Part IV: Public Health, Human Services, and Departmentwide Issues

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Table of Contents

NOTE: Summaries of OIG audit and evaluation reports in this publication contain rounded figures. Monetary amounts in case narratives are rounded to the next lower dollar, where appropriate.

Public Health Reviews

Centers for Disease Control and Prevention

Public Health > CDC > Vaccine > Schools

2009 H1N1 School-Located Vaccination Program Implementation

Most selected localities in our review reported School-Located Vaccination (SLV) to be a useful method for vaccinating a large number of children in a short time, and localities reported challenges and lessons learned for future SLV programs.

SLV is any vaccination program that takes place on school grounds. Schools provide a convenient location with large spaces such as gymnasiums and cafeterias to host the event. Although the Centers for Disease Control (CDC) considers SLV to be a viable, large-scale vaccination method for children, it indicated in meetings with the Office of Inspector General (OIG) in late summer 2009 that onsite evaluations of the administration of H1N1 vaccine at SLV sites would be useful because data about local implementation of SLV programs have been limited, especially during influenza pandemics.

We found that, by locality, selected SLV sites vaccinated an average of 28 percent of enrolled students during their 1-day programs, ranging from 14 percent to 45 percent. This compares favorably to relevant State and national vaccination rates obtained over a longer period and through a variety of methods. For example, the average vaccination rate in the 6 corresponding States was 37 percent. However, this statewide percentage reflects the number of children vaccinated over about 3 months using multiple methods (e.g., private providers, commercial pharmacies, SLV) and for a wider age range.

We also found a number of challenges associated with implementing SLV programs. For example, we observed the majority of selected SLV sites used recommended vaccine storage containers but did not monitor and record vaccine storage temperature. All selected localities reported challenges obtaining sufficient SLV staff and distributing them effectively across staffing functions. Selected SLV sites reported experiencing challenges communicating a clear and consistent message to parents about potential vaccination adverse reactions and the need for a second vaccine dose. Most of the selected localities had not established a system to bill third-party payers for H1N1 vaccine administration.

The selected localities reported a number of things they would do differently in future SLV programs. These include simplifying the consent form and educational materials; standardizing the consent form review process; devoting more staff to registration, triage, and translation; streamlining staff communication and training; developing a centralized information-sharing system; and distributing information to parents and participating schools earlier.

Our data indicate that SLV can be a viable strategy for vaccinating a large number of students in a short period of time. However, SLV programs require a significant amount of planning and resources. To help mitigate challenges in future SLV programs, SLV planners will need specific, timely guidance and sufficient lead time for planning. This report contains no recommendations. (OEI-04-10-00020)

Public Health > CDC > Vaccine > Prompt Payment Administration

Payments by the Centers for Disease Control and Prevention to Vaccine Manufacturers and Suppliers

CDC generally paid invoices for vaccines in a timely manner and calculated and paid required interest on late payments. Of the 179,129 invoices that CDC paid from April 2005 through August 2006, 172,566 (more than 96 percent) were paid within the required period. For the 6,563 remaining invoices, which were not paid within the required period, CDC paid appropriate interest or did not owe interest on 4,895 invoices but had not paid interest totaling approximately $1 million on 1,668 invoices as of August 31, 2006. In the absence of other contractual provisions, an agency generally must pay a proper invoice within 30 days of the later of the receipt of the invoice or the receipt of the supplies. If an invoice is not paid on time, the agency incurs interest from the day after the payment was due until the payment is made. In addition, we determined that CDC had paid 46 invoices twice, resulting in duplicate payments totaling $2 million.

We recommended that CDC (1) pay $1.7 million in interest due one vendor; (2) recover $687,000 in duplicate payments (net of interest due) from four vendors; and (3) consider reviewing all replacement paper invoices paid after August 31, 2006, to identify any unpaid interest or duplicate payments. CDC disagreed with our findings and recommendations. In response to CDC's comments, we reviewed additional documentation and found that CDC had recovered some of the duplicate payments noted in our draft report. We reduced the number and dollar value of duplicate payments reported in our final report accordingly. We maintain that our findings and recommendations, as revised, are valid. (A-04-06-01042)

Public Health > CDC > Preparedness

Preparedness Program Funding in Louisiana

We found that for the period August 31, 2004, through August 30, 2006, Louisiana claimed some costs to CDC's preparedness program that were not allowable, allocable, and reasonable. Pursuant to the Public Health Service Act, CDC provides funds to State and major local health departments to improve preparedness and response capabilities for bioterrorism and other public health emergencies. From 1999 to 2005, CDC provided this funding through the Public Health Preparedness and Response for Bioterrorism Program. Since 2005, CDC has provided funding through the Public Health Emergency Preparedness Program. We refer to these two programs collectively as "the program." Our review found that Louisiana claimed $11,000 in

unallowable program costs: $7,000 for technical training that was paid for but not taken and $4,000 related to payroll errors. These deficiencies occurred because the State (1) did not have controls in place to ensure that a prepaid technical training coupon package was fully used and (2) made clerical errors. In addition, we set aside $1 million of contract costs because we were unable to determine whether the amount allocated to the program accurately reflected the relative benefits received. The remaining $7.9 million in program expenditures that we reviewed was allowable, allocable, and reasonable.

