by fraud, abuse, and waste. We are committed to doing everything in our power to make the program work well and will constantly seek ways to find improvements.

Attachments

Chart I - Summary of Validation Activity Through FY 1980

Chart II - Reports Issued in Final During Fiscal Years 1979 and 1980 and Overpayments and Other Savings Identified

Chart III - Reports Issued in Draft But Not Finalized As of September 30, 1980 and Tentative Overpayments and Other Savings Identified

Chart IV - Summary of Draft Reports Completed in FY 1980

Chart V - Summary of Total Central Office and Regional Office Program Validation Review Draft Reports Planned for FY 81

Chart VI - Detailed Listing of Program Implementation Reviews by Subject Area

Chart VII - Detailed Listing of Systematic Abuse Reviews by Subject Area

Chart VIII - Operations Management System: Tier II Performance; Initiative - Perform Program Validation Reviews

Chart IX - "Boiler Plate" Language for RA/PID Use in Formating FY 81 Workplans

Chart X - Letter from Blue Cross of Southern California

Chart XI - Letter from Ohio State Medicaid Agency

Chart I

Summary of Fourth Quarter 1980 Validation Activity

Region or Central Office Component	Final Reports Issued								Draft Reports Issued								Reviews Started			
	ACS		SAR		PIR		Total		ACS		SAR		PIR		Total					
	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	ACS	SAR	PIR	TOT
Central Office	1	$ 0	0	$ 0	0	$ 0	1	$ 0	13	$ 219,409	6	$ 166,381	4	$55,029,067	23	$55,414,857	3	2	3	8
Boston	0	0	0	0	0	0	0	0	4	8,800	2	277,350	1	78,400	7	364,550	4	0	0	4
New York	0	0	0	0	1	0	1	0	2	205,726	0	0	5[3/]	174,449[3/]	7	380,175	1	0	0	1
Philadelphia	0	0	0	0	1	0	1	0	1	802,042	4[6/]	2,761,853[6/]	3	1,100,000	8	4,663,895	0	2	2	4
Atlanta	1	60,000	0	0	2	939,859	3	999,859	5	459,047	0	0	4[7/]	2,204,373	9	2,663,420	2	0	1	3
Chicago[1/]	2	0	1	664	4[1/]	15,487,557[1/]	7	15,488,221	5	833,077	2	2,242	4[2/]	5,596,062[2/]	11	6,431,381	3	1	4	8
Dallas	1[2/]	487,371[2/]	0	0	2[4/]	7,357,873	3	7,845,244	4	586,586	0	0	3	438,266	7	1,024,852	1	0	0	1
Kansas City	0	0	0	0	0	0	0	0	4[7/]	42,329	2	23,214	2	0	8	65,543	2	0	1	3
Denver	0	0	0	0	0	0	0	0	3	13,782	1	0	2	0	6	13,782	1	2	0	3
San Francisco	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Seattle	0	0	0	0	2[5/]	707,717[5/]	2	707,717	1	253,011	1	1,406,469	3	283,000	5	1,942,480	0	0	0	0
TOTAL	5	$347,371	1	664	12	$24,493,006	18	$25,041,041	42	$3,425,809	18	$4,637,309	31	$64,903,617	91	$72,966,935	17	7	11	35

1/ The Chicago RO made report changes which affect previous summaries as follows:
(a) Changed a PIR draft report with $1,576,523 to an ACS draft report.
(b) Changed A PIR final report with $8,996,[illegible] to an ACS final report.
(c) Eliminated one draft ACS report with no dollars as not having been a validation report at all.

Includes final reports and dollars from prior quarters which were inadvertantly committed on previous reports as follows:
2/ One report and $487,371 from the 3rd Quarter FY 1980.
3/ Two reports and $5,592,012 from the 3rd Quarter FY 1980.
4/ One report and $2,648,948 from the 2nd Quarter FY 1980.
5/ One report and $500,000 from FY 1979 and one report and $207,717 from the 3rd Quarter FY 1980.

Includes draft reports and dollars from prior quarters which were inadvertantly committed on previous reports as follows:
6/ One report counted in 2nd Quarter of FY 1980 with no dollar results revised on 7/3/80 to reflect $2,089,129 in program saving.
7/ One report with no dollars from 3rd Quarter FY 1980.
8/ Four reports with $24,449 from 3rd Quarter FY 1980.
9/ One report with $5,592,012 from 3rd Quarter FY 1980.

Chart II

Reports Issued in Final During Fiscal Years 1979 and 1980 and Overpayments and Other Savings Identified

Region or Central Office Component	Institutional (Aberrant Cost Studies)				Noninstitutional (Systematic Abuse Reviews)				Program Implementation Reviews				Total	
	FY 1979		FY 1980		FY 1979		FY 1980		FY 1979		FY 1980			
	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars	No.	Dollars
Central Office	0	$ 0	7	$ 1,086,472	0	$ 0	0	$ 0	0	$ 0	0	$ 0	7	$ 1,086,472
Boston	1		4	216,198	0	0	0	0	0	0	1	30,600	6	246,798
New York	0	0	2	7,301,200	0	0	1	2,405,000	0	0	3	13,500,000	6	23,206,200
Philadelphia	1	0	4	10,298	0	0	2	0	0	0	1	0	8	10,298
Atlanta	0	0	1	60,000	1	77,800	3	58,022	1	0	3	4,439,859	9	4,635,681
Chicago	2	0	4	8,096,682	0	0	5	2,371	0	0	4	15,487,555	15	23,586,608
Dallas	2	410,4[illegible]0	2	658,071	0	0	0	0	0	0	2	7,357,873	6	8,426,424
Kansas City	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Denver	0	0	1	10,828	5	0	1	1,225	0	0	0	0	7	12,053
San Francisco	1	923,499	1	150,000	0	0	4	0	0	0	0	0	6	1,073,499
Seattle	2	79,434	1	226,591	0	0	0	0	2	500,000	1	207,717	7	1,013,742
TOTALS	9	$1,413,413	28	$17,816,340	6	$77,800	16	$2,466,618	3	$500,000	15	$41,023,604	77	$63,297,775

Chart III

Reports Issued in Draft But Not Finalized As of 9/30/80 and Tentative Overpayments and Other Savings Identified

Region or Central Office Component	Institutional (ACS)		Noninstitutional (SAR)		Program Implementation Reviews		Total	
	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
Central Office	11	$ 382,809	8	$ 290,591	7	$59,406,244	26	$60,079,644
Boston	4	8,800	4	336,229	2	78,400	10	423,429
New York	2	205,726	2	575,953	5	412,949	9	1,194,628
Philadelphia	2	804,432	8	2,770,407	3	1,100,000	13	4,674,839
Atlanta	13	694,639	4	185,900	3	2,204,373	20	3,084,912
Chicago	6	2,410,000	4	43,032	2	0	12	2,453,032
Dallas	8	1,852,665	0	0	6	438,266	14	2,290,931
Kansas City	7	94,628	3	23,214	2	0	12	117,842
Denver	8	277,671	18	2,855	3	8,126	29	288,652
San Francisco	10	4,900,000	0	0	2	0	12	4,900,000
Seattle	3	437,923	2	1,458,481	6	335,530	11	2,231,934
TOTALS	74	$12,069,293	53	$5,686,662	41	$63,983,888	168	$81,739,843

Chart IV

Summary of Draft Reports Completed in FY 1980

	Projected				Completed				Over/(Under)			
	SAR	ACS	PIR	TOTAL	SAR	ACS	PIR	TOTAL	SAR	ACS	PIR	TOTAL
Central Office	8	16	7	31	8	19	7	34	0	3	0	3
Boston	4	4	4	12	4	7	3	14	0	3	(1)	2
New York	5	3	6	14	5	4	8	17	0	1	2	3
Philadelphia	5	7	4	16	8	6	4	18	3	(1)	0	2
Atlanta	5	10	6	21	6	9	6	21	1	(1)	0	0
Chicago	5	6	6	17	8	8	6	22	3	2	0	5
Dallas	0	8	7	15	0	8	8	16	0	0	1	1
Kansas City	4	6	2	12	3	7	2	12	(1)	1	0	0
Denver	6	7	5	18	6	7	3	16	0	0	(2)	(2)
San Francisco	0	10	4	14	0	10	2	12	0	0	(2)	(2)
Seattle	4	5	6	15	2	4	7	13	(2)	(1)	1	(2)
TOTALS	46	82	57	185	50	89	56	195	4	7	(1)	10

Chart V

Summary of Total Central Office and Regional Office
Program Validation Review Draft Reports Planned for FY 81

	Systematic Abuse Reviews	Aberrant Cost Studies	Program Implementation Reviews	Total Reviews
Central Office	6	18	6	30
Region I	2	5	5	12
Region II	3	3	7	13
Region III	4	5	3	12
Region IV	5	11	6	22
Region V	5	3	7	15
Region VI	1	2	5	8
Region VII	1	1	5	7
Region VIII	2	2	5	9
Region IX	2	11	5	18
Region X	2	3	4	9
TOTALS	33	64	58	155

Chart VI

Detailed Listing of Program Implementation Reviews By Subject Area

	End Stage Renal Disease	Nursing Home Rates	Nursing Home Other Surveys	Electronic Medium Billing Surveys	Teaching Hospital Research	Overpayments	PSRO Surveys	EPSDT Surveys	Carrier Procedure Coding Surveys	Third Party Liability Surveys	Medicaid Transportation	Radiology Study	Services Furnished Under Arrangements	Drug Dispensing Fee	Prosthetic Lens	Anesthesiologists	Liquid Oxygen	Physician Gang Visits	Hospital Grant Revenues	Routine Cost Limits Survey	Medicaid Recipient Lock-in	Duplicate Payments for DME	Colorado Pharmacy Survey	Emergency Room Physician Contracts	Physician Assistants	Former Intermediary Employees-Conflict of Interest	Specialized Alcoholic Rehabilitation Institute	Other	Total Reviews
Central Office	X*	X*	X	X	X	X																							6
Region I	X						X	X	X		X																		5
Region II	X				X		X			X	X	X																1	7
Region III	X						X						X																3
Region IV	X														X	X	X	X										1	6
Region V					X*		X	X		X				X					X									1	7
Region VI	X	X	X											X*						X									5
Region VII		X		X					X					X							X								5
Region VIII	X	X					X															X	X						5
Region IX			X																					X	X	X	X		5
Region X	X				X		X		X																				4
TOTALS	8	4	3	2	4	1	6	2	3	2	2	1	1	3	1	1	1	1	1	1	1	1	1	1	1	1	1	3	58

* Lead component on multiregional review.

Chart VII

Detailed Listing of Systematic Abuse Reviews by Subject Area

	Psychiatrists	Radiologists	Home Health Prepayment	Blood Surveys	Medical Technology Surveys	Laboratories	Podiatry	Orthopedists	Transportation Services	Physicians - Other	Pharmacies	DME Suppliers	DME-Other	Carrier Screens for Physician Office Lab Referrals	Portable X-rays	Hospital-based Radiologists	Other	Total Reviews
Central Office	1	1	1	1	1						1							6
Region I	1					1												2
Region II					1		1*	1										3
Region III									2	1	1							4
Region IV							1					1					3	5
Region V							1		1		1		1	1				5
Region VI				1														1
Region VII				1														1
Region VIII										2								2
Revion IX												1			1			2
Region X										1						1		2
TOTALS	2	1	1	3	2	1	3	1	3	4	3	2	1	1	1	1	3	33

* Lead component on multiregional review

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OPERATIONS MANAGEMENT SYSTEM: TIER II PERFORMANCE

DATE _____

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Chart VIII

COMPONENT - BQC

INITIATIVE Perform program validation reviews

Office of Program Validation

OBJECTIVE Identify HCFA reimbursement areas vulnerable to incorrect or inappropriate program expenditures

REGIONAL INVOLVEMENT: YES X NO ____

1. PERFORMANCE INDICATORS OR STANDARDS FOR OBJECTIVE 2. OPERATING STEPS	TYPE R,L,A	RES. DIV.	PERSON YEARS*		PROJECTED COMPLETION DATE									
					1ST QUARTER		2ND QUARTER		3RD QUARTER		4TH QUARTER		TOTAL	
			PROF.	SUPP.	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	AC.
PERFORMANCE INDICATORS OR STANDARDS FOR OBJECTIVE														
1) Identify and conduct reviews on HCFA program implementation with a goal of preparing draft reports by 9/30/81 establishing current or future program savings of at least $12 million														
OPERATING STEPS														
Conduct review and complete draft reports.														
(1) Central Office														
(a) Reviews - 6 reports					1		1		2		2			
(b) Dollars - $3 million					20%		40%		70%		100%			
(2) Regional Offices														
(a) Reviews - 52 reports					9		13		14		16			
(b) Dollars - $9 million					15%		35%		65%		100%			

OPERATIONS MANAGEMENT SYSTEM: TIER II PERFORMANCE

DATE _____

COMPONENT - BQC

INITIATIVE Perform program validation reviews

Office of Program Validation

OBJECTIVE Identify HCFA reimbursement areas vulnerable to incorrect or inappropriate program expenditures

REGIONAL INVOLVEMENT: YES_____ NO_____

1. PERFORMANCE INDICATORS OR STANDARDS FOR OBJECTIVE 2. OPERATING STEPS	TYPE R,L,A	RES. DIV.	PERSON YEARS*		PROJECTED COMPLETION DATE									
					1ST QUARTER		2ND QUARTER		3RD QUARTER		4TH QUARTER		TOTAL	
			PROF.	SUPP.	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	/
PERFORMANCE INDICATORS OR STANDARDS FOR OBJECTIVE														
2. Identify and conduct reviews on hospitals, nursing homes, and other institutions providing services to HCFA beneficiaries with a goal of preparing draft reports establishing past overpayments for recovery and other program savings of at least $10 million by 9/30/81.														
OPERATING STEPS														
Conduct reviews and complete draft reports.														
(1). Central Office														
(a) Reviews - 18 reports					3		3		5		7			
(b) Dollars - $2 million					15%		30%		60%		100%			
(2) Regional Offices														
(a) Reviews - 46 reports					8		10		12		16			
(b) Dollars - $8 million					15%		34%		65%		100%			

OPERATIONS MANAGEMENT SYSTEM: TIER II PERFORMANCE

DATE _____

PAGE 3

COMPONENT - BHC

INITIATIVE Perform program validation reviews

Office of Program Validation

OBJECTIVE Identify HCFA reimbursement areas vulnerable to incorrect or inappropriate program expenditures

REGIONAL INVOLVEMENT: YES____ NO____

1. PERFORMANCE INDICATORS OR STANDARDS FOR OBJECTIVE 2. OPERATING STEPS	TYPE R,L,A	RES. DIV.	PERSON YEARS*		PROJECTED COMPLETION DATE									
					1ST QUARTER		2ND QUARTER		3RD QUARTER		4TH QUARTER		TOTAL	
			PROF.	SUPP.	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	ACTUAL	PLANNED	AC
PERFORMANCE INDICATORS OR STANDARDS FOR OBJECTIVE														
3. Identify and conduct reviews on clusters of physicians and other noninstitutional providers with a goal of preparing draft reports establishing past overpayments for recovery and other program savings of at least $3 million by 9/30/81.														
OPERATING STEPS														
Conduct reviews and complete draft reports.														
(1) Central Office														
(a) Reviews - 3 reports					1		1		2		2			
(b) Dollars - $600,000					20%		40%		70%		100%			
(2) Regional Offices														
(a) Reviews - 27 reports					5		7		7		8			
(b) Dollars - $2.4 million					20%		40%		70%		100%			

Chart IX

HCFA PERFORMANCE APPRAISAL WORK PLAN

NAME	POSITION	ORGANIZATION	PAGE 1 OF 2
	Regional Quality Control Division Directors	10 Regional Offices	

EMPLOYEE'S SIGNATURE, DATE	SUPERVISOR'S SIGNATURE DATE	ORIGINAL DATE:	REVISION 1	REVISION

KEY FUNCTIONS AND OBJECTIVES I.F. OBJECTIVES AND CRITICAL ELEMENTS[a]	OHS TIER 1, 2 or 3	PRIORITY VALUE	STANDARDS/RANGES OF PERFORMANCE QUANTITY	TIMELINESS	QUALITY
Supervises and gives executive direction to the Validation Review Branch in the conduct and reporting of validation studies.	2	3.0	(a) Oversee completion of validation review reports to a preliminary draft report stage (for circulation to other RO components and OPV Central Office) at least consistent with the numbers shown in the HCFA 1981 Audit Plan (HCFA-81-40006). (b) Oversee completion of final validation draft reports (for circulation to States, Medicare contractors, etc. for comments and action plans) to ensure that all preliminary draft reports issued in FY 1979 and 1980 are issued as final draft reports and 75 percent of preliminary draft reports issued during FY 1981 are issued as final draft reports during FY 1981. (c) Oversee completion of final validation reports (with State and Medicare contractor comments and action plans incorporated, analyzed, and rebutted as necessary) to ensure that	(a) Workload should be spread out over the year so that a minimum of 15 percent of reports are completed during the first quarter, 35 percent are completed by the end of the second quarter, 65 percent are completed by the end of the third quarter, and, of course, all are completed by the end of the fiscal year. (b) Final draft report issued with 90 days of issuance of preliminary report. (c) Final report issued within 6 months of issuance of final draft report.	(a) through (d) All validation reports including followup reporting to be completed consistent with OPV issued instructions on validation reporting standards (currently in letter instructions which will be manualized during the fiscal year).

HCFA PERFORMANCE APPRAISAL WORK PLAN

NAME	POSITION	ORGANIZATION	PAGE 2 OF 2
	Regional Quality Control Division Directors	10 Regional Offices	

EMPLOYEE'S SIGNATURE / DATE	SUPERVISOR'S SIGNATURE / DATE	ORIGINAL / REVISION 1 / REVISION DATE:

KEY FUNCTIONS AND OBJECTIVES		OMS TIER 1,2 or 3	PRIORITY VALUE	STANDARDS/RANGES OF PERFORMANCE		
F	OBJECTIVES AND CRITICAL ELEMENTS[a]			QUANTITY	TIMELINESS	QUALITY
				all draft reports issued during FY 1979 and 1980 and 25 percent of preliminary draft reports issued during FY 1981 are issued as final reports during FY 1981.		
				(d) Oversee completion of final status reports (ensuring that all actions outlined to be taken in final validation reports have been accomplished) to ensure that 80 percent of final reports issued during FY 1979 and 1980 result in final actions having been accomplished.	(d) No specific standard on individual reports.	
				(e) Oversee completion of at least two research papers for proposing future multi-regional validation reviews (beyond FY 1981). These proposals should typically be based on findings determined during ongoing validation reviews that appear to have a strong need to be expanded to a multi-regional review.	(e) At least one to be completed by March 31, 1981, and at least one other paper to be completed by September 30, 1981.	(e) Prepared in accordance with standard protocol for proposing multi-regional validation reviews (attached).

TO : All Program Integrity Directors

JUL 16 1979

FNV-13

FROM : Acting Director
Division of Validation Reviews
Office of Program Validation, SQC

SUBJECT: Updating of Regional Recommendations for Program Implementation Validation Reviews

In October and November of 1978, most OPI Regional Offices responded to a central office request and recommended several potential areas for program implementation validation reviews. A list of the subject areas which your region recommended is attached (other regions that suggested similar validation reviews are noted in parentheses).

Because we are now ready to begin full implementation of the program validation effort, please review the attached list and update the items by (1) deleting those subject areas that are no longer potentially productive as validation targets, (2) adding any possible target areas that have come to your attention in recent months, and (3) summarizing each recommended project.

The summary sheet for each potential program implementation project should not exceed one or two pages and should include a statement of issues and background (including the estimated extent of the problem), the proposed methodology for conducting the validation review, the estimated resources required, and the expected results or benefits, including potential dollar recoveries, if any. Any other information which will facilitate evaluation of the proposal should also be included. An example of a proposed project summary is attached for your convenience.

After the updated lists, with summaries, are received in central office, we will evaluate the potential effect and scope (national, regional, or statewide interest) to determine those projects in which central office staff will work with the regions on actual implementation of validation efforts. Your office may be asked to provide additional information on those subject areas selected for further central office action.

Please return the updated list of recommendations and summaries to the Bureau of Quality Control, Office of Program Validation, Division of Validation Reviews, by August 20, 1979. If you have any questions concerning this request, please contact Les Caplan, of my staff, at (FTS) 934-8726.

Frank DeLillo

Attachments

BUREAU OF QUALITY CONTROL (HCFA)
OFFICE OF PROGRAM VALIDATION - SPECIAL REVIEWS
REGIONAL PROPOSALS - NATIONAL PROGRAM VALIDATION REVIEWS

Regional Office: _____ Contact Person: _____

Title of Project:

Statement of Issue(s):

(In describing the issue, this item should include a sufficient explanation of the condition which exists; the probable cause of the problems; and the effect the issue is having on the Medicare/Medicaid programs. The background/justification presented must substantiate the key assumptions upon which the issue is based and should include sufficient preliminary information to allow a go/no go decision.)

Recommended Methodology:

(A key element in evaluating the feasibility of a proposal is the complexity of the proposed job; availability of the necessary data and policy to support the issue; and the presentation of alternative approaches for achieving the stated objective. Accordingly, this item will include a concise statement of the techniques to be utilized, availability and accessibility of records, and the identification of key hurdles to be overcome. In essence, this item will describe "what" needs to be done and "how" it will be done.)

Resource Requirements:

(This item will include an estimate of the staff requirements needed for the major tasks associated with the project (man-days). Staff needs will be expressed in terms of number, skills, and staff days, and should incorporate the staffing considerations of other regions. Matching the right people with the right job is essential so that individual, job, and institutional needs are weighed and meshed to produce the best overall results.)

Expected Results/Outputs:

(The proposed outcome of the study is an essential factor in measuring the worth and contribution of a proposed validation review. Whether the result is an alternative method of reimbursement, clarification or change to ineffective policy, improvement in carrier/intermediary performance, or potential targets for further fraud and abuse investigations, an evaluation of the expected results should be made before resources are committed or increased. Where possible, the expected findings will include an estimate of the potential recoveries/program savings to be generated from the project.)

— EXAMPLE — 7

Title of Project: Carrier-Intermediary-PSRO Coordination on Disallowed Hospital Stays

Statement of Issues:

On occasion, a hospital Utilization Review Committee, an intermediary, a medicaid fiscal agent or a PSRO determines that all or part of an inpatient hospital stay is unnecessary. On this basis, payment to the hospital is cut off. However, if the beneficiary remains in the hospital and a physician continues to visit the patient, the carrier or the Medicaid fiscal agent pays for these possibly unnecessary visits. Thus, program funds may be needlessly expended.

At present, there exists no mechanism by which an intermediary notifies a carrier of the date on which a stay is determined to be noncovered. There is also no cross reference between intermediary and carrier claims files. In addition to the situation described above, this lack of cross checks could lead to other situations of improper payments, such as office visits being paid while the patient is hospitalized. We need to determine if either situation is occurring to any significant degree.

Proposed Methodology:

Contact intermediaries and state agencies for a recent listing of hospital cases in which the inpatient stay was either cut off or denied. From these lists, select a sample of inpatient claims. Request beneficiary histories covering the same time period to determine what medical services were paid for after the cut off. Request that a medical consultant make a determination as to the necessity of the services in light of the fact that the hospitalization was unnecessary. Analyze results of comparison.

Estimated Resources:

Two R.O. analysts for approximately four weeks. At least one medical consultant for one week.

Expected Results:

1) Depending upon the outcome of the study, propose a system under which carriers and Medicaid fiscal agents can receive notification routinely when coverage of an inpatient stay is terminated.

2) Propose [illegible] by which this information can be used to assure that at least on a sample basis all bills for medical services after the cut-off date but prior to discharge are reviewed for medical necessity before payment. Solutions to the problem may differ according to the situation: Medicare with or without PSRO involvement and Medicaid with or without PSRO involvement.

Governor
State of Ohio
KENNETH B. CREASY
Director
CHARLES E. NOGGLE
Assistant Director

DEPARTMENT OF PUBLIC WELFARE
OFFICE OF THE DIRECTOR
30 East Broad Street
Columbus, Ohio 43215

September 23, 1980

Martin L. Kappert, Director
Bureau of Quality Control
Department of Health and Human Services
Health Care Financing Administration
Baltimore, Maryland 21235

Dear Mr. Kappert:

Thank you for your recent letter regarding the findings of your office's preliminary validation review of the department's rate-setting process. This review was particularly beneficial because it was conducted at the time the department was instituting a new rate-setting methodology.

The review revealed that the audits conducted by the two consulting firms under contract were deficient in several areas. Such deficiencies had a material impact in the calculation of one of the components of the nursing home per diem. As a result of the timely identification of the deficiencies, the department is able to initiate corrective action and avoid the needlessly expenditure of state and federal dollars. The identification of a potential 6.5 million dollar overpayment constitutes approximately two percent of the department's total Medicaid expenditure for nursing home care.

In fact, the department's experience with HCFA in the development and implementation of the new nursing home program has been exceptionally positive. In addition to your office's assistance, the Division of Alternative Reimbursement has been most cooperative in its timely and extensive review of the reimbursement policy to ensure its federal approvability.

The point I'm trying to emphasize in this letter is that expertize provided while a system is in its development and early implementation phase is the most beneficial because it prevents problems.

Very truly yours,

CLARK R. LAW
Executive Assistant
to the Director

CRL:dk
cc: Tom Jazwicki

SEP 18 1980

FMM-13
458
1-11-0010-06

Mr. Clark Law
Executive Assistant
Department of Public Welfare
State Office Tower
30 East Broad Street
32nd Floor
Columbus, Ohio 43215

Dear Mr. Law:

The purpose of this letter is to stress the immediate action needed to correct one of the problems identified during our preliminary validation survey of Ohio nursing homes last month. During the review, we found that the maximum allowable rate for general and administrative expenses per day in nursing homes beginning July 1, 1980 was erroneously computed. The error in the maximum occurred because it was not based on audited data which accommodated the State criteria for limitations on nursing home administrative salaries. As a result, the sample of cost reports utilized to determine the general and administrative (G&A) maximum contained nursing home salaries which were greater than Ohio's criteria for allowable administrative salaries.

Upon my staff's disclosure of this problem to you, the Department of Public Welfare recomputed the G&A maximum using the correct criteria for administrative salary limitations to determine the significance of the problem. Your analysis showed that the G&A maximum should be reduced from $10.10 to $9.63 per patient day. Based on last year's patient day statistics of over 14 million Medicaid patient days reimbursed in nursing homes, the $.47 per day reduction in the G&A maximum should realize a saving of $6.5 million on an interim basis and approximately $5 million in final payments to nursing homes.

It is our opinion that because of the significance of the error, the present G&A maximum should be reduced to the proper level immediately. Any payments already made to nursing homes using this erroneous maximum should be retroactively adjusted based on the correct amount. Should the State of Ohio, despite our pointing out the need for an adjustment, reimburse based on the erroneous amount, it will be paying these costs entirely from State funds as Federal financial participation in such a clearly unallowable expenditure cannot be made.

I would like to take this opportunity to commend you on your timely action to review the significance of the problem. However, your further action is needed to reduce the G&A maximum to the correct amount as soon as possible. Should you have any questions pertaining to Federal financial participation in Medicaid expenditures, you may refer them directly to David McNally, Director, Division of Financial Operations, Bureau of Program Operations, (301) 597-1397. Also, if I can be of any assistance to help you to take action on this matter, please do not hesitate to call me.

Sincerely yours,

Martin L. Kappert
Director
Bureau of Quality Control

cc:
Regional Administrator, Chicago
Regional Medicaid Director, Chicago
Regional PI Director, Chicago
D. McNally - BPO
Ken Creasy - Director, Department of Public Welfare
M. Kappert
M. Seabrooks
PCIB
D. Nicholson
F. DeLillo
G. Whooley
L. Berman
Branch
RFCs

FNV-13 LBerman/FDeLillo:gaf 9/11/80
9/15/80

APPENDIX K

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Date FEB 06 1981

FNV22
451

FEB 19 19

From Director
Bureau of Quality Control

Subject Lack of Criminal Fraud Convictions in the Miami Area (Your Memorandum of December 19, 1980)—INFORMATION

To Regional Administrator
Atlanta

The Acting Administrator has asked me to respond to your very informative memorandum explaining the prevailing situation concerning criminal fraud convictions and problems associated with fraud matters in the Miami, Florida area.

I share the concerns you have expressed about the historical problems that exist in the Miami area in terms of Medicare fraud. I also realize that the drastic decline in criminal convictions serves as a detriment to the Health Care Financing Administration's (HCFA's) efforts. Your planned orientation training for acquainting the Office of Investigations (OI) staff with the health insurance programs is commendable. I am hopeful that it will serve as a means to help resolve the problem in your region, and, as you have noted, may well serve as a useful tool in other regional jurisdictions.

In your memorandum, you suggested that HCFA should support a "strike force" effort to deal with cases in certain areas of the country, particularly in south Florida. A strike force consisting of the Justice Department's prosecutors and Federal Bureau of Investigation's investigators would perhaps be a viable remedy to the problem with regard to manpower needs. However, I believe that a response to your specific request would be more appropriate after we have had an opportunity to discuss total strategies of fraud and abuse control with the new departmental leadership and the new HCFA Administrator.

Undoubtedly, you are aware that our staff has been working with the Office of the Inspector General's (OIG's) staff centrally regarding pending OI Medicare cases across the nation. In December 1980, a memorandum was sent to all Regional Administrators advising Program Integrity Regional Office (PIRO) staff that the Special Agents-In-Charge have agreed to more fully represent the administrative concerns of the PIROs in dealing with the United States Attorneys. Every attempt is being made to secure OIG cooperation in a national effort to either investigate and refer our cases for prosecution, or return them to the PIRO for administrative sanctions action, if appropriate. This approach should enhance HCFA's position in taking action to help protect its programs.

Thank you very much for bringing this matter to our attention. Be assured you have my support in these matters. Please contact me if I can be of further assistance. Your staff should direct questions on this subject to Mr. Clarke Bowie, Office of Program Validation, Field Operations Branch on (FTS) 934-2077.

Martin L. Kappert

Attachment

HEALTH CARE FINANCING ADMINISTRATION

Attachment 1

Memorandum

Date December 19, 1980

From Regional Administrator
HCFA, Atlanta

BQC;Action
CC; Ebeler/Newman
Altman/Collier
FORD: HARRIS
Glennie; OFO

Admin Sig
Due 1/14

Subject Lack of Criminal Fraud Convictions in the Miami, Florida, Area

To Administrator, HCFA

In 1976, responsibility for the investigation of criminal fraud cases involving the Medicare program was passed from our Office of Program Integrity to the Inspector General's Office of Investigations. Since OI needed time to acquire staff, etc., only a few cases were actually transferred to OI from OPI until early 1978. Since 1976, with the exception of cases handled to completion by OPI, there have been no criminal convictions involving Medicare in the South Florida (Miami) area.

Given the large Medicare population and the concentration of Medicare providers in that area, opportunities are certainly available for fraudulent activity. Our past experience with the area (some 21 criminal convictions obtained by OPI in the 1976-78 period) and the continuation of the same kinds of potentially criminal activity reflected in the cases OPI now refers to the Office of Investigations lead us to believe that a major problem continues to exist in terms of Medicare fraud in that area.

This lack of criminal convictions has had further effects. Due to the large number of initial complaints of potential fraud and abuse we received from Medicare beneficiaries through Social Security offices in South Florida, the Social Security Administration years ago set up a special unit in the Miami Beach District Office to which all Social Security offices in the area referred initial complaints. This special unit, staffed with as many as six Field Representatives, screened these complaints and referred on to OPI only those which had good potential as fraud cases. The volume of complaints has now fallen to the point that the unit was disbanded several months ago. We believe this drop in the number of complaints is directly attributable to the lack of criminal convictions and the attendant publicity such convictions received in the media.

We have also detected in Medicare carriers and intermediaries serving this area a change in attitude toward reporting matters of potential fraud to us as such. They seem to feel that there is almost no chance of any action criminally and that to report such cases to us can only result in several years of no action at all followed by the return of the case to them for resolution. The facts seem to lend credence to their feelings. We, of course, continue to work with them to see that cases are reported prope[illegible]

I met with the OI Special Agent in Charge and OPI representatives in late summer to present this problem and to offer whatever assistance we could to resolve it. OI seems to feel that the problem is caused by other business (drug cases, immigration, etc.) tying up the U.S. Attorney's Office and that the Medicare law and regulations are too "loose" and do not contain specific penalties for specific fraudulent acts. U.S. Attorneys have, of course, always had many more cases to prosecute than they can ever handle, and Medicare cases have always had to compete with cases involving a variety of other offenses. With regard to this and the "looseness" argument, I believe OPI's record speaks for itself.

At the meeting, I proposed a training program or orientation for OI staff to acquaint them more adequately with Medicare and Medicaid. The SAC saw real value in the proposal, and we are now in the process of finalizing the agenda. I hope that this training can serve as a pilot project for other regions experiencing similar problems. Other than this training, no concrete action plan to resolve the problem came out of our meeting.

This leads to the main purpose of this memorandum, which is to suggest that we in HCFA offer whatever support we can to recent recommendations by congressional committees and congressional staff that some kind of "strike force" effort be mounted to deal with Medicare fraud in certain areas of the country such as South Florida. This "strike force" would reportedly be made up of Justice Department prosecutors and investigators from the FBI or other similar investigative agency who would be free of other caseload constraints and would be able to direct concentrated intensive efforts toward securing criminal indictments and convictions in Medicare cases. I believe that such a force could have significant impact in a relatively short period of time. I believe that any success could only have positive effects in protecting the program from those who would defraud it, in revitalizing our fraud detection system and in recreating the deterrent effect on others that only criminal convictions can have.

Virginia M. Smyth

(Mrs.) Virginia M. Smyth

Director, Bureau of Quality Control September 14, 1979

Regional Director, Office of Program Integrity OPI:BP
Atlanta

Medicare Fraud Deterrance

Following the discussions you had with the OPI staff here several employees created the attached graphics to illustrate their concerns about the decline in convictions since fraud responsibilities were transferred to the Inspector General. I am passing them on for your information.

Attachment A is a graph illustrating the nationwide decline in Medicare fraud convictions in the last few years. While OPI referrals to U. S. Attorneys dropped off as soon as OI arrived on the scene, convictions remained high as long as OPI's cases were being adjudicated--approximately another year.

Attachment B breaks out the data for this region only and illustrates the same decline locally. I am not aware of any Medicare conviction OI-Atlanta has achieved independently. Joint investigations have been unwieldy due to different orientations and approaches of the two staffs and, hence, have been infrequent.

Attachment C illustrates the close correlation between OI case presentations to the U. S. Attorney and prosecutive declinations. On page 69 of his 1978 Annual Report the Inspector General discusses the rapidity with which OI has obtained declinations on what are termed "weak cases." This is contrasted to figures on declinations received by OPI in the same period. I cannot understand these figures as we in OPI-Atlanta have only received perhaps a half dozen declinations in a decade of activity, none since the creation of OI, and in no case was declination due to case merit. Mitigating and extralegal factors (such as one suspect's pre-existing incarceration for murder) were mentioned to us by U. S. Attorneys.

OI has indicated to us that it seeks a prosecutive commitment from U. S. Attorneys on our cases before deciding to investigate further. Under the Memorandum of Understanding, we have been referring cases to OI when they "show a strong potential for fraud warranting a full-scale investigation". It was never our policy to present cases to

the U. S. Attorney at this stage of partial development and I cannot be surprised at the high rate of declination (particularly in view of OI's presentation techniques discussed in your meeting here). The rate of referrals to OI has declined slightly due to a reevaluation on our part of the degree of development expected by OI before referral.

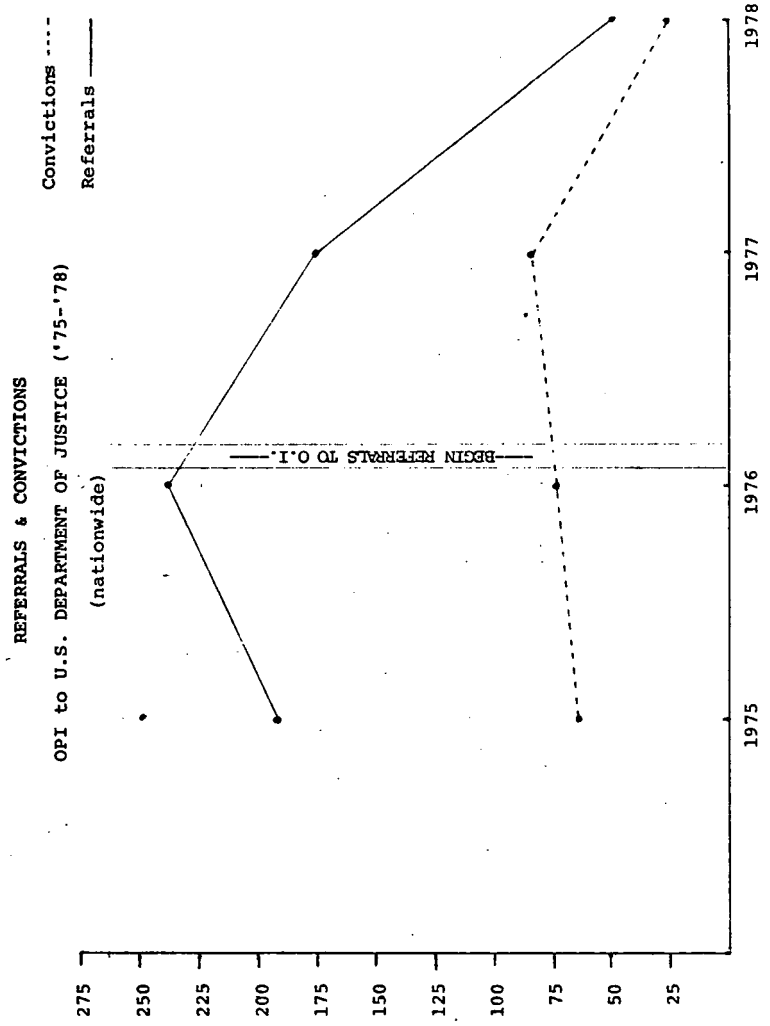
Attachment D summarizes the figures represented in Attachments B and C. These figures do not always agree with those presented in the Inspector General's Annual Report. In that regard, you may wish to re-read my earlier memo (Attachment E). OPI's figures can be supported with specific case references, but we can only measure OI activities by what they have reported to us.

I felt you would want these charts for your reference in view of the public posture the Inspector General has recently taken in forums such as the Chiles' hearings. If you have any questions on any of this data, Chris or I will be happy to discuss it with you.

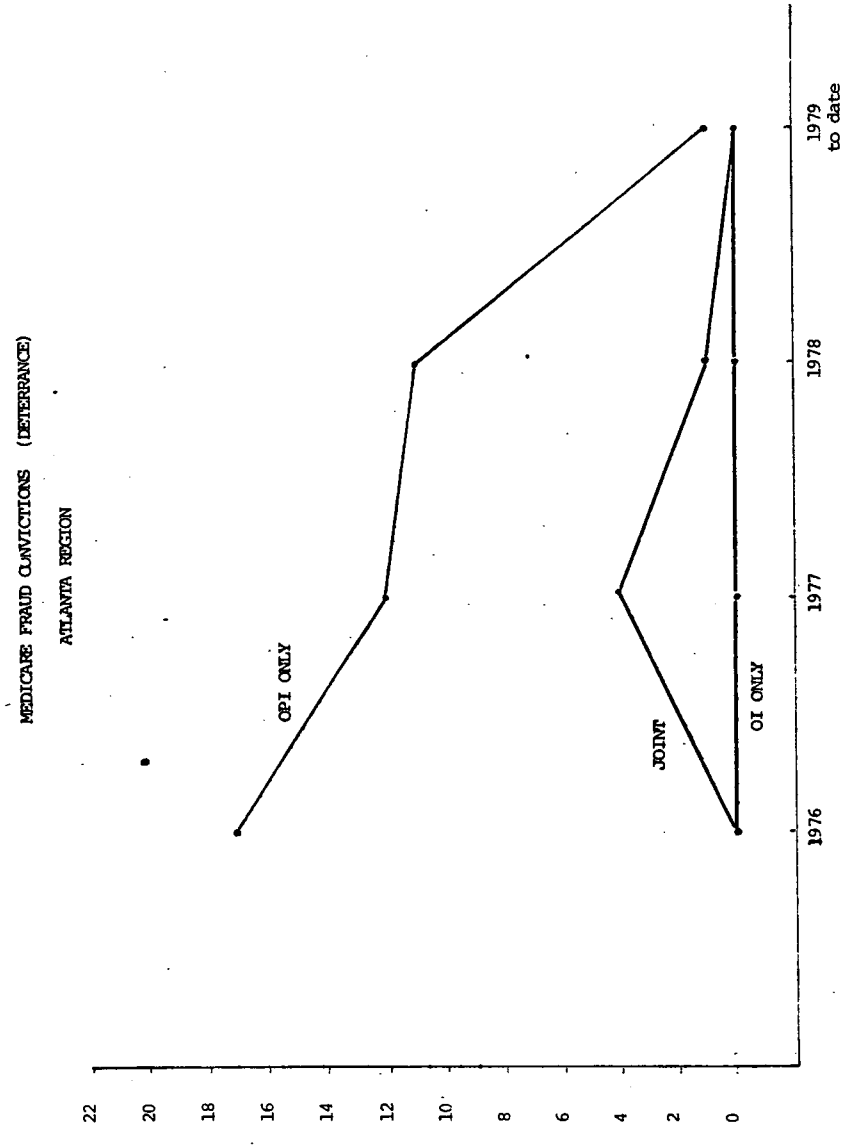
Frank D. White

HCFA:OPI:Foster:keb 9/14/79

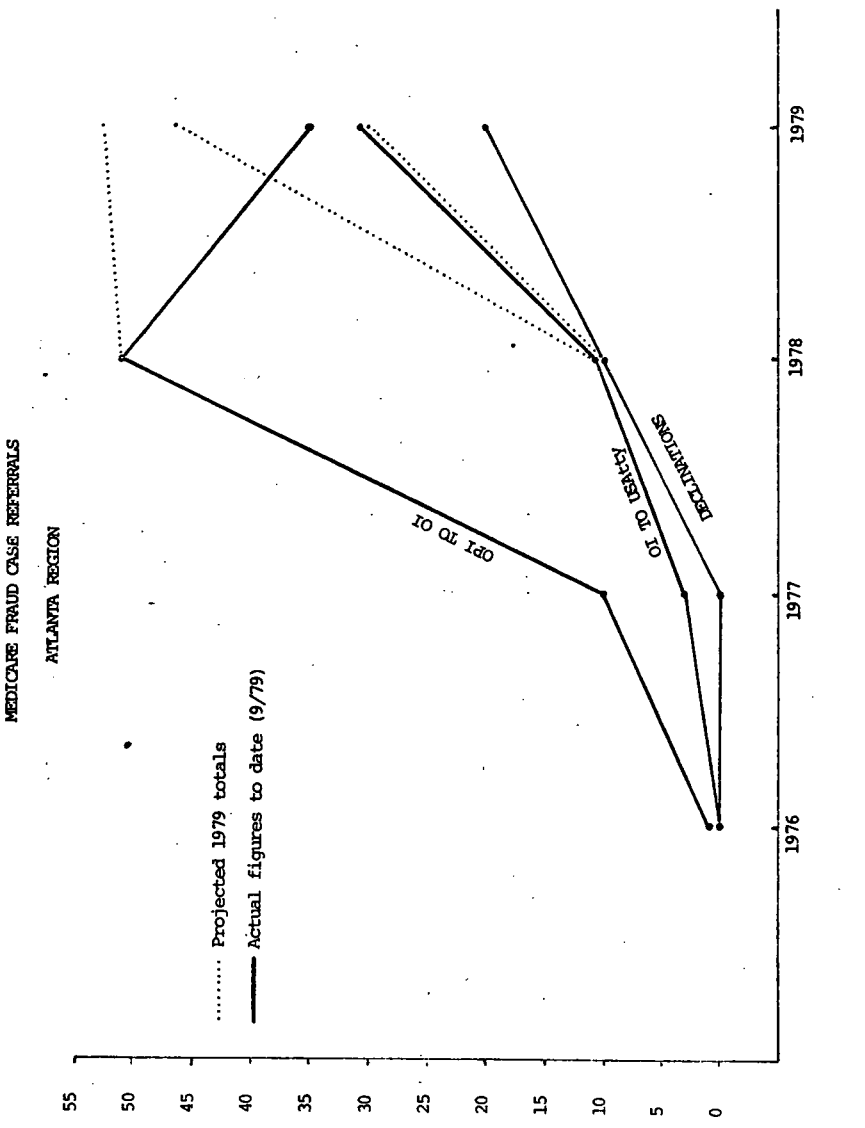
Attachment A



Attachment B



Attachment C



Health Care Financing Administration

November 7, 1980

Frank D. White, Regional Director
Office of Program Integrity, HCFA/Atlanta

Refer To: OPI:DS

Wayne Bailey
d/b/a Columbia Medical Rentals, Irmo, South Carolina
(File A-49-0-504)

Special Agent In Charge
Office of Investigations, Atlanta

After reviewing your memorandum of May 7, 1980, which states " A review of the file disclosed no criminal violation or other basis to schedule a criminal investigation," we forwarded the file to our central office for their review. We have received their reply which quotes the Office of General Counsel's opinion on this case as follows:

> "The language in section 1877 (b)(2)(B), prohibiting the offer of any remuneration in kind to any person to induce such person to purchase, lease, order... any... item is most clear, and the described practice, if conducted, would fall squarely within the prohibition of this statute."

