



Department of Health and Human Services

Semiannual

Report to Congress

October 1, 2006-March 31, 2007



OIG

Office of Inspector General



Message from the Inspector General

This report, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG) for the 6-month reporting period that ended March 31, 2007.

The time period encompassed by this semiannual report coincides with an unusual confluence of milestones. During the last 6 months, OIG marked the 30th anniversary of its establishment, the 20th anniversary of the enactment of the False Claims Amendments Act of 1986 (FCA), and the 10th anniversary of the enactment of the 1986 Health Insurance Portability and Accountability Act. These statutes are the legal and policy foundations upon which much of OIG's work is based.

Our accomplishments over the past 6 months continue to reflect the impact of these historic statutes, as well as OIG's relatively new oversight responsibilities under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and Medicaid integrity efforts pursuant to the Deficit Reduction Act of 2005. OIG's focus on the Department's public health emergency preparedness and response activities also continued in earnest during this reporting period.

OIG's authorities under the FCA were critical in resolving two significant cases during this reporting period: a \$900 million settlement with Tenet Healthcare Corporation, operator of the Nation's second-largest hospital chain, and a \$49.5 million settlement with Omnicare, Inc., a nationwide institutional pharmacy. With respect to health care work, OIG's focus on the integrity of Medicare and Medicaid payments continued, with reviews of payments for Medicare home oxygen equipment and eligibility of beneficiaries for Medicaid in New York State. OIG also reviewed the compliance plans of prescription drug programs participating in Medicare Part D. In addition to health care related accomplishments, OIG added to its robust portfolio of emergency preparedness work by evaluating the response of the Commissioned Corps to Hurricanes Katrina and Rita, the largest deployment of officers in the Corps' 207-year history.

I want to express my sincere appreciation to Congress as well as to the senior management of the Department for their support over the last 6 months. I am honored to be leading an organization of highly professional and talented employees who are committed to the mission of OIG and the important programs administered by the Department.

A handwritten signature in black ink that reads "Daniel R. Levinson". The signature is written in a cursive, flowing style.

Daniel R. Levinson
Inspector General

Highlights

Summary of Accomplishments

For the first half of fiscal year (FY) 2007, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported expected recoveries of \$2.9 billion: \$1.5 billion in audit receivables and \$1.4 billion* in investigative receivables.

Also for this semiannual period, OIG reported exclusions of 1,278 individuals and entities for fraud or abuse involving Federal health care programs and/or their beneficiaries; 209 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 123 civil actions, which include False Claims Act and unjust enrichment suits filed in Federal district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

The Commissioned Corps' Response to Hurricanes Katrina and Rita

OIG found that, in response to Hurricanes Katrina and Rita, Public Health Service Commissioned Corps officers provided valuable support to States. However, more officers, especially nurses, mental health professionals, and dentists, were needed. In addition, although most deployed officers met Corps readiness standards, many lacked prior deployment experience, effective training, and familiarity with response plans. Logistical difficulties involving contacting officers for deployment, making travel arrangements, and communicating assignments, delayed officers' arrival to the field. OIG noted that the Department's initiative to transform the Corps may alleviate many of the issues the Corps experienced in responding to Hurricanes Katrina and Rita and made several recommendations to improve the Corps' effectiveness and efficiency in deploying for and responding to disasters.

\$900 Million Settlement With Tenet Healthcare Corporation

Tenet Healthcare Corporation, operator of the Nation's second largest hospital chain, agreed to pay the Government \$900 million plus interest and enter into a 5-year Corporate Integrity Agreement (CIA) to resolve its liability under the False Claims Act and related authorities. Of the settlement amount, Tenet will pay over \$788 million to resolve claims related to outlier payments Tenet received based on inflated charges for inpatient and outpatient care.

\$49.5 Million Settlement With Omnicare, Inc.

Omnicare, Inc., a nationwide institutional pharmacy that exclusively services nursing home patients, agreed to pay \$49.5 million and enter into a 5-year CIA for allegedly improperly switching capsules for tablets. The switches, allegedly made to avoid Federal upper payment limits placed by the Centers for Medicare & Medicaid Services, did not comply with State "lowest price" requirements. The improper switches cost Medicaid

*This amount represents HHS investigative receivables only; receivables of other Federal agencies, States, and other entities are not included here.

Highlights

and the Federal Government approximately \$26 million more than if the drugs had not been switched.

South Florida Durable Medical Equipment Suppliers' Compliance With Medicare Standards: Results from Unannounced Visits

OIG officials made unannounced site visits to 1,581 suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in three South Florida counties to determine whether the suppliers comply with certain Medicare standards. Investigators found that, contrary to Medicare requirements, 31 percent of suppliers in Miami-Dade, Broward, and Palm Beach Counties did not maintain facilities or their facilities were not open for business or staffed. OIG recommended that CMS strengthen the Medicare DMEPOS supplier enrollment process and ensure that suppliers meet Medicare supplier standards.

Medicare Home Oxygen Equipment

Although home oxygen equipment is relatively inexpensive to buy, durable, and easy to maintain, Medicare allows long-term rentals that cost much more than the equipment. Specifically, OIG found that based on the 2006 median fee schedule amount, Medicare will allow \$7,215 for 36 months' rental of concentrators that cost \$587, on average, to purchase new. OIG recommended that CMS work with Congress to further reduce the rental period allowed for oxygen equipment.

Medicaid Eligibility in New York State

During a 6-month period in 2005, New York State made Federal payments totaling an estimated \$230.4 million on behalf of beneficiaries who did not meet Medicaid eligibility requirements. In addition, New York's documentation did not adequately support eligibility determinations for an estimated \$2.8 billion in Federal payments. OIG did not recommend recovery of Federal dollars because a disallowance may occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program. Instead, OIG recommended that New York use the results of this review to help ensure compliance with Federal and State eligibility requirements.

Former Dermatologist Sentenced for Performing Unnecessary Surgeries

A former dermatologist was sentenced to 22 years in prison, ordered to pay \$3.7 million in restitution, forfeit an additional \$3.7 million, and pay a \$25,000 fine for performing 3,086 medically unnecessary surgeries on 865 Medicare beneficiaries. The dermatologist falsely diagnosed patients with skin cancer so he could bill Medicare for expensive surgeries.

Prescription Drug Plan Sponsors' Compliance Plans

OIG found that although all prescription drug plan sponsors had compliance plans, 72 of 79 compliance plans did not address one or more of CMS's 17 requirements. One required element of compliance plans is the development of a comprehensive plan to detect, prevent, and correct fraud, waste and abuse. This requirement was addressed in some way by all plans, yet only 15 of 79 compliance plans addressed all 11 recommendations regarding the design of these anti-fraud plans.

Unobligated Bioterrorism Grant Funds

As of the close of the Public Health Preparedness and Response for Bioterrorism Program, States and major local health departments had not expended almost 16 percent of the approximately \$996 million awarded. Because many awardees did not submit timely financial status reports, the Centers for Disease Control and Prevention (CDC) did not always have the information needed to encourage the expenditure of funds. Under the new Public Health Emergency Preparedness Program, which began in 2005, CDC has strengthened its guidance and established additional controls. OIG recommended that CDC ensure that awardees under the new program submit financial status reports in a timely manner; follow its new guidance to better manage grant funds; and, when appropriate, offset new-year awards by unobligated funds carried over from the prior budget year.

Departmental Financial Statement Audit

The Department received a “clean” opinion on its FY 2006 consolidated/combined financial statements for the eighth consecutive year. OIG found that the Department’s statements were reliable and fairly presented. However, auditors noted material weaknesses in financial management systems and reporting and in information systems controls.

Office of Inspector General's Hurricane-Related Activities

In response to the Gulf Coast hurricanes of 2005, OIG launched an aggressive, coordinated oversight effort to ensure that Federal response and recovery funds are spent appropriately; that those attempting to defraud the Government are brought to justice; and that the individuals responsible for the relief efforts are wise stewards in their work assisting those affected by the hurricanes and their aftermath.

OIG continues to work with Federal, State, and local partners in this effort, including participating as a member of the President's Council on Integrity and Efficiency (PCIE) Homeland Security Roundtable and the Disaster Relief Working Group, which are coordinating the oversight activities of the Federal Inspectors General. OIG took the lead in developing information related to State and local liaisons as part of a comprehensive Hurricane Action Plan developed by the Homeland Security Roundtable. In addition, along with other members of the Inspector General (IG) community, OIG is a member of the Department of Justice Katrina task force in Baton Rouge. That task force is investigating allegations of fraud related to Federal outlays in connection with Hurricane Katrina.

OIG has initiated extensive audit, evaluative, and investigative activities related to the oversight of HHS's hurricane recovery efforts. A list of recently completed and ongoing projects follows:

Department Accounting for Federal Emergency Management Agency Assignments

As of February 28, 2007, the spending authority for HHS Federal Emergency Management Agency-requested mission assignments totaled \$307 million. This spending authority is contained within 117 individual mission assignments with different magnitudes and objectives. OIG's audits will determine whether HHS is appropriately accounting for these costs.

Auditing Hurricane-Related Procurements

OIG is auditing all HHS hurricane-related contractual procurements over \$100,000. These audits focus specifically on the methods of procurement; costs incurred; and the quantity, quality, and timeliness of deliverables. OIG plans to audit 72 procurements with a total value of \$92.7 million. As of February 28, 2007, OIG had issued 21 audit reports with an audited value of \$29.3 million. All 21 reports noted that the awarding agencies had complied with procurement requirements. OIG is in the process of completing and issuing an additional 51 reports with an audited value of \$63.4 million.

Transporting Medically Needy Evacuees

OIG is auditing the performance and monetary charges of a contractor responsible for returning to Texas, Louisiana, and Mississippi all evacuees who required en route medical care and therefore could not travel via commercial air or without medical assistance. It is estimated that 6,000 individuals were transported. This contractor was awarded \$21 million to transport evacuees back to their medical facilities.

Hurricane-Related Activities

Duplication of Benefits

At the request of the Department of Homeland Security (DHS) OIG and the PCIE Homeland Security Roundtable, OIG completed a program survey to identify potential duplication of benefits provided in declared disasters associated with Hurricanes Katrina, Rita, and Wilma. OIG distributed the survey request to various operating divisions within HHS and asked each operating division to complete the program survey form provided by the DHS IG. Many Federal agencies provided record levels of support, both financial and nonfinancial, through programs they administer during presidentially declared disasters. The DHS IG and PCIE will use this survey to determine which programs have the greatest risk of duplicative, excessive, and improper payments.

Emergency Response to Hurricane Katrina: Use of the Government Purchase Card

OIG recently issued a draft report analyzing the use of purchase cards by HHS personnel deployed in response to Hurricane Katrina. The purchase card program was designed to save the Government money by avoiding costly paperwork and expediting the process of making purchases. In response to Hurricane Katrina, Public Law 109-62 authorized agencies to streamline certain purchasing requirements for procurement of supplies or services to support rescue and relief operations. The objectives of this report were to determine whether Government purchase card purchases related to Hurricane Katrina complied with selected requirements for the use of the card and to identify lessons learned from Hurricane Katrina purchases to assist in the administration of the Government purchase card program during future emergency situations.

The Commissioned Corps' Response to Hurricanes Katrina and Rita

In a recent final report, OIG found that although Commissioned Corps officers deployed to Hurricanes Katrina and Rita provided valuable services, the Corps could improve its response to public health emergencies. The Corps provided valuable support to States; however, more officers, especially nurses, mental health professionals, and dentists, were needed. Although most deployed officers met Corps readiness standards, many lacked experience, effective training, and familiarity with response plans. Agencies were unwilling or unable to allow some officers to deploy, while logistical difficulties delayed others' arrival in the field. Confusion surrounded some officers' arrival, but most field assignments were appropriate and officers felt safe at their locations. Most officers were equipped adequately, but some lacked working communications devices and other basic tools. Many officers personally incurred mission-related expenses and some were not reimbursed promptly, which could affect their ability to deploy to future public health emergencies.

OIG recommended that the Corps institute more effective training for officers, improve the system used to contact officers for deployment, work with the Office of the Assistant Secretary for Preparedness and Response (formerly the Office of Public Health Emergency Preparedness) to streamline deployment-related travel, stagger deployments to ensure continuity of operations, improve its ability to coordinate mission assignments and communications in the field, and ensure that all deployable officers have Federal Government travel credit cards. The Assistant Secretary for Health agreed with these recommendations. As part of the Corps' comprehensive transformation process and its

efforts to improve the Office of Force Readiness and Deployment's practices, the Corps currently is addressing the recommendations in this report.

Medicaid Payments and Services Under Hurricane-Related Demonstration Projects

Because of the effects of Hurricanes Katrina and Rita, beneficiaries of HHS programs who resided in the Gulf Coast States may have been evacuated to various places around the United States or otherwise significantly affected. In response to this situation, and to ensure that victims of Katrina and Rita received needed health care, HHS used Section 1115 waiver and expenditure authority to expand Medicaid coverage criteria. In this study, OIG will describe the payments and services made under Section 1115 Medicaid demonstration projects for victims of Katrina and Rita.

Investigations of Health Care Fraud, Quality-of-Care Lapses, and Other Issues

As of the end of this reporting period, OIG had 11 open investigations involving allegations of health care fraud, poor quality of care, and patient abandonment and is assisting in investigations of circumstances surrounding the deaths of nursing home residents and hospital patients. OIG is also involved in two other cases that include allegations of individuals fraudulently obtaining benefits based on false information.

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Please note: Numerical information in this report is rounded.

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare and Medicaid programs. Financed by the Federal Hospital Insurance Trust Fund, Medicare Part A provides hospital and other institutional insurance for individuals 65 years old or older and for certain disabled persons. Medicare Part B (Supplementary Medical Insurance) is an optional program that covers most of the costs of medically necessary physician and other services and is financed by participants and general revenues. Medicare Part C (Medicare Advantage) enables beneficiaries of Medicare Parts A and B to choose to receive all their health care services through a coordinated Medicare Advantage plan, which replaced the previous Medicare+Choice managed care plans. Medicare Part D is a new, optional program offering prescription drug coverage through private drug plans. Beneficiaries may opt to either enroll in a stand-alone prescription drug plan and receive their Part A and Part B benefits through a fee-for-service health plan or enroll in a Medicare Advantage prescription drug plan and receive all Medicare benefits, including drug coverage, through a Medicare Advantage plan.

The Medicaid program provides funding to States for medical care and other support and services for low-income individuals. State expenditures for medical assistance are matched by the Federal Government using a formula that compares per capita income in each State with the national average. The State Children's Health Insurance Program (SCHIP) expands health coverage to uninsured children whose families earn too much for Medicaid but too little to afford private coverage.

OIG devotes significant resources to investigating Medicare and Medicaid fraud, waste, and abuse and to monitoring these programs through audits and evaluations. These activities have helped to ensure the cost-effective delivery of Medicare, Medicaid, and SCHIP services; to safeguard quality of care to program beneficiaries; and to reduce the potential for fraud, waste, and abuse. In addition, these efforts have led to criminal, civil, and/or administrative actions against perpetrators of fraud and abuse.

