United States General Accounting Office
Washington, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 9:30 a.m., EST
Wednesday, December 9, 1981

STATEMENT OF

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BEFORE THE

SENATE COMMITTEE ON FINANCE AND

THE SPECIAL COMMITTEE ON AGING,

ON WAYS TO

IMPROVE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

INSPECTOR GENERAL'S OPERATIONS AND

RELATIONSHIP WITH THE FBI

Messrs. Chairmen and members of the committees, I am pleased to appear here today to discuss our review of the relationship between the FBI and the Inspectors General in investigating fraud against the Federal Government. We reviewed the investigative activities of Inspectors General at seven departments or agencies and their coordination with and relationship to the investigative activities of the FBI. However, as you requested, my testimony today focuses on the results of our work at the Office of the Inspector General (OIG) in the Department of Health and Human Services (HHS). Also, as you requested, my testimony includes information on the involvement of HHS's Health Care Financing

Administration (HCFA) in referring potential Medicare fraud cases to the OIG.

We identified five areas in which the Department's OIG operations could be improved. However, the first four of these areas were not unique to HHS. In fact, these problems existed in varying degrees at all seven Inspector General offices. Specifically, we found that:

(1) Coordinating the development of the Department's automated OIG management information system with other OIGs could improve the system and possibly save money.

(2) Sharing complete and timely information with the FBI could prevent duplicative investigative efforts and improve analysis of data on fraud cases.

(3) More thorough followup of case disposition and of recommendations for improved program control could better assure that fraud perpetrators are appropriately sanctioned, and that needed program changes are made to prevent fraud from recurring.

(4) Clarifying the OIG's investigative role could eliminate confusion, and improve accountability and fraud control efforts.

(5) Changing the present system of referring potential fraud cases from carriers through the HCFA regional offices to the OIG could facilitate the timely disposition of the cases, thus improving the carriers' chances to recover overpayments.

During our recently completed fieldwork, we also contacted 11 U.S. Attorney's Offices and other Department of Justice organizations to determine their role in coordinating and managing Federal fraud investigations. We plan to issue a report to the Congress on improvements that can be made in Federal investigative fraud control efforts. At HHS we focused primarily on the Office

of Investigations in the OIG. We conducted work at HHS headquarters and three regional offices in Atlanta, Chicago, and Seattle.

Our findings concerning the role of HCFA in referring potential Medicare fraud cases come from a broader review of Medicare contractors' (carriers) activities. The work involved nine carriers under the jurisdiction of the HHS Atlanta, Boston, Chicago, and Philadelphia Regional Offices. We examined how carriers identify and prevent payment for unnecessary physicians' services and make recoveries where appropriate.

ESTABLISHMENT, ORGANIZATION, AND ACCOMPLISHMENTS OF THE OIG

Public Law 94-505, dated October 15, 1976, authorized the establishment of an OIG in the Department of Health, Education, and Welfare (HEW) to create an independent and objective unit which would, among other things, (1) conduct and supervise audits and investigations of HEW programs and operations, (2) provide leadership and coordination, and (3) recommend policies for activities to prevent and detect fraud and abuse in such programs and operations. On October 17, 1979, the President signed the "Department of Education Organization Act," which transferred to the new Department of Education most education programs from HEW and created an OIG in the new Department. That portion of HEW's OIG staff performing audits and investigations specifically related to these programs were also transferred. The remainder was redesignated the Department of Health and Human Services.

The Inspector General Act of 1978 (Public Law 95-452) dated October 12, 1978, authorized OIGs in 12 additional departments and agencies. On August 4, 1977, the Department of Energy Organization Act (Public Law 95-91) authorized an OIG in that Department, and on October 17, 1980, the Foreign Service Act of 1980 (Public Law 96-465) authorized an OIG for the State Department.