We realize that you may not be happy to see this case again; however, in light of the OGC opinion and for the other reasons given below we feel it is our responsibility to return the case to you for a second look.

Wayne Bailey is a major supplier of durable medical equipment to Medicare beneficiaries in South Carolina. As a leader in the field, many other suppliers look to his practices in order to judge their own conduct. If his practice in this case is allowed to go unchallenged, we can expect other suppliers in South Carolina and elsewhere to likewise offer such a deal as no suppliers in this very competitive field can go long with such a competitive edge.

We have no administrative sanction or other action which can effectively deal with the problem.

Under the circumstances, we hope that you will review the matter again in light of the OGC opinion.

HCFA:OPI:DS:Simmons:vrc:11/7/80

MEDICARE FRAUD CASES
ATLANTA REGION

	REFERRALS			CONVICTIONS		
	OPI TO OI	OI TO USAtty	USAtty DECLINATION	OPI	JOINT	OI
69				2		
70				1		
71				8		
72				2		
73				13		
74				4		
75				3		
76	1	0	0	17	0	0
77	10	3	0	12	4	0
78	51	11	10	11	1	0
79 to da	35(52.5)	31(46.5)	20(30)	1	0	0
TOTALS	97	45	30	74	5	0

(Projected 1979 totals)

OPI:BF:0979

Attachment D

Acting Director
Bureau of Quality Control

June 6, 1980

Regional Director
Office of Program Integrity, HCFA/Atlanta

OPI: WDS

Office of the Inspector General (OIG) Cooperation in Case Handling Development and Disposition--ACTION--your memorandum Dated May 19, 1980

Your memorandum states that the OIG has contacted you requesting a staff paper describing ways in which they can assist OPV and OPI in the performance of our functions. In our opinion this is putting the cart before the horse. What is desperately and critically needed are Medicare criminal indictments and convictions to deal with criminal fraud and to recreate a deterrent for committing fraudulent acts. We are having no particular problems in detecting and referring to OI what we consider to be very good cases of potential fraud. The very best way the OIG can assist us in the performance of our functions is to aggressively investigate these cases and present matters of criminal fraud to U.S. Attorneys. We stand ready as we have since the creation of the OIG to assist them in any way we can to secure these much needed indictments and convictions.

Having said that, there are several specific suggestions which we would like to offer on how the present process might be improved. These follow the outline contained in your memorandum.

1. Any instances in which cooperation between our organizations could improve the performance of either or both units.

Since criminal indictments and convictions are of paramount importance, no new initiatives or responsibilities such as civil fraud or beneficiary fraud should be placed upon OI so that all their efforts can be devoted to criminal matters.

Discussions of referred cases between OPI case development staff and OI case agents prior to OI's initiating any investigative activity on a given case would provide OI with more background into the alleged violation, Medicare policies and procedures etc., as well as possible lines of inquiry they might want to follow. This might seem to be an obvious suggestion, but this kind of discussion does not take place here. The OIG might consider

making such discussions mandatory.

Currently OI's position on suspensions of payments in fraud cases is that they simply are not involved, that suspensions are HCFA's concern, not their's. Since they feel no responsibility for the decision, no priority at all is given to such cases. This causes us to be extremely reluctant to suspend payments even in blatant cases of fraud since an investigation may not even begin for literally years. In referred cases where we have not suspended payments, OI feels no responsibility to notify us if an investigation does produce sufficient evidence of fraud to warrant suspension action. We have been unable to convince them that as a part of the Department of Health and Human Services, they have a responsibility to participate in and even initiate discussions on suspensions to prevent the Department from continuing to make erroneous payments to providers. Some attention to these areas by the OIG would be of help to us.

2. Any policies or procedures currently implemented on a regional basis which have improved the cooperation between both organizations.

We have nothing to offer here.

3. Instances in which OPI's opinion should be solicited prior to determining the final disposition of a case.

There has been an extremely high incidence of declinations by U.S. Attorneys of cases that seem to us to have very good prosecutive merit. We would like to be consulted at the point when OI makes a decision to present a case to the U.S. Attorney, so that OI might have the benefit of our suggestions, views, etc. Also a "dry run" presentation to someone knowledgeable about the facts in the case might assist OI in making a "better," more complete presentation.

In addition, our being consulted prior to OI's going to U.S. attorneys might have prevented the situations outlined in the attached write-ups of the cases involving Scott Stein, M.D. and Yolanda Somont and Maria Santiago.

4. Any policies or procedures that could be implemented to improve our ability to effectuate sanctions actions.

The single most helpful thing OI could do to help us in the sanction area would be to secure criminal convictions. The same comment applies to civil fraud action as well since a summary judgement is all that is needed to prevail in a civil case after a criminal conviction.

We hope that these suggestions will be helpful.

Frank D. White

cc: All Regional OPI Directors

HCFA:OPI:WDSimmons:vrc:6/6/80

Acting Director, BQC May 1, 1980

Regional Director, OPI OPI:WDS

Joint OI/OPI Effort to Reduce Pending Backlog--ACTION--Your Memorandum of April 10, 1980

Attached are the completed forms you requested. Per a telephone conversation with Bob Emanuel, we have not completed the column headed "Date of Complaint(s)" due to the amount of time necessary to gather this information. If it is needed later, please let us know.

This listing of cases pending in OI includes only cases we have referred which to our knowledge have not already been referred to U.S. Attorneys.

We have a number of concerns with what you are proposing to do, such as:

1. A joint effort between OI and OPI staff to present a large number of cases (some 63 in this region) to U.S. Attorneys represents a major workload we have not budgeted for. Our Case Development staff is heavily engaged in CIEPs and State assessments and will be for the remainder of the fiscal year. What activities are we prepared to abate in order to do this new activity?

2. Such joint presentations will put us back very much in the fraud business again. U.S. Attorneys recognize competence and commitment when they see it. Many will accept cases only if we agree to continue to work with them. We aren't prepared to do that.

3. These cases will be very difficult to present properly. One of the first things the U.S. Attorney will ask is how much money is involved here. We won't know since the case has not been developed. We will be obligated to point out from the very beginning that these cases have not been investigated, so we have very few facts to present to him. U.S. Attorneys like to deal in facts, not suspicions; therefore:

4. We can expect a great many if not most of these

cases will be declined. If the problem is a lack of convictions, why are we going through all this?

5. Based on our past experience, we can expect a considerable amount of opposition from OI. In this region, they have consistently refused any assistance we have ever offered. What makes us think they will accept this offer?

6. What assurances do we have that there will be real commitment of time, effort, etc., necessary to investigate and help prosecute any cases that are accepted by U.S. Attorneys as a result of this joint effort? Will we have to go through this again next year to clear out the pending cases then?

In summary, we certainly share your concern over the large number of cases pending in OI. We are deeply disturbed, however, with the plans you have outlined to deal with these cases and seriously question that they will in any way be successful in dealing with the real problems.

Frank D. White

Attachment

cc:
All Regional PI Directors

HCFA:OPI:WDSimmons:keb 5/1/80

Acting Director.
Bureau of Quality Control 2/3/80

Regional Director
Office of Program Integrity, HCFA/Atlanta OPI:WDS

Revised Memorandum of Understanding Between the Office of the Inspector General/Office of Investigations and the Health Care Financing Administration-Medicare/Medicaid Fraud--ACTION--Your Memorandum, January 24, 1980

We appreciate the opportunity to comment on the proposed revised memorandum of understanding.

We certainly approve of the proposals to strengthen the MOU by giving examples of what the term "strong potential for fraud" really means. This has caused problems in the past which undoubtedly will continue but pinning it down some will definitely help. Any further "pinning down" you can do will be appreciated.

The written notice within 45 days of referral will also help considerably. We would like to see the second paragraph on page 3 further strengthened by amending this section to read "OI will inform HCFA regionally in writing as to whether they have specific objection to the taking of concurrent administration/sanction action by HCFA and their reasons for such objection". We would like to get something in here that would prohibit such objection based on vague feelings that HCFA actions will somehow "mess up" the criminal action. In this same paragraph, we suggest adding the words "and when" after "...whether they intend to schedule the case for investigation".

On page 4 with respect to civil fraud, we would like to see some flexibility retained on a region-by-region basis. In regions where OI is unable or declines to handle civil fraud, OPI should be able to take up the slack. If we go with the MOU as written, we can only say that in our opinion this will effectively end civil fraud actions in this region. OI here has never shown any inclination to get involved with civil fraud. We have never been satisfied that sufficient criminal investigation is done in most cases; since civil fraud requires almost the same effort in investigation, we simply will see the demise of what can be an effective tool for dealing with fraud. Enough said.

Frank D. White

MORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

II-E-14

DATE: APR 1 3 1978

REFER TO: FPQ-1

TO : Director
Office of Program Integrity

FROM : Frank E. DeLillo, Director
Division of Field Operations
Office of Program Integrity

SUBJECT: Continued Need for Program Integrity (PI) Staff To Work Cases Referred to the Office of Investigations (OI)

As you know, I had to commit Joe Birdsong, from our Atlanta Regional Office, to be available for a period up to 6 months to assist a Justice Department team of central office attorneys prosecute a major home health agency chain. This case had been referred through the HEW Office of Investigations (OI). I was trying to limit Birdsong's future involvement by obtaining a commitment that OI staff would perform any interviewing or re-interviewing of witnesses required by Justice. Of course, I understood that Birdsong would be required to be available in court to explain schedules he had prepared which traced ownership arrangements and other financial transactions related to these home health agencies.

Lorna Kent, the Justice Department attorney in charge of the team working this case, advised me by telephone that she needed Joe Birdsong to work with her on the prosecution and unless we make him available she will recommend that Justice drop the case, citing non-cooperation of HEW as the reason. I explained my quandary regarding Joe and Lorna said that she could use OI investigators to interview non-accounting type witnesses, but she would need Birdsong along on interviews with any accounting related type witnesses. She explained that she might need Birdsong for 6 full weeks in the courtroom and to have him available for consultation during a period which could extend to 6 months on this case. Lorna Kent said she had explained to Nathan Dick, of OI central office, and would be glad to tell anyone else that what Justice needs from HEW on this type of case is assistance in the form of someone who has Medicare program knowledge and accounting/auditing experience.

We do not wish to have Justice drop the case since a conviction could have significant impact on getting other home health agency chain-type organizations to stop illegal and unethical practices, deterring the

establishment of new home health agency chains intent upon defrauding the government in a similar manner, and setting precedent for additional prosecution of other existing home health agency violators. Nathan Dick agreed to assign a recently hired OI investigator in the Atlanta region, who has an audit background, to assist Birdsong in the hope that such experience would enable OI to carry similar cases in the future. Thus, I have instructed Atlanta OPI to make Birdsong available to work on this investigation. This will result in some delay in review efforts and administrative overpayment recovery actions we anticipated based on Birdsong's ongoing work related to several other home health agency claims. I expect to throw some central office accounting office help into this breech in the form of Joe Brewster, Gary Kramer or both to assist Atlanta with these other reviews.

Frank E. DeLillo

cc: Frank White
Irv Cohen
Bob Dunker
Bob Filan

APPENDIX L

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

Mr. Bill Halamandaris
Investigator, Special Committee on Aging
Room G-233
Dirksen Senate Office Building

Dear Mr. Halamandaris:

In response to your request for background material concerning HCFA/OPI's ~~level of~~ support of the Office of Investigations' operations, I am enclosing ~~a copy~~ of the following:

1. Six memorandums from Philadelphia dated August 27, 1981, to November 10, 1981, documenting HCFA Quality Control Division's refusal to assist the OIG and the U.S. Attorney.

2. Memorandum from Robert E. Griffin, OI Special Agent-In-Charge, Denver, dated December 19, 1980, asking his HCFA counterpart to note a decrease in HCFA referrals and the small dollar amount of past referrals.

3. Memorandum from Special Agent-In-Charge MacAulay, Kansas City, dated November 7, 1980, pointing out that HCFA/Office of Program Validation correspondence dated October 17, 1980, (enclosed) allows Regional Program Integrity Directors to use their own discretion whether to report a criminal violation to OI.

4. Memorandum from Special Agent-In-Charge Campbell, Seattle, dated October 7, 1980, and attachment a letter from Denver Office of Program Integrity (OPI) Director explaining to a carrier OPI's decreased role in fraud and abuse investigations.

5. Memorandum from Special Agent-In-Charge Brock, New York, dated August 15, 1980, which critiques an operating statement proposed by the Acting Director of HCFA's Bureau of Quality Control (enclosed).

If I or my staff can be of further service to you, please do not hesitate to call on us.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Investigations
Region III ENCLOSURE I

CONFIDENTIAL

Memorandum

November 10, 1981

To: David H. Snipe
Acting Assistant Inspector General
for Investigations

From: Acting Special Agent-in-Charge
Philadelphia Field Office, OI

Subject: Regional Quality Control, HCFA (Formerly OPI)

Attached are five (5) memorandums and letters involving one case matter and a three part relationship with HCFA Quality Control, formerly OPI, U.S. Attorney and Office of Investigations.

The period of time spans 5 months and simply involves requests from OI and the U.S. Attorney in writing for assistance from program persons to work a case. As you may see from this correspondence, it is a typical example of relationships with this office much to the detriment of the agencies mission.

The Audit Director and I will take no further action to attempt to secure services of HCFA Quality Control Division based on their refusal to assist the OIG and the U.S. Attorney's office.

This information is provided to you for whatever action you may deem appropriate.

This is another example of why an MOU within the agency has effectively worked to hamper our functions.

Jerry Von Tempske

Attachments

11/12/81

August 27, 1981

Timothy McLain
Acting Associate Regional Administrator
Division of Quality Control

Assistant Special Agent-in-Charge, DHHS
Philadelphia, PA

Program Assistance
BA-9-308

In July, 1981, Lou Faiola, Audit Agency, and myself met with Allan Hoffman of your staff regarding an investigation being conducted by this office of [redacted] This case was referred by your office and is assigned to SA George Hallett of this office. It is alleged that [redacted] draws blood from Medicare beneficiaries and sends the specimen to [redacted] for the required tests. [redacted] forwards the results of the tests to [redacted] together with an invoice listing the regular price and a discounted price.

[redacted] also attaches individual bills for each beneficiary at the standard price. [redacted] pays [redacted] the discounted price. However, the beneficiary is given the bill with the standard price which he/she pays to ODE and subsequently submits to PBS as an unassigned claim.

It is requested that your office provide assistance in conducting a validation review of the records, to determine the excess charge to Medicare for these unassigned inflated claims for the period of January, 1979 through February, 1980. Subpoenaed records of [redacted] and [redacted] are in this office along with payment information we have received from Pennsylvania Blue Shield. The United States Attorney's Office has requested this review be done as soon as possible.

Please advise me of your decision before the close of business on September 11, 1981.

Jerry Von Tempske

OI:JVONTEMPSKE:wr:8/27/81

Memorandum

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

TO : Assistant Special Agent-in-Charge
DHHS Office of the Inspector General
Baltimore Field Office

DATE: SEP 3 1981

FROM : Acting Associate Regional Administrator
Division of Quality Control

SUBJECT : Program Assistance - BA-9-308 (Your Memorandum of 8/27/81)

At the present time, our entire staff is engaged in intensive fiscal year-end activities related to our primary responsibilities, as was previously discussed with you by Allan Hoffman. I do not expect staff to be available to assist your office in conducting a validation review of records necessary to determine any excess Medicare charges arising from this potential kickback case until after 10/15/81. Should you require our assistance after that time, I will ask a Program Integrity Branch analyst to participate in your review, if you will provide me with specific information as to the scope of the review, the review method, and the time frames anticipated.

Timothy D. McLain

United States Attorney
Eastern District of Pennsylvania

GSG: sas

3310 United States Courthouse
Independence Mall West
601 Market Street
Philadelphia, Pennsylvania 19106

October 2, 1981

Jerry Von Tempske
Assistant Special Agent-in-Charge
Office of Investigations, Inspector General
P.O. Box 8049
Philadelphia, PA 19101

Dear Mr. Von Tempske:

In July 1979, this office issued subpoenas for documents to be produced by principals in the case of [redacted] et al.

Since this case is of interest to the U. S. Attorney's Office, it would be appreciated if we be advised of the current status of the investigation and an estimated projection of when a prosecutive report will be available.

We are aware that investigations of this nature are complicated and, in many instances, audit assistance is necessary to examine and analyze the numerous documents involved. We are also aware of the many demands made on the limited resources of your department. However, in view of previous experience, it appears that program validation assistance with audit supervision and investigative participation is most productive from the prosecution standpoint. Accordingly, it is requested that you consider giving this matter some priority so that we may determine the prosecution merits of the case.

Please advise if we can be of any assistance in expediting this matter. This letter was not requested by anyone assigned to the Office of Investigations, Department of Health & Human Services, Philadelphia, Pa.

Very truly yours,

Peter F. Vaira
United States Attorney

Gary S. Glazer
Assistant United States Attorney

Office of Investigations
Region III

October 30, 1981

Timothy McLain
Acting Associate Regional Administrator
Division of Quality Control, HCFA

Acting Special Agent-in-Charge
Philadelphia Field Office

[redacted]
File #BA-9-308(PH)

In your memorandum of September 3, 1981 in response to our request of August 27, 1981, you advised that after October 15, 1981, an analyst from your office would assist on the captioned subject matter to resolution.

By letter of October 2, 1981, the U.S. Attorney requested that program validation assistance with Audit supervision and investigative participation be provided on a priority basis to determine prosecutive merits of the subject matter.

In a telephone conversation with you on October 8, 1981, you advised that Allen Hoffman of your staff would get back to me on this matter. I have not been contacted as of this date.

In your memorandum of September 3, 1981 advising your intention to provide assistance you indicated you would need specific information as to the scope of the review, method and the time frames anticipated. The time frame is anticipated at 40 calendar days and the scope and the method will be provided by the U.S. Attorney.

Please provide your response to me the week of November 2, 1981. Attached are copies of our correspondence and the letter from the U.S. Attorney.

Jerry Von Tempske

Attachments

Blind cc: David H. Snipe, AIGI
Linda Z. Marston, Regional Director
Gary Glazer, AUSA

OI:JVONTEMPSKE:wr:10/30/81

Memorandum

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PA 201.2

DATE: NOV 09 1981

TO : Acting Special Agent-in-Charge
Office of Investigations
Region III

FROM : Associate Regional Administrator
Division of Quality Control

SUBJECT : [redacted]
File #BA-9-308(PH)

IRS
OFFICE OF INVESTIGATION
Refer to: DQC:R3 (1)
NOV 1981
RECEIVED
11/9

This is in response to your memorandum of October 30, 1981, concerning assistance in the investigation of the subject case.

We indicated in our September 3, 1981 memorandum that we are willing to provide appropriate assistance in the investigation of this fraud case. However, the type of assistance we contemplated was more advisory than participatory. Under the Memorandum of Understanding, currently in effect, our organization is responsible for the preliminary investigation of fraud, and, the referral to the Office of Investigations of cases that have strong potential for fraud. The memorandum of understanding stipulates that assistance of our organization in full scale fraud investigations should be rare; and; must be cleared by our central office.

In your memorandum of October 30, 1981, you did not specify the type of assistance you needed. However, after contact with a member of your staff, we concluded that the assistance you are requesting would involve scheduling charges and costs of laboratory services provided to beneficiaries in a Skilled Nursing Facility. The type of work involved seems to be clerical in nature, and, does not appear to be an appropriate assignment for one of our Program Analysts. Furthermore, you estimated in your memorandum that the duration of the assignment would be 40 calendar days. We are committed to meeting goals established in a negotiated workplan. A 40 day assignment of one of our Program Analysts to a fraud investigation could severely hamper our efforts to meet our goals. Therefore, I am offering you assistance in establishing procedures for reviewing and scheduling data taken from the documents pertinent to this case. If you feel that this assistance is not sufficient, you should direct a request for expanded assistance to the HCFA Regional Administrator, and, the Director of the Office of Program Validation in the Bureau of Quality Control Central Office.

Timothy J. McLain

cc: E. Bryant
R. Howard
D. Nicholson
A. Hoffman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Investigations
Denver Field Office ENCLUSRE II

Memorandum

Date: December 29, 1980

From: Robert E. Griffin, Special Agent-in-Charge

Subject: Fraud Referrals to OI From HCFA/OPI

To: Frank Ishida, Regional Administrator, HCFA

Refer to:

Beginning October 1, 1978, HCFA/OPI began referring fraud cases to OI. During the past year, the number of referrals has declined and, during the past six months, there has only been one.

YEAR FY 79	1st QTR	2nd QTR	3rd QTR	4th QTR	TOTAL FY 79
HCFA/OPI Referrals	10	2	6	4	22
YEAR FY 80	1st QTR	2nd QTR	3rd QTR	4th QTR	TOTAL FY 80
HCFA/OPI Referrals	5	5	2	0	12
YEAR FY 81	1st QTR				
HCFA/OPI Referrals	1				

Of the 35 referrals made over the 27 month period, OI accepted 33. OI closed out five referrals after preliminary inquiries and opened full scale investigations of the other 28. As of this date, 25 investigations have been completed and the remaining three are still on-going. These investigations have resulted in four indictments and two convictions. (Indictments involving the [redacted] (D-9-86) had to be dismissed after key witnesses made conflicting statements).

An analysis of these 28 cases determined that a large majority were providers suspected of false billing, double billing, or billing for services not rendered. A breakdown of the type of providers referred revealed the following:

Doctors, MD	10
Podiatrists	7
Chiropractors	1
Laboratories	4
Ambulance company	1
DME	2
Nursing Home Owners	1
Hospitals	1
Hospital Ancillary Services	1

A breakdown of these providers by state showed the following:

Colorado	16
Utah	5
Montana	4
South Dakota	1
North Dakota	2
Wyoming	0

A further analysis of these statistics leads to the following questions:

1. Why has there been such a sharp decline in fraud referrals to OI?

2. Why have the majority of the referrals been Medicare Part B providers and relatively small dollar amounts in question?

3. Why has not one Medicare Part A case been referred to OI during the 27 month period?

I know from previous discussions with you and the HCFA/OPI Regional Director that there are potentially many answers to these questions including: low population and low Medicare/Medicaid utilization in Region VIII area; lack of referrals from carriers; change in HCFA internal structure; etc. I believe all of us realize that Region VIII does not have the same fraud problems that some of the other larger populated regions have, but I don't believe any of us think that we have eliminated fraud in the Medicare/Medicaid programs in this region.

After you have had an opportunity to digest this material, I would like to discuss with you and your staff your thoughts on how we could mutually motivate carriers and others to refer potential fraud cases for investigation.

Copies to: Nathan D. Dick, AIG-I, OIG
Leon Rollin, Regional Director, HCFA/OPI, Region VIII

DEPARTMENT OF HEALTH & HUMAN SERVICES

ENCLOSURE III

Memorandum

Date • November 7, 1980

From Special Agent in Charge
Kansas City Field Office

Subject Memo from Don Nicholson to Program Integrity Directors dated October 17, 1980
Re: Development of Cases Suitable for Civil Fraud/ Administrative Sanction

To

To Nathan D. Dick
Assistant Inspector General
for Investigations

Attached is a copy of the above-referenced memo. It appears that if this action is implemented, that the Regional Program Integrity Directors will use their own discretion whether to report a criminal violation to OI, or, if in their opinion, it is in HCFA's best interest that the matter be handled civilly or administratively.

Ian E. MacAulay

Thomas J. Tantillo

By: Thomas J. Tantillo
Acting Special Agent in Charge

Attachment

OFFICE OF INVESTIGATIONS, HCFA
RECEIVED
NOV 13 1980
Cesario

For info and guidance in draft of OI/HCFA MOU with DAIG.

MEMORANDUM

DEPARTMENT OF HEALTH, AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OCT 17 1980

TO Program Integrity Directors

RECEIVED
OCT 0 1980
OPI KC

DATE:

REFER TO: FNV21

FROM : Director
Office of Program Validation

SUBJECT: Development of Cases Suitable for Civil Fraud/Administrative Sanction Action—ACTION

As I indicated to you during the October 2 conference call, we are recommending that the regional offices expand their involvement in the identification and development of cases suitable for civil fraud/administrative sanction action. The purpose of this memorandum is to further outline the scope of our recommendations.

In PIRL 80-1 ("Reviewing Potential Fraud and Abuse Cases for Exclusion/Termination Action"), we indicated that regional offices should become more aggressive in identifying and developing cases for administrative sanction action. As we indicated in this regional letter, the administrative sanction authorities provide HCFA flexibility in dealing with situations involving abusive or potentially fraudulent institutional and noninstitutional providers.

We are now expanding this policy by recommending that when the regional office (RO) has identified the nature of the impropriety, it must make a determination as to the appropriate course of action to pursue in dealing with the provider; i.e., the course of action which best serves HCFA's interest in preserving the integrity of the programs and ensuring that inappropriate program payments are stopped.

In the case of medically unnecessary services or services which fail to meet professionally recognized standards of care, the case should be referred to a Professional Standards Review Organization for an 1157 determination and possible 1160 referral. In the case of billings for services not rendered, false cost report entries, or other misrepresentations or false statements in requests for payment, the RO must evaluate the nature and severity of the improprieties to determine whether the case should be referred immediately to the Office of Investigations (OI) without indepth development by RO staff or whether HCFA's interest would be best served by the RO developing the case for civil fraud/administrative sanction action prior to referral for OI development.

In making its determination to refer/develop the case, the RO should carefully weigh the nature of the improprieties, the potential for future improper payments if civil/sanction action is not pursued, and the most appropriate corrective action to deal with the provider. This will obviously require that RO personnel become involved in case development to a greater extent than they are currently. It will require that the RO develop the case sufficiently so that (1) any administrative sanction action taken by HCFA will stand up before an Administrative Law Judge

(ALJ) hearing, and/or (2) any civil suit pursued by the U.S. Attorney will prevail. This may entail beneficiary contacts, on-site reviews of records, on-site audits, etc. Case development of this intensity will require that the RO carefully select those providers it will review indepth, in order to most efficiently use the resources available. However, the potential benefits to be realized from developing these cases and taking sanction action or successfully prosecuting the case in a civil suit will enhance our ability to deal with institutional/noninstitutional providers engaged in improper practices and will demonstrate that we are making full use of the "tools" provided to the Secretary to protect the Medicare and Medicaid programs.

Our efforts in this area will require establishing and maintaining a relationship with U.S. Attorneys responsible for civil fraud in order to establish guidelines for when a case should be referred for civil action, the types of evidence required to successfully prosecute the case, and other factors relevant to a successful civil suit. We have contacted the Department of Justice on this matter and they have agreed to provide someone to discuss this topic at our next conference.

We have attached a draft manual instruction to implement these recommendations. We will be sending a copy of this memorandum and attachment to each Regional Administrator with a cover note containing suggested language to be incorporated into your 1981 workplans. Please review the material and feel free to submit written comments. If there are questions which you want to discuss, please contact either Jim Patton (FTS 934-8000) or myself (FTS 934-8470).

Don Nicholson

Attachment

Identification and Development of Cases Suitable for Civil Fraud or Administrative Sanction Action

General.—Once the regional office has identified the nature of the alleged impropriety, either as a result of the contractor's or the RO's conduct of a preliminary review of the provider, the RO must determine the most appropriate course of action to deal with the provider; i.e., the course of action which best serves HCFA's interest in preserving the integrity of the programs and ensuring that inappropriate program payments are not made.

In the case of medically unnecessary services or services which fail to meet professionally recognized standards of care, the case should be referred to a PSRO for a determination (pursuant to section 1157 of the Act) of whether a violation of the obligations imposed under section 1160 of the Act has been committed.

In the case of billings for services not rendered, false cost report entries, or other misrepresentations or false statements in requests for payments, the RO must determine whether the nature and severity of the improprieties warrant an immediate referral of the case to OI for investigation for criminal fraud. The factors which the RO should consider in determining whether to refer the case immediately to OI are as follows:

1) Are the nature and severity of the improprieties so egregious so as to permit OI's expeditious handling of the case.

2) Is the impropriety one which should be immediately referred to OI: kickbacks, rebates, and bribes; certification fraud; Medigap fraud (after referral to BPO)?

3) What are the potential adverse consequences to the programs and its beneficiaries if administrative sanction and/or civil fraud action is delayed? What is the likelihood that inappropriate program payments will continue to be made to the provider if administrative sanction action is not taken? What is the amount of the potential program overpayment which has been made to the provider (including administrative costs and other damages resulting from the provider's improprieties) and which may be recoverable in a civil suit against the provider?

Where the RO determines, based on its evaluation of these factors, that it is in HCFA's best interest to pursue civil fraud/administrative sanction action against the provider (i.e., civil fraud/administrative sanction action is the most appropriate and most expedient method of dealing with the provider and ensuring that inappropriate program payments do not continue to be made to the provider), then the RO should proceed with development of the case for civil fraud/administrative sanction action.

Because of the level of proof required to uphold an administrative sanction in an ALJ hearing and to prevail in a civil action, it will be necessary to fully develop each case you intend to pursue civilly or administratively. This may necessitate beneficiary contacts, on-site reviews of records, on-site audits, and other time-consuming case development activities. Case development of this intensity will require that the RO carefully select those providers it will review indepth, in order to most effectively use the available manpower resources. We would anticipate, for example, that no more than 15 such cases would be pending in the RO at any one time.

Notification to OI.—Once the case has been sufficiently developed to warrant (1) a recommendation to central office to sanction the provider, and/or (2) a referral to the U.S. Attorney for civil fraud action, the RO should prepare a written notification to OI stating that the case has been referred for administrative sanction and/or civil fraud action. This notification should also indicate the nature of the improprieties and findings to date, as well as the adverse consequences to the programs if civil fraud/administrative sanction action is not taken (e.g., improper payments). The notification should be sent to OI at the same time that the recommendation to sanction is sent to central office, and/or the referral to the U.S. Attorney is made.

If OI contacts the RO and states its belief that the case should be pursued criminally, the RO should inform OI that unless a written statement from the U.S. Attorney is received by the RO which directs the RO not to pursue civil fraud/administrative sanction action because the U.S. Attorney intends to pursue the matter criminally, HCFA will continue its efforts to sanction the provider and/or to pursue civil action against the provider.

UNITED STATES GOVERNMENT

MEMORANDUM

ENCLOSURE IV

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE INSPECTOR GENERAL
M/S 618 REGION X, SEATTLE

TO : Mr. N. D. Dick, Assistant Inspector General for Investigations

DATE: 10-7-80

REFER TO:

FROM : Special Agent in Charge
Seattle Field Office

SUBJECT: Decreasing OPI Activity in Fraud and Abuse

Enclosed is a copy of a letter from the Region X OPI Director to the Medicare Carrier in the State of Washington. The letter advises the carrier that OPI will no longer participate in the development of fraud cases and that the carriers will be responsible for resolving integrity issues and fully developing potential criminal cases. These criminal cases are to be referred to OPI for "coordinating any full scale criminal investigation."

I think that this supports our position in recommending that OI obtain slots from OPI and that these slots be staffed by Special Agents whose efforts would be directed toward case development (enclosed is the proposal we prepared for the SAC-AC relative to obtaining slots from OPI).

The State of Washington has a carrier system which is rather unique in that there are actually 17 different carriers affiliated through a common contractor. I have been meeting with these individual carriers to introduce them to OI. I have been advising them that although they have certain reporting requirements (i.e. to the common contractor and then on to OPI) that if they wish or have a need that they can call OI direct for assistance. In light of OPI's instructions, I will emphasize this point more strongly. I think that closer contacts with the claims processing personnel will increase the number of quality referrals.

Earl M. Campbell

Enclosures

OFFICE OF INVESTIGATIONS, H.H.
RECEIVED
OCT 10 1980

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION X
M/S 715 ARCADE PLAZA BUILDING
1321 SECOND AVENUE
SEATTLE, WASHINGTON 98101

HEALTH CARE
FINANCING ADMINISTRATION

Refer to: HCFA-ROX
P:CC

Les Wall
Government Programs Director
Washington Physicians Service
4th & Battery Building, 6th Floor
Seattle, Washington 98121

Dear Mr. Wall:

As you know, during the past eighteen months the Office of Program Integrity has begun numerous initiatives aimed at curbing abuse and waste in the Medicare program. In particular, we have launched a program validation effort directed both at reviewing provider performance at the point services are delivered and identifying HCFA policies, specifically in reimbursement, that may be contributing to inappropriate expenditures. Also, much greater emphasis is now being given to Medicare and Medicaid administrative sanctions activities, i.e., implementation of regulations pertaining to Sections 1157, 1862(d), and 1862(e) of the Social Security Act.

As a consequence, our personnel resources which were formerly devoted to integrity reviews and preliminary full-scale investigations nationally will now be used to augment these new initiatives. Therefore, in the near future, the carrier's role in developing Medicare integrity review cases will be expanded. The Medicare Carriers Manual (Chapter XI) is currently being revised to provide adequate instructions for the contractors. These revisions will be forwarded to you under separate cover.

Up until now, carriers have had primary responsibility for accomplishing the major portion of integrity review development, whether fraud or abuse. Such development was generally carried out under step-by-step OPI/RO direction, with some carriers being given more latitude than others in appropriate situations. The participation of carriers in the development of suspected fraud cases, in particular, has been limited to furnishing information about claims and payments. Under the expanded role, carriers will be responsible for effectively resolving most integrity review cases, and fully developing those remaining, for referral to us for coordinating any full-scale criminal investigation.

We anticipate that the transfer of the integrity review function to carriers will take place beginning December 1, 1980. We have discussed this matter with the Medicare Regional Office, and together we do not feel that the function will require additional funding. If need for additional resources becomes apparent over time, we will be willing to consider the need for a supplemental budget request.

My staff is currently in the process of developing a training program in early November to instruct your staff on the proper procedures for the handling of integrity reviews covered by the new manual chapters. Also included in this training are several other important subject areas. We feel the training session will be most beneficial to those staff members directly responsible for carrying out the functions described in the training agenda. A copy of the training program currently being formulated is attached. If you have additional topics which you would like addressed please inform Mr. Len Hagen of my staff who will be contacting you to arrange for the up-coming training session and to answer any questions you might initially have on the transfer of the integrity review functions. Mr. Hagen may be reached on (206) 442-0547.

Sincerely,

John W. Daise
Director
Office of Program Integrity

Enclosure

ENCLOSURE V

MEMORANDUM

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

TO : Assistant Inspector General
for Investigations

DATE: August 15, 1980

REFER TO:

FROM : Special Agent-in-Charge, OI
New York Field Office

SUBJECT: HCFA/OIG MOU

As you are aware, the Special Agents-in-Charge Advisory Committee (SACAC), in its role of providing you with input from the field on different matters, has addressed the issue of Memorandums of Understanding (MOU) with various components of HEALTH AND HUMAN SERVICES. Within that context, SACs have been polled, and unanimously agree that the need for MOUs no longer exists. The sentiment among all is that the OI/OIG knows its mandate well under the Act creating it statutorially, presumes that other departments of HEALTH AND HUMAN SERVICES are aware of their statutory and regulatory responsibilities, and are prepared to discharge them.

With the above in mind, a copy of the HCFA memorandum, dated 7/14/80, from the Acting Director, BUREAU OF QUALITY CONTROL, to the Office of the Inspector General, Subject: "Revised Operating Statement Between the Office of Investigations/Office of the Inspector General and the HEALTH CARE FINANCING ADMINISTRATION", was received with the attached revised MOU or "operating statement". A review of that document points out that the HEALTH CARE FINANCING ADMINISTRATION, as with other operating components of HHS, desires to "do business as usual" which, according to Senator EAGLETON from Missouri, is precisely what Congress did not want when they created the Inspector General. There follows an examination, point by point, of the revisions advocated by HCFA and the feelings of this SAC as to the disadvantages to OI if those amended provisions are put into effect.

In their chart, prepared for a comparison of the HCFA version, OIG version, and revisions made to the OIG version, beginning with the first page reflecting on II.A1, the matter refers to non-institutional fraud cases and HCFA's insistence upon a formula to determine whether or not a case merits referral. Their formula precludes the possibility that a case of fraud may exist if less than four out of ten violations occur or are reported. As anyone in criminal investigations knows one such instance could qualify the case as a strong fraud case if there are aggravating circumstances that would cause the United States Attorney to feel that the case has prosecutive appeal.

In addition to the above, with reference to this particular subject matter, it has been proposed by the SACAC that HCFA/OPI no longer be the conduit

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between the carrier or intermediary and OI. Those referrals should be made directly to OI, and OI make the determination as to whether or not fraud exists, and if not to refer it back then to OPI/HCFA for administrative or civil action. In that way OI becomes the sole judge as to the merits of the case with reference to investigation of fraud or prosecutive potential by being able to discuss it with United States Attorneys. In New York, for the past several months, HCFA/OPI has only acted as the conduit for all cases referred by BLUE CROSS/BLUE SHIELD. Aggravating that particular situation is the instance when OI has an existing case which has been referred by BLUE CROSS and subsequent information is developed by BLUE CROSS. They insist upon routing that new information through OPI/HCFA well aware that HCFA is not conducting any investigation. BLUE CROSS/BLUE SHIELD OF GREATER NEW YORK, the major carrier in Region II, insists that it does this upon HCFA's specific instructions.

Under II.A.1 it appears as though HCFA misunderstood the intent of the CIG version. They delete the first paragraph, which to us is extremely important. They take issue with number five and seven because they maintain that under five the wording is unclear and would seem to indicate that HCFA would be performing a full scale investigation type activity. That was not the intent at all of the fifth statement in that paragraph. It meant that in the event HCFA did perform investigations that they would document discrepancies found. The paragraph does not suggest that HCFA is to conduct an investigation. Under seven they maintain that they will not comply with that because "its a great deal of effort". This particular point was made at the urging of a United States Attorney. In the event of prosecution, the United States Attorney wants to know if HCFA or any other administrative review overlooked prior unallowable costs without bringing them to the attention of the provider.

Under V.E HCFA restructures the paragraph and completely eliminates the preferred meaning stating that they are making the referral process for institutional and non-institutional cases consistent. This does not assist us one iota as they are two completely different types of investigation, and in the instance of the institutional case, unless the preliminary review determines that the kickback/rebate was reported and offset against reimbursable costs, there is no federal violation.

Under V.A there is apparently a typographical error where HCFA version reads "Responsibility for investigation and referral to U.S. Attorney's a beneficiary/recipient fraud cases will rest with OI". I'm sure they meant HCFA/OPI.

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Under V.B HCFA maintains that there is no difference in their version from OIG, yet there is a significant phrase added to the OIG version which is, "After clearly ascertaining the nature and details of the allegation". This gives HCFA license to hold up referral of the case and to interfere in the investigation in the preliminary stages, to no purpose.

Under V.C HCFA is retaining the right to go to the Postal authorities in Medicare check forgery cases, maintaining that regulations vest HCFA with check forgery responsibility and that HCFA has established procedures to handle forgery cases. Even though HCFA maintains that under 42 CFR they are vested with the authority of check forgery responsibility there is no way that the Code of Federal Regulations may abrogate statutory law as included under 42 USC.

HCFA also maintains that under V.C "OI will continue to provide HCFA with handwriting analysis support through the FBI Document Lab on all cases of forgery which do not involve postal violations or cases declined by Postal Service due to manpower limitations". This suggests that HCFA has jurisdiction over forgery cases, which is simply not accurate.

Under VIII.D HCFA added the paragraph "The 45 day rule mentioned in Section IIA.1 above will be closely adhered to by HCFA if no written OI objection is received in HCFA within this time and there has been no notice that objection is in transit, appropriate administrative action will be done by HCFA on the 46th day after referral to OI". This places the onus upon OI to report to HCFA, when with every other agency in HHS the ASI as a notification of a full field investigation is the deterrent to administrative action, and is the document on which OI should rest.

Under II.A.2 HCFA is ignoring their responsibilities as the administrating agency of Medicare. OI is not an operating entity, a program agency, and should have no civil responsibilities under the act. The last paragraph "Should OI require HCFA assistance in performing its civil fraud responsibilities, specific requests should be made pursuant to Section VIIIA. Assistance may then be provided either independent of or in conjunction with OI so long as other HCFA workload responsibilities allow such involvement". The whole paragraph is an insult to the OI statute which requires cooperation by every Federal agency including HCFA. For OPI/HCFA to suggest that OI has civil fraud responsibilities is to interpret the statute differently from Congress.

Under II.A.1 is stated, under the HCFA version, "In the course of the settlement of the criminal case, HCFA Regional Office will be actively involved in any

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pre-sentencing negotiations which would have a bearing on HCFA's ability to take.....". And continuing under III.E "HCFA will be actively involved in the negotiation of any restitution of funds agreement reached in plea bargaining or the probationary determination process". Both paragraphs suggest a complete naivete in the Federal prosecutive process. Any United States Attorney would take issue with HCFA dictating a role in the prosecutive process. In any event we could not bind the U.S. Attorney to this agreement.

Under II.B the HCFA version deletes an important paragraph from the OIG version, and yet under their revisions made to OIG version they state "Basically no change" when in fact there is a substantial change by deleting the second paragraph.

Under III.B. I am adamantly opposed to the dissemination of any Report of Investigation to an operating component who is going to use that Report of Investigation for an administrative purpose. I see no need for it. The action of HCFA administratively may be based only upon the result of the final adjudication of the matter in a court of law and not upon any unadjudicated raw data that may be contained in an OI investigative report. I disagree with the requirement that OI will provide a copy of the judgment at the time an action takes place - either the judgment of acquittal or the judgment of conviction. It's simply not pertinent to the issue. The mere fact that we report the judgment is adequate without going to the trouble and possible expense of getting copies of judgments and providing them to OPI/HCFA.

Under VIII.A again HCFA is placing conditions upon its cooperation, and under the law no such condition is allowable. We may, through courtesy, understand when they are not able to provide a particular service but for them to determine the reasonableness of the request is beyond reason itself.

Under III.A the HCFA version is unnecessary. Contractors, fiscal agents, Social Security offices need only be advised one time of OI's jurisdiction and that may be done by the Inspector General rather than by HCFA. The only thing that is needed from HCFA is their assurance that as the administrator of the program they will insist upon cooperation of the contractors and fiscal agents with OI.

Under III.C and D second paragraph of HCFA version the parenthesis is not necessary.

Under IV HCFA adds, "Quarterly exchange of case listings between the OI/RO's and HCFA/RO's will be made in order to prevent duplication of investigations".

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This should be reworded since OI now reports to HCFA on each case it opens, as it is opened. We should include a statement to the effect that HCFA/RO's will keep OI/RO's advised of any cases that may cause duplication of effort. The quarterly exchange would be unnecessary, redundant, and cause considerably more work for OI.

Under III.G HCFA adds another section "Access to Records". The first sentence of their paragraph "If access to records is denied during any initial review, OI should be immediately contacted to discuss the possibility of their exercising subpoena power". This would be an improper use of the IG subpoena since the return would be made to an officer of the Inspector General and custody relinquished subsequently to OPI. This could cause serious problems because of the lack of security in most OPI offices. In addition, OPI/HCFA has access to Secretarial subpoena power, which would be more proper in these instances. In addition, they have sanction authority in such an eventuality of limiting, suspending or terminating any contractor who does not comply with the regulations under 42 CFR.

The suggested rewording of Section VIII.A by HCFA places them in a controlling role over OI which is anathema to independence.

J. Richard Brock

Attachment

APPENDIX M

Memorandum

Date December 19, 1980

From Regional Administrator
HCFA, Atlanta

Subject Lack of Criminal Fraud Convictions in the Miami, Florida, Area

To Administrator, HCFA

BQC;Action
CC; Ebeler/Newman
Altman/Collier
FORD: HARRIS
Glennie; OFO

Admin Sig
Due 1/14

In 1976, responsibility for the investigation of criminal fraud cases involving the Medicare program was passed from our Office of Program Integrity to the Inspector General's Office of Investigations. Since OI needed time to acquire staff, etc., only a few cases were actually transferred to OI from OPI until early 1978. Since 1976, with the exception of cases handled to completion by OPI, there have been no criminal convictions involving Medicare in the South Florida (Miami) area.

Given the large Medicare population and the concentration of Medicare providers in that area, opportunities are certainly available for fraudulent activity. Our past experience with the area (some 21 criminal convictions obtained by OPI in the 1976-78 period) and the continuation of the same kinds of potentially criminal activity reflected in the cases OPI now refers to the Office of Investigations lead us to believe that a major problem continues to exist in terms of Medicare fraud in that area.

This lack of criminal convictions has had further effects. Due to the large number of initial complaints of potential fraud and abuse we received from Medicare beneficiaries through Social Security offices in South Florida, the Social Security Administration years ago set up a special unit in the Miami Beach District Office to which all Social Security offices in the area referred initial complaints. This special unit, staffed with as many as six Field Representatives, screened these complaints and referred on to OPI only those which had good potential as fraud cases. The volume of complaints has now fallen to the point that the unit was disbanded several months ago. We believe this drop in the number of complaints is directly attributable to the lack of criminal convictions and the attendant publicity such convictions received in the media.

We have also detected in Medicare carriers and intermediaries serving this area a change in attitude toward reporting matters of potential fraud to us as such. They seem to feel that there is almost no chance of any action criminally and that to report such cases to us can only result in several years of no action at all followed by the return of the case to them for resolution. The facts seem to lend credence to their feelings. We, of course, continue to work with them to see that cases are reported properly.