OIG also reports on audits of CMS financial statements, which currently account for more than 82 percent of the Department's net costs. In addition to issuing an opinion on the statements, auditors assess compliance with Medicare laws and regulations and the adequacy of internal controls.

CMS-Related Reports

Organ Acquisition Costs Claimed by Certified Transplant Centers

OIG found that 11 certified transplant centers did not always comply with Medicare regulations and guidelines for claiming approximately \$203 million in organ acquisition costs during various periods between 1997 and 2002. Of the almost \$80 million of costs audited, approximately \$47 million did not comply with Medicare's definition of organ acquisition costs, exceeded Medicare's limits on physician salaries, or was not allocated or documented properly. Based on the fiscal intermediaries' revisions to the 11 centers' cost reports for unallowable and unsupported costs, OIG estimated that Medicare's share of the \$47 million was approximately \$28 million.

OIG recommended that CMS consider the results of the 11 audits in prioritizing areas to be evaluated in annual audits by the fiscal intermediaries. CMS agreed with the recommendation. (A-09-05-00034)

Hospital Reporting of Deaths Related to Restraint and Seclusion

OIG found that hospitals failed to report to CMS 44 out of the 104 documented deaths related to the use of restraint and seclusion for behavior management between August 2, 1999, and December 31, 2004. Among deaths that were reported directly to CMS, less than one-third were reported in a timely manner. OIG also found that CMS and State survey agencies were not consistent in the timeliness of their response to reported deaths, limiting their ability to address potentially harmful conditions. Although CMS requires State survey agencies to educate hospitals about the reporting requirement, relatively few State survey agencies indicated that they provide hospitals with regular guidance. In addition, CMS does not maintain comprehensive and reliable information about hospital deaths related to restraint and seclusion.

To improve hospital reporting of deaths related to restraint and seclusion, OIG recommended that CMS seek legislation to establish intermediate sanctions for hospitals that fail to report such deaths directly to CMS and consider regulatory changes that would implement broader reporting requirements. To improve the accuracy of its data and the timely identification of deaths related to restraint and seclusion, CMS should instruct its regional offices and State survey agencies to adhere to timelines, encourage State survey agencies to provide ongoing training to hospitals about the mandatory reporting requirement, and instruct regional offices to request periodic updates about deaths related to restraint and seclusion from other Federal and State agencies.

CMS concurred in part with OIG's recommendations and indicated that it will provide written instructions to regional offices and State survey agencies and that it will consider regulatory changes that would simplify reporting requirements. However, the agency indicated that expanding sanction options is a statutory issue that is best addressed through congressional action. In addition, CMS stated that, in the future, the agency will seek the support of hospital provider groups and accreditation organizations to provide ongoing training on the reporting requirements. (OEI-09-04-00350)

Availability of Quality of Care Data in the Medicare End Stage Renal Disease Program

OIG found that End Stage Renal Disease (ESRD) networks had access to multiple sources of data in ESRD facilities during 2004 and 2005, but that these data sources provided limited help in identifying facilities with quality of care problems. The data were fragmented; duplicative; or lacked facility-specific, comprehensive, and clinical performance measures. Such data limitations may impair the networks' efforts to ensure that patients in ESRD facilities receive high-quality care and limit CMS's ability to implement a pay-for-performance system for ESRD.

OIG recommended that CMS increase its efforts to collect data regularly on all clinical performance measures from all patients and all facilities to address quality of care in the ESRD program. CMS outlined its efforts to improve the quality of care in the ESRD program and acknowledged that further improvements are needed. (OEI-05-05-00300)

Identifying Beneficiaries Eligible for the Medicare Part D Low-Income Subsidy

OIG found that there was no effective way to identify beneficiaries who may be eligible for a subsidy to help pay the out-of-pocket costs associated with their Medicare prescription drug coverage. CMS has overall responsibility for implementing the prescription drug benefit and the Social Security Administration (SSA) was given responsibility for processing the subsidy applications and determining eligibility. Neither CMS nor SSA had a comprehensive source of income data to accurately identify potential beneficiaries.

OIG concluded that legislation is needed to allow CMS and SSA to more effectively identify beneficiaries who are potentially eligible for the subsidy. Specifically, access to Internal Revenue Service earnings data would help CMS and SSA identify beneficiaries most likely to be eligible for the subsidy. The identification of these beneficiaries would allow for a more targeted and effective outreach effort to ensure that all those who qualify for the subsidy receive this important assistance. (OEI-03-06-00120)

Prescription Drug Plan Sponsors' Compliance Plans

Prescription drug plan (PDP) sponsors approved to provide Part D benefits in 2006 are required by Federal regulation to have compliance plans in place. These compliance plans must address eight elements, including a comprehensive fraud and abuse plan. CMS guidance documents state that compliance plans must address 17 requirements regarding the eight compliance plan elements. An OIG review of 79 PDP sponsors found that all had compliance plans, yet 72 of 79 compliance plans did not address 1 or more of the 17 requirements. Further, many compliance plans lacked detail regarding requirements involving compliance processes or programs. Although all compliance plans addressed the fraud and abuse element in some way, only 15 of 79 plans (19 percent) addressed all 11 CMS recommendations regarding fraud detection, correction, and prevention that we included in our review. In addition, many of the plans that addressed recommendations regarding fraud detection, correction, and prevention procedures lacked sufficient detail.

Centers for Medicare & Medicaid Services

OIG recommended that CMS ensure that PDP sponsors' compliance plans address all requirements presented in its fraud, waste, and abuse manual chapter regarding the eight elements set forth in regulation. In addition, CMS should encourage sponsors to provide sufficient detail in their compliance plans to demonstrate clearly how sponsors are actually implementing the compliance plan requirements. CMS concurred with our recommendations. (OEI-03-06-00100)

Carrier Determination of Copayments for Medicare Mental Health Services

OIG found that carriers inconsistently calculated copayments for Medicare Part B mental health claims made in 2003. OIG determined that the difference in Medicare beneficiary copayments for mental health services provided in different geographical areas can be more than double, ranging from 20 percent to 50 percent of the cost of exactly the same mental health service. Medicare carriers did not uniformly apply the outpatient mental health treatment limitation, causing a disparity in beneficiaries' copayments. Among the 57 carrier service areas, OIG identified nine different payment policies for application of the limitation. In addition, OIG found that between 2001 and 2004, carriers were incorrectly applying the mental health treatment limitation to claims for medical management services for beneficiaries diagnosed with Alzheimer's disease and related disorders. As a result, over a 4-year period, Medicare underpaid \$27 million for these services, passing the costs on to beneficiaries as higher copayments.

OIG recommended that CMS issue new guidance to its carriers regarding the limitation, ensure that it is consistently applied among all carriers, and require carriers to adjust the copayments for the beneficiaries who were overcharged. CMS stated that it planned to issue more precise guidance to its carriers; post educational materials to its Web site; and, where feasible, require its carriers to open and adjust incorrectly processed claims. (OEI-09-04-00221)

South Florida Durable Medical Equipment Suppliers' Compliance With Medicare Standards: Results From Unannounced Visits

On the basis of unannounced site visits in 2006 to 1,581 suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in Miami-Dade, Broward, and Palm Beach Counties, OIG found that 31 percent (491) did not maintain facilities or their facilities were not open for business or staffed. As of November 30, 2006, these DMEPOS suppliers billed Medicare for almost \$237 million and were allowed over \$97 million between January 1 and November 30, 2006. OIG referred these suppliers to CMS to consider potential revocation of their Medicare billing numbers. Through unannounced site visits, OIG also found that 14 percent of the suppliers (216) did not meet one of three other Medicare requirements reviewed, such as the need to post hours of operation.

OIG recommended that CMS strengthen the supplier enrollment process for DMEPOS suppliers and ensure that suppliers meet Medicare standards and suggested several specific actions CMS could take to do so. CMS agreed with the recommendations and will consider the options OIG provided to implement them. (OEI-03-07-00150)

Medical Equipment Suppliers: Compliance with Medicare Standards

Of 169 unannounced visits made in late 2005 to suppliers of medical equipment, prosthetics, orthotics, and supplies (DMEPOS), OIG found that 6 percent (10) did not exist at their business addresses, yet billed almost \$393,000 in the 2 months after OIG had determined that they were absent. These out-of-cycle visits, conducted in 27 counties and 10 States, also revealed that six suppliers physically existed but were closed during their posted hours of operation at the time of the site visit. These six collectively billed Medicare almost \$102,000 in the 2 months after OIG discovered that they were closed and received almost \$52,000 in reimbursements as of December 31, 2005.

DMEPOS suppliers undergo site inspections from the National Supplier Clearinghouse on a 3-year cycle at the time of enrollment and reenrollment into the Medicare program. OIG's findings suggest that out-of-cycle site visits of these suppliers may be warranted in other areas of the country to assess compliance with Medicare standards. CMS concurred with OIG's findings and stated it will take more aggressive actions in identifying suppliers who are no longer in business or do not meet basic supplier standards. (OEI-04-05-00380)

Medicare Home Oxygen Equipment: Cost and Servicing

In a study of home oxygen equipment, OIG found that if Medicare rental payments for oxygen were limited to 13 months, the program and its beneficiaries would save approximately \$3.2 billion over 5 years. OIG found that based on the 2006 median fee schedule, Medicare will allow \$7,215 for 36 months for concentrators that cost \$587, on average, to purchase. Beneficiaries will incur \$1,443 in coinsurance. Suppliers commonly provide used concentrators, which can last for several years. If Medicare treated concentrators like capped rental items and limited rental payments to 13 months, the program and its beneficiaries would realize considerable savings. Based on our analysis, minimal servicing and maintenance of concentrators and portable equipment are necessary. Beneficiaries are trained to perform limited routine maintenance on their concentrators, and major manufacturers recommend more comprehensive preventive maintenance annually or after several thousand hours of use. Servicing for portable equipment consists mostly of cylinder deliveries.

OIG recommended that CMS work with Congress to further reduce the rental period for oxygen equipment and determine the necessity and frequency of nonroutine maintenance and servicing for concentrators. In addition, CMS should determine if a new payment methodology is appropriate for portable oxygen. CMS concurred with our recommendations and noted that the President's budget for FY 2007 would reduce the rental period to 13 months. In addition, the CMS proposed rule of August 3, 2006, addresses our recommendations regarding nonroutine maintenance and servicing for concentrators and the payment methodology for portable oxygen. (OEI-09-04-00420)

Hospital Wage Data

In a summary report on 21 hospitals' cost reports, OIG found wage data totaling \$377.9 million that did not comply with Medicare requirements. Under the acute care hospital inpatient prospective payment system, CMS adjusts the Medicare base rate paid

to participating hospitals by the wage index applicable to the area in which the hospital is located. CMS updates wage indexes annually based on data that hospitals include in their cost reports. However, the 21 hospitals reported unallowable, misstated, unsupported, and misclassified wages and other costs, as well as related hours. As a result, 17 of the 21 hospitals overstated their average hourly wage rates, and the remaining 4 hospitals understated their rates.

Generally, hospitals that overstate wage data will receive higher Medicare reimbursement at the expense of hospitals that report accurate or understated wage data. The inclusion of unallowable costs in cost reports can also compromise the reliability of the wage data that CMS uses to develop the market basket index and labor-related share. CMS uses the labor-related share in conjunction with the wage index to determine the geographic adjustment for hospital payments. OIG therefore recommended that CMS develop a corrective action plan to address hospital reporting errors and offered specific steps for CMS's consideration. CMS generally agreed and provided information on actions already taken to address hospital reporting errors.

Included in OIG's summary report were reviews of five hospitals in California that inaccurately reported wage data on pension and postretirement benefit costs in their FY 2004 Medicare cost reports. These data were overstated by a total of approximately \$312.4 million. OIG recommended that the hospitals submit revised cost reports to correct the inaccurate data and ensure that the wage data reported in future cost reports are accurate, supportable, and in compliance with Medicare requirements. The hospitals generally disagreed. (A-01-05-00504, A-09-06-00024, A-09-06-00025, A-09-06-00026, A-09-06-00027, A-09-05-00039)

Oversight and Evaluation of the Hospital Payment Monitoring Program

In a review of the FY 2006 Hospital Payment Monitoring Program (HPMP), OIG found that CMS had ensured that the clinical data abstraction contractor and the quality improvement organizations had appropriate controls to ensure that sampling procedures, admission-necessity and diagnosis-related group (DRG) validation screenings, and quality control reviews followed established procedures and operated effectively. In addition, CMS informed OIG of several actions that it had taken toward initiatives to reduce the HPMP error rate. CMS and its HPMP contractors have taken appropriate action on the recommendations in OIG's FY 2005 audit report. (A-03-06-00010)

Oversight and Evaluation of the Comprehensive Error Rate Testing Program

In a review of the FY 2006 Comprehensive Error Rate Testing (CERT) program, OIG found that CMS had ensured that its two CERT contractors had appropriate controls to ensure that medical and quality assurance reviews and initial and follow-up document requests followed established procedures and operated effectively. In addition, CMS described several actions it had taken toward initiatives to reduce the CERT error rate. CMS and the contractors have taken appropriate action on the recommendations in OIG's FY 2005 audit report. (A-03-06-00011)

Postretirement Benefit Costs Claimed by Medicare Contractors

OIG found that two Medicare contractors claimed unallowable costs for postretirement benefit (PRB) costs. Medicare reimburses a portion of the annual contributions that contractors make to their PRB plans. In claiming costs, contractors must follow cost reimbursement principles contained in the Federal Acquisition Regulation, Cost Accounting Standards, and Medicare contracts.

One Medicare contractor claimed nearly \$3.6 million in unallowable pension costs for the period subsequent to its termination. The claim, submitted in August 2004, represented a retroactive change in the accounting basis, an immediate recognition of the transition obligation, and a request for reimbursement of unfunded costs. None of these costs are allowable under the Federal Acquisition Regulation; therefore they were unallowable for Medicare reimbursement. The contractor disagreed. (A-07-06-00210)

Another Medicare contractor claimed \$3.1 million of unallowable pension costs for FYs 1991 through 2004 because it did not claim the costs in accordance with the Medicare contracts. OIG recommended that the contractor revise its Final Administrative Cost Proposals to reduce claimed pension costs by \$3.1 million and claim future pension costs in accordance with the Medicare contracts. The contractor disagreed in part but did agree to reduce its pension costs by \$2.7 million. (A-07-06-00209)

Potential Duplicate Payments Identified by a CMS Recovery Audit Contractor

OIG found that none of the duplicate payments identified by a California recovery audit contractor (RAC) were in fact duplicates. The RAC had identified 241 duplicate Medicare inpatient hospital claims totaling \$11.3 million while performing work as part of a CMS demonstration project mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

OIG recommended that CMS consider the performance of the RAC when reporting to Congress on the demonstration project's impact on Medicare savings and on CMS's decision to expand the project. CMS concurred with the recommendation. (A-03-06-00004)

Fee-for-Service Payments for Medicare Beneficiaries Enrolled in Managed Care Risk Plans

OIG found that fiscal intermediaries did not always comply with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare managed care organization (MCO) beneficiaries. The intermediaries incorrectly paid 803 fee-for-service inpatient claims totaling \$4.6 million in calendar years 2003 and 2004 for costs that CMS had already reimbursed as part of the capitation payments it makes to the MCOs for all medically necessary services, including inpatient services. These payments occurred because enrollment data were not always correctly updated from the Group Health Plan system, which should contain information on every Medicare beneficiary enrolled in an MCO, to the Common Working File, which should contain eligibility information for every Medicare beneficiary.