As of January 1981, the HHS OIG had the largest staff of auditors and investigators of all Inspector General organizations, but its investigative staff was the fourth largest. In addition to the Inspector General and his immediate staff, the OIG in HHS includes three groups--Audits, Investigations, and Health Care and Systems Review--each headed by a Senior Assistant or Assistant Inspector General. The Office of Investigations, headed by an Assistant Inspector General for Investigations, includes 4 headquarters divisions--Investigations, Training and Review; Investigative Systems; Special Assignments; and Security and Protection--11 field offices and 19 suboffices. At the end of fiscal year 1981, the Office had 123 investigators--111 in the field and 12 in headquarters. The OIG's annual report for calendar year 1980 states that, historically, OIG investigators have opened about 350 cases each year. Accomplishments cited in the same report included 137 indictments, 145 convictions, and $4.7 million in recoveries, fines, and restitutions.

In addition to the OIG, HCFA gets involved in Medicare-related fraud investigations. Prior to the 1976 Act which established the HHS OIG, Medicare fraud cases were usually

investigated and referred for prosecution by the Office of Program Integrity within the Bureau of Health Insurance of the Social Security Administration. 1/ Since the OIG was established, several joint operating statements between HCFA and the OIG have made the OIG the focal point for investigating and referring fraud cases to prosecutors. However, these agreements have generally maintained HCFA as the initial contact point for referrals of potential fraud cases from Medicare carriers.

THE FBI ALSO INVESTIGATES HHS-RELATED CASES

In fiscal year 1980, the FBI opened 752 HHS-related fraud cases. Generally, these cases were opened on the basis of allegations from agency headquarters or local program staff, local FBI fraud hotlines, the news media, private citizens, or anonymous sources. Early in its investigation the FBI consults with a U.S. attorney concerning the case's prosecutability. If the U.S. attorney decides to prosecute the case, the FBI will work with the attorney and finish the investigation. If the U.S. attorney declines to prosecute, the FBI closes the case and refers it to HHS for appropriate action. For fiscal year 1980, the FBI reported that HHS-related investigations resulted in 130 indictments, 175 convictions, and about $2.5 million in fines and recoveries.

1/In March 1977, HCFA was established and the Bureau of Health Insurance including the Office of Program Integrity was transferred to the new organization.

INFORMATION SYSTEM DEVELOPMENT SHOULD BE COORDINATED

We reported in September 1978 1/ that one of the biggest weaknesses in Federal fraud control efforts had been the lack of information to measure the extent, location, patterns, and characteristics of the fraud problem. Only recently have the OIGs in all agencies begun to develop automated systems to obtain such information. Although some voluntary sharing of system design information occurs, most of the OIGs, including HHS, are developing these systems independently.

Our current review did not focus on the technical merits of any of these systems, but we did look at planned data collection elements, output formats, and estimated costs--all of which varied considerably. We recognize that information needs can vary because of differences in agency programs. However, we believe there is enough similarity of purpose among OIGs that coordination of their efforts to develop information systems could help assure similarity in (1) data gathered, (2) type of output, and (3) analysis performed. In addition, comparing computer equipment and software needed among all OIGs may indicate opportunities for cost savings.

Obviously, the OIGs are in the best position to determine their information gathering and analysis needs. By working together and sharing ideas, each could gain a better understanding as to what information is useful, and the OIG automated

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1/"Federal Agencies Can, And Should, Do More to Combat Fraud In Government Programs" (GGD-78-62, Sept. 19, 1978).

information systems could thus become a more valuable resource. Coordinating their efforts could help minimize differences in the type of data gathered and in the analyses of the data and could make each system capable of arraying data in similar formats. Comparable data could aid in evaluating the OIG's performance, help identify perpetrators of fraud across agency lines, and be used to compile more accurate Government-wide statistics on the fraud problem and the progress made toward controlling it.

Because of differences in past OIG annual and semiannual reports, meaningful comparisons of OIG results have been virtually impossible. A Department of Transportation OIG analysis of some recent Inspector General reports for 13 agencies showed differences in presentation or content for virtually every legislative reporting requirement. For example, Section 5 (a) (3) of the Inspector General Act of 1978 requires an identification of each significant recommendation described in previous semiannual reports on which corrective action has not been completed. The Transportation report states, in part, "Two of the thirteen [Inspectors General] * * * reported prior significant items in a separate chapter of the report, four included them in the chapter on 'Audit Activities,' and two presented the data as an appendix. [One] * * * made occasional reference to prior problem areas * * * but did not devote a separate section of the report to the matter. [HHS] * * * gave a general discussion of 'Unresolved Audit Reports Over Six Months Old' but did not list specific prior

recommendations not yet implemented. In three reports we did not find any discussion of prior recommendations * * *."