I met with the OI Special Agent in Charge and OPI representatives in late summer to present this problem and to offer whatever assistance we could to resolve it. OI seems to feel that the problem is caused by other business (drug cases, immigration, etc.) tying up the U.S. Attorney's Office and that the Medicare law and regulations are too "loose" and do not contain specific penalties for specific fraudulent acts. U.S. Attorneys have, of course, always had many more cases to prosecute than they can ever handle, and Medicare cases have always had to compete with cases involving a variety of other offenses. With regard to this and the "looseness" argument, I believe OPI's record speaks for itself.

At the meeting, I proposed a training program or orientation for OI staff to acquaint them more adequately with Medicare and Medicaid. The SAC saw real value in the proposal, and we are now in the process of finalizing the agenda. I hope that this training can serve as a pilot project for other regions experiencing similar problems. Other than this training, no concrete action plan to resolve the problem came out of our meeting.

This leads to the main purpose of this memorandum, which is to suggest that we in HCFA offer whatever support we can to recent recommendations by congressional committees and congressional staff that some kind of "strike force" effort be mounted to deal with Medicare fraud in certain areas of the country such as South Florida. This "strike force" would reportedly be made up of Justice Department prosecutors and investigators from the FBI or other similar investigative agency who would be free of other caseload constraints and would be able to direct concentrated intensive efforts toward securing criminal indictments and convictions in Medicare cases. I believe that such a force could have significant impact in a relatively short period of time. I believe that any success could only have positive effects in protecting the program from those who would defraud it, in revitalizing our fraud detection system and in recreating the deterrent effect on others that only criminal convictions can have.

Virginia M. Smyth

(Mrs.) Virginia M. Smyth

APPENDIX N

United States Senate

SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

November 19, 1981

Joseph E. Ross, Chief
Congressional Research Service
American Law Division
Library of Congress
Washington, D.C. 20540

Dear Mr. Ross:

The Senate Special Committee on Aging, which I chair, and the Senate Finance Committee, chaired by Senator Bob Dole, have scheduled oversight hearings on the Office of the Inspector General of the Department of Health and Human Services for December 9, 1981. In preparing for this activity, we have encountered considerable confusion with regard to the legislation establishing the office and its intended operation.

In general, these questions center around issues of authority and independence. Specifically, we could use your assistance in determining the following:

1) In terms of the Inspector General's operation within the Department of Health and Human Services, how much autonomy was intended with regard to budgeting, reporting, hiring, and firing?

2) Was it intended that all existent resources dedicated to the control of the fraud, abuse and program mismanagement at the time the office was created be consolidated under the IG? If not, what guidance, if any was provided by Congress?

3) What documentation must HHS have developed in order to effect the transfer? Please consider all applicable statutes and regulations.

4) How broadly was the role of HHS IG conceived? Was it to encompass all activities relating to fraud, abuse and waste? Was it conceived to be more limited in authority? Specifically, was it conceived to be essentially an "audit" function? Or, were there broader concerns relating to the identification of fraud, abuse and waste; recommendations for program change; and case investigations to support civil and criminal prosecutions.

5) What was Congress' intent with respect to law enforcement powers for the IG? Is there a discrepancy in the treatment of the HHS IG and other statutory IGs in this regard?

6) What remedies are available under existing statutes to deal with the problems identified by the IG in the performance of his duties? Please include civil, criminal, and administrative sanctions to the extent possible.

(Please include relevant proposals in the pending criminal code revision legislation in your review.)

7) What is the legal relationship of the IG, the FBI and the Attorney General?

8) With regard to questions of jurisdiction and general authority, please examine the policies contained in the items listed below for their consistency with Congress' intent in creating the IG, DHHS:

A. Office of Management and Budget
   1. Circular A-19 (September 20, 1979)
   2. Circular A-73 (December 3, 1979)

B. Executive Office of U.S. Attorney's manual revision (supplied to Maureen Murphy of your staff -- 11/18/81)

C. FBI transmittal, 7/24/81 from Director Webster to SAC (copy supplied to Maureen Murphy -- 11/18/81)

D. Office of Program Validation/HCFA

   1. Memo, dated September 10, 1981, from Don Nicholson to David Snipe (copy supplied to Maureen Murphy -- 11/18/81)

   2. Memo, dated September 16, 1981, including transmittal from Don Nicholson (copy supplied to Maureen Murphy -- 11/18/81)

9) Please compare the HHS IG with other statutory IGs for any substantive discrepancy in authority or independence of operation.

We appreciate your assistance in this matter. If you have any questions on this matter, please contact Bill Halamandaris or David Holton of my Aging Committee staff at 224-5364.

Sincerely,

JOHN HEINZ
Chairman

JH/bht

LEGISLATIVE COORDINATION AND CLEARANCE

Circular No. A-19
Revised

EXECUTIVE OFFICE OF THE PRESIDENT

OFFICE OF MANAGEMENT AND BUDGET

SEPTEMBER 1979

Circular No. A-19
Revised

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

CIRCULAR NO. A-19
Revised

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Legislative coordination and clearance

1. Purpose. This Circular outlines procedures for the coordination and clearance by the Office of Management and Budget (OMB) of agency recommendations on proposed, pending, and enrolled legislation. It also includes instructions on the timing and preparation of agency legislative programs.

2. Rescission. This revision supersedes and rescinds Circular No. A-19, Revised, dated July 31, 1972.

3. Background. OMB performs legislative coordination and clearance functions to (a) assist the President in developing a position on legislation, (b) make known the Administration's position on legislation for the guidance of the agencies and information of Congress, (c) assure appropriate consideration of the views of all affected agencies, and (d) assist the President with respect to action on enrolled bills.

4. Coverage. All executive branch agencies (as defined in section 5b) are subject to the provisions of this Circular, except those agencies that are specifically required by law to transmit their legislative proposals, reports, or testimony to the Congress without prior clearance. OMB will, however, honor requests from such agencies for advice on the relationship of particular legislation, reports, or testimony to the program of the President. The municipal government of the District of Columbia is covered to the extent that legislation involves the relationship between it and the Federal Government. Agencies of the legislative and judicial branches are not covered by this Circular.

5. Definitions. For the purpose of this Circular, the following definitions apply:

a. Advice. Information transmitted to an agency by OMB stating the relationship of particular legislation and reports thereon to the program of the President or stating the views of OMB as a staff agency for the President with respect to such legislation and reports.

b. Agency. Any executive department or independent commission, board, bureau, office, agency, Government-owned or controlled corporation, or other establishment of the Government, including any regulatory commission or board and also the municipal government of the District of Columbia.

c. Proposed legislation.* A draft bill or any supporting document (e.g., Speaker letter, section-by-section analysis, statement of purpose and justification, etc.) that an agency wishes to present to Congress for its consideration. Also, any proposal for or endorsement of Federal legislation included in an agency's annual or special report or in other written form which an agency proposes to transmit to Congress, or to any Member or committee, officer or employee of Congress, or staff of any committee or Member, or to make available to any study group, commission, or the public.

d. Pending bill. Any bill or resolution that has been introduced in Congress or any amendment to a bill or resolution while in committee or when proposed for House or Senate floor consideration during debate. Also, any proposal placed before the conferees on a bill that has passed both Houses.

e. Report (including testimony).* Any written expression of official views prepared by an agency on a pending bill for (1) transmittal to any committee, Member, officer or employee of Congress, or staff of any committee or Member, or (2) presentation as testimony before a congressional committee. Also, any comment or recommendation on pending legislation included in an agency's annual or special report that an agency proposes to transmit to Congress, or any Member or committee, or to make available to any study group, commission, or the public.

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* The terms "proposed legislation" and "report" do not include materials submitted in justification of appropriation requests or proposals for reorganization plans.

f. Enrolled bill. A bill or resolution passed by both Houses of Congress and presented to the President for action.

g. Views letter. An agency's written comments provided at the request of OMB on a pending bill or on another agency's proposed legislation, report, or testimony.

6. Agency legislative programs.

a. Submission to OMB. Each agency shall prepare and submit to OMB annually its proposed legislative program for the next session of Congress. If an agency has no legislative program, it should submit a statement to this effect.

b. Purposes of legislative program submission. The essential purposes for requiring agencies to submit annual legislative programs are: (1) to assist agency planning for legislative objectives; (2) to help agencies coordinate their legislative program with the preparation of their annual budget submissions to OMB; (3) to give agencies an opportunity to recommend specific proposals for Presidential endorsement; and (4) to aid OMB and other staff of the Executive Office of the President in developing the President's legislative program, budget, and annual and special messages.

c. Timing of submission to OMB. (1) Each agency shall submit its proposed legislative program to OMB at the same time as it initially submits its annual budget request as required by OMB Circular No. A-11. Timely submission is essential if the programs are to serve the purposes set forth in section 6b.

(2) Items that are not included in an agency's legislative program and have significant upward budget impact will not be considered after the budget is prepared unless they result from circumstances not foreseeable at the time of final budget decisions.

d. Number of copies. Each agency shall furnish 25 copies of its proposed legislative program to OMB. These copies will be distributed by OMB within the Executive Office of the President.

e. Program content. Each agency shall prepare its legislative program in accordance with the instructions in Attachment A. Agency submissions shall include:

(1) All items of legislation that an agency contemplates proposing to Congress (or actively supporting, if already pending legislation) during the coming session, including proposals to extend expiring laws or repeal provisions of existing laws. These items should be based on policy-level decisions within the agency and should take into account the President's known legislative, budgetary, and other relevant policies. Agencies' proposed legislative programs should identify those items of sufficient importance to be included in the President's legislative program.

(2) A separate list of legislative proposals under active consideration in the agency that are not yet ready for inclusion in its proposed legislative program. For each item in this list, the agency should indicate when it expects to reach a policy-level decision and, specifically, whether it expects to propose the item in time for its consideration for inclusion in the annual budget under preparation.

(3) A separate list of all laws or provisions of law affecting an agency that will expire between the date the program is submitted to OMB and the end of the two following calendar years, whether or not the agency plans to propose their extension.

(4) All items in the submissions that are proposed, or expected to be proposed, for inclusion in the annual budget shall be accompanied by a tabulation showing amounts of budget authority and outlays or other measure of budgetary impact for the budget year and for each of the four succeeding fiscal years. See section 201(a)(5),(6), and (12) of the Budget and Accounting Act, 1921, as amended (31 U.S.C. 11(a)(12)). Criteria in OMB Circular No. A-11 shall be used in preparing these tabulations.

(5) All items covered by section 6e(4) above shall also be accompanied by estimates of work-years of employment and of personnel required to carry out the proposal in the budget year and four succeeding fiscal years.

f. Relationship to advice. Submission of a legislative program to OMB does not constitute a request for advice on individual legislative proposals. Such requests should be made in the manner prescribed in section 7 of this Circular.

7. Submission of agency proposed legislation and reports.

a. Submission to OMB. Before an agency transmits proposed legislation or a report (including testimony) outside the executive branch, it shall submit the proposed legislation or report or testimony to OMB for coordination and clearance.

b. Agency scheduling of submissions. Agencies should not commit themselves to testify on pending bills or to submit reports or proposed legislation to Congress on a time schedule that does not allow orderly coordination and clearance. To facilitate congressional action on Administration proposals and to forestall hasty, last-minute clearance requests, agencies should plan their submissions to OMB on a time schedule that will permit orderly coordination and clearance. Particular care should be given to ensuring that draft legislation to carry out Presidential legislative recommendations is submitted promptly to OMB to allow sufficient time for analysis and review.

c. Timing of agency submissions.

(1) Agencies should submit proposed legislation, reports, and testimony to OMB well in advance of the desired date of transmission to Congress.

(2) Agencies should include in their submissions to OMB of proposed reports and testimony a copy of any committee request for such reports and testimony, if the request calls for special information or includes specific questions to be covered in the reports or testimony.

(3) Depending on the complexity and significance of the subject matter, the policy issues involved, and the number of agencies affected, an adequate period for clearance by OMB may range from several days to a number of months. Agencies shall consult with OMB staff as to necessary periods for clearance, particularly in cases of major or complex legislation.

(4) On occasion, very short periods for clearances may be unavoidable because of congressional time schedules or other factors. Nevertheless, agencies should make every effort to give OMB a minimum of five full working days for clearance of proposed reports or testimony.

(5) Agencies shall state in their transmittal letters to OMB any information on congressional schedules or other special circumstances that may require expedited clearance.

d. Number of copies. Agencies should furnish to OMB 10 copies of proposed legislation and supporting materials and six copies of draft reports or testimony. If wide circulation or expedited action is required, the originating agency shall consult informally in advance with OMB staff on the number of copies to be supplied. Similarly, agencies should furnish to OMB six copies of their views letters on other agencies' proposed legislation, reports, or testimony.

e. Submission of legislation authorizing the enactment of new budget authority.

Section 607 of P.L. 93-344, the Congressional Budget Act of 1974, requires year-ahead requests for authorizing the enactment of new budget authority, as follows:

> "Notwithstanding any other provision of law, any request for the enactment of legislation authorizing the enactment of new budget authority to continue a program or activity for a fiscal year (beginning with the fiscal year commencing October 1, 1976) shall be submitted to the Congress not later than May 15 of the year preceding the year in which such fiscal year begins. In the case of a request for the enactment of legislation authorizing the enactment of new budget authority for a new program or activity which is to continue for more than one fiscal year, such request shall be submitted for at least the first 2 fiscal years."

Attachment B sets forth instructions, necessitated by section 607 of P.L. 93-344, for the preparation and submission to Congress of legislative proposals authorizing additional appropriations or providing new budget authority outside of appropriation acts.

f. Items to be included in agency submissions.

(1) Agencies should identify proposed legislation submitted to OMB by using the number assigned to the proposal in the agency's legislative program submission; e.g., Agriculture, 96-12 (see Attachment A). Each legislative proposal shall include a draft transmittal letter to the Speaker of the House and the President of the Senate as well as background information and justification, including where applicable:

(a) a section-by-section analysis of the provisions of the proposed legislation;

(b) comparison with existing law presented in "Ramseyer" or "Cordon" rule form by underscoring proposed additions to existing law and bracketing the text of proposed deletions (This need be done only when it would facilitate understanding of the proposed legislation.);

(c) budgetary and personnel impacts as described in sections 6e(4) and (5), including a statement of the relationship of these estimates to those previously incorporated in the President's budgetary program. (Public Law 89-554, 5 U.S.C. 2953, requires in certain cases that agencies, in proposing legislation and in submitting reports favoring legislation, provide estimates of expenditures and personnel that would be needed. Public Law 91-510, sections 252(a) (2 U.S.C. 190j) and 252(b) imposes similar requirements on congressional committees.);

(d) comparison with previous agency proposals or related bills introduced in the Congress;

(e) an identification of other agencies that have an interest in the proposal;

(f) an indication of any consultation with other agencies in the development of the proposal; and

(g) information required by statute or by Administration policies, as, for example, that noted in section 7h below.

(2) Similarly, in their letters to OMB requesting advice on reports or testimony, agencies should identify

related bills and set forth any relevant comments not included in the report or testimony itself. As indicated in section 7f(1)(c), certain reports or testimony favoring legislation are required by law to include budget and personnel estimates. Where such estimates are not included in other reports or in testimony favoring or opposing legislation, agencies should provide in their letters to OMB a statement of budgetary and personnel impacts as described in sections 6e(4) and (5), including a statement of the relationship of these estimates to those previously incorporated in the President's budgetary program.

(3) In cases where legislation carries out a Presidential recommendation, agencies should include in the proposed report or the letter transmitting proposed legislation a statement identifying the recommendation and indicating the degree to which the legislation concerned will carry it out.

g. Views letters. In views letters to OMB, an agency should indicate whether it supports, opposes, or has no objection to all or part of a pending bill or of another agency's proposed legislation, report, or testimony and should state the reasons for its position. If an agency proposes changes to a pending bill or to another agency's submission, its views letter should recommend, insofar as practicable, specific substitute language.

h. Certain statutory and other requirements and Administration policies. Agencies shall carefully consider and take into account certain requirements of existing statutes and Executive orders and Administration policies and directives that are of general applicability. Agency reports and proposed legislation shall, to the maximum extent possible, contain or be accompanied by appropriate recommendations, statements, or provisions to give effect to such requirements, including but not limited to:

(1) Civil rights

(2) Environmental impact

(3) Economic impact

(4) Federal budgetary impact and personnel requirements

(5) Federal and non-federal paperwork requirements.

(7) State and local government impact

(8) Urban and community impact

i. Drafting service. Agencies need not submit for clearance bills that they prepare as a drafting service for a congressional committee or a Member of Congress, provided that they state in their transmittal letters that the drafting service does not constitute a commitment with respect to the position of the Administration or the agency. Agencies shall advise OMB of these drafting service requests while the requests are being complied with, and supply a copy of the request, if in writing. A copy of each such draft bill and the accompanying letter should be furnished to OMB at the time of transmittal, together with an explanatory statement of what the bill would accomplish if that is not contained in the transmittal letter.

j. Use of "no comment" reports. Agencies should submit no comment reports only when they have no interest in the pending legislation or nothing to contribute by way of informed comment. Agencies should submit such reports for clearance, unless a different procedure is informally arranged with OMB. In either event, they should furnish OMB with one copy of each such report at the time it is transmitted to Congress.

8. Clearance of agency proposed legislation and reports.

a. OMB action on agency submissions.

(1) OMB will undertake the necessary coordination with other interested agencies of an agency's proposed legislation or report. If congressional committees have not requested reports from all of the interested agencies, OMB will request other agency views within specified time limits. OMB will consult with the President, when appropriate, and undertake such staff work for him as may be necessary in cooperation with other Presidential staff. OMB may request the originating agency to provide additional information or may call interagency meetings to exchange views, resolve differences of opinion, or clarify the facts.

(2) When coordination is completed, OMB will transmit advice to the appropriate agencies, either in writing or

by telephone. In transmitting advice, OMB may indicate considerations that agencies should or may wish to take into account before submitting proposed legislation or reports to Congress.

b. Forms of OMB advice. The exact form of OMB advice will vary to suit the particular case. The basic forms of advice that are commonly used are set forth and explained in Attachment C.

c. Agency action on receipt of advice from OMB.

(1) Agencies shall incorporate the advice received from OMB in their reports and in their letters transmitting proposed legislation to Congress. Advice on testimony is usually not included in the testimony as delivered unless it would be likely to have a significant effect on a committee's consideration of particular legislation or would not otherwise be available to a committee through a written report.

(2) In the case of reports, receipt of advice contrary to views expressed does not require an agency to change its views. In such cases, however, the agency will review its position. If it decides to modify its views, the agency shall consult with OMB to determine what change, if any, in advice previously received is appropriate. If, after the review, the views of the agency are not modified, it shall incorporate in its report the full advice it received.

(3) In the case of proposed legislation, the originating agency shall not submit to Congress any proposal that OMB has advised is in conflict with the program of the President or has asked the agency to reconsider as a result of the coordination process. In such cases, OMB will inform the agency of the reasons for its action.

(4) Agencies are expected to transmit reports and proposed legislation to Congress promptly after receiving OMB clearance. Should circumstances arise that make prompt transmittal inadvisable, the agency shall immediately notify OMB. Similarly, in the case of cleared testimony, the agency shall immediately notify OMB if its testimony has been cancelled or rescheduled.

(5) Agencies should observe the instructions in House and Senate rules to forward proposed legislation or various reports required by law to the Speaker of the House and the President of the Senate. Reports that have been requested by committee chairmen on bills and resolutions pending before their committees should be transmitted directly to the requesting committees.

(6) Agencies shall furnish to OMB two copies of all proposed legislation, transmittal letters and accompanying materials, and reports (including testimony) in the form actually transmitted to the Congress. If reports or testimony cover more than one bill, agencies shall furnish two copies for each bill.

d. Agency action where prior clearance has not been effected.

(1) Agencies shall not submit to Congress proposed legislation that has not been coordinated and cleared within the executive branch in accordance with this Circular.

(2) If congressional time schedules do not allow an agency to send its proposed report to OMB in time for the normal clearance and advice, the agency shall consult informally with OMB as to the advice to be included in the proposed report. OMB may advise the agency to state in its report that time has not permitted securing advice from OMB as to the relationship of the proposed legislation to the program of the President. Agencies shall send to OMB six copies of such reports at the same time that they are transmitted to Congress. Where appropriate, OMB will subsequently furnish advice on the report, which the agency shall transmit promptly to Congress.

(3) In cases where an agency has not submitted a report for clearance and its views on pending legislation are to be expressed in the form of oral, unwritten testimony, OMB will undertake such coordination and give such advice as the circumstances permit. In presenting oral testimony, the agency should indicate what advice, if any, has been received from OMB. If no advice has been obtained, the agency should so indicate.

e. Reclearance requirements. The advice received from OMB generally applies to all sessions of each Congress, but it does not carry over from one Congress to the next. Generally, agencies do not need to seek reclearance of reports on which they have already received advice before making the same reports on identical bills introduced in the same Congress, unless considerable time has elapsed or changed conditions indicate that the need for reclearance is appropriate or should be rechecked. Prior to transmitting such reports, however, agencies shall consult informally with appropriate OMB staff to determine whether reclearance is necessary. In cases where reclearance does not take place, agencies shall include in the subsequent report appropriate reference to the advice received on the original report. They shall also send one copy of any subsequent report to OMB at the same time that it is transmitted to Congress. The transmittal letter to OMB should identify the related report that was previously cleared.

9. Interagency consultation. In carrying out their legislative functions, agencies are encouraged to consult with each other in order that all relevant interests and points of view may be considered and accommodated, where appropriate, in the formulation of their positions. Such consultation is particularly important in cases of overlapping interests, and intensive efforts should be made to reach interagency agreement before proposed legislation or reports are sent to OMB. In order that the President may have the individual views of the responsible heads of the agencies, however, proposed legislation or reports so coordinated shall be sent to OMB by the individual agencies involved, with appropriate reference to the interagency consultation that has taken place.

10. Enrolled bills. Under the Constitution, the President has 10 days (including holidays but excluding Sundays) to act on enrolled bills after they are presented to him. To assure that the President has the maximum possible time for consideration of enrolled bills, agencies shall give them top priority.

a. Initial OMB action. OMB will obtain facsimiles of enrolled bills from the Government Printing Office and immediately forward one facsimile to each interested agency, requesting the agency's views and its recommendation for Presidential action.

b. Agency action. Each agency receiving such a request shall immediately prepare a letter presenting its views and deliver it in duplicate to OMB not later than two days (including holidays but excluding Sundays) after receipt of the facsimile. OMB may set different deadlines as dictated by circumstances. Agencies shall deliver these letters by special messenger to OMB.

c. Preparation of enrolled bill letters.

(1) Agencies' letters on enrolled bills are transmitted to the President and should be written so as to assist the President in reaching a decision. Each letter should, therefore, be complete in itself and should not, as a general rule, incorporate earlier reports by reference.

(2) Agencies' letters on enrolled bills are privileged communications, and agencies shall be guided accordingly in determining their content.

(3) Because of the definitive nature of Presidential action on enrolled bills, agency letters shall be signed by a Presidential appointee.

(4) Agencies' letters shall contain:

(a) an analysis of the significant features of the bill including changes from existing law. OMB staff will advise the agencies on which one should write the detailed analysis of the bill where more than one agency is substantially affected;

(b) a comparison of the bill with the Administration proposals, if any, on the same subject;

(c) comments, criticisms, analyses of benefits and shortcomings, or special considerations that will assist the President in reaching a decision;

(d) identification of any factors that make it necessary or desirable for the President to act by a particular date;

(e) an estimate of the first-year and recurring costs or savings and the relationship of the estimates to

those previously incorporated in the President's budgetary program;

(f) an estimate of the additional number of personnel required to implement the bill; and

(g) a specific recommendation for approval or disapproval by the President.

(5) Agencies recommending disapproval shall submit with their letters a proposed veto message or memorandum of disapproval, in quadruplicate, prepared on legal-size paper and double-spaced. Such messages or memoranda should be finished products in form and substance that can be used by the President without further revision.

(6) Agencies may wish to recommend issuance of a signing statement by the President. Agencies so recommending shall submit with their letters a draft of such statement, in the same form and quantity as required for a proposed veto message. In some cases, OMB may request an agency to prepare a draft signing statement.

(7) Agencies' letters on private bills shall cite, where appropriate, precedents that support the action they recommend or that need to be distinguished from the action recommended.

d. Subsequent OMB action. OMB will transmit agencies' letters to the President, together with a covering memorandum, not later than the fifth day following receipt of the enrolled bill at the White House.

11. Agency legislative liaison officers. To assist in effecting interagency coordination, each agency shall furnish OMB with the name of a liaison officer who has been designated by the agency to handle the coordination of legislative matters under this Circular. From time to time, OMB will send agencies lists of the liaison officers so designated. Agencies should promptly notify OMB of any change in their liaison officers.

12. Communications to OMB.

a. Written agency communications to OMB transmitting proposed legislation, proposed reports, views letters on

other agencies' proposed legislation or reports, and letters on enrolled bills should be addressed to:

Director, Office of Management and Budget
Attention: Assistant Director for
Legislative Reference

The envelope containing such communications should be addressed:

Legislative Reference Division
Office of Management and Budget
Room 7201, New Executive Office Building

unless a different arrangement is made with an appropriate OMB staff member.

b. Questions on status of proposed legislation, reports, testimony, or enrolled bills should be directed to appropriate OMB staff or to the Legislative Information Center (telephone 395-3230).

JAMES T. McINTYRE
DIRECTOR

Attachments

A-1

ATTACHMENT A
Circular No. A-19
Revised

INSTRUCTIONS RELATING TO THE PREPARATION OF AGENCY LEGISLATIVE PROGRAMS

1. Agencies' proposed legislative programs should be divided into two parts:

PART I -- PRESIDENT'S PROGRAM PROPOSALS

Those items that the agency believes are of sufficient importance to be included in the President's legislative program and given specific endorsement by him in one of the regular annual messages, such as the budget message, or in a special message.

PART II -- ALL OTHER PROPOSALS

2. Within each Part, agencies should list the items in order of relative priority. Each item of proposed legislation should be given a separate number for purposes of ready identification, using a numbering system which identifies the Congress; e.g., Agriculture, 96-12.

3. With respect to each item, agencies should provide the following information:

a. A brief description of the proposal, its objectives, and its relationship to existing programs. Agencies should include greater detail on the specific provisions of proposals included in Part I or where the subject matter of the proposal contains new policies or programs or raises complex issues;

b. Pertinent comments as to timing and readiness of draft legislation;

c. Pertinent references to bills and reports concerning the subject of the proposal in current or recent sessions of Congress;

d. An estimate for each of the first five fiscal years of (1) any budget authority and outlays that would be required, (2) any savings in budget authority and outlays, (3) any changes in budget receipts, and (4) work years of employment and numbers of personnel. These estimates should be prepared in accordance with the instructions in OMB Circular No. A-11.

4. The lists of (a) legislative proposals still under consideration in an agency and (b) expiring laws (see section 6 of the Circular) should be presented separately from Parts I and II. The following special instructions apply to them:

a. Items still under consideration should be listed in approximate order of priority and each briefly described in terms of subject matter and status.

b. Each expiring law should be described in terms of (1) the subject, (2) the citation, (3) the date of expiration, (4) the agency's views as to whether the law should be extended or permitted to expire, and (5) other pertinent information. If an agency recommends extension, the proposal should also be included in Part I or Part II, as appropriate.

5. The legislative program submission should be prepared on letter-size paper. General conformance to the format of the attached exhibit will greatly facilitate the use of these programs.

A-3

EXHIBIT FOR ATTACHMENT A
Circular No. A-19
Revised

DEPARTMENT OF GOVERNMENT

PROPOSED LEGISLATIVE PROGRAM FOR THE ____ SESSION
OF THE ____ CONGRESS

(Items in each Part are listed in order of priority)

PART I -- PRESIDENT'S PROGRAM PROPOSALS

96-3 Amend the provisions of the 1902 Reclamation Act regarding acreage limitation, residency, leasing, excess land sales, the use of Class 1 Equivalency, contracts and contracting procedures, and certain administrative procedures. This proposal would modify and update the acreage limitation provisions of Federal Reclamation law to reflect and accommodate modern agricultural practices, but at the same time retain the basic concept of the Reclamation program--providing opportunities for family farms.

The Department has recommended that legislation amending the law reflect the following: Eligibility to receive project water would be limited to adults--18 years of age or older; Residency as provided in the Reclamation Act of 1902, and defined as a maximum distance of 50 miles from the land, would be reimposed on both lessors and lessees of project lands, with specific guidelines for phasing in the requirement; the acreage entitlement for which project water would be available would be increased to 320 acres owned per adult individual, with an additional allowance of 160 acres leased, or the entire 480 acres could be leased (family corporations and multiple ownerships could hold up to 960 acres without regard to the number of people in the arrangement); Class 1 equivalency would be authorized for general use for projects with a frost-free growing season of 180-days or less and would be applied on a project-by-project basis; contracts with districts containing provisions for exemption from acreage limitation provisions upon payout of construction

charges would be approved; Sale of excess land by the owner to immediate family members, long-time tenants, employees, or adjoining neighbors would be permitted; Charitable and religious organizations holding project lands on January 1, 1978, would be exempt from acreage limitations.

Cost: The estimated cost to the government of administering this proposal would be comparable to the estimated cost of implementing the compliance program under regulations which are being promulgated at this time. The estimated cost of the compliance program for the 5-year period after the final rules are published (not including EIS costs prior to the final rules) is:

	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984
(millions)	2.4	2.4	2.0	2.0	2.0

Personnel requirements: Estimated personnel requirements are:

	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984
(work-years)	76	76	64	64	64
(personnel)	85	85	70	70	70

PART II -- ALL OTHER PROPOSALS

96-14 Amend Federal Power Commission Act of 1920. This proposal would amend the Federal Power Commission Act of 1920 to provide that a license will be issued only after the Secretary administering affected public lands makes a determination that the license will not interfere or be inconsistent with the purposes for which such lands are reserved. The Federal Power Commission has interpreted Section 4(e) to require only consideration of the affected Secretary's recommendations.

The proposal would also amend the act to provide for extinguishment of withdrawals created by the Federal Energy Regulatory Commission (FERC) applications if

the FERC has not responded to the applicant within 6 months or as of date of denial or expiration, surrender, revocation, or termination of the license. Most applications do not result in FPC licenses; yet the land is withdrawn. The administrative process of removing the withdrawals is cumbersome and time consuming and constrains the land managing agency from fully managing these lands for their resource values or from using these lands in exchanges. Revocation of the FERC withdrawal within a specified time period would be consistent with the provisions of Title II of the Federal Lands Policy and Management Act relating to withdrawals.

No additional appropriations or outlays would be required.

B-1
ATTACHMENT B
Circular No. A-19
Revised

INSTRUCTIONS FOR THE PREPARATION AND SUBMISSION TO CONGRESS OF LEGISLATIVE PROPOSALS AUTHORIZING THE ENACTMENT OF ADDITIONAL APPROPRIATIONS OR PROVIDING NEW BUDGET AUTHORITY OUTSIDE OF APPROPRIATION ACTS

1. Legislative proposals providing authorizations to continue programs or activities.

Under section 607 of P.L. 93-344, the Congressional Budget Act of 1974, legislative proposals to extend authorizations scheduled to expire at the end of a given fiscal year should be transmitted to Congress by May 15 of the fiscal year preceding that fiscal year. (For example, if an authorization expired on September 30, 1979, draft legislation to extend the authorization should have been transmitted to Congress by May 15, 1978.) If such proposals were not transmitted or were not enacted, new or revised proposals with language covering the budget year (i.e., the upcoming fiscal year) should be included in the same bill as proposals for the budget year plus one and subsequent years.

More specifically:

a. Proposals for agencies and programs that are customarily authorized on an annual basis (e.g., NASA, NSF, State, Justice, Peace Corps, military procurement and construction) should cover, in the same bill, proposed language for the budget year plus one and resubmittals or revisions of previously proposed authorizations for the budget year. Subsequent years should also be included if agencies deem it desirable and feasible.

b. Other legislative proposals to extend authorizations for the enactment of new budget authority expiring at the end of the budget year should cover, in the same bill, the budget year plus one and such subsequent years as is customary or deemed desirable for the particular program or activity involved.

c. Any proposals that provide for authorizations for the budget year or the current fiscal year should be submitted to Congress immediately after OMB clearance.

2. Legislative proposals providing authorizations for new programs or activities.

a. Proposals authorizing enactment of budget authority for a new program or activity should include at least two fiscal years, unless such new program or activity is proposed to be effective for only one fiscal year and to terminate at the end of that year.

b. Proposals that provide for authorizations to begin in the budget year plus one should, to the extent feasible, be prepared for submission to Congress no later than May 15 of the current fiscal year.

3. General instructions for legislation authorizing the enactment of new budget authority.

a. In keeping with the intent of section 401 of P.L. 93-344, proposals including contract authority or borrowing authority should provide that such authority is to be effective only to such extent or in such amounts as are provided in appropriation acts. Backdoor financing provisions may be proposed only when the exceptions set forth in section 401(d) of P.L. 93-344 apply.

b. As a general rule, bills submitted to Congress authorizing new budget authority for the current fiscal year or budget year will contain specific dollar amounts for those years. These amounts should be those approved for the Budget. For subsequent years, the bills should include "such sums as may be necessary" authorizations unless the agency and OMB agree that special circumstances warrant inclusion of specific amounts.

(1) Where specific amounts are included for years beyond the budget year, those amounts should be consistent with the five-year projections of budget authority printed in the Budget pursuant to P.L. 93-344. Such amounts will be based on the criteria provided for long-range projections in OMB Circular No. A-11.

(2) Authorizing legislation covering principally salaries and administrative expenses which heretofore has been enacted without specific dollar amounts may continue to be proposed for "such sums as may be necessary" for all fiscal years, including the current and budget fiscal years.

c. Agencies should draft their authorizing bills to incorporate the highest feasible level of aggregation for new budget authority.

4. Required materials.

a. Budget year authorization extensions. Proposed legislation authorizing the continuation of existing programs in the budget year should have been submitted to Congress not later than May 15 of the fiscal year preceding the current fiscal year. In cases where Congress did not enact budget year authorizations, new or revised authorizations should be submitted to Congress at the earliest possible date after the budget is published.

Accordingly, each agency will submit to OMB no later than December 15 of each year 10 copies of drafts of proposed authorizing legislation to extend programs and activities that are authorized through the current fiscal year, but for which it will be necessary to propose new or revised authorizations for the budget year and subsequent years.

Since the specific amounts of the authorizations to be included cannot be determined until after decisions are made in connection with the budget, the draft bills as submitted to OMB should contain blank spaces for these amounts. When the budget decisions are final, OMB and the agencies will agree on the figures to be inserted.

b. Authorization extensions for the budget year plus one. Proposed legislation authorizing the continuation of existing programs in the budget year plus one must be submitted to Congress not later than May 15 of the current fiscal year. To meet this deadline, sufficient time must be provided for the legislative coordination and clearance process.

Accordingly, each agency will submit to OMB as early as possible but no later than February 28 of each year 10 copies of legislative proposals for programs and activities that are authorized through the budget year, but for which an authorization request is necessary for the budget year plus one and subsequent years.

These draft legislative proposals should include "such sums as may be necessary" authorizations, unless the agency and OMB agree that special circumstances warrant inclusion of specific amounts. These figures should be the amounts agreed on as a result of the budget review and should be consistent with the five-year projections included in the Budget.

c. Authorizations of new programs or activities. In cases where decisions have been made during the budget review calling for authorizing legislation for new programs or activities proposed to begin in the budget year plus one, draft bills reflecting those decisions should be submitted to OMB no later than February 28 of each year, as in paragraph 4b of this Attachment.

ATTACHMENT C
Circular No. A-19
Revised

BASIC FORMS OF OMB ADVICE

The basic forms of advice and their implications are set forth below:

1. "In accord (not in accord) with the program of the President." When an agency or a committee of Congress is advised that enactment of a bill would be in accord with the program of the President, the advice means that the bill is of sufficient importance for the President to give it his personal and public support. That identification of the legislative proposal with the President is made in a variety of ways; e.g., by inclusion in one of his regular messages (State of the Union, Economic, Budget), a special message, speech, press conference, letter, or leadership meeting.

"Not in accord" advice indicates that a bill is so contrary to the President's legislative proposals or other policies or is otherwise so objectionable that should it be enacted in its current form, a veto would be considered. It is not, however, necessarily a commitment to veto.

2. "Consistent (not consistent) with the Administration's objectives." "Consistent with" advice is used where the relationship of a legislative proposal to the Administration's objectives is direct and the Administration's expressed support is desirable, but the item does not warrant personal identification with, or support by, the President. "Not consistent with" advice signals to Congress that there are major objections to a bill, but does not indicate as clearly as "not in accord" advice that a veto would be considered if it were enacted.

3. "No objection from the standpoint of the Administration's program." Advice that there is no objection to a bill from the standpoint of the Administration's program is given on the large number of agency draft bills that deal with matters primarily of agency concern and do not bear a direct or immediate relationship to the President's program or the Administration's objectives. In effect, such advice indicates to Congress that OMB knows of no reason why the President would not approve the bill if Congress should enact it.

Advice to an agency that there is no objection from the standpoint of the Administration's program to its submission of a report (or testimony) on a bill to a committee of Congress does not indicate any commitment as to ultimate Presidential approval or disapproval of the bill if it is enacted. Nevertheless, such "no objection" clearance does set up certain presumptions. If all agencies' views are favorable, the presumption is that no major objection to the bill is known and that the agencies affected will recommend Presidential approval if it becomes enrolled. If all agencies' views are adverse, the presumption is that the agencies may wish to recommend a veto if the bill becomes enrolled.

Infrequently, "no objection" clearance is given to agency reports expressing divergent views on the same bill. When this is done, it normally means that there is no objection to the bill if Congress acts favorably after considering the adverse views. Occasionally, it means that the Administration's position is being reserved pending resolution of the agencies' differences, and this reservation may be explicitly stated. The interested agencies are advised of each other's differing views in these cases.

4. Qualified advice. In some cases the advice given is qualified. For example, the advice may be that there would be no objection to enactment of the bill from the standpoint of the Administration's program, or that the bill would be consistent with the Administration's objectives, if it were revised in specified respects.

OFFICE OF MANAGEMENT AND BUDGET

[Circular No. A-73; Revised Transmittal Memorandum No. 1]

Audit of Federal Operations and Programs

November 27, 1979.

This Transmittal Memorandum revises OMB Circular A-73, "Audit of Federal Operations and Programs," by replacing paragraph 7.h. with a new paragraph 8 (attached).

The revision requires semiannual reports to the head of an agency, procedures for resolving major disagreements between audit and program offices, a maximum of six months to determine agency action on audit recommendations, and a requirement for periodic evaluations of an agency's system.

James T. McIntyre, Jr.,
Director.

Circular A-73, "Audit of Federal Operations and Programs"

Circular A-73 is revised by replacing paragraph 7.h. with a new paragraph 8. Other paragraphs are renumbered accordingly.

"8. *Followup.* a. Each agency will establish policies for prompt and proper resolution of audit recommendations. Timely action on recommendations by responsible management officials is an integral part of an agency audit system, and is the key to its effectiveness.

b. Agency followup systems must provide for a complete record of action taken on audit findings and associated disallowed, suspended, or questioned costs. Such systems must provide for the following:

(1) Designate officials responsible for audit followup.

(2) Maintain accurate records of all audit reports or significant findings until final resolution. Records will be maintained to insure appropriate accounting and collection controls over amounts determined to be due the Government.

(3) Make written determinations promptly on all audit findings, and initiate action to assure that these determinations are carried out. Such determinations shall be made within a maximum of six months after issuance of the report. Final resolution should proceed as rapidly as possible.

(4) Assure that resolution actions are consistent with law and regulation, including written justification and the legal basis for decisions not to seek recovery of amounts due as a result of audit reports.

(5) Forward to the head of the agency or to a designee for resolution, all major disagreements between the audit office and officials responsible for acting on recommendations, and all reports or recommendations on which responsible officials have failed to provide a written determination within six months.

(6) Provide semiannual reports to the agency head on the status of all audit reports over six months old, the number of reports or findings resolved during the period, collections, or offsets made, and demands for payment made.

(7) Provide for an evaluation of whether the audit followup system is adequate and results in timely and proper resolution of audit findings and recommendations. The first evaluation will be made within one year of implementation of the system, and evaluations will be made every two years thereafter.

c. When audit recommendations requiring corrective action involve more than one program, agency, or level of government, the agency making the audit must coordinate its corrective action with that of other affected organizations."

Circular A-73, "Audit of Federal Operations and Programs"

AGENCY: Office of Management and Budget.

ACTION: Final Policy.

SUMMARY: This notice advises that OMB Circular A-73 has been revised by replacing paragraph 7.h. with a new paragraph 8. Previously, Circular A-73 provided that agencies were to have adequate followup systems for resolving audit recommendations and findings. Based upon our assessment of agency's followup systems, including recommendations in a GAO report on this matter, and subsequent Congressional hearings, we are specifying in the Circular the key elements each agency's system must contain.

The revision requires semiannual reports to the head of an agency, procedures for resolving major disagreements between audit and program offices, a maximum of six months to determine agency action on audit recommendations, and a requirement for periodic evaluations of an agency's system.

EFFECTIVE DATE: This revision becomes effective upon issuance.

FOR FURTHER INFORMATION CONTACT: John J. Lordan, Chief, Financial Management Branch, Office of Management and Budget, Washington, D.C. 20503 (202) 395-6823.

SUPPLEMENTARY INFORMATION: On July 10, 1979, a notice was published in the Federal Register (44 FR 40461) to amend Circular A-73. Interested persons were invited to submit written comments by August 10, 1979. About 15 comments were received from Federal and State agencies. The comments were considered in developing these final regulations. Although all commenters agreed with our objective of strengthening agency followup systems, some raised questions or made suggestions for clarifying changes. The more significant comments received, and OMB's responses to them are discussed below.

Changes in Final Regulation:

Set forth below are changes that have been adopted in the final regulations. The paragraphs are keyed to the proposed regulations published on July 10, 1979.

1. Subparagraph (2) has been amended to clarify that records must be kept on audit recommendations until they are resolved.

2. Subparagraph (3) was revised to make it clear that resolution of audit findings should be accomplished as quickly as possible.

3. Subparagraph (4). A clause was added to make it clear that the legal basis for decisions not to seek recovery of amounts determined to be due the Government must be included in the written justification for such decision.

Suggested Changes Not Considered Necessary:

Comment: One commenter pointed out that reports on proposal evaluations may contain opinions on contractor estimates of future costs which are not true "questioned costs." As such, they need not be included in the same system of records that accounts for questioned incurred costs.

Response: We agree the inclusion of these costs would be misleading. However, these reports are subject to most of the other elements of the audit followup system. Specifically, they must be recorded as open reports until a written determination is made, and they are subject to top management review as provided in paragraph 8.b(5).

Comment: Several commenters felt contract audits should be excluded from some of the audit followup requirements.

Response: Our review of agency's followup systems indicated no need for such an exemption, except as noted above.

4-A03123 0148(09)(30-NOV-79-16.26.03)

Comment: One commenter suggested that we qualify the wording in subparagraph (5) to provide that when a "designee" is assigned to resolve a disagreement arising between the audit organization and a program office that the designee be independent of the program office.

Response: We believe this is understood.

John J. Lordan,

Chief, Financial Management Branch.

[FR Doc. 79-37035 Filed 11-30-79, 8:45 am]

BILLING CODE 3110-01-M

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

See memo #1, 11-27-79

March 15, 1978

CIRCULAR NO. A-73
Revised

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Audit of Federal Operations and Programs

1. Purpose. This Circular sets forth policies to be followed in the audit of Federal operations and programs.

2. Supersession. This Circular supersedes Federal Management Circular 73-2, dated September 27, 1973. The Circular is revised and reissued under its original designation of OMB Circular No. A-73.

3. Summary of significant changes. The revised Circular implements the President's memorandum of September 9, 1977, (copy attached) to the heads of executive departments and agencies on coordination of audits of grants to State and local governments. It also strengthens the provisions on audit followup.

4. Background. The primary objectives of this Circular are to promote improved audit practices, to achieve more efficient use of audit staff, to improve coordination of audits, and to emphasize the need for early audits of new or substantially changed programs.

5. Applicability and scope. The provisions of this Circular are applicable to all agencies of the executive branch of the Federal Government and include all internal and external audit functions of such agencies.

6. Definitions.

a. The term "audit" as used in this Circular means a systematic review or appraisal to determine and report on whether:

(1) Financial operations are properly conducted;

(2) Financial reports are presented fairly;

(3) Applicable laws and regulations have been complied with;

(4) Resources are managed and used in an economical and efficient manner; and

(5) Desired results and objectives are being achieved in an effective manner.

The above elements of an audit are most commonly referred to as financial/compliance, items (1), (2), and (3); economy/efficiency, item (4); and program results, item (5). Collectively, they represent the full scope of an audit and provide the greatest benefit to all potential users of Government audits. In developing audit plans, however, the audit scope should be tailored to each specific program according to the circumstances relating to the program, the management needs to be met, and the capacity of the audit facilities.

b. The term "audit standards" refers to those standards set forth in Standards for Audit of Governmental Organizations, Programs, Activities & Functions issued by the Comptroller General of the United States.