Centers for Medicare & Medicaid Services

OIG recommended that CMS direct the fiscal intermediaries to recoup \$4.6 million of duplicate payments and periodically compare the Group Health Plan with the Common Working File, reconcile any discrepancies in enrollment data, and have the fiscal intermediaries take necessary action on apparent duplicate payments. CMS agreed. (A-07-05-01016)

Inpatient Rehabilitation Facility Claims

OIG found that, during FY 2003, inpatient rehabilitation facilities (IRF) did not always code claims as “discharged to home with home health agency services” in compliance with Medicare’s transfer regulation. Nationwide, OIG identified 585 IRF claims coded and paid as discharges to home with home health agency services that potentially should have been paid as transfers. Medicare pays a lesser amount for a transfer than a discharge to home. Four IRFs that were responsible for 44 of the 585 claims identified verified that all 44 sampled claims should have been coded as transfers. OIG repriced a sample of 100 of the 585 claims and estimated that potential overpayments to IRFs totaled approximately \$2.3 million in FY 2003.

OIG recommended that CMS instruct the fiscal intermediaries to review the claims in question and to recover, as appropriate, the estimated \$2.3 million in overpayments; instruct the fiscal intermediaries to review claims paid after OIG’s audit period for possible coding errors; and implement edits in the Common Working File to identify potentially miscoded claims. CMS concurred with the recommendations. (A-04-04-00013)

Medical Review of a Rehabilitation Facility’s Services for Medicare Outlier Claims

OIG found that an IRF submitted outlier claims that did not meet Medicare requirements. Of the 100 sampled outlier claims, 69 included services that were not medically necessary, reasonable, or adequately documented. As a result, the IRF received approximately \$1.6 million in unallowable Medicare payments. Based on the sample results, OIG estimated that Medicare overpaid the IRF approximately \$3.3 million for outlier claims for 2002.

OIG recommended that the IRF refund approximately \$3.3 million; work with its fiscal intermediary to identify and refund overpayments for subsequent years’ IRF outlier claims; and ensure that its procedures provide reasonable assurance that beneficiaries admitted for IRF services are in need of treatment at the IRF level of care, capable of significant practical improvement, able to participate in intensive rehabilitation, and medically stable. The IRF disagreed with the results of the medical determinations and with many other aspects of the review. (A-04-04-00010)

Place-of-Service Coding for Physician Services

OIG found that physicians in five States incorrectly coded 81 of the 100 sampled claims submitted to one carrier for calendar years 2002 and 2003 by using the office place-of-service code, even though they performed the services in another setting. Medicare Part B pays a higher amount for services that physicians provide in their offices instead of an outpatient center of a hospital or an ambulatory surgical center.

As a result of incorrect coding, the carrier overpaid the physicians \$5,400 for the sampled claims. Based on the sample results, OIG estimated that the carrier overpaid physicians \$4.3 million for incorrectly coded services during the audit period.

OIG recommended that the carrier recover the \$5,400 in overpayments for the sampled services, review the estimated \$4.3 million in incorrectly coded services and recover any overpayments, reemphasize to physicians and their billing agents the importance of correctly reporting the place of service, and work with the program safeguard contractor to identify services at high risk for miscoding and recover resulting overpayments. The carrier generally agreed to implement the recommendations. (A-01-06-00502)

Graduate Medical Education for Dental Residents

OIG found that a hospital in Texas inappropriately included dental residents in its direct and indirect full-time-equivalent (FTE) counts used to compute FY 2002 graduate medical education (GME) payments. The Medicare program makes payments to teaching hospitals to support GME programs for physicians and certain other practitioners. The payments, which cover both direct and indirect GME costs, are based in part on the number of FTE residents that the hospitals train.

In this case, the hospital included FTEs for dental residents not in an approved residency program and for dental residents who had exceeded their initial residency period. As a result, the hospital overstated its FY 2002 GME claims by nearly \$20,000.

OIG recommended that the hospital file amended cost reports, institute procedural improvements, determine whether similar errors occurred in Medicare cost reports after FY 2002 and refund any overpayments, and work with CMS to resolve payments related to the didactic time of residents assigned to nonhospital settings. The hospital agreed. (A-04-04-06004)

Medicare Part B Services for Nursing Home Residents: 2002

In this memorandum report, OIG described Medicare Part B services and analyzed Medicare payments for nursing home residents not in a Medicare Part A covered stay during calendar year 2002. Previous studies by OIG have determined that Medicare Part B payments for beneficiaries residing in nursing homes are particularly vulnerable to fraud and abuse. In this review, OIG found that Medicare allowed \$5.3 billion for Part B services provided to 1.8 million nursing home residents who were not in a Part A-covered stay in 2002. The \$5.3 billion represents 5 percent of the total amount that Medicare allowed for all Part B services during CY 2002. Ten categories of service account for 79 percent of payments for Part B services for nursing home residents. In addition, payments varied by State for each of the top 10 categories. Building on this work, OIG plans to assess more current data to help identify potential patterns and areas of questionable billing. As appropriate, OIG will review identified areas to establish the extent of excessive or duplicative payment and recommend controls to minimize or alleviate these payments. (OEI-05-06-00240)

Medicare Contractor Information Security

In accordance with the MMA, OIG reviewed the FY 2004 independent evaluations of all 33 Medicare fiscal intermediaries and carriers and reported to Congress on the areas in which the contractors did not meet information security requirements. OIG's report included the results of the contractor information security program evaluations and the results of the data center technical assessments.

The information security program evaluations identified a total of 217 security gaps, which are differences between Federal information security requirements and the contractors' implementation of those requirements. Most of the gaps occurred in the areas of continuity-of-operations planning, security programs and system security plans, policies and procedures to reduce risk, security awareness training, incident response, and testing of information security controls. In addition, technical assessments of the 14 data centers that operate claims-processing systems identified a total of 412 security gaps. Most of these gaps occurred in the areas of access controls, organizational practices, physical security, and personnel security. CMS generally agreed with OIG's conclusions. (A-18-05-02600)

California's Section 1115 Medicaid Demonstration Project Extension for Los Angeles County

OIG found that during FYs 2001 through 2004, California followed the requirements of a Medicaid extension agreement with CMS when claiming Federal Ambulatory and Supplemental funds and adequately supported costs claimed for outpatient clinic services under both components. However, Los Angeles County could not identify approximately \$285.2 million (Federal share) in claimed Supplemental expenditures with specific costs incurred. The agreement with CMS extended the federally funded Los Angeles County demonstration project under section 1115 of the Social Security Act.

Although the extension agreement did not require that claimed Supplemental expenditures be based on specific costs incurred, there was no assurance that the county would use the Supplemental funding for the intended purposes without such a requirement. County documentation indicated that the Supplemental disbursements had contributed to a county reserve fund of approximately \$306.4 million.

Given OIG's finding that the county placed a significant portion of Federal funds in a reserve account, OIG recommended that CMS, in future demonstration project agreements with California and the county, deny or limit such use of Federal funds. OIG also recommended that if CMS approves future section 1115 agreements, it require documentation by the State and county for claimed expenditures. CMS agreed with the recommendations. (A-09-04-00038)

Medicaid Eligibility

In three States, OIG determined whether Medicaid beneficiaries met Federal and State eligibility requirements and the States provided adequate documentation of eligibility determinations for payments made from January 1 through June 30, 2005.

■ **New York State** made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements. Furthermore, the State did not always adequately document all eligibility determinations. Based on its sample results, OIG estimated that New York made more than 4.2 million payments totaling \$230.4 million (Federal share) on behalf of ineligible beneficiaries. In addition, OIG estimated that case file documentation did not adequately support eligibility determinations for an additional 15.3 million payments totaling \$2.8 billion (Federal share).

OIG did not recommend recovery because a disallowance may occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program. However, OIG recommended that New York use the results of this review to help ensure compliance with Federal and State Medicaid eligibility requirements. Specifically, New York should reemphasize to beneficiaries the need to provide accurate and timely information and require district office employees to verify eligibility information and maintain appropriate documentation in all case files. In its comments, New York described actions being taken to help ensure compliance with Federal and State Medicaid eligibility requirements but disagreed with some of OIG's specific findings. (A-02-05-01028)

■ **California** made some Medicaid payments on behalf of beneficiaries who did not meet Federal and State eligibility requirements and did not ensure that the county offices adequately documented all eligibility determinations. Based on its sample results, OIG estimated that California made 4.7 million payments totaling \$133 million (Federal share) on behalf of ineligible beneficiaries. OIG also estimated that case file documentation did not adequately support eligibility determinations for an additional 2.5 million payments totaling \$117 million (Federal share).

OIG did not recommend recovery because a disallowance may occur only if the errors are detected through a State's Medicaid Eligibility Quality Control program. OIG recommended that California use the results of the review to help ensure compliance with Federal and State Medicaid eligibility requirements. California agreed with the recommendation. (A-09-06-00028)

■ **Florida** generally made Medicaid payments on behalf of beneficiaries who met Federal and State eligibility requirements and provided adequate documentation of eligibility determinations. OIG recommended that Florida use the results of the review to help ensure continued compliance with Federal and State Medicaid eligibility requirements. Florida agreed with the recommendation. (A-04-06-00020)

Medicaid School-Based Health Claims

OIG found that two States claimed unallowable costs for Medicaid school-based health services. The Medicaid program allows reimbursement for covered health-related services provided in a school setting under the Individuals with Disabilities Education Act, as well as associated administrative costs. Because both non-Medicaid- and Medicaid-eligible students benefit from administrative activities associated with school-based health services, the service costs must be allocated between the groups. States use proportional Medicaid share ratios to ensure that they claim only costs related to Medicaid-eligible children.

Results of the State audits follow:

■ **Minnesota** used incorrect proportional Medicaid share ratios, included indirect costs that were allocable to non-Medicaid grants, and used inaccurate cost reports. As a result, \$9.7 million of the \$13.4 million Federal share claimed in State FY 2004 for the 60 sampled school districts was unallowable.

OIG recommended that Minnesota refund the \$9.7 million, use correct proportional Medicaid share ratios, and make other procedural improvements. Minnesota disagreed with the recommendations. (A-05-05-00040)

■ **Nevada** claimed \$5.8 million for unallowable school-based administrative expenditures for calendar years 2003 and 2004. In addition, it claimed \$775,000 for the summer quarter of 2004, but because the State did not conduct a timestudy for the quarter, OIG was unable to express an opinion on the claim. Finally, Nevada allowed confidential data to be released to a contractor without written assurance that the information would be adequately safeguarded.

OIG recommended that Nevada refund \$5.8 million, review claims subsequent to the audit period and refund any unallowable costs, ensure that it claims Federal funds only for expenditures that are allowable and supported, require school districts to conduct timestudies during summer quarters and work with CMS to determine the allowability of the \$775,000, and ensure that confidential health data are safeguarded. Nevada generally agreed with the recommendations. (A-09-05-00054)

Medicaid Outpatient Drug Expenditures in Nebraska

OIG found that Nebraska had not fully complied with Federal requirements in claiming costs for Medicaid outpatient drugs. For FYs 1998 through 2004, the State claimed \$13 million in duplicate Medicaid expenditures for drugs. OIG determined that the State had refunded approximately \$12.8 million of the \$13 million associated with the duplicate payments but had not refunded \$295,000 as of the end of OIG's fieldwork. For FYs 2003 and 2004, the State claimed \$267,000 in unallowable expenditures for drugs that were terminated, less than effective or inadequately supported, and \$609,000 for drugs not listed on the quarterly drug tapes provided by CMS. These latter expenditures may not be allowable for Medicaid reimbursement because the State had not verified whether drugs missing from the tape were covered by Medicaid. Under the Medicaid drug rebate program, CMS provides the States with a quarterly drug tape listing all covered outpatient drugs, and States are to use the tape to verify coverage of the drugs for which they claim reimbursement.

OIG recommended that Nebraska refund \$562,000 for duplicate and unallowable Medicaid drug expenditures, work with CMS to resolve payments for drugs that were not listed on the quarterly drug tapes, and strengthen its internal controls. Nebraska concurred with the recommendations. (A-07-05-04056)

Arkansas Reporting of Medicaid Overpayments Collected by Contractors

OIG found that Arkansas did not fully report overpayments collected by contractors in accordance with Federal requirements during the period October 1, 2000, through April 30, 2005. Specifically, the State did not report approximately \$3.7 million (\$2.7 million Federal share) in overpayments and reported approximately \$6.6 million (\$4.9 million Federal share) in overpayments in an untimely manner. State contractors collected and deposited these overpayments in a cash holding account, but the State agency did not report the Federal share of any interest earned on funds held in this account.

OIG recommended that Arkansas report the \$3.7 million to CMS and refund the \$2.7 million Federal share, determine the Federal share of any interest earned on the overpayments and refund that amount, and ensure that all future overpayments are reported in accordance with Federal requirements. The State agreed. (A-06-06-00023)

Selected States' Medicaid Payments for Services Claimed To Have Been Provided to Deceased Beneficiaries

OIG found that providers in 8 of 10 audited States received an estimated total of \$27.3 million (\$15.1 million Federal share) in Medicaid overpayments, which the States never recovered, for services claimed to have been provided after beneficiaries' deaths. Prepayment screening by some States did not successfully identify the overpayments because the States did not use all available information sources to identify deceased beneficiaries, and their payment systems had data entry, matching, and processing problems. Furthermore, postpayment screening did not identify all overpayments associated with deceased beneficiaries.

OIG recommended that CMS work with States to ensure that they use all available data sources to identify deceased beneficiaries, match those data against paid claims files and recover identified overpayments, and encourage States to establish postpayment reviews to mitigate the effect of delays in receiving data regarding beneficiaries' dates of death. CMS concurred with the recommendations. (A-05-05-00030)

Medicaid Reimbursement for Distinct-Part Nursing Facilities in California

In a review of three distinct-part nursing facilities in California, OIG determined that the State properly established the three facilities' eligibility for additional reimbursement; however, the State did not claim additional Federal reimbursement amounts for two of the facilities in accordance with State and Federal requirements. As a result, California was overpaid \$3.6 million. A distinct-part nursing facility is a nursing facility that is part of a hospital and is certified to provide skilled nursing services. Eligible facilities may receive additional Medicaid reimbursement for the Federal share of certified public expenditures in excess of their per diem payments.