Relatively large differences in cost estimates for the various OIG information systems hold out the possibility that some cost savings could be achieved if all the OIGs coordinated the development of these systems. HHS's latest cost estimate for information system development and implementation is $680,000, which is higher than the estimates for systems in other agencies--for example, $135,300 at the Department of Agriculture and $93,000 at Housing and Urban Development. Evaluating the whys and wherefores of the differences would require a detailed technical analysis that was beyond the scope of our work. However, such an analysis, including all the OIG systems, may show ways to economize or improve upon equipment and data processing capabilities that would not be clear to the OIGs individually.

IMPROVED INFORMATION SHARING WITH THE FBI NEEDED

Although some information sharing occurs, HHS and FBI investigators are usually unaware of what the other is doing. Moreover, neither HHS nor any of the other OIGs we reviewed included information on FBI fraud cases in their information systems. Thus, although some OIGs track FBI cases to assure appropriate action is taken, the thousands of Government fraud cases investigated by the FBI are excluded from any formal OIG analysis of the location, extent, characteristics, or patterns of fraud in an agency.

Informally, HHS investigators may call FBI investigators to find out whether the FBI is investigating a particular case, and the FBI occasionally will call HHS. This is sometimes the only, and certainly the most timely, information each agency has about the other's cases. HHS does not formally notify the FBI of open investigations. On the other hand, FBI procedures require its field offices to notify FBI headquarters by memorandum within 30 days of opening a case. In turn, FBI headquarters officials said these memos were forwarded to HHS headquarters. HHS headquarters then sends the memos to the appropriate HHS field location. An FBI headquarters official told us that field offices were actually allowed up to 60 days to send in the memos. One FBI field office official said his office does not send the notifying memos on cases that take less than 30 days to investigate. Thus, HHS field locations might not become aware of FBI investigations until long after a case is opened. Duplication of investigative effort is usually avoided because investigators of both agencies interview the same people at the start of a case and discover each other early in the investigation.

The FBI also sends each agency a memo at the end of its case investigations which describes the particulars of the investigation. The HHS OIG usually forwards these memos to the program office for possible administrative action and does nothing further with the information.

NEED FOR IMPROVED FOLLOWUP

The HHS OIG investigates primarily potential criminal matters. All others, including criminal cases that U.S. attorneys decline to prosecute, are referred to the appropriate HHS program office for action. The OIG does not systematically follow up on these referrals to determine whether appropriate administrative or civil actions are taken. This is especially important because most cases involving fraud against the Government are declined for prosecution. Similarly, although its investigators make recommendations for program changes to avoid recurrence of fraud, the OIG does not follow up with the program offices to determine whether the recommended changes are made. As we have testified on many occasions, fraud prevention activities such as improving program controls are the best way to control fraud against the Government.

HHS has one employee who tracks the most significant cases to conclusion, but for the most part case disposition is left to the program office and is not tracked. The HHS OIG was the only OIG we reviewed that normally does not investigate civil or administrative cases, but instead remands them to the relevant HHS program office. The HHS OIG also declines investigation of Medicare and Medicaid beneficiary fraud in favor of other HHS or State actions. FBI-investigated cases which have been declined for prosecution and referred back to the OIG are usually forwarded directly to the program office for action. Unless OIG staff are

involved in a criminal prosecution, the OIG does not follow the case to determine whether all civil or administrative sanctions available are imposed. In some other agencies, cases are closed only when the OIG and program managers agree on the action to be taken.

We reported in May 1981 1/ that 61 percent of all cases that agencies referred for prosecution from October 1976 through March 1979 were declined. Therefore, civil or administrative action is the only action that will be taken on a majority of cases involving fraud against the Government. However, our May 1981 report also states that during the 2-1/2-year period covered by our review, agencies referred a total of 393 cases to the Department of Justice for civil legal action. The Department filed only 28 civil actions on these cases. In addition, as one agency official stated, getting program managers to take administrative action on cases declined for prosecution can be difficult. He said program managers sometimes assume that a declination means either the suspect was innocent or that the evidence was insufficient, and therefore they take no action. However, many cases are declined not for lack of evidence, but because (1) they lack jury appeal, (2) the dollar loss is considered insignificant, or (3) administrative action is considered more appropriate. The extent to which agencies take administrative action is the subject of another ongoing GAO review.