7. Policies and procedures. Agencies are responsible for providing adequate audit coverage of their programs as an aid in determining whether funds have been applied efficiently, economically, effectively, and in a manner that is consistent with related laws, program objectives, and underlying agreements. The audit standards will be the basic criteria on which audit coverage and operations are based. Agencies administering Federal grant, contract, and loan programs will encourage the appropriate application of these standards by non-Federal audit staffs involved in the audit of organizations administering Federal programs. Each agency will implement the policies set forth in this Circular by issuing policies, plans, and procedures for the guidance of its auditors.

a. Organization and staffing. Audit services in Government are an integral part of the management process. Audit services and reports must be responsive to management needs. However, it is important in order to obtain the maximum benefit from this function that agency audit organizations have a sufficient degree of independence in carrying out their responsibilities. To provide an

appropriate degree of independence, the audit organization should be located outside the program management structure, report to an agency management level sufficiently high to ensure proper consideration of and action on audit results, and be given reasonable latitude in selecting and carrying out assignments. Adequate and qualified staff should be assigned this important function. The audit of all programs under a single Federal department or agency must be coordinated, and where economies and a more effective audit service will result, especially in large and geographically dispersed programs, the audit operations within a department should be consolidated. It is also important to establish close coordination between audit and such other management review activities as may exist in an agency.

b. Determination of audit priorities. Each agency will establish procedures requiring periodic review of its individual programs and operations to determine the coverage, frequency, and priority of audit required for each. The review will include consideration of the following factors:

(1) Newness, changed conditions, or sensitivity of the organization, program, activity, or function;

(2) Its dollar magnitude and duration;

(3) Extent of Federal participation either in terms of resources or regulatory authority;

(4) Management needs to be met, as developed in consultation with the responsible program officials;

(5) Prior audit experience, including the adequacy of the financial management system and controls;

(6) Timeliness, reliability, and coverage of audit reports prepared by others, such as State and local governments and independent public accountants;

(7) Results of other evaluations; e.g., inspections, program reviews, etc.;

(8) Mandatory requirements of legislation or other congressional recommendations; and

(9) Availability of audit resources.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

See memo #1, 11-27

March 15, 1978

CIRCULAR NO. A-73
Revised

TO THE HEADS OF EXECUTIVE DEPARTMENTS AND ESTABLISHMENTS

SUBJECT: Audit of Federal Operations and Programs

1. Purpose. This Circular sets forth policies to be followed in the audit of Federal operations and programs.

2. Supersession. This Circular supersedes Federal Management Circular 73-2, dated September 27, 1973. The Circular is revised and reissued under its original designation of OMB Circular No. A-73.

3. Summary of significant changes. The revised Circular implements the President's memorandum of September 9, 1977, (copy attached) to the heads of executive departments and agencies on coordination of audits of grants to State and local governments. It also strengthens the provisions on audit followup.

4. Background. The primary objectives of this Circular are to promote improved audit practices, to achieve more efficient use of audit staff, to improve coordination of audits, and to emphasize the need for early audits of new or substantially changed programs.

5. Applicability and scope. The provisions of this Circular are applicable to all agencies of the executive branch of the Federal Government and include all internal and external audit functions of such agencies.

6. Definitions.

a. The term "audit" as used in this Circular means a systematic review or appraisal to determine and report on whether:

(1) Financial operations are properly conducted;

c. Cross-servicing arrangements. To conserve staff resources, promote efficiency, and minimize the impact of audits on the operations of the organizations subject to audit, each Federal agency will give full consideration to establishing cross-servicing arrangements under which one Federal agency will make audits for another--whenever such arrangements are in the best interest of the Federal Government and the organization being audited. This is particularly applicable in the Federal grant-in-aid and contract programs where two or more Federal agencies are frequently responsible for programs in the same organization or in offices located within the same geographical area. Under such circumstances, it will be the primary responsibility of the Federal agency with the predominant financial interest to take the initiative in collaborating with the other appropriate Federal agencies to determine the feasibility of one agency making audits for the others, and to work out mutually agreeable arrangements for carrying out the required audits on the most efficient basis.

d. Reliance on non-Federal audits. In developing audit plans, Federal agencies administering programs in partnership with organizations outside of the Federal Government will consider whether these organizations have periodic audits. This is especially necessary for those agencies that administer Federal grant-in-aid programs subject to OMB Circulars A-102 (State and local government organizations) and A-110 (nonprofit organizations). These Circulars provide standards for financial management systems of grant-supported activities, and require that such systems provide, at a minimum, for financial/compliance audits at least once every two years. Federal agencies will coordinate their audit requirements with State and local governments and nonprofit organizations to the maximum extent possible. The scope of individual Federal audits will give full recognition to the non-Federal audit effort. Reports prepared by non-Federal auditors will be used in lieu of Federal audits, if the reports and supporting workpapers are available for review by the Federal agencies, if testing by Federal agencies indicates the audits are made in accordance with generally accepted auditing standards (including the audit standards issued by the Comptroller General), and if the audits otherwise meet the requirements of the Federal agencies.

e. Audit plans. Based on the considerations set forth in b, c, and d, above, each agency will prepare an audit plan at least annually. At a minimum, such plans will reflect the:

(1) Audit universe (all programs and operations subject to audit);

(2) Programs and operations selected for audit, with priorities and specific reasons for selection;

(3) Audit organization that will make the audit;

(4) Audit cycle or frequency, the locations to be audited, and the reasons therefor;

(5) Scope of audit coverage to be provided and the reasons therefor; and

(6) Anticipated benefits to be obtained from the audits.

The plans should be adjusted as necessary to provide for audit coverage of unforeseen priorities.

f. Coordination of audit work.

(1) General. Federal agencies will coordinate and cooperate with each other in developing and carrying out their individual audit plans. Such actions will include continuous liaison; the exchange of audit techniques, objectives, and plans; and the development of audit schedules to minimize the amount of audit effort required. Similar coordination and cooperation should take place among Federal and non-Federal audit staffs where there is a common interest in the programs subject to audit.

(2) Audit of State and local governments. In order to facilitate coordination, Federal agencies shall make public the State and local portion of the audit plans required by paragraph 7.e., above. The plans will be available to State and local governments, to the National and Regional Intergovernmental Audit Forums, and to other interested parties. The plans will be submitted to the Office of Management and Budget prior to the fiscal year in which they are implemented.

g. Audit reports. Reporting standards are set forth in the audit standards for the guidance of Federal agencies. With respect to public release of audit reports, each agency will establish policies in consonance with applicable laws, including the Freedom of Information Act. To the maximum extent possible, agencies will provide for the release of

audit reports, in whole or in part, to those interested in them.

b. Followup. Each agency will establish policies for following up on audit recommendations. Timely action on recommendations by responsible management officials is an integral part of an agency's audit system, and has a direct bearing on its effectiveness. Policies will provide for designating officials responsible for followup, maintaining a record of the action taken on recommendations, establishing time schedules for responding to and acting on recommendations, and submitting periodic reports to agency management on action taken. When audit recommendations requiring corrective action involve more than one program, agency, or level of government, the agency making the audit should coordinate its corrective action with that of other affected organizations.

5. Responsibilities. Federal agencies will review the policies and practices currently followed in the audit of their operations and programs, and will initiate such action as is necessary to comply with the policies set forth in this Circular. The head of each Federal agency will designate an official to serve as the agency representative on matters relating to the implementation of this Circular. The name of the agency representative should be sent to the Financial Management Branch, Budget Review Division, Office of Management and Budget, Washington, D.C. 20503.

9. Reporting requirements.

a. Each Federal agency awarding grants to State and local governments will submit the State and local portion of their annual audit plan to the Office of Management and Budget prior to the fiscal year it is to be implemented. The plan will show the actions taken to improve interagency cooperation on audits, to increase coordination with State and local auditors, and to increase reliance on audits made by others.

b. Copies of agency issuances on the implementation of this Circular will be available to the public upon request.

THE WHITE HOUSE

WASHINGTON

September 9, 1977

MEMORANDUM FOR THE HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

SUBJECT: Sharing Federal Audit Plans

The Administration is committed to forging new ties of cooperation among all levels of government. We want to eliminate the duplication and wasteful effort that too often has accompanied the management of Federal grants to State and local governments.

One area where improvements can be made is in coordinating the audit of these grants. All three levels of government have audit responsibilities; but it does not make sense for them all to audit the same transactions. Therefore, in order to improve coordination, I am ordering all Federal executive agencies to make public the State and local portion of the annual audit plans required by Federal Management Circular 73-2. The plans will be available to State and local governments, to the National and Regional Intergovernmental Audit Forums, and to other interested parties. The plans would also be available to the general public, and would be submitted to OMB prior to the beginning of the fiscal year in which they are to be implemented. They should be updated periodically throughout the year as significant changes are made.

I expect Federal agencies to use their audit plans as a basis for making greater efforts to improve interagency cooperation on audits, to increase Federal coordination with State and local auditors, and to increase reliance on audits made by others.

Jimmy Carter

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 15, 1978

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5. Applicability and scope. The provisions of this Circular are applicable to all agencies of the executive branch of the Federal Government and include all internal and external audit functions of such agencies.

6. Definitions.

a. The term "audit" as used in this Circular means a systematic review or appraisal to determine and report on whether:

(1) Financial operations are properly conducted;

(2) Financial reports are presented fairly;

(3) Applicable laws and regulations have been complied with;

(4) Resources are managed and used in an economical and efficient manner; and

(5) Desired results and objectives are being achieved in an effective manner.

The above elements of an audit are most commonly referred to as financial/compliance, items (1), (2), and (3); economy/efficiency, item (4); and program results, item (5). Collectively, they represent the full scope of an audit and provide the greatest benefit to all potential users of Government audits. In developing audit plans, however, the audit scope should be tailored to each specific program according to the circumstances relating to the program, the management needs to be met, and the capacity of the audit facilities.

b. The term "audit standards" refers to those standards set forth in Standards for Audit of Governmental Organizations, Programs, Activities & Functions issued by the Comptroller General of the United States.

7. Policies and procedures. Agencies are responsible for providing adequate audit coverage of their programs as an aid in determining whether funds have been applied efficiently, economically, effectively, and in a manner that is consistent with related laws, program objectives, and underlying agreements. The audit standards will be the basic criteria on which audit coverage and operations are based. Agencies administering Federal grant, contract, and loan programs will encourage the appropriate application of these standards by non-Federal audit staffs involved in the audit of organizations administering Federal programs. Each agency will implement the policies set forth in this Circular by issuing policies, plans, and procedures for the guidance of its auditors.

a. Organization and staffing. Audit services in Government are an integral part of the management process. Audit services and reports must be responsive to management needs. However, it is important in order to obtain the maximum benefit from this function that agency audit organizations have a sufficient degree of independence in carrying out their responsibilities. To provide an

appropriate degree of independence, the audit organization should be located outside the program management structure, report to an agency management level sufficiently high to ensure proper consideration of and action on audit results, and be given reasonable latitude in selecting and carrying out assignments. Adequate and qualified staff should be assigned this important function. The audit of all programs under a single Federal department or agency must be coordinated, and where economies and a more effective audit service will result, especially in large and geographically dispersed programs, the audit operations within a department should be consolidated. It is also important to establish close coordination between audit and such other management review activities as may exist in an agency.

b. Determination of audit priorities. Each agency will establish procedures requiring periodic review of its individual programs and operations to determine the coverage, frequency, and priority of audit required for each. The review will include consideration of the following factors:

(1) Newness, changed conditions, or sensitivity of the organization, program, activity, or function;

(2) Its dollar magnitude and duration;

(3) Extent of Federal participation either in terms of resources or regulatory authority;

(4) Management needs to be met, as developed in consultation with the responsible program officials;

(5) Prior audit experience, including the adequacy of the financial management system and controls;

(6) Timeliness, reliability, and coverage of audit reports prepared by others, such as State and local governments and independent public accountants;

(7) Results of other evaluations; e.g., inspections, program reviews, etc.;

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c. Cross-servicing arrangements. To conserve staff resources, promote efficiency, and minimize the impact of audits on the operations of the organizations subject to audit, each Federal agency will give full consideration to establishing cross-servicing arrangements under which one Federal agency will make audits for another--whenever such arrangements are in the best interest of the Federal Government and the organization being audited. This is particularly applicable in the Federal grant-in-aid and contract programs where two or more Federal agencies are frequently responsible for programs in the same organization or in offices located within the same geographical area. Under such circumstances, it will be the primary responsibility of the Federal agency with the predominant financial interest to take the initiative in collaborating with the other appropriate Federal agencies to determine the feasibility of one agency making audits for the others, and to work out mutually agreeable arrangements for carrying out the required audits on the most efficient basis.

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8. Responsibilities. Federal agencies will review the policies and practices currently followed in the audit of their operations and programs, and will initiate such action as is necessary to comply with the policies set forth in this Circular. The head of each Federal agency will designate an official to serve as the agency representative on matters relating to the implementation of this Circular. The name of the agency representative should be sent to the Financial Management Branch, Budget Review Division, Office of Management and Budget, Washington, D.C. 20503.

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b. Copies of agency issuances on the implementation of this Circular will be available to the public upon request.

10. Inquiries. Further information concerning this Circular may be obtained by contacting the Financial Management Branch, Budget Review Division, Office of Management and Budget, Washington, D.C. 20503, telephone 395-3993.

James T. McIntyre, Jr.
Acting Director

Attachment

(No. A-73)

Congressional Research Service
The Library of Congress

Washington, D.C. 20540

December 3, 1981

TO : Senate Special Committee on Aging
Attention: Hon. John Heinz, Chairman

FROM : American Law Division

SUBJECT : Legal Questions Relating To Office of Inspector General, Department of Health and Human Services

This responds to the issues raised in your November 19, 1981, letter to Joseph E. Ross, chief of this division. We will attempt to respond to the nine specific questions you raised in the order presented in your letter. Insofar as possible our answers will be based upon the legislative history of the statutes creating the office in question, the Office of Inspector General (IG), Department of Health and Human Services (HHS). For each issue we will, where possible: (1) state your question, (2) summarize our conclusion, and (3) analyze the statutes and legislative history that led us to draw the conclusion.

Question 1: In terms of the Inspector General's operation within the Department of Health and Human Services, how much autonomy was intended with regard to budgeting, reporting, hiring, and firing?

Conclusion: Neither the statutes [1] nor the committee reports [2] and hearings [3] unambiguously delineate the degree of autonomy Congress intended for the IG at HHS. The legislation contains provisions that provide something of an independent base for the IG, particularly those permitting direct reporting to Congress. It also clearly subordinates the IG to the supervision of the agency head, who, in turn must respond to the President. The act also does not disturb the broad powers of the agency head with regard to directing resources and workforces assigned to the agency to meet the responsibilities conferred on the agency by law. [4]

Discussion: The legislation contains provisions designed to promote autonomy and others that clearly subordinate the IG to the authority of the Secretary. Among the former are: (1) the statement of purpose calling for an "independent and objective unit," 42 U.S.C. § 3521; (2) the requirement of presidential appointment and Senate confirmation, 42 U.S.C. § 3522; (3) the prohibition against removal except by the President and then only upon notification to both Houses of Congress as to reasons, 42 U.S.C. § 3522; (4) the organizational

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1/ Pub. L. 94-504, titl 2, § 201, 90 Stat. 2429, 42 U.S.C. §§ 3521-3527, 94th Cong., 2d Sess. (1976); as amended by Pub. L. 96-226, title II, § 201, 94 Stat. 315, 96th Cong., 2d Sess. (1980), Pub. L. 95-142, § 4 (c), 91 Stat. 1183, 94th Cong. 1st Sess. (1977).

2/ H.R. Rep. No. 786, 94th Cong., 2d Sess. (1976); H.R. Rep. No. 1593, 94th Cong., 2d Sess. (1976); S. Rep. No. 1324, 94th Cong., 2d Sess. (1976); H.R. Rep. 96-425, 96th Cong., 1st Sess. (1979); S. Rep. 96-570, 96th Cong., 2d Sess. (1980); H.R. Rep. 95-393, Part II, 95th Cong., 1st Sess. (1977).

3/ HEW Procedures and Resources for Prevention and Detection of Fraud and Program Abuses, Hearings before a Subcomm. of the Comm. on Government Operations, House of Representatives, 94th Cong., 2d Sess. (1975).

4/ 5 U.S.C. § 301, for instance, authorizes "[t]he head of an Executive department... [to] prescribe regulations for the government of his department, the conduct of its employees, the distribution and performance of its business. .

alignment of the IG, reporting directly to the Secretary or Undersecretary, 42 U.S.C. § 3522(a)(1) and (5) the broad administrative powers conferred upon the IG, including access to agency materials and to the Secretary, subpoena authority, authority to notify Congress of budget alterations, authority to seek assistance outside the agency, to appoint subordinates and consultants and to enter into contracts, 42 U.S.C. § 3525 (a).

The basic delegation of authority from the Congress to the IG, 42 U.S.C. § 3523 (a), seems to point out the ambiguity of the IG's position. It lists the duties and responsibilities of the IG, according to him only one duty that seems to be unambiguously independent: "to supervise, coordinate, and provide policy direction for auditing and investigative activities relating to programs and operations of the Department." 42 U.S.C. § 3523(a) (1). That authority or responsibility is rather limited if well defined. It is also subject to the control and supervision of the Secretary. The other duties included in subsection (a) of section 3523 are broader in scope but much less clearly defined and, it would seem, because they are advisory, more dependent upon how much managerial authority the Secretary is willing to delegate to the IG. These duties seem to be very close to the heart of management review and program analysis, and ultimate agency policy direction. They are:

> (2) to recommend policies for, and to conduct, supervise, or coordinate other activities carried out or financed by the Department for the purpose of promoting economy and efficiency in the administration of, or preventing and detecting fraud and abuse in, its programs and operations;
>
> (3) to recommend policies for, and to conduct, supervise, or coordinate relationships between the Department and other Federal agencies, State and local governmental agencies, and nongovernmental entities with respect to (A) all matters relating to the promotion of economy and efficiency in the administration of, or the prevention and detection of fraud and abuse in, programs and operations administered or financed by the Department, or (B) the identification and prosecution of participants in such fraud or abuse; and
>
> (4) to keep the Secretary and the Congress fully and currently informed, by means of the reports required by section 3524 of this title and otherwise, concerning fraud and other serious problems, abuses, and deficiencies relating to the administration of programs and operations administered or financed by the Department, to recommend corrective action concerning such problems, abuses, and deficiencies, and to report on the progress made in implementing such corrective action.

One other provision of the legislation needs mention: the dual reporting requirements. According to 42 U.S.C. § 3524, the IG is to present an annual report to the Secretary and to appropriate Congressional committees on significant abuses about which the IG has reported but which in the judgment of the IG have not experienced sufficient progress, and an immediate report to the Secretary and to Congress seven days later on flagrant deficiencies in program administration. In addition, under 42 U.S.C. § 3524(d), the IG is authorized to make other reports and investigations and to provide information directly to Congress or its committees. All of these reports are to be transmitted "to the Secretary and Congress without further clearance or approval," the annual and quarterly reports to be presented to the Secretary "sufficiently in advance of the due date for their submission to Congress to provide a reasonable opportunity for comments of the Secretary to be appended to the reports when submitted to Congress." 42 U.S.C. § 3524(e). The legislative history indicates that the purpose of this reporting requirement is "to prevent lengthy delays from . . . [HHS] 'clearance' procedures." H.R. Rep. 94-1573, at 2.

This statutory scheme seems to indicate the intention of Congress that, with regard to its investigation of fraud and abuse and in its auditing functions, the Office of the IG was to be insulated from pressures from the Secretary or elsewhere within the agency to revise IG studies or investigations in light of policy objectives of agency officials with program responsibilities.

The specific areas of budgeting, reporting, hiring, and firing which your inquiry addressed are each treated slightly differently in the legislation:

(1) Budgeting. The only reference to budgeting contained in the Act is found in 42 U.S.C. 3525 (a) (5):

> [I]n the event that a budget request for the Office of Inspector General is reduced, before submission to Congress, to an extent which the Inspector General deems seriously detrimental to the adequate performance of the functions mandated by this subchapter, the Inspector General shall so inform the Congress without delay.

This provision of law clearly contemplates HHS review of IG budgetary requests and modification of them but places a check upon agency action to the extent that the IG may directly petition Congress on the basis of a determination that the agency modification of the budget request is "seriously detrimental to the adequate performance" of IG functions.

2. Reporting. As mentioned earlier, the legislation seems to contemplate independent reporting with secretarial action limited to commentary, rather than alteration of the final report. This provision applies to the quarterly and annual reports specifically, and seems to cover them explicitly when they are in final form. It is quite possible that informal review of draft reports by the Secretary or agents of the Secretary would be consistent with Act.

3. Hiring and Firing. The only provisions of the legislation specifically mentioning these functions refer to the IG's authority to appoint two assistant inspectors general "in accordance with applicable laws and regulations governing the civil service," 42 U.S.C. § 3522(e); "to select, appoint, and employ such officers and employees as may be necessary for carrying out the functions, powers, and duties of the Office subject to the provisions of Title 5, governing appointments in the competitive service. . .," 42 U.S.C. § 3525(a)(6); and to obtain consultants, 42 U.S.C. §§ 3525(a)(7), to contract for services, 42 U.S.C. § 3525 (a)(8), and to approve or disapprove the use of outside auditors. 42 U.S.C. § 3523(b). These seem to give relative autonomy to the IG, but since hiring and firing of employees, employing consultants or contracting for services fall within HHS agency matters, for which the Secretary has ultimate responsibility, it would seem likely that the IG, being subject to the authority of the Secretary, would be required to follow HHS agency guidelines on these matters.

Question 2: Was it intended that all existent resources dedicated to the control of the fraud, abuse and program mismanagement at the time the office was created be consolidated under the IG? If not, what guidance if any was provided by Congress?

Answer: No. The Act clearly requires only the transfer of functions, powers, and duties of the HHS (then HEW) Audit Agency and the Office of Investigations. 42 U.S.C. § 3526(a)(1) and (2), along with their "personnel, assets, liabilities, contracts, properties, records and other unexpended balances of appropriations, authorizations, allocations and other funds employed, held, used, arising from, available or to be made available," to them. 42 U.S.C. § 3526(b).

DISCUSSION: The hearings and the Report, adopted by the House Committee on Government Operations, "Department of Health, Education, and Welfare (Prevention and Detention of Fraud and Program Abuse)," H.R. Rep. 94-786, at 18-19, identified, on the basis of department level replies to a Committee questionnaire, five offices as "having significant responsibilities for prevention, detection, and investigation of fraud in HEW programs: the Office of Investigations and Security, the Audit Agency, the Office of Guaranteed Student Loans in the Office of Education, the Fraud and Abuse Surveillance Branch of the Medical Services Administration in the Social and Rehabilitation Services Administration, and the Investigations Branch of the Office of Administration in the Social Security Administration; two outside units were also identified as having significant responsibilities: the FBI and the Program Fraud Unit of the Criminal Division at the Department of Justice. Id. Identified as "contributing to the anti-fraud effort" were: the Division of Management Survey and Review of the National Institutes of Health, the Policy Management Staff of the Food and Drug Administration and the Program Integrity staffs of the various Bureaus of the Social Security Administration along with the United States Postal Service, the Internal Revenue Service, the

General Accounting Office, and the States' Attorneys General. Id. The report, Id., at 19, quite correctly pointed out inconsistencies in the response to its questionnaire from the various components of HHS agencies, including the fact that four program bureaus of the Social Security Administration with a combined staff of thousands were identified as having anti-fraud responsibilities. The Committee report examined the data submitted to it and identified the following offices as "major fraud and abuse units": Office of Investigations and Security, Audit Agency, Office of Guaranteed Student Loans, MSA Fraud and Abuse Surveillance Branch, SSA Investigations Branch, and SSA Bureaus of Retirement and Survivors Insurance, Disability Insurance, Health Insurance and Supplement Income. Id. 21-26. The report concluded, Id., 27, that the organizational structure was "fragmented and confused, that only two units, the Office of Investigations and the Audit Agency, had department wide responsibility, and that "the primary role of the Audit Agency is in the field of economy and efficiency, and its fraud and abuse activities are only a by-product of its basic mission," that it did not have trained investigators and its audit workload exceeded its available resources. With regard to the Office of Investigations and Security, the report found that its department wide authority was nullified by a reportedly unwritten agreement excluding from its purview the department's major programs, and that even with this limited mandate, its resources were inadequate. Id.

With these findings, the two officers with department wide responsibility, neither of which was adequately staffed for its severly restricted responsibilities, were the only ones designated by the Act for transfer to the Inspector General, and no new budget authority was extended with the Act.

With regard to the other fraud fighting offices, the Act subjects their transfer to the discretion of the Secretary. Subsection (a)(3) of 42 U.S.C. § 3526 effects the transfer of:

> such other offices or agencies or functions, powers, or duties thereof, as the Secretary may, with the consent of the Inspector General, determine are properly related to the functions of the Office and would, if so transferred, further the purposes of this subchapter.

The one guideline given is that "program operating responsibilities" may not be transferred under that clause. 42 U.S.C. § 3526(a). H.R. Rep. 94-1573, at 10, makes the following comment on this provision:

> Section 6(a) transfers the functions, powers and duties of the present Audit Agency and Office of Investigation to the Office of Inspector General. It also provides that the Secretary may transfer additional offices or agencies, or functions, powers or duties thereof, where appropriate and with consent of the Inspector General. In order to assure that the independence and objectivity of the Office is not compromised, transfer of program operating responsibilities to the Office would be prohibited.

Question 3. What documentation must HHS have developed to effect the transfer?

Answer: Not having access to HHS policy and procedural manuals and HHS personnel administration operating directives, we are unable to state with any degree of specificity what documentation would be required.

DISCUSSION: Theoretically new organizational charts, new entries for telephone directories, new budget and payroll designations, notices to affected employee official personnel folders, organization and function statements for the newly created offices, and changes in affected regulations and directives would be included in such a planned reorganization. If there were an applicable collective bargaining agreement, the organization certified to represent the affected employees might have to be presented with a detailed plan. HHS should be in a position to respond more fully to this question.

Question 4: How broadly was the role of the HHS IG conceived?

Answer: The responsibilities delegated by the legislation to the IG seem to presume broad authority for the IG to monitor both auditing and investigative activities of the agency. At least one commentary characterizes the legislative history as evidencing a presidential and congressional intent the Inspector Generals created under the 1978 Act have broad powers. Muellenberg, K. and Volzer, H., "The Inspector General Act of 1978," 53 Temple Law Quarterly 1049, 1054 (1978). The HHS legislation, itself, however, contains inherent obstacles to the exercise of such broad authority. The transfer of only two offices, both of which were known to be not well staffed for the limited duties assigned to them before the Act was to confer additional duties, and neither of which had developed investigative staff expertise, was the major practical obstacle to the IG's exercising broad responsibility at least immediately.

DISCUSSION: The authority delegated to the IG by the Act clearly contemplates both investigative and auditing responsibilities. The primary duty assigned to the IG under 42 U.S.C. § 3523 (a)(1) is "to supervise, coordinate, and provide policy direction for auditing and investigative activities relating to programs and operations of the Department." The General Accounting Office Act of 1980, amended the HHS IG act to require conformity with GAO auditing standards and to clarify the relationship of the IG's investigative efforts with the prosecutorial and investigative responsibilities of the Department of Justice. Henceforth the IG is under an obligation to "report expeditiously to the Attorney General whenever the Inspector General has reasonable grounds to believe there has been a violation of federal criminal law." 42 U.S.C. § 3523(b)(4).

The kinds of reports the IG is required to make to Congress under 42 U.S.C. § 3524 include reports on the progress of investigative activities. The Senate Report accompanying the legislation establishing the HHS IG contains language illustrating the intent of Congress that the IG be given broad investigative authority. In commenting on what was to become 42 U.S.C. § 3524, (d), for instance, the Report, S. Rep. No. 1324, 94th Cong., 2d Sess. (1976), at 7-8, stated that the subsection would provide "that the Inspector General may make such additional investigations and reports relating to the programs and operations of the Department as are, in the judgment of the Inspector General, necessary or desirable. The purpose of this langauge is to insure that no restrictions are placed upon the Inspector General's freedom to investigate fraud, program abuse and other problems relating to. . . [HHS] activities."

It must be noted that the legislative history seems to accord the IG something of a subordinate role to the Department of Justice in criminal investigations. H.R. Rep. 94-1573, at 7-8, in commenting on what was to be 42 U.S.C. § 3523(a), says, "[t]he Inspector General would not conduct prosecutions, decide whether prosecution should or should not be conducted, but would undoubtedly provide assistance to officers charged with prosecuting such cases."

Another provision of law clearly pointing to a role in criminal investigations for the IG is 42 U.S.C. § 3524(a), as amended by Pub. L. 95-142, §4(c), 91 Stat. 1183 (1977), requiring the IG's annual report to include "a detailed description of the cases referred by the Department of Health and Human Services to the Department of Justice during the period covered by the report, an evaluation of the performance of the Department of Justice in the investigation and prosecution of criminal violations relating to fraud in the programs of

health insurance and medical assistance,. . . and any recommendation with respect to improving the performance of such activities by the Department of Justice" and a requirement that the Attorney General make a report to Congress on HHS IG criminal referrals. The House Report accompanying the bill that was to become Pub. L. 95-142, H.R. Rep. 95-393, Part II, 95th Cong., 1st Sess., at 54-55 (1977), indicates that the provision was added because the House Committee on Ways and Means believed that the Department of Justice should develop adequate resources to investigate and combat medicaid and medicare fraud and because the Attorney General had agreed to take steps toward that end rather than have Congress "dictate in law a particular subordinate organization within the Criminal Division" of the Department of Justice.

Question 5: What was the Congressional intent with respect to law enforcement powers for the IG? Is there a discrepancy in the treatment of the HHS IG and other statutory IGs in this regard?

Answer: Neither the HHS IG legislation nor any other legislation confers upon the IG or his staff the following powers generally thought to be law enforcement authority: to carry firearms, to execute and serve warrants, arrest warrants, administrative inspection warrants, subpoenas and summonses issued under the authority of the United States, to make arrests without warrant for offenses against the United States committed within their presence or for felonies cognizable under the laws of the United States upon probable cause.

DISCUSSION Such powers are given to Drug Enforcement Administration personnel, 21 U.S.C. § 878-880, Federal Bureau of Investigation inspectors and agents, 18 U.S.C. § 3052, United States marshalls, 18 U.S.C. § 3053, Secret Service personnel, 18 U.S.C. § 3056, and other law enforcement agents by specific statutes. Currently there is an amendment to H.R. 3603 pending which would give certain of these powers to Department of Agriculture agents under the supervision of

the Inspector General of that agency for their performance with regard to the Food Stamp Program. It also might be noted that under 18 U.S.C. § 3105 only an officer authorized by law may serve a search warrant.

Question 6: What remedies are available under existing statutes to deal with problems identified by the IG in the performance of his duties?

Answer: The range of authority in the IG act includes making recommendations to the Secretary for corrective action, 42 U.S.C. § 3524, and making reports to Congress. Included among the recommendations could be recommended program changes and revised auditing controls as well as disciplinary actions against federal employees or administrative sanctions against private sector suppliers, health care deliverers, or contractors. Administrative actions against federal employees would be governed by title 5 of the United States Code and agency regulations. Section 7513 of title 5, for instance, permits removal for cause of people in the competitive service. Administrative sanctions against others would be governed by the applicable legislation. Any administrative sanction would require procedures guaranteeing due process rights and would probably be monitored by other offices in HHS.

The HHS IG legislation also includes the remedy of reporting upon reasonable cause suspected violation of federal criminal law to the Attorney General, 42 U.S.C. § 3523(b)(4). Possible crimes include:

18 U.S.C. § 371, conspiracy to defraud the United States

18 U.S.C. § 1001, making false statement in a matter before an agency of the United States

18 U.S.C. § 641 stealing a thing a value of the United States

18 U.S.C. § 1702, 1704, 1706-1710, 1721, mail theft

18 U.S.C. §§ 286-288 making false claims against United States

18 U.S.C. § 1002 possessing with intent to defraud the United States a false document to enable another to obtain money from the United States.

42 U.S.C. 2703 embezzling of EEOC grants

42 U.S.C. § 1395, 1396 embezzling from certain SSA health insurance and medical assistance programs

This is merely a sampling of the statutes under which, with proper factual circumstances, fraud in matters under the jurisdiction of the HHS IG could be prosecuted by the United States Attorneys.

Before the current Congress are three bills that would amend the federal criminal code, H.R. 1647, H.R. 4711, and S. 1630. Senator Thurmond introduced S. 1630 for himself and for several members of the Judiciary Committee including Senator Kennedy who sponsored similar omnibus legislation in earlier Congresses. It would consolidate some of the federal larceny statutes and create a new offense, obstruction of a government process by fraud, a proposal to respond to criticism of current law that it includes conspiracy to defraud as a crime but has no offense covering the actual obstruction of the government function. S. 1630 also includes what would be a new offense that would permit federal prosecution of certain thefts from federally funded programs: failure to keep a government record. There would also be a lesser included misdemeanor offense: failure to keep a government record required as a condition of federal funding with intent to defraud. The federal bribery statutes would also be extended, under S. 1630, if enacted, to include bribery of an agent of a state or local government who is charged with the administration of money or property derived from a federal program where the official duty or action sought to be influenced involves the administration of the program.

The reach of the theft provision of S. 1630 would extend current law to include theft from federally funded programs, a provision designed as a remedy for the perceived gap in the requirement of 18 U.S.C. § 641 that money alleged to be stolen by proved to be the property of the United States government. The S. 1630 provision reflects the Senate Judiciary Committee finding that while payment of federal funds to a state or local program usually results in the passage of title, "the Federal government clearly retains a strong interest in assuring the integrity of such program moneys." S. Rep. 96-533, 96th Cong., 1st Sess., at 694-695 (1979).

Question 7: What is the legal relationship of the IG, the FBI, and the Attorney General?

Answer: The IG reports to and answers administratively to the Secretary, except that only the President may remove the IG from office. The Director of the FBI reports to the Attorney General. Like any other government official the IG of any agency is required to give the Attorney General, the chief federal criminal prosecutor, notice of suspected violations of federal criminal laws. The role of the IG seems to fuse internal audit with investigation of fraud in federal programs. It is, thus, a hybrid, which includes criminal investigation and detection. Its main focus, like that of the IRS Criminal Division, is detection of fraud and other economic or white collar crimes. Its jurisdiction with respect to crimes against the person or the more violent forms of crimes against property would seem to be much more limited that the FBI.

DISCUSSION The basis of the requirement in the IG legislation that suspected criminal violations be reported to the Attorney General is the role assigned to the Attorney General by the Congress in conducting the litigation of the United States. That role is crucial to understanding the authority that the Attorney General has over the investigative functions of other federal agencies.

It is from his authority to advise the President and the executive agencies and from his authority to pursue litigation in the federal courts that the Attorney General has the greatest impact upon law enforcement. This has been described as follows:

> By far the greatest contribution of the Attorney General has been the aid rendered to the President and the heads of executive departments in the execution of the laws. Although all officers, agents, and employees of the United States are concerned in some way with the execution of the laws, no one approaches the Attorney General in importance. The first interpretation of a statute after its enactment, its defense in the courts, prosecution of violators, and ultimate supervision of the marshal who enforces a judicial decree or order, all come within the range of the Attorney General's law enforcement powers.
>
> Law enforcement begins in the offices to which has been committed the authority to enforce the statues. Frequently anterior to enforcement is a determination of the meaning and scope of the law. Under the statutes, it is the Attorney General's duty to give such advice to the President and the heads of executive departments. This is a most critical state of administration, for not only are citizens' rights involved, but also basic considerations of public policy.
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> Nealon, R.W., The Opinion Function of the Federal Attorney Attorney General, 25 N.Y.U.L. Rev. 825, 835-836 (1950).

The basic legal authority for the office of Attorney General derives from statutes, not from the Constitution directly. Under the Constitution, the role of enforcing the laws of the United States is assigned to the President: "he shall take care that the Laws be faithfully executed. . ." U.S. Const. art. II, § 3. The Constitution assumes the existence of executive departments and envisions their chief officers as presidential advisors: "The President. . . may require the Opinion in writing, of the principal Officer in each of the executive Departments, upon any subject relating to the Duties of their respective Officers. . ." U.S. Const. art. II, § 2.

Today, the Department of Justice has broad authority to conduct the litigative business of the United States. 5/ Sections 515-519 of title 28 of the United States Code detail the statutory function of the Attorney General for representation of the interests of the United States before the federal courts. The Attorney General, or any attorney retained for that purpose, is authorized to proceed generally, and is given the authority to conduct civil or criminal proceedings in any court of the United States. By section 515(a):

> The Attorney General or any other officer of the Department of Justice, or any attorney specially appointed by the Attorney General under law, may, when specifically directed by the Attorney General, conduct any kind of legal proceeding, civil or criminal including grand jury proceedings and proceedings before committing magistrates, which United States attorneys are authorized by law to conduct, whether or not he is a resident of the district in which the proceeding is brought.

It is not, however, the only agency with that authority. That fact is recognized by the provision in 28 U.S.C. § 516 reading:

> Except as otherwise authorized by law, the conduct of litigation in which the United States, an agency or officer thereof, is a party, or is interested, and securing evidence therefor, is reserved to officers of the Department of Justice, under the direction of Attorney General.

If another agency has authority to litigate in behalf of the United States, the Department of Justice seems to have the authority to coordinate such litigation. Section 519 of title 28 provides:

5/ The general litigation authority of the Department and the arrangements made with the other departments and agencies having litigation responsibility are discussed in J. David, Department of Justice Control of Agency Litigation, Administrative Conference of the United States 17, (1975).

> Except as otherwise provided by law, the Attorney General shall supervise all litigation to which the United States, an agency, or officer thereof is a party, and shall direct all United States attorneys, and special attorneys appointed under section 543 of this title in the discharge of their respective duties.

A final piece of authority of the Department of Justice over litigation is found in 5 U.S.C. § 3106:

> Except as otherwise provided by law, the head of an Executive Department or military department may not employ an attorney or counsel for the conduct of litigation in which the United States, an agency, or an employee thereof is a party, or is interested, or for the securing of evidence therefore, but shall refer the matter to the Department of Justice. This section does not apply to the employment and payment of counsel under section 1037 of title 10. 6/

6/ Section 1037 of title 10, U.S.C. refers to the employment of counsel for the defense of courts martial before the military departments.

The phrase "except as otherwise provided by law," appearing in each of these statutes is the reviser's recognition of the activity of Congress in legislatively authorizing individual independent agencies, and in the enforcement of particular statutes, executive branch departments, to appear and represent themselves before the inferior courts of the United States. From this has developed interagency agreements between the Department of Justice and other agencies that attempt to resolve disputes and disagreements about the proper scope and authority of agency attorneys to go into court.

Whatever the situation is with regard to civil litigation, the Department of Justice's Criminal Division has closely guarded criminal prosecution jurisdiction as its exclusively.[7/] Rule 54(c) of the Federal Rules of Criminal Procedure defines "attorney for the government," as "an authorized assistant of the Attorney General, a United States Attorney, or an authorized assistant of a United States Attorney."

Buttressing this broad prosecutorial power is broad investigative authority. Not only is the Federal Bureau of Investigation assigned to the Department of Justice, 28 U.S.C. § 531, but the Attorney General has wide authority to investigate: Section 533 of title 28 provides:

> The Attorney General may appoint officials—
> (1) to detect and prosecute crimes against the United States;
> (2) to assist in the protection of the person of the President; and

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7/ See United States Attorneys Manual § 5-1.513 (January 11, 1977), cautioning United States Attorneys against delegating prosecutorial authority in criminal cases by making special appointments of attorneys from other agencies. To make such appointments approval must be secured from one of the top three officials in the Department.

> (3) to conduct such other investigations regarding official matters under the control of the Department of Justice and the Department of State as may be directed by the Attorney General.

Another provision of section 533 indicates that this investigative authority is to be exercised concurrently with other agencies. It is susceptible to the interpretation that grants of investigative authority to other agencies do not preempt or limit the investigative authority of the Attorney General: "This section does not limit the authority of departments and agencies to investigate crimes against the United States when investigative jurisdiction has been assigned by law to such departments and agencies." 28 U.S.C. §533.

This authority together with the prosecutorial authority operates as a de facto power to supervise the investigative functions of the other agencies when those agencies refer cases to the Department of Justice for prosecution.

The referral of cases to the Department of Justice for prosecution involves first a decision on the part of the referring agency that possible criminal activities are involved and, secondly, a decision within the Department of Justice, either at the headquaters level or in one of the United States Attorneys' offices, as to whether to proceed with a criminal prosecution, whether another type of legal action is demanded, or whether the case should be turned down. Factors considered in deciding how or if to proceed with a particular referral include: the quality of the investigation, the strength of the evidence, the availability of necessary expert witnesses, the extent of harm caused, the severity of possible sentencing, the likelihood of future deterrence, and the available resources. The variation in the success rate of agencies in securing prosecution for their referrals is marked. Some agencies receive

constant litigation support, while others receive little or none.[8/] Policies of United States Attorneys in determining which cases to pursue vary amoung the districts, for the most part determined on the basis of local priorities and considerations.[9/]

In deciding which cases or types of cases to prosecute the Attorney General through the Criminal Division and the various United States Attorneys can have a profound influence on investigative techniques and policies of other agencies. The decision to enforce selectively is often a cooperative decision between the Department of Justice and other agencies.[10/]

In addition to the general authority that prosecutorial discretion confers on the Attorney General there are other statutory authorities specifically authorizing supervisory responsibility with regard to certain government wide investigative functions. Title III of the Organized Crime Control and Safe Streets Act of 1968, 82 Stat. 216, 18 U.S.C. §2516, for example, requires that the Attorney General, or any Assistant Attorney General specially designated by the Attorney General "authorize an application to a Federal judge of competent jurisdiction . . . . an order authorizing or approving the interception of wire or oral communications by the Federal Bureau of Investigation, or any Federal agency having responsibility for the investigation of the offenses as to which the application is made." In particularly exigent situations, the

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8/ See, Rabin, Agency Criminal Referrals in the Federal System: An Empirical Study of Prosecutorial Discretion, 24 Stan. L. Rev. 1036 (1972).

9/ See, United States Attorneys Manual (1977, looseleaf) discussed in Beck, L., The Administrative Law of Criminal Prosecution: The Development of Prosecutorial Policy, 27 Am. U.L. Rev. 310, 313-321, 337-374 (1978). Hereinafter referred to as The Administrative Law of Criminal Prosecution.

10/ The Administrative Law of Criminal Prosecution, 317, n. 24 and accompanying text.

Attorney General will move to exert an influence over an agency having investigative authorities. In 1968, for instance, responding to the Supreme Court decision in United States v. United States District Court, 407 U.S. 297 (1972), holding that the federal government could not conduct electronic surveillance on citizens without judicial authorization in certain circumstances, the Attorney General requested that the National Security Agency "immediately curtail the further dissemination of such information ... acquired by you through the use of electronic devices pursuant to requests from the FBI and Secret Service." Letter, dated October 1, 1968, from Elliot Richardson, Attorney General, to Lt. General Lew Allen, Jr., National Security Agency. "The National Security Agency and Fourth Amendment Rights," 5 Intelligence Activities, Senate Resolution 21, Hearings before the Sen. Select Comm. to Study Governmental Operations with Respect to Intelligence Activities 160-161, 94th Cong., 1st Sess. (1975).

Question 8: Whether the following are consistent with the intent of Congress in creating HHS, IG.

A. OMB Circular A-19, Legislative Coordination and Clearance

OMB Circular A-73, Audit of Federal Opeations and Programs

DISCUSSION We have not yet examined OMB Circular A-19. It apparently was not published in the Federal Register. We did, however, find OMB Circular A-73, 44 Fed. Reg. 69590 (Dec. 3, 1979). It prescribes some policies and reporting requirements for agency auditing. It, thus, may be read as adding other criteria to HHS IG auditing systems. The Act creating the HHS IG does not make reference to OMB. There are other statutes, however, that recognize implicitly OMB authority to provide guidance to agency personnel monitoring fiscal programs. Section 15 of title 31 of the United States Code, for instance, sets up the OMB in the Executive Office of the President and authorizes it to "under such

rules and regulations as the President may prescribe ... prepare the Budget, and any proposed supplemental or deficiency appropriations, and to this end shall have authority to assemble, correlate, revise, reduce, or increase requests for appropriations of the several departments or establishments." This broad grant seems to imply sufficient authority to monitor the auditing of agency fiscal controls to insure a degree of uniformity and accuracy in reporting among the departments.

B. U.S. Attorney Manual, §9-42.501, Relationship and Coordination with the Statutory Inspector Generals.

DISCUSSION

This is an internal operating directive within the Department of Justice, over which the Attorney General has administrative responsibility. As discussed in conjunction with question 7, the authority of the Attorney General and the United States Attorneys to bring federal criminal prosecutions implicitly gives the Attorney General the authority to provide federal investigative agents, such as the IG, guidance in reporting suspected criminal activities. The 1979 amendment to the HHS IG legislation, moreover, emphasizes congressional recognition of the need for Department of Justice guidance in this area.

D. FBI Transmittal to All SAC's

DISCUSSION

This document seems to represent FBI internal policy directives. There appears to be no clear cut legislative directive as to whether the FBI or the IG's have primary jurisdiction over various title 18 offenses. Some of the ramifications of the broad statutory grant of investigative authority to the

Attorney General, under whom the FBI serves, are discussed in conjunction with Question 7. The broad grant to the FBI of the kinds of law enforcement powers considered in question 5 might also be pointed out as reinforcement for an argument as to the central role of that agency in enforcing the criminal laws over which the IG has jurisdiction.