OIG recommended that the State refund \$3.6 million, review additional reimbursement amounts paid to the selected facilities subsequent to the audit period and refund any overpayments, provide instructions to all facilities to ensure that expenditures are properly calculated, and strengthen its monitoring procedures. The State agreed in part with the recommendations. (A-09-05-00050)

States' Requirements for Medicaid-Funded Personal Care Service Attendants

OIG found that States have established multiple sets of attendant requirements that often vary among programs and by delivery models within programs, resulting in 300 sets of attendant requirements nationwide. The Medicaid State Manual requires States to develop qualifications for attendants who provide care to Medicaid beneficiaries; it does not list specific qualifications but offers examples of requirements States may establish to ensure that attendants provide high quality personal care.

Because States had established different requirements for various programs and/or delivery models, attendants may need to meet different requirements depending on the programs and delivery models through which they are serving beneficiaries. Only seven States applied uniform requirements to all the programs within that State, and there were five programs nationwide using the consumer-directed delivery model that had no requirements. The six most commonly established requirements for attendants included background checks, training, supervision, age, health, and education/literacy. However, States defined these requirements differently and used them in different combinations. Of the 300 requirement sets, 245 included a background check, 227 included training, 218 included minimum age, 197 included supervision, 161 included health, and 124 included literacy or education.

Most States were monitoring compliance with these attendant requirements on two levels. First, States delegated responsibility for ensuring that attendants met requirements to another entity (e.g., home health or personal care service agency, beneficiary, case manager). Second, the State retained direct responsibility by ensuring that the entities with primary responsibility fulfilled their oversight duties. (OEI-07-05-00250)

Medicaid Provider Enrollment Standards: Medical Equipment Providers

In a study of 15 States, OIG found that States employed a variety of provider enrollment standards to safeguard their Medicaid durable medical equipment (DME) programs. Such standards included licensure of providers, posting a sign and hours of operation, and obtaining surety bonds. We found that only seven of the States required Medicaid providers to enroll as providers in the Medicare program, which subjects Medicaid providers in these States to Medicare standards. The remaining eight States did not require providers to enroll in the Medicare DME program.

Despite the presence of standards, we found that most of the 15 States were not routinely verifying whether providers met all State DME provider enrollment standards, and 7 of the 15 States were not conducting routine site visits at initial enrollment. Finally, only 6 of the 15 States reported that they either routinely reenrolled providers or had recent initiatives to reenroll providers to ensure all met the provider enrollment standards. (OEI-04-05-00180)

Preadmission Screening and Resident Review for Younger Nursing Facility Residents With Serious Mental Illness

OIG reviewed the extent to which Preadmission Screening and Resident Review (PASRR) requirements were addressed for Medicaid nursing facility residents with serious mental illness aged 22 to 64 in 20 facilities in five selected States. OIG found

that almost all sampled residents with serious mental illness had a Level I screen that met all Federal requirements. Two-thirds of sampled residents had evidence of a Level II PASRR. Only 5 percent of these Level II PASRRs met all Federal requirements. For sampled residents who received a Level II PASRR, 85 percent received mental health service recommendations. Thirty-three percent had all the recommended services in their nursing facility care plan. Federal regulations require the consideration of alternative placements to nursing facilities during the Level II PASRR. OIG found that only two of five selected States' Level II PASRR evaluation forms prompt evaluators to consider community-based placements. Lastly, OIG found that, while all five selected States monitor aspects of the PASRR process, CMS provides limited oversight.

OIG recommended that CMS hold State Medicaid agencies accountable for ensuring compliance with Federal requirements, hold States accountable for considering community placements during the Level II PASRR process, and revise survey and certification requirements to ensure systematic oversight of the PASRR. CMS concurred with all OIG recommendations. (OEI-05-05-00220)

Preadmission Screening and Resident Review for Younger Nursing Facility Residents With Mental Retardation

OIG reviewed the extent to which PASRR requirements were addressed for Medicaid nursing facility residents aged 22 to 64 with mental retardation within 20 nursing facilities in five selected States. OIG found that while Level I screens were present in 88 percent of selected resident case files, one-fourth of these were completed late. Fifty-two percent of selected resident case files contained neither a Level II evaluation nor a Level II determination. Additionally, 22 percent of sampled Level II evaluations did not contain evidence that the evaluator assessed whether the individual's total needs could be met in a community setting. Lastly, we found that CMS and the survey and certification agencies in the five States we reviewed conducted limited oversight.

OIG recommended that CMS hold State Medicaid agencies accountable for ensuring compliance with Federal requirements, hold States accountable for considering community placements during the Level II PASRR process, and revise survey and certification requirements to ensure that State surveyors sample residents with mental retardation and review the PASRR documentation for timely completion. CMS concurred with all OIG recommendations. (OEI-07-05-00230)

Review of the Centers for Medicare & Medicaid Services' Medicaid Financial Management Oversight

Under a contract with OIG, Ernst & Young (E&Y) reviewed the current CMS management structure, examined prior studies and audits, compared the financial management structures and activities of Medicare to those of Medicaid, held discussions with various stakeholders, and analyzed the issues identified through these activities. The E&Y report contains a series of findings, conclusions, and recommendations for improving the financial management of the Medicaid program. (OEI-06-04-00480)

CMS Financial Statement Audit

The CMS FY 2006 financial statements received an unqualified audit opinion, which means that the statements were fairly presented in accordance with generally accepted

accounting principles. However, auditors identified a material weakness in CMS's Medicare electronic data processing. This material weakness was based on a number of specific deficiencies. For example, numerous security weaknesses would allow internal users to access and update Medicare claims data without proper authorization. (A-17-06-02006)

Outreach

As part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry, OIG has continued to issue advisory opinions and other guidance.

Advisory Opinions

In accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), OIG, in consultation with the Department of Justice, issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. This authority allows OIG to provide case-specific formal guidance regarding the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. For the period October 1, 2006, through March 31, 2007, OIG received 31 advisory opinion requests and issued 11 advisory opinions.

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG established a set of comprehensive guidelines for voluntary self-disclosure, titled "Provider Self-Disclosure Protocol," available on the Internet at <http://www.oig.hhs.gov> in the Fraud Prevention & Detection section under "Self-Disclosure Information."

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that appear to constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments). After making an initial disclosure, the provider or supplier is expected to undertake a thorough internal investigation of the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action.

During this reporting period, self-disclosure cases resulted in \$3.8 million in HHS receivables. For example:

■ **Connecticut** – Following a self-disclosure filed pursuant to OIG's Provider Self-Disclosure Protocol, Danbury Hospital, Inc., agreed to pay the Government \$2.3 million and enter into a 3-year certification of compliance agreement (CCA). Danbury, a 371-bed not-for-profit hospital, resolved its liability for allegedly causing improper assignment of DRG codes on claims for inpatient stays from October 2000 to September 2003. As a result of the improper DRG codes, Danbury received payments from Medicare in excess of what it was entitled to receive. OIG agreed to a 3-year CCA

after an extensive review of Danbury's compliance program showed, among other measures, that it has taken considerable steps to ensure that such coding issues do not occur in the future.

■ **Georgia** – Gwinnett Hospital System, Inc., agreed to pay \$18,000 to resolve its liability under the Civil Monetary Penalties Law (CMPL). In a matter reported under OIG's Provider Self-Disclosure Protocol, the agreement resolves Gwinnett's liability in connection with its employment of an excluded staff pharmacist at Gwinnett Medical Center from February 28 to June 18, 2002. The pharmacist had been excluded for a period of 5 years but did not apply for and receive reinstatement until June 18, 2002. The hospital did not have a screening process in place at the time the staff pharmacist was hired, and the pharmacist was not identified as having been excluded until December 2005. As part of the agreement, for 3 years Gwinnett will submit to OIG an annual certification that it has policies and procedures in place to prevent hiring or contracting with any excluded individuals and will perform at least an annual screening of current employees and contractors.

Federal and State Partnership: Joint Audits of Medicaid

Another major OIG outreach initiative has been to work closely with State auditors in reviewing the Medicaid program. To this end, a partnership plan was developed to foster joint reviews and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 25 States.

Reports issued to date have resulted in identification of more than \$260 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

Office of Inspector General Administrative Sanctions

During this reporting period, OIG administered 1,289 sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. A brief explanation of OIG's sanction authorities can be found in Appendix C.

Program Exclusions

During this reporting period, OIG excluded 1,278 individuals and entities from participating in Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. Examples include the following:

■ **New Jersey** – A registered nurse (RN) was excluded for a minimum period of 95 years based on his conviction on multiple counts related to patient abuse or neglect. The RN was sentenced to multiple consecutive life sentences for the murder and the attempted

murder of patients under his care. In addition, his nursing license was revoked in the States of New Jersey and Pennsylvania.

■ **Florida** – A physician was excluded for a minimum period of 70 years based on her conviction related to a prescription drug fraud scheme that resulted in the death of one of her patients. From April 1998 through March 2002, the physician prescribed controlled substances that were not medically necessary. One of the physician's patients died of a drug overdose in 2001. The physician was sentenced to 50 years' incarceration. She surrendered her license to practice medicine in the State of Florida.

■ **California** – An owner of a counselling center was excluded for a minimum period of 28 years based on his conviction regarding a theft and Medi-Cal fraud scheme that occurred from May 1996 to November 2004. The subject was sentenced to 365 days in jail and ordered to pay approximately \$2.5 million in restitution.

Also in California, a nursing assistant was excluded for a minimum period of 15 years based on his conviction related to patient abuse or neglect. The subject committed a sex act on a patient who, at the time, was incapable of giving consent. The subject was sentenced to 8 years' incarceration and the State revoked his license.

Civil Monetary Penalties Law

The CMPL authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits claims to a Federal health care program that the person knows or should know are false or fraudulent. During this reporting period, OIG collected over \$932,000 in civil monetary penalties and assessments. The following is among the civil monetary penalties actions resolved during this reporting period:

■ **Tennessee** – Williamson County Hospital District, doing business as Williamson Medical Center, agreed to pay \$705,000 to resolve its liability under the CMPL for its improper lease arrangements with physicians. In a matter self-disclosed to OIG, Williamson had lease arrangements with the owners of a medical office building adjacent to the hospital from 1995 to 2001. The lease agreements contractually required Williamson to pay for vacant office space. The subsequent investigation revealed that Williamson leased numerous office suites at above fair market value and sublet the space to physicians at below fair market value, in potential violation of the Stark Law and the anti-kickback statute.

Patient Dumping

Of the total civil monetary penalties OIG collected between October 1, 2006, and March 31, 2007, \$80,000 represents collections from three hospitals under the Emergency Medical Treatment and Labor Act, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements involving alleged violations of that statute:

■ **Puerto Rico** – Hospital Hermanos Melendez paid \$30,000 to resolve allegations that it failed to provide an appropriate medical screening examination and/or stabilizing treatment to two individuals who presented to its emergency department. The first

individual (2 months old, born prematurely and having recently left a pediatric intensive care unit), presented with anemia and potential bronchitis. The second individual (3 years old) complained of vomiting after falling from a bed.

■ **California** – Sierra Kings District Hospital paid \$15,000 to resolve allegations that it failed to provide an appropriate medical screening exam, stabilizing treatment or an appropriate transfer of an 81-year-old man. He presented to the emergency department complaining of nausea, diarrhea, burning on urination, right upper quadrant pain and shortness of breath. He was seen by a physician and discharged home. Two days later he became unconscious and was diagnosed with urosepsis, pneumonia, and cerebral vascular accident. He died 4 days later.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the civil False Claims Act (FCA). A description of these enforcement authorities can be found in Appendix C. The successful resolution of such matters often involves the combined investigative efforts and resources of OIG, the Federal Bureau of Investigation (FBI), Medicaid Fraud Control Units, and other law enforcement agencies.

OIG has the responsibility of assisting the Department of Justice in bringing and settling cases under the FCA. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter integrity agreements with OIG to avoid exclusions and to be permitted to continue participating in Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent activities.

During the semiannual period ending March 31, 2007, the Government's enforcement efforts resulted in \$1.3 billion in HHS investigative receivables, representing civil and administrative settlements or civil judgments related to Medicare, Medicaid, and other Federal health care programs. Some of those successful actions, as well as notable criminal enforcement actions, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Hospitals

■ **Washington, DC** – Tenet Healthcare Corporation, operator of the Nation's second largest hospital chain, entered into a global civil settlement to resolve a number of allegations of unlawful billing practices, improper outlier payments, kickbacks, and other conduct. Tenet agreed to pay the Government \$900 million plus interest and enter into a 5-year CIA to resolve its liability under the FCA and related authorities. Over \$788 million of the settlement is attributable to claims related to outlier payments that were based on inflated charges Tenet billed for inpatient and outpatient care. More than \$47 million will resolve Tenet's liability for allegedly paying a kickback to physicians for

patient referrals and for billing Medicare for services that were ordered or referred by a physician with whom Tenet had a financial relationship. Another \$46 million is attributed to allegations that to increase its reimbursements, Tenet submitted claims that assigned DRG codes that were improper or were not supported by patient records, a practice known as “upcoding.”

As part of the resolution of its civil and administrative liability, Tenet agreed to a 5-year CIA in September 2006. Under the CIA, Tenet will implement a comprehensive compliance program and engage independent review organizations to review its DRG claims, outlier payments, physician relationships, and clinical quality management. The CIA also includes unprecedented provisions requiring the Quality, Compliance and Ethics Committee of Tenet’s Board of Directors to review and inform OIG of the effectiveness of Tenet’s compliance program.

■ **Louisiana** – Our Lady of Lourdes Regional Medical Center, Inc. (OLOL) agreed to pay the Government \$3.8 million and enter into a 5-year CIA to resolve its liability under the False Claims Act. The Government alleged that between May 1999 and November 2003, OLOL submitted claims to the Medicare, Medicaid, and TRICARE programs for interventional cardiac procedures, such as angioplasty and angiograms performed by one of its physicians, which were determined to be medically unnecessary.

Prescription Drugs

■ **Illinois** – Pursuant to a qui tam complaint, Omnicare, Inc., a nationwide institutional pharmacy that services exclusively nursing home patients, agreed to pay \$49.5 million and enter into a 5-year CIA to resolve its liability under the False Claims Act. The Government alleged that Omnicare improperly substituted Ranitidine capsules for the tablet form of Ranitidine – the generic version of the drug commercially known as Zantac. An investigation revealed that Omnicare also allegedly switched drug forms of Fluoxetine and Bupropion. The switches were allegedly made to avoid Federal upper limits placed by CMS on certain forms of each drug and did not comply with State “lowest price” requirements. Thus, the improper switches cost Medicaid and the Federal Government approximately \$26 million more than if the drugs had not been switched. The CIA requires Omnicare to develop a centralized process to implement “therapeutic interchanges” taking into account prices to payors and therapeutic attributes of the switched drugs.