We recommended that Louisiana (1) refund $11,000 for costs that were improperly charged to the program, (2) work with CDC to determine what portion of the $1 million in set-aside expenditures is allocable to the program and refund the unallowable portion to CDC, and (3) develop a policy for allocating contract costs and document its allocation methodology. The State generally concurred with our recommendations. (A-06-08-00064)

Public Health > CDC > Audit Resolution

Centers for Disease Control and Prevention's Resolution of Audit Recommendations

CDC resolved 815 of the 1,167 audit recommendations that were outstanding during fiscal years (FY) 2007 through 2009. However, CDC did not resolve 274 of the 815 recommendations within the required 6-month period. As of September 30, 2009, CDC had not resolved 352 audit recommendations, of which 213 were past due for resolution. The dollar amount associated with the 213 recommendations is $249.7 million. Office of Management and Budget (OMB) Circular A-50 requires that CDC resolve audit recommendations within 6 months after receipt of each audit report. Because CDC did not resolve all audit recommendations in a timely manner, it did not have reasonable assurance that it was exercising proper stewardship over Federal dollars.

We recommended that CDC (1) resolve all audit recommendations within the required 6-month audit resolution period and (2) resolve the 213 outstanding audit recommendations that were past due as of September 30, 2009. In response, CDC identified actions that it planned to take to meet the required resolution period in a responsible manner, consistent with laws, rules, and regulations. (A-07-09-03131)

Food and Drug Administration

Public Health > FDA > Foreign Clinical Trials Inspections

Challenges to FDA's Ability To Monitor and Inspect Foreign Clinical Trials

We found that in FY 2008, sponsors relied heavily on data from foreign clinical trials to support their marketing applications for drugs and biologics. Eighty percent of approved marketing applications for drugs and biologics contained data from foreign clinical trials. Over half of clinical trial subjects and sites were outside the United States. Although FDA inspected clinical

investigators at few clinical trial sites overall, FDA's inspections of foreign sites were at an even lower rate—less than 1 percent of foreign sites.

The Food, Drug, and Cosmetic Act (FDCA) requires all new investigational drugs and biologics to undergo clinical trials on human subjects to demonstrate the safety and efficacy of these products before approval for sale in the United States. The Food and Drug Administration (FDA) ensures the rights, safety, and well-being of subjects who participate in these trials and verifies that the clinical trial data collected are both accurate and reliable. Sponsors may submit data from foreign and domestic clinical trials to support marketing applications. However, critics have raised concerns about the increased prevalence of foreign clinical trials.

Challenges in conducting foreign inspections and data limitations inhibit FDA's ability to monitor foreign clinical trials. For example, if a sponsor has not submitted an Investigational New Drug (IND) application or consulted with FDA in some other way about its foreign clinical trials, FDA has no way of knowing whether and where such clinical trials are taking place and therefore cannot conduct inspections while the trials are underway. Further, despite guidelines, sponsors generally submitted data that were in non-standard formats, making it difficult to locate clinical trial information, particularly site locations and subject enrollment.

We recommended that FDA require standardized electronic clinical trial data and create an internal database of clinical trial data. FDA should also monitor trends in foreign clinical trials not conducted under INDs and, if necessary, take steps to encourage sponsors to file INDs. FDA should continue to explore ways to expand its oversight of foreign clinical trials. FDA agreed with all of our recommendations. (OEI-01-08-00510)

Public Health > FDA > Food Facilities Inspections

FDA Inspections of Domestic Food Facilities

Our report identified significant weaknesses in FDA's inspections of food facilities. FDA inspects food facilities to ensure food safety and compliance with regulations. We found that from FYs 2004 through 2008, FDA inspects less than a quarter of food facilities each year. In addition, more than half of all food facilities have gone 5 or more years without an FDA inspection.

When FDA identifies violations that are significant enough to warrant an "official action indicated" (OAI) classification, some type of regulatory action should be recommended. This action could include issuing a warning letter, holding a regulatory meeting, or initiating an enforcement action such as a seizure or an injunction. In FY 2007, FDA took action against 46 percent of the facilities that initially received OAI classifications. FDA either lowered the classification or took no regulatory action for the remaining facilities. We also found that most of the facilities that received OAI classifications had a history of violations and that some facilities refused to grant FDA access to their records.

For 36 percent of the facilities that received OAI classifications, FDA took no additional steps to ensure that the violations were corrected. For the remaining facilities, FDA either reinspected

the facilities or reviewed some type of evidence from the facility that demonstrated that the facility had corrected violations.

Based on the findings of this report, we recommended that FDA (1) increase the frequency of food facility inspections, with particular emphasis on high-risk facilities; (2) provide additional guidance about when it is appropriate to lower OAI classifications; (3) take appropriate actions against facilities with OAI classifications, particularly those that have histories of violations; (4) ensure that violations are corrected for all facilities that receive OAI classifications; (5) consider seeking additional statutory authority that would allow FDA to impose civil penalties through administrative proceedings; and (6) seek statutory authority to allow FDA access to facilities' records during the inspection process.

FDA supported our two recommendations to seek additional statutory authority and agreed with our recommendation to provide additional guidance about when it is appropriate to lower OAI classifications. FDA noted several actions it has taken, or plans to take, to address the remaining three recommendations. (OEI-02-08-00080)

Health Resources and Services Administration

Public Health > HRSA > HIV/AIDS

Ryan White Title II Funding in Florida

Florida did not always comply with Federal requirements in administering funds provided under Title II of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990 (CARE Act). From April 1, 2003, through March 31, 2006, Florida (1) did not fully comply with the requirement that Title II funds not be used to pay for drugs that are eligible for coverage by other Federal, State, or private health insurance and (2) did not always use Title II funds for clients whose files contained the documentation needed to determine eligibility for the AIDS Drug Assistance Program (ADAP). Based on our sample results, we estimated that Florida claimed $4.4 million in unallowable Federal funding. Title II grants fund the purchase of medications through ADAP and other health care and support services for people who have HIV/AIDS and who have no health insurance or are underinsured.