D. Office of Program Validation/HCFA Memorandum dated September 10, 1981 from Don Nicholson to David Snipe

September 16, 1981 memorandum to Don Nicholson

DISCUSSION

These documents seem to indicate decisions by one of the HHS program agencies that affect operations of the Office of Investigations, presumably within the IG's office. The materials submitted do not fully explicate what is involved. Whether this action constitutes subordination of the IG to an officer of HHS other than the Secretary of Undersecretary is not clear from the facts presented. One question arises concerning the ability of a program agency to let a form that the IG depends upon to lapse. It would be interesting to know whether IG has made recommendations on the forms control program of the department.

Question 9: Is there any substantive discrepancy in the authority or independence of operation of the HHS IG as compared with other statutory IG's?

DISCUSSION

There appears to be no basic legal difference in the HHS IG authority. There are, however, differing reporting requirements which are detailed in the attached copy of a CRS report by Frederick M. Kaiser of the Government Division, "Inspector General Reporting Requirements," issued in July 1980. In terms of

the actual operation of any IG office, we are not in position to evaluate the day to day relationships in any agency. One journalist, J. Nocera, has attempted to do so. We attach a copy of his work, " Inspector General: The Fraud in Fighting Fraud," 10 Washington Monthly 31 (1979).

We hope this information is helpful to you. If you have any further questions please do not hesitate to call upon our office.

M. Maureen Murphy
Legislative Attorney
American Law Division
December 3, 1981

Inspectors General: The Fraud in Fighting Fraud

by Joseph Nocera

Fraud in government is a hot topic these days, thanks in large measure to CETA, Medicaid, student loans, defense contracts, GSA, and Joseph Califano, the inimitable Secretary of Health, Education and Welfare. The first five make the newspapers with some degree of regularity because of the fraud they have engendered; Califano, meanwhile, is in the news almost as much because of his much-ballyhooed effort to stamp out fraud in his gargantuan ($136 billion in fiscal 1977) department.

The Secretary's latest coup was his sponsorship, a few months ago, of a national conference on waste, fraud, and abuse that attracted hundreds of government gumshoes from all over the country (as well as what has become, for Califano, the requisite dose of favorable publicity). As he has in the past, Califano used the occasion to expound at some length on the basic theme of his anti-fraud pitch. It might be entitled, "The Liberal Case Against Fraud and Abuse."

The nation, he has said, has been hurt "by the false claim that many large federal programs, despite substantial expenditures, do not work. . . . It was the challenge of liberalism in the 1960s to enact long-delayed and much-needed social programs. It is the challenge for liberalism in the 1970s to manage those programs well."

Joseph Nocera is an editor of The Washington Monthly.

Jimmy Carter, who himself has not been shy about deploring waste and fraud in government, was a featured speaker at the conference, as was Francis M. Mullen, Jr., a heavyweight at the FBI, who assured the assembled multitudes that they need not fear for job security. "There's plenty of fraud out there for everyone," he said.

In the crowd, mingling with the state and local investigators, the FBI agents and the postal inspectors, was the newest breed of government sleuth: the people who work in the various federal agencies under the aegis of the inspector general's offices. It was only last October that Carter signed into law a bill establishing an Office of Inspector General in each of 12 federal agencies, and it is a law the President is taking very seriously indeed. Despite his well-documented distaste for personnel matters, Carter has asked each agency for the names of the three finalists for the position of inspector general, and he is personally interviewing the candidates.

The Office of Inspector General is supposed to house an elite corps of internal investigators for each agency who will serve as the advance troops in the war against fraud, abuse, mismanagement, error, theft, and all the other ways the government wastes money. They are supposed to have a free hand to investigate anything that strikes their fancy, and enough independence and autonomy from their department heads to insure that

they can do that. In addition to their crime-busting function, inspectors general are supposed to figure out how to *prevent* crimes from happening in the first place.

To keep a department secretary's potentially meddlesome hands off his inspector general, the law strips the secretary of the power to fire him (only the president can do that, with due cause, and GAO must then investigate the reasons), and it instructs the inspector general to file reports periodically to appropriate congressional subcommittees, compiling a list of what he's looked into and what he's found. It allows the secretary to comment upon—but not to edit—the reports. (Typically, the Justice Department opposed these features of the bill when it was first being discussed, citing the "separation of powers" doctrine of the Constitution. An inspector general, Justice said, couldn't serve both Congress and a department head at the same time. This was roundly scoffed at on Capitol Hill, and after Carter made it known he liked the bill just fine the way it was, Justice decided that maybe the idea wasn't so unconstitutional after all.)

As a companion to the cops-and-robbers responsibilities, the inspector general, in theory at least, has a third job. As the article by Amy Merrill in this issue makes painfully clear, the higher up one is in the bureaucracy, the less one sees of the life below. Days become a mind-numbing mish-mash of programs and projects, of projections and processes, of inputs and outputs, of neat little hierarchical boxes on a blackboard. It is one of the most natural, if most unfortunate, tendencies of bureaucracy that the more powerful your position, the more time you'll spend on any given day listening to baloney.

The inspector general is supposed to be the one who can cut through the layers of baloney and tell the secretary (and the Congress, which wants in on all this potentially juicy information) the truth, the whole truth, and nothing but the truth.

Inspectors general are supposed to be looking at programs with the jaundiced eye of an outsider; "asking all the stupid and obvious questions no one connected with the program has asked for ten years," in the words of one administration official; getting out of their offices and into the field where the caseworkers and the recipients reside and where the frustrations are too immediate to be glossed over; and in general, finding out the answer to that eternal if seldom-asked question of the bureaucracy: "What the hell is going on out there?"

In theory, at least....

Early on in the administration—indeed, well before Carter signed the bill—two agencies set up Offices of Inspector General. One of these, of course, was Califano's HEW, where the Secretary eagerly embraced the idea, decrying the excessive waste allowed by the Republicans that had given HEW a bad name and launching his "new-liberalism-is-sound-management" campaign. In March, 1977, the HEW inspector general began operation.

The other agency was the newly created Department of Energy, where an Office of Inspector General was written into the statute that brought DOE to life. Here the reaction of the Secretary was quite a bit different from Califano's. Although he did not protest too loudly in public (how would it *look*, after all, to say you were against an office dedicated to wiping out fraud?), James Schlesinger was not at all keen about having people around who would be looking over his shoulder and questioning his programs. After a good deal of behind-the-scenes kicking and screaming, Schlesinger accepted his inspector general's office with all the grace of a kid who's just been ordered to his room. He promptly exiled the inspector general to a condemned building far away from the main Department of Energy headquarters.

Because both HEW and DOE have had a head start on the other agencies in establishing offices of inspector

general, they have track records on which their performance may be judged. Indeed, at HEW, the inspector general was put in place early for precisely that reason: both Congress and the administration were curious to find out how the office worked and whether it should be copied government-wide. Subsequent actions—the bill having passed Congress in a landslide, and Carter having signed it with considerable fanfare—make it clear that both thought the answer was a resounding "yes." But a closer look reveals that the results in this experiment in good government have been a lot more mixed than anyone connected with it has been willing to admit thus far. At the Department of Energy, because of Schlesinger's unwillingness to take them seriously, his in-house investigators have been neither aggressive nor effective. At HEW, the record is nowhere near that dismal; because of Califano's boosterism, staff morale is high, attitudes are reasonably aggressive, and the investigators have scored a number of victories against fraud. But the office has not been the stirring, smashing success the secretary likes to make it out to be.

On The Other Side

First, though, some history. Neither the idea nor the title, the actual *words* "inspector general," are new to bureaucracy. Agencies have always had their share of people who were supposed to be internal investigators—and more than a few of them were called "inspector general"—and they generally have a sordid past. "Bah," said A. Ernest Fitzgerald, the king of whistle-blowers, when asked about the new push for inspectors general in government, "they won't do any good. *They're on the other side.*"

The military has had inspectors general since 1813, officers charged with looking into military abuses, people formally independent of other channels of command, but to people like Fitzgerald, they have always been on "the other side." And for good reason. The combination of bureaucratic pressures within the military has thoroughly overwhelmed any desire by an inspector general to do the kind of job the military needs. That can ruin a promising career—it makes superiors mad, superiors who might sit on a promotion board, say. The same forces have made military inspectors general more than willing to go after whistle-blowers instead of those they accuse.

Deena Weinstein, an associate professor at DePaul University who has spent some time studying the Army's inspectors general, finds them generally ineffective even in investigating something as basic as soldier's complaints. The problem, she writes, is that "the I.G. personnel are recruited from the line officers who, after a brief stint, return to the line." Thus, "the officer serving in the I.G. has been socialized to see the value of the chain of command," and doesn't take kindly to soldiers who complain to him. She cites one rather chilling anecdote:

"Sergeant Hayden filed a complaint against a superior officer charging him with conduct unbecoming an officer. An officer of the Inspector General conducted a two-week inquiry and not only confirmed the charges but found further detrimental information against the accused major: '... petty theft, drinking on duty, and calling the Air Force Secretary a meddling fool and an idiot.' The Inspector General asked Hayden to drop the charges and when Hayden refused he was ordered to the mental health clinic for evaluation. There, too, he was asked to drop the charges. His refusal led to his transfer into the psychiatric facility at another base, Lackland. Fortunately for Hayden, the doctors at Lackland discharged him with 'a clean bill of health' after two weeks of examination."*

*The Weinstein material is from her book, *Bureaucratic Opposition: Challenging Abuses at the Workplace*, to be published next month by Pergamon Press.

Of course, that sort of thing doesn't go on only in the military. In the State Department, top-level foreign service officers are required to put in a two-or-three-year stint inspecting the work of our embassies overseas and other State Department offices. This hardly encourages stinging critiques. Here's how the GAO put it recently: "On the one hand, the Foreign Service Officer has extensive experience in the foreign affairs area, but on the other hand, this same experience could lead the officer to accept present operating methods without raising questions that might occur to an independent observer."

Not only "could" but does—all the time. According to one person who has seen the process in action, most of the evaluation is done over a long, leisurely lunch where, for example, the London embassy people complain bitterly about the lack of support they get from the State Department, while the evaluator sits there nodding sympathetically. Then he writes a report about what a great job they are doing in London under the most trying of circumstances. With luck, this might get him a transfer to London when his tour of duty as an investigator is up.

In his forthcoming book, *The Search for the Manchurian Candidate*, John Marks notes another common phenomenon of being an inspector general—the fear that if you do too good a job, you won't have one. Lyman Kirkpatrick, the longtime CIA Inspector General had known about unwitting LSD tests performed by the CIA, Marks writes, but "had never raised any noticeable objection. He now states he was 'shocked' by the unwitting testing, but that he 'didn't have the authority to follow up.... I was trying to determine what the tolerable limits were of what I could do and still keep my job.'"

And then there is the matter of loyalty, the misplaced loyalty that puts the agency and personal friendships over any sense of commitment to the government as a whole and, to be blunt, to the truth as well. Of all the thousands of reports issued by government investigators in recent years, perhaps the most telling in this regard was one put out by the Nuclear Regulatory Commission called the McTiernan Report. Thomas McTiernan was the head of the internal investigations unit at the NRC, a man who had held a number of jobs in the government's nuclear establishment and was only a few years from retirement. A year ago last summer, another high-ranking NRC official, one Lee Gossick, was caught fudging on the truth before two congressional committees. Naturally, the committees demanded a full investigation, and McTiernan was given the task of finding out whether or not Gossick had lied. It was not a coveted assignment, inasmuch as McTiernan had been around a long time, and Gossick had been around just as long, and if they weren't bosom buddies, they felt a certain kinship as veterans of the nuclear bureaucracy. McTiernan produced a long and windy report that went on for hundreds of pages, but he could not bring himself to face up to the fact that Gossick probably had lied; in the summary, he said that Gossick might have made a misleading statement or two, but they certainly weren't intentional and were made at a time when Gossick was under tremendous strain.

There was a striking, if understandable, empathy for Gossick in this report. However at the same time McTiernan went after the person who had blown the whistle on Gossick with the bureaucratic equivalent of sharp knives. *That* person, McTiernan implied in another report, ought to be drummed out of the NRC. One of his superiors, quoted anonymously, suggested he might be a security risk; another thought he might do well to see a psychiatrist.

Can't Get The Money Back

Most of the new inspectors general have sent around department-wide memos encouraging whistle-blowers to

come forward, and for the most part they have been resolutely ignored. Given the history of internal investigations, that is hardly a surprise. "You're a fool to be a whistle-blower, but you're a *real* fool if you blow the whistle to him (the inspector general)," said a veteran HEW dissident. Whistle-blowers have a hard time seeing much difference between these inspectors general and the offices they replaced. Most departments already had in place an office of audit and an office of investigations, and the people who worked in these sections were never known for their aggressiveness in finding and pursuing internal wrongdoing. Which brings us to one of the biggest hitches with the new inspectors general: where they come from.

When the office was set up in each department, the inspector general had to take the people who were already there, those who worked in the old office of audit or investigations. The civil service wouldn't have it any other way—which meant that the auditor who had been looking at department books for the last 20 years under the office of audit would continue to do that, except that now he would be doing it for the inspector general.

As a result, long-standing practices have continued of their own inertia. For example, at the Department of Energy, the audit staff and the investigations staff (both of which had existed at ERDA and FEA, the two chief agencies that combined to form DOE) had a history of not communicating with each other. That hasn't changed, even though they now both work for the inspector general. At HEW, although they have over 1,000 auditors who regularly find money misspent or contracts misused, the department has never been very good at getting any of the money *back*. That, for the most part, is still the case.

"The types of people you're going to inherit," says one government investigator, "are so narrow in focus they will miss the forest for the trees every time. The investigations work is incredibly parochial—never looks at a big picture, never focuses past one person or one crime. The audit staffs are still full of green eyeshade types, people who check the figures all day and if they add up, give the program a clean bill of health."

Even the new people hired haven't improved matters all that much. Most of the new investigators at DOE, for example, are former FBI agents (there is an incredible network of former FBI agents all working vigorously to hire each other), who have been well-schooled in how to catch bank-robbers, but not in figuring out *why* a crime took place and how to prevent it, or in chasing down more complicated kinds of computer crime. The one improvement that has been made at most agencies is ending the practice of having bureaucrats serve for a few years as investigators before moving elsewhere in the bureaucracy.

Carter is said to be looking for young, sharp lawyers to head the office of inspector general, people who have the smoothness to handle the press and no desire to become career bureaucrats. But neither Ken Mansfield, the Inspector General at DOE, nor Thomas Morris at HEW fits that bill. Both are career government investigators known primarily for their ability to survive, to compromise and who have learned, in Lyman Kirpatrick's phrase, the tolerable limits of what they can do and still keep their jobs.

See No Evil....

Mansfield, it is said, got his job because he is a long-time crony of Senator Henry Jackson, chairman of the Senate Energy Committee, and he has continued to be a survivor. For all the talk of the independence of the inspector general, Schlesinger knows he has someone at DOE who will never cause him any serious problem or embarrassment; Mansfield will always stay under control. As a result at DOE the inspector general's office has fallen into the sadly

typical role of seeing, speaking, and hearing as little evil as possible. They are undoubtedly, as Fitzgerald would put it, on Schlesinger's side, and have no more inclination to uncover problems in the department than Schlesinger has. Schlesinger and Mansfield are casebook studies in how easy it is to render impotent the vision of an independent inspector general.

That is not to say that DOE does not have its own internal critics; the place is crawling with whistle-blowers. They give Schlesinger the headaches the inspector general's office won't—by leaking to the staff of the House subcommittee on energy and power chaired by Rep. John Dingell. (One of the little truisms about bureaucracy is that whistle-blowers much prefer to leak to Congress and then let the congressional staffs leak to the press. That way, they are insulated from reporters by an extra layer of leakage.) Dingell's staff is full of good, aggressive people who like nothing better than to call some high official at DOE on the carpet or to slip a little nugget to Jack Anderson, who regularly excoriates the department courtesy of the subcommittee staff.

As a result, the DOE inspector general has spent very little time finding fraud or waste on his own, and a good deal of time reacting to the latest subcommittee charge. Although they should be working together, the inspector general's office and the subcommittee staff are not on friendly terms, and the inspector general has reacted defensively (read: bureaucratically) to any charge that's made.

So when the subcommittee discovered one DOE employee taking worthless trips courtesy of the government and turning in fraudulent travel vouchers, the investigator from the inspector general's office went to the employee's superiors, and asked them if he was doing anything wrong. When they replied no, the investigation ended.

In a more serious case last summer, the subcommittee questioned the fitness for office of a high-ranking DOE official, claiming that he had, among other things, falsified his educational background, claimed two jobs he never held, claimed an award he never won, threatened potential DOT contractors while working for that agency, ordered the shredding of government documents to thwart public access, and committed a host of other sins.

Here the inspector general (and remember, this is a man with statutory independence—he can't be fired by the secretary) showed his mettle. First his investigators intimidated the witnesses by acting so obviously hostile they felt they were being threatened. Then the investigators made each witness sign a single form. This showed witnesses who else was talking and, more importantly, showed them that there wasn't going to be a lot of confidentiality in the investigation. Then the inspector general turned in his report: hundreds of pages of notes, interviews, and memoranda that failed to identify possible violations of federal laws, agency regulations, and standards of conduct, and ignored the most serious finding of impropriety. Finally, after the report was issued, the inspector general held off taking any action in the hope that the official would retire voluntarily, as it is rumored he might. This would keep the inspector general from having to do anything unpleasant.

The Numbers Game

At HEW, the situation is better. Undoubtedly, much of this springs from a genuine desire on Califano's part to root out fraud in his department, but it also comes from the realization that if he didn't do it, someone else would. When Califano came into office, the rise in the rate of student loan defaults was on the front pages, and Medicaid scandals were breaking all around him. Califano had reason to worry. If he didn't do

something quickly, Congress could take matters into its own hands—budgets could get cut, programs might be slashed, all the things that give Cabinet secretaries nightmares.

So Califano's inspector general, Thomas Morris, has been busy working up computer techniques that allow HEW to pinpoint duplicative welfare payments (savings, according to HEW: $50 million), to identify physicians and pharmacists filing improper Medicaid bills (nine indictments, three convictions, and "54 other cases sent to prosecutors"), to reduce the error rate in social security payments ($93 million saved), and to improve student loan payback rates ($50 million saved). The inspector general's office has also been quick to chase down fraud exposed in the papers, and quick to insure that they receive proper credit. When I was in the office of Bob Wilson, the inspector general's p.r. man, I saw a large stack of copies of a letter from Califano to Rep. John Moss, promising to go after two contractors. This bit of private correspondence had originally been "leaked" to *The Washington Star*.

The idea has been to show quick results and large savings. It is a numbers game. To any reporter who asks, Wilson will gladly hand over a two-page list of all the ways the office has saved government money since coming into existence. It adds up to hundreds of millions of dollars. Morris explained in an interview, "We have to depend on numbers because that's what the Congress and the press look at to show results." To keep Congress and the press happy, Morris has set quotas and target levels for reducing waste up through 1981. It all seems terribly efficient, except as one HEW investigator said, "I'd hate to be the one to have to prove those numbers."

From the beginning, Califano made it clear that this was the way he wanted the office to run. Soon after the office was established, Califano exclaimed grandly that the office's computers had estimated that between $5.5 and $6.5 *billion* was wasted every year at HEW. Those were big numbers, big enough that newspapers all over the country picked them up and have been using them ever since. What has not been mentioned much is that Califano blamed a great deal of this on *legislated* waste (as opposed to fraud)—for instance, he said the failure to pass a hospital cost containment bill was one reason the government wasted billions.

That was a sound criticism—health care costs have gotten way out of hand, and the government deserves a good helping of the blame. This is program failure of the first magnitude. But Califano has not allowed the kind of criticism he leveled at Congress to be directed at on-going HEW programs by his inspector general. Although Califano has not laid out any explicit directives to this effect, he has not had to; Morris understands the parameters. When I asked him if he felt restrained in how far he could go in criticizing Califano's beloved HEW programs, Morris replied: "I believe in all those programs too."

And that is the problem. Like Congress and the press (not so coincidentally) the inspector general at HEW is terrific at finding crooks and robbers. What he is not good at is taking the next (and indeed, the more important) step. He can collar all the student loan defaulters in America, but he can't (or won't) tell Califano what's wrong with the student loan program and how it should be changed. He can find phony education consultants, but can't explain why so many of HEW's education programs haven't improved the quality of education in America. In this, Califano's inspector general's office comes complete with a convenient set of blinders, for the game they are playing is based on the idea that if you can keep coming up with a steady stream of fraud, you don't have to worry about the billions wasted every year on sheer (but oh-so-legal) nonsense.

It would not be completely fair to say that *no one* at HEW looks at programs. In the inspector general's

office, a department with well over 1,000 investigators and auditors, a grand total of 15 people have been given that vital assignment. They are called the division of "Health Care and Systems Review."

Sadly, they do not have the bureaucrats quaking, partly because they are so terribly understaffed and partly because they have the endemic problem of producing unreadable reports, written in the technojargon understandable only to a GS-14. As long as the bureaucrats are the only ones who can understand these reports, they can also blithely "minimize their impact." It is the implicit threat of exposure that makes any evaluation effective, and that can work only if the exposes are written so that the congressman on the oversight committee and the reporter on the beat can understand them. Systems reviewese threatens no one.

The SPRO Fiasco

Perhaps the most telling example of how an inspector general's office can fail is the case of the Department of Energy's SPRO program (for Strategic Petroleum Reserve Office). Under SPRO, the energy department is supposed to buy and store oil in various locations in the Southwest, and for the past three years it has ostensibly been doing that. Unquestionably, this is one of the most important and useful things the government can do these days. With the threat of another oil shortage always hanging over our heads (witness the recent turmoil in Iran and its potential implications for U.S. oil supplies), here was the program that would ease us through any future crunch, the first line of attack in our moral equivalent of war.

The DOE inspector general has also been there from time to time to make sure everything was running smoothly and legally. According to someone involved in those investigations, the investigators spent their whole time looking into specific allegations and complaints—possible misconduct by this official, potential theft by that workman. What they failed to look at was the broader and more important picture, the justifications for the money being spent; evaluations of whether the policy was being carried out; a tough look at whether the program managers had a firm grasp on the situation.

While they were busy missing all this, the projected costs of the program were rising daily (from $25 to $30 billion), the work had fallen far behind schedule, and there were only 68-million barrels placed in the ground in three years instead of the scheduled 250 million. In one of its most vital programs, DOE has completely botched the job, and the inspector general's office was nowhere to be found with the criticism that would have raised the red flags. They either didn't see or didn't want to.

An inspector general who was doing the job the way it could be done would have raised those red flags early and often, would have woken up the Congress and the public to the problems, would have forced changes in the SPRO program before it had become so horribly mismanaged, and would have saved us billions of dollars.

That is the kind of potential that lies in the offices of the inspector general and that is why their creation is so important. This is also why what has happened at DOE and HEW is so lamentable. In their own ways, both Morris and Mansfield have fallen into the oldest trap of all—instead of asserting independence and authority, they have come to function exactly as their respective Cabinet secretaries want them to. And if the rest of the inspectors general go the way of these two, the hundreds of program managers in Washington will have nothing to fear. Despite all the hoopla over inspectors general, there still won't be anyone asking the question: "What the hell is going on out there?"

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INSPECTOR GENERAL PERIODIC REPORTING REQUIREMENTS

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INSPECTOR GENERAL PERIODIC REPORTING REQUIREMENTS

As with a substantial and growing number of Federal agencies, offices, and positions, 1/ statutorily established inspectors general (IG) have periodic (annual or semiannual) reporting requirements to the Congress. However, the requirements vary among the different offices of inspector general, since no one statute applies to all such entities.

I. OVERVIEW

Of the eighteen IGs created by public law, only two—those in the Army and in the Navy 2/—lack express obligations to report to the Congress. Interestingly, the Army IG, which was initially established by the Continental Congress in 1777 at the recommendation of General George Washington and other general officers, 3/ was the first such establishment and included specific reporting requirements. The resolution, approved Dec. 13, 1777, determined that "it is essential to the promotion of discipline in the American army, and to the reformation of the various abuses which prevail in the different

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1/ In the 96th Congress, for instance, more than 2000 provisions in public laws mandated reports from the President, Executive Departments and agencies, independent commissions, and public, quasi-public, and private corporations chartered by Congress. U.S. Congress. House. Committee on House Administration. Reports to Be Made to Congress; Communication from the Clerk, U.S. House of Representatives. H. Doc. No. 96-14, 96th Cong., 1st Sess. Washington, U.S. Govt. Print. Off., 1979.

2/ The present establishments and their authority and duties are codified at 10 U.S.C. 3039 for the Army and at 10 U.S.C. 5088 for the Navy.

3/ U.S. Department of the Army. The Army Almanac. U.S. Govt. Print. Off., 1950. p. 747.

departments, that an appointment be made of inspectors-general . . . ." 4/

The Continental Congress, which then exercised consolidated national authority, specified three types of information and findings which the IG was to report:

> Resolved, That the inspectors-general, respectively, shall make this review minutely, man by man, attending to the complaints and representations of both soldier and officer, and transmitting to Congress what petitions and grievances he shall think worthy of notice: that not solely depending upon the accounts and characters of officers as given him by the colonels of regiments, the inspectors-general shall examine the said officers in person, direct them to command different maneuvres, and take such measures as shall enable him to give an exact account to Congress.
>
> Resolved, That these reviews, when closed, be transmitted to Congress by the inspector-general making the review, who is to furnish the major of the respective regiments with a copy of the same, and to keep another for his own government and assistance in proceeding to the next review.
>
> Resolved, That the inspectors-general shall examine, from time to time, the pay-books of the respective regiments, which are to be kept in an uniform manner, agreeable to such regulations as may be established for that purpose, giving immediate notice to Congress of any malversation or mismanagement which he may discover. 5/

In addition to the inspectors general in the Army and Navy, sixteen other statutory offices, created by five public laws since 1976, presently exist. Among these there are three basic models that govern the periodic reports from the IGs: (1) the Inspector General Act of 1978 (P.L. 95-452), requiring

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4/ Journals of Congress, v. 2, Dec. 3, 1777. p. 872.

5/ Ibid., p. 873. An Inspector General's Department was later created by the Congress, under the Constitution, through the Act for the Better Organization of the General Staff of the Army of the United States, approved March 3, 1813 (12th Congress, Chapter 52; 2 Stat. 819-820). However, that enactment did not provide for IG reports to the Congress.

semiannual reports containing six specified types of information; (2) the 1976 enactment creating an IG for the Department of Health, Education and Welfare [now Health and Human Services (P.L. 94-505)], including four types of information; and (3) the Energy Security Act of 1980 (P.L. 96-294), calling for an IG in the U.S. Synthetic Fuels Corporation, whose annual reports will differ from its counterparts already established. There is also some variation in language controlling the submission and transmittal of IG reports--either directly to the Congress or via the agency head--and affecting comments which the agency head might append to such reports.

II. SPECIFIC STATUTORY REQUIREMENTS

This section examines the periodic reporting requirements of the 16 offices of inspector general established by statute with express mandates to report annually or semiannually to the Congress. Each of the five public laws creating those entities--12 of which were incorporated in the Inspector General Act of 1976 and one in each of the remaining four enactments--will be surveyed with respect to the following requirements: types of information; direct submission or transmittal via agency head to the Congress; semiannual or annual reports; and, where appropriate (i.e. annual reports), calendar or fiscal year reporting periods.

A. The Inspector General Act of 1978 (P.L. 95-452; 92 Stat. 1101)

This enactment created offices of inspector general in 12 Federal departments and agencies:

Departments	Agencies
Agriculture	Community Services Administration
Commerce	Environmental Protection Agency
Housing and Urban Development	General Services Administration
Interior	National Aeronautics and Space Administration
Labor	Small Business Administration
Transportation	Veterans' Administration

In terms of IG reporting, the Inspector General Act presents the most comprehensive requirements. Each IG must submit a semiannual report, by April 30 and by October 31 of each year, "summarizing the activities of the Office during the immediately preceding six-month period." Sec. 5(a) directs that such reports are to include, but need not be limited to, the following six items:

> (1) a description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of such establishments disclosed by such activities during the reporting period;
>
> (2) a description of the recommendations for corrective action made by the Office during the reporting period with respect to significant problems, abuses, or deficiencies identified pursuant to paragraph (1);
>
> (3) an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed;
>
> (4) a summary of matters referred to prosecutive authorities and the prosecutions and convictions which have resulted;
>
> (5) a summary of each report made to the head of the establishment under section (6)(b)(2) during the reporting period [i.e., the circumstances under which information or assistance requested by the Inspector General was "unreasonably refused" or not provided];
>
> (6) a listing of each audit report completed by the Office during the reporting period.

The report is "furnished to the head of the establishment and shall be transmitted by such head to the appropriate committees or subcommittees of the Congress within thirty days after receipt of the report, together with a report by the head of the establishment containing any comments such head deems appropriate." Within sixty days thereafter, the reports are to be made available to the public by the agency head at a reasonable cost. 6/

B. The Department of Education Organization Act (P.L. 96-88; 93 Stat. 668)

The 1979 creation of a Department of Education also included an office of inspector general, established in accordance with the provisions in the Inspector General Act of 1978 (P.L. 95-452). Even though the new Department was extracted primarily from the Department of Health, Education and Welfare (HEW) and its inspector general functions were transferred to the new IG, the Inspector General, Education is directed to conform to the reporting obligations of the Inspector General Act, rather than to those of its predecessor office in HEW, which had been created by Congress in 1976.

C. Act of Congress, Oct. 15, 1976 (P.L. 94-505; 90 Stat. 2429)

The first of the recent series of statutorily established offices of inspector general, the IG for the Department of Health, Education and Welfare, now the Department of Health and Human Services (HHS), has different

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6/ In 1979, via the Department of Justice Authorization Act for FY80 (P.L. 96-132; 93 Stat. 1051), a temporary Special Investigator was authorized for the Immigration and Naturalization Service (INS). Although the office was to be staffed by an appointee of the Attorney General, and not a Presidental nominee confirmed by the Senate, as in the case of IGs established by the Inspector General Act, the Special Investigator/INS was directed to abide by the reporting requirements of P.L. 95-452.

periodic reporting requirements than those operating under the Inspector General Act of 1978. Under P.L. 94-505, the IG/HHS is to report annually, not later than March 31, summarizing the activities of the Office during the preceding calendar year.

The report, which is submitted to the Secretary of the Department and to the Congress, is to include, but need not be limited to, the following four categories of information:

> (1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Department disclosed by such activities;
> (2) a description of recommendations for corrective action made by the Office with respect to significant problems, abuses, or deficiencies identified and described under paragraph (1);
> (3) an evaluation of progress made in implementing recommendations described in the report or, where appropriate, in previous reports; and
> (4) a summary of matters referred to prosecutive authorites and the extent to which prosecutions and convictions have resulted.

Three of these four are identical to that required under the subsequently enacted Inspector General Act of 1978. Item (3) under P.L. 94-505 differs, calling for "an evaluation of progress made in implementing recommendations . . in comparison to the Inspector General Act inclusion of "an identification of each signficant recommendation described in previous semiannual reports on which corrective action has not been completed . . . ." Moreover, the Inspector General Act also required two types of information that are not contained in P.L. 94-505: i.e., a summary of the reported circumstances under which information or assistance was not provided or "unreasonably refused" and a listing of each audit report completed by the Office.

Section 204(e) of P.L. 94-505 also calls for a direct submission of the IG annual reports to the Congress, "or committees or subcommittees thereof . . . without further clearance or approval." Nonetheless, advance copies may be furnished to the Secretary, "insofar as feasible . . . sufficiently in advance of the due date for their submission to Congress to provide a reasonable opportunity for comments of the Secretary to be appended to the reports when submitted to Congress."

D. The Department of Energy Organization Act (P.L. 95-91; 91 Stat. 565)

Within a year after enactment of P.L. 94-505, Congress established a second office of inspector general, in the newly created Department of Energy, modeled after the IG in Health, Education and Welfare and following the same reporting guidelines. The only difference regarding the annual reports is that the IG/Energy, in addition to submitting advance copies to the head of the Department for comments, is to submit it, when feasible, to another entity, if applicable: i.e., the Federal Energy Regulatory Commission, which might also append comments.

E. The Energy Security Act (P.L. 96-294)

The most recent statutory establishment of an office of inspector general—in the United States Synthetic Fuels Corporation (SFC)—was provided by the Energy Security Act (P.L. 96-294), signed into law on June 30, 1980. The periodic reporting provisions, contained in section 122, are an amalgam of those in the Inspector General Act of 1978 and in the 1976 act creating an IG/HEW (P.L. 94-505), plus separate unique requirements. Consequently, the reporting requirements for the IG/SFC represents a third basic model:

i.e., an annual report of the immediately preceding fiscal year's activities, submitted to the Board of Directors of the Corporation, which, in turn, transmits it to the President, the Speaker of the House, and the Senate Committee on Energy and Natural Resources within thirty days after receipt. The Board may append its own report "containing any comments it deems appropriate."

Moreover, the IG's annual report, due not later than Nov. 30 of each year, is to be made available to the public by the Board of Directors "upon request and at a reasonable cost within sixty days after its transmittal to the Congress."

The legal strictures defining the contents of the IG/SFC annual reports are more abbreviated than the provisions affecting counterpart offices. Section 122(c) requires only three basic elements:

> (1) an identification and description of significant problems, abuses, and deficiencies relating to the administration of programs and operations of the Corporation disclosed by such activities;
> (2) a description of recommendations for corrective action with respect to significant problems, abuses, or deficiencies identified and described under paragraph (1); and
> (3) a summary of matters referred to law enforcement authorities and the extent to which prosecutions and convictions have resulted.

All the IGs are required to identify and describe significant problems, abuses, and deficiences as well as describe the recommendations for corrective action. The IG/SFC, however, is directed to include a summary of matters referred to "law enforcement authorities," vis-a-vis "prosecutive authorities," the language adopted in the Inspector General Act and in the Act of 1976 creating an IG/HEW. There is no explanation for this language

difference in the conference committee report on the Energy Security Act, 7/ although, potentially, "law enforcement authorities" encompasses a significantly broader scope of officials than does "prosecutive authorites." The latter refers primarily to Justice Department officials responsible for receiving IG reports of probable violations of Federal criminal law, 8/ whereas the former could extend to officials in numerous entities beyond the Attorney General's office, including other inspectors general, especially the IG/Energy, the Federal Bureau of Investigation, and other law enforcement units among the more than 100 of the Federal Government. 9/

7/ As initially passed in the House, H.R. 3930 did not include a Synthetic Fuels Corporation, although the amended Senate version of S. 932 did, when approved on Nov. 8, 1979. However, the office of inspector general was not a part of that initial Senate version, added instead in conference. U.S. Congress. Conference Committee, 1980. Energy Security Act. Conference Report to Accompany S. 932. Senate Report No. 96-824, 96th Cong., 2d Sess. Washington, U.S. Govt. Print. Off., 1980.

8/ Sec. 4(c) of the Inspector General Act of 1978 (P.L. 95-452) and a conforming amendment to th 1976 Act establishing the IG/HEW, in the General Accounting Office Act of 1980 (P.L. 96-226; 94 Stat. 315), instruct the IGs to report "expeditiously to the Attorney General whenever the Inspector General has reasonable grounds to believe there has been a violation of Federal criminal law." Such reports to the Attorney General would presumably provide the basis for the "summary of matters referred to prosecutive authorites" required of the relevant IGs. With regard to the IG/SFC, P.L. 96-294 contains a similar directive—to report to the Attorney General suspected violations of Federal criminal law. But that would not, conceivably, comprise the bulk of "matters referred to law enforcement authorites."

9/ In 1978, the President's Reorganization Project Task Force on Law Enforcement identified 113 Federal law enforcement units, of which a majority engage in activities closely related to or overlapping with inspectors general: e.g., criminal investigations and enforcement (57 units) and internal employee investigations (58 units). Where subject matter jurisdiction is appropriate, many of these entities might be eligible recipients of IG/SFC "matters referred to law enforcement authorites." U.S. Office of Management and Budget. President's Reorganization Project. Federal Law Enforcement, Police and Investigative Activities: A Descriptive Report. Washington, 1978.

An even more important difference between the contents of IG/SFC reports and those of other statutory inspectors general is that the former expressly includes only three types of information, in contrast to the four types required of the IG/HHS (by P.L. 94-505) and of the IB/Energy (P.L. 95-91), or the six types required for the 12 IGs under the Inspector General Act (P.L. 95-452) and the IG/Education (P.L. 96-88). Absent from the IG/SFC annual reporting reqirements are these items:

—(1) an identification or evaluation of previously recommended but uncompleted corrective action;

—(2) a listing of each audit report completed by the office during the reporting period; and

—(3) a summary of instances in which information or assistance was not provided or "unreasonably refused" by other offices.

As noted above, 10/ the Conference Committee on the Energy Security Act, which erected an IG in the Synthetic Fuels Corporation, offered no explanation as to why particular matters were included or excluded in the IG reporting requirements.

III. SUMMARY OF IG PERIODIC REPORTING REQUIREMENTS

The following table summarizes the significant differences among the periodic reporting requirements associated with the sixteen offices of inspector general identified in the previous section. These are the statutorily created offices with express annual or semiannual reporting obligations to the Congress: i.e., sixteen offices among the present eighteen statutory IGs, operating

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10/ See footnote 6/ on p. 5.

under five public laws of origination. The five statutes include three distinct kinds of IG periodic reporting requirements, as shown in the table below.

In each case, the chart lists whether the report is annual or semiannual; whether the reporting period is the calendar or fiscal year, if an annual report; the final date of submission; whether it is automatically submitted to the agency head (and another entity) for comments before being transmitted to Congress or submitted only if feasible; and the number (3, 4, or 6) of specifically required items in the contents.

Inspector General Periodic Reporting Requirements

Statute	Annual(A) or Semiannual(S)	If annual, calendar(C) or fiscal year(F)	Date of submission	Automatic advance submission to agency head or only if feasible	No. of specified items
Inspector General Act (P.L. 95-452; 92 Stat. 1101) & Department of Education Act (P.L. 96-88; 93 Stat. 668)	S	—	April 30 & Oct. 31	Automatic	6
IG/HEW Establishing Act (P.L. 94-505; 90 Stat. 2429) & Department of Energy Act (P.L. 95-91; 91 Stat. 565)	A	C	March 31	If feasible	4
Energy Security Act (P.L. 96-294)	A	F	Nov. 30	Automatic	3

FMK/rla

APPENDIX O

11/19/77

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TO : All Regional Medicare Directors, HI

DATE:

[illegible] HHI-541

FROM : Director, Bureau of Health Insurance

SUBJECT: Identical Memorandum 77- --Responsibilities for the Investigating Function of Medicare Criminal Fraud Cases Memo of Understanding

The attached Memorandum of Understanding has been agreed to by the Social Security Administration and the Office of Investigations. This document delineates the respective responsibilities of both parties in cases of criminal fraud against the Medicare program. The Bureau of Health Insurance will continue its present program integrity activities with respect to Medicare, except where there is evidence warranting presentation to a United States Attorney or in certain other types of cases discussed in detail in the attachment. Medicare beneficiary fraud cases, however, will be referred, when appropriate, to the U.S. Attorney by BHI.

never occurred

The transfer from SSA to OI of manpower equivalent to that utilized in presenting cases to the U.S. Attorney and in subsequent support activities will be done with the concurrence of the Assistant Secretary, Comptroller. This transfer will involve budget adjustments of overall position ceilings of the respective organizations and will not require the actual transfer of people.

You may also be aware of memoranda between the Department of Justice, the U.S. Attorneys, and the Federal Bureau of Investigation concerning fraud investigations in the programs administered by the Department of Health, Education, and Welfare. The Department of Justice has decided to put greater emphasis on the investigations of suspected fraud in the health care delivery areas. The Federal Bureau of Investigation has instructed its agents to make themselves available to the U.S. Attorneys for investigative manpower in this area. They have also been instructed to coordinate their efforts with HEW's Office of Investigations.

Federal Bureau of Investigation resources may prove quite helpful in some of the more complex Medicare cases. Any contacts with the FBI should be coordinated with OI and both agencies should receive our complete cooperation.

Thomas M. Tierney

Attachment

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : Mr. Frank D. DeGeorge
Associate Commissioner for
Management & Administration, SSA

DATE: January 19, 1977

FROM : Deputy Director, OI

SUBJECT: SSA-OI Memo of Understanding
Ref IAD-37

Enclosed is the SSA copy of the OI-SSA Memorandum of Understanding signed by you and by John Walsh, Director, OI. We share your confidence that this agreement will support effective working relationships between OI and SSA for the future.

Nathan D. Dick

Nathan D. Dick

1 Enclosure

MEMORANDUM OF UNDERSTANDING

Pursuant to the Under Secretary's memorandum of October 8, 1976, the Social Security Administration and the Office of Investigations, Office of the Inspector General, Office of the Secretary, have reached the following understanding concerning the responsibilities of the parties in SSA cases involving criminal fraud and other violations of law.

I. Bureau of Health Insurance-Medicare Program

1. OI/OS will immediately assume investigative responsibility for all cases in which there is evidence warranting presentation to a United States Attorney that a crime has been committed by a physician, provider, or other supplier of items or services under the Medicare program. Point of Referral

2a. BHI/SSA will continue to perform all other present program integrity functions designed to identify physician or provider practices possibly involving fraud or other forms of abuse of the program, including inquiry into unsubstantiated allegations or other circumstances that could involve fraud under the Medicare program; and will advise OI/OS of any case in which it finds evidence of criminal violations of law warranting presentation to a United States Attorney for prosecutive interest.

2b. BHI/SSA will continue to investigate Medicare beneficiary fraud cases and will make direct referrals of such cases to the U.S. Attorney as appropriate.

3. BHI/SSA will continue to refer to OI/OS any case in which there is reason to suspect criminal involvement of a Government employee, a Medicare administrative agent, or organized crime as soon as there is reason to suspect such involvement. BHI will also continue to refer to OI/OS any case in which more than one HEW program is substantially involved as soon as such circumstances are established.

4. OI/OS, at its option, will refer to BHI/SSA unsubstantiated allegations or other circumstances that could involve fraud or abuse for development as described under 2., above.

5. The referrals and reports indicated by the foregoing will generally be made at the regional level; i.e., between the Health Insurance Regional Office and the parallel OI Field Office.

6. OI assumption of responsibility for a case under 2. or 3., above, may be carried out by direct control or monitoring of SSA inquiries depending on OI's assessment of the nature of the case and its other commitments.

7. All requests for assignment of HEW staff to U.S. Attorneys' Offices or Task Forces in connection with Medicare fraud matters will be forwarded to OI/OS for consideration.

8. Complaints concerning handling of Medicare cases by U.S. Attorneys should be submitted to OI/OS for consultation with Justice.

9. Manpower equivalent to that currently used by BHI for presentation of evidence to United States Attorney and subsequent case development (i.e., investigation and other activities in preparation for and support of prosecution following presentation to the U.S. Attorney) should be reprogrammed from SSA to OI.

II. Office of Program Operations--Cash Benefit Programs (Retirement, Survivors and Disability Insurance and Supplemental Security Income)

1. OPO/SSA will continue to investigate title II and title XVI fraud cases and will make direct referrals of such cases to the U.S. Attorney as appropriate.

2. OPO/SSA will continue to refer to OI/OS any title II or title XVI case in which there is reason to suspect criminal involvement of a Government employee, or of organized crime, as soon as there is reason to suspect such involvement. OI/OS investigation or advice will continue to be available in any other aggravated situation, and may be requested in any case, including those involving:

   (a) Large scale activities of persons who help or represent claimants in connection with their claims, and who are suspected of violating sections 206, 208, 1631, or 1632 of the Act.

   (b) Highly sensitive situations in which prompt investigation of suspected violations is necessary to prevent adverse public reaction.

   (c) Suspected violations by persons of high repute in the community when the district office believes an investigation by its own people would hamper its future effectiveness.

   (d) Unusually complex cases in which lack of knowledge of accounting practices or legal problems preclude effective investigation at the local level.

(e) Suspected violations in joint claims situations referred to the SSA by other Federal or State agencies and in which such agencies have an interest.

(f) The U.S. Attorney requests additional evidence or information not of a routine nature.

(g) Cases involving multiple service areas or regions when it is desirable that a single investigator handle the complete investigation.

3. OI/OS, at its option, will refer to OPO/SSA unsubstantiated allegations or other circumstances that could involve fraud for development as described under 1., above.

4. The referrals and reports indicated by the foregoing will generally be made at the regional level.

5. All requests for assignment of HEW staff to U.S. Attorneys' Offices or Task Forces in connection with title II and title XVI fraud matters will be forwarded to OI/OS for consideration.

6. Complaints concerning handling of title II or title XVI cases by U.S. Attorneys should be submitted to OI/OS for consultation with Justice.

III. Violation of Title 18, U.S.C. Involving HEW Employees

1. In accordance with Chapter 5-20, HEW General Administration Manual (currently being revised), violation of Title 18, U.S.C. by employees will be reported to the Director, OI. Title 18 is a codification of statutes involving crimes against the U.S.

2. In accordance with Section 535 of Title 28, U.S.C. and instructions of the Attorney General, the Director, OI, has the responsibility for the timely referral of Title 18 violations by Department employees to the Department of Justice or local office of the U.S. Attorney.