■ **Ohio** – A pain management physician convicted in a jury trial was sentenced to life in prison and ordered to pay \$14.3 million in restitution for health care fraud resulting in death. He was additionally sentenced to 20 years in jail for illegal drug distribution, mail fraud, wire fraud, and health care fraud. The investigation revealed that the doctor conducted unnecessary and painful procedures on patients in exchange for prescriptions for narcotic drugs. In turn, the physician submitted claims to health care benefit programs falsely indicating that he performed multiple complex procedures such as nerve block or epidural injections. Many of the patients endured painful treatments because they were addicted to drugs, while other patients, who initially had legitimate injuries, fell victim to the physician’s scheme and became addicted. Two of his patients died of

drug overdoses in 2001. The physician is subject to supervised release and deportation if his life sentence is overturned.

Transportation

■ **Texas** – American Medical Response, Inc. (AMR) agreed to pay \$9.2 million and enter into a 5-year CIA to resolve its liability under the FCA. AMR allegedly entered into contracts known as “swapping arrangements” with certain Texas hospitals in violation of the anti-kickback statute. The Government alleged that from January 1994 through December 2001, AMR gave discounts to certain Texas hospitals on their facility-responsible transports in exchange for all or some of the hospitals’ nonemergency transports for patients being discharged.

Practitioners

■ **Florida** – A former dermatologist was sentenced to 22 years in prison, ordered to pay \$3.7 million in restitution, forfeit an additional \$3.7 million, and pay a \$25,000 fine for performing 3,086 medically unnecessary surgeries on 865 Medicare beneficiaries. The dermatologist was found guilty of health care fraud and false statements following a 4-week trial that showed that the doctor routinely falsely diagnosed patients with skin cancer in order to bill Medicare for expensive and unnecessary invasive surgeries. The dermatologist established an internal laboratory in his office so no one other than he reviewed specimens for diagnosis. From 1998 through 2004, a detailed analysis showed that nearly all the biopsies that he performed were diagnosed as cancer and resulted in invasive surgeries. In fact, some of the specimens that he diagnosed as skin cancer were actually slides which contained chewing gum, Styrofoam, or skin tissue of his employees. During the trial, it was also revealed that the doctor had established a quota whereby he performed five surgeries each day for which Medicare paid between \$1,500 and \$2,000 per surgery.

Also in Florida, a physician was sentenced to 46 months in prison and ordered to pay \$2.3 million in joint and several restitution for her involvement in a massive kickback scheme involving pharmacies, medical equipment companies, and Medicare beneficiaries. The investigation revealed that the physician entered into improper relationships with owners of DME companies. The owners brought “patients” to the physician and specified which equipment and medications they wanted her to prescribe. The physician performed cursory examinations of patients and then signed the prescriptions for equipment and medications regardless of medical necessity. The physician received cash kickbacks from the DME company owners based on the reimbursement rate for the item or medication prescribed. In addition to the sentencing of the physician, several DME company owners had previously been sentenced for their roles in the scheme, including one who was sentenced in June 2006 to 46 months in prison and ordered to pay \$674,000, a portion of the joint and several restitution amount.

■ **Michigan** – Three physicians and their medical practice agreed to pay \$1 million to resolve their False Claims Act liability. The Government alleged that, from January 1996 through December 2004, the defendants billed Medicare for medical services performed

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by nurse practitioners, clinical nurse specialists, and physician assistants as though the services were performed by physicians. The three physicians agreed to enter individual integrity agreements and the medical practice entered into a comprehensive CIA.

■ **Pennsylvania** – A physician specializing in cardiology agreed to pay the Government \$435,000 and enter into a 5-year integrity agreement to resolve his liability for submitting false claims to Medicare, Medicaid, and the Federal Employees Health Benefits Program from October 1997 through October 2002. The physician allegedly submitted claims for consultation services that were not supported by patient medical records or that did not meet the criteria of a consultation. The Government also alleged that he submitted false claims for evaluation and management services when he had already received payment for such services in connection with his claims for nuclear stress testing.

■ **Texas** – A licensed speech therapist was sentenced to 5 years' probation and ordered to pay \$355,000 in restitution for defrauding the Medicaid program and the State Children's Health Insurance Program. The investigation revealed that from March 1998 through February 2003, the speech therapist submitted claims indicating that she provided one-on-one speech therapy when she actually provided group speech therapy.

Clinics

■ **Tennessee** – Dialysis Clinic, Inc. (DCI) agreed to pay \$1.8 million to resolve its liability under the FCA, the CMPL, and the OIG's permissive exclusion authority. DCI provides health care services to Medicare beneficiaries with end stage renal disease at its clinics located in more than 30 states. The settlement resolved conduct related to DCI's administration and billing of the drug Epogen allegedly provided to patients when it was medically unnecessary. In addition, DCI allegedly allowed hospital labs to bill Medicare separately for tests for DCI patients even though DCI was paid for the lab services as part of Medicare's composite rate payment, resulting in duplicate payments. As part of the settlement agreement, DCI entered into a 3-year CIA.

Durable Medical Equipment Suppliers

■ **Idaho** – Lincare Inc. agreed to pay the Government \$1.2 million to resolve allegations that its Idaho facilities violated the FCA by submitting false claims to Medicare, Medicaid, and the Veterans Affairs programs. From January 1998 through December 2000, Lincare allegedly submitted claims for home oxygen using supporting certificates of medical necessity that were falsified by Lincare employees and also submitted claims for new patients without performing a required 30-day review. An existing CIA contains provisions that address the alleged misconduct at issue in this settlement.

Billing Consultant or Contractor

■ **Ohio** – A consultant and two of his companies were sentenced for conduct related to a fraudulent billing scheme. The consultant, who was a former chiropractor, was sentenced to 41 months in prison and ordered to pay \$1.1 million in restitution. His two companies,

which have now closed, were held jointly and severally responsible for \$820,000 of the restitution amount. In a nationwide investigation, it was revealed that through his consulting business, the consultant informed chiropractors attending his billing seminars that he knew of a company that could help identify chiropractic services that were performed but had not been previously billed. The consultant, who claimed to be “certified” by OIG, did not reveal that he owned the company with which chiropractors were encouraged to contract. However, the contracted company reviewed only a small sampling of patient records, if any, but billed for additional services by using modifier codes for virtually every patient for every date of service during the prior 12-18 months.

Nursing Homes

■ **Pennsylvania** – A nursing home and its owner/operator were sentenced for health care fraud and false statements. The nursing home and its owner/operator were convicted after a 6-week trial in which evidence showed that employees were directed to falsify medical records to conceal the nursing home’s deficiencies. As a result of the scheme, the nursing home billed Medicare and Medicaid for services provided to residents, most of whom suffered from Alzheimer’s disease, that were either not provided or were substandard. The nursing home, which is now closed, was ordered to pay a \$490,000 fine. The owner/operator was sentenced to 5 years in jail and ordered to pay a \$50,000 fine. The investigation also revealed that although the nursing home claimed that it did not have the ability to pay food and pharmaceutical vendors, it donated \$1 million to another nonprofit company which in turn paid the owner/operator an exorbitant salary.

Laboratories

■ **California** – A neurophysiologist was sentenced to 13 months’ imprisonment and ordered to pay \$400,000 in restitution for his scheme to defraud Medicare and Medi-Cal, California’s Medicaid program. Because the neurophysiologist is a technician who conducts diagnostic tests and is not considered a physician, he did not qualify for Medicare or Medi-Cal provider numbers. To gain access to provider numbers, the neurophysiologist entered into business relationships with physicians and other medical professionals. Once he obtained the physicians’ provider numbers, he improperly billed for ultrasounds, nerve conduction studies, and pulmonary function tests. One of the improper business relationships involved a doctor who falsely indicated on his provider number application that he was running his own practice. Through the course of the investigation, it was determined that the neurophysiologist actually operated the practice, and the doctor was paid a small salary for the use of his number. In June 2006, the doctor was ordered to pay \$50,000 in restitution for his part in the scheme. The investigation also revealed that the neurophysiologist employed marketers who paid patients to undergo various unnecessary diagnostic tests and services.

Medicaid Fraud Control Units

Investigations

Currently, 49 States and the District of Columbia have MFCUs, which investigate and prosecute, or refer for prosecution, providers charged with defrauding the Medicaid

program or abusing, neglecting, or financially exploiting beneficiaries in Medicaid-sponsored facilities. During this semiannual period, OIG provided oversight for and administration of approximately \$160 million in Federal grant funds to the units.

Examples of cases worked jointly by OIG with MFCUs during this reporting period include the following:

■ **North Carolina** – The State of North Carolina agreed to repay the Government \$151.5 million to settle claims in connection with Medicaid Disproportionate Share Hospital and Hospital Supplemental Payment program funds. The State administers the Medicaid program, which is both federally and State-funded and makes payments to hospitals in the State’s Medicaid program. During fiscal years 1997 through 2002, the State plan covering hospital payments required that certain of the payments made during those years be adjusted based on cost data made available through cost reports submitted by the hospitals. The Government alleged that, despite having identified overpayments resulting from the use of erroneous data provided by the State’s data processing contractor, adjustments were not made in a timely manner and hospitals continued to receive the overpayments. The Government collected \$100 million from the State in 2006. The balance is to be paid over a 3-year period in equal annual installments. The investigation involved OIG, the North Carolina MFCU, and the FBI.

■ **Maryland** – Pediatrix Medical Group, Inc., agreed to pay the Government \$25 million and enter into a 5-year CIA to resolve its liability under the FCA for improperly billing Medicaid, TRICARE, and the Federal Employees Health Benefits Program for neonatal services provided by their doctors. Through its network of affiliated physician groups, Pediatrix provides neonatal services at various hospital neonatal intensive care units in 32 States and Puerto Rico. Pediatrix allegedly used improper billing codes for neonatal services provided at several of these units located throughout the country. The Government alleged that from January 1996 to December 1999, Pediatrix billed critical care services for infants when, in fact, many of the infants were not critically ill. The settlement also resolved a Colorado case being investigated for the same misconduct. The investigations involved OIG, the Office of Personnel Management, the Defense Criminal Investigative Service, and MFCUs for the States of North Carolina, South Carolina, New Jersey, and Maryland, coordinated through the National Association of Medicaid Fraud Control Units.

■ **Texas** – A physical therapy clinic operator was sentenced to 51 months in prison and ordered to pay \$1.32 million in restitution for conspiracy to commit wire fraud and health care fraud. Her codefendant was sentenced in August 2006 to 33 months in prison and held jointly responsible for the restitution. The two women billed the Medicare and Medicaid programs for services not rendered and billed for physical therapy services as if they were either performed or supervised by a licensed physician. The investigation revealed that the defendants hired unlicensed foreign medical graduates to perform the services of a licensed physician. The investigation involved OIG, the Texas MFCU, and the FBI.

■ **Oregon** – Oregon Imaging Center (OIC) agreed to pay \$510,000 and enter into a 5-year CIA to resolve its liability under the FCA for allegedly submitting false claims to Medicare and Medicaid from January 1998 through March 2004. The Government alleged that OIC billed Medicare and Medicaid for radiology tests that the patients' treating physician did not order. The investigation involved OIG and the Oregon MFCU.

■ **Connecticut** – A physician agreed to pay \$160,000 to resolve his liability under the FCA for submitting false claims to Medicare and Medicaid from January 1998 through October 2002. The Government alleged that the physician billed office visits that were rendered in whole or in part by an employee who was not licensed to practice medicine. The employee, a foreign medical school graduate, was unable to pass the medical school graduate examination. Despite knowing that the employee was not licensed to practice medicine, the physician directed him to treat approximately 25 percent of the physician's patients. Prior to the settlement, the physician pled guilty to conspiracy to commit health care fraud and was subsequently sentenced to 18 months in prison and ordered to pay \$156,000 in restitution. In December 2006, the employee pled guilty for his involvement in the conspiracy and was sentenced to 2 months' imprisonment, 4 months' home confinement, and ordered to pay a \$4,000 fine. The investigation involved OIG, FDA, the Connecticut MFCU, and the FBI.

Suspected Medicaid Fraud Referrals

OIG found that Medicaid Fraud Control Units (MFCU) reported receiving a total of 13,733 suspected fraud referrals over a 3-year period (July 2002 through June 2005), of which 29 percent came from State Medicaid agencies. Eighty-four percent of the MFCUs that provided information reported receiving less than half of all suspected fraud referrals from their respective State Medicaid agencies. MFCU-accepted referrals are matters that the MFCU retains for further investigation. Overall, MFCU-accepted referrals from State Medicaid agencies increased in numbers but their percentage of total referrals remained constant over a 3-year period. Within individual States these trends varied widely. Fifty-nine percent of MFCUs reported accepting fewer referrals from their respective State Medicaid agency in the last year of our review compared to the average number of referrals over all 3 years. One State Medicaid agency contributed to 67 percent of the increase in the number of MFCU-accepted referrals over the 3-year study period. OIG recommended that CMS establish fraud referral performance standards for State Medicaid agencies. CMS concurred. (OEI-07-04-00181)

Public Health Agencies

The activities that HHS public health agencies conduct and support represent this country's primary defense against acute and chronic diseases and disabilities. The programs provide the foundation for the Nation's efforts in promoting and enhancing the health of the American people. Public health agencies within the Department include:

- Agency for Healthcare Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Centers for Disease Control and Prevention (CDC)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

OIG continues to examine the policies and procedures of these agencies to determine whether appropriate controls are in place to guard against fraud, waste, and abuse. These activities include preaward and recipient capability audits and evaluations. This oversight work has provided valuable recommendations to program managers for strengthening the integrity of agency policies and procedures and improving program performance.

OIG is also involved in investigating specific allegations of fraud, waste, and abuse affecting HHS public health service agency programs. These investigations are often complex cases and include such allegations as misuse or theft of grant monies, conflict of interest, kickbacks, and employee misconduct.

Public Health Agency-Related Reports

Unobligated Balances of Funds Awarded Under the Public Health Preparedness and Response for Bioterrorism Program

OIG found that from August 31, 1999, until the end of the Public Health Preparedness and Response for Bioterrorism Program on August 30, 2005, CDC awarded almost \$3 billion to States and major local health departments (awardees). At the close of the program, unobligated balances totaled more than \$157 million, representing 15.8 percent of the approximately \$996 million awarded for the last budget period. Many awardees did not fully execute their expenditure plans or submit timely financial status reports, so CDC did not always receive the information needed to encourage the expenditure of funds and minimize unobligated balances.

