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June 2003

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Review of the Management of Inspector General Operations

GAO-03-685

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-03-685, a report to the Chairman and Ranking Minority Member, Senate Committee on Finance and the Ranking Minority Member, Senate Special Committee on Aging

Why GAO Did This Study

Janet Rehnquist became the Inspector General of the Department of Health and Human Services (HHS) in August 2001. GAO was asked to conduct a review of the Inspector General's organization and assess her leadership, independence, and judgment in carrying out the mission of the Office of Inspector General (OIG). GAO examined indicators of the OIG's productivity and compared them to the organization's past performance. GAO also determined whether employee morale has been sustained by surveying all OIG employees and comparing the results to those obtained through an identical survey administered in 2002.

On March 4, 2003, the Inspector General resigned her office effective June 1, 2003. However, in this report we refer to Ms. Rehnquist as the Inspector General.

What GAO Found

The credibility of inspectors general is largely premised on their ability to act objectively and impartially—both in substance and in perception. Some of the HHS Inspector General's actions—including her decision to delay a politically sensitive audit—created the perception that she lacked appropriate independence in certain situations. The Inspector General exhibited serious lapses in judgment that further troubled many OIG staff. For example, she inappropriately obtained a firearm that she briefly possessed at her workplace and OIG credentials that identified her as a law enforcement officer. The Inspector General also initiated a variety of personnel changes in a manner that resulted in the resignation or retirement of a significant portion of senior management, disillusioned a number of higher level OIG officials and other employees, and fostered an atmosphere of anxiety and distrust. Ultimately, the collective effect of these actions compromised her ability to serve as an effective leader of HHS's Office of Inspector General.

Examining productivity trends is difficult because the work of the OIG often involves multiyear efforts and the results recorded for a single year are heavily dependent on work initiated in prior years. Similarly, savings achieved in any one year can be attributable to the culmination of efforts made over several years. Given these constraints, GAO noted that productivity at the OIG over the last 3 years increased in some areas and declined in others. Overall savings attributable to the OIG's efforts—as reported in its semiannual reports to the Congress—increased from $15.6 billion in fiscal year 2000 to $21.8 billion in fiscal year 2002. The number of individuals convicted for violating HHS program statutes and regulations—another key indicator of the OIG's performance—also increased. On the other hand, declines were noted in the number of settlements with providers who submitted false claims to the government and the OIG's education and outreach activities.

GAO's survey results showed that employees' overall views of the organization, management, and their personal job satisfaction generally remained positive and relatively unchanged between 2002 and 2003. However, field office staff and those in lower level positions were considerably more positive in their views of the organization than their counterparts in headquarters and at the highest levels of management. Two units in particular—the OIG's Office of Counsel and the Office of Evaluation and Inspections—also had marked declines in morale. Both reported significantly lower levels of trust and confidence in the organization and less job satisfaction, compared to 1 year earlier.

The Inspector General generally disagreed with some of our findings. In our response, we address why these findings raise concerns about the management of the OIG. We also provided our draft report to the Office of the HHS Secretary, but did not receive comments.

www.gao.gov/cgi-bin/getrpt?GAO-03-685.

To view the full product, including the scope and methodology, click on the link above. For more information, contact William J. Scanlon (202) 512-7114.

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Abbreviations

CIA	Corporate Integrity Agreement
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
DOJ	Department of Justice
GS	General Schedule
HHS	U.S. Department of Health and Human Services
MOU	Memorandum of Understanding
OAS	Office of Audit Services
OCIG	Office of Counsel to the Inspector General
OEI	Office of Evaluation and Inspections
OI	Office of Investigations
OIG	Office of Inspector General
OMP	Office of Management and Policy
PCIE	President's Council on Integrity and Efficiency

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Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

June 10, 2003

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

This report responds to your October 21, 2002, letter asking us to conduct a review of the Department of Health and Human Services (HHS) Office of Inspector General (OIG). As agreed with your office, we examined the activities at the OIG under the leadership of Inspector General Janet Rehnquist, who took office in August 2001 and resigned her office effective June 1, 2003.[1] Accordingly, the objectives of our review were to (1) assess the Inspector General's leadership, independence, and judgment in carrying out the OIG's mission, (2) identify changes in the OIG's productivity over the last 3 years, and (3) determine whether employee morale has been sustained over the last few years.

To perform our review, we interviewed more than 200 current and former OIG employees. We examined more than 8,000 pages of documents—including OIG reports, internal studies, personnel records, and policies and procedures. We also replicated a Web-based employee survey conducted by the OIG in January 2002—administered in January and February 2003—to assess any changes in employee views about their work environment.[2] In addition, to assess the level of cooperation between the OIG and some of its law enforcement partners, we spoke with officials from the Department of Justice (DOJ), Medicaid Fraud Control Units from

[1]Although Ms. Rehnquist recently resigned, for purposes of this report, we will refer to her as the Inspector General.

[2]We included three additional questions regarding employee morale and trust, and obtained demographic information about respondents that was not captured in the OIG's survey.

several states, and the National Association of Medicaid Fraud Control Units. We also interviewed three current or former inspectors general from other federal agencies to better understand their role and the conduct expected of them. We performed our review from October 2002 through May 2003 in accordance with generally accepted government auditing standards. For a detailed description of our scope and methodology, see appendix I.

Results in Brief

During her tenure, the Inspector General took a number of actions that damaged her credibility and ultimately created an atmosphere of anxiety and distrust within certain segments of the OIG. Concerns regarding her independence—including those arising from her decision to delay a politically sensitive audit and her intervention in ongoing cases in response to external requests—and personnel changes she initiated among senior management, disillusioned members of her senior staff, headquarters employees, and employees working in two OIG units. In addition, the Inspector General's brief possession of a firearm at the workplace and law enforcement credentials represented serious lapses in judgment. We also believe that the Inspector General should have devoted more attention to some aspects of OIG operations, such as a major budgetary shortfall, which limited travel and training and required senior managers to reallocate staff positions regardless of where those positions were most needed.

Examining the productivity of the OIG in a given time period is complex. The OIG engages in a variety of activities so that its productivity involves several dimensions. Moreover, comparing success from one year to the next is difficult because results are dependent on work in the pipeline that was initiated in prior years. Given these constraints, measures of the OIG's performance over the last 3 years reveal gains in some productivity indicators and declines in others. On one hand, overall savings attributable to its work increased from $15.6 billion in fiscal year 2000 to $21.8 billion in fiscal year 2002. On the other hand, we identified some downward changes. For example, there was a significant decline in the number of settlements with providers who submitted false claims to the government. As a consequence, the recoveries associated with these settlements also declined, from about $974 million in fiscal year 2000 to about $519 million in fiscal year 2002. We also found that the OIG's outreach activities that increase public and provider awareness of fraud and abuse problems in health care, and the OIG's efforts to combat them, have dropped appreciably since fiscal year 2001.

Employee views of the organization, management, and their personal job satisfaction remained positive and relatively unchanged from 2002 through 2003, in the aggregate. However, we identified several groups of OIG employees whose morale had been adversely affected during this time period. In particular, there were considerably more negative views expressed by those at headquarters and those in senior management positions than their counterparts in the field and in lower level positions. These groups were concerned with a range of issues including the organization's respect for staff, clarity of goals, and communication efforts. In addition, there were distinct declines since 2002 in the positive views of employees working in the evaluation unit and the Office of Counsel. These groups had low levels of trust and confidence in the organization and expressed a significantly lower level of job satisfaction compared to 1 year earlier.

In written comments on a draft of this report, the Inspector General disagreed with some of our findings related to her independence and judgment, the agency's productivity, and employee morale. In our response, we address why these findings raise concerns about the management of the OIG. We also provided our draft report to the Office of the HHS Secretary, but did not receive comments.

Background

In 1978, Congress passed the Inspector General Act, creating Inspector General offices in 12 federal agencies.[3] This followed growing reports of serious and widespread breakdowns in agencies' internal controls. These new OIGs were established as independent and objective offices within their respective agencies to promote economy, efficiency, and effectiveness in government programs and operations and to prevent and detect fraud and abuse. In addition, they were created to keep agency heads and Congress fully informed about problems and deficiencies in program operations, as well as needed corrective action. Over the years, the act has been amended to increase the number of inspectors general. The President, with the advice and consent of the Senate, appoints inspectors general at cabinet-level departments and other large agencies, including HHS. The inspectors general at smaller, independent agencies and other federal entities are appointed by the heads of their organizations and have essentially the same authorities and duties as those appointed by

[3]Pub. L. No. 95-452, 92 Stat. 1101 (1978) (5 U.S.C. App. (2000)).

the President. Presently, there are 28 inspectors general appointed by the President and 29 appointed by their agency heads.

Inspectors general hold a unique place in the executive branch of government. They report to and are subject to the general supervision of their agency heads, but carry out their duties independently. In addition, they have reporting obligations to both the heads of their agencies and Congress.[4] Those that are presidentially appointed are among the few such appointees that are to be selected "without regard to political affiliation and solely on the basis of integrity and demonstrated ability."[5] To help maintain their independence and fulfill their mission—which often involves being publicly critical of their own departments—inspectors general must familiarize their departmental colleagues with their special role.

Because they are charged with independently protecting the integrity of federal programs, inspectors general must be impartial in fact and appearance. *Government Auditing Standards*,[6] effective in January 2003, call for auditors to "be free, both in fact and appearance from personal, external, and organizational impairments to independence." These standards also require that auditors "avoid situations that could lead reasonable third parties with knowledge of the relevant facts and circumstances to conclude that the auditor is not capable of exercising objective and impartial judgment . . .." Given that their independence and impartiality is so critical, inspectors general need to be sensitive to how their actions might be perceived and interpreted by their staffs, the administration, Congress, and the public.

[4]The inspector general Act of 1978, as amended, requires that Inspectors General report semiannually to the head of the department or agency and Congress on the activities of the office during the 6-month periods ending March 31 and September 30. The semiannual reports are intended to keep the agency heads and Congress fully informed of significant findings and recommendations initiated by the inspectors general.

[5]5 U.S.C. App. § 3(a).

[6]U.S. General Accounting Office, *Government Auditing Standards: Amendment No. 3 Independence*, GAO-02-338G (Washington, D.C.: Jan. 25, 2002). Although issued in 2002, this revised standard on independence did not become effective until January 1, 2003, to allow audit organizations sufficient implementation time. However, the previous standard also stressed the importance of independence. For example, it required auditors to "be free from personal and external impairments to independence" and stated that auditors "should be organizationally independent and should maintain an independent attitude and appearance."

About 300 of the approximately 1,600 HHS OIG employees are employed in its Washington D.C. headquarters. The remainder work in its 8 regional offices and 85 field offices in all 50 states. The OIG consists of five components, or major units, each headed by a deputy inspector general. The office is led by 13 Senior Executive Service level employees, who all work in headquarters, and about 60 GS-15 level employees.[7] About two-thirds of the GS-15 employees are spread across the various components in headquarters with the remaining third located in the OIG's regional offices.