3. SSA headquarters personnel will report allegations of criminal violations by employees directly to the Director, OI, in Washington, D.C. Field personnel will report allegations to the local OI field office located in the Regional Office cities.

John J. Walsh
John J. Walsh, Director
Office of Investigations

1/18/77
Date

F. D. DeGeorge
F. D. DeGeorge
Associate Commissioner for
Management and Administration

1/15/77
Date

8/12/77

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
ATLANTA FIELD OFFICE
OFFICE OF INVESTIGATIONS

TO :Mr. Thomas Morris
Inspector General

Mr. Donald Nicholson
Director, Office of Program Integrity

DATE: November 10, 1977

FROM :Regional Director, HCFA/PI, IV
Special Agent In Charge, OI, Atlanta

OFFICIAL USE ONLY

SUBJECT:Operating Relationship Between OI and PI

Re joint memo by addressees 10/28/77, subject as above.

Rememo concerns operating relationships between OI and PI Regional staffs and requested a summary of regional procedures established to ensure proper identification of case to OI opened by OPI for full fraud investigation.

OPI has an established internal procedure whereby a formal decision is made to enter cases into a "full-scale investigative work load category". When cases move to this category OPI will notify OI. A form is being developed for this purpose. (OPI is in the process of reviewing cases currently in this category and will furnish OI a list of these cases.)

Cases ready for referral to the U. S. Attorney are referred to OI. In practice OPI usually brings the cases to the attention of OI prior to them reaching this point. For example, where appropriate, OI has been informed about and invited to participate in confrontation interviews for the benefits accruing to OI and OPI. Usually a "pre-referral conference" is arranged giving OI the opportunity to decide whether the case is ready for referral or whether OPI should do additional work before referral. These conferences are also initiated when OPI thinks early consultation with the U. S. Attorney is advisable. When a referral is consummated OI gives OPI a "receipt" thereby indicating formal assumption of control.

Regional guidelines reached prior to formal national guidelines and those currently in place under the "Operating Statement" were informal in nature. These informal procedures are now being formalized to more completely document discussion, referral, the OI decision regarding continuing activity, and the development of cases done by OPI exclusively to ensure the responsibility of the Inspector General is met.

OFFICIAL USE ONLY

OFFICIAL USE ONLY

The enclosed form has been developed to guarantee communication and to provide an audit trail showing case development should it be required. A copy of the form with accompanying instructions is enclosed.

Robert L Evans for Bufred M. Mosley

Frank D. White

OFFICIAL USE ONLY

MEMORANDUM

OFFICE OF THE SECRETARY
ATLANTA FIELD OFFICE
OFFICE OF INVESTIGATIONS

DATE:

FROM :

SUBJECT:

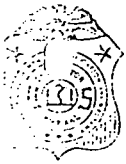
Reference Medicare/Medicaid Fraud Operating Statement, OIG/HCFA, 8/12/77.

I. Subject case was ☐ discussed ☐ referred by PIS _____ to SA _____ on _____.

II. Material furnished ☐ Memo ☐ Report ☐ File

III. Determination of future activity

- ☐ Close
- ☐ PI continue
- ☐ PI continue under OI direction
- ☐ OI accept case
- ☐ Present to U.S.Attorney _____ District of _____ on _____
- ☐ Presentation by PI
- ☐ Presentation by OI
- ☐ Presentation by PI and OI
- ☐ Post presentation case to be investigated by PI
- ☐ Post presentation case to be investigated by OI
- ☐ Post presentation case to be investigated by OI/PI
- ☐ Post presentation case to be investigated by FBI



IV. OI requirements of HCFA/PI on cases with USA when case is to be investigated by PI.

OI will be provided the following, at a minimum

A. 30 day case briefing memo, and if requested by OI or HCFA, a briefing

B. Discussion prior to, followed by supporting memo, involving major case activities, including

1. Subpoena Served by_____
2. Search Warrant Executed by_____with_____
3. Additional subjects
4. Grand Jury
5. Indictment
6. Conviction
7. Sentence

Bufred M. Mosley

OPERATING RELATIONSHIP BETWEEN OI AND PI
MEDICARE/MEDICAID FRAUD MATTERS

Instruction #1

Attached is one copy of form to which this instruction relates for your information and assistance.

Each Special Agent of the Office of Investigations, Atlanta Field Office has been issued a quantity of the attached forms with instructions to complete one upon each PI contact. There is no requirement on PI to complete the form. Copies as applicable will be forwarded to OI Headquarters, HCFA/PI, Region IV, and the case file. This dissemination will enable the Inspector General to have current information in order to fulfill his responsibilities to the Secretary and to Congress.

Items I-III are self-explanatory.

Item IV places reporting requirements on PI. These requirements are at a minimum. PI Specialists should use their judgement on matters they feel are of sufficient import to bring to the attention of the Inspector General through OI. Examples might be media interest and inquiries, unusual resistance or legal activity by subjects, etc. Appointments should be scheduled to hold formal discussions and briefings. No appointment will be required on matters of unusual urgency.

Exceptions to the general requirements are anticipated. A U. S. Attorney may be interested in a particular matter prior to discussion with OI. A U. S. Attorney might direct specific subpoenaes be served. Where the impetus is from outside PI, the PI Specialist should expeditiously inform OI and follow with supporting documentation. Copies of the legal documents involved; subpoena, search warrant with affidavit, indictment, etc. are required.

For those cases already pending with U. S. Attorneys, the form will serve as a guideline for preparation of the briefing memorandum with attachments.

OPERATING STATEMENT
OFFICE OF INSPECTOR GENERAL/OFFICE OF INVESTIGATIONS

HEALTH CARE FINANCING ADMINISTRATION/PROGRAM INTEGRITY
MEDICARE-MEDICAID FRAUD

I. Introduction

This statement sets out guidelines for a cooperative effort to control Medicare/Medicaid fraud by the Office of Inspector General's Office of Investigations (OI), and the Health Care Financing Administration's Program Integrity Staff (PI). By law and regulation the Inspector General has the responsibility to supervise, coordinate and provide direction for investigations relating to all the Department of Health, Education, and Welfare (DHEW) programs; the Inspector General's Office of Investigations contains professionally qualified criminal investigators and is responsible to him for all Departmental criminal investigations. The Health Care Financing Administration's (HCFA) Program Integrity Staff brings to this effort a staff experienced in investigating fraud cases and with extensive program knowledge. These guidelines are based on the principle that, recognizing the Inspector General's overall responsibility, the effective control of Medicare/Medicaid fraud can only take place through the most effective use of the strengths and skills of both staffs.

II. Development of Fraud Cases

A. Initial Complaints and Other Indications of Fraud - Except as noted in IV-B below, PI will ordinarily handle complaints and other indications of fraud received by PI. At its discretion, OI will either refer Medicare/Medicaid complaints received by OI to PI for screening and initial investigation or will develop them directly. Regional OI and PI will keep each other informed of complaints that cannot be closed through preliminary screening and which have passed to the initial investigation stage.

B. Substantiated Cases

1. OI will be informed immediately of all substantiated cases (cases in which fraud has definitely been identified) and will in turn advise PI of all such Medicare/Medicaid cases where OI developed the case. Cases believed to be particularly sensitive or complex by OI or PI will be discussed to explore investigative techniques and to make personnel assignments. Where grand jury involvement is anticipated, this discussion should include methods for the safeguarding of grand jury proceedings. Also plans to suspend payments to the suspect should be covered so that this decision can take into account both program and prosecutorial needs. *

2. PI will bring to OI's attention cases in which it is believed an initial informal contact to discuss case development with the U. S. Attorney (USA) is appropriate. At the discretion of OI, such contact will be made by OI and PI jointly or by OI or by PI.

3. In view of their ongoing relationship with Medicare contractors, the Medicaid State agencies and fiscal agents, and Social Security offices, contact with such offices for documents, technical assistance, etc., for use by OI will ordinarily be made by PI.

4. Contact with the FBI, the Postal Inspectors and other investigative agencies on individual cases will be made by OI, or at the discretion of OI by PI. (Continuing contacts with State agencies for monitoring and management purposes will be maintained by PI.)

III. Formal Referral to the U. S. Attorney

PI will inform OI of all cases which have been subject to complete investigation and which are ready for formal referral to the USA or which PI proposes to close. At the discretion of OI, formal referral of fraud cases to the USA will be made by OI or PI or jointly. Referrals of cases developed by PI will ordinarily be made by OI-PI jointly or by PI.

IV. Special Categories of Cases

A. Primary responsibility for investigation and referral of beneficiary/recipient fraud cases will rest with PI.

B. PI will refer to OI all cases involving the possibility of a crime by (1) Federal employee, (2) a contractor or State Agency employee or (3) organized crime.

At the discretion of OI, PI staff may be requested to assist in the investigation of such a case, but the control of the case will remain with OI.

V. Administration

A. Requests for assignment of PI staff to USA office or task forces received by PI will be referred to OI for consultation with Justice.

B. Referrals mentioned in this agreement will generally be made at the regional level.

C. Issues on general questions of approach and policy and issues on specific cases between OI and PI should be resolved locally. At the discretion of OI, issues on specific cases may be discussed with the USA for resolu-

tion. Issues that cannot be resolved locally should be submitted to OI and PI c/o components for resolution.

D. OI will assume the lead in providing training to PI in investigative procedures and will call on PI to provide or arrange for training in Medicare/Medicaid program areas.

E. This statement supersedes all previous agreements on the matter of Medicare-Medicaid fraud development. It remains in effect until it is itself superseded or specifically withdrawn.

Thomas Morris
Inspector General

Donald Nicholson
Acting Assistant Administrator
PI/HCFA

AUG 12 1977

Major imbarkation of OI on taking over our cases

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY

TO : Special Agents-in-Charge, OI
Regional Program Integrity Directors

DATE: April 6, 1978

FROM : Inspector General
Director, Office of Program Integrity

SUBJECT: OPI/OI Relationships; Criminal Investigation

In light of our experience over the past several months, we have begun to reassess the roles and relationships of OI and OPI in the conduct of Medicare and Medicaid investigations--both those where evidence of fraud exists and those where administrative and civil action may be warranted. We hope, over the course of the next 60-90 days, to create and implement a plan for transferring to OI operational responsibility for all criminal investigations and to revise our August 1977 Memorandum of Understanding accordingly.

Our goal in this process is to ensure that both the Department's investigative and its program integrity functions are performed in the most effective manner. We intend to achieve that goal in a way that will protect the integrity of both those functions as well as the career interests of all OI and PI staff.

We will begin by conducting on-site surveys of existing caseloads and staffing needs in all the regions and then, with the assistance of senior staff of both offices, will develop procedures for phasing in a new division of responsibility. Obviously, this process will require maximum cooperation from all concerned, and we will be in touch with all SAC's and Regional PI Directors in the near future to discuss their roles.

Thomas D. Morris
Inspector General

Don E. Nicholson, Director
Office of Program Integrity,
HCFA

9/14/78

HCFA
Regional Office Manual
Part 3
PROGRAM INTEGRITY GUIDELINES

U.S. Department of Health, Education, and Welfare

Health Care Financing Administration

Transmittal No. 3

June 1, 1979

OPI/FPQ21

New Material	Page No.	Replaced Pages
Table of Contents, Ch. XII	-	
Chapter XII	12-1 - 12-16	

NEW MANUAL -- Effective Date: June 1, 1979

Chapter XII - Administrative Items

The above chapter represents a revision of the former Health Insurance Regional Office Manual. The revisions take the form of a reorganization of the material, rewritten portions where appropriate, and a manualization of pertinent Program Integrity Memoranda. Additional chapters will be distributed as they are completed.

Don Nicholson
Director
Office of Program Integrity

CHAPTER XII

ADMINISTRATIVE ITEMS

9010 IDENTIFICATION CREDENTIALS

In the course of conducting Medicare and Medicaid investigations, Program Integrity personnel require adequate identification to assure those being interviewed of their authority. The central office has developed special identification credentials for Program Integrity Specialists to serve this purpose. However, because of the increased need for some form of Administration-wide official identification, OPI has established a new system for issuing and maintaining control of identification cards.

The Administrative and Appraisal staff in OPI's central office is now responsible for all administrative and procedural aspects involved in the procurement, issuance, and control of special purpose identification cards issued to OPI personnel both in central office and in the field. All requests for issuance or replacement of identification cards should be made through this staff.

Some control should be maintained in the RO to identify the holders of the special purpose identification cards by serial number. The Administrative and Appraisal staff will maintain a similar profile of each RO employee in possession of the special credentials.

The credentials form is a two portion card inserted in a leather carrying case which identifies the bearer as an officer of the Health Care Financing Administration, Office of Program Integrity and states his/her authority to conduct reviews or investigations for the Medicare and Medicaid provisions of the Social Security Act.

To request a credentials set, the RO should send a memorandum to the Administrative and Appraisal staff which includes the following information on the individual for whom the credentials set is intended:

1. Name
2. Position title
3. Social Security number
4. Organizational location, and
5. Two prints of a photograph of the individual

The photographs should be front views of head and shoulders of the employee and should measure 1 inch in width and 1½ inches in height. They should be in color and single weight. The employee's name should be written in pencil on the back of the prints for identification purposes in the event they are separated from the other material during processing. If official photographic facilities are not available in the field, the RO should purchase the necessary prints.

(5)

should be obtained which repeat the questioned signature at least five times, i.e., ONE SIGNATURE ON FIVE SEPARATE SHEETS OF PAPER. In the case of a questioned handwritten letter that involves a considerable amount of writing, it will not be necessary to obtain five specimens if the request writing is sufficient to show clearly the various writing characteristics of the individual. In such cases, two or three specimens which repeat the questioned writing will generally suffice.

When procuring specimens of handwriting, the same kind and size of paper should be used to prepare the known sample as is used in the questioned document; that is, ruled or unruled, bond, thin carbon sheets, wrapping paper, letter paper, envelopes, etc. If the endorsement or writing on a check is questioned, a blank check of the same variety should be used, or if one cannot be obtained then slips of paper comparable to the size of the check in question should be used. If any lines appear on the questioned document, these lines should be duplicated on the known document before the request specimens are written. A similar type of writing instrument should be used in the preparation of the request specimen as was used in writing the questioned material; that is, black lead pencil (with soft, medium, hard lead), indelible pencil, fountain pen, ball point pen, etc. In the event that the questioned writing was prepared with a broad felt tip or fibre tip pen, specimens prepared with both a broad tip and a regular tip pen should be obtained.

Conditions identical with or similar to those that existed at the time the questioned writing was prepared should be duplicated as nearly as possible when the request specimens are written. For example, if it is indicated that the questioned writing was prepared when the writer was in a standing position, some specimens should be obtained with the writer in a standing position. It is also desirable to obtain specimens written while the writer is in a sitting position, and sometimes it may even be necessary to obtain specimens when the writer is in a prone or supine position, as might be the case with a hospital or bedridden individual.

The words to be written should be dictated, and the writer should not be allowed to see the document in question until after the handwriting specimens are obtained. As soon as the specimen has been completed it should be removed from the view of the writer to prevent him from effectively disguising his handwriting and copying the disguise on each succeeding specimen. The specimen should exactly repeat the questioned writing, whether it be a signature, note, letter, or merely small portions of writing.

It should be noted that a "family resemblance" in handwriting frequently exists, i.e., other members of the same household often have similar writing characteristics. Thus, where it is indicated that another member of the subject's family may have been responsible for the questioned writing, it is

7. Does the document contain mechanical or chemical erasures, different colored inks, different kinds of type, alterations, interlineations or substitutions of any kind?

8. Is there good continuity of language and writing style between succeeding pages; does the typewriting show similar ribbon intensity with other records of the same date?

9. If the document is a letter, does the envelope (including postage stamp, postmark, cancellation stamp, and manner of sealing and opening) appear to be genuine and consistent with the letter itself?

10. Are there indentations or embossments in the questioned document which may have resulted from writing or typing on a paper which was on top of the subject document?

11. Do the names, streets, dates or events referred to in the questioned document appear to be consistent with other evidence developed?

9030 GIVING THE MIRANDA WARNING

When requesting information, records, etc., in connection with a criminal (full-scale fraud) investigation which the Office of Investigations has authorized or requested OPI to conduct, there are certain situations in which the individual from whom the information is requested should be given the Miranda warning, to allow the admission of the information received as evidence in court. (See section 4020.G, p. 5-20 for the rights which must be read the individual.) The following guidelines should be applied in determining whether the Miranda warning should be given.

When OPI requests information, records, etc., from an individual as part of a criminal investigation, and that individual is suspected of involvement in the criminal offense under investigation, the Miranda warning should be given the individual prior to requesting the information, records, etc. Similarly, when OPI confronts an individual to question that individual of his knowledge of the matters which are being investigated, the Miranda warning should be given the individual prior to the confrontation.

However, when OPI requests information, records, etc., from a provider, supplier, practitioner, or other person as part of a program validation study, integrity review, or other OPI activity, OPI need not give the Miranda warning to an individual, unless the request for information is specifically directed to that individual and that individual is suspected of criminal involvement in an activity under investigation and could by disclosing the requested information, incriminate himself.

effectively absolves the informant from any legal liability.

If the OPI RO determines that there is a need for obtaining a subpoena, the OPI RO should contact the OI RO to notify them of OPI's intention to subpoena information; OI may, based on the information in the possession of OPI, wish to assume jurisdiction and have the subpoena issued by the Inspector General.

B. Obtaining Subpoenas.--Subpoenas can be granted administratively from the Secretary of HEW, the IG, or the Principal Regional Officials (PROs), of HEW. Procedures for the issuance of subpoena by the PROs are contained in Administrative Directive Guides SSA195-3, Section VII - Procedures for Issuance of Subpoenas. The RO OPI staff will confer with the central office before recommending to the PRO that a subpoena be issued.

The Inspector General also has subpoena power by law. This authority is granted to the Inspector General only and is not delegated to Office of Investigations' personnel.

Subpoenas are also obtainable from the court. The grand jury can issue a subpoena in its investigation. The OPI staff investigating the case will make requests for subpoenas to the United States Attorney who acts as an agent of the grand jury. Court subpoenas for the trial proceedings are issued in accordance with the procedures contained in Rule 17, Federal Rules of Criminal Procedure.

9050 OI/OPI OPERATING STATEMENT

During the summer of 1977, with the establishment of the Office of the Inspector General and the Health Care Financing Administration, it became clear that in the area of criminal fraud investigations, both the Office of Investigations of the Inspector General's Office and the Office of Program Integrity, HCFA, had been carrying out many similar functions.

In order to more clearly define roles and responsibilities during the period of transition, an operating statement was signed by the Inspector General and the Acting Assistant Administrator of Program Integrity.

As the two organizations began to implement their respective functions, it became necessary to more fully define the respective roles of the two organizations. Therefore, a new operating statement was prepared and signed to reflect their new responsibilities. This new operating statement dated September 14, 1978, superseded the August 24, 1977 operating statement. It was previously issued as Program Integrity Memorandum No. 78-51.

A copy of this revised operating statement is found at Exhibit 1.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFAR
OFFICE OF THE SECRETARY

TO : Office of Investigations Staff
Office of Program Integrity Staff

DATE: September 14, 1978

FROM : Inspector General
Assistant Administrator for Program Integrity

SUBJECT: Revised OI/OPI Operating Statement

During the summer of 1977, with the establishment of the Office of the Inspector General and the Health Care Financing Administration, it became clear that in the area of criminal fraud investigations, both the Office of Investigations of the Inspector General's Staff and the Office of Program Integrity, HCFA, had been carrying out many similar functions.

In order to more clearly define roles and responsibilities during this period of change, an operating statement was signed by the Inspector General and the Acting Assistant Administrator of Program Integrity.

As the two organizations have implemented their respective functions, it has become necessary to more fully define the respective roles. Therefore, we have prepared and signed a new operating statement reflecting our revised responsibilities. This new operating statement supersedes the August 24, 1977 operating statement for OI and OPI.

In establishing the new procedures, we recognize there will be an interim period during which cases presently being worked by OPI must be handled in one of the following ways:

1. Cases already referred to U. S. Attorneys by OPI will be completed by OPI.

2. Cases undergoing active field investigation by OPI will go to OI or stay with OPI depending on the extent of developmental work already done by OPI. OPI will complete those cases where continued OPI work will result in the most effective handling of the case. This could be for a variety of reasons including the extent of work completed,

OFFICE OF INSPECTOR GENERAL/OFFICE OF INVESTIGATIONS

HEALTH CARE FINANCING ADMINISTRATION/
OFFICE OF PROGRAM INTEGRITY
MEDICARE-MEDICAID FRAUD

I. Introduction

This statement sets out guidelines for a cooperative effort to control Medicare/Medicaid fraud by the Office of the Inspector General's Office of Investigations (OI) and the Health Care Financing Administration's Program Integrity Staff (OPI). By law and regulation, the Inspector General has the responsibility to supervise, coordinate and provide direction for investigations relating to all the Department of Health, Education, and Welfare (HEW) programs. To meet this responsibility, the IG's Office of Investigations is staffed by professionally qualified criminal investigators who are responsible for all departmental criminal investigations. The Health Care Financing Administration's (HCFA) Program Integrity Staff brings to this effort professional staff with extensive program knowledge who have demonstrated a strong capability and experience in developing and investigating cases of Medicare and Medicaid fraud and abuse. These guidelines are based on the principle that, recognizing the Inspector General's responsibility, the effective control of Medicare/Medicaid fraud can only take place through the most effective use of the strengths and skills of both staffs.

II. Preliminary Review

OPI will perform a preliminary review on complaints which it receives and on other information regarding aberrant practices which it identifies or receives.

A. Fraud

At the point in the preliminary review where OPI staff have sufficient information to believe a strong potential for fraud warranting full-scale investigation exists, the case will be referred to OI and all additional developmental work will be performed by OI.

Operative language is ... strong potential for fraud ...

but which do not present potential for fraud will be developed by OPI for administrative action.

III. Contacts with Other Offices and Organizations

A. In view of their ongoing relationship with Medicare contractors, Medicaid State agencies and fiscal agents, and Social Security offices, OPI will inform these organizations, upon learning that OI has accepted a matter for criminal investigation, except in those cases where such notification would in any way compromise the investigation, that they may be contacted by OI for information to support their investigation. All other contacts on individual fraud cases (with exception of those covered in item B) will be made by OI.

It is further understood that there may be occasions when OI will need direct contact with the agencies and entities mentioned in this paragraph, at the very onset of an inquiry. Where appropriate, OI will advise OPI of such contacts. OPI will utilize its relationship with these agencies and entities to educate them to this possibility. OI will apprise OPI of any problems in obtaining information from contractors and States.

B. With respect to withholding of payments in criminal cases, particularly where Grand Jury action has not begun, OPI will decide the appropriateness of the withholding action and will instruct contractors and advise State agencies. At the time of referral to the U. S. Attorney or earlier if at all possible, OI will provide OPI access to case file information consistent with applicable law, necessary to justify the withholding action and the estimated dollar amount overpaid.

Upon indictment and disposition in any Medicare or Medicaid case, OI will follow the requirements in the Medicaid/Medicare Fraud Reporting System and will immediately notify OPI and furnish OPI with copies of the judgment so that HCFA can take appropriate suspension or termination action. In addition, in the case of a physician or other practitioner, OI, consistent with applicable law,

V. Special Categories of Cases

A. Primary responsibility for investigation and referral to U. S. Attorneys of beneficiary/recipient fraud cases will rest with OPI unless there is an indication of a conspiracy with a third party such as an employee of the paying agent or a medical provider in which instance the case will be the responsibility of OI.

B. OPI will refer to OI without any preliminary investigation all allegations involving the possibility of a crime by (1) a Federal employee, (2) a contractor or State agency employee, or (3) organized and recognized major criminal elements.

C. OPI will refer forgery cases to the Postal Inspectors or appropriate local authorities.

D. OPI will handle cases involving assignment violations and will refer cases involving potential prosecutions to OI for additional investigation and submission to a U. S. Attorney.

E. With respect to complaints involving a practitioner, OPI will conduct its normal initial review. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendants should be deferred to OI.

F. In cases involving supplier fraud, OPI will conduct its initial review process which will include the analysis of supplier records, laboratory records, etc.

G. With regard to institutional fraud, including fraud in the certification process, because of case complexities and the various kinds of fraud perpetrated, it is not possible to formulate the type of case to be referred. OPI will have the responsibility, based on initial development, to document the facts of a case which warrant a recommendation for a full-field investigation by OI. However, OPI will advise and periodically brief OI on the institutional case workload in which the potential for fraud may exist.

H. OI will be immediately notified of any allegation or

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whether a case should be investigated for fraud or handled administratively.

D. This statement supersedes all previous OI/OPI agreements on the matter of Medicare/Medicaid fraud development. It remains in effect until it is itself superseded or specifically withdrawn.

Thomas D. Morris 9/13/78
Thomas D. Morris
Inspector General

Donald E. Nicholson 9/13/78
Donald E. Nicholson
Assistant Administrator
for Program Integrity

Note the different esteem granted these SSA investigators. Contrast it with the attitude of OPI implicit in our MOUs. 1979

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND SOCIAL SECURITY ADMINISTRATION

IF-8-2

DATE: DEC 18 1979

REFER TO: SLB-1

TO : All Field Assessment Officers
Attention: Directors, Integrity Staffs

FROM : John B. Schwartz, Director
Office of Security and Program Integrity

SUBJECT: Policy and Procedures Statement on OI/SSA Program Integrity Relationship--INFORMATION

The attached statement which addresses the interrelationship between the Office of Investigations and the Integrity Staffs was prepared by Don Dick following your meeting with him. It is intended to implement the OI/SSA Memorandum of Understanding and to provide a basis for an improved relationship between the two organizations. I think it particularly significant that the statement stresses that the staff of the Office of Investigations and the Integrity Staffs are full partners in the effort to combat fraud and related violations in in SSA programs.

I am sure you will do your utmost to promote the spirit of cooperation evidenced in the statement.

If you run into problems which you think the statement should have taken care of, please let us know. If you have questions, you can call Ron Santo on (FTS) 934-1688.

John B. Schwartz

Attachment

NOV 19 [illegible]

OI Policy and Procedures to Implement
OI/SSA Memorandum of Understanding

1. OI staff and PIO staff are full partners in the effort to combat fraud and related violations in SSA programs. This is not a part time or limited partnership but full partnership.

2. In the discharge of their duties and responsibilities, as covered by the MOU, to investigate beneficiary fraud cases, PI investigators are criminal investigators. They will be afforded the courtesy of OI as criminal investigators regardless of what their position classification series may be or their position title.

   In the performance of this portion of their work they are conducting criminal fraud investigations, preparing cases for presentation to the U.S. Attorney and assisting in trial preparation of beneficiary fraud cases.

3. Any criminal investigator training deficiencies for SSA PI investigators are the problem of SSA management. It is not OI's position to judge the competence of PI's investigators nor is it OI policy to make their job more difficult through an OI superiority attitude. (OI has experienced some of this from FBI personnel looking down on OI Special Agents. We do not like it nor do the PI investigators.)

4. OI personnel will assist SSA, upon request, in training sessions for their investigators to the degree that OI workload permits and a particular training expertise is available. Such training may be at SSA Headquarters or in the Field.

5. The "rule of thumb" on when an SSA employee matter should be referred to OI is: When a possible violation of law has been established or when during an administrative inquiry interview by SSA the employee makes an admission against interest of an action which is a violation of law.

6. Definition of "referral to OI": A referral to OI can range from a verbal discussion with the SAC or his designated representative to a formal written referral to the SAC or to OI Headquarters.

7. OI options at time of referral:

   a. Permit SSA to continue the investigation under the supervision and guidance of OI
   b. OI/SSA joint investigation
   c. OI takes the case exclusively

   It must be recognized that OI staff is limited with a heavy workload. Also there may be urgent program reasons for an SSA desire to continue the case or participate in the investigation. Use their talent and assistance when appropriate. Make the partnership work.

8. When SSA desires to take administrative action in a case under OI investigation the PIO will make this known to the SAC. The SAC will seek approval from the U.S. Attorney, whenever possible to do so, recognizing that SSA must protect the public trust in the management and operation of its programs.

9. There shall be an open line of communication between the OI SAC and the SSA PIO. It should not only occur when there is a problem but rather on a fairly regular basis to facilitate a joint effort to accomplish the objective.

10. The PIO will assist OI in obtaining SSA documents and records when asked to do so. Frequently they are able to save OI time and trouble.

11. OI will afford SSA employee referral cases appropriate priority attention within existing OI guidelines on all employee cases--i.e., referral to the Attorney General, the U.S. Attorney or the FBI within ten work days after receipt. When OI workload is such that prompt investigation of the alleged violation cannot be conducted by OI or SSA PI/OI, consideration should be given to referral of the case to the FBI for investigation.

Nathan D. Dick

Nathan D. Dick
Assistant Inspector General
for Investigations

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELF
HEALTH CARE FINANCING ADMINISTRATION

TO : Regional Administrators

DATE: JAN 24 1980

REFER TO: FNV22

FROM : Acting Director
Bureau of Quality Control

SUBJECT: Revised Memorandum of Understanding Between the Office of the Inspector General/Office of Investigations and the Health Care Financing Administration - Medicare/Medicaid Fraud—ACTION

Attached for your information is a draft copy of a proposed Memorandum of Understanding (MOU) between the ~~Office of the Inspector General/~~ Office of Investigations (OI) and the Health Care Financing Administration (HCFA), which revises and updates the current MOU dated September 14, 1978, between the OIG and the Office of Program Integrity (OPI).

In general, the proposed new MOU emphasizes the increased role of OI in the investigation, coordination, and direction of overall Medicare/Medicaid fraud investigative activities and HCFA's increased responsibilities in the areas of validation/administrative sanctions. Major specific revisions are set forth as follows:

1. Within 45 days of referral, OI will inform HCFA regionally in writing as to whether they have specific objection to HCFA taking concurrent administrative/sanction action (page 3).

2. HCFA will assume no responsibility for civil fraud activity in the future except in an advisory capacity on an ad hoc basis (page 4).

3. Effective July 1, 1980, HCFA will no longer perform any monitoring role as regards fraud investigative activities in those States which do not have certified Medicaid fraud control units. OI will assume these duties as of the above date (page 8).

4. HCFA will maintain the national Medicare/Medicaid Fraud and Abuse Workload Reporting System for both fraud and abuse cases until July 1, 1980. All Medicare/Medicaid fraud data in the system, at that time, as well as all historical Medicare fraud data not included in the current system, will be transferred to OI. OI will then have complete

responsibility for the further maintenance of the national Medicare/Medicaid fraud workload system (page 11).

5. After July 1, 1980, compliance with all requests of any kind, from whatever source, for statistical data on past and present Medicare/Medicaid fraud cases/ investigations, will be the sole responsibility of OI (page 12).

6. HCFA staff may be requested to assist OI in a specific case or related group of cases, but only after formal written request has been made by OI, and approval has been received from HCFA/CO. In these instances, the ultimate presentation of the case(s) to the U.S. Attorney will be made jointly by both OI and HCFA staff members (pages 12-13).

Should members of your staff wish to discuss the revised MOU in greater detail, contact should be made with Clarke Bowie, Field Operations Branch at (FTS) 934-2077.

If you wish to comment on the proposed attached MOU, please do so in writing, to the Field Operations Branch, Office of Program Validation, no later than close of business February 4, 1980, in order that we might comply with a very tight schedule for negotiation with the Office of the Inspector General.

Your cooperation in this matter is appreciated.

Martin L. Kappert

Attachment

cc:
Program Integrity Directors

Operating Statement

Office of the Inspector General/Office of Investigations

Health Care Financing Administration

Medicare/Medicaid Fraud

I. Introduction

This statement sets forth revised guidelines for a cooperative effort to control Medicare/Medicaid fraud by the Office of the Inspector General's Office of Investigations (OI), and the Health Care Financing Administration (HCFA).

These revisions are necessitated by the need to firmly establish the current OI role in the investigation, coordination, and direction of overall fraud investigative activities in the Medicare/Medicaid programs, as well as to set forth a clear delineation of the decreasing role of HCFA in the fraud area, and the increased HCFA responsibilities as regards validation/administrative sanctions.

This revision also updates the current OI/OPI operating statement dated September 14, 1978, to more clearly set forth the general duties and responsibilities of the respective two offices, eliminates those sections which are no longer applicable; adds appropriate new sections, and provides for signoff by present top management officials.

II. Preliminary Integrity Reviews

HCFA will perform an integrity review on complaints which it receives, and on other information regarding aberrant practices which it identifies or receives:

A. Criminal and Civil Fraud

1. Criminal Fraud

At the point in the integrity review where HCFA staff have sufficient information to believe a strong potential for fraud warranting full-scale investigation exists, the case will be referred to OI, and all additional developmental work will be performed by OI.

In a non-institutional case (Part B), strong potential for fraud would exist when the integrity review investigation results in a 30 percent success ratio as regards beneficiaries contacted (i.e., 3 of 10, 6 of 20, etc., beneficiaries contacted during the integrity review phase deny receiving services as billed by the provider).

In an institutional case (Part A), strong potential for fraud would exist when an investigation is extended beyond the desk audit stage into the field audit stage, and the field audit reveals cost report entries which cannot be explained away as clerical error (e.g., personal expenses are charged to the cost report; nurses whose salaries are charged to the certified portion of a facility are signing medical records of patients located in the non-certified portion; costs disallowed in previous years are included in the current year's costs, etc).

The referral will consist of HCFA preparing a narrative summary of all activity and information on the case, and transmitting this to OI together with the complete case file. In the narrative, HCFA will set forth a listing of the various administrative/sanction activities which it plans to take concurrent with the criminal investigation to be undertaken by OI.

Within 45 days of referral, OI will inform HCFA regionally in writing as to whether they have specific objection to the taking of concurrent administrative/sanction action by HCFA. In the same memorandum, OI will inform the regional HCFA office whether they intend to schedule the case for investigation; and, if not, OI will return the case to HCFA along with the memorandum.

HCFA will immediately refer to OI any case where a Medicare or Medicaid fraud complaint has been received on a matter which is currently under a full-scale Medicare or Medicaid investigation by OI, any other Federal investigative agency or by a State agency or State Medicaid Fraud Control Unit.

In the course of the settlement of the criminal case, OI will always involve the HCFA regional office in any presentencing negotiations which would have a bearing on HCFA's ability to take present or future administrative overpayment determination/recovery action, as well as sanction activity as regards termination/exclusion/suspension.

2. Civil Fraud

In those cases investigated by OI where a decision by the U.S. Attorney to prosecute or not to prosecute criminally has been made; OI will have the responsibility for pursuing either civil fraud under the False Claims Act (31 U.S.C. 231) or common law recovery action. HCFA will assume no responsibility for any part of the civil fraud investigation except in advisory capacity on an ad hoc basis in cases involving civil negotiation as opposed to prosecution by civil suit. HCFA will also be involved in all presentencing negotiation which involves the settlement of the civil suit, where such negotiation would have a bearing on HCFA's ability to take present or future administrative overpayment/recovery action and/or termination/ exclusion/suspension activity.

3. Reporting in Criminal/Civil Fraud Cases

Until July 1, 1980, when OI accepts a case for full-scale investigation, it will be OI's responsibility to prepare a HCFA-50 (HEW-654), and submit the form to the HCFA regional office for entry into the Medicare/Medicaid Workload Reporting System. OI will be responsible for all updating entries on the form and timely submittal to HCFA, through completion of the civil fraud disposition section of the form. (See Section VI below for further discussion on workload reporting duties and responsibilities.)

B. Non-Fraud Cases

Those situations where aberrant practices exist, but which do not present potential for fraud, will be developed by HCFA for administrative action.

III. Contacts with Other Offices and Organizations

A. In view of their ongoing relationship with Medicare contractors, Medicaid State agencies and fiscal agents, and Social Security offices, HCFA will inform these organizations, upon learning that OI has accepted a matter for criminal investigation, except in those cases where such notification would in any way compromise the investigation, that they may be contacted by OI for information to support their investigation. All other contacts on individual fraud cases (with exception of those covered in item B) will be made by OI.

It is further understood that there may be occasions when OI will need direct contact with the agencies and entities mentioned in this paragraph, at the very onset of an inquiry. Where appropriate OI will advise HCFA of such contacts. HCFA will utilize its relationship with these agencies and entities to educate them to this possibility. OI will apprise HCFA of any problems in obtaining information from contractors and States.

B. With respect to withholding of payments in criminal cases, particularly where Grand Jury action has not begun, HCFA will decide the appropriateness of the withholding actionand will instruct contractors and advise State agencies. At the time of referral to the U.S. Attorney, or earlier if at all possible, OI will provide HCFA access to case file information consistent with applicable law, necessary to justify the withholding action and the estimated dollar amount overpaid.

Upon indictment and disposition in any Medicare or Medicaid case, OI will follow the requirements in the Medicare/Medicaid Workload Reporting System, i.e., update of HCFA-50 (HEW-654), and will immediately notify HCFA and furnish HCFA with copies of the judgment so that HCFA can take appropriate suspension action pursuant to HR 3, P.L. 95-142, termination or exclusion action pursuant to HR 1, P.L. 92-603, or other appropriate sections of the Social Security Act. In addition, in the case of a physician or other practitioner, OI, consistent with applicable law, will provide HCFA with all information necessary to determine the length of the suspension.

C. Continuing contacts with Medicaid State agencies and contractors for monitoring and management purposes will be maintained by HCFA. OI will assume these responsibilities as regards State Medicaid Fraud Control Units and State investigative agencies in States which do not have certified units under Section 17, P.L. 95-142, (HR 3).

D. Contact with the FBI, Postal Inspector (except in forgery cases covered in Section V.C. of this paper) and other investigative agencies on matters under criminal or potential criminal investigation will be made by OI. OI may ask HCFA to provide ad hoc programmatic assistance to investigative agencies.

E. OI will consult with HCFA on any restitution of funds agreement reached in plea bargaining or the probationary determination process. (See also Section II, A. 1 and 2 above).

F. HCFA will expeditiously notify OI of any suspension from participation in the Federal Health Care Programs, of any payment withheld, and of any termination of a provider agreement, in any case that was investigated by OI or has been scheduled for investigation by OI, in any case that has been referred to OI to another agency for investigation, Federal or State, or in any task force effort where OI had either an investigative or a monitoring role.

G. If access to records is denied during any initial review, OI should be immediately contacted to discuss the possibility of their exercising subpoena power. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendants should be deferred to OI.

IV. State Medicaid Fraud Control Units

Total responsibility for the certification, recertification, monitoring, funding, etc., of the State Medicaid Fraud Control Units will rest with OIG. OI will also assume the timely preparation and submittal of new and updated Forms HCFA-50 (HEW-654) into the Medicare/Medicaid Workload Reporting System. These forms will be submitted according to a predetermined singular plan either through the HCFA regional office to HCFA central office or from OI central office to HCFA central office. Only one method of input into the system will be allowed in order to provide continuity, and to assure that all necessary forms are, in fact, placed into the system for control purposes.

OI will also establish liaison with State agencies which do not have certified units, and will provide similar assistance as described above as regards input of case data into the system. Effective as of July 1, 1980, HCFA will no longer have any monitoring role as regards fraud investigative activity of any type, either State or Federal. (See Section VI below for further discussion of workload reporting duties and responsibilities.)

V. Special Categories of Cases

A. Primary responsibility for investigation and referral to U.S. Attorneys of beneficiary/recipient fraud cases will rest with HCFA unless there is an indication of a conspiracy with a third party such as an employee of the paying agent or a medical provider, in which instance the case will be the responsibility of OI.

B. HCFA will refer to OI without any preliminary investigation all allegations involving the possibility of a crime by (1) a Federal employee, (2) a contractor of State agency employee, or (3) organized and recognized major criminal elements.

C. HCFA will refer Medicare check forgery cases to the U.S. Postal Inspection Service or appropriate local authorities. OI will continue to provide HCFA with handwriting analysis support through the FBI Document Lab on all cases of forgery which do not involve postal violations, or cases declined by the Postal Service due to manpower limitations.

D. HCFA will handle cases involving assignment violations, and will refer cases involving potential prosecutions to OI for additional investigation and submission to a U.S. Attorney.

E. With respect to complaints involving a practitioner, HCFA will conduct its normal initial integrity review. Once the potential for fraud is identified in the integrity review process, all interviews with potential suspects or defendants should be deferred to OI.

F. In cases involving supplier fraud, HCFA will conduct its integrity review process which will include the analysis of supplier records, laboratory records, etc.

G. With regard to institutional fraud, including fraud in the certification process, because of case complexities and the various kinds of fraud perpetrated, it is not possible to formulate the type of case to be referred. HCFA will have the responsibility, based on initial development, to document the facts of a case which warrant a recommendation for a full-field investigation by OI. However, HCFA will advise and periodically brief OI on the institutional case workload in which the potential for fraud may exist.

H. OI will be immediately notified of any allegations or information concerning kickbacks or rebates coming to the attention of HCFA. OI will then assume the responsibility for that phase of the investigation.

VI. Medicare/Medicaid Workload Reporting System

HCFA will maintain the national Medicare/Medicaid Workload Reporting System consisting of pending and closed fraud and abuse cases reported by OI, HCFA, State agencies, Medicare contractors, and State Medicaid Fraud Control Units.

The system will be maintained by HCFA centrally at the outset, with ultimate transfer of case input responsibilities to the various HCFA regional offices at such time as regional data input capability can be established.

HCFA will produce computer printouts for analysis by OI on request, or at regular intervals to be decided, involving pending and closed fraud case data input from HCFA-50's (HEW-654's) prepared by OI, State investigative agencies or State Medicaid Fraud Control Units.

OI will be responsible for assuring the timely preparation and update of HCFA-50's (HEW-654's) by the OI regional offices, State investigative agencies and State Medicaid Fraud Control Units, and for proper submittal of all such forms to HCFA for system input.

OI will also have responsibility for preparation, update, and submittal of HCFA-50's (HEW-654's) to HCFA on all full-scale cases not referred to OI by HCFA. Likewise, when OI is informed that another investigative body has a Medicare or Medicaid fraud case under full-scale investigation, OI should prepare a HCFA-50 (HEW-654), and transmit it to HCFA. OI will also be responsible for the submittal of all update forms on cases of the above types until the criminal and civil fraud aspects have been completely disposed.

HCFA will continue to maintain the national Medicare/Medicaid Workload Reporting System for both fraud and abuse cases until no later than July 1, 1980. At that time all Medicare/Medicaid fraud data then in the system, as well as all historical Medicare fraud data not included in the current system, will be transferred to OI. OI will then have complete and total responsibility for the further maintenance of the national Medicare/Medicaid fraud workload system, and HCFA will assume responsibility for maintaining data within its system regarding national Medicare/Medicaid abuse case data only.

After July 1, 1980, compliance with all requests of any kind, from whatever source, for statistical data on past and present Medicare/Medicaid fraud cases/investigations, will be the sole responsibility of OI.

VII. HCFA Reporting to OI

HCFA will continue to provide the present monthly report to OI on all full-scale Medicare fraud cases under investigation by HCFA regional offices without OI involvement, all HCFA Medicare cases pending with U.S. Attorneys without OI involvement, and all Medicare convictions obtained by HCFA during the month in cases in which OI was not directly involved, until such time as these cases have been completely resolved.

However, as of July 1, 1980, HCFA will no longer report to OI on a monthly basis regarding Medicaid fraud convictions obtained by non-certified State investigative agencies. OI will establish its own State agency liaison for purposes of gathering this data.

VIII. Administration

A. In some cases, it may be necessary for HCFA staff to assist OI on a specific case. These situations should be rare, and HCFA participation will be requested for a specific case or related group or cases in a formal memorandum for the record. Such requests will require CO/HCFA clearance. Wherever possible, staff and time considerations will be estimated.

When HCFA does participate with OI on a specific case(s), presentation to the U.S. Attorney will be made jointly by both OI and HCFA staff members.

B. Case referrals mentioned in this memorandum will generally be made at the regional level.

C. Issues on general questions of approach and policy, and issues on specific cases between OI and HCFA should be resolved locally. Issues that cannot be resolved locally should be submitted to OI and HCFA central office components for resolution. This includes disputes between OI/HCFA staff on whether a case should be concurrently administratively via overpayment determination/ recoupment and/or termination/exclusion/suspension action.

D. The 45-day rule mentioned in Section A.1 above will be closely adhered to by HCFA. If no written OI objection is received in HCFA within this time, appropriate administrative action will be begun by HCFA on the 46th day after referral to OI.

E. This statement supercedes all previous OI/OPI agreements on the matter of Medicare/Medicaid fraud, and more specifically the current such agreement dated September 14, 1978, as signed by former Inspector General Thomas D. Morris and Don E. Nicholson, former Assistant Administrator for Program Integrity.

Richard Lowe
Acting Inspector General,
DHEW

Leonard Schaeffer
Administrator

Regional comments on ileo draft

Acting Director,
Bureau of Quality Control

2/8/80

Regional Director
Office of Program Integrity, HCFA/Atlanta

OPI:WDS

Revised Memorandum of Understanding Between the Office of the Inspector General/Office of Investigations and the Health Care Financing Administration-Medicare/Medicaid Fraud—ACTION—Your Memorandum, January 24, 1980

We appreciate the opportunity to comment on the proposed revised memorandum of understanding.

We certainly approve of the proposals to strengthen the MOU by giving examples of what the term "strong potential for fraud" really means. This has caused problems in the past which undoubtedly will continue but pinning it down some will definitely help. Any further "pinning down" you can do will be appreciated.