We recommended that Florida (1) refund $4.4 million to the Federal Government; (2) follow its procedures for billing HIV/AIDS drugs to the Federal, State, or private health insurance plans with primary payment responsibility; and (3) follow its procedures for documenting clients' eligibility for ADAP funds. Florida said that refunding the money would have a devastating effect on ADAP clients but did not directly address our other recommendations. Florida did not provide any additional information that would cause us to modify our findings or recommendations. (A-04-08-06002)

Indian Health Service

Public Health > IHS > Cost Administration

Fiscal Year 2005 Cost Statements

We reviewed the allowability of obligations included in the FY 2005 cost statements for 2 of the 12 Indian Health Service (IHS) area offices and found duplicate and unsupported costs, erroneous reporting, and costs on which we could not express an opinion.

The Social Security Act authorizes Medicare and Medicaid reimbursement to IHS providers. IHS providers use all-inclusive reimbursement rates to bill for certain Medicare and Medicaid services. These rates are developed from financial data reported in cost statements submitted by IHS and certain tribal hospitals. IHS Headquarters and area-office cost statements identify the portion of obligations from Headquarters and the area offices that is allowable under Medicare and allocable to IHS providers. Allowable Headquarters obligations are allocated to each area office.

The results of our reviews follow:

- Navajo area office. Of the $29 million of obligations that was reported and that we reviewed, $2.5 million pertaining to duplicate costs and erroneously reported depreciation was unallowable. The cost statement also included $4.8 million for unsupported salaries, fringe benefits, and related obligations on which we could not express an opinion.

  We recommended that IHS (1) adjust its next cost statement for the Navajo area office for $2.5 million of unallowable costs; (2) review the Navajo area office's cost statements before and after FY 2005 and adjust its next cost statement for duplicated costs caused by contractor errors and for unallowable depreciation; (3) strengthen its policies and procedures to ensure that depreciation is not reported for items that are fully depreciated; (4) work with the Centers for Medicare & Medicaid Services (CMS) to determine how much of the $4.8 million reported for salaries, fringe benefits, and related obligations was allowable and adjust its next cost statement for obligations that are determined to be unallowable; and (5) develop and implement policies and procedures to ensure that estimates used to allocate obligations in cost statements are supported with cost information that is current, accurate, and in sufficient detail. IHS concurred with all of our recommendations and described corrective actions that it planned to implement. (A-07-08-02721)

- Oklahoma City area office. We found that the $14.7 million of obligations reported included $260,000 in duplicate obligations of the National Supply Service Center (which manages the purchase and distribution of drugs and other medical supplies in all 12 IHS areas) and $430,000 for salaries, fringe benefits, and depreciation costs on which we could not express an opinion.

We recommended that IHS (1) adjust its next cost statement for the Oklahoma City area office to correct the $260,000 of reported unallowable costs, (2) improve its oversight of cost statement preparation, (3) work with CMS to determine how much of the $286,000 in reported salaries and fringe benefits was allocable and adjust its next cost statement for obligations determined to be unallocable, (4) develop and implement policies and procedures to ensure that obligations are allocated in a timely manner, (5) work with CMS to determine how much of the $144,000 in reported depreciation costs was allowable and adjust its next cost statement for depreciation determined to be unallowable, (6) review the Oklahoma City area office's cost statements after FY 2005 and adjust its next cost statement for any unallowable depreciation costs, and (7) develop and implement policies and procedures to ensure that depreciation records contain the necessary information to properly support depreciation costs. IHS generally agreed with our recommendations. (A-06-07-00080)

National Institutes of Health

Public Health > NIH > Contract Administration

Appropriations Funding for National Institutes of Health Contracts

From November 2008 through February 2009, a Department of Health & Human Services (HHS) internal review group assessed 176 HHS contracts, including 21 National Institutes of Health (NIH) contracts. Our reviews of 3 of the 21 NIH contracts assessed compliance with appropriations funding requirements and found that NIH funded the contracts in compliance with the purpose, time, and amount requirements specified in appropriations statutes. NIH had a bona fide need for the items and appropriately funded the contracts and their modifications from the pertinent appropriations year(s). These reports contain no recommendations.

- Office of Research Facilities Development and Operations (ORF) contract HHSN292-03-D-0107, call order number NJE37991. ORF awarded this contract, totaling $3.9 million, during FY 2005. Subsequently, ORF issued four change orders totaling approximately $95,000 in FY 2006 and one change order for $178,000 in FY 2007 for additional material and work. (A-03-10-03101)
- National Library of Medicine (NLM) contract HHSN276-2007-00186U. In FY 2007, NLM awarded this contract, which totaled $464,000. (A-03-10-03112)
- NLM contract HHSN276-2007-00005U. NLM awarded this contract, totaling $19.5 million, in FY 2007 and modified the contract in FYs 2008 and 2009 for $19.5 million each year. (A-03-10-03111)

Public Health > NIH > Superfund Administration

Superfund Financial Activities at the National Institute of Environmental Health Sciences