Consistent with the act, the OIG maintains the Office of Audit Services (OAS) and the Office of Investigations (OI).[8] They each represent about 40 percent of the OIG's budget. OAS is responsible for auditing a variety of HHS health care programs and generally spends about 80 percent of its resources on projects related to the Medicare and Medicaid programs.[9] Its findings can result in program improvements and the return of overpayments to the federal government. In addition, OAS provides audit support to OI. OI investigators typically pursue allegations of criminal conduct that they receive from contractors that process Medicare claims, state Medicaid Fraud Control Units, officials involved in administering HHS's many grant programs, and others. When investigators find evidence of potential wrongdoing, they refer the matter to DOJ for possible prosecution or the OIG may opt to impose other sanctions.

The OIG has established three additional components to enable it to fulfill its mission. The Office of Evaluation and Inspections (OEI) conducts short-term management evaluations of HHS programs that generally involve significant expenditures and services to beneficiaries or in which important management issues have surfaced. Its reports are expected to identify opportunities for improvement in departmental programs. While OAS may audit the same federal programs examined by OEI, the scope of

[7]The General Schedule (GS) is a personnel classification and pay system used by the federal government. It includes a range of levels of difficulty and responsibility for positions graded GS-1 through GS-15. Senior Executive Service managers are subject to a different system of promotion criteria and higher pay.

[8]Section 3(d) of the Inspector General Act requires each inspector general to appoint an assistant inspector general for auditing and an assistant inspector general for investigations.

[9]Medicare is the federal health insurance program that serves the nation's elderly and certain disabled individuals. Medicaid is a jointly funded, federal-state health insurance program for certain low-income people.

OEI studies is typically broader and would more likely involve the use of surveys, interviews, and other qualitative research methods. A relatively small component, OEI represents about 10 percent of the office's resources. The Office of Counsel to the Inspector General (OCIG) provides legal services to the OIG. Among other things, it renders advisory opinions to health care providers and develops model industry guidance for compliance with relevant laws and regulations. It also has several sanctions at its disposal to penalize those who abuse HHS programs. Finally, the Office of Management and Policy (OMP) is responsible for the administration of the office, which includes overseeing the budget, supporting the office's information technology needs, and working with the media. It is also responsible for the OIG's human resource management activities, but obtains significant personnel support from the department's centralized Program Support Center. OCIG and OMP each represent about 5 percent of the OIG's budget.

The OIG plays an instrumental role in identifying and investigating individuals and entities that may have abused HHS programs. It may make referrals to DOJ for possible prosecution under applicable criminal statutes. In addition, health care providers who violate federal laws and regulations may face a variety of civil sanctions. The OIG may make use of the False Claims Act[10]—the federal government's primary civil remedy for false or fraudulent claims—and refer such matters to DOJ. The act imposes substantial penalties on those who knowingly submit false claims to Medicare and other federal programs.

If a provider has filed a false claim that DOJ opts not to pursue through the use of the False Claims Act, the OIG may impose other sanctions, such as civil monetary penalties (CMP), against that health care provider. CMPs are also imposed for other types of improper conduct, such as violations of statutory prohibitions on "kickbacks" in connection with patient referrals.[11] The OIG also can assess CMPs against hospitals for "patient dumping," that is, failing to provide appropriate treatment to patients

[10]31 U.S.C. §§ 3729-3733.

[11]The antikickback provisions of the Social Security Act generally prohibit persons from paying or soliciting remuneration in order to induce another to refer business reimbursed under a federal health care program. *See* 42 U.S.C. § 1320a-7b(b).

presenting a medical emergency.[12] The amount of the CMP imposed is related to each provider's specific violation. The OIG may also exclude health care providers from participating in Medicare, Medicaid, and other federal health programs if they have, for example, been convicted of a criminal offense related to Medicare—including health care fraud or patient abuse and neglect—or had their license suspended or revoked. OCIG may also opt to negotiate corporate integrity agreements with health care providers.[13]

Although the OIG focuses the majority of its attention on health care programs, its activities extend to other areas as well. For example, the OIG has made the detection, investigation, and prosecution of absent parents who fail to pay court-ordered child support a priority. The OIG works with other federal, state, and local agencies to expedite the collection of these payments. Parents who repeatedly fail to honor such obligations are subject to criminal prosecution. The OIG's recent activities with respect to parents who have defaulted on their child support payments resulted in 152 convictions and more than $7 million in court-ordered criminal restitution in fiscal year 2002.

Examination of the Inspector General's Actions Regarding Independence and Judgment

We examined the independence that was reflected in the Inspector General's decision-making during her tenure. In addition, we reviewed personnel changes that she initiated and evaluated her judgment in several instances. We interviewed appropriate staff, including the Inspector General herself, and examined relevant documentation.

The Inspector General's Independence

Current and former OIG headquarters employees frequently expressed concerns about the Inspector General's independence. These concerns centered on several incidents—some of which were widely reported by the media. Employees also identified other audits and investigations that

[12]Under the Emergency Medical Treatment and Active Labor Act (EMTALA), all hospitals that participate in Medicare are required to screen—and if an emergency medical condition is present, stabilize—any patient who comes to the emergency department, regardless of the individual's ability to pay. *See* 42 U.S.C. § 1395dd(a).

[13]Under corporate integrity agreements, providers agree to take affirmative steps to improve compliance and report periodically to the OIG. The OIG, in turn, agrees not to seek further administrative penalties for the behavior in question.

they felt may have suffered from inappropriate management intervention. We concluded that the following four incidents involved actions on the part of the Inspector General that at least contributed to the perception of a lack of independence.

Florida Pension Audit

In the spring of 2002, the OIG was scheduled to begin an audit of the Florida Retirement System. The objective was to evaluate whether the state appropriately charged the federal government for the pension expenses of state agency employees who help administer federal programs. The auditors specifically wanted to determine whether funds designated as federal contributions to the retirement system were used to provide for pension expenses, and whether the federal contribution rates were reasonable.

The OIG's first meeting to discuss this audit with Florida pension officials was scheduled for April 16, 2002. The day before, the Chief of Staff to the Florida governor placed an urgent call to the Office of the HHS Secretary, requesting that the audit be delayed to accommodate the new pension department director who was going to assume his position in a few weeks. This call was ultimately referred to the Inspector General, who instructed her Deputy for Audit Services to delay the audit for a few days. The Inspector General subsequently ordered a second delay until July. Due to subsequent scheduling problems affecting both OIG and Florida pension staff, the audit team did not begin its work until September 2002. Allegations made by OIG employees and the media suggested that the federal government's contributions to the Florida retirement system could be excessive and that a report on these contributions might affect the outcome of the Florida governor's race that November.

When asked about the incident, the Inspector General stated that she agreed to temporarily postpone the audit until she could determine the appropriate response to the request and did not have any involvement in subsequent delays. She also insisted that audits are frequently delayed, that her decision to delay the audit was not politically motivated, and that, even if the audit had begun in April, it would not have been completed before the election. She told us that, in hindsight, she could have handled the situation differently by referring the request to the Deputy for Audit Services, but she did not believe she acted inappropriately in these circumstances.

We believe that the Inspector General did not appropriately investigate the implications of her decision before agreeing to delay what ultimately resulted in a report containing significant monetary findings. First, Florida

pension department officials could have known that a substantial overpayment existed, and that a delay in the OIG's audit could have benefited the state by changing the time frames used to calculate the amount it owed. In fact, the draft report on the Florida pension audit contains a finding that there were excessive federal contributions totaling about $517 million, which the state will be required to return or offset against the amount of future federal contributions to the retirement fund. Second, given that the team was scheduled to begin its work in April 2002 and had estimated that the audit report would be drafted in 6 months, it is conceivable that the report could have been available by election day, if the audit had begun when originally planned. Finally, contrary to the Inspector General's recollection, we found that she sent an e-mail message to her Deputy for Audit Services in April 2002 instructing him to postpone the audit until July 2002. The Inspector General acknowledged that, although short delays in commencing audits are common, it was admittedly unusual for a request for a delay to be directed to, and resolved at, her level.

York Hospital

In February 2000, the OIG alleged that York Hospital—located in York, Pennsylvania—had submitted improper claims for services provided to Medicare beneficiaries. The OIG had notified the hospital that it planned to impose a CMP and was engaged in negotiations with the hospital when the Inspector General assumed office.[14] The OIG attorneys had estimated that York Hospital's potential liability was $726,000.

Soon after taking office, the Inspector General received a letter from three members of Congress encouraging her to settle the case quickly. According to the former Chief Counsel,[15] the Inspector General told him, "I hate this case; get rid of it." Feeling as though they had to move fast, OIG attorneys lost the benefit of time—which they explained is a key factor in resolving a case in the government's favor—and quickly settled the matter. The former Chief Counsel also noted that the settlement amount of

[14]Prior to imposing a CMP, the OIG typically seeks to resolve the matter through negotiations. The negotiation process allows the government to obtain a monetary recovery and spares the provider from having to admit liability. When a settlement is not pursued or cannot be reached, the OIG must give the provider the opportunity for a hearing.

[15]On January 8, 2003, the Inspector General waived the attorney-client privilege pertaining to both her former and current Chief Counsels concerning matters that arose during her tenure, except with respect to open investigations pending before the grand jury, matters under court seal, confidential sources, or other open inquiries.

$270,000 was far less than the attorneys believed the government could have received had negotiations proceeded as they had planned.

The Inspector General indicated that she in no way directed a settlement or personally involved herself in the York Hospital negotiations. She also stated that if her OCIG staff perceived that they were under pressure to settle the case quickly, they misinterpreted her instructions. She told us that she simply wanted to settle this case in a timely manner.

Although the Inspector General said she did not intend to pressure her staff, the former Chief Counsel told us that he and those responsible for negotiating with hospital officials clearly perceived a sense of urgency. He also told us that her staff perceived that timing, rather than maximizing the settlement amount, was her main concern. We believe that her staff acted accordingly, possibly against the government's financial interest.

Lithotripsy Claims

Two medical societies representing providers of lithotripsy[16] services threatened to sue the Centers for Medicare & Medicaid Services (CMS) over a regulation resulting in the denial of claims submitted for payment to the Medicare program. The CMS regulation implemented statutory restrictions on physician referrals to providers in which the physicians have an ownership interest and included lithotripsy services within the scope of these restrictions. The medical societies maintained that Congress did not intend to include lithotripsy services within the scope of the statute and intended to litigate this matter, if a settlement could not be reached quickly.

A partner in the law firm representing the two medical societies, who was also a friend of the Inspector General, contacted her for assistance in expediting this case. The Inspector General directed her former Chief Counsel to contact the law firm and begin negotiating the matter, which was under the jurisdiction of CMS and not the OIG. The former OIG Chief Counsel was hesitant to intervene until the appropriate attorney representing CMS in this matter could be consulted. Because CMS's attorney was unavailable for about a week, the former Chief Counsel took no action during this time. According to the former Chief Counsel, the Inspector General admonished him severely when she discovered that he had not followed her instructions to immediately contact the law firm.

[16]Lithotripsy is a procedure typically performed by urologists to break up kidney stones without the need for surgery.

The Inspector General asserted that her office had a legitimate role in this matter. Although the issue was being disputed between the medical societies representing the lithotripsy providers and CMS, the Inspector General believed that her OCIG staff, which advised Congress on physician referral matters, was in a unique position to resolve the issue. She pointed out that she did not personally involve herself in the matter, nor instruct her staff about how to resolve the issue. Instead, she stated that her goal was to help resolve a matter in which her attorneys had vast expertise.