Under the new Public Health Emergency Preparedness Program, which began August 31, 2005, CDC has strengthened its guidance and established additional controls. OIG recommended that CDC ensure that awardees under the new program submit financial status reports in a timely manner; follow program guidance to better manage grant funds among eligible entities and preparedness priorities; and, when appropriate, offset new-year awards by the amount of unobligated funds carried over from the prior budget year. CDC concurred and stated that it had taken a number of actions that had helped reduce unobligated balances significantly. (A-05-05-00031)

Security of Stockpile Sites

During this semiannual period, OIG issued reports on the security of the Strategic National Stockpile at selected sites and identified ways to increase the sites' protection against theft, tampering, destruction, or other loss. CDC manages the stockpile to provide ready access to drugs and medical supplies during public emergencies. CDC responded that it was actively addressing the concerns raised. Site reports are considered sensitive and thus are not publicly available. OIG expects to issue additional site reports in the next semiannual period.

The Commissioned Corps' Response to Hurricanes Katrina and Rita

OIG found that although Commissioned Corps officers deployed to Hurricanes Katrina and Rita provided valuable services, the Corps could improve its response to public health emergencies. The Corps provided valuable support to States; however, more officers, especially nurses, mental health professionals, and dentists, were needed. Although most deployed officers met Corps readiness standards, many lacked experience, effective training, and familiarity with response plans. Agencies were unwilling or unable to allow some officers to deploy, while logistical difficulties delayed others' arrival in the field. Confusion surrounded some officers' arrival, but most field assignments were appropriate and officers felt safe at their locations. Most officers were equipped adequately, but some lacked working communications devices and other basic tools. Many officers personally incurred mission-related expenses and some were not reimbursed promptly, which could affect their ability to deploy to future public health emergencies.

OIG recommended that the Corps institute more effective training for officers, improve the system used to contact officers for deployment, work with the Office of the Assistant Secretary for Preparedness and Response (formerly the Office of Public Health Emergency Preparedness) to streamline deployment-related travel, stagger deployments to ensure continuity of operations, improve its ability to coordinate mission assignments and communications in the field, and ensure that all deployable officers have Federal Government travel credit cards. The Assistant Secretary for Health agreed with these recommendations. As part of the Corps' comprehensive transformation process and its efforts to improve the Office of Force Readiness and Deployment's practices, the Corps currently is addressing the recommendations in this report. (OEI-09-06-00030)

Corrective Actions Concerning the Food and Drug Administration's Human Subject Research Program

At the request of the Commissioner of Food and Drugs, OIG assessed the implementation of corrective actions designed to address problems identified in a clinical study and to prevent future problems in FDA's human subject research program. The objective of the review was to determine the status, as of October 2005, of the six corrective actions specified in the Commissioner's letter of March 21, 2003. The corrective actions directed FDA's centers and the Office of Science to initiate an inventory and audit of clinical studies, examine research-monitoring programs and develop quality assurance programs, establish a policy of accountability to the Commissioner, have the Chief Counsel's Office help ensure appropriate regulatory schemes," provide additional funding for oversight, and initiate a mandatory education and certification program.

OIG found that FDA had undertaken several efforts to implement corrective actions to improve its human subject research program but that some efforts were still underway at the time of the review. OIG recommended that FDA increase its efforts to complete the Commissioner's corrective actions. FDA agreed with the recommendation. (A-06-06-00042)

Food and Drug Administration's Resolution of Audit Recommendations

OIG found that, as of December 31, 2005, FDA had not resolved eight audit recommendations, all of which had exceeded the required 6-month resolution timeframe. Additionally, during calendar years 2003 through 2005, FDA resolved 306 of the 314 audit recommendations that were outstanding during this period, but it did not resolve 287 of these recommendations within the required timeframe. OIG recommended that FDA resolve the outstanding audit recommendations and resolve all audit recommendations within 6 months of receiving the audit reports, as required. FDA concurred with all findings. (A-07-06-03083)

Management of Unobligated Funds Provided by the Ryan White CARE Act

OIG found that, in managing funds under Title I of the Ryan White Comprehensive AIDS Resources Emergency Act, HRSA did not always comply with Departmental policy that, during the audit period, limited the carryover of unobligated grant balances to the next budget period. For grant years 1999 to 2003, HRSA authorized 46 of the 51 eligible metropolitan areas that received Title I grants to carry over unobligated funds totaling \$45.1 million for periods ranging from 2 to 5 years beyond the original budget

Public Health Agencies

period. These funds had been awarded to HIV/AIDS health care and support services during a specific budget period.

OIG recommended that HRSA comply with current departmental policy guidance which now permits the carryover of unobligated grant balances into either of the next two budget periods. HRSA concurred with the recommendation. (A-02-03-02006)

Safeguards Over Controlled Substances at an Indian Health Service Hospital

OIG found that an IHS hospital in Oklahoma did not always comply with applicable requirements to secure and account for its Schedule II substances, which are addictive drugs regulated under the Controlled Substances Act of 1970. The hospital did not appropriately secure or have adequate internal controls over its Schedule II substances. The hospital also did not appropriately account for its Schedule II substances, leaving them vulnerable to theft and mismanagement.

OIG recommended that IHS direct the hospital to enforce enhanced security and internal controls and enhanced accountability controls. IHS concurred and stated that the hospital had implemented, or was currently implementing, all recommended corrective actions. (A-06-06-00035)

Royalty Payments Received by the National Institutes of Health

OIG found that NIH did not adequately monitor the FY 2004 royalty payments that it received or ensure their timely collection. NIH did not take all steps required to collect delinquent royalty payments, nor did it terminate license agreements, or seek to impose interest and penalty charges. NIH enters into license agreements to move technologies developed through in-house research to the private sector. NIH retains title to these technologies and receives royalty payments from the licensees.

OIG recommended that NIH finalize its guidance to ensure the review of all sales and royalty reports as required; revise its compliance audit policy; and enforce the requirement to send late notices, terminate license agreements when appropriate, and forward delinquent licensees to the NIH Debt Collection Office to be considered for interest and penalty charges. NIH partially agreed with the recommendations and reported that it had implemented revised policies and procedures facilitating proper administration of royalty payments and audits. (A-03-04-03000)

Financial Statement Audit of the National Institutes of Health Service and Supply Fund

OIG contracted with an independent external auditor to audit the FY 2004 financial statements of the NIH Service and Supply Fund. The auditors determined that the statements were reliable and fairly presented. No material weaknesses were noted. (A-17-04-00005)

Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking education in health-related fields of study. The students are allowed to defer repayment of the loans until after they have graduated and

begun to earn an income. Although the Department's Program Support Center (PSC) takes all steps it can to ensure repayment, some loan recipients ignore their indebtedness.

After PSC has exhausted efforts to secure repayment of a debt, it declares the individual in default. Thereafter, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid, and all 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. During the period covered by this report, 23 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 exclusion is stayed while they pay specified amounts each month to satisfy the debt. If they default on these settlement agreements, they may be excluded until the entire debt is repaid and cannot appeal the exclusion. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debts.

After being excluded for nonpayment of their HEAL debts, a total of 2,070 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. That figure includes the 38 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment is \$147.2 million. Of that amount, \$2.9 million is attributable to this reporting period.

In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- **A California psychologist** – \$134,000
- **A Florida chiropractor** – \$104,000
- **An Ohio chiropractor** – \$23,000

Public Health-Related Investigations

OIG also investigates cases involving the misuse of public health agency funds and threats to public health and safety, such as the improper use of select agents.

The following is an example of a case involving improper use of HHS grant funds resolved during this reporting period:

- **Virginia** – A former caseworker for a nonprofit AIDS organization that received HHS grant funds was sentenced to 4 months' home detention for engaging in a scheme to defraud. She repaid the nonprofit organization \$7,500. The caseworker worked on a project to identify individuals who were at a high risk of being infected with HIV and/or AIDS. Employees working on the project earned a bonus for each completed questionnaire and saliva sample obtained. During a 6-month period, the individual

Public Health Agencies

submitted 91 samples of her own saliva and risk assessment questionnaires that she completed using fictitious names and personal identifiers.

Administration for Children and Families; Administration on Aging

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families. Some of the major programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant. OIG reviews these programs and makes recommendations to increase the efficient use of program dollars; implement programs more effectively; better coordinate programs among the Federal, State, and local governments; and strengthen States' financial management practices.

The Administration on Aging (AoA) awards grants to States for establishing comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. Socially and economically disadvantaged elderly and low-income minority elderly are targeted for assistance, including supportive and nutrition services, education and training, low-cost transportation, and health promotion. Over the years, OIG has reported on opportunities for program improvements to target the neediest for services, expand available financial resources, upgrade data collection and reporting, and enhance program oversight.

OIG works closely with ACF's Office of Child Support Enforcement and other Federal, State, and local partners to detect, investigate, and prosecute noncustodial parents who fail to pay child support obligations. In addition, OIG also investigates specific allegations of fraud, waste, and abuse affecting ACF and AoA programs. These investigations are often complex cases and include such allegations as misuse or theft of grant monies, conflict of interest, kickbacks, and employee misconduct.

Administration for Children and Families-Related Reports

Lebanon Repatriation Program Funds

At the Secretary's request, OIG reported to Congress on ACF's use of Lebanon Repatriation Program funds. Under this program, ACF offered temporary emergency assistance to repatriates at ports of entry in Georgia, Maryland, New Jersey, and Pennsylvania.

OIG found that ACF expended \$1.2 million to provide temporary assistance to more than 12,000 individuals repatriated from Lebanon. Approximately \$1 million represented reimbursement of States' administrative costs, and the remaining \$215,000 represented temporary assistance provided directly to about 350 individuals and household heads. ACF generally followed Federal requirements in administering these funds. However, as of December 6, 2006, ACF had reimbursed Pennsylvania for approximately \$125,000 in estimated, rather than actual, administrative costs and had not submitted bills for temporary assistance loans totaling about \$135,000 that repatriates were required to repay. These problems occurred because ACF made clerical errors and did not request or monitor reports on the status of loan collections from PSC, ACF's collection agent.

OIG recommended that ACF obtain a refund from Pennsylvania, provide PSC with all necessary information on temporary assistance loans and direct PSC to bill repatriates for these loans, ensure that States are aware of the requirement to provide adequate documentation for administrative costs, and implement written monitoring procedures to ensure that PSC bills for temporary assistance loans. ACF generally agreed with the recommendations. (A-01-07-02501)

Undistributable Child Support Collections

OIG found that two States did not fully comply with Federal requirements pertaining to undistributable child support collections. Undistributable collections result when a State receives a child support payment but cannot identify or locate the custodial parent or return the funds to the noncustodial parent. States are required to offset Child Support Enforcement program costs, for which they receive Federal matching funds, by recognizing and reporting undistributable collections as program income at the time the funds are considered abandoned under State law.

■ **Massachusetts** did not report program income totaling \$1.3 million (Federal share) for undistributable child support collections. In addition, OIG deferred review of \$2.3 million (Federal share) of interest earned on undistributed collections to the Office of Child Support Enforcement.

OIG recommended that the State report child support collections totaling \$1.3 million as undistributable and program income and revise its procedures to ensure that undistributable collections meeting the State's abandoned property requirements are reported as undistributable and program income on the quarterly Federal financial reports. The State generally agreed. (A-01-06-02500)

■ **Connecticut** did not report program income totaling \$1.1 million (Federal share) in outstanding unclaimed or undistributed child support collections that were held more than 3 years.

OIG recommended that the State report child support collections totaling \$1.1 million as undistributable and program income and implement controls to ensure that State unclaimed property procedures are adhered to and that future undistributable collections are reported as undistributable and program income on the quarterly Federal financial reports. The State generally agreed. (A-01-06-02502)

Title IV-E Adoption Assistance Training Costs in Two States

OIG reviewed two States' claims for Title IV-E training costs. ACF provides funding at a 50-percent rate for State administrative expenditures and at an enhanced 75-percent rate for certain State training expenditures.

■ **Maryland** – For calendar years 1999 through 2001, Maryland overstated its Federal share of Title IV-E training costs by \$3.2 million, including \$2.9 million in administrative and indirect costs incorrectly claimed at the enhanced training rate and almost \$380,000 for training not allowable under Title IV-E.

OIG recommended that Maryland refund to the Federal Government \$3.2 million in overstated Title IV-E claims, review Title IV-E training costs claimed subsequent to the audit period and make the appropriate adjustments, and strengthen internal controls to ensure that future training costs are claimed in accordance with Federal requirements. Maryland partially agreed with the findings. (A-03-06-00563)

■ **New Mexico** – For the 2 years ended September 30, 2002, New Mexico claimed \$1.2 million (Federal share) in unallowable or unsupported Title IV-E training costs incurred by three State universities under contract with the State. In addition, New Mexico claimed almost \$48,000 for one university that incorrectly computed administrative costs using an unsupported indirect-cost rate.

OIG recommended that New Mexico refund \$1.2 million to the Federal Government, work with ACF to identify the allowable portion of the \$48,000 in indirect costs allocated to the Title IV-E program, implement procedures to review and amend university contracts as necessary to comply with Federal requirements, and implement procedures to ensure that universities bill only for costs that are allowable and supported. New Mexico partially agreed with the findings. (A-06-06-00045)

Connecticut's Title IV-E Adoption Assistance Costs

OIG reviewed 1,000 of Connecticut's Title IV-E adoption assistance claims for State FY 2002 and found that 298 children did not meet Federal eligibility requirements. The State agency continued to claim adoption assistance payments for all 298 ineligible children in FY 2003 and for 294 of these children in FY 2004. As a result, the State agency overclaimed \$4.3 million (Federal share) in adoption assistance payments for FYs 2002 through 2004.

OIG recommended that Connecticut make a financial adjustment of \$2.8 million for children who did not meet income eligibility requirements, work with ACF to resolve \$1.5 million in overpayments for children who did not meet voluntary placement or judicial determination requirements, and review adoption assistance payments claimed after the audit period to ensure compliance with Federal reimbursement requirements. Connecticut concurred with the recommendations. (A-01-06-02506)

Administration on Aging-Related Reports

Cost Sharing for Older Americans Act Services

OIG found that States' implementation of cost sharing for Older Americans Act (OAA) services has been limited. In 2000, amendments to the OAA allowed but did not require States to implement cost sharing for certain OAA services. A total of 12 States have implemented cost sharing for at least one OAA service in at least one part of their State. None of these States have implemented cost sharing for all allowed OAA services. The States that have implemented cost sharing do not always follow all OAA requirements for cost sharing that are designed to protect low-income individuals' access to services. OIG also found that AoA has provided limited guidance to States about implementing cost sharing and that State officials are often confused about cost sharing under the OAA. Additionally, AoA's participation data cannot be used to determine the impact of cost sharing on participation rates primarily because States report participation data in the National Aging Program Information System/State Program Reports (NAPIS/SPR) differently.