In our review of Superfund financial transactions at the National Institute of Environmental Health Sciences (NIEHS) for FY 2009, we found that the transactions were allowable, allocable, and reasonable in accordance with applicable laws and regulations. NIEHS receives Superfund funding to train people who handle hazardous waste and manage hazardous waste facilities and to conduct research on the effects of hazardous substances on human health. We conducted this audit pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, which requires the inspector general of a Federal organization with Superfund responsibilities to audit all uses of the Superfund. Our report contained no recommendations. (A-04-10-01076)

Public-Health-Related Legal Actions and Investigations

Health Education Assistance Loan Program

Under the Health Education Assistance Loan (HEAL) program, the Health Resources and Services Administration (HRSA) guarantees commercial loans to students seeking education in health-related fields. The students are allowed to defer repayment of the loans until after they have graduated and begun to earn income. Although HHS's Program Support Center (PSC) takes steps to ensure repayment, some loan recipients do not resolve their indebtedness.

After PSC has exhausted efforts to secure repayment of a debt, it declares an individual in default. Thereafter, the Social Security Act permits exclusion from Medicare, Medicaid, and all other Federal health care programs for nonpayment of these loans. Exclusion means that the individual may not receive reimbursement under these programs for professional services rendered nor can any other provider receive reimbursement for services ordered or prescribed by the individual. OIG is responsible for excluding individuals who have defaulted on HEAL loans from participation in Federal health care programs.

During the semiannual period, we conducted evaluations of and excluded individuals from the HEAL program. Results of this work are below.

HEAL Exclusions

During the period covered by this report, 29 individuals and related entities were excluded as a result of PSC referral of their cases to OIG. Individuals who have been excluded as a result of default may enter into settlement agreements whereby the exclusions are stayed while they pay specified amounts each month to satisfy their debts. If they default on these settlement agreements, they may be excluded until the entire debts are repaid and they may not appeal the exclusions. After being excluded for nonpayment of their HEAL debts, 2,292 individuals have chosen to enter into settlement agreements or completely repay their debts. That figure

includes the 18 individuals who have entered into such settlement agreements or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment is $170.7 million. Of that amount, $1.5 million is attributable to this reporting period.

Each of the following individuals entered into a settlement agreement to repay the amount indicated:

- **Pennsylvania** – Dentist William Jakavick - $110,545
- **California** – Chiropractor Mark Dankman - $105,305
- **New York** – Dentist Joan Baisch-Ferraro - $90,175
- **Idaho** – Chiropractor William Dennis - $82,443
- **Virginia** – Dentist Ethel Miles - $47,150

Human-Services-Related Reviews

Administration on Aging

Human Services > AoA > Grantee Performance

Senior Medicare Patrol Projects: May 2010 Performance Report

We found that total savings attributable to the Senior Medicare Patrol projects were over three times higher in 2009, compared to totals in 2008. The savings benefited Medicare, Medicaid, beneficiaries and others.

The Senior Medicare Patrol Projects receive grants from the Administration on Aging (AoA) to recruit retired professionals to serve as educators and resources in helping beneficiaries to detect and report fraud, waste, and abuse in the Medicare program. At least 1 project is in each of the 50 States, as well as in the District of Columbia, Puerto Rico, Guam, and the Virgin Islands.

In 2009, the 55 projects had a total of 4,444 active volunteers. These volunteers educated beneficiaries in 7,177 group education sessions and held 33,855 one-on-one counseling sessions. In addition, the projects conducted 311,377 media outreach activities and 5,684 community outreach education events. Medicare funds recovered attributable to the projects were $76,176 and total savings to Medicare, Medicaid, beneficiaries, and others were $214,060. The projects had 5 percent fewer active volunteers in 2009, compared to the number in 2008.

In December 2005, AoA asked that OIG continue to collect and report performance data for the Senior Medicare Patrol Projects to support AoA's efforts to evaluate and improve the performance of these projects. OIG agreed to collect performance data every 6 months but to report the data on an annual basis. We continue to emphasize that the number of beneficiaries

who have learned from the Senior Medicare Patrol Projects to detect fraud, waste, and abuse, and who subsequently call the OIG fraud hotline or other contacts, cannot be tracked. Therefore, the projects may not be receiving full credit for savings attributable to their work. In addition, the projects are unable to track substantial savings derived from a sentinel effect whereby fraud and errors are reduced in light of Medicare beneficiaries' scrutiny of their bills. (OEI-02-10-00100)

Administration for Children and Families

Human Services > ACF > Head Start

Health and Safety at Head Start Grantees

As described below, we found that Head Start grantees' failure to consistently comply with Federal and State requirements jeopardized the health and safety of children in their care.

As part of a series of reviews requested by the Administration for Children & Families' (ACF) Office of Head Start, we assessed various Head Start grantees' compliance with Federal and State requirements on ensuring the health and safety of children in their care. The major objectives of the Head Start program include promoting school readiness and enhancing the social and cognitive development of low-income children by providing health, educational, nutritional, and social services. In FY 2009, Congress appropriated $7.1 billion to fund the Head Start program's regular operations. The American Recovery and Reinvestment Act of 2009 (Recovery Act) provides an additional $2.1 billion for the program during FYs 2009 and 2010.