Despite the OIG's expertise in this matter, we agree with the former Chief Counsel that it would have been inappropriate for the OIG to intervene by contacting the law firm to initiate discussions, particularly in the absence of CMS's attorney. If the Inspector General wanted OCIG's expertise to be offered to CMS, it would have made sense for OCIG to contact CMS's attorney before proceeding. CMS's attorney responsible for handling this matter told us that she would have been troubled if the OIG had commenced discussions without her agency's participation. Given the Inspector General's personal relationship with the medical societies' attorney and the OIG's lack of jurisdiction in the matter, her actions created the impression that she was more interested in helping a friend than offering advice to CMS, which called her independence into question.

Adjusted Community Rating Audit

On February 20, 2001, the OIG sent its draft report on adjusted community rate proposals for Medicare+Choice organizations[17] to CMS for comment. This report was of potentially significant interest to congressional committees, which were then considering the adequacy of payments in the Medicare+Choice program. While OIG guidelines generally provide up to 45 days for audited entities to comment on its draft reports, the publication of this report was delayed for 14 months while the OIG waited for comments from CMS. Ultimately CMS agreed with the OIG's findings in written comments on April 16, 2002.

Some employees alleged that the delay in issuing this report reflected a lack of independence on the Inspector General's part. They suggested that the Inspector General should have taken a more active role in expediting

[17]Medicare+Choice was designed to expand Medicare beneficiaries' health plan choices by encouraging the wider availability of HMOs and other types of health plans, such as preferred provider organizations. Adjusted community rate proposals detail the revenue that Medicare+Choice organizations project is needed to cover contributions to profit or reserves and the direct medical and administrative costs of delivering services to enrollees.

the report's issuance. They pointed out that the CMS Administrator initially disagreed with the draft report's findings and hired a consultant to validate the OIG's results. According to these employees, it took CMS more than a year to replicate the OIG's work and determine that it agreed with the report's findings. OIG employees told us that the Inspector General tolerated this situation because she was unwilling to issue a relatively controversial report without the benefit of CMS's agreement. The delay in issuing this report diminished its usefulness because congressional committees were focused on other concerns by the time the report was finalized.

The Inspector General stated that she was only vaguely familiar with this project but was certain that she did not direct her audit team to delay the report's issuance. Although she recalled that the CMS Administrator initially disagreed with the report's conclusions, she told us that she did not remember the specific time frames associated with it.

Our evidence shows that the Inspector General's staff tried to enlist her assistance in expediting CMS's comments to no avail. By permitting CMS to delay the report's publication, the Inspector General created the appearance among her staff of being unduly influenced by CMS. In our view, a time sensitive report of congressional interest should have, at the very least, garnered more of the Inspector General's attention.

The Inspector General's Personnel Changes

During the Inspector General's tenure, staff turnover among the OIG senior headquarters staff has been considerable. Between September 2001 and November 2002, at least 20 OIG senior managers retired, resigned, or were reassigned. Ten of these were Senior Executive Service[18] employees, most of whom had over 25 years of government service and had played an important leadership role at the OIG for many years. The others were GS-15 employees who were instrumental in carrying out specific office functions.[19] The Inspector General's representative characterized these changes as voluntary and beneficial to the overall mission of the office.

[18]In several important areas, including reassignments and reductions in grade, federal regulations allow greater flexibility for personnel decisions regarding Senior Executive Service employees than for general schedule employees. Under these regulations, the Inspector General had more discretion with respect to Senior Executive Service-level managers in the OIG than GS-15-level managers.

[19]The Inspector General made many of these changes by taking advantage of opportunities presented to her when two of the Deputy Inspectors General decided to retire.

The Inspector General told us that these changes were made to provide senior managers with new insights into agency operations and to capitalize on the fresh perspectives they could bring to their new jobs. However, we found that the sudden and unexplained nature of many of the Inspector General's actions resulted in a widespread perception of unfairness among her staff. In addition, the promotion of a close advisor to the Inspector General, to the position of Director of Public and Congressional Affairs, raises a legal concern.

We found the circumstances surrounding the departures of eight senior OIG managers to be particularly troubling. Four of these eight managers who left the OIG or were detailed elsewhere were members of the Senior Executive Service. One of the four took an early retirement after the Inspector General proposed that the department assign him to a position outside of his local commuting area with the assumption that he would retire instead. Another retired after most of his responsibilities were reassigned to another official or eliminated. A third resigned about 6 weeks after the Inspector General reassigned his job responsibilities and directed that he not report to his office and instead spend his time seeking new employment. Finally, one manager was detailed to a temporary position within HHS and was also instructed not to return to his OIG office. He is currently seeking new employment.

These four individuals told us that the Inspector General had not informed them of specific deficiencies in their performance, given them any opportunity to improve their performance, worked with them to find a mutually satisfactory resolution to her concerns, or provided an adequate rationale for her decisions to remove them from their positions. Moreover, three of these managers told us that they were shocked with the urgency she displayed when asking them to leave the OIG, and two perceived that a single event ultimately led to the Inspector General's decision to remove them. For example, in one instance, a senior manager linked his removal to an incident in which a problem had to be resolved in the Inspector General's absence. Although he successfully contacted her and proposed a solution, she did not wish to address the matter until her return to the office. He delayed taking action, as she directed. However, according to this official, when the Inspector General returned, she was angry and suggested that he had tried to pressure her into accepting his proposed solution, essentially excluding her from the decision-making process. Describing their departures from the OIG, these four individuals told us that they felt they had no alternative but to leave their positions. Other OIG staff also told us that these four changes—all of which were initiated by the Inspector General—were involuntary.

The other four individuals whose departures were particularly troubling were GS-15 level managers from OMP, OCIG, OI, and the Inspector General's Immediate Office.[20] One manager resigned after being reassigned twice within 9 months. According to several OIG employees, the purpose of this manager's second reassignment was to accommodate the Inspector General's preference that this manager no longer work in the OIG headquarters building. The Inspector General gave no explanation why she wanted this individual to work in a remote location. A second was reassigned to an interagency task force for an indefinite period after his position was abolished. The Inspector General reportedly no longer wanted him in the OIG headquarters building. The third individual was temporarily reassigned to a position at another HHS agency and subsequently resigned. He told us that his duties were curtailed following a briefing of congressional staff in which he voiced an official OIG opinion that conflicted with that of CMS. The fourth individual retired after being reassigned from the Inspector General's Immediate Office to another component. Some staff members perceived that the reassignment of this individual resulted, in part, from her requesting—without the Inspector General's knowledge—a gun safe to properly store a firearm that the Inspector General had recently acquired. Like the reassignments at the senior executive level, the Inspector General initiated these changes.

Some of the employees we interviewed were skeptical that these changes were necessary and asserted that they actually damaged the organization's effectiveness. Specifically, they were concerned with the sheer number of personnel moves made in a relatively brief period of time and that their new component heads lacked experience in the areas that they were going to lead. They also expressed concerns about the Inspector General's motivations because they felt that the changes generally had not been adequately explained to the employees involved. The abruptness of these changes and the lack of any overall explanation for them heightened employees' mistrust. Although some employees were supportive of the Inspector General's organizational changes or felt unaffected by her actions, comments made during our interviews and in our employee survey highlighted the frustration many employees—especially at headquarters—felt due to the perception of unfairness associated with

[20]The Immediate Office provides direct support to the Inspector General. It is not affiliated with the OIG's five components, and it maintains a relatively small staff of about 10 employees.

these personnel changes. We found that the magnitude and abruptness of the Inspector General's actions raised fear and anxiety among her staff.

We asked the Inspector General about each of the individuals to obtain her rationale in making these personnel decisions. The Inspector General told us that she was concerned about the individuals' privacy and that she was uncomfortable discussing the circumstances involving these managers with us.

Finally, we identified one matter giving rise to a legal concern. We obtained information suggesting that a member of the OIG's staff may have been preselected for a GS-15 position as the Director of Public and Congressional Affairs.[21] Specifically, as explained below, e-mail communication by one of the Inspector General's closest advisors implies that a decision had been made to promote this employee to the GS-15 level prior to the initiation of a competitive selection process. Citing the individual's outstanding performance as a GS-14 in the same office,[22] the Inspector General had directed the employee's supervisor to promote her to a GS-15 at the earliest opportunity. Shortly thereafter, an advisor to the Inspector General contacted the individual's supervisor and emphasized that the Inspector General believed that it was important for the individual to have a GS-15 in her current position. The advisor urged him to initiate the promotion process so that the GS-15 would be effective on the date of her eligibility for promotion, or soon thereafter. The advisor further explained that the Inspector General had made a commitment when the individual agreed to take the GS-14 position that she would be promoted to a GS-15 one year later. In addition, the OIG included a "selective placement factor" in the GS-15 position description, reportedly to favor the employee. OIG staff told us that, although the GS-15 position was advertised both inside and outside of the agency, there was a widespread perception that the selection had already been made. This perception may

[21]Preselection is prohibited under federal law. Specifically, under 5 U.S.C. § 2302(b)(6), an employee with personnel authority may not grant any preference or advantage not authorized by law, rule, or regulation to any employee or applicant for employment (including defining the scope or manner of competition or the requirements for any position) for the purpose of improving or injuring the prospects of any particular person for employment.

[22]One year before her promotion to a GS-15, this individual had been promoted from a GS-13 position in OCIG to a supervisory GS-14 position in the OIG's Office of Public and Congressional Affairs, following the reassignment of the GS-15 staff person who had previously performed similar duties.

account for the fact that there was only one applicant for the position. While the information we obtained raises concern about a possible preselection, we have not conducted the type of formal, factual inquiry that would ultimately be necessary to determine whether the Inspector General's actions were unlawful.[23]

The Inspector General's Judgment

We identified several matters that raised concerns about the adequacy of the Inspector General's leadership. Some employees questioned the Inspector General's judgment in regard to her possession of a firearm in the office, as well as law enforcement credentials. Others raised concerns about the manner in which she conducted her business travel. In addition, several employees interpreted some of the Inspector General's actions as demonstrating a lack of interest in key office operations.

Report by the President's Council on Integrity and Efficiency

In the fall of 2002, the Integrity Committee of the President's Council on Integrity and Efficiency (PCIE)[24] received an allegation that the Inspector General had improperly requested and obtained a firearm from her Deputy Inspector General for Investigations. Subsequently, the Integrity Committee received a second allegation that the Inspector General had improperly obtained supervisory special agent law enforcement credentials. After consulting with DOJ officials, who declined to pursue these allegations, the Integrity Committee proceeded with its investigation. The PCIE forwarded its report to the Deputy Secretary of HHS on April 4, 2003.

The PCIE found that the Inspector General had obtained a firearm from an OIG special agent and maintained it in her Washington, D.C. office for a short period of time. An OIG Memorandum of Understanding (MOU) with DOJ and the Federal Bureau of Investigation set forth a process for deputizing OIG special agents to allow them to carry firearms, make arrests, and execute warrants when carrying out their law enforcement

[23]We are referring this matter to the Office of Special Counsel of the Merit Systems Protection Board, which is tasked with investigating such allegations.