1/"Fraud In Government Programs:--How Extensive Is It?--How Can It Be Controlled?" (Volume 1, AFMD-81-57, May 7, 1981).

Since mid-1980, HHS has required its investigators to write Management Implication Reports on cases where their investigation reveals a management problem that should be corrected. The investigators suggest legislative or procedural changes to help prevent the fraud from recurring. The reports are sent to the OIG Health Care and Systems Review office in headquarters which finalizes the recommendations and sends them to the appropriate program offices. However, there is no followup to determine whether the suggested changes are made or to provide feedback on the results to the field investigator. Thus, the effectiveness of this procedure is uncertain. Again, in some other agencies, when investigators recommend program changes, the case is closed only when program managers and the OIG agree on the change to be made.

A CLEAR DEFINITION OF THE OIG INVESTIGATIVE ROLE IS NEEDED

Neither Inspector General legislation nor any other overall guidelines specifically delineate what the investigative role of an OIG should be. As a result, the Inspectors General operate their investigative offices in different ways, and established criteria against which to measure their effectiveness do not exist. As we mentioned previously, there is a lack of data on the extent and characteristics of the fraud problem against which to compare OIG accomplishments, and differences in data collection and analysis exist among the OIGs. These factors further complicate an analysis of OIG operations.

Although legislation concerning fraud against the Government requires OIG's to expeditiously report apparent criminal violations to the Attorney General, it does not specify which Federal agency has primary jurisdiction for criminal investigations. The FBI believes it does. Some OIGs agree, but most do not, including HHS. Little progress has been made between the FBI and the OIGs in negotiating comprehensive written agreements that would clarify their respective roles. The extent and quality of coordination between them has varied. Before the OIGs can be held accountable for their investigative results, and before the Federal Government can have unified and coordinated fraud investigations, the investigative role of the OIGs must be clearly defined.

Authorizing legislation is vague and comprehensive memoranda of understanding do not exist

HHS OIG legislation provides the OIG authority to request information and assistance from other Federal entities. However, neither OIG nor FBI legislation authorizing investigations of fraud against the Government provides specifics about how each should relate to the other. Although OIGs and the FBI have attempted to negotiate comprehensive memoranda of understanding that would more fully explain their relative roles and responsibilities, none have yet been completed.

The legislation establishing an OIG in HHS requires the OIG to supervise, coordinate and provide policy direction for investigations of fraud relating to HHS and its program operations. It

also requires the OIG "to recommend policies for, and to conduct, supervise or coordinate relationships between the Department and other Federal agencies * * * 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, Department programs and operations * * * or (B) the identification and prosecution of participants in such fraud and abuse * * *." The legislation does not provide any specifics about the extent to which OIG investigators should investigate criminal fraud cases or about the relationship between the OIG and the FBI.

According to 28 U.S.C. 535, the FBI may investigate any fraud violation involving Government officers and employees despite any other provision of law. In addition, the FBI has authority and responsibility to investigate all criminal violations of Federal law not exclusively assigned to another Federal agency. FBI officials view OIG legislation as making no such exclusive assignment, and thus the FBI investigates cases involving fraud against the Government, including cases in each of the agencies having an OIG.

At the time of our fieldwork, HHS had a 1976 memorandum of understanding with the FBI concerning referral of quality cases as opposed to a large volume of routine recipient-type frauds. However, it had been used very little. As with all the other OIGs, no comprehensive agreement existed. In March 1981 the President's Council on Integrity and Efficiency was formed to coordinate and implement Government policies concerning integrity

and efficiency in Federal programs. One of its first priorities was to negotiate such agreements between the FBI and the OIGs. However, FBI officials told us that the FBI should investigate criminal matters, and the role of the OIGs should be prevention and detection of fraud, not criminal investigations once fraud has been detected. On the other hand, OIGs are already investigating criminal cases and appear unwilling to give them to the FBI. Negotiations are still in process for these agreements. The estimated completion date for the first one is some time this week.