- Grantee A in California. As of June 2009, the grantee had not obtained criminal record checks for 4 of its 35 employees. The grantee also did not obtain criminal record checks on six employees until after they were hired, and the files on four other employees did not contain the required documentation of criminal record clearances or a signed statement regarding criminal history. In addition, the grantee's four childcare facilities that we reviewed did not meet all Federal Head Start and State requirements for protecting children from unsafe materials and equipment. Furthermore, one of these facilities did not provide a fully secure environment for the children in its care. For example, kitchen doors were unlocked, allowing children access to stoves and other items that could pose a danger. We recommended that the grantee strengthen and consistently follow its existing procedures to ensure that (1) criminal record checks are obtained before hiring employees and all employee files contain documentation of criminal record clearances or exemptions and employee signed statements regarding criminal history and (2) all unsafe materials and equipment are stored in locked areas out of the reach of children, other unsafe conditions are addressed, and all facilities are secure. The grantee generally agreed with our findings and described actions taken to address the deficiencies. (A-09-09-00089)

- Grantee B in California. As of April 2010, the grantee had not obtained criminal record checks or signed statements regarding criminal history for 10 of its 159 employees. The grantee also did not obtain criminal record checks on six employees until after they were hired, and the files on four other employees did not contain the required documentation of criminal record clearances. In addition, the grantee's 13 childcare facilities did not meet all Federal Head Start and State requirements for protecting children from unsafe materials and equipment. Furthermore, two of these facilities did not provide a fully secure environment for the children in their care. For instance, a playground fence had a 10-inch gap. We recommended that the grantee strengthen and consistently follow its existing procedures to ensure that (1) criminal record checks are obtained before hiring employees and all employee files contain documentation of criminal record clearances or exemptions and employee-signed statements regarding criminal history and (2) all unsafe materials and equipment are stored in locked areas out of the reach of children, other unsafe conditions are addressed, and all facilities are secure. In response, the grantee described its completed and ongoing actions to address the deficiencies that we identified. (A-09-10-01008)
- Grantee A in Colorado. As of October 2009, employee files showed that 10 of the grantee's 52 employees were hired before their criminal background checks were completed. In addition, the grantee's four facilities did not meet all Federal Head Start and State health and safety regulations on protecting children from unsafe conditions. For example, some electrical outlets at three of the four facilities lacked protective safety plugs. We recommended that the grantee develop and consistently implement procedures to ensure that (1) employees are hired only after passing criminal background checks and (2) all unsafe conditions identified in this report are addressed in a timely manner. The grantee concurred with our recommendations but disagreed with our finding regarding the hiring of employees before their criminal background checks were completed. Nothing in the grantee's comments caused us to change our finding. (A-07-09-02763)
- Grantee B in Colorado. As of May 2009, the files on 9 of the grantee's 25 employees lacked documentation of criminal background checks, checks of the State child abuse and neglect system, or bus driver qualifications, and 1 employee's child abuse and neglect check was not completed within 10 days of employment as required. In addition, the grantee's two facilities did not meet all Federal Head Start and State health and safety regulations on protecting children from unsafe conditions. At both facilities, for instance, cleaning and other toxic materials were accessible to children. We recommended that the grantee develop and consistently implement procedures to ensure that (1) employees are hired only after passing criminal background checks, all employee files contain documentation of criminal background checks and checks of the child abuse and neglect system, and bus driver employee files contain documentation of background checks and other bus driver qualifications and (2) all unsafe conditions identified in this report are addressed in a timely manner. The grantee concurred with our findings and described its completed and ongoing actions to address the deficiencies that we identified. (A-07-09-02761)

- Grantee C in Colorado. As of September 2009, the grantee had not obtained criminal background checks on 5 employees or child abuse and neglect checks on 15 employees. Additionally, child abuse and neglect checks on 20 employees likely were not requested within the required timeframe. Furthermore, the grantee's five facilities did not meet all Federal Head Start and State health and safety regulations on protecting children from unsafe conditions. For example, flammable materials were stored near the water heaters at three facilities, and toothbrushes were kept next to the diaper-changing tables at one facility. We recommended that the grantee develop and consistently implement procedures to ensure that (1) employees are hired only after passing criminal background checks, all child abuse and neglect checks are requested within 10 days of employment, and all employee files contain documentation of criminal background and child abuse and neglect checks and (2) all unsafe conditions identified in this report are addressed in a timely manner. The grantee concurred with our findings and described its completed and ongoing actions to address the deficiencies that we identified. (A-07-09-02764)
- Grantee in Connecticut. As of December 2009, the files on 58 of the grantee's 59 Head Start employees lacked required documentation on fingerprint cards, child abuse and neglect registry checks, criminal record checks, and/or signed employee declarations. Further, the grantee did not meet all Federal Head Start and State requirements on protecting children from unsafe materials and equipment, and the grantee did not always provide a secure environment for the children in its care. Broken fencing between the playground and the parking lot and exposed wiring in an area accessible to children were among the hazards noted. We recommended that the grantee develop and consistently follow procedures to ensure that (1) all employee files contain evidence of completed fingerprint cards (for employees hired after September 1, 2000), evidence of a check of the State child abuse and neglect registry, documentation of a criminal background check, and an employee-signed declaration; (2) unsafe materials are stored in locked areas out of the reach of children and other unsafe conditions are addressed; and (3) all buildings are secure. The grantee generally agreed with our findings and described the actions it was taking. (A-01-10-02500)
- Grantee in the District of Columbia. As of June 2009, the files on all 19 of the grantee's Head Start employees lacked evidence of checks of the child protection register, evidence of completed background checks, or employee-signed declarations listing any relevant criminal convictions. Further, the grantee's two childcare facilities did not meet all Federal Head Start and State requirements on protecting children from unsafe materials and equipment, and one of the facilities did not provide a secure environment for the children in its care. Specifically, the facility's playground was not enclosed by a fence or natural barrier to prevent children from leaving the premises and entering a parking area. We recommended that the grantee develop and consistently implement procedures to ensure that (1) all employee files contain evidence of checks of the child protection register, evidence of completed background checks, and employee-signed declarations listing any relevant criminal convictions; (2) all unsafe materials and equipment are stored in locked

areas out of the reach of children and other unsafe conditions are addressed; and (3) all facilities are secure. The grantee concurred with our recommendations. (A-03-09-00361)