[24]The PCIE, an organization composed primarily of the presidentially appointed inspectors general, was created to address integrity, economy, and effectiveness issues that transcend individual government agencies, and increase the professionalism and effectiveness of inspector general personnel throughout the government. The PCIE's Integrity Committee is charged with receiving, reviewing, and investigating allegations of administrative misconduct against Inspectors General, and, in certain cases, members of their staffs.

functions.[25] However, the PCIE found that the Inspector General had not met the job classification and training requirements outlined in the MOU and had not been deputized. In an interview with PCIE investigators, the Inspector General stated that she believed that inspectors general were statutorily authorized to possess firearms and that she had not reviewed the MOU for deputation of OIG special agents.

In regard to the second allegation, the PCIE found that the Deputy Inspector General for Investigations obtained supervisory special agent credentials for the Inspector General because she did not want the Inspector General to have any difficulty gaining access to secured areas in the event of a terrorist incident.[26] The Inspector General told PCIE investigators that other inspectors general did not seem to know how to handle the issue of access to secured areas in the event of a terrorist attack, but she had never asked them if they had law enforcement credentials. She also told investigators that she had the credentials in her possession for a short time, and returned them to her Deputy for Investigations to store in a safe. (Before the PCIE investigated this issue, concerns about the ease with which OIG credentials could be obtained came to our attention. We examined the internal controls for the credentialing system and identified several weaknesses, which are described in appendix II. OIG officials have since told us that they have taken steps to correct these weaknesses.)

The PCIE report identified several criminal statutes as relevant to the allegations, including provisions of federal and District of Columbia law concerning the possession of firearms, which are applicable to those working in federal buildings. At the conclusion of the investigation, DOJ officials advised the PCIE that it declined to prosecute the Inspector General for any possible violations of criminal statutes regarding the possession of a firearm or law enforcement credentials. In addition, in the letter to the Deputy Secretary of HHS accompanying its report, the PCIE advised that the Inspector General's resignation mooted the need to take any administrative actions against her. It also expressed deep concern

[25]The PCIE report stated that under OIG policy employees could not possess or carry firearms without being deputized, as set forth in the MOU.

[26]The credentials stated that Ms. Rehnquist was a supervisory special agent of the Office of Inspector General authorized to carry firearms, execute warrants, administer oaths, make arrests, and perform other duties as authorized by law and/or departmental regulations.

about the actions of some OIG employees who facilitated the Inspector General's acquisition of these items.

The Inspector General's Travel

Another issue that persistently surfaced during our review was perceptions of the propriety of the Inspector General's business travel. As the head of a large organization with offices nationwide, the Inspector General is entitled—and expected—to periodically visit these offices to provide oversight, guidance, and support to her staff. In addition, the Inspector General may engage in other business-related travel, such as attending conferences and meeting with provider organizations and other external groups. Inspectors general—like other government employees—are not prohibited from planning personal travel in conjunction with their business trips. However, we spoke with current and former inspectors general from other federal agencies, and they told us that they generally refrain from including personal travel with their business trips for fear of raising suspicion about their motivation or integrity. While no one alleged that the Inspector General violated travel regulations, some current and former officials questioned her motivation for planning certain trips that included a personal element, such as sightseeing activities—sometimes with two senior OIG managers.

To better understand the purpose of the Inspector General's travel, we examined all of the documentation related to her trips, including travel orders, vouchers, and detailed itineraries prepared by her office. We found that during the first 4 months of the Inspector General's tenure she took four trips outside of the Washington D.C. area. None of these trips included a personal element or any companions. However, over the next 12 months, the Inspector General traveled eight more times and included personal activities on half of these trips. In addition, she invited one or two senior managers to accompany her on six of these eight trips.

Three of the Inspector General's trips in particular raised concerns, arising from a perception that this travel was motivated by other than official duties. In some of these cases, large blocks of time could not always be accounted for. For example, the Inspector General took one trip to San Francisco and Phoenix that spanned 8 days and included 2 days of personal time on a weekend. In examining the business portion of this trip, we were only able to determine that the Inspector General made two half-hour speeches and traveled between these cities and Washington, D.C. Further, in some cases, personal activities—sometimes involving the participation of the two senior managers—were included. While we did not validate the managers' activities on these trips beyond their own assertions, we believe that it is appropriate for the Inspector General to

ask managers to accompany her as needed on business-related travel. However, including her colleagues in her personal activities during travel contributed to a perception that the business reasons for these trips were pretexts and that the trips were planned solely for nonbusiness purposes.

In responding to our inquiries regarding the Inspector General's travel, she indicated that all of her trips were made for legitimate business purposes. She also told us that she was not concerned with any perceptions OIG employees may have had about her travel. Finally, in a written response to our inquiry regarding approximately 3 days of unaccounted time during her San Francisco and Phoenix trip, she indicated that she spent her time performing office work and preparing for one of her two speeches. She offered no other elaboration on her business activity.

The Inspector General's Leadership in Resolving Budgetary Problems

During our study, the Deputy Inspectors General were grappling with a major budgetary shortfall due to aggressive hiring in fiscal year 2002, lower than expected attrition throughout the OIG, and uncertain funding levels for fiscal year 2003 that had yet to be resolved. Senior OIG officials told us that they were concerned that, without a quick solution, they might ultimately violate the Antideficiency Act.[27] In February 2003, the Deputy Inspectors General were developing various proposals to react to their forecasted budget shortfall. The deputies had severely limited travel, training, and other human resource activities in their components. In addition, they were reallocating staff positions to accommodate the budget—regardless of where the positions were actually needed. Positions that became vacant through attrition were transferred to the overstaffed components. By gaining the vacant positions, the overstaffed components were able to reduce the number of staff considered to be in excess in their units.

Some of the deputies expressed strong resentment about the chaos this situation caused within their components. For example, a relatively small component that lost a key member of one of its functional teams could not replace that individual, and instead had to continue to meet mission goals with one fewer supervisor. Other component heads explained that the lack of funds to perform routine duties in the field affected morale and could impact long-term productivity.

[27]Among other things, the Antideficiency Act prohibits agencies from incurring financial obligations that exceed their available budget authority. *See* 31 U.S.C. § 1341(a).

This situation could have been avoided if OIG leadership had developed a human resource hiring and development plan that contained realistic budget projections and hiring goals that all deputies would have to follow. Historically, the Inspector General's Principal Deputy was responsible for ensuring that component heads worked together to carry out such a plan, but the Principal Deputy position had been vacant for months. As a result, component heads we spoke with felt that they did not have the authority to fill the leadership void that developed in this instance, and relied on the Inspector General to impose whatever fiscal constraints were necessary to establish an equitable budget allocation among the components. While the Inspector General expressed concern about funding issues, she did not take aggressive steps to remedy the situation. Although the deputies ultimately resolved their financial situation, at the time of her resignation, the component heads were still struggling among themselves with these budgetary challenges.

Evaluation of OIG Productivity

The OIG conducts a variety of activities that aim to improve program operations, identify and recover overpayments, and investigate and sanction those who violate statutes and regulations governing HHS programs. Evaluating the effect of the Inspector General's recent actions on productivity is difficult to assess in the short term. For example, in addition to the decisions she made and the personnel moves she initiated, a variety of other factors contribute to productivity. Two factors make it impossible to reach an overall conclusion about OIG productivity for any limited period of time. First, fluctuations in performance are to be expected in any given year, given the multitude of the OIG's activities. Second, it is difficult to compare performance from one year to the next because the results in one period are heavily dependent on work in the pipeline that was initiated in prior years. For example, it could take 2 or 3 years from the time a project is initiated until a recommendation is made and subsequently implemented; investigating potential criminal activity and prosecuting the individuals involved could take even longer. Many of the OIG's productivity measures remain comparable to prior years or showed increases, but we found that several other key indicators of performance have declined since the Inspector General took office.

Savings, OAS Reports, and Convictions

We analyzed a wide variety of performance measures to evaluate the OIG's effectiveness and found that many of these measures indicated that the

OIG may be performing well, as table 1 shows. For example, in its semiannual reports covering fiscal year 2002, the OIG identified almost $22 billion in savings attributable to its work.[28] The OIG consistently reported increases in these savings since fiscal year 1997. In addition, the number of OAS reports published has increased each year since fiscal year 2000. Also, the number of convictions resulting from the OIG's investigative referrals has steadily increased over the last 6 years.

Table 1: Select OIG Performance Measures—Fiscal Year 1997 through Fiscal Year 2002

	Fiscal year 1997	Fiscal year 1998	Fiscal year 1999	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
Savings (in billions of dollars)	$7.6	$11.6	$12.6	$15.6	$18.0	$21.8
Number of OAS reports	324	187	207	300	311	333
Convictions	215	261	401	414	423	517

Source: HHS OIG.

OI officials, who told us that the number of convictions is an important measure of their success, also said that they appear to be on target in achieving even more convictions in fiscal year 2003. At the midpoint of the current fiscal year—March 31, 2003—the OIG reported 320 convictions.

Although it is difficult to measure the "sentinel" effect of some of the OIG's activities, it has taken steps to encourage lawful and ethical conduct by the health care industry, which we believe should be acknowledged. For example, in recent years the OIG has actively worked with the private sector to develop compliance guidance to prevent the submission of improper claims and to discourage inappropriate conduct by providers. In March 2003, the OIG issued compliance guidance for ambulance suppliers. This was followed by the publication of compliance guidance for pharmaceutical manufacturers in April 2003.

Exclusions from Medicare

Like convictions, the number of providers excluded from the Medicare program is a strong indicator of OI effectiveness. Although the number of

[28]This amount consisted of almost $20 billion in savings related to the implementation of OIG recommendations and other actions, $426 million saved as a result of OIG audits, and $1.5 billion recovered due to OIG investigations.

exclusions imposed declined in fiscal year 2002, reversing a trend of increases since fiscal year 1999, we were unable to determine whether this decline reflects diminishing productivity. The OIG Chief Counsel explained that, in 2002, the Department of Education became responsible for processing most of the exclusions of health care providers who had defaulted on the repayment of their federally funded student loans. The Chief Counsel told us that in 2001, when the OIG still had this responsibility, it excluded 518 providers who had defaulted on these loans. In 2002—the transition year—the number of such providers excluded by the OIG dropped to 166. Table 2 shows the OIG's exclusions imposed since fiscal year 1997.

Table 2: Medicare Exclusions Imposed—Fiscal Year 1997 through Fiscal Year 2002

Fiscal year 1997	Fiscal year 1998	Fiscal year 1999	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
2,719	3,021	2,976	3,350	3,756	3,448

Source: HHS OIG.

Settlements, Recoveries, CMPs, and CIAs

We found declines in the use of sanctions available to the OIG. For example, we noted reductions in the number of settlements and recovery amounts that result from the OIG's False Claims Act referrals to DOJ. Similarly, there were declines in the number of CMPs and CIAs recently imposed. Table 3 shows that both the number of settlements and amount of recoveries declined significantly in fiscal year 2002, compared to fiscal years 2000 and 2001.

Table 3: Number and Amount of False Claims Act Settlements, Fiscal Years 2000 through 2002[a]

	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
Number of settlements	245	248	161
Amounts recovered (in millions)	$974.0	$2,063.0[b]	$518.7

Source: HHS OIG.