Some OIG investigative policies minimize the FBI's role

Lacking a clear role definition, the OIGs' investigative operations vary considerably depending on factors such as the philosophy of the Inspector General, caseload, and resources available. Some OIGs referred a majority of their cases to the FBI as soon as there was any indication that a crime had been committed. Others, like HHS, referred almost no cases to the FBI, preferring instead to work directly with the U.S. attorney through prosecution of the case. Still other OIGs investigated some cases and referred others according to their choice.

HHS OIG investigators generally do not refer cases to the FBI unless ordered to by a U.S. attorney or unless the FBI has primary jurisdiction, as in bribery cases. As stated previously, the HHS OIG investigates primarily potential criminal cases. Its investigators told us they usually contact a U.S. Attorney's Office early in their investigations to determine whether the case

is prosecutable. If not, the investigators refer it to the appropriate program office for administrative or civil action.

HHS OIG regional offices are nearly autonomous in selecting cases to investigate; OIG special agents-in-charge may open and close cases at their discretion. One field office special agent-in-charge told us that his office needs and wants no help from the FBI except when there are too many cases for his agents to handle or when he lacks resources such as recording equipment. Both situations happen rarely, he said. Likewise, another OIG regional office special agent-in-charge said he rarely referred cases to the FBI and only when his region lacked sufficient staff to perform the investigations or when travel considerations precluded OIG involvement.

Extent and quality of coordination with the FBI varies

As mentioned previously, information sharing between the OIGs and the FBI should be improved. We found that the extent and effectiveness of other forms of coordination between these agencies varied depending on the individual investigator, agency, location, and the particular case under investigation. We believe that by looking long enough, almost any example of coordination--good or bad--could be found. For the most part, HHS OIG and FBI investigative activities are performed independently. Occasionally, they participate in a joint investigation, but we found very few of these, and they had usually been mandated by the U.S. Attorney's Office when both agencies were working the same case but failed to agree on which should take the lead. An

HHS regional OIG official told us that when both the FBI and OIG start an investigation on the same case, each wants the other to drop the case. We interviewed headquarters and regional officials of the OIG, FBI, and U.S. attorneys about the extent and effectiveness of coordination.

An HHS headquarters OIG official said cooperation with the FBI varies considerably depending upon the level of personnel involved, individual personalities, and office geographic location. The Assistant Inspector General for Investigations described the relationship with top FBI officials--the Executive Assistant Director of Investigations; Assistant Director, Criminal Investigation Division; and Director, White Collar Crime Section--as "very smooth" through formal and informal meetings and contacts about individual cases. However, he said he participated in a conference of several organizations involved in health care fraud investigations at which each entity seemed interested in protecting its own "turf," and he was discouraged by the FBI's position on the OIG's role in fraud control.

In one region, two HHS OIG investigators were participating with FBI investigators on a joint Medicare/Medicaid fraud task force directed by the Economic Crime Specialist in the U.S. Attorney's Office. Cooperation appeared to be good on both sides with each learning something from the other. Agents from each group participated in training seminars sponsored by the other. On the other hand, OIG agents in the same region said they felt they were treated less than equally by the FBI agents because of

their lack of full law enforcement powers (search and seizure, carrying a gun, and arrest authority).

FBI and U.S. attorney personnel in another region said HHS OIG investigators are the least cooperative of all the agencies. A regional FBI memo to headquarters concerning the President's dismissal of all the Inspectors General stated that instead of cooperating with each other on investigations, the FBI and OIGs are in competition. FBI regional officials said their caseloads had decreased since the OIGs began work. According to an FBI study, this has occurred in several regions. Although FBI officials complain about the reduced caseload, an HHS OIG official in the same region told us that the FBI does not desire to investigate most HHS cases because the cases require too much effort. A lack of communication is evident in this region.

The extent to which OIGs conduct criminal investigations affects their entire organizations, including the number and qualifications of investigators, training requirements, and the extent of law enforcement powers needed. It also apparently affects the FBI's investigative caseload.