- Grantee in Georgia. As of June 2009, the files on 21 of the grantee's 162 employees did not contain evidence of criminal record checks, and as of May 2009, 7 of the grantee's 8 childcare facilities did not meet all Federal Head Start and State regulations on protecting children from unsafe materials and equipment. The lack of protective safety plugs on electrical outlets was the most common hazard noted. We recommended that the grantee consistently follow its existing procedures to ensure that (1) all employee criminal record checks are completed and employee files contain evidence of the checks and (2) all necessary repairs are completed and all unsafe conditions are addressed. In response, the grantee described its actions to address the deficiencies that we identified. (A-04-09-03527)
- Grantee A in New York. As of July 2009, the grantee's files showed that the grantee had not obtained timely criminal background checks on 21 of its 36 Head Start employees. In addition, the grantee's childcare facility did not meet all Federal Head Start and State regulations on protecting children from unsafe materials and equipment. For example, in one classroom, a bingo marker with a warning label that stated "KEEP AWAY FROM CHILDREN" was left in an area accessible to children. We recommended that the grantee develop and consistently follow procedures to ensure that (1) all employee files contain documentation of timely criminal background checks and (2) all unsanitary and unsafe conditions are corrected. The grantee concurred with our findings and described its completed and ongoing actions to address the deficiencies that we identified. (A-02-09-02013)
- Grantee B in New York. As of October 2009, the grantee had not obtained criminal background checks, timely criminal background checks, and/or child abuse and maltreatment checks on 27 of its 92 Head Start employees. In addition, two of its five bus drivers did not have a timely tuberculosis screening or medical examination. Furthermore, 9 of the grantee's 10 childcare facilities did not meet all Federal Head Start and State regulations on protecting children from unsafe materials and equipment. For example, at one facility, a rusty screw was protruding from a piece of playground equipment. We recommended that the grantee develop and consistently follow procedures to ensure that (1) all employee files contain documentation of timely criminal background checks and child abuse and maltreatment register checks, (2) all bus drivers have an initial health examination that includes screening for tuberculosis, and (3) all unsanitary and unsafe conditions are corrected in a timely manner. The grantee generally concurred with our findings and described its completed and ongoing actions to address deficiencies that we identified. (A-02-10-02004)
- Grantee C in New York. As of June 2009, the files on 38 of the grantee's 110 Head Start employees and 1 of the 6 contracted bus drivers showed that the grantee had not obtained criminal background checks, timely criminal background checks, or child abuse and maltreatment checks, and none of the 6 contracted bus drivers had been screened for

tuberculosis. In addition, the grantee's nine childcare facilities that we reviewed did not meet all Federal Head Start and State regulations on protecting children from unsafe materials and equipment. Finally, four of the nine childcare facilities that we reviewed did not provide a fully secure environment for the children in their care. At two facilities, for instance, cleaning materials and other toxic substances were accessible to children. We recommended that the grantee develop and consistently follow procedures to ensure that (1) all employee and contracted bus driver files contain documentation of timely criminal background checks and child abuse and maltreatment register checks, (2) all contracted bus drivers have an initial health examination that includes screening for tuberculosis, (3) all unsanitary and unsafe conditions are corrected in a timely manner, and (4) all facilities are secure. The grantee generally concurred with our findings and described its actions to address deficiencies that we identified. (A-02-09-02018)

- Grantee A in Texas. As of December 2009, although the files on the grantee's 85 employees and contractors contained evidence of the required background checks, the grantee did not always request these checks when they were due. In addition, four of the six grantee childcare facilities that we visited did not meet all Federal Head Start and State requirements on protecting children from unsafe materials and equipment. Finally, two of the six grantee childcare facilities that we visited did not provide a fully secure environment for the children in their care. At two facilities, for example, exterior doors were unlocked, allowing unrestricted access into the facilities. We recommended that the grantee develop and consistently follow procedures to ensure that (1) required background checks are completed when due, (2) all unsafe conditions are corrected and all necessary repairs are addressed in a timely manner, and (3) all facilities are secure. In response, the grantee described actions that it had taken or planned to take to address the deficiencies that we identified. (A-06-09-00081)
- Grantee B in Texas. As of February 2010, the files on 28 of the grantee's 130 employees did not contain evidence of all required background checks. Although the files on the 102 remaining employees contained evidence of the required background checks, the grantee did not always request these checks when they were due. In addition, 13 of the grantee's 15 childcare facilities that we visited did not meet all Federal Head Start and State requirements on protecting children from unsafe materials and equipment. Finally, 7 of the grantee's 15 childcare facilities that we visited did not provide a fully secure environment for the children in their care. For example, a hammer was left unattended on a handrail leading to a building entrance. We recommended that the grantee share this report with Community Development Institute (CDI), which currently operates the grantee's Head Start program, to ensure that (1) required background checks are completed when due, (2) all unsafe conditions are corrected and all necessary repairs are addressed in a timely manner, and (3) all facilities are secure. The grantee stated that it had no staff to verify whether the deficiencies noted in the report had been corrected because ACF had suspended financial assistance to the grantee's Head Start program. The grantee added that CDI, ACF's national interim management contractor, would operate the Head Start program during the

suspension. We revised our recommendations to reflect CDI's role during the grant suspension period. (A-06-10-00060)