[a]The OIG was unable to provide comparable data for fiscal years 1997 through 1999.

[b]A substantial portion of the amount recovered in fiscal year 2001 is attributable to a single settlement of $875 million.

OIG officials told us that its False Claims Act cases are strongly tied to DOJ's efforts to combat health care fraud, which have had to compete with investigative resources dedicated to the September 11, 2001, terrorist attacks. In addition, DOJ has reduced the number of its national health care antifraud initiatives in recent years as well as the number of individual cases that it pursues under the auspices of each initiative. OIG officials also attribute this decline to its increasing emphasis on program compliance, which the OIG believes has had a sentinel effect on providers. Although the number of False Claims Act settlements and recoveries have declined, DOJ officials and the Medicaid Fraud Control Unit representatives we spoke to told us that they were pleased with the quality of the support they received from the OIG in pursuing abusive or fraudulent providers. However, several of these officials were concerned that the OIG could not devote more resources to assist them in their investigations.

Another important indicator of OIG productivity is the imposition of CMPs. As shown in table 4, the number of these cases had a marked decline since fiscal year 2000.

Table 4: Number and Amount of CMPs Imposed, Fiscal Year 1997 through Fiscal Year 2002

	Fiscal year 1997	Fiscal year 1998	Fiscal year 1999	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
Number of CMP cases	16	58	67	58	30	34
Amount of CMPs (in millions of dollars)	$0.5	$2.2	$1.9	$9.7	$1.1	$2.4

Source: HHS OIG.

In explaining the declining number of CMPs imposed, OIG officials offered two explanations. First, they told us that the increase in convictions may account for the decline in CMPs, which are typically imposed when more stringent penalties cannot be used. Because convictions have recently increased, there would be fewer opportunities to impose CMPs. Second, officials suggested that the office's previous aggressiveness in pursuing patient dumping cases—which generally made up between 65 and 90 percent of all CMPs imposed each year—has been a strong deterrent. The officials also emphasized that patient dumping cases have proven to be resource intensive. As a result, the OIG can only afford to pursue the most egregious cases.

CIAs, typically negotiated in conjunction with False Claims Act settlements, are also an indicator of the OIG's productivity. CIAs consist of "integrity provisions" that are intended to ensure that a provider's future transactions with Medicare and other federal health care programs are proper and valid. Such provisions include implementing an OIG-approved compliance program, use of an independent review organization to annually review provider billings, and other periodic monitoring and reporting requirements. Providers accept the imposition of the CIAs and, in turn, OCIG agrees not to seek additional administrative sanctions. As table 5 shows, the number of active CIAs, as well as the number of newly negotiated CIAs, has declined since 2001.

Table 5: Number of Active CIAs and Newly Negotiated CIAs for Fiscal Year 1997 through Fiscal Year 2002

	Fiscal year 1997	Fiscal year 1998	Fiscal year 1999	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
CIAs active at end of the fiscal year	122	340	418	470	498	324
New CIAs negotiated during the fiscal year	83	233	138	101	112	63

Source: HHS OIG.

OCIG officials attributed the most recent decline to several factors. First, the number of civil False Claims Act settlements declined between 2001 and 2002, resulting in fewer providers with whom to negotiate CIAs. Second, in fiscal year 2002, OCIG began implementing the Inspector General's November 20, 2001, "Open Letter to Health Care Providers" regarding CIAs. CIAs had long been a concern of providers because of the costs associated with implementing the specified integrity provisions—such as retaining an independent review organization each year to review a statistically valid sample of billings. The November open letter announced that the OIG's policies and practices regarding CIAs were being modified in response to those concerns.

The letter noted, in part, that the OIG would no longer seek to negotiate CIAs with every provider settling a False Claims Act case with the government. In some situations, corporate compliance matters would be negotiated separately, after settlement of the False Claims Act case. The letter also indicated that the OIG would consider increasing its reliance on providers' internal audit capabilities. For example, some providers may not be required to retain an independent review organization. Similarly,

not all billing reviews would be subject to statistically valid random sampling. Instead, these providers would be able to self-certify compliance based on the error rate indicated by reviewing an initial sample of their billings. Further, the new approach to CIAs could also be applied to previously negotiated CIAs. As a result, in fiscal year 2002, OCIG renegotiated 94 existing CIAs associated with False Claims Act settlements. The revised CIAs contained "certification agreements," permitting providers to self-certify their compliance with the specific provisions contained in their agreements, instead of retaining an external review organization for this verification.

Outreach and Education Activities

We also found that there has been a considerable drop in the testimonies and outreach and education activities performed by OIG employees. Prior to the current Inspector General's tenure, the OIG frequently provided assistance to congressional staff developing legislative proposals related to HHS programs, offered informal advice about program oversight, and testified at congressional hearings. In addition, OIG employees routinely presented the results of their work at conferences, meetings, and in other educational forums. However, as shown in table 6, the number of testimonies and speeches and other presentations by OIG employees revealed a significant decline in the assistance provided during the last fiscal year—especially among OCIG employees.

Table 6: Testimonies, Speeches, and Other Presentations by Component for Fiscal Years 2000, 2001, and 2002

	Testimonies			Speeches and other presentations		
	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
Inspector General and Principal Deputy	7	3	6	3	3	7
OAS	0	1	0	4	24	17
OI	1	0	0	25	93	49
OEI	5	4	0	52	45	32
OMP	0	0	0	0	0	8
OCIG	1	2	0	58	49	15
Total	**14**	**10**	**6**	**142**	**214**	**128**

Source: GAO analyses of HHS OIG data.

We spoke with several congressional staff working for committees with jurisdiction over HHS programs who told us that they were not satisfied with the level of support they were currently receiving from the OIG. While formal requests for assistance were fulfilled, congressional staff indicated that OIG employees no longer discussed issues with them informally, as they had in the past. In our interviews, primarily at headquarters, several OIG employees recognized that they were no longer providing what congressional staff members considered to be a valuable service and what they considered to be a meaningful part of their work.

OIG officials emphasized that their responsiveness to Congress is still an extremely high priority. They explained that the Inspector General instituted a more centralized approach to providing assistance to congressional staff and other external groups than had her predecessors in an attempt to ensure the quality and appropriateness of the assistance provided. In response to the declining number of testimonies, OIG senior officials told us that they are very willing to appear at congressional hearings when they have relevant material to present. However, they explained that the Inspector General does not consider the number of testimonies to be a relevant performance measure.

In regard to speeches and other presentations, the decline was partly due to a policy change in the spring of 2002 that moved approval authority for these activities from the individual component heads to the Director of Public and Congressional Affairs. A lack of travel funds for collateral activities in the first half of the fiscal year also limited OIG's staff participation in discretionary events. According to this Director, because she could not approve all of the requests, she considered the nature and size of the audience, in addition to the cost of the trip, in deciding whether approval would be granted.

OEI Reports

A number of employees of OEI told us that they have been frustrated with the cancelation of projects since the Inspector General took office. According to these individuals, many projects were well under way at the time of their termination. Although OEI managers could not tell us how many projects have been canceled under the current Inspector General's tenure, they could tell us how many of the OEI projects begun in fiscal years 2000, 2001, and 2002 were subsequently canceled. As table 7 shows, 27 reports, or about 26 percent of reports started in 2002, were canceled by the end of February 2003. According to OEI management, although some projects have been canceled, the work performed on these projects has been used by OEI teams involved in related OEI projects.

Table 7: Number and Percentage of OEI Projects That Were Begun in Fiscal Years 2000, 2001, and 2002 and Canceled by February 28, 2003

	Fiscal year 2000	Fiscal year 2001	Fiscal year 2002
Reports Started	103	80	103
Number Subsequently Canceled	18	14	27
Percent Subsequently Canceled	18	18	26

Source: GAO analysis of HHS OIG data.

We followed up on several projects that recently had been canceled to better understand management's rationale for doing so. Staff members brought these projects to our attention during the course of our work.[29] In one instance, a project was canceled 7 months after the team had conducted the exit conference with the agency. More than 4,000 staff hours had been expended on this project, which included three full-time and one part-time staff and a paid intern. The Deputy Inspector General ultimately told the team that the report lacked sufficient evidence and would not be presented to the Inspector General for signature. Although the team subsequently prepared two memoranda as substitutes for the report, no product was ever issued—despite interest from the provider community and relevant agency.

We have learned that OEI projects continue to be canceled. For example, in March 2003 the Inspector General took the unusual step of recalling a draft report, which had been sent to the relevant agency for comment in February 2003. Both the Deputy Inspector General for OEI and the Inspector General approved this draft. Also in March 2003, a related project, which had begun in fiscal year 2002, was canceled as the OEI team prepared for an exit conference with the agency it had evaluated. OEI management decided to combine the results of both projects into a single report. Although the OEI staff involved with these projects contend that they briefed management several times over the course of these assignments, the Deputy Inspector General for OEI explained that he made this decision once he realized there were inconsistencies between the two projects that needed to be reconciled. As of late April 2003, no report had been published.

[29]We could not determine whether these examples were representative of the average amount of staff time expended on canceled projects, as OEI does not retain these data.

In conversations with the Inspector General and the Deputy for OEI, we learned that they had been particularly concerned with the appropriateness of criteria used by OEI staff in evaluations. They told us that they were uncomfortable with the policy-oriented work that OEI had done and were taking actions in the pipeline of OEI reports to address what they viewed as shortcomings in the accuracy and sufficiency of evidence in OEI products. The Deputy for OEI also explained that they were providing training to all OEI staff on evidence standards with the hope of improving the quality of future projects. OEI managers and staff that we spoke to expressed surprise and frustration at these concerns and pointed out that in the past, OEI had been recognized and praised by Congress, the public, and the press for its high-quality evaluation work.

Measure of Employee Morale

Based on our survey and extensive interviews, we found in the aggregate that employee views about the organization, management, and their personal job satisfaction remained positive and relatively unchanged between 2002 and 2003. However, we identified several groups of employees whose morale was of concern, namely, employees working at headquarters, those at the highest levels of management, and staff working in two OIG components. Our analysis of open-ended survey comments also revealed areas of dissatisfaction that were not fully captured by other items on our survey.

Our survey and interviews found, in the aggregate, a high level of satisfaction among OIG employees. Overall, positive responses to survey items in both 2002 and 2003 averaged over 80 percent and no item responses changed more than 5 percentage points between the 2 years. Positive responses were especially prevalent both years for statements such as “All things considered, my component is a good place to work” (89 percent and 87 percent, respectively) and “I believe that my work is important to the success of the component” (94 percent and 93 percent, respectively). Similarly, our interviews revealed an overall high level of job satisfaction, typified by comments such as “I believe my work makes a difference.” Staff repeatedly cited their close relationships with their immediate work groups and their involvement on important issues as reasons for their job satisfaction. We also identified some examples of improvement. For instance, in both the survey and interviews, OI employees indicated there had been an increase in communication with upper management in their component over the last year.

We found that positive responses to most survey items were lower for headquarters employees than for field staff. For example, we found that

there was a marked difference in positive responses—10 percentage points—to the statement that "Everyone is treated with respect." We also found a 14 percentage point difference in positive responses to the statement, "I have confidence and trust in my organization." This pattern of more positive responses from the field was consistent with statements made during our interviews. Whereas many headquarters staff expressed concern about the Inspector General's actions, most field employees told us that they felt insulated from, and largely unaffected by, the personnel and other changes that occurred in headquarters.