The written notice within 45 days of referral will also help considerably. We would like to see the second paragraph on page 3 further strengthened by amending this section to read "OI will inform HCFA regionally in writing as to whether they have specific objection to the taking of concurrent administration/sanction action by HCFA and their reasons for such objection". We would like to get something in here that would prohibit such objection based on vague feelings that HCFA actions will somehow "mess up" the criminal action. In this same paragraph, we suggest adding the words "and when" after "...whether they intend to schedule the case for investigation".

On page 4 with respect to civil fraud, we would like to see some flexibility retained on a region-by-region basis. In regions where OI is unable or declines to handle civil fraud, OPI should be able to take up the slack. If we go with the MOU as written, we can only say that in our opinion this will effectively end civil fraud actions in this region. OI here has never shown any inclination to get involved with civil fraud. We have never been satisfied that sufficient criminal investigation is done in most cases; since civil fraud requires almost the same effort in investigation, we simply will see the demise of what can be an effective tool for dealing with fraud. Enough said.

Frank D. White

HCFA:OPI:WDSimmons:vrc:2/8/80

~~BB~~
~~DWL~~
~~DS~~

Office of the Inspector General

Acting Director
Bureau of Quality Control

never implemented

Revised Operating Statement Between the Office of Investigations/Office of the Inspector General and the Health Care Financing Administration—ACTION

Attached for your review is a proposed revision to the Operating Statement prepared by your office (draft dated 5/15). We have also attached a chart which compares the language contained in your 5/15 document with the language contained in the proposed document which we sent to you on March 17, 1980, and which discusses the revisions to your 5/15 document which have been proposed in the attached revision; we hope that this chart will facilitate a discussion of the various proposed documents.

The revised Operating Statement which we are proposing corresponds in large part to your 5/15 draft. The changes we have proposed generally attempt to clarify and make more specific the language contained in your draft document. Only in limited instances (e.g., in forgery cases, administrative costs in OI investigations) have we proposed revisions to your language which represent a major policy/procedural change. In addition, we have proposed a new section (which was not contained in either our March 27 version or your 5/15 draft) which would require the OI and HCFA regional components to meet periodically to discuss common problems, concerns, and issues.

To expedite the finalization of an OI/HCFA Operating Statement, we propose that representatives of our staffs meet on July 8, 1980 to discuss the revision we have proposed and resolve any concerns or problems which may exist with regard to this document. Necessary arrangements can be made regarding time and place for the meeting by having your staff contact James Patton on (FTS) 934-8000. Should you wish to discuss any concerns you might have prior to this July 8 meeting, please feel free to contact either Mr. Patton, or myself on (FTS) 934-5878.

Martin L. Kappert

cc:
Nicholson
Patton
Broglie
File
RFC

FNV21/Broglie:lb 6-16-80

OPERATING STATEMENT
OFFICE OF INVESTIGATIONS/OFFICE OF THE INSPECTOR GENERAL
AND THE
HEALTH CARE FINANCING ADMINISTRATION

I. Purpose

The purpose of this document is to delineate the responsibilities of the Health Care Financing Administration (HCFA) and the Office of Investigations (OI), Office of the Inspector General (OIG) with respect to the handling of suspected criminal violations involving the Medicare/Medicaid programs. It also provides guidelines to be used by HCFA and OI in the processing of such cases, and outlines policy and procedures to be followed in certain related program and investigative matters.

II. Background

HCFA is responsible for the administration of the Federal health care programs (Medicare and Medicaid). OI is responsible for the supervision, coordination, and direction of all criminal investigations relating to the programs administered by, and the employees, contractors, and grantees of, the Department of Health and Human Services. The HCFA staff consists of persons with extensive program expertise, and experience in identifying various patterns of abuse, as well as potential fraud, by the HCFA program participants. The OI staff consists of professional criminal investigators who specialize in the investigation of economic and other white collar crime. The effective control of fraud against the HCFA programs must involve the effective application of the strengths and skills of both professional staffs.

III. Preliminary Review and Referral

HCFA will perform or direct an initial review on complaints it receives and on other information regarding questionable practices which it identifies or receives. At the point in the initial review where HCFA staff have sufficient information to believe a strong potential for fraud warranting full-scale investigation exists, the case will be referred to OI, and additional developmental work will be performed by OI.

A. Noninstitutional Fraud Cases

In a noninstitutional (Part B) case, HCFA will consider a strong potential for fraud to exist when the initial review results in a 40 percent success ratio with respect to beneficiaries contacted (i.e., including the initial complainant, 40 percent of the beneficiaries contacted during the initial review who can definitely either affirm or deny that a service was provided, deny receiving services as billed by the provider). While HCFA will use this success ratio as a general guideline, it will also consider such factors as the extent of the potential fraud in terms of potential loss or impact on the programs, and prior or continuing problems with the provider in question, when deciding whether referral to OI is warranted. Once HCFA determines that there is strong potential for fraud and refers the case to OI, all interviews with subjects or targets should be deferred to OI, except where HCFA is pursuing administrative action in the case.

If there is not strong potential for fraud, HCFA will initiate appropriate administrative action without referral to OI.

B. Institutional Fraud Cases

In an institutional (Part A) case, HCFA will consider strong potential for fraud to exist when a review is extended beyond the desk review stage into the field audit stage and the field audit reveals cost report entries which cannot be explained away as clerical error (e.g., personal expenses are charged to the cost report; nurses whose salaries are charged to the certified portion of a facility are signing medical records of patients located in a noncertified portion; costs disallowed in previous years are included in the current year's costs).

While recognizing that the preliminary review for an institutional case may vary as to the scope, depth, and type, HCFA's review will at a minimum consist of the following activities: (1) analyzing the allegation or other basis for investigation; (2) determining that, if true, the facts alleged would constitute a violation of applicable law or regulations and citing such law or regulations; (3) determining that the alleged unallowable cost(s) appears on the provider's books and records; (4) determining that the unallowable cost(s) was carried forward to and was included in the cost report; (5) determining Federal reimbursement to the institution and its Medicare and Medicaid utilization rates; (6) determining action taken by the intermediary in its last audit or desk review in relation to the costs under scrutiny; (7) determining ownership of the institution and whether such owners are involved in other such institutions; and (8) determining that the cost report was filed.

Where a strong potential for fraud does not exist, HCFA will pursue the case administratively without referral to OI.

C. Beneficiary/Recipient Fraud Cases

Primary responsibility for investigation and referral to U.S. Attorneys of beneficiary/recipient fraud cases at this time will rest with HCFA unless there is an indication of a Controlled Substances violation by the prescribing physician, pharmacist or recipient, or a conspiracy with a third party such as an employee of the paying agent or a medical provider. In these instances, the case will be the responsibility of OI after an initial review by HCFA.

D. Kickback, Rebate, and Bribe Cases

Because of the unique nature of such cases and the level of investigative effort required (i.e., discussions with individuals who have knowledge or information of such alleged activities), HCFA will immediately refer to OI any allegations or information concerning kickback, rebate, or bribe situations after first analyzing the allegations or information and determining that, if true, the alleged facts would constitute a violation of applicable law. OI will then assume responsibility for the ensuing criminal investigation. HCFA will not contact or review the records of the provider.

E. Certification Fraud Cases

HCFA will be responsible for conducting an initial review of alleged certification frauds, but will refer cases involving strong potential for fraud to OI for additional investigation and presentation to a U.S. Attorney.

F. Assignment Agreement Violations

HCFA will handle cases involving assignment violations, but will refer cases involving potential prosecutions to OI for additional investigation and submission to a U.S. Attorney.

G. Cases Involving Alleged Fraud by Federal, State, or Contractor Employees, or Organized Crime

HCFA will refer to OI without any preliminary investigation, all allegations involving the possibility of a crime by: (1) a Federal employee; (2) a contractor or State agency employee; or (3) organized and recognized major criminal elements.

H. Medicare Check Forgery Cases

Pursuant to regulations at 42 CFR 405.1695-1697, HCFA will refer Medicare check forgery cases to the U.S. Postal Inspection Service or appropriate local authorities. OI will continue to provide HCFA with handwriting analysis support through the FBI Document Lab on all cases of forgery which do not involve postal violations, or cases declined by the Postal Service due to manpower limitations.

I. Information Relating to Ongoing Investigations

HCFA will immediately refer to OI any complaint received on a matter which is currently under a full-scale investigation by OI, any other Federal investigative agency, or by a State agency or State Medicaid Fraud Control Unit.

IV. The Referral Package

The referral will consist of HCFA preparing a narrative summary of all activity and information on the case, and transmitting this to OI together with the complete case file. A copy of the narrative and case file will be retained by HCFA. In the narrative, HCFA will set forth a listing of the various administrative/sanction activities, e.g., suspension of payments, overpayment determination/recovery, termination/exclusion/suspension development, etc., which it plans to take concurrent with the criminal investigation to be undertaken by OI.

V. Acceptance or Return of the Referral Package, and Followup by HCFA

Within 45 days of referral, OI will inform HCFA regionally in writing as to whether they intend to schedule the case for investigation. In these cases, OI will also

state whether they have specific objection to the taking of concurrent administrative/sanction action by HCFA, and their reasons for such objection. The effect of the OI objection will be that HCFA will take no concurrent administrative/sanction action pending resolution of the criminal aspects of the case. If the case is not to be scheduled for investigation, OI will return it to HCFA.

VI. Recoveries

A. Civil Litigation

HCFA will be responsible for the development of all civil fraud cases, except where a case has previously been referred to and accepted by OI for criminal investigation. Therefore, in those cases which were lacking strong potential for fraud which were not referred to OI and in those cases which were referred to OI but were declined by OI for investigation, HCFA will be responsible for civil action, including common law recovery and actions pursuant to the False Claims Act (31 U.S.C. 231).

OI will be responsible for the development of civil action only in those cases which were referred to and accepted by OI for investigation. HCFA will honor all reasonable requests by U.S. Attorneys or DOJ Attorneys in the preparation of civil litigation in such cases that were developed criminally by OI or another investigative agency.

In addition, HCFA will be actively involved in all negotiations which involve the settlement of the civil suit where such negotiations would have a bearing on HCFA's ability to take present or future administrative overpayment determination/recovery action, and/or termination/exclusion/suspension sanction action.

B. Administrative Recoveries in Non-Fraud Cases

Where the initial review identifies an aberrant practice, but not a strong potential for fraud, HCFA will develop the case for appropriate administrative action.

C. Plea Bargains in Criminal Cases

To the extent of OI's involvement in the presentencing negotiations, HCFA will be consulted and afforded the opportunity to participate fully where such negotiations would have a bearing on HCFA's ability to take present on future administrative overpayment determination/recovery action, as well as termination/exclusion/suspension sanction action.

VII. Cooperation in HCFA Administrative/Sanction Action

With respect to withholding of payments in criminal cases, particularly where Grand Jury action has not begun, HCFA will decide the appropriateness of the withholding action and will instruct contractors and advise State agencies. In order to avoid the loss of potential overpayments, not only through the ultimate settlement of suit reports, but also to be able to respond to appeals on the withholding of payments to providers, OI will advise HCFA upon request, as to the stage of the investigation/prosecution.

Upon indictment and disposition in any Medicare or Medicaid case, OI will follow the requirements in the Medicare/Medicaid Workload Reporting System, i.e., update of HCFA-50 (HEW-654), and a copy of the report of investigation will be sent to the HCFA regional office. OI will also notify the HCFA regional office and furnish that office with copies of the indictment and report of the disposition, so that HCFA can take appropriate suspension action pursuant to P.L. 95-142, termination or exclusion action pursuant to P.L. 92-603, or other appropriate action of the Social Security Act. The purpose of the above documents is to allow HCFA to determine the length of the suspension. OIG will obtain, where practical and not prohibited by law, and provide the report of investigation, indictment, and judgment for all cases investigated by either OI, the Medicaid State Fraud Control Units, or State investigative agencies where no fraud control unit has been certified. OI will assure that the U.S. Attorney is advised of all possible administrative/sanction actions that are available to HCFA (termination, exclusion, suspension, recovery, etc.).

HCFA will expeditiously notify OI of any administrative/sanction action taken on an OI case, either during the course of an investigation or subsequently. By an OI case, we mean (1) any case that was investigated by OI or has been accepted by OI for investigation; (2) any case that has been referred by OI to another agency for investigation; or (3) any case resulting from a task force effort where OI had either an investigative or a monitoring role.

VIII. Miscellaneous Provisions

A. Administrative Costs in OI Investigations

Whenever OI requires the assistance (in providing information or records) of a Medicare carrier or intermediary during the OI criminal investigation, or is contemplating the issuance of a subpoena to a provider for records, OI will consult with the appropriate HCFA regional office to discuss the potential cost to the Medicare program of providing such assistance or complying with such subpoena, and to determine, in appropriate cases, whether alternative, less costly means exist to obtain the information/records required by OI.

B. Technical Assistance by HCFA in OI Investigations

In some specific cases, it may be necessary for HCFA staff to provide technical/programmatic assistance to an OI investigation. When such a request is made by OI, HCFA will, as expeditiously as practicable, provide such assistance where such a request is reasonable and essential to the successful outcome of the case. Similar considerations will apply to HCFA's responding to similar requests for assistance by other investigative agencies with HCFA cases.

C. Obtaining Cooperation in Investigations

When OI notifies HCFA that it has accepted a case for criminal investigation, HCFA will inform Medicare contractors, Medicaid State agencies and fiscal

agents, and Social Security offices that they may be contacted by OI for information to support their investigation.

This notification will be withheld in those cases where OI advises HCFA that such notification would in any way compromise the investigation or is otherwise not desirable. All further contacts on individual fraud cases (with exception of those covered in item B) will be made by OI, except where HCFA is conducting a directly parallel development, for sanctions purposes.

HCFA will utilize its relationship with these agencies and entities to educate them to the need to cooperate in OI investigations. OI will apprise HCFA of any problems in obtaining information from contractors and States, and HCFA will intercede to obtain cooperation.

D. Action Levels for OI and HCFA

Case referrals mentioned in this memorandum will generally be made at the regional level.

Issues on general questions of approach and policy, and issues on specific cases between OI and HCFA should be resolved locally. Issues that cannot be resolved locally should be submitted to OI headquarters and HCFA central office by the respective field components for resolution.

E. Contacts with Other Agencies

Contacts with Medicaid State agencies and contractors for monitoring and management purposes will be maintained by HCFA. Contacts with State Medicaid Fraud Control Units and investigative agencies in States which do not have certified units under section 17, P.L. 95-142 will be maintained by OI or OIG.

Contact with the FBI, Postal Inspector (except for forgery cases covered in section III, H. of this paper) and other investigative agencies on matters under criminal or potential criminal investigation will be made by OI. OI may request HCFA to provide ad hoc programmatic assistance to investigative agencies.

F. State Investigative Agencies

Total responsibility for the certification, recertification, monitoring and funding of the State Medicaid Fraud Control Units will rest with OIG.

OIG will monitor the Medicaid fraud investigative activities in States which do not have certified units under section 17, P.L. 95-142. HCFA will provide OIG with any information needed to evaluate the State agency fraud activities.

G. Fraud Workload Reporting System

OI will, as soon as practicable, establish and maintain a system for tracking the Medicare/Medicaid fraud workload. Until this system is in place, HCFA will continue tracking the fraud on their present system.

H. Form 1513 Procedure

HCFA will establish and maintain a system for compiling the information described in sections 3 and 8 of P.L. 95-142. Such information will be furnished to OI upon request.

I. HCFA Reporting to OI

HCFA will continue to provide the present monthly report to OI on all full-scale Medicare fraud cases under investigation by HCFA regional offices without OI involvement, all HCFA Medicare cases pending with U.S. Attorneys without OI involvement, and all Medicare convictions obtained by HCFA during the month in cases in which OI was not directly involved, until such time as these cases have been completely resolved. However, effective with the signing of this statement, HCFA will no longer report to OI on a monthly basis regarding Medicaid fraud convictions obtained by noncertified State investigative agencies. OI will establish its own State agency liaison for purposes of gathering this data.

J. HCFA Coordination with OI When Access to Records is Denied

If access to records is denied during any initial review, OI should be immediately contacted to discuss the possibility of their exercising subpoena power. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendants should be deferred to OI.

K. Periodic OI/HCFA Meetings

On a periodic basis (not less frequently than quarterly), OI and HCFA regional office staff will meet to discuss issues of common concern and interest. Such meetings will include, at a minimum, a discussion of the following: (1) cases that have been referred to OI where HCFA is not pursuing administrative action, but where OI believes such action may be appropriate; (2) cases where HCFA has proposed administrative action, but OI has objected to such action; (3) specific cases where problems in initial development by HCFA or subsequent investigation by OI have arisen; (4) other specific problems or concerns about current procedures, practices, etc.

The first such meeting shall take place no later than 45 days from the signing of this agreement.

IX. Superseded Material

This statement supersedes all previous OI/HCFA agreements on the matter of Medicare/Medicaid fraud, and more specifically the agreement dated September 13, 1978.

Richard B. Lowe III Date
Acting Inspector General
DHHS

Howard N. Newman Date
Administrator, HCFA

'oint of Referral to OI	At the point in the initial review where HCFA staff have sufficient information to believe a strong potential for fraud warranting full-scale investigation exists, the case will be referred to OI, and additional developmental work will be performed by OI.		
'on-institutional Fraud Cases	(II.A.1) In a non-institutional case (Part B), strong potential for fraud would exist when the initial review results in a 40 percent success ratio as regards beneficiaries contacted (i.e., including the initial complainant, 4 of 10, 8 of 20, etc., beneficiaries contacted during the integrity review phase who can definitely either affirm or deny that a service was provided, duly receiving services as billed by the provider). If these success ratios are not met, or if the dollar amount of the suspected fraudulent activity is estimated to be $1000 or less, when projected against the providers total Medicare or Medicaid profits, HCFA will initiate appropriate administrative action without referral to OI. The examples set forth above are intended to serve as guidelines only. Other factors such as prior and/or continuing problems with the practitioner in question, the size of the judicial district (i.e., large city vs. small community), the extent of the potential fraud (e.g., numerous false claims involving the same beneficiary), etc. must also be considered by the HCFA regional office when deciding whether referral to OI is warranted.	(III.A) At the point in the preliminary review where HCFA has sufficient information to believe a strong potential for fraud, warranting full-scale investigation exists, the case will be referred to OI and all additional development work will be performed by OI. In deciding whether to refer a case, HCFA will consider such things as the number of beneficiaries who denied receiving a service, the ratio of denials within the sample reviewed, prior or continuing problems with the practitioner, supplier or provider in question, and the extent of the potential fraud in terms of potential loss or impact upon the programs. With respect to complaints involving a practitioner, HCFA will conduct its initial review. Once potential fraud is identified in the initial review process, all interviews with subjects or targets should be deferred to OI. In cases involving supplier fraud, HCFA will conduct its initial review process which will include the analysis of supplier records, laboratory records, etc.	Revised to indicate that HCFA will use 40 percent success rate as one criteria for referral to OI. Otherwise, language is basically the same.

itutional Fraud Cases	(II.A.1) In an institutional case (Part A), strong potential for fraud would exist when a review is extended beyond the desk review stage into the field audit stage, and the field audit reveals cost report entries which cannot be explained away as clerical error (e.g., personal expenses are charged to the cost reports; nurses whose salaries are charged to the certified portion of a facility are signing medical records of patients located in the non-certified portion; costs disallowed in previous years are included in the current year's costs, etc.). As with non-institutional cases discussed above, if the dollar amount of the suspected fraudulent activity is estimated to be $1000 or less, HCFA will pursue the case administratively without referral to OI.	(III.C) The cost report case usually a very time-consuming undertaking which for a successful resolution could require the skills of the program expert, the auditor the professional investigator and the prosecutor. The mortality rate from a criminal standpoint can be very high under the best circumstances. Ultimately, most will be resolved civilly or administratively. Only those with the greatest fraud potential will be accepted for criminal investigation. However, the percentage of cases accepted for investigation could increase with any corresponding increase in the OI staffing. HCFA will have responsibility for documenting the facts of a case which warrant a recommendation for a full investigation. However, HCFA will advise and periodically brief OI on the cost report case workload in which the potential for fraud may exist. Normally, cases will be accepted or not accepted for investigation by OI at these periodic briefing sessions. The preliminary review for the cost report case will vary widely as to the scope, depth and type. However, in all cases the review will consist of 1) analyzing the allegation or other basis for investigation, 2) determining that if true, the facts alleged would constitute a violation of applicable law or regulations and citing such laws or regulations, 3) determining that the alleged unallowable cost appears on the Provider's books and records, 4) determining that the unallowable cost was carried forward to and was included in the cost report, 5) documenting discrepancies found in the books and records and in oral and written statements, 6) determining federal reimbursement to the institution and its Medicare and Medicaid utilization rates,	"Strong potential for fraud" is defined; examples are provided. Initial paragraph is deleted. Periodic briefing format for referral is deleted; a new provision is added at end of MOU to deal with periodic meetings between OI and HCFA staffs. Numbers 5 and 7 under HCFA's responsibilities have been deleted; number 5 because the wording is unclear and would seem to indicate that HCFA would be performing a full-scale investigation type activity; number 7 because we view this as entailing a great deal of time and effort.

		7) determining if alle. unallowable costs impact on prior cost studies, 8) determining action taken by the intermediary in its last audit or desk review in relation to the costs under scrutiny, 9) determining ownership of the institution and the owner's involvement in other such institutions, and 10) determining that the cost report was filed.	OIG VERSION
kback, Rebate, Bribe Cases	(V.E) HCFA will immediately refer to OI any allegations or information concerning kickbacks or rebates. OI will then assume responsibility for the ensuing criminal investigation.	(III.D) In the institutional setting, the preliminary review will consist of the steps outlined in III C above. In all cases, HCFA will determine whether the kickback/rebate was reported and offset against reimbursable costs. However, HCFA will not contact or review the records of the payer. In the non-institutional setting, HCFA will immediately refer to OI any allegations or information concerning kickbacks or rebates. OI will then assume responsibility for the ensuing criminal investigation	The referral process for institutional and non-institutional cases have been made consistent.
ıficiary/ ıpient Fraud ıs	(V.A) Responsibility for investigation and referral to U.S. Attorneys of beneficiary/recipient fraud cases will rest with OI.	(III.B) Primary responsibility for investigation and referral to U.S. Attorneys of beneficiary/recipient fraud cases at this time will rest with HCFA unless there is an indication of a Controlled Substances violation by the prescribing physician, pharmacist or recipient, or a conspiracy with a third party such as an employee of the paying agent or a medical provider. In these instances, the case will be the responsibility of OI after an initial review by HCFA.	No change.

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		OIG VERSION	REVISIONS MADE TO OIG VERSION
ses Involving leged Fraud by deral, State, or ntractor Employees Organized Crime	(V.B) HCFA will refer to OI without any preliminary investigation, but after clearly ascertaining the nature and details of the allegation, all allegations involving the possibility of a crime by: (1) a Federal employee; (2) a contractor or State agency employee; or (3) organized and recognized major criminal elements.	(III.C) HCFA will refer to OI, without any preliminary investigation, all allegations involving the possibility of a crime by: (1) a Federal employee; (2) a contractor or State agency employee; or (3) organized and recognized major criminal elements.	No change.
gery Cases	(V.C) HCFA will refer Medicare check forgery cases to the U.S. Postal Inspection Service or appropriate local authorities. OI will continue to provide HCFA with handwriting analysis support through the FBI Document Lab on all cases of forgery which do not involve postal violations, or cases declined by the Postal Service due to manpower limitations.	(III.H) HCFA will refer forgery cases directly to OI for evaluation and possible referral to another investigative agencies.	Regulations vest HCFA with check forgery responsibilities. HCFA has established procedures to handle forgery cases. Therefore, we have revised section to indicate HCFA's responsibilities.
ignment ement Violations	(V.D) HCFA will handle cases involving assignment agreement violations, but will refer cases involving potential prosecutions to OI for additional investigation and submission to a U.S. Attorney.	(III.F) HCFA will handle cases involving assignment agreement violations, but will refer cases involving potential prosecutions to OI for additional investigation and presentation to a U.S. Attorney.	No change.
ification Fraud		(III.E) HCFA will be responsible for the development of certification frauds, but will refer cases involving potential prosecution to OI for additional investigation and presentation to a U.S. Attorney. Since HR-3 provided a felony penalty which had not been used to date, HCFA will apply more effort to this area than it has in the past.	"Strong potential for fraud" substituted as criteria for referral.

			OIG VERSION
mat for Referra. Subsequent Action	(II.A.1) The referral will consist of HCFA preparing a narrative summary of all activity and information on the case, and transmitting this to OI together with the complete case file. A copy of the narrative and case file will be retained by HCFA. In the narrative, HCFA will set forth a listing of the various administrative/sanction activities, e.g., suspension of payments, overpayment determination/recovery, termination/exclusion/suspension development, etc., which it plans to take concurrent with the criminal investigation to be undertaken by OI. Within 45 days of referral, OI will inform HCFA regionally in writing as to whether they intend to schedule the case for investigation. In these cases, OI will also state whether they have specific objection to the taking of concurrent administrative/sanction action by HCFA, and their reasons for such objection. The effect of the OI objection will be that HCFA will take no concurrent administrative/sanction action pending resolution of the criminal aspects of the case. If the case is not to be scheduled for investigation, OI will return it to HCFA. (VIII.D) The 45-day rule mentioned in Section II A.1 above will be closely adhered to by HCFA. If no written OI objection is received in HCFA within this time, and there has been no notice that an objection is in transit, appropriate administrative action will be begun by HCFA on the 46th day after referral to OI.	(IV & V) The referral will consist of HCFA preparing a narrative summary of all activity and information on the case, and transmitting this to OI together with the complete case file. A copy of the narrative and case file will be retained by HCFA. In the narrative, HCFA will set forth a listing of the various administrative/sanction activities, e.g., suspension of payments, overpayment determination/recovery, termination/exclusion/suspension development, etc., which it proposes to take. Acceptance or Return of the Referral Package, and Follow-Up by HCFA OI will inform HCFA regionally in writing as to whether they intend to accept the case for investigation. In these cases, OI will also state whether they have specific objection to the taking of concurrent administrative/sanction action by HCFA. The effect of the OI objection will be that HCFA will take no concurrent administrative/sanction action pending resolution of the criminal aspects of the case, unless OI subsequently withdraws the objection. If the case is not accepted for investigation, OI will so advise HCFA.	45-day guideline for OI response has been added.
rmation About ing Investigation ucted by OI	(II.A.1) HCFA will immediately refer to OI any case where a Medicare or Medicaid fraud complaint has been received on a matter which is currently under a full-scale Medicare/Medicaid investigation by OI, any other Federal investigative agency, or by a State agency or State Medicaid Fraud Control Unit.	(III.I) HCFA will immediately refer to OI any complaint received on a matter which is currently under a full-scale investigation by OI, any other Federal investigative agency, or by a State agency or State Medicaid Fraud Control Unit.	No change.
l Fraud	(II.A.2) In those cases lacking strong potential for fraud which were not referred to OI; were referred to OI but were declined for investigation; or were referred to OI and not forwarded to the USAT as a result of the investigation; HCFA will assume responsibility for civil fraud action pursuant to the False Claims Act (31 U.S.C. 231). However, in those cases investigated by OI where a decision by the U.S. Attorney to prosecute or not to prosecute criminally has been made, OI will have the responsibility for pursuing either civil fraud under the False Claims Act (31 U.S.C. 231) or common law recovery action. Should OI require HCFA assistance in performing its civil fraud responsibilities, specific request should be made pursuant to Section VIII A. Assistance may then be provided, either independent of, or in conjunction with OI, so long as other HCFA workload responsibilities allow such involvement.	(VI) HCFA will be responsible for the development of all cases in which civil litigation is proposed by the Justice Department, including common law recovery and actions pursuant to the False Claims Act (31 USC 231). While it is recognized that HCFA has procedures in place for the negotiation and settlement of amounts due its Programs, the federal false claims procedure is preferable wherever applicable. However, this preference could change with the enactment of the presently proposed civil money penalties legislation.	Distinction between types of cases HCFA will have responsibility for and those which OI will have responsibility for has been made clearer. The reference to the civil money penalty provision has been deleted.

ivil Fraud (cont'd.)

Where civil liti[illegible]on is predicated upon information developed in a criminal investigation by OI, OI will, consistent with reason, applicable law and the Federal Rules of Criminal Procedure 1) provide pertinent and necessary material in the OI file, 2) facilitate necessary access to any audit report, workpapers or other material in possession of OI or the OIG Audit Agency, 3) make the OI case agent(s) available to explain and answer questions on the OI development, and testify in Civil Court, and 4) assist if possible in facilitating access to any essential Grand Jury material used in the criminal investigation.

Where civil litigation is predicated upon information developed in a criminal investigation by another Agency, OI will, consistent with reason and applicable law, assist in facilitating access to information in that Agency's file.

Although preparation for civil litigation is the primary responsibility of HCFA, when a case is based entirely, or almost entirely, upon the development in an OI criminal investigation, OI will upon request by HCFA, and agreement by the Assistant Inspector General for Investigations, assume responsibility for such a civil case. However, in the event of a settlement prior to trial, responsibility will revert to HCFA for consulting with and assisting the U.S. Attorney in arriving at amounts and terms of the settlement. OI will not be involved.

HCFA will honor all reasonable requests for assistance by U.S. Attorneys or DOJ Attorneys in the preparation of civil litigation in cases that were developed criminally by OI or by another investigative agency.

otiations of tlements	In addition, HCFA will be actively involved in all negotiations which involve the settlement of the civil suit, where such negotiations would have a bearing on HCFA's ability to take present or future administrative overpayment determination/recovery action, and/or termination/exclusion/suspension sanction activity. (II.A.1) In the course of the settlement of the criminal case, the HCFA regional office will be actively involved in any preseniencing negotiations which would have a bearing on HCFA's ability to take present or future administrative overpayment determination/recovery action, as well as sanction activity as regards termination/ exclusion/suspension. OI will assure that the USAT is properly informed of all possible such administrative/sanction actions available to HCFA. (III.E) HCFA will be actively involved in the negotiation of any restitution of funds agreement reached in plea bargaining or the probationary determination process. (See also Section II, A.1 and 2 above.)	to the extent of OI's involvement in the negotiation of any restitution of funds agreement, either in a plea bargaining or the probationary case, HCFA will be consulted and if practicable, afforded an opportunity to participate fully.1/ 1/ Experience has shown that the monetary recovery in a criminal case usually will be restricted to the monetary loss described in the indictment or information, although there are exceptions. The evidentiary requirements to convict are greater than those required to sustain a civil or administrative action. Therefore an earnest offer to plead to an indictment should not be hindered by an Agency attempt to collect an amount that does not relate to the indictment. For example, the criminal case might cover an actual inflation of costs in a cost report while another cost item may have been disallowed simply because the Provider's supporting records were not properly kept. An offer to plead and make restitution on the criminal charge should not be declined because the Provider wished to contest the other amount.	HCFA's role in both criminal and civil settlements has been clarified. The footnote will be incorporated into HCFA's operating instructions for the regions.
Fraud Cases	(II.B) Those situations where aberrant practices exist, but which do not present strong potential for fraud, will be developed by HCFA, either directly or through contractors, for administrative action.	(VI.B) Where the initial review identifies an aberrant practice but not a potential for fraud, HCFA will develop the case for appropriate administrative action. Where an OI investigation did not result in a prosecution, or where a prosecution left the Government's loss unsettled, and there is no DOJ or HCFA proposal for civil litigation, the case will be returned to HCFA for appropriate administrative action.	Basically no change.

operation with FA Administrative Sanction fort	where Grand Jury action has not begun, HCFA will decide the appropriateness of the withholding action and will instruct contractors and advise State agencies. In order to avoid the loss of potential overpayments, not only through the ultimate settlement of cost reports, but also to be able to respond to appeals on the withholding of payments to providers, OI will advise HCFA, upon request, on the status of the case(s) in order to justify continued withholdings. Upon indictment and disposition in any Medicare or Medicaid case, OI will follow the requirements in the Medicare/Medicaid Workload Reporting System, i.e., update of HCFA-50 (HEW-634), and a copy of the report of investigation will be sent to the HCFA regional office. OI will also immediately notify the HCFA regional office and furnish that office with copies of the indictment and the judgment at the time such action takes place, so that HCFA can take appropriate suspension action pursuant to P.L. 93-142, termination or exclusion action pursuant to P.L. 92-603, or other appropriate sections of the Social Security Act. The purpose of the above documents is to allow HCFA to determine the length of the suspension. OIG will obtain and provide the judgment and the other documentation described above(i.e., report of investigation, indictments), for all cases either investigated by OI, the Medicaid State Fraud Control Units, or State investigative agencies where an Fraud Control Unit has been certified.	particularly where Grand Jury action has not begun, HCFA will decide the appropriateness of the withholding action and will instruct contractors and advise State agencies. In order to avoid the loss of potential overpayments, not only through the ultimate settlement of cost reports, but also to be able to respond to appeals on the withholding of payments to providers, OI will advise HCFA, upon request, as to the stage of the investigation/prosecution. Upon indictment and disposition in any Medicare or Medicaid case, OI will follow the requirements in the Medicare/Medicaid Workload Reporting System, i.e., update of HCFA-50 (HEW-634), and a copy of the report of investigation will be sent to the HCFA regional office. OI will also notify the HCFA regional office and furnish that office with copies of the indictment and the advise of the disposition, so that HCFA can take appropriate suspension action pursuant to P.L. 93-142, termination or exclusion action pursuant to P.L. 92-603, or other appropriate action of the Social Security Act. The purpose of the above documents is to allow HCFA to determine the length of the suspension. OI will assure that the U.S. Attorney is advised of all possible Administrative/Sanction actions that are available to HCFA (termination, exclusion, suspension, recovery, etc.).	Basically the same, with language added regarding providing report of investigation, indictment, and judgement to HCFA.
ification of inistrative ion	(III.F) HCFA will expeditiously notify OI of any suspension from participation in the Federal health care programs, of any payment withheld, and of any termination of a provider agreements (1) in any case that was investigated by OI or has been scheduled for investigation by OI; (2) in any case that has been referred by OI to another agency for investigation, Federal or State; or (3) in any task force effort where OI had either an investigative or a monitoring role.	HCFA will expeditiously notify OI of any Administrative/Sanction action taken on an OI case, either during the course of an investigation, or subsequently.	"OI case" is clarified.

Technical Assistance by HCFA	technical, program assistance to OI. These situations should become increasingly rare, and HCFA participation should be formally requested for a specific case or related group of cases. Regionally such requests should be directed to the HCFA Regional Administrator; centrally, to the Director, Bureau of Quality Control. In situations of this type, HCFA will generally not assume financial responsibility for the conduct of the criminal case, either before or during the trial. However, in unusual situations, OI may make a request to the Regional Administrator. HCFA will honor such requests where budget funds are or can be made available, and where the request is reasonable and essential to the successful outcome of the case.	[illegible] requested by OI, HCFA will provide technical, programmatic support to an OI investigation, and such requests will be assigned a high priority by HCFA. As requested, HCFA will provide similar assistance to other investigative agencies with HCFA cases.	Basically the same language; HCFA must consider t reasonableness and the n[illegible]or the requested assistance.
Obtaining Cooperation in Investigations	(III.A) When OI notifies HCFA that it has accepted a case for criminal investigation, HCFA will inform Medicare contractors, Medicaid State agencies and fiscal agents, and Social Security offices that may may be contacted by OI for information to support their investigation. This notification will be withheld in those cases where OI advises HCFA that such notification would in any way compromise the investigation or is otherwise not desirable. All further contacts on individual fraud cases (with exception of those covered in item B) will be made by OI, except where HCFA is conducting a directly parallel development, for sanctions purposes. HCFA will utilize its relationship with these agencies and entities to educate them to the need to cooperate in OI investigations. OI will apprise HCFA of any problems in obtaining information from contractors and States, and HCFA will intercede to obtain cooperation.	(VIII.D) HCFA will make certain that its contractors, the States and the Health Care community are advised of OI's statutory jurisdiction over the investigation of HCFA criminal cases, and stress the importance of their cooperation with OI in all such matters.	We believe HCFA language is more explicit about HCF responsibilities. It is consistent with OI languag
tion Levels for and HCFA	(VIII.B & C) Case referrals mentioned in this memorandum will generally be made at the regional level. Issues on general questions of approach and policy, and issues on specific cases between OI and HCFA should be resolved locally. Issues that cannot be resolved locally should be submitted to OI and HCFA central office by the respective field components for resolution. This includes disputes between OI/HCFA staff on whether a case should be concurrently investigated for fraud as well as being handled administratively via overpayment determination/recoupment and/or termination/exclusion/suspension action.	(VIII.E) Case referrals mentioned in this memorandum will generally be made at the regional leve. Issues on general questions of approach and policy, and issues on specific cases between OI and HCFA should be resolved locally. Issues that cannot be resolved locally should be submitted to OI headquarters and HCFA central office by the respective field components for resolution.	No change.
ntacts with her Agencies	(III.C & D) Continuing contacts with Medicaid State agencies and contractors for monitoring and management purposes will be maintained by HCFA. OI will assume these responsibilities as regards State Medicaid Fraud Control Units and State investigative agencies in States which do not have certified units under Section 17, P.L. 95-142. If the investigative unit is part of the Medicaid State agency, HCFA will provide OI with information needed to evaluate the State agency fraud activities. Contact with the FBI, Postal Inspector (except for forgery cases covered in Section V.C. of this paper) and other investigative agencies on matters under criminal or potential criminal investigation will be made by OI. OI may request HCFA to provide ad hoc programmatic assistance to investigative agencies.	(VIII.F) Contacts with Medicaid State agencies and contractors for monitoring and management purposes will be maintained by HCFA. Contacts with State Medicaid Fraud Control Units and investigative agencies in states which do not have certified units under Section 17, P.L. 95-142 will be maintained by OI or OIG. Contact with the FBI, Postal Inspectors and other investigative agencies on matters under criminal or potential criminal investigation will be made by OI.	Same language except for provision on forgery cases

...ntrol Units	... OI will also establish liaison with State agencies which do not have certified units, and will provide similar assistance as described above as regards input of case data into the system. HCFA will no longer have any monitoring role as regards full-scale fraud investigative activity of any type, either State or Federal. (See Section VI below for further discussion of workload reporting duties and responsibilities.)	...monitoring and funding of the State Medicaid Fraud Control Units will rest with OIG. OIG will moni...id Medicaid fraud investigative activities in States which do not have certified units under Section 17, P.L. 95-142. HCFA will provide OIG with any information needed to evaluate the State agency fraud activities.	No change.
...rkload ...porting	(VI) OI will maintain a system to control fraud workload and any requests received by HCFA for data will be sent to OI. Quarterly exchange of case listings between the OI/RCOs and HCFA/RCOs will be made in order to prevent duplication of investigations.	(VIII.H) OI will establish and maintain a system for tracking the Medicare/Medicaid fraud workload. Until this system is in place, HCFA will continue tracking the fraud on their present system.	Basically no change.
...A Reporting ...OI	(VII) HCFA will continue to provide the present monthly report to OI on all full-scale Medicare fraud cases under investigation by HCFA regional offices without OI involvement, all HCFA Medicare cases pending with U.S. Attorneys without OI involvement, and all Medicare convictions obtained by HCFA during the month in cases in which OI was not directly involved, until such time as these cases have been completely resolved. However, effective with the signing of this statement, HCFA will no longer report to OI on a monthly basis regarding Medicaid fraud convictions obtained by non-certified State investigative agencies. OI will establish its own State agency liaison for purposes of gathering this data.	(VIII.J) HCFA will continue to provide the present monthly report to OI on all full scale Medicare fraud cases under investigation by HCFA regional offices without OI involvement, all HCFA Medicare cases pending with U.S. Attorney without OI involvement, and all Medicare convictions obtained by HCFA during the month in cases in which OI was not directly involved, until such time as these cases have been completely resolved. However, effective with establishment of the system described in VIII H, HCFA will no longer report to OI on a monthly basis regarding Medicaid fraud convictions obtained by non-certified State investigative agencies. OI will establish its own State agency liaison for purposes of gathering this data.	Basically no change.
...ceeded Material	(VIII.E) This statement supersedes all previous OI/OPI agreements on the matter of Medicare/Medicaid fraud, and more specifically the current such agreement dated September 13, 1978, as signed by former Inspector General, Thomas D. Morris and Don E. Nicholson, former Assistant Administrator for Program Integrity.	(IX) This statement supersedes all previous OI/HCFA agreements on the matter of Medicare/Medicaid fraud, and more specifically the agreement dated September 13, 1978, as signed by former Inspector General, Thomas D. Morris and Don E. Nicholson, former Assistant Administrator for Program Integrity.	Names and title of signers of previous MOU have been deleted.

TOPICAL AREA	HCFA VERSION	OIG VERSION	REVISIONS MADE TO OIG VERSION
:cess to Records	(III.C) If access to records is denied during any initial review, OI should be immediately contacted to discuss the possibility of their exercising subpoena power. Once the potential for fraud is identified in the initial review process, all interviews with potential suspects or defendants should be deferred to OI.		New section has been added.
nancial ability of oviding Informa- on	Where OI wishes to request records and/or information from a Medicare contractor or provider, and the cost to the Medicare program of furnishing the records/information would be substantial (i.e., over $100 for non-institutional providers, and over $130 for institutional providers), then OI will first consult with the appropriate HCFA regional office to determine whether alternative, less costly means exist to obtain the information required by OIG. In cases where the cost to the Medicare program of furnishing the information would not exceed these amounts, then OI may contact the contractor or provider directly to obtain the information.	(VIII.A) HCFA will fund the cost of responding to OIG subpoenas issued on HCFA cases, in accordance with the fee schedules set forth in 42 CFR 219. HCFA will also assure that its contractors and the States respond to OI requests for records without additional funding by OI.	Language has been revised: OI will consult with HCF whenever assistance in providing ·ords/information is needed.
quests for ditional eliminary Develop- nt		(VIII.C) Occasionally in the course of an investigation, a new issue or a new aspect of a known issue will come to light. Upon request by OI, HCFA will conduct or direct the preliminary development of such an issue on a priority basis.	Deleted.
m 1513 Procedure		(VIII.I) HCFA will establish and maintain a system for compiling and analyzing the information described in Sections 3 and 8 of P.L. 95-142. Such information will be furnished to OI upon request. HCFA will assume the reporting responsibility in Section 8 of P.L. 95-142 for Title XVIII, XIX and XX Providers.	Basically the same, with "analyz·ng" deleted.
iodic OI/HCFA tings			New section has been added.

APPENDIX P

TRANSMIT VIA: AIRTEL

CLASSIFICATION: UNCLAS

DATE: 7/24/81

FROM: DIRECTOR, FBI

PERSONAL ATTENTION

TO: ALL SACs

OFFICES OF INSPECTOR GENERAL (OIGs)
JURISDICTIONAL MATTER

Enclosed for each office is a draft copy of Executive Order 12301 and one copy of "Policy Statement of the DOJ on its Relationship and Coordination with the Statutory IGs of the Various Departments and Agencies of the U. S."

PURPOSE: To bring field divisions current on the issue of FBI jurisdiction as it relates to U. S. Government Departments and Agencies with statutory Inspectors General (IGs) and to set forth FBI policy concerning Fraud and Bribery investigations involving the programs and functions of these governmental entities.

BACKGROUND: Historically with few exceptions, the FBI has exercised primary criminal investigative jurisdiction involving allegations of fraud and bribery in U. S. Government programs and operations. Since the establishment of the various OIGs, the FBI's jurisdiction has been seriously challenged.

By appropriate legislation, an OIG was established within the Department of Health, Education and Welfare (HEW) and the Department of Energy on 10/15/76, and 8/4/77, respectively. Effective 10/1/78, the Inspectors General Act of 1978, (the Act), became law, establishing an OIG within 12 additional U. S. governmental entities, to wit: the Departments of Agriculture (DOA), Commerce, Housing and Urban Development, Interior, Labor, Transportation, Community Services Administration, Environmental Protection Agency, General Services Administration (GSA), National Aeronautics and Space Administration, Small Business Administration, and the Veterans Administration. In addition, although an OIG was not established

Enclosures - 2

for the Department of Defense (DOD), the Act mandates certain requirements for DOD similar to those agencies with OIGs. Further, on 5/4/80, when the "Education" function of HEW (redesignated the Department of Health and Human Services (HHS) was elevated to a separate entity, i.e., the Department of Education (DOED), an OIG was created therein. At present, there are fifteen statutory IGs, and for your information, U. S. House of Representatives bill HR 2098 proposes the creation of OIGs within DOD, DOJ, Department of Treasury, and the Agency for International Development.

Most IGs interpret their respective originating legislation as granting the OIG primary jurisdiction in Title 18 violations affecting their agencies. A few consider this jurisdiction as theirs exclusively. As staffing levels permit, OIGs, with ever increasing regularity, have engaged in criminal investigations which traditionally were handled by the FBI. FBIHQ has learned that some OIGs have established a policy of not referring any matters to the FBI, even if they lack manpower to work the cases developed. They plan to use the backlog to justify additional personnel. Other OIGs presently refer what they cannot handle, however, in some instances these are low priority cases with which the OIGs chose not to be bothered. In spite of this, some FBI field offices, by setting up target squads, developing informants and sources, utilizing hot lines and other creative means, have been able to generate their own quality cases, penetrating illegal schemes within the myriad of programs administered by these agencies and departments. On a field-wide basis, however, both the quantity and quality of cases in these categories continue to decline and with few exceptions, referrals from most of these agencies have stopped.