OIG recommended that AoA ensure that States' cost-sharing practices comply with the OAA requirements designed to protect low-income individuals' access to services, provide additional guidance to States on cost sharing; and improve the quality of the NAPIS/SPR data so that any effects of cost sharing can be measured. In general, AoA agreed with our finding that cost sharing is limited but does not agree that it has provided limited guidance to States. AoA also did not agree with OIG's recommendation regarding NAPIS/SPR. AoA stated that it will follow up on OIG's observations and correct instances of noncompliance with the provisions of the OAA and will provide additional guidance to States. (OEI-02-04-00290)

Administration on Aging's Resolution of Audit Recommendations

OIG found that, as of December 31, 2005, AoA had not resolved 28 audit recommendations, all of which were within the allowable 6-month timeframe for resolution. Also, during calendar years 2003-2005, AoA resolved 291 of the 319 audit recommendations that were outstanding during that period. However, it did not resolve 207 of the 291 recommendations within the required timeframe. OIG recommended that AoA resolve all audit recommendations within 6 months of receiving the audit reports, as required. AoA concurred with the recommendation and stated that it had implemented more rigorous internal control procedures to resolve all recommendations within 6 months. (A-07-06-03084)

Child Support Enforcement

The detection, investigation, and prosecution of noncustodial parents who fail to pay court-ordered child support are priorities for OIG. Working with the Federal Office of Child Support Enforcement (OCSE), the Department of Justice, U.S. Attorneys' Offices, the U.S. Marshals Service, and other Federal, State, and local partners, OIG develops ways to expedite the collection of child support. Since 1995, OIG has opened 3,307 investigations of child support cases nationwide, resulting in 1,276 convictions and court-ordered restitution and settlements of \$68.7 million.

Task Forces

In 1998, OIG and OCSE initiated "Project Save Our Children," a child support initiative made up 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 both 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, wherein 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.

To date, the task force units have received more than 10,897 cases from the States. As a result of the work of the task forces, 802 Federal arrests have been made and 748 individuals have been sentenced. The total ordered amount of restitution related to Federal investigations is \$39.6 million.

Investigations to date at the State level have led to 482 arrests and 422 convictions or civil adjudications, resulting in \$28.3 million in restitution ordered.

Overall, more than \$38 million of court-ordered restitution has actually been collected and distributed to families.

Investigations

Nationwide, OIG investigations of child support cases resulted in 51 convictions and court-ordered restitution and settlements of \$3.7 million during this semiannual period. Examples of OIG's enforcement results for failure to pay child support include the following:

■ **Minnesota** – Based on his guilty plea, a man was sentenced to 5 years' probation and ordered to pay \$213,000 in restitution for failure to pay child support. Of the restitution amount, approximately \$91,000 is owed in a Virginia case and the remaining \$122,000 is owed for a case in Minnesota. In addition, the man was ordered to participate in a mental health program for evaluation and/or treatment.

■ **Michigan** – A man was sentenced to 16 months' imprisonment, 1 year of probation, and ordered to pay \$130,000 in restitution for failure to pay child support. Although the

man was employed for approximately 30 years, he failed to pay his child support obligation. At his sentencing hearing, the man attempted to mitigate his actions by advising the court that he has a gambling addiction and is supporting his current family.

■ **Connecticut** – Based on his guilty plea, a man was sentenced to 5 years’ probation and ordered to pay \$75,000 in restitution that included an immediate payment due of \$15,000 for failure to pay child support. Despite being ordered to pay support for his two children in 1992, the man made payments only sporadically. His last payment was made in 1998.

■ **Virginia** – A man was sentenced to 4 years’ probation, ordered to stay current on all child support and spousal support orders and to file an annual financial affidavit for failure to pay child support. Prior to sentencing, the man paid \$38,000, the amount of his child support and spousal support arrearage. The investigation revealed that the man traveled frequently with his girlfriend and concealed his expenses by using his girlfriend’s credit cards. His travel included trips to Australia and New Zealand, a Caribbean cruise, a 3-week stay in Las Vegas, and a stay in a luxury hotel in New Orleans. Meanwhile, the custodial parent and their four children were receiving public assistance.

■ **Indiana** – A man was sentenced to 8 years in prison (all suspended except for 112 days already served), 8 years’ probation, and ordered to pay \$32,000 in restitution for failure to pay child support. With the help of the Department of Veterans Affairs (VA), the man was located and arrested in the State of Washington. The man was using an alias to avoid his child support obligation but was receiving VA benefits under his true name. The man was extradited back to Indiana where he pled guilty. In addition to the child support arrearage, the man was ordered to pay almost \$4,000 in extradition costs.

General Oversight

The Office of the Assistant Secretary for Resources and Technology (formerly the Office of the Assistant Secretary for Resources and Budget, Technology, and Finance) is responsible for developing and executing the HHS budget; ensuring that HHS performance measurement and reporting are in compliance with the Government Performance and Results Act; establishing and monitoring departmental policy for financial management (including debt collection, audit resolution, cost policy, and financial reporting); and developing and monitoring HHS information technology policy (including information technology security). The Assistant Secretary is the Department's Chief Financial Officer and oversees the Department's Chief Information Officer. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the indirect cost rates and methods that many outside entities, such as State and local governments, use for administering HHS and other Federal programs.

The Office of the Assistant Secretary for Administration and Management is responsible for HHS policies regarding human resources and acquisition management. This office also oversees the Program Support Center, which provides a range of services, such as human resource system support, financial management, administrative operations, acquisitions, and Federal occupational health services.

OIG has general oversight responsibility for these activities. Another major responsibility derives from Office of Management and Budget (OMB) Circular A-133, under which HHS is the cognizant agency to audit the majority of major research institutions and nearly all State and local governments. As the cognizant agency, OIG oversees the work of non-Federal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG is responsible for auditing the Department's financial statements.

OIG reviews audits, evaluations, and studies performed by others, such as OMB's Program Assessment and Rating Tool and reports of the Government Accountability Office. It takes these studies into account when planning its own work and examines management actions designed to correct the deficiencies cited in these prior studies.

General Oversight-Related Reports

Departmental Financial Statement Audit

The Chief Financial Officers Act of 1990, as amended, requires OIG or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards. Independent external auditors provided an unqualified opinion on the FY 2006 HHS consolidated/combined financial statements. This means that for the eighth consecutive year, the statements were reliable and fairly presented. However, the report on internal controls noted two material weaknesses:

■ **Financial Management Systems and Reporting** – As in prior years, HHS continued to have serious internal control weaknesses in its financial management systems and processes for producing timely and reliable financial statements. Substantial manual procedures, significant adjustments to balances, and numerous accounting entries recorded outside HHS’s general ledger system were necessary.

■ **Departmental Information Systems Controls** – For several systems, the auditors reported numerous issues in the areas of access to data and controls over changes to edits. In addition, weaknesses continued in the Entitywide Security Program and Service Continuity Planning and Testing, and some slippage occurred in systems software controls since the FY 2005 audit. (A-17-06-00001)

Special-Purpose Financial Statements

OIG contracted with an independent external auditor to audit the HHS FY 2006 reclassified balance sheet and the related reclassified statements of net cost and changes in net position (the special-purpose financial statements). Auditors determined that the statements were reliable and fairly presented. No material weaknesses were noted. (A-17-06-00006)

Departmental Service Organizations

To support the audit of the Department’s FY 2006 financial statements, OIG contracted for examinations of several service organizations that provide common administrative, data processing, and accounting services to the operating divisions. In accordance with Statement on Auditing Standards No. 70, independent certified public accounting firms examined the organizations’ controls and tested their operating effectiveness.

Auditors found that controls were suitably designed and operating with sufficient effectiveness, with the exception of certain conditions, at the following service organizations: NIH’s Center for Information Technology; PSC’s Division of Payment Management, Division of Financial Operations, and Enterprise Support Service. (A-17-06-00009, A-17-06-00010, A-17-06-00011, A-17-06-00012)

Emergency Response to Hurricanes Katrina and Rita

Following the Gulf Coast hurricanes of 2005, HHS was extensively involved in recovery efforts. To obtain assistance in these efforts, HHS agencies awarded or extended many contracts to vendors. Some of the contracts were in response to assignments from the

Department of Homeland Security’s Federal Emergency Management Agency; others were self-initiated.

During this semiannual period, OIG reviewed the award processes for 12 contracts related to hurricane recovery. CDC, NIH’s National Institute of Environmental Health Sciences, and PSC awarded these contracts. The objective of each audit was to determine whether the awarding agency complied with Federal and departmental requirements during the contract award process. In all 12 cases, the agencies complied with the requirements. (A-03-06-00514, A-03-06-00519, A-03-06-00527, A-03-06-00528, A-03-06-00529, A-03-06-00530, A-03-06-00531, A-03-06-00536, A-04-06-01030, A-04-06-01031, A-04-06-01034, A-04-06-01036)

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 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 entity’s management of Federal funds. In the first half of FY 2007, OIG’s National External Audit Review Center reviewed 1,267 reports that covered \$463.6 billion in audited costs. Federal dollars covered by these audits totaled \$109.3 billion, about \$54.5 billion of which was HHS money.

OIG’s oversight of non-Federal audit activity informs Department 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. OIG identifies entities for high-risk monitoring, alerts program officials to any trends that could indicate problems in HHS programs and profiles non-Federal audit findings of a particular program or activity over time to identify systemic problems. OIG also provides training and technical assistance to grantees and members of the auditing profession.

OIG maintains a quality control review 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 box below.

Reports issued:	
without changes or with minor changes	1,052
with major changes	136
with significant inadequacies	79
Total	1,267

The 1,267 reports included 5,089 recommendations for improving management operations. In addition, these audit reports provided information for 124 special memorandums that identified concerns for increased monitoring by management.

Resolving Recommendations

The following tables are provided in accordance with section 5 of the Inspector General Act and indicate the dollar value of actions taken on OIG's recommendations.

Table 1: Reports With Questioned Costs*

Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
For which no management decision had been made by the beginning of the reporting period ¹	339	\$2,666,100,000	\$165,146,000
Issued during the reporting period	42	\$ 391,888,000	\$ 9,652,000
Total Section 1	381	\$3,057,988,000	\$174,798,000
Section 2			
For which a management decision was made during the reporting period ^{2,3}			
Disallowed costs	173	\$1,502,878,000	\$ 53,697,000
Costs not disallowed	20	\$ 31,363,000	\$ 1,559,000
Total Section 2	193	\$1,534,241,000	\$ 55,256,000
Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	188	\$1,523,747,000	\$119,542,000
Section 4			
For which no management decision was made within 6 months of issuance ⁴	150	\$1,142,521,000	\$114,251,000

*Supporting notes and list of reports are in Appendix A.

Table 2: Funds Recommended To Be Put to Better Use*

Reports	Number of Reports	Dollar Value
Section 1		
For which no management decision had been made by the beginning of the reporting period ¹	52	\$ 981,996,000
Issued during the reporting period	6	\$ 593,309,000
Total Section 1	58	\$1,575,305,000
Section 2		
For which a management decision was made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	14	\$ 397,189,000
Based on proposed legislative action		\$ 0
Value of recommendations not agreed to by management		\$ 122,000
Total Section 2	14	\$ 397,311,000
Section 3		
For which no management decision had been made by the end of the reporting period ²		
Total Section 1 minus Total Section 2	44	\$1,177,994,000

*Supporting notes and list of reports are in Appendix A.

Legislative and Regulatory Review and Development

Regulatory Review Functions

Section 4(a) of the Inspector General Act of 1978 requires that the Inspector General review existing and proposed legislation and regulations and make recommendations in this report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, evaluations, investigations, and other activities highlighted in this and previous semiannual reports.

During this reporting period, OIG was involved in the review and clearance of the implementing regulations and other policy guidance from the various provisions of MMA and DRA. Among the CMS final rules reviewed by OIG during this reporting period, OIG provided substantive comments addressing Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Stark III), Revisions to Payment Policies Under the Physician and Ambulance Fee Schedules, Hospital Conditions of Participation for Organ Transplant Centers, and the joint CMS/IHS final rule on the Limitation of Charges for Services Furnished by Medicare Participating Hospitals to Indians. In addition, among the various proposed rules reviewed during this period, OIG prepared comments and recommendations on Revisions to the Medicare Advantage and Part D Prescription Drug Confidentiality, Disclosure, Determinations, Appeals, and Intermediate Sanctions Processes, and the Medicare Prescription Drug Benefit.

Regulatory Development

OIG is responsible for the development and publication of a variety of sanction regulations addressing civil money penalty and program exclusion authorities administered by the Inspector General, as well as regulations promulgating safe harbors related to the anti-kickback statute. During this semiannual reporting period, OIG continued to develop final rulemaking addressing shared risk exceptions to the safe harbor provisions and a new safe harbor for Federally Qualified Health Centers, as well as new proposed rulemaking addressing the reorganization and revisions to 42 CFR part 1003, which sets forth OIG's regulatory authorities for imposing civil monetary penalties and assessments.

In addition, OIG periodically publishes *Federal Register* notices that, among other things, offer guidance to alert program beneficiaries, health care providers, and other entities about potential problems or areas of special interest. During this semiannual period, OIG:

- Prepared and published a *Federal Register* notice revising OIG's Privacy Act Systems of Records for Criminal Investigative Files (71 FR 71180; December 8, 2006).
- In accordance with section 205 of HIPAA, published an annual notice soliciting proposals and recommendations for developing new and modifying existing safe harbor

provisions under the Federal anti-kickback statute, as well as for developing new OIG special fraud alerts (71 FR 71501; December 11, 2006).

■ Prepared and published a *Federal Register* notice addressing revisions to the current OIG organizational statement and setting forth the alignment of certain functions and responsibilities of several OIG components to better reflect the current work environment and priorities and to more closely delineate responsibilities for the various offices within OIG (71 FR 76674; December 21, 2006).

Employee Fraud and Misconduct

Most people employed by HHS are dedicated, honest civil servants. Occasionally, however, employees violate their ethical and fiduciary responsibilities. OIG conducts or oversees investigations of serious allegations of wrongdoing by Department employees, as in the following examples:

■ **Maryland** – An NIH scientist was sentenced for a conflict of interest violation. The scientist provided consulting services for a drug company without the required prior approval of and disclosure to NIH officials. As part of his sentencing, the scientist was ordered to pay \$300,000, the amount of income and expenses that he received for his consulting services.

■ **South Dakota** – An IHS employee was sentenced to 12 months' incarceration and ordered to pay \$100,000 in joint and several restitution for conspiracy to commit health care fraud. This individual, an IHS medical records technician, and four codefendants were involved in a scheme to defraud the American Family Life Assurance Company of Columbus (AFLAC). The technician and another IHS coworker used their positions to access patient records. The records were altered to reflect their own names or the names of family members and then submitted to AFLAC for medical services they did not receive. The coworker and the other three defendants were previously sentenced for their part in the scheme. All five of these individuals are held responsible for various portions of the joint and several restitution amount.

■ **Washington, DC** – A former FDA commissioner was sentenced to 3 years' supervised release, 50 hours of community service, and ordered to pay over \$89,000 in fines for conflict of interest and false writing violations. The investigation found that the former commissioner filed false financial reports to Government officials. On the reports, he failed to disclose holdings in companies regulated by FDA.