In addition, our survey indicated that senior management staff—specifically members of the Senior Executive Service and GS-15 employees—were considerably more concerned than all other employees about OIG leadership. While 88 percent of employees at the GS-14 and lower levels agreed with the statement, "As an organization, the OIG has clear goals," only 67 percent of the senior management staff—those at the GS-15 level and members of the Senior Executive Service—responded positively to that statement. Further, about 70 percent of the employees at the GS-14 level and lower levels indicated that they had confidence and trust in the organization. On the other hand, only 56 percent of senior managers agreed with that statement. In our interviews, some senior management staff were extremely clear about, and supportive of, the Inspector General's goals, but others expressed confusion about the Inspector General's priorities for their components. Many in senior management were disquieted by the decisions that resulted in some of their colleagues retiring, resigning, or being reassigned during 2002. These managers explained that they were uncomfortable because they did not fully understand the motivations behind the Inspector General's actions.

Our survey revealed a substantial deterioration in OEI employees' views of the organization, management, and their personal job satisfaction. For example, a statement focusing on whether "upper management clearly communicates the goals of my component," elicited an almost 50 percentage point drop in positive responses between January 2002 and February 2003 (compared to a 1 percentage point decrease in the aggregate). Similarly, there was a 34 percentage point drop in positive responses to the statement about being "fully informed about major issues affecting my job" (compared to a 5 percentage point drop overall). Finally, about 62 percent of OEI employees indicated a lack of trust and confidence in their organization (compared to 30 percent overall).

The decline in the overall climate in OEI can be linked to a number of changes that profoundly affected the staff in that component. OEI staff

told us that they were negatively affected by the abrupt departure of the Deputy Inspector General, decreased communications from headquarters management, changes and delays in the report review process, canceled projects, and a narrowing of the scope of their work. In addition, OEI staff explained that they have been disappointed by a decrease in the number of their assignments that has resulted in what are considered to be "high-profile" products—those signed by the Inspector General, those issued as standard blue-cover reports, and those placed on the OIG's Web site.[30]

Our employee survey also identified a distinct decline in positive responses to survey items among OCIG employees—almost all of whom work in headquarters. Of particular concern were answers to survey statements addressing the adequacy of communication and job satisfaction. For example, compared with 2002 survey results, there was a 22 percentage point drop in positive responses to the statement about being kept fully informed about major job issues. OCIG employees also reported a 16 percentage point drop in positive responses to the item "I am satisfied with my job" and a 12 percentage point drop in their opinion that "everyone is treated with respect," compared with last year's survey. Our results also showed that 54 percent of OCIG employees lack trust and confidence in their organization. The decline in the views of OCIG staff can, in part, be attributed to changes implemented by the Inspector General, and the atmosphere of anxiety and distrust that her actions created. OCIG employees expressed concern about the circumstances under which the former Chief Counsel and other senior managers left the OIG. In addition, we were told that the curtailment of education and outreach activities and contact with congressional committee staff had an adverse effect on OCIG employee morale.

Finally, we analyzed the written comments that some employees opted to write in the comment box provided on our survey. In total, 578 of the 1,451 survey respondents (40 percent) elected to write comments, which allowed them to express opinions about issues that were not covered in detail in our other survey items. Our analysis of these comments showed that the majority were negative in tone (75 percent). Overall, the most

[30]OEI products can be signed by the Inspector General or a variety of individuals within the component. Products may also be issued as a standard blue-cover report, a white-cover report, a memorandum, or, on rare occasions, an e-mail. Reports signed by the Inspector General receive the widest distribution and blue-cover reports are considered the most prominent. In contrast, white-cover reports or memoranda signed by a regional OIG official are considered to be of less importance and may receive only minimal distribution.

frequently mentioned categories were: morale (82 percent negative), recent changes in headquarters management (61 percent negative), sufficiency of training or equipment (85 percent negative), and quality of headquarters management (80 percent negative). The demographic characteristics of those who wrote comments were generally similar to the overall sample of respondents, although those planning to leave the OIG in the next 5 years and OEI staff were more likely to provide comments than other survey respondents.

Agency Comments and Our Evaluation

We met with officials from the OIG and the Office of the HHS Secretary and briefed them on our findings. We also provided them with a copy of our draft report. In written comments on a draft of this report, the Inspector General disagreed with some of our findings and characterizations of certain events. The Office of the Secretary did not provide comments.

In reference to our discussion about the OIG's productivity, the Inspector General stated that the OIG had achieved substantial accomplishments under her leadership and direction and cited the savings attributable to its work in fiscal year 2002. In addition, she highlighted some of the OIG's nonmonetary achievements during her tenure. As we noted in our draft report, many of the OIG's productivity measures have remained steady or improved, including those cited in the Inspector General's letter. However, we also pointed out that making a conclusive determination regarding productivity in the short term is extremely difficult because current savings are often the result of efforts started in prior years. Our draft also identified declines in other important areas, such as settlements and recoveries.

In addressing our findings related to employee morale, the Inspector General pointed out that our survey of OIG employees showed that employee morale remained positive and relatively unchanged during her tenure. However, our survey also identified several groups of employees whose morale was of concern. For example, senior managers were considerably more disturbed than all other employees about OIG leadership. Further, headquarters employees expressed less satisfaction with the organization and leadership than their counterparts in the field. While the majority of OIG staff are located in field offices and generally were more satisfied with their work environment than headquarters employees, they also felt less affected by the changes instituted by the Inspector General than their colleagues in headquarters. A striking exception to field office employee satisfaction, as discussed in our draft,

was staff in OEI, whose dissatisfaction increased substantially compared to last year.

The Inspector General also took issue with our discussion of the circumstances surrounding the delay in beginning the Florida pension audit. We included this example of her decision-making in our draft because we believe that it demonstrated a lack of awareness and appreciation of the need for the Inspector General to closely safeguard her independence. We believe it is imperative that an inspector general perform due diligence when responding to external requests—particularly where independence could be questioned. We continue to believe that the Inspector General's decision to intervene at the request of senior officials in the Florida governor's office and her subsequent instructions to her staff to delay the audit created a perception that her independence was compromised. The Inspector General did not address the issue of her independence in her comments. Instead, she disagreed with our suggestion that the OIG's report could have been available prior to the November 2002 election, if the audit had begun 7 months earlier, in April 2002, as initially planned. While we cannot be certain that the final report would have been issued by the election, we believe that it is likely that the findings would have been made public—particularly since the actual findings of the audit were reported by the media in March 2003, 6 months after the work commenced.

Regarding the York Hospital matter, the Inspector General stated that she discussed her concerns about the proposed settlement with her staff and that she believed that seeking a larger settlement was not fair or justifiable. However, during the course of our work, the Inspector General told us that she did not direct a settlement or involve herself in negotiations with the hospital. In any case, we believe that the Inspector General's actions in response to a letter from several members of Congress contributed to the perception that she was not independent. The Inspector General stated in her comments that she discussed this matter with her attorneys and determined the OIG's case was weak. However, the former Chief Counsel and other OCIG attorneys told us that when she instructed them to "get rid of" the case, she did not address the specific facts or sufficiency of the evidence collected in this matter. Further, the former OIG Chief Counsel did not share the Inspector General's belief that this was a weak case, and told us that he believed the government could have obtained a higher settlement, absent any pressure to close the case quickly.

Concerning the OIG's delayed report on the adjusted community rate proposals, the Inspector General pointed out that the report was already delayed 7 months by the time she took office. While we acknowledge this fact, in our view, the already lengthy delay should have prompted her to take more aggressive action to either obtain CMS's comments or publish the OIG's report without them. Although the Inspector General stated that she relied on the advice of her senior staff in delaying the issuance of this report, our evidence indicates that some of her senior managers were very concerned that she took little action to expedite CMS's comments. The Inspector General indicated that she spoke to the CMS administrator regarding this matter, but she did not indicate when this discussion occurred or how CMS responded. However, the Inspector General did not indicate—nor did we find any evidence to suggest—that she took more rigorous steps to obtain CMS's comments, such as imposing a deadline for the publication of the report, regardless of the status of the comments. The Inspector General also stressed that the delay in publishing the OIG's report had nothing to do with her independence. However, the fact that CMS strenuously objected to the OIG's findings, and that CMS was allowed to delay its comments for over a year, in our view, at least contributed to the perception that the Inspector General was not independent. In addition, the Inspector General disputed our statement that this report was a time sensitive one of congressional interest. We disagree. During the summer and fall of 2001, Medicare+Choice legislative proposals were developed in both the House and Senate. Also congressional hearings were held on the status of the Medicare+Choice progam, which included the issue of adjusted community ratings.

Regarding our assessment of personnel changes in the OIG, the Inspector General stated that her actions were appropriate and that the nature of the Senior Executive Service encourages rotations among staff. While we do not dispute the Inspector General's authority to reassign staff to meet office needs, the manner in which she made these changes clearly created an atmosphere of anxiety in the OIG. The Inspector General stated that she explained the rationale for her decisions "over and over again." However, our discussions with staff members revealed that they did not understand why many of the changes had been made. Moreover, most of the eight senior managers whose departures we found particularly troubling told us that the Inspector General never explained to them why she wanted them to leave their positions. The Inspector General also commented that our employee survey suggested that there were no widespread negative perceptions among staff concerning her personnel decisions. We disagree with this observation because our survey did not contain a question related to her personnel changes. Instead, our survey

focused on employee satisfaction within their immediate work groups—most of which are in the field where the consequences of the Inspector General's changes were least felt. The Inspector General noted that most of the individuals who left the OIG following her changes were in new positions that were "at least equal to or better than" the ones they occupied at the OIG and that she always promoted from within the organization. We do not think that the current employment situations of these former staff members are relevant to the Inspector General's personnel decisions, nor is her practice of promoting other employees from within the organization.

In our draft report, we also discussed the OIG's budgetary difficulties. In her comments, the Inspector General described her efforts to respond to this situation, which primarily consisted of directing one of her senior managers—who was in an acting deputy position—to develop strategies for resolving the OIG's financial problems and to work with other senior OIG managers to develop a spending plan. While we would fully expect that the Inspector General would want to call on her management team to confront the agency's budgetary problems, our concern was that she personally played only a minor role in resolving this matter, particularly in the absence of a Principal Deputy. Given the Inspector General's limited personal involvement, the OIG's senior management team lacked a leader with sufficient authority to mediate any disagreements between them and to take aggressive steps to identify appropriate solutions to the organization's fiscal challenges.

Finally, the Inspector General's comments pointed out that OI had taken steps to correct the deficiencies we noted in its credentialing system. We acknowledged that corrective action has been initiated and this was reflected in our draft report.

We have reprinted the Inspector General's letter in appendix III.

We are sending copies of this report to the Secretary of HHS, the HHS Acting Principal Deputy Inspector General, the former Inspector General, and other interested parties. We will also make copies available to others upon request. In addition, this report will be available at no charge on GAO's Web site at http://www.gao.gov. We will also make copies available to others upon request.