A recent Department of Justice policy directive may have the effect of unilaterally limiting the OIGs' investigative role. Under the new policy, OIGs are required to refer all potential criminal cases to the U.S. attorney and the FBI as soon as there is any indication a crime has been committed. The U.S. attorney, along with the FBI, will then decide who will investigate the case. This new policy will no doubt be unpopular with some of the

OIGs. Since it was not issued until our fieldwork was completed, we do not know what impact this change will have on the OIGs' investigative operations.

THE MEDICARE FRAUD REFERRAL PROCESS NEEDS TO BE CHANGED

The process of referring potential fraud cases from Medicare carriers through the HCFA regional offices to the OIG causes investigations to be delayed and carriers to lose the opportunity to recover overpayments. In addition, the number of convictions resulting from these investigations has consistently declined since this arrangement began. HCFA and OIG personnel agree that having both offices involved in the referral process has contributed to increases in the time investigations are in process, declines in the number of fraud convictions, and the loss of abuse overpayment recoveries.

Under the current operating agreement between HCFA and the OIG, HCFA is the initial contact point for referrals of potential fraud cases from the Medicare carriers. When HCFA has sufficient information to believe a strong potential for fraud exists, it is required to refer the cases to the OIG. According to HFCA and OIG personnel, problems occur because (1) the OIG investigates and presents Medicare fraud cases for prosecution without staff experienced in the extremely complex Medicare program, while experienced Medicare investigators have been retained in HCFA and (2) HCFA maintains an investigative function in addition to the OIG's which results in some duplication of effort.

Our review of 108 recently closed and open case referrals showed that the resolutions of potential fraud case referrals are lengthy. We reviewed 87 closed cases that had been referred to HCFA regional offices by eight Medicare carriers. These were taken from the carriers' lists of cases referred during 2-year periods between January 1, 1978, and September 30, 1980. In addition, we analyzed 21 referrals opened during that period that were still open at June 30, 1981, for 6 of the 8 carriers. Of the 87 closed cases, 31 were closed in less than 12 months; however, 34 were closed in 1 to 2 years, and 22 were closed over 2 years after the carriers' referrals. For the 21 open cases, only 1 had been in process less than 12 months, 8 had been in process from 1 to 2 years, and 12 for over 2 years. For 44 of these 108 cases we determined they were with HCFA an average of 8 months and with the OIG an average of 14 months.

Under HCFA instructions, carriers are not allowed to attempt to recover overpayments on cases where an OIG fraud investigation is in process because such an effort might jeopardize the OIG's case. Carrier officials told us about a number of cases where the opportunity to recover overpayments had been lost due to lengthy fraud investigations which resulted in no convictions. For example, a carrier suspected a podiatrist of fraudulently misrepresenting services and referred the case to HCFA in December 1977. In May 1979, a year and a half after receiving the case, HCFA referred it to the OIG. In July 1980, over 2-1/2 years after the case was initially referred to HCFA, it was declined for

prosecution because of insufficient evidence and returned to the carrier for overpayment collection action. Although the carrier estimated that overpayments for services in excess of those actually performed totaled $9,700, it was able to recover only $2,535. Because of the 2-1/2 year time lapse, the carrier was no longer able to prove and recover the remaining overpayments totaling $7,165.

For fiscal year 1976, the last full year of HCFA's lead role in fraud investigation, the agency reported 83 Medicare fraud convictions. For 1980 and 1981, the OIG reported 19 and 15 Medicare fraud convictions respectively. OIG records show that none of the 87 closed cases included in our case review had resulted in Medicare convictions. According to both HCFA and OIG personnel, judgements about the prosecutability of these cases could be made much earlier in the investigative process.

We believe the present system of referring potential fraud cases should be changed. It is clear to us that one step in the process should be eliminated.

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In summary, changes in HHS' OIG operations could improve its information system, help assure that perpetrators of fraud receive appropriate punishment, improve its fraud prevention activities, and streamline its Medicare fraud referral process. However, without a specific definition of the respective investigative roles of the FBI and the OIGs, problems will continue to exist, and

holding the OIGs accountable for their results as well as achieving a unified and coordinated Federal attack on fraud will be difficult.

Messrs. Chairmen, this concludes our prepared statement. We shall be happy to answer any questions that you or other members of the Committees might have.