- Grantee C in Texas. As of January 2010, the files on 6 of the grantee's 75 employees and contractors did not contain evidence of all required background checks. The files on the 69 remaining employees and contractors contained evidence of the required background checks, but the checks were not always requested when they were due. In addition, the grantee's 11 childcare facilities did not meet all Federal Head Start and State requirements on protecting children from unsafe materials and equipment. Finally, three of the grantee's childcare facilities did not provide a fully secure environment for the children in their care. For instance, the chain-link fence around one facility's playground had barbed wire tangled between its links. We recommended that the grantee develop and consistently follow procedures to ensure that (1) required background checks are completed when due, (2) all unsafe conditions are corrected and all necessary repairs are addressed in a timely manner, and (3) all facilities are secure. The grantee agreed with most of our findings and described actions that it had taken or planned to take to address most of the deficiencies that we identified. (A-06-10-00053)
- Grantee A in Wisconsin. As of May 2009, the grantee could not provide any evidence that its two contracted bus drivers had received driving record checks, preemployment medical examinations, or required training. In addition, the grantee's three childcare facilities did not meet all Federal Head Start and State regulations on protecting children from unsafe materials and equipment and providing a secure environment for children. For example, at one facility, the door to the faculty lounge was unlocked, allowing children access to a gas stove. We recommended that the grantee develop and consistently follow procedures to ensure that (1) if it resumes transportation services, all Federal requirements related to bus driver qualifications and training are met and documented and (2) all unsafe materials and equipment are stored in locked areas out of the reach of children, all necessary repairs are addressed in a timely manner, and all facilities are secure. The grantee agreed with our recommendations and with most of our findings. (A-05-09-00079)
- Grantee B in Wisconsin. As of December 2009, employee files showed that the grantee had not obtained a criminal record check on 1 of its 94 employees before employment. In addition, 13 of the grantee's 15 bus drivers did not meet all Federal bus driver qualification requirements before employment, and the grantee's files contained no evidence that it had provided classroom and behind-the-wheel instruction to any bus drivers before they transported children. Finally, three of the grantee's five childcare facilities did not meet all Federal Head Start and State regulations on protecting children from unsafe materials and equipment. At one facility, for instance, a movable rack of folding chairs obstructed an exit. We recommended that the grantee develop and consistently follow procedures to ensure that (1) employees are hired only after passing criminal background checks, (2) all Federal requirements related to bus driver qualifications and training are met and documented, and (3) all unsafe conditions are addressed. The grantee generally agreed with

our findings and described the actions that it had taken or planned to take to address them. (A-05-10-00022)

- Grantee C in Wisconsin. As of February 2010, the grantee's files provided no evidence that the paint coatings at any of its 15 childcare facilities were free from hazardous quantities of lead. In addition, 10 of the grantee's 12 childcare facilities that we visited did not meet other Federal Head Start and State regulations on protecting children from unsafe materials and equipment. For example, at nine facilities, trash cans in classrooms and other areas accessible to children were uncovered. We recommended that the grantee develop and consistently follow procedures to ensure that all unsafe conditions are addressed in a timely manner. In response, the grantee described actions that it had taken or planned to take to address most of our findings. (A-05-10-00040)

Human Services > ACF > Foster Care > Federal Share

Foster Care Costs Claimed on Behalf of Delinquent Children in Georgia

We found that Georgia's Title IV-E foster care claims on behalf of delinquent children did not meet all Federal requirements for child eligibility and allowable costs. Title IV-E of the Social Security Act authorizes Federal funds for State foster care programs and establishes eligibility requirements, such as age, income, and specified judicial determinations. At the Federal level, ACF administers the program.

Based on our sample results, we estimated that the State claimed unallowable Title IV-E costs for FYs 2005 and 2006 totaling $596,000 (Federal share), including $60,000 in maintenance payments and $536,000 in associated administrative costs. We were unable to determine the allowability of the remaining maintenance payments totaling $664,000 and associated administrative costs totaling $6 million because the State was unable to demonstrate that the daily maintenance rates for Title IV-E eligible children did not contain unallowable costs. The State's claims met Federal requirements for childcare institution eligibility.