If you or your staffs have any questions about this report, please call me at (202) 512-7114. Additional GAO contacts and other staff members who made key contributions to this report are listed in appendix IV.

William J. Scanlon
Director, Health Care Issues

Appendix I: Scope and Methodology

To conduct our review, we focused on three key areas—the leadership exhibited by the current Inspector General, Janet Rehnquist, the productivity of the Office of Inspector General (OIG) in recent years, and employee morale. To do our work, we became familiar with the organization and structure of the OIG and many of its policies and procedures related to its budgeting, work planning, and report processing activities. We also examined its personnel practices and controls over certain OIG operations. As part of our efforts, we interviewed over 200 current and former OIG employees—including the Inspector General—and conducted a Web-based survey of all employees to obtain their views about their work environment. We also interviewed two current and one former inspectors general from other federal agencies to better understand their unique role and the principles they embraced to manage their offices.

Our review included the examination of more than 8,000 pages of documents, including material related to the OIG's general policies and procedures, human resource management, productivity measures, and reporting standards. Many of these documents were given to us by OIG managers and other employees. In addition, we requested—and were given access to—the e-mail accounts of eight senior OIG managers. This enabled us to retrieve selected messages that these individuals sent or received for approximately a 6-month period on a wide variety of topics affecting the management of the office. We also obtained documentation from other organizations, including the President's Council on Integrity and Efficiency (PCIE), which recently issued a report on some of the Inspector General's actions.[1]

Interviews with Current and Former Employees

To obtain the views of OIG employees, we conducted a series of semistructured interviews. These interviews relied on open-ended questions regarding the Inspector General's leadership, productivity, morale, and other OIG operations. We interviewed three categories of employees—those who were selected randomly, those who volunteered for interviews, and those we selected because of their knowledge or position within the OIG.

[1]The PCIE's review focused on allegations that the Inspector General improperly possessed a firearm and law enforcement credentials. Before these allegations were brought to the attention of the PCIE, we planned to examine these matters. However, once the PCIE commenced its investigation, we agreed with our requestors to exclude these matters from the scope of our work and report on the PCIE's findings.

The randomly selected staff were chosen for interviews from five of the OIG's eight regional offices as well as employees in OIG headquarters. This provided us with a broad geographic representation of OIG employees. Our regional interviews were conducted in Atlanta, Boston, Chicago, Dallas, and San Francisco. In order to afford confidentiality to interviewees, we conducted our regional interviews in GAO offices in those cities or in other non-OIG space. Some regional interviews were also conducted by telephone. Headquarters staff were given the option of being interviewed in either the OIG headquarters or GAO headquarters building.

At each of the five regional offices we visited, we interviewed approximately 20 randomly selected employees who ranged from the GS-7 through the GS-15 levels. One hundred and six randomly selected regional staff members were interviewed in total. Interviewees were selected using a stratified, random sampling technique. Employees from the Office of Audit Services (OAS), the Office of Investigations (OI), and the Office of Evaluation and Inspections (OEI) were included in our random interviews at each regional location.[2] We also interviewed 32 randomly selected staff from the OIG's headquarters in Washington, D.C. and in nearby field offices, including those in Baltimore, Columbia, and Rockville, Maryland.

To supplement our random interviews and to enhance identification of issues of concern to all OIG employees, regardless of their location, we invited all employees, through an OIG officewide e-mail, to contact us if they wished to participate in an interview. We received 28 requests for interviews and conducted many of these by telephone. We generally used the same set of questions that were posed during the random interviews.

In both the random interviews and in discussions with those employees who requested to be interviewed, we asked individuals to bring to our attention any topic that they felt was noteworthy but which our questions did not address. Some interviewees provided us with supporting documentation that they felt was relevant. In some instances, interviewees were reluctant to provide us with documentary evidence and were also concerned about confidentiality. In these situations, we attempted to corroborate the information they shared with us through other means, without jeopardizing their confidentiality.

[2]The OIG does not employ members of the Senior Executive Service in its regional locations. In addition, the Office of Management and Policy (OMP) and the Office of Counsel to the Inspector General (OCIG) typically maintain only a few staff members in regional offices.

As our work progressed, we identified a number of individuals whom we believed would be able to supply us with important information in areas we had identified as potential areas of concern, including the independence of the Inspector General, turnover among senior OIG personnel, and changes in productivity and morale. In total, we interviewed 44 such individuals, many of whom were current or former OIG employees with first-hand knowledge about issues central to our review.

Evaluation of the Inspector General's Independence

To determine the extent to which policies and procedures were in place to ensure that all OIG employees maintained a high degree of independence, we reviewed existing OIG policies, procedures, and protocols. We also reviewed guidance issued to the Inspector General community by the PCIE and the Government Auditing Standards pertaining to independence. We also discussed the OIG's protocols for responding to requests for information or assistance from external entities with selected current and former senior-level OIG officials. In addition, we obtained information regarding specific instances concerning the Inspector General's independence from interviews with current and former OIG officials as well as the Inspector General.

Review of Personnel Information

To evaluate recent personnel changes among OIG officials, we examined detailed personnel information for 24 current or former OIG employees who had resigned, retired, been reassigned, or promoted during the Inspector General's tenure.[3] We reviewed the official personnel files for these individuals and collected relevant information including their history of government service; time employed by the OIG; and any awards, bonuses, and letters of commendation that they had received. We also reviewed the performance appraisals these individuals had received for the prior 3 years.

Finally, we reviewed documentation specifically concerning the promotion of an OIG staff member to the position of Director of Public and Congressional Affairs. Among other things, we examined relevant position descriptions, job announcements, and e-mail communications.

[3]We requested the official personnel files of 25 individuals but 1 file could not be located. We do not believe that this had a material effect on our review.

We also interviewed OIG officials regarding this and other personnel decisions made during the Inspector General's tenure.

Examination of the Inspector General's Travel

To understand the purpose, frequency, and duration of the Inspector General's travel, we examined the itineraries, travel orders, and travel vouchers for all of the trips she had taken from August 2001 through November 2002. For trips for which the itineraries lacked sufficient information about the Inspector General's business activities, we requested additional information and discussed these trips with the Inspector General. We also identified all OIG employees that accompanied her when she traveled. We obtained similar travel records for two senior staff members who accompanied the Inspector General on several occasions and discussed their roles during these trips with them.

Analysis of OIG Performance Measures

To determine whether the OIG has experienced any changes in productivity since the current Inspector General took office in August 2001, we reviewed OIG publications, such as its semi-annual reports, to determine how savings, recommendations, and other performance indicators changed since fiscal year 2000. From OAS and OEI, we collected data about the number of projects initiated, reports published, and reports canceled in fiscal year 2002. We compared these data to the number of reports that were initiated, published, and canceled from fiscal years 2000 and 2001—before the current Inspector General's tenure.

To measure productivity in OI and OCIG, we reviewed data on investigations, prosecutions, and convictions, and exclusions from fiscal year 1997 through fiscal year 2002. We also examined relevant monetary accomplishments including the number and amounts of fines and penalties assessed, civil settlements and judgments, cost savings claimed, and recoveries and court-ordered restitutions. Our review included an examination of OCIG files pertaining to eight civil monetary penalty cases. We also judgmentally selected 18 corporate integrity agreements instituted since fiscal year 2000, to determine the extent to which new policies outlined in the Inspector General's November 20, 2001, open letter to providers had been implemented.

In addition, we discussed the OIG's productivity with some of its partners in the law enforcement community to determine whether there have been recent changes in the level of OI's or OCIG's support. Specifically, we spoke to officials from the Department of Justice and seven of its U.S. Attorneys' Offices. We also discussed this matter with officials from

Medicaid Fraud Control Units in California, Florida, Illinois, and New York and a representative from the National Association of Medicaid Fraud Control Units.

Finally, we assessed the OIG's productivity in terms of its outreach and education activities. To do this, we collected information regarding the number of speeches, presentations, and testimonies given by various OIG employees. We also discussed this matter with OIG employees and professional staff members at several congressional committees with jurisdiction over Medicare and other federal health programs.

Analysis of Web-Based Survey Results

To elicit broad-based views of OIG employees on morale and other issues, we conducted a Web-based survey. We solicited OIG employee participation by e-mail, using an e-mail list provided by the OIG. We first sent a notification e-mail alerting the employees to the upcoming survey and to check for inaccurate e-mail addresses. We verified with the OIG that the individuals whose e-mails were returned as "not deliverable" were no longer active OIG employees. We then sent an activation e-mail to each employee, containing a unique user name, password, and instructions for accessing the survey on the GAO Web site. We sent three follow-up reminder e-mails to nonrespondents. Employees were given 1 month to complete the survey. Of the 1,621 employees on our list, 1,451 completed the survey for a response rate of 90 percent.

The survey contained 29 items asking employees for their views on the organization, management, and their personal job satisfaction. The four possible responses were: strongly agree, somewhat agree, somewhat disagree, and strongly disagree. The first 26 items on the survey were identical to those from an employee survey conducted by the OIG in January 2002, which we used as a basis for comparing our survey results. We included three additional items: "Overall, the OIG is improving as a place to work and make a difference," "I have confidence and trust in my organization," and "In the last 15 months, morale in my work group has improved." We also included seven demographic items and provided an open-ended comment box. We included a final item for the respondent to mark the survey as "Completed," which, if checked, indicated that the respondent gave us permission to include his or her responses in our analyses.

In total, 578 of the 1,451 survey respondents (40 percent) elected to write open-ended comments. We coded 573 of the comments for tone (positive, negative, neutral) and content. To code content, we used 36 categories

related to morale, productivity, management, personnel issues, independence, propriety, and other topics. The comments of three respondents were not coded because they did not fit into any of our coding categories. The comments of two additional respondents were not coded because they did not mark their surveys as "Completed." The unit of analysis was the comment—not the respondent. For example, if one respondent made several comments that fell into different categories, each comment was coded separately.

Appendix II: Insufficient Internal Controls Over the OIG's Credentialing System

In response to allegations that certain employees, including the Inspector General, possessed improper credentials, we evaluated the security of the OIG's credentialing system. OIG employees are issued credentials that display their photographs, signatures, job titles, and, in the case of OI investigators, their status as law enforcement officers. Because adequate internal controls are key to preventing mismanagement and operational problems, our evaluation centered on the controls governing this computer-based system, physically located in the OIG headquarters building. In addition, recent advances in information technology have heightened the importance of ensuring that controls over electronically stored information are frequently reviewed and updated to minimize the threat of improper use. Changes in information technology led to revisions in *Standards for Internal Controls in the Federal Government*,[1] which became effective at the beginning of fiscal year 2000, to reflect new guidance for modern computer systems. Our work revealed serious weaknesses in the internal controls governing the OIG's credentialing system.

The physical security of the computer system used to produce credentials was inadequate. The system was housed in a public file room with unrestricted access. Because the room also contained a copier machine, many individuals routinely entered the area. The system's backup tapes were located in an unlocked drawer in the credentialing system desk. In addition, we also found the stock paper containing the agency's insignia, used in the production of all credentials, stored unlocked in a cabinet in the same room.