Also as IG personnel become more involved in criminal investigations, they have recognized that they are not equipped to properly handle many of these matters. This has not, however, deterred them from proceeding with these investigations nor has it prompted them to refer these cases to the FBI. Instead, the OIGs have requested technical equipment (GSA recently expended $20,000 for body recording equipment), specialized training and, via legislative initiatives, full law enforcement powers including authority to execute search warrants; make arrests and carry firearms (Some GSA investigators, under color of authority extended to the Federal Protective Service, are carrying firearms). FBIHQ

does not believe this approach to be necessary, nor cost effective, since the FBI is trained, equipped, nationally dispersed, and willing to investigate all criminal allegations that the U. S. Attorney (USA) considers worthy of prosecution.

Since the establishment of the OIGs, FBIHQ has vigorously attempted to solicit DOJ support in finally resolving the issue regarding the respective roles of the OIG, the DOJ, and the FBI concerning criminal investigative jurisdiction. It now appears that a satisfactory solution is near.

CURRENT DEVELOPMENTS: On 3/26/81, President Reagan signed Executive Order 12301 (copy enclosed) establishing the "President's Council on Integrity and Efficiency" (the Council) consisting of all statutory IGs and others, including the Executive Assistant Director-Investigations (EAD), FBI. The Council is chaired by the Deputy Director of the Office of Management and Budget, presently Edwin Harper, who is also a member of the President's White House Staff. The Council is charged with the responsibility of developing plans for coordinating Government-wide activities which attack fraud and waste in Government programs and operations.

At the first Council meeting, held on 4/3/81, an IG raised the issue of the ongoing jurisdictional disagreements between certain IGs and the FBI and suggested that the prosecutor be allowed to rule on a case by case basis whether the OIG would continue to handle a particular investigation after criminality was detected. EAD, FBI, disagreed and stated that the FBI is prepared to investigate all allegations of criminality that a USA or the DOJ is willing to prosecute. Thereafter, the Council Chairman advised that the Administration had decided that the FBI would take the policy lead in the investigative/law enforcement area.

During the Council meeting on 5/4/81, the Chairman designated the FBI representative to the Council, Chairman of the Council's newly formed Investigations-Law Enforcement Committee. This committee will resolve all issues involving criminal investigative matters.

On 6/1-3/81, the Council held an Indoctrination/Orientation Seminar for all IG designates at the FBI Academy. During this seminar the enclosed Departmental Policy Statement concerning the

role of the IG within the criminal justice system was delivered. The Department's position clearly re-establishes the FBI as the primary criminal investigative agency and outlines the primary role of the IG as a detection and preventive function.

FBI POSITION:

This section outlines the FBI's position on the issue of criminal investigative jurisdiction involving all U. S. Government departments and agencies (with and without a statutory IG).

I. FBI has primary investigative jurisdiction over violations of Title 18, United States Code (USC).

A. The FBI has exclusive jurisdiction in Bribery/COI and fraud involving U. S. Government employees.

B. IGs will refer to the FBI all Bribery/COI, fraud involving U. S. Government employees as well as all other matters, when criminality is discovered and case meets USA's guidelines for prosecution.

C. Where no guidelines exist, the IGs will refer all criminal matters to FBI.

1. FBI will present these cases to the USA for a preliminary prosecutive opinion and initiate investigation if USA will consider prosecution.

2. Cases presented for preliminary prosecutive opinion and declined by the USA will be immediately referred back to the IG (by LHM).

D. The FBI will investigate all matters USAs will prosecute except certain cases which various agencies have traditionally investigated with the concurrence of the FBI.

For example, the Bureau does not usually investigate Davis-Bacon Act violations; DOA's large investigative force usually handles the vast majority of criminal allegations concerning their programs and operations unless Bribery/COI or fraud involving a U. S. Government employee is present; DOL handles Unemployment Compensation matters; HHS handles Social Security Administration cases, etc.

Specific information regarding these exceptions will be provided the field as individual agreements are reached with each agency.

Buairtel to All SACs
RE: OIG JURISDICTION MATTER

E. IGs will investigate all matters not criminally prosecutable but targeted at alternative remedies.

1. False claims civil when prosecution is declined in favor of civil suit.

2. Civil investigations stemming from completed FBI criminal cases where civil remedies are also being considered.

3. Administrative investigations for adverse action against employees and debarment proceedings.

II. A "Memorandum of Understanding," where required, will be entered into by FBI and appropriate IGs to eliminate FBI involvement in the following criminal matters:

A. Minimum impact - high volume cases.

B. FAG - Procurement - isolated cases - low dollar amount.

C. FAG - Program - non pattern cases involving individual program participants.

D. TGP-CGR - minimum dollar amount.

E. Exceptions referred to in Part I, D, above.

III. FBI will:

A. Provide 24-hour response time to all Bribery allegations.

B. Unless circumstances preclude, advise IG by LHM of existence of criminal investigation within 30 days in Bribery/COI and fraud cases. This LHM must contain the initial allegation; any investigation to round out allegation; a preliminary prosecutive opinion from the USA and available descriptive data regarding subject(s).

NOTE: The OIG has a statutory right to be made aware of FBI investigation involving their agency as soon as possible. Withholding such information must be completely justified in the cover communication accompanying the LHM. An "Undercover Operation,"

allegations involving OIG personnel, involvement of an informant/source will usually justify no dissemination until such time as disclosure will not jeopardize the undercover Special Agent(s), informant, or integrity of the investigation. In some instances, however, providing information (all or part) orally to the IG personally by FBIHQ would be appropriate. In these rare cases, FBIHQ will fully discuss the matter with office of origin.

C. Provide IG with summary of investigation upon its conclusion.

Normally the initial notification will suffice until the case is completed. Upon closing the case the agency will be provided an LHM containing the facts and prosecutive outcome (minus Rule 6(e) material, informant and other sensitive information), as well as a complete physical description of all subjects.

NOTE: Some cases, because of the large dollar amount, agency employee involvement or pending contract awards to the subject vendor, may require more expeditious handling and/or periodic LHM updates to keep the concerned agency informed of the status. FBIHQ will, however, attempt to keep these instances to a minimum.

D. Provide IG with information concerning program weaknesses discovered during FBI investigations.

The closing LHM must also highlight any program deficiencies detected during the course of the investigation which were contributing factors, and suggested remedies where appropriate. This information is extremely important to the concerned agency or agencies, since the Council has mandated that each agency report on all corrective action taken to improve program controls, etc., where abuses have occurred.

E. Furnish FBI reports (minus Rule 6(e) material and source information) for administrative proceedings against employees and for debarment of program participants, initiated by OIG.

F. Provide Special Agent testimony on limited basis at administrative proceedings initiated by OIG.

G. Provide name checks for OIG at FBIHQ level.

H. Conduct laboratory examinations for OIG.

I. Conduct NCIC inquiries for OIG.

J. Furnish identification records for OIG.

K. Consider OIG UCO proposals.

L. Provide training at Quantico in specific topic areas where demonstrated need exists to supplement current IG training.

During transition period IG criminal investigations already underway should not, absent special circumstances, be accepted for FBI investigation.

INSTRUCTIONS TO SAC:

The enclosed policy statement has been forwarded by DOJ to all USAs with a cover letter stressing the obligation of the FBI and USA to respond to IG reports and keep the IG informed. The cover letter also stresses the requirements; 1) for IGs to report criminal allegations at an early stage; 2) to get the FBI involved more in fraud matters both independently as well as jointly (where appropriate with IG personnel) and; 3) to make the criminal justice system more responsive to IGs and their agencies in promptly investigating and prosecuting fraud and corruption in their programs.

In this regard, each SAC is instructed to personally contact USAs and Economic Crime Specialists in your Division to insure there is a clear, mutual understanding of what the DOJ policy statement imports. This meeting should also open lines of communication for the early and immediate resolution of future problems and disagreements, including any modification of the FBI position set out above to accommodate a situation unique to your division.

It would be extremely naive to presume that recent developments and events will finally resolve the FBI - OIG jurisdiction issue without aggressive action on our part. For example, some IG personnel accustomed to investigating criminal matters without referral to the FBI will undoubtedly find change a difficult if not impossible process.

Buairtel to All SACs
RE: OIG JURISDICTION MATTER

The personnel of your office are to be instructed to be alert for instances where major criminal matters which should have been referred for FBI investigation were not. In these cases, immediate aggressive action will be expected of you to insure the spirit of the DOJ policy is adhered to. FBIHQ stands ready to assist you in this regard at the headquarters level with the agency involved, DOJ and/or the Council.

Be assured that the OIGs will bring to the attention of the Council instances where cases referred experience lengthy delays and/or a lack of appropriate investigative attention. Those cases accepted for FBI investigation must receive the highest priority. Therefore, field managers of your division must closely follow the progress of all cases involving programs and operations of other agencies to insure timely handling and reporting.

The President personally considers restoring public confidence in the Federal Government's ability to properly manage its programs and functions a number one priority of his Administration. At the present time, the current Administration, the Council, DOJ, and FBIHQ are confident the FBI is capable of efficiently and effectively handling the "lion's share" of major criminal investigative matters involving fraud and abuse in U. S. Government operations. Fraud Against the Government (FAG) matters involving U. S. Government officials or losses exceeding $25,000; bribery and other public corruption cases involving Federal officials have been redesignated the number one priority within the White-Collar Crimes Program.

You will be kept apprised of future developments concerning this matter.

APPENDIX Q

U.S. Department of Justice

9-42.502

POLICY STATEMENT OF THE DEPARTMENT OF JUSTICE ON ITS RELATIONSHIP AND COORDINATION WITH THE STATUTORY INSPECTORS GENERAL OF THE VARIOUS DEPARTMENTS AND AGENCIES OF THE UNITED STATES

June 3, 1981 (Revised)

U.S. Department of Justice

Executive Office for United States Attorneys

Washington, D.C. 20530

August 21, 1981

TO: Holders of the United States Attorneys' Manual Title 9

FROM: United States Attorneys' Manual Staff
Executive Office for U.S. Attorneys

D. Lowell Jensen
Assistant Attorney General
Criminal Division

RE: Relationship and Coordination with the Statutory Inspectors General

NOTE: 1. This is issued and EXPIRES unless reissued or incorporated pursuant to USAM 1-1.550.
2. Distribute to Holders of Title 9.
3. Insert after 9-42.500.

AFFECTS: USAM 9-42.501 and 9-42.502

9-42.501 Relationship and Coordination with the Statutory Inspectors General

The investigation and prosecution of fraud and corruption in federal programs is a major priority of the Department of Justice. On June 3, 1981, the Deputy Attorney General issued a "Policy Statement of the Department of Justice on its Relationship and Coordination with the Statutory Inspectors General of the Various Departments and Agencies of the United States." A copy of this statement appears at 9-42.502. The statement was first announced at a meeting of the President's Council on Integrity and Efficiency and was the result of a combined effort of the Criminal Division, the Federal Bureau of Investigation and the Executive Office for United States Attorneys.

The Policy Statement has two principal purposes -- early alert system for prosecutors relative to ongoing investigations and increased emphasis on coordination and cooperation between the FBI and the Inspectors General.

Several particular provisions deserve special emphasis. Consistent with the Inspector General's obligation to "report to the Attorney General whenever the Inspector General has reasonable grounds to believe there has been a violation of law," the Inspector General is to report to "the United States Attorney in the District where the crime occurred..." Simultaneously, the Inspector General is expected to notify the appropriate FBI field office. The FBI is committed to investigating every criminal violation which the prosecutor determines will be prosecuted, if proved.

The timing of the report to the prosecutor is discussed in the Policy Statement (see 9-42.502). In an ordinary investigation involving completed past events, the Policy Statement simply tracks the Inspector General legislation and requires a report whenever there are reasonable grounds, i.e., some evidence, to believe that a federal crime has occurred. Immediate report is required for crimes of an ongoing nature, as well as organized crime allegations. Such urgent and sensitive matters often require use of sophisticated investigative techniques, and the Inspector General is to make an immediate report upon receipt of the information. The Policy Statement requires the FBI to advise the Inspector General when the Bureau initiates an investigation as well as to keep the Inspector General regularly informed of its progress.

After the report is made to the U.S. Attorney, the Policy Statement places special obligations on the prosecutor to make a variety of decisions, including whether to initiate a grand jury investigation, decline prosecution, or refer the prosecutor, and the FBI will address whether to ask the Inspector General to conduct a joint investigation with the FBI.

Implementation of the Policy Statement requires the cooperation and support of the U.S. Attorneys, the FBI and the Inspectors General. The Fraud Section of the Criminal Division is charged with overseeing the operations of the policy and resolving any uncertainties or differing interpretations which arise in its implementation. Any questions or information should be directed to the Chief of the Fraud Section at FTS 724-7038 or to the Chief of the Government Fraud Branch of the Fraud Section at FTS 724-7028.

INTRODUCTION

The serious problem of fraud and waste in federal programs is one of the most important challenges facing the federal law enforcement community, which includes not only the Federal Bureau of Investigation, other investigative agencies and Department of Justice prosecutors but also the audit and investigation staffs of the Inspectors General. To meet this challenge we must effectively use our limited audit, investigative and prosecutorial resources and produce meaningful results. The Department of Justice has high expectations for the Inspectors General, but in the past, in some circumstances, we have not addressed and resolved in any comprehensive way how they are to work in the criminal justice system. The Department has now developed a framework for coordination of its efforts with the Inspectors General, which is outlined below.

LEGAL FOUNDATION

The implementing statutes place with Inspectors General the responsibility for conducting investigations relating to the programs and operations of their agencies. The statutes also require Inspector General to "report expeditiously to the Attorney General whenever the Inspector General has reasonable grounds to believe there has been a violation of criminal law."

The FBI is charged, in various sections of the United States Code, with the duty of investigating violations of law of the United States, and every Department and Agency head is required to report violations of Title 18 involving officers and employees of the Government to the Department of Justice. The Attorney General is the chief law enforcement officer of the United States, and the President's Executive Order 12301 establishing the

Council on Integrity and Efficiency recognized "the pre-eminent role of the Department of Justice in matters involving law enforcement and litigation."

GOAL OF POLICY

The Inspectors General were created in large part in response to the need for increased detention of fraud, waste, abuse and mismanagement in federal programs. In law enforcement, we have come to recognize that the United States is best served by formally initiating matters of possible criminality into the criminal justice system as early as possible. Accordingly, current FBI procedures generally provide for a preliminary prosecutive opinion before the initiation of a full-scale criminal investigation. This early alert system enables the Department of Justice to mount a coordinated and directed investigation and prosecution effort. In addition to enhancing the opportunity for a successful investigation and prosecution, this early review of the case allows for conservation of government resources, as well as for the opportunity to consider alternative or additional remedies such as civil and administrative action.

NOTIFICATION POLICY

With this as the background the Department offers the following guidance to Inspectors General on how to initiate a matter into the criminal justice system.

When to Report

The basic rule is that whenever there is reason to believe a federal crime has occurred, the Department of Justice should be advised. There are two subcategories.

One category involves possible crimes which are completed past events and which, although they require prompt investigative and prosecutive attention, are not so urgent, or so sensitive as to suggest accelerated reporting and/or

utilization of special law enforcement techniques. This first category of criminal allegations may require further investigation by the Inspector General to confirm, and should be reported whenever there is a reasonable indication, i.e., some evidence, to believe that a federal crime has occurred.

The second category involves possible crimes which are of such an urgent or sensitive nature that upon receipt of the mere allegation, accelerated reporting is required to allow for immediate prosecutive and investigative action. This second category involves allegations such as bribery, conflict of interest, fraud against the government and the like involving federal employees, and, in addition, any criminal conduct of an ongoing nature. Because of the law enforcement sensitivity, this category also includes information pertaining to the element generally known as organized crime. These urgent and sensitive matters necessitate immediate reporting to the Department because the FBI may be called on to employ body recorders, undercover operations, search warrants, Title III and other specialized law enforcement techniques which need FBI expertise and may require Department approval.

The wide variety of criminal matters prevents any more detailed description of these areas. Criminal investigators and prosecutors who are experienced in the criminal justice system generally know the types of allegations that suggest criminality as opposed to program abuse and waste. The differences can be subtle at times. The best guidance the Department can give the Inspectors General at this time is: if the case is close, report it. With experience, guidance will develop which will assist the Inspectors General in drawing the line between criminal matters and matters of abuse and waste more appropriately addressed within their agencies.

Where to Report

The Attorney General's interests include not only criminal investigation and prosecution but also the civil interests of the United States. To fulfill all these interests and coordinate other actions, the Inspectors General should report the above described possible violations to the prosecutor. This normally will be the United States Attorney in the district where the crime occurred or is occurring. In certain circumstances the reporting may be to the appropriate section of the Criminal Division. These situations include matters in which venue is uncertain or headquarters coordination or action is suggested by the nature of the crime or program.

To assist the prosecutor and expedite any investigation by the FBI, the Inspector General should notify the FBI field office simultaneously with the report to the prosecutor concerning either category of allegation. The prosecutor will be responsible for notifying the Civil Division in all cases in which possible civil action is suggested.

What and How to Report

The report should generally consist of a written statement of the allegation, the facts developed, the evidence -- both documentary and testimonial -- supporting the facts, the history and status of the Inspector General investigation. The Criminal Division is developing a recommended reporting format which will identify important questions to be addressed in the report to the prosecutor.

Presentation of the written report may be made by mail or in person. In urgent or sensitive cases, the written report should be preceded by a telephone call or personal visit from an authorized representative of the Inspector General immediately upon receipt of the allegation.

THE FBI AND PROSECUTOR ROLE

The FBI stands ready to make a total commitment to the investigation of fraud and corruption in federal programs. The FBI, with the primary role in investigating prosecutable violations of federal criminal law, will investigate every criminal violation which the prosecutor advises at the preliminary opinion stage will be prosecuted, if proved. To fulfill this total commitment in the fraud and corruption area the FBI is prepared to adjust its investigation priorities, if required.

At the time of reporting, the prosecutor, consulting with the FBI and the Inspector General, will be called on immediately to make a number of decisions, including whether:

- to initiate a grand jury investigation,
- to decline prosecution, or
- to refer the matter for civil and/or administrative action.

In many circumstances, with the early reporting system, the prosecutor and the FBI will ask the Inspector General to conduct a joint investigation with the FBI or continue the investigation. In any event, the FBI and the Prosecutor will often depend on the Inspector General and the agency to provide technical support to the investigation in the form of program expertise, location of documents, application of regulations, audit assistance and the like.

DEPARTMENT OF JUSTICE COMMITMENT

The requirement this policy places on the Inspectors General to report matters at an early stage places special obligations on the Department as well. The Depatment has undertaken substantial new responsibilities:

1. United States Attorneys and the Criminal and Civil Divisions will give investigations of Inspector General matters a high priority and make special efforts to keep the Inspectors General informed of the progress of prosecutive actions.

2. The Fraud Section of the Criminal Division will be charged with overseeing the operations of the policy and resolving any uncertainties of differing interpretations which may arise.

3. Recognizing the importance to the Inspectors General of expeditious action and reporting in investigations involving subjects who continue to do business with the agency, or who are federal employees, or who are under consideration for benefits, grants or contracts by the agency, the FBI will keep the Inspectors General regularly informed of the progress of the investigation except in those rare instances where disclosure might endanger FBI agents or adversely affect the investigation.

4. The FBI will notify the Inspector General, at the same time it seeks a preliminary prosecutive opinion, of FBI investigations which are predicated on information or allegations other than an Inspector General report (with the same safety and security of investigation caveat).

5. The FBI will furnish a written summary at the conclusion of an investigation on the nature of judicial action, if any, taken. If administrative action is being considered by the federal agency, the FBI will, upon written request, provide for the exclusive use of the agency Inspector General, existing detailed investigative data less any Federal Grand Jury or other material, the disclosure of which is not deemed to be in the best interest of the FBI operations (such as informant data).

6. The FBI will furnish, at the conclusion of the investigation and upon a written request which identifies the exact data needed, FBI investigative documents and Special Agent testimony for use in administrative proceedings consistent with existing Department regulations.

7. At the conclusion of a case the FBI and the prosecutor will attempt to provide for the Inspector General's use, an analysis of any underlying problems in the federal program or procurement procedures and practices that were uncovered during the course of the investigation and which need corrective action.

8. The FBI will provide the following services:

a. Appropriate indices checks;

b. Laboratory examinations;

c. National Crime Information Center inquiries;

d. Identification record searches and other appropriate services.

9. The FBI has completed a major Inspector General/FBI undercover operation and is seeking the support of the Inspectors General in developing other such efforts. Substantial progress has been made in coordinating the prosecutive and investigation planning in this area through the Bureau's Undercover Review Committee. The Department expects to increase the use of this technique in the government fraud and corruption area.

10. Training is a major and important element to this relationship between the FBI and the Inspectors General. The FBI Academy alone and jointly with the Federal Law Enforcement Training Center will provide relevant training to Inspector General personnel to enhance this new team relationship. A dialogue between FLETC and the Academy has already begun.

MEMORANDA OF UNDERSTANDING

As the Department and the Inspectors General gain experience with the principles set forth in this statement, refinements within the framework of the underlying policy will be formulated. It is contemplated that the FBI and the Inspectors General, consultation with the United States Attorneys and the Criminal Division will address matters such as local working relationships, joint investigative procedures, threshold reporting requirements, and delegation of investigative responsibility. These may take the form of procedural and operating memoranda of understanding.

CONCLUSION

The Department of Justice intends that the new policy statement will enhance the attention given to the problems of fraud and abuse in government programs. This can only be achieved through the cooperative and coordinated efforts of federal investigators, auditors and prosecutors, both civil and criminal. This policy is a first step in insuring that the limited law enforcement resources available to meet the challenges are used to the best advantage.

APPENDIX R

United States Department of Justice
OFFICE OF
UNITED STATES ATTORNEY
WESTERN DISTRICT OF TENNESSEE
1058 FEDERAL OFFICE BUILDING
MEMPHIS, TENNESSEE 38103

August 15, 1980

Richard B. Lowe III
Inspector General
Department of Health
and Human Services
HHS North Building, Room 5451
330 Independence Avenue, SW
Washington, D. C. 20201

Dear Mr. Lowe:

A number of HHS cases have been referred to me, several of which have been the subject of extensive investigations and/or prosecutions, including, most recently, the case of United States of America v. Winston Hall Worthington, M.D. (CR. No. 78-20181). As you will recall, that case resulted in Dr. Worthington's conviction on 82 counts of Medicare/Medicaid fraud, and involved an extensive two-year investigative effort, which continued through the nine-week trial.

I am in almost daily contact with your special agents assigned to both the Memphis and Atlanta offices, as we are presently involved in several investigations. Accordingly, I am to some extent aware of certain problems occurring with respect to investigative needs and manpower shortages. The purpose of this letter is to detail, briefly, some of the problems which I have experienced, and to request your assistance in the resolution of these problems.

I am aware that the agents assigned to the Memphis sub-office have responsibility for not only Western Tennessee, but six other judicial districts as well. Although it seems that to some extent their efforts have been concentrated in the West Tennessee area, we have experienced problems in marshalling manpower, at times, even in West Tennessee. For example, during the investigation of Dr. Worthington it was necessary for an agent in the Atlanta office (Phil Pringle) to spend approximately ten to twelve entire months in Memphis assisting on the case because the agents assigned to the Memphis sub-office were required to divide their duties between the Worthington case and other pending investigative matters. This was

not due to any reluctance on the part of the agents in Memphis to assist in the Worthington investigation; but the extensive investigation that was carried out in the Worthington case required more effort than the four agents assigned to the Memphis office could carry out in conjunction with their other investigations. Therefore, Phil Pringle from the Atlanta office and, additionally, an agent from the Miami office, were assigned to assist in the Worthington case. It would have been more economical to have been able to assign two agents in the Memphis office to the Worthington case on an almost full-time basis for a period of approximately fifteen months than to have drawn on the Atlanta and Miami offices for support.

I'm also aware that the agents in the Memphis sub-office are currently investigating approximately seventeen HHS fraud matters, and that there are two or more extensive West Tennessee investigations still being handled by Pringle. We are always extremely pleased to have Pringle assigned to West Tennessee cases because he does an excellent job, as I noted in a prior letter. The lack of sufficient manpower in the Memphis office makes these investigations to which an Atlanta agent is assigned significally more expensive, however.

Additionally, we have had to rely on support from the Postal Service and the Tennessee Medicaid fraud unit where our manpower resources were insufficient. In the former case, we have been pleased, and the latter case we have not always been pleased with the quality of investigative work and dedication to the pursuit of crime. Because many HHS investigations require particular HHS program expertise, we are not always ~~able to farm out investigative~~ assignments, and I think we would do better if there were sufficient number of HHS agents to keep our efforts uniform.

I should add that the fact that HHS agents are not authorized to carry firearms, make arrests and serve search warrants will, increasingly handicap their efforts. This is particularly true where our investigations center on organized crime, as in the field of nursing home fraud.

This letter is too brief to fully address the manpower shortage problem that exists in this area. If I can be of any assistance in this regard, please feel free to get in touch. I am firmly of the opinion that

the number of HHS-based indictments returned in the Western District of Tennessee is dependent on the number of agents assigned to the Memphis sub-office; and I urge you to consider the addition of at least one agent in Memphis. May I say, however, that we are fully pleased with the work that your agents have done in this district.

Very truly yours,

W. J. MICHAEL CODY
UNITED STATES ATTORNEY

By _____
Arthur S. Kahn
Assistant United States Attorney

ASK:ew

WAYNE MINAMI
ATTORNEY GENERAL

RICK J. EICHOR
JAMES P. DANDAR
DEPUTY ATTORNEYS GENERAL

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
1000 BISHOP STREET, SUITE 908
HONOLULU, HAWAII 96813

CABLE ADDRESS
ATTGEN

PHONE:
(808) 548-6777

August 29, 1980

Mr. Richard B. Lowe III
Inspector General
Department of Health and Human
Services
HHS North Building, Room 5451
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Lowe:

You may recall that we met at the Medicaid Fraud Conference in San Diego in early 1979. I am writing to point out some problems and concerns of which I am sure you are aware, but which I feel are sufficiently important to call to your attention.

There are no Special Agents of the Inspector General's Division of Investigation assigned to Hawaii on a permanent basis. Agents do come to the islands to cover leads and to work on cases, but I do not feel this is sufficient coverage. I was instrumental in setting up the Medicaid Fraud Control Unit at a time when there were no fraud cases in the islands. As you know, we began with two investigators, two attorneys, and a secretary. Our staff now consists of two attorneys, three investigators, three auditors, and three clerks.

In a State that had no reported fraud or abuse we have indicted and convicted seven providers for Medicaid and Medicare fraud. We believe the establishment of an OIG sub-office on the islands would similarly uncover a significant level of fraud since HHS distributes in excess of $600 million annually.

You might also be interested to learn of the support provided by the U.S. Attorney. My associate and I have both been appointed Special Assistant U.S. Attorneys and have prosecuted both in State and Federal Courts.

I would additionally recommend in order to do a full professional law enforcement job, your agents should be fully authorized, completely trained and equipped.

We have had an excellent working relationship with your staff and look forward to continued cooperation.

Yours very truly,

Rick J. Eichor
Senior Attorney

RJE/cmy

United States Attorney
Northern District of Texas

RCP:js

1100 Commerce Street, Room 16G28
Dallas, Texas 75242

August 20, 1980

Richard B. Lowe, III
Inspector General, Designate
Department of Health and Human Services
HHS North Bldg, Room 5451
Washington, D.C. 20201

Dear Mr. Lowe:

We would like to congratulate you on your recent designation as the Inspector General of the Department of Health and Human Services (HHS). Your mission "to root out all the fraud" in HHS with the very limited resources you have to work with is not an envious one, but is certainly a challenge.

As you are aware, this office has worked primarily on HHS and HEW matters for nearly six years now. An impressive list of indictments and convictions has been compiled working with OIG personnel. Most of these cases were much longer and more complicated than the average cases presented to this office by other agencies. We have learned a lot from our association with your auditors and investigators and appreciate all the long hours and "above the call of duty" work that they have done.

We wish to share with you a few problem areas that you may or may not already be aware of, but are of mutual interest:

1. Your local field office in Dallas has been most helpful in supplying the investigative expertise as well as the clerical support to aid in numerous prosecutions, but there just are not enough Special Agents and support personnel to take on any more cases of the magnitude of LTV, Bishop College, Carl Wehling, or Bernstein and Bowers. We have had to decline criminal prosecution on a number of cases where audits had identified problems, but personnel were not available to follow up. When the cases were reached, the statutes of limitation in the criminal cases had expired or were close to expiration and chances of any civil recovery were jeopardized by the lapse of time. Other cases apparently have not been worked in over two years due to the lack of investigative, clerical and program personnel.

2. If your agency is to be pro-active in its mission, there probably should be at least another twenty agents for the State of Texas alone. HEW funded over eight billion dollars in Texas last year in over 300 programs. How can HHS expect twelve agents to police all these vast programs? While continuing to vigorously prosecute fraud cases, an emphasis is to be given to prevention through detection and agency house-cleaning. Whether detecting the fraud or trying the case, adequate manpower is a necessity.

3. There has been very little work done in institutional fraud (hospitals, nursing homes, etc.) in the past few years. We believe that the potential for fraud in this area is limited only by the imagination of the owners and managers of these institutions. We need specialized units of investigators and auditors to work with the United States Attorneys in these areas. In 1975, we received information concerning the use of federal funds by organized crime elements to acquire nursing homes. These leads were not investigated due to lack of resources.

4. The Office of Investigations (OI) recently convicted a Social Security Administration (SSA) employee here in Texas for accepting bribes and selling SSA cards to illegal aliens. We are told that this case will involve at least six other individuals who are known to have paid bribes to this SSA employee in order to purchase SSA cards for resale to illegal aliens. We feel that the potential for future SSA investigations in a large border state like Texas is very good. A large scale operation such as "Project Baltimore" which is now on-going in Chicago and New York could produce a significant number of criminal cases in the state of Texas. Here again, this type of large scale project requires a significant commitment of manpower by OI.

5. The Public Health Service grants millions of dollars for research with very little oversight by HHS. OI recently worked a case at Tulane University in which a professor was indicted for submitting the same bills for reimbursement to HHS and to the American Cancer Society. Since there seems to be no coordination between HHS and the private sector, this is a good example of what could be a widespread area of concern about potential fraud. Again, it takes more manpower to do projects that identify possible fraudulent activities in institutions.

6. In nearly all Head Start programs funded through the states and local governments there appear to be no coordination with other federal agencies. The Department of Agriculture and Department of Labor as well as CSA nearly always have money in the same programs as HHS and yet there has been very little coordinated effort to police these activities.

7. Finally, if the Office of Investigations is to be truly effective in its investigative efforts, it must be given the same law enforcement powers as the FBI, DEA, Postal Inspectors and other law enforcement agencies. OI should not have to continue to "borrow" agents from agencies to serve search warrants simply because they do not have the statutory authority to carry fire arms. Additionally, their work can be and is dangerous. Your agents are all professionals and are well-trained in all aspects of criminal investigations, but they do not have the tools of their trade. In recent bribery cases, they even had to borrow recording devices from other agencies. This is unprofessional.

In summary, we have been very pleased with the support that OI has given us in the past. However, to put a dent in the fraud in HHS, more agents with the full tools of law enforcement are needed.

If we can be of any assistance or if you need any more information involving our association with OI, please do not hesitate to call.

Yours very truly,

KENNETH J. MIGHELL
United States Attorney
Northern District of Texas

ROBERT C. PRATHER
Economic Crime Specialist
Special Assistant U.S. Attorney
Northern District and Western District of Texas
United States Department of Justice

cc: Donald Foster, Director, OECE, DOJ
Ray Jahn, AUSA, ECEUS, WD TX
Gene Richardson, SAC, OI, OIG, HHS

United States Attorney
Eastern District of California

Room 3305 Federal Building
United States Courthouse
650 Capitol Mall
Sacramento, California 95814

916/440-2331

August 29, 1980

Richard B. Lowe III
Inspector General
Department of Health and Human Services
HHS N. Building, Room 5451
330 Independence Ave., S.W.
Washington, D.C. 20201

Dear Mr. Lowe:

Congratulations on your appointment as Inspector General for the Department of Health and Human Services. The task can be overwhelming, and the elimination of all program fraud within the broad scope of HHS will require more agents than you presently have; and, in my opinion, will require that the agents have more authority than they presently possess.

The amount of federal funds processed through our state is almost immeasurable, and the task of tracking the money requires persons who have been properly trained and are familiar with and knowledgeable of all of the programs funded by your agency. It is obvious to me that your agents are the most qualified persons to fill that need.

The major problem, of course, is that there is an inadequate number of agents in the Eastern District to properly police and audit all of these programs. I would strongly urge that you seek additional positions, or in the alternative, reassign personnel to our area. Although there has been discussion of jurisdiction problems, rest assured that, in our district, there has been a good working relationship between the agents from your agency and the agents from the FBI.

Looking forward to supporting you in your task and efforts, I remain

Very truly yours,

HERMAN SILLAS
United States Attorney

cc: Bob Evans

United States Department of Justice

UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF GEORGIA
P. O. BOX 8999
SAVANNAH, GA. 31412

August 15, 1980

Mr. Richard B. Lowe III
Inspector General
Department of Health and Human Services
HHS N. Building, Room 5451
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Lowe:

This letter is to express the support of the United States Attorney's Office in the Southern District of Georgia for the expansion of the Office of Investigation of the Inspector General's Staff. We support the planned expansion of the resident agent offices in the State of Georgia to include establishing an office in Savannah staffed by two investigators.

At the present time, there are no investigative agents actively servicing in the Southern District of Georgia. As a direct result of the lack of investigators specifically assigned to the Department of Health and Human Services, fraud and cases of this nature are seldom made. It is the opinion of this office that incidents of fraud are going undetected, causing the loss of millions of dollars in tax monies, simply for the lack of adequately trained and properly motivated investigators specializing in this area. Currently, the only cases presented to this office come from Federal Bureau of Investigation agents, who because of their pressing other duties are unable to devote full time to what we feel may be existing fraud schemes within our District.

It is our view that the expansion of office of investigations to include establishment of a regional field office in Savannah with resident agents will

have a positive impact on public opinion in our area. One source of constant criticism of Department of Health and Human Services constantly raised by the residents of our District is the inability of the Department to adequately investigate and prosecute incidents of fraud involving large sums of taxpayers' money. The emphasis appears to be on the disbursements of funds without adequate investigative safeguards that funds are received in accordance with Program guidelines and Department specifications. The United States Attorney's Office in the Southern District of Georgia encourages investigations of these types of programs and pledges a vigorous prosecution of cases which would be uncovered by these investigations.

The United States Attorney's Office supports the establishment of a regional field office in Savannah and would be glad to cooperate in any possible way to assist in having an office with agents established here. If we may be of further assistance, please contact us.

Sincerely,

WILLIAM T. MOORE, JR.
UNITED STATES ATTORNEY

Wm. H. McAbee II

William H. McAbee II
Assistant United States Attorney

WHM:fpr

cc: Mr. Austin Lemon
Atlanta Regional Office
Department of Health and Human Services

United States Attorney
Western District of Kentucky

JLS:slg

Room 211, U.S. P. O. & Courthouse
601 West Broadway
Louisville, Kentucky 40202

502/582-5911
FTS/352-5911

August 14, 1980

Mr. Richard B. Lowe III
Inspector General
Dept. of Health and Human Services
HHS N. Building, Room 5451
330 Independence Avenue, S.W.
Washington, D. C. 20201

Dear Mr. Lowe:

On this date I have been visited by Jerald M. Messer, Special Agent, Office of Investigations, Department of Health and Human Services, presently stationed in the Memphis, Tennessee office. Mr. Messer informed me of your current plans to locate a resident office in Kentucky. Let me congratulate me on your decision to do that. In our district, the Western District of Kentucky, we take great pride in the personal working relationship we have with all our federal investigative agencies. In your agency's case that has been a difficult thing to do because under your current organization you only have nineteen Special Agents for eight states. Under your proposed changes we can work much closer with your agents and better serve the public.

I personally believe you and your staff have done an excellent job under trying conditions. I am certain under this proposed change we will all do better.

It is my opinion that four Special Agents for both districts in Kentucky will be sufficient. While our caseload may not be as large as some of our other districts, nevertheless we must constantly strive to improve the quality of our product.

Our office stands ready to support you in any way possible to see that you receive the support you need to do an effective job of law enforcement.

Respectfully,

John L. Smith

JOHN L. SMITH
United States Attorney

United States Attorney
Western District of Oklahoma

4434 United States Courthouse
200 N.W. 4th Street
Oklahoma City, Oklahoma 73102

405/231-5281
FTS/736-5281

August 1, 1980

Richard B. Lowe III, Inspector General
Department of Health and Human Services
HHS N. Building, Room 5451
330 Independence Ave., S.W.
Washington, D.C. 20201

Dear Mr. Lowe:

The purpose of this letter is to point out some problems, which I am sure you are already aware of, regarding the current status in Oklahoma of the Inspector General's Office of the Department of Health and Human Services (HHS). Recently, I have been assigned the responsibility of lead federal prosecutor assigned to coordinate all major investigations of fraud within the many programs relating to the Department of HHS. Our principal effort to date has been in the area of medicade abuse within the Nursing Home Industry.

Currently assigned to investigate all the fraud and program abuse which may occur within the jurisdiction of HHS in this State is one agent, Richard Boggs. Mr. Boggs has done a splendid job with the very limited resources provided him by your department. However, his appearance and efforts simply cannot be construed as anything other than token when compared to the tremendous problem faced by your office in seeking to carry out the congressional mandate to "clean house" and eliminate program fraud and abuse within HHS programs in Oklahoma.

No doubt, I am probably no more than echoing your frustration in stating that the job simply cannot be done in Oklahoma with one agent who is not even given a secretary. Obviously, more manpower is needed. The only way the job can even partially be done is with the help of sister agencies, such as the Federal Bureau of Investigation, who somehow always seem to have enough manpower to carry out their charged responsibilities.

However, there is an obvious jurisdictional problem since Congress has given primary responsibility to your office to investigate and eliminate fraud in HHS. Fortunately, because of the good working relationship developed between Special Agent Boggs and the Agents from the FBI here locally, we have not had a problem when working together. Nevertheless, the job

could be much more effectively done by those people who are properly trained within your department. As you know, to investigate the types of fraud involved in HHS programs requires a special expertise. This takes extensive training and experience and is something that the average investigator cannot be expected to adequately handle unless he has been especially equipped and trained to deal in this area.

I would estimate that in a state the size of Oklahoma we could easily use six or more agents fully supported with a staff of at least two secretaries. If the government would commit the amount of money to pay these salaries and provide the staffing necessary, I am certain that we could save the government, in the longrun, millions of dollars here in Oklahoma. For example, in the nursing home case we just recently prosecuted, the evidence indicated that the operators had bilked the government out of at least a million dollars. One agent was able to successfully investigate the case. The net saving to the taxpayers could run into the millions of dollars when the deterrent impact is considered.

One last note. It is my understanding that you are not only charged with a tremendous task, that of investigating and eliminating all program fraud within the broad scope of HHS, but are charged with doing so without adequate tools to properly investigate. There is no question that if you are to do your job properly, your Special Agents must be given the same law enforcement capabilities as the FBI, Secret Service, Postal Inspectors, or any one of the other numerous federal investigators. A castrated IG simply cannot do the job. Your agents must have the authority to carry a firearm, make arrests, serve search warrants, and all the other indicia that accompanies any other federal law enforcement agent. In other words, the IG force must be upgraded and improved in not only number, it must become a full fledged member of the federal law enforcement community.

Our office would be glad to support you in any way possible in your effort to see that Oklahoma, as well as other states, receives the support you need in order to effectively do a good job.

Respectfully,

Charles Lee Waters
Assistant United States Attorney
Western District of Oklahoma

United States Department of Justice

UNITED STATES ATTORNEY
NORTHERN DISTRICT OF ALABAMA
200 FEDERAL COURTHOUSE
BIRMINGHAM, ALABAMA 35203
(205) 254-1785
FTS 229-1785

August 22, 1980

ADDRESS REPLY TO UNITED STATES ATTORNEY AND REFER TO INITIALS AND FILE NUMBER
CEA:SME

Richard B. Lowe, III
Inspector General
Department of Health and Human Services
HHS N. Building, Room 5451
330 Independence Avenue, S. W.
Washington, D. C. 20201

Dear Mr. Lowe:

As you may know, this Administration has made economic crime an enforcement priority; and, Alabama and Mississippi have been selected as two of the first states to reflect this new emphasis through the creation of an Economic Crime Enforcement Unit based in the United States Attorney's Office in Birmingham, Alabama. One of the main goals of the unit is to combat fraud and abuse in federal programs and agencies. In accordance with this goal I met with representatives of your staff assigned the duty of policing these states and I must say that I am troubled by the lack of manpower you have in this area. I know that your office is doing the best job it can with the personnel it has been authorized, but I think the time has come to approach Congress to seek additional funds for additional investigators in these states. I have no doubt that if additional funds were authorized and utilized for more investigators that, in the long run, we could save the government millions of dollars in these states.

Economic crime is insidious. It is the hardest to detect and yet causes a great loss of monies to the government every year. If the unit is to succeed in its goal of improving the detection, prevention and prosecution of economic crimes in Alabama and Mississippi, it will be through the assistance of the Department of Health and Human Services; and this can only be accomplished with additional investigators in these states.

Yours very truly,

J. R. BROOKS
United States Attorney

Charles E. Auslander Jr.

CHARLES E. AUSLANDER, JR.
Economic Crime Enforcement Specialist

cc:
Fred Mosley, SAC
Office of Investigations
Department of Health and Human Services
P.O.Box 2201
Atlanta, Georgia 30301

APPENDIX S

memorandum

DATE: May 2, 1980

REPLY TO ATTN OF: Mark L. Horwitz, AUSA

SUBJECT: Medicare Fraud Cases

TO: Gary L. Betz
United States Attorney
Tampa, Florida

Enclosed herewith please find the letter for your signature to the Inspector General of Health, Education and Welfare.

As you will recall, we previously discussed the fact that this office has not been receiving the quantity of medicare fraud cases that were produced in the past, and that there is apparently a problem within the Department of Health, Education and Welfare in their investigations that has resulted in a decline in the flow of cases and information into this office.

For your information, it is my understanding that the Bureau of Program Integrity presently has the responsibility of initially working up cases on medicare fraud. After they have developed the case to the point where fraud is suspected, it is then referred to the Inspector General for further action. It is my understanding that cases are going to the Inspector General concerning medicare fraud currently within the Middle District; however, we are not seeing these cases.

Perhaps a meeting between yourself and the Inspector General will have some positive effect in clearing any road blocks that might exist within the Department of Health, Education and Welfare that have caused the cases to be stalled in the Inspector General's office. As you can imagine, this will be a delicate topic because it involves the jurisdiction between the Inspector General's office and the Bureau of Program Integrity. Whenever two bureaus are fighting over jurisdiction, each tends to guard its area of responsibility in an attempt to expand that area, and if possible to exclude other competing agencies. It is possible that such a situation exists between the Inspector General's office and the Bureau of Program Integrity.

In light of the past experiences of the Bureau of Program Integrity in making fraud cases, I believe that this office as well as the public is not being served with its best interests if, under the new organizational set up within the Department of Health, Education and Welfare, the Bureau of Program Integrity personnel are insulated from direct contact with the United States Attorney's office in matters involving fraud investigations.

Perhaps, if you held a meeting with the Inspector General, steps can be taken to insure that cases will flow quickly through the system to this office and that any artificial barriers imposed upon the Department of Health, Education and Welfare investigators do not hamper successful investigation prosecution.

MLH:ddd

enclosure

UNITED STATES ATTORNEY
MIDDLE DISTRICT OF FLORIDA
ORLANDO, FLORIDA

(305) 420-6341
FTS 820-6341

STREET ADDRESS:
SUITE 301, FEDERAL BUILDING AND
UNITED STATES COURTHOUSE
80 NORTH HUGHEY AVENUE
ORLANDO, FLORIDA 32801

May 2, 1980

Richard B. Lowe, III
Acting Inspector General
Department of Health,
Education and Welfare
Room 5262, North
330 Independence Avenue, S.W.
Washington, D. C. 20201

Dear Mr. Lowe:

RE: STATUS OF CRIMINAL INVESTIGATIONS

The Middle District of Florida, as you are well aware, encompasses a large population of citizens who receive social security benefits including medicare and medicaid. In the past years, this office has successfully prosecuted numerous cases involving frauds perpetrated upon the United States and in particular the Department of Health, Education and Welfare. As you are no doubt aware, such prosecutions serve a vital interest in safeguarding the integrity of Health and Human Services programs through the natural deterrent effect of any criminal proceeding.

In the past, social security, and in particular medicare cases, were presented to this office by the Bureau of Program Integrity. That Bureau constantly produced high quality investigation reports as well as rendering invaluable assistance to this office throughout the complex trials that were normally associated with medicare fraud cases.

As you know, the Department of Justice has given government fraud cases a high priority. As the United States Attorney, it is my responsibility to ensure that such cases are vigorously investigated and prosecuted within the Middle District of Florida. In that regard, I would like to meet with you to discuss the status of investigations into medicare fraud, as well as any imagined or real problems that may be hampering the flow of information and cases from Health and Human Services investigators to this office.

Please contact me in the near future so that a convenient time to meet may be arranged.

Very truly yours,

GARY L. BETZ
United States Attorney

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