We recommended that the State (1) refund to the Federal Government $596,000 for unallowable costs, (2) ensure that permanency hearings are held within the specified timeframe and that appropriate documentation is maintained, (3) ensure that the daily maintenance rates for Title IV-E children include only allowable costs, and (4) work with ACF to resolve the allowability of maintenance payments totaling $664,000 and associated administrative costs totaling $6 million. The State said that it would work to settle the unallowable costs and resolve the administrative costs. The State did not specifically address our second and third recommendations. (A-04-07-03519)

Human Services > ACF > Adoption Assistance > Federal Share

Adoption Assistance Subsidies in New Jersey

New Jersey claimed Federal reimbursement twice for the same $9.6 million ($4.8 million Federal share) in adoption assistance subsidies identified as a result of its contingency-fee contract with a private company. This error occurred because the State's procedures for reporting adoption assistance subsidies on its quarterly expenditure reports were inadequate. Pursuant to Title IV-E of the Social Security Act, ACF administers the adoption assistance program. The adoption assistance program provides Federal funds to States to facilitate the timely placement of children whose special needs or circumstances would otherwise make them difficult to place with adoptive families. We recommended that the State refund $4.8 million to the Federal Government. The State concurred with our recommendation. (A-02-09-02019)

Child Support Enforcement

Human Services > ACF > Child Support Enforcement

Child Support Intergovernmental Collaboration

Congress annually appropriates funds to OIG to detect, investigate, and prosecute noncustodial parents who fail to pay court-ordered child support. These activities are priorities for OIG. OIG works closely with the Office of Child Support Enforcement (OCSE); DOJ; U.S. Attorneys' Offices; the U.S. Marshals Service; and other Federal, State, and local partners to expedite the collection of child support.

Child Support Task Forces

In 1998, OIG and OCSE initiated Project Save Our Children, a child support initiative that united the efforts of multiagency, multijurisdictional investigative task forces for child support enforcement. The task forces are designed to identify, investigate, and prosecute egregious criminal nonsupport cases on the Federal and State levels by coordinating law enforcement, criminal justice, and child support office resources. Task force screening units receive child support cases from the States; conduct preinvestigative analyses; and forward the cases to the investigative task force units, where they are assigned and investigated. The task force approach streamlines the process by which the cases best suited for criminal prosecution are identified, investigated, and resolved.

Child Support Investigations

OIG investigations of child support cases, nationwide, resulted in 28 convictions and court-ordered restitution and settlements of $2.5 million during this semiannual period. Examples of OIG's enforcement results for failure to pay child support include the following:

- **Maine** – David Carlson, convicted after a 4-day trial, was sentenced to 12 months and 1 day in prison and ordered to pay $43,728 in restitution for failure to pay child support. Evidence presented at trial showed that, prior to his divorce, Carlson had withdrawn over $120,000 from investment accounts, yet failed to make a single voluntary child support payment from the time he was ordered to pay in January 2004 until his arrest in September 2008. The Government was able to demonstrate that Carlson, an industrial engineer, elected not to work rather than pay child support, claiming that physical ailments prevented him from obtaining employment. However, Carlson found a job and was physically able to work after being ordered to obtain employment as part of his pretrial release.
- **Tennessee** – Shaun Martin was sentenced to 42 consecutive weekends in prison and ordered to pay $128,854 in restitution for failure to pay child support. Investigators found that Martin, who was living and working in Tennessee, willfully failed to pay child support to his child's custodian who was living in Indiana. As part of the sentencing, Martin was ordered to spend 100 hours of community service speaking about the importance of paying child support.

Highlights of recent enforcement actions to which OIG has contributed are posted to OIG's Web site at: http://www.oig.hhs.gov/fraud/enforcement/criminal/.

Departmentwide Issues

Non-Federal Audits

OMB Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities must conduct annual organizationwide "single audits" of all Federal money they receive. These audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entities' management of Federal funds. In this semiannual period, OIG's National External Audit Review Center reviewed 1,422 reports that covered $2.2 trillion in audited costs. Federal dollars covered by these audits totaled $798 billion, about $325 billion of which was HHS money.

OIG's oversight of non-Federal audit activity informs HHS managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs that require formal resolution by Federal officials. We identify entities for high-risk monitoring, alert program officials to any trends that could indicate problems in HHS programs, and profile non-Federal audit findings of a particular program or activity over time to identify systemic problems. We also provide training and technical assistance to grantees and members of the auditing profession.

OIG maintains a process to assess the quality of the non-Federal reports received and the audit work that supports selected reports. The non-Federal audit reports reviewed and issued during this reporting period are categorized in the following table.

Reviews of Non-Federal Audits

Reports issued:	
Without changes or with minor changes	1,307
With major changes	106
With significant inadequacies	9
Total	1,422

The 1,422 reports included 4,175 recommendations for improving management operations. In addition, these audit reports provided information for 45 special memorandums that identified concerns for increased monitoring by management.

Other Departmentwide Reports

Departementwide Issues > Recovery Act > Data Quality

Data-Quality Reviews of Information Reported by Recipients of Recovery Act Funds

For the first and second reporting periods (February 17 through September 30, 2009, and October 1 through December 31, 2009), we found that HHS's limited data-quality reviews of recipient-reported Recovery Act information identified material omissions and significant errors.

Section 1512 of the Recovery Act requires recipients of certain Recovery Act funds to report to the applicable Federal agency, not later than 10 days after the end of each calendar quarter, (1) the total amount of Recovery Act funds received and the amount that was expended or obligated, (2) a detailed list of all projects for which Recovery Act funds were expended or obligated, and (3) detailed information on payments to subrecipients and vendors. Federal agencies are required to conduct limited data-quality reviews intended to identify material omissions and/or significant errors in the recipients' reported information. HHS took several steps to minimize material omissions and significant errors. Consequently, this report contains no recommendations. (A-09-10-01001)

Resolving Recommendations

In accordance with the IG Act, § 5, 5 U.S.C. App., tables indicating the dollar value of actions taken on OIG's recommendations in this semiannual period have been developed and are provided in Appendix B.