In addition, we found deficiencies in the system itself, making it even more vulnerable to misuse. For example, we found that neither the computer's screen saver nor the credentialing software programs on the computer were password protected, and the employee photo and signature files were not adequately protected. The system also did not have the capability to create a history log or audit trail to identify past users. Given the system's unsecured location, we determined that the system itself was easily susceptible to unauthorized access through the use of several techniques, such as a device that could identify recent keystrokes to capture the names of recent users and their passwords.

[1]U.S. General Accounting Office, *Standards for Internal Controls in the Federal Government,* (GAO/AIMD-00-21.3.1, November 1999).

When we visited the credentialing room we found it empty, the computer on, and the screensaver active. By touching the computer's mouse we were able to cancel the screensaver and observed an open record on display. We found that we could access, copy, modify, and delete sensitive files including employee photos, digital signatures, and personnel information with little likelihood of detection or system recovery. It would also have been possible to create a false, unauthorized set of credentials. OIG officials have since told us that they have taken steps to correct these weaknesses.

Appendix III: Comments from the Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAY 30 2003

Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues
United States General Accounting Office
441 G Street, NW – Room 5A14
Washington, DC 20548

RE: GAO-03-685

Dear Ms. Aronovitz:

I appreciate the opportunity to review and comment on the General Accounting Office (GAO) assessment of the management functions of the Department of Health and Human Services, Office of Inspector General (OIG).

As you know, the real measure of management success is in productivity and employee satisfaction. The GAO report shows that overall savings attributable to OIG work increased from $15.6 Billion in fiscal year 2000 to $21.8 Billion in fiscal year 2002 – an increase of nearly 50% in just two years. Further, the GAO report shows that employee morale remains positive and relatively unchanged between 2002 and 2003 – with 89% and 87% respectively showing a high level of satisfaction with the OIG, OIG management, and personal job satisfaction.

This organization has achieved substantial and varied accomplishments under my leadership and direction. The accomplishments include: (1) the largest ever settlements with major drug manufacturers for defrauding the Medicare program; (2) innovative approaches in child support enforcement in which 70 of the nation's most wanted deadbeat parents in 29 states were arrested in a two-day sweep; (3) rapidly assessing and helping to strengthen the public health system after the tragic events of September 11, 2001; and (4) development of a comprehensive strategy to address substantial problems in the administration and oversight of grants awarded by the Department.

Throughout my tenure as Inspector General, I have acted in the best interest of the Department of Health and Human Services, the Office of Inspector General and the American taxpayer, and I am proud of our accomplishments. I am honored to have served as Inspector General and to have contributed to an organization which has such a far-reaching impact on the quality of life of all Americans.

Page 2 – Ms. Leslie G. Aronovitz

I have attached an Exhibit to this letter, to be included in the record and this report, that demonstrates that the GAO report consists largely of opinions, speculation, hearsay, and pre-determined conclusions not supported by the weight of the evidence.

Sincerely,

Janet Rehnquist

Janet Rehnquist
Inspector General

Attachment

EXHIBIT TO GAO-03-685

Florida Pension Audit, pp. 8-9

The Inspector General Act of 1978 states that "it shall be the duty and responsibility of each Inspector General....to provide policy direction for and to conduct, supervise, and coordinate audits...."

The report states that "... the team was scheduled to begin its work in April, 2002 and had estimated that the audit would be drafted in six months, it is conceivable that the report could have been available by election day, if the audit had begun when originally planned."

The key words in this statement are "estimated" and "conceivable". The following facts speak for themselves. I authorized a delay until July, 2002. After further delays, which were authorized by career employees in the field, the audit started in September, 2002. The draft report was released to the State of Florida in March, 2003. The State disagrees with the report on the extent of liability. As of May 30, 2003, fully 8 months after the audit started, the OIG has not issued the final report. It is the final report, not the draft, that is available to the public.

As demonstrated by historical information on 10 years of pension fund audits which this office provided to the GAO, the average time from the beginning of an audit to issuance of a final report was 509 days, or 16 months.

While a staff member in the Office of Audit Services **"estimated"** a **draft** report might be completed in six months, that estimate was optimistic and was an internal management tool used to manage the project. In any event, the draft report would not have been issued to the public. The facts, therefore, demonstrate that neither the planned timing nor the issuance of the report had any bearing on the gubernatorial election in Florida in 2002. Engaging in conjecture about "conceivable" outcomes is hardly the purview of a typical GAO report.

York Hospital, pp. 9-10

The report states: "The OIG attorneys had estimated that York Hospital's potential liability was $726,000... the settlement amount of $270,000 was far less than the attorneys believed the government could have received...".

As you know, this matter was brought to my attention by a letter from Senators Specter and Santorum and Representative Todd Platts. The investigation was prompted by a qui tam relator alleging PATH violations. The Department of Justice and OIG investigated the matter for two years. The Department of Justice declined the case and the relator was paid a $5,000 settlement. OIG decided to pursue the matter administratively.

EXHIBIT - Page 1

The OIG administrative demand letter states that the OIG alleged that York had submitted improper claims seeking $296,469 in Medicare reimbursement. This number was based on a projection derived from a statistical sample. It is important to understand that the OIG was not asserting that this was the amount of reimbursement received by York or the amount of damages to the government from these improper claims.

In fact, based on the projection from the sample, the OIG believed that the damages resulting fromYork's improper claims was less than $200,000. While it is true that additional assessments could have been imposed to increase the settlement amount, I discussed this matter with my legal staff and determined that, due to the weak posture of the case, it was not fair or justifiable to impose such substantial additional assessments.

York had many defenses to the OIG's allegations, particularly the fact that the allegations were several years old and had been declined by the Department of Justice. In a hearing, an Administrative Law Judge may have found no liability or found that the amount claimed was less than what the OIG asserted. Without even considering York's defenses, the York settlement of $270,000 was significantly more than the OIG's initial estimate of loss to the government.

Adjusted Community Rating Audit, pp. 12-13

The report states that "... the delay in issuing this report reflected a lack of independence on the Inspector General's part."

This conclusion is similarly not supported by the evidence. As the report states, this matter was pending for seven months before I took office. Both the Principal Deputy Inspector General and the Deputy Inspector General for Audit Services made decisions to delay the issuance of this report from February 2001 when it was issued in draft through September 2001 when I was confirmed. In other words, the final report was delayed a full 7 months before I took office.

The delay in issuing this report has nothing whatsoever to do with my independence. Indeed, I relied heavily on the advice of the managers in the Office of Audit Services, as well as the Principal Deputy Inspector General. I personally contacted the Administrator of the Centers for Medicare and Medicaid to discuss the status of CMS comments and the need to receive them expeditiously.

The delays in receiving the CMS comments began long before I was confirmed as the Inspector General. Soon after the draft was issued in February 2001, CMS officials, including the Acting Administrator, questioned (1) whether a summary report of the 55 individual audits was justified based on the memorandum of understanding that was signed between the OIG and CMS outlining how these audits were to be conducted among other things, and (2) the validity and accuracy of the OIG methodology followed in conducting the 55 audits and developing the summary draft report.

EXHIBIT - Page 2

Both the audit management staff and I decided it was important to have the facts in the summary draft report correct in all respects. OIG auditors suggested that it was prudent to wait for the comments from CMS (which were going to be based on the results of a peer review of the 55 audit audits and the resultant summary draft report contracted for by CMS). Several meetings from March 2001 through late winter 2001 were held between OIG auditors, CMS staff and the consultant group hired by CMS to evaluate the OIG audit work.

You also indicate this report was "... time sensitive report of congressional interest." There is no basis for this assertion. Neither my staff nor I were made aware of any particular congressional interest in this topic. In fact, although the OIG attempted to generate congressional interest on this issue, these efforts were not successful.

Personnel Changes, pp. 13-16

The report states: "... the sudden and unexplained nature of many of the Inspector General's actions resulted in a widespread perception of unfairness among her staff.... Some of the employees we interviewed were skeptical that these changes were necessary and asserted that they actually damaged the organization's effectiveness."

The facts simply do not support this opinion or conclusion. First, it is important to point out that the personnel actions I took were appropriate, legal, well thought-out, and designed to match the skill sets of individuals with their portfolios. I explained the rationale for these actions over and over again. The very nature of the Senior Executive Service allows for and encourages different assignments. To further enhance the effectiveness of the organization, one SES retirement permitted the reassignment of other SES staff to different components. Second, the overwhelmingly positive results of the employee survey by the GAO show that there was not a widespread negative perception of my personnel decisions.

The report indicates that eight of the personnel actions were "troubling." To the extent I thought appropriate, I explained to the organization and to GAO that the basis for my decisions was to further the changes and reforms I thought the organization needed to make. As the head of the organization, I needed to have full confidence in my top management team.

For the most part, the people who left the organization are in positions that are at least equal to or better than those they occupied in this office. For example, one of the SES staff is now employed by a law firm in Washington, DC; and another is a Deputy Assistant Secretary in the Administration of Aging in the Department.

Another key point is that in no instance was a career employee replaced by a person outside the organization, much less a non-career employee. In fact, I always promoted from within the OIG and took particular care to hire and promote career employees who had experience in field offices. It is my belief that the high morale in the field was at least in part due to these management efforts.

EXHIBIT - Page 3

Resolving Budgetary Problems, pp. 20-21

The report states that the difficult budget situation "... could have been avoided if OIG leadership had developed a human resource hiring and development plan that contained realistic budget projections and hiring goals..."

The Principal Deputy Inspector General and the Deputy Inspector General for the Office of Management and Policy did, in fact, develop human resource hiring and development plans during the spring of 2002. The implementation of those plans created the difficult budget situation we found ourselves in during 2003 when, as you note in the report, we experienced lower than projected attrition rates, reduced funding from the HCFAC account, and a number of Congressional continuing resolutions.

In the Fall of 2003, I instructed my Acting Deputy Inspector General for Management and Policy to work with the Department to expedite the negotiations for the HCFAC funding with the Department of Justice, to implement hiring freezes, travel and training restrictions, and work with the senior management to develop a spending plan that would allow us to continue mission critical functions.

Credentials, p. 18; Appendix II

Immediately after the Office of Investigations (OI) became aware of the noted deficiencies, an action plan was implemented to take corrective measures to eliminate the system control weaknesses.

The OI has taken the following actions to improve credentialing system security:

- OI moved the credentialing system to a secure, physically-monitored and locked room. The use of this room is restricted to two employees, both of whom have a need for the credentialing system information. The individuals responsible for its use continuously monitor this room during normal business hours. The office is locked when the employees are out of the office for any reason. During non-duty hours the room where the system is housed is locked behind two sets of doors.

- The sensitive supplies and backup tapes associated with the credentialing system are stored within the same room as the credentialing system.

- The system software is now accessed by first entering a user name and password. A time-out feature, currently set at two minutes of inactivity, further enhances the system software security. Upon the activation of the time-out feature, the system user must re-enter an authorized user name and password to continue or begin using the credentialing system.

EXHIBIT - Page 4

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contacts

Leslie G. Aronovitz, (312) 220-7600
Geraldine Redican-Bigott, (312) 220-7678

Acknowledgments

Major contributors to this report were Enchelle D. Bolden, Helen Desaulniers, Curtis Groves, Shirin Hormozi, Behn Kelly, Terry Richardson, Christi Turner, and Anne Welch.

GAO's Mission

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