Prosecutions

During this semiannual reporting period, OIG investigations resulted in 209 successful criminal actions. Also during this semiannual period, 498 cases were presented for criminal prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Prosecutors brought criminal charges against 312 individuals and entities.

General Oversight

In addition to terms of imprisonment and probation imposed in the judicial processes, \$1.4 billion was ordered to be returned, or was returned, as a result of OIG investigations during this reporting period. This amount includes civil settlements from investigations resulting from audit findings

Appendixes

Notes to Tables 1 and 2

Notes to Table 1

¹The opening balance was adjusted upward \$270.2 Million

²During the period, revisions to previously reported management decisions included:

- CIN*: A-02-99-58263 PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD SUPPORT – Based on supporting documentation provided by grantee, ACF determined that \$6.7 million in previously disallowed costs were allowable.
- CIN: A-02-03-74060 PUERTO RICO DEPARTMENT OF THE FAMILY – Based on supporting documentation provided by grantee, ACF determined that \$21.6 million in previously disallowed costs were allowable.
- CIN: A-06-04-00017 AUDIT OF ORGAN ACQUISITION COSTS AT BAYLOR UNIVERSITY MEDICAL CENTER – Additional recoveries of \$12.8 million were identified in addition to the previously reported amount of \$13.4 million
- CIN: A-07-95-01126 BLUE CROSS AND BLUE SHIELD OF FLORIDA – CHARGING OF PENSION COSTS – Additional unallowable costs of \$2.3 million were identified.

Other revisions to previously disallowed management decisions totaled \$3.9 million.

³Included are management decisions to disallow \$369 million that was identified in nonfederal audit reports.

⁴Due to administrative delays, many of which are beyond management control, resolution of the following 150 audits were not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

- CIN: A-05-01-00099 UNIVERSITY OF ILLINOIS AT CHICAGO HOSPITAL DISPROPORTIONATE SHARE HOSPITAL PAYMENT LIMITS, OCT 2004, \$140,281,912
- CIN: A-09-02-00054 AUDIT OF STATE OF CALIFORNIA DISPROPORTIONATE SHARE HOSPITAL PROGRAM FOR FY 1998, MAY 2003, \$128,269,448
- CIN: A-09-02-00071 AUDIT OF CA DISPROPORTIONATE SHARE HOSPITAL PROGRAM FOR FY 1998 - LA COUNTY, MAY 2003, \$98,190,042
- CIN: A-04-03-02027 REVIEW OF MEDICAID UPPER PAYMENT LIMIT CALCULATIONS IN ALABAMA, DEC 2005, \$73,432,381
- CIN: A-04-04-03000 COMPLIANCE WITH MEDICARE'S POST ACUTE CARE TRANSFER POLICY - FY 01 & 02, APR 2005, \$72,369,964
- CIN: A-03-03-00002 NATIONWIDE REVIEW OF IDTF SERVICES AND PROVIDERS, JUN 2006, \$71,664,839
- CIN: A-02-03-01003 REVIEW OF SCHOOL-BASED HEALTH SERVICES IN NEW JERSEY, MAY 2006, \$52,309,695
- CIN: A-01-04-00527 REVIEW OF HOME HEALTH AGENCIES' BILLING FOR SERVICES PRECEDED BY A HOSPITAL DISCHARGE, MAR 2006, \$48,135,395
- CIN: A-05-01-00058 OHIO MEDICAID HOSPITAL-SPECIFIC DISPROPORTIONATE SHARE HOSPITAL PAYMENT LIMITS, JUN 2004, \$47,000,000
- CIN: A-04-01-02006 MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS IN ALABAMA, JUN 2004, \$45,763,327

* Central Identification Number

Appendix A

CIN: A-02-03-01021 UPPER PAYMENT LIMIT REVIEW - NEW YORK, OCT 2005, \$43,284,850
CIN: A-01-02-00006 REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID
SCHOOL BASED HEALTH SERVICES - CONNECTICUT, MAY 2003,
\$32,780,146

CIN: A-01-04-00513 REVIEW OF MEDICARE PART B PAYMENTS FOR AMBULANCE
SERVICES RENDERED TO BENEFICIARIES DURING AN INPATIENT
STAY, MAR 2006, \$21,705,010

CIN: A-01-04-00528 REVIEW OF MEDICARE PART B PAYMENTS FOR RADIOLOGY
SERVICES RENDERED DURING AN INPATIENT STAY, AUG 2006,
\$20,011,162

CIN: A-09-01-00098 AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE
HOSPITAL PAYMENTS FOR FY 1998, SEP 2002, \$19,446,435

CIN: A-01-04-00006 REVIEW OF TARGETED CASE MANAGEMENT SERVICES RENDERED
BY THE MASSACHUSETTS DEPT OF SOCIAL SERVICES DURING
FEDERAL FISCAL YEARS 2002 AND 2003, MAY 2006, \$13,460,989

CIN: A-01-02-00509 REVIEW OF MEDICARE ADMINISTRATIVE COSTS - PART A & B -
UNITED HEALTHCARE INSURANCE COMPANY, MAR 2005, \$12,991,420

CIN: A-04-04-00008 PPS PAYMENTS TO REHABILITATIVE HOSPITALS FOR TRANSFERS,
SEP 2006, \$11,967,555

CIN: A-06-03-00027 REVIEW OF HUMANA'S BIPA MODIFICATIONS, JUL 2005, \$10,500,000
CIN: A-09-04-00069 REVIEW OF PHYSICAL THERAPY SERVICES PROVIDED BY
INDEPENDENT PRACTITIONER, JUN 2006, \$9,984,065

CIN: A-06-02-00034 REV OF COST REPORTS & MEDICARE FEE-FOR-SERVICE PAYMENTS
AT SCOTT & WHITE, MAY 2003, \$8,229,574

CIN: A-09-01-00085 AUDIT OF UC SAN DIEGO MEDICAL CENTER DISPROPORTIONATE
SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEP 2002, \$7,999,212

CIN: A-06-04-00065 REVIEW OF INTERNAL CONTROLS AT TRISPAN HEALTH SERVICES,
SEP 2006, \$7,958,659

CIN: A-07-02-03033 CAREFIRST SEGMENTATION AUDIT, MAY 2003, \$6,788,644
CIN: A-05-05-00055 REVIEW OF ILLINOIS COMMUNITY MENTAL HEALTH SERVICES FOR
FEDERAL FISCAL YEAR 2003, SEP 2006, \$5,971,577

CIN: A-01-04-00525 REVIEW OF INTERRUPTED STAYS AT INPATIENT REHABILITATION
FACILITIES, DEC 2005, \$5,868,697

CIN: A-09-03-00042 REVIEW OF HHA PRECEDING HOSPITAL STAY UNDER PPS - UGS,
FEB 2004, \$5,306,825

CIN: A-06-02-00060 REVIEW PACIFICARE OK BIPA MODIFICATIONS TO CY 2001 ACRP,
JUN 2004, \$5,204,042

CIN: A-05-03-00096 REVIEW OF ADMINISTRATIVE COSTS FOR ADMINASTAR FEDERAL,
AUG 2004, \$5,000,598

CIN: A-07-05-00187 PENSION COSTS CLAIMED REVIEW AT ANTHEM INSURANCE
COMPANIES - ADMINASTAR FEDERAL, DEC 2005, \$4,833,704

CIN: A-04-04-02003 MEDICARE OUTLIER PAYMENTS TO COMMUNITY MENTAL HEALTH
CENTERS, APR 2006, \$4,762,036

CIN: A-02-03-01020 REVIEW OF ADMINISTRATIVE COSTS CLAIMED BY EMPIRE
MEDICARE SERVICES, MAR 2006, \$4,686,611

CIN: A-09-03-00051 REVIEW OF BLUE SHIELD CALIFORNIA BIPA MODIFICATIONS TO
CALENDAR YEAR 2001 ACRP, OCT 2004, \$4,555,992

CIN: A-05-01-00102 MT. SINAI HOSPITAL-DISPROPORTIONATE SHARE HOSPITAL
PAYMENT LIMITS, OCT 2004, \$4,516,112

CIN: A-02-00-01047 DEMO BSWNY - FINANCIAL, MAR 2002, \$4,505,051
CIN: A-03-01-00225 VIRGINIA IMD UNDER 21, MAR 2004, \$3,948,532
CIN: A-04-04-06012 GRADUATE MEDICAL EDUCATION FOR DENTAL RESIDENTS - CA,
JUL 2006, \$3,904,527

CIN: A-01-02-00525 MAINE ANTHEM BCBS - MEDICARE ADMINISTRATIVE COSTS,
APR 2004, \$3,389,716

CIN: A-06-04-00076 MEDICAL REVIEW OF SYNERGY'S PHP CLAIMS, MAR 2006, \$3,098,296

CIN: A-01-04-00004	REVIEW OF MAINE'S MEDICAID RETROACTIVE CLAIMS FOR SCHOOL-BASED HEALTH SERVICES - JANUARY 2001 THROUGH JUNE 2003, JAN 2005, \$3,044,211
CIN: A-03-04-00207	MEDICAID OVERPAYMENTS-WEST VIRGINIA, JUN 2005, \$2,940,469
CIN: A-03-03-00220	DELAWARE MEDICAID MANAGED CARE FAMILY PLANNING FACTOR VALIDATION AUDIT, JAN 2006, \$2,916,288
CIN: A-01-02-00508	REVIEW OF MEDICARE CONTRACT TERMINATION COSTS - UNITED HEALTHCARE, NOV 2003, \$2,894,010
CIN: A-04-05-03003	AUDIT OF THE KY MEDICAID AGENCY'S BUY-IN OF MEDICARE PARTS A AND B, AUG 2006, \$2,799,784
CIN: A-07-03-03039	CAREFIRST OF MARYLAND UNFUNDED PENSION COSTS, MAY 2003, \$2,611,100
CIN: A-01-04-00523	REVIEW OF ADMINISTRATIVE COSTS - PART A & B AT RHODE ISLAND BLUE CROSS AND BLUE SHIELD, SEP 2005, \$2,582,664
CIN: A-05-05-00051	AUDIT OF ILLINOIS'S MEDICAID PAYMENTS FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL, JUN 2006, \$2,427,853
CIN: A-01-05-02502	REVIEW OF CONNECTICUT'S TRAINING AND IV-E ADOPTION ASSISTANCE COSTS, JUL 2006, \$2,400,000
CIN: A-07-04-03050	PENSION SEGMENTATION REVIEW AT HIGHMARK, INC. OF PENNSYLVANIA, JAN 2005, \$2,394,501
CIN: A-07-04-00173	REVIEW OF UNFUNDED PENSION COSTS FOR PENNSYLVANIA BLUE SHIELD, NOV 2004, \$2,154,481
CIN: A-05-03-00063	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF MEDICARE NORTHWEST (BLUE CROSS BLUE SHIELD OF OREGON), OCT 2003, \$2,100,000
CIN: A-07-05-00190	PENSION SEGMENTATION REVIEW AT REGENCE BLUE CROSS BLUE SHIELD OF UTAH, APR 2006, \$2,040,174
CIN: A-07-05-04048	MEDICAID DRUG REBATE FOLLOW-UP - COLORADO, NOV 2005, \$1,925,367
CIN: A-01-02-00516	REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES UNITED GOVERNMENT SERVICES, MAR 2003, \$1,768,783
CIN: A-03-01-00228	PENNSYLVANIA IMD UNDER 21, JUL 2005, \$1,694,148
CIN: A-05-06-00047	ESRD #11 PRE-AWARD AUDIT, MAY 2006, \$1,420,997
CIN: A-03-04-00209	VIRGINIA MEDICAID MANAGED CARE FAMILY PLANNING FACTOR VALIDATION AUDIT, JUN 2005, \$1,388,506
CIN: A-07-02-03021	ANTHEM BCBS OF CONNECTICUT - PENSION SEGMENT CLOSING, FEB 2004, \$1,351,284
CIN: A-04-03-02024	REVIEW OF BCBSFL RESPONSE TO SET-ASIDE COSTS IN PRIOR FACP AUDIT, APR 2003, \$1,277,247
CIN: A-07-04-00169	PENSION SEGMENTATION REVIEW AT PBS, NOV 2004, \$1,214,985
CIN: A-04-02-72903	STATE OF TENNESSEE, SEP 2002, \$1,213,353
CIN: A-03-04-00010	MARYLAND ORGAN ACQUISITION COSTS - UNIVERSITY OF MARYLAND MEDICAL CENTER, APR 2006, \$1,024,852
CIN: A-07-04-00182	PENSION SEGMENTATION REVIEW AT BLUE CROSS AND BLUE SHIELD OF MAINE, OCT 2005, \$942,882
CIN: A-07-05-00195	REVIEW OF SERP COSTS CLAIMED BY ADMINASTAR FEDERAL, JAN 2006, \$934,728
CIN: A-06-03-00046	REVIEW OF OKLAHOMA'S MEDICAID ADMINISTRATIVE COSTS, APR 2005, \$853,915
CIN: A-04-01-05004	REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MAR 2002, \$836,711
CIN: A-06-03-00013	MEDICARE ADMINISTRATIVE COST PROPOSAL-ARKANSAS BLUE CROSS BLUE SHIELD, OCT 2003, \$759,748
CIN: A-03-05-00351	AUDIT OF LLEGO GRANTS, JUN 2006, \$703,181

Appendix A

CIN: A-09-03-00046 AUDIT OF ORGAN ACQUISITION COSTS AT ST VINCENT, JUL 2004, \$683,315

CIN: A-03-05-00202 COUNTY ADMINISTRATIVE SERVICE COSTS CLAIMED THROUGH MARYLAND'S CAP, FEB 2006, \$666,694

CIN: A-06-05-00062 MEDICARE PRESCRIPTION DRUG DISCOUNT CARD PROGRAM, JUL 2006, \$652,135

CIN: A-06-03-00032 AUDIT OF ADMIN COSTS PART A & PART B OF MEDICARE PROGRAM-TRAILBLAZERS, APR 2004, \$622,078

CIN: A-01-04-00012 REVIEW OF UMASS MEDICAL SCHOOL'S ADMINISTRATIVE COST CLAIMS - FY 2003 - FY 2004, MAR 2006, \$614,022

CIN: A-07-04-00170 REVIEW OF PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT FOR VERITUS, AUG 2004, \$594,806

CIN: A-07-02-03015 BCBS OF MINNESOTA PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEB 2003, \$550,083

CIN: A-05-02-72811 COMMUNITY ACTION OF GREATER INDIANAPOLIS INC., AUG 2002, \$547,899

CIN: A-05-06-00030 DUPLICATE MEDICARE PAYMENTS COST-BASED HMOS FOR EXCELLUS HEALTH PLAN, SEP 2006, \$539,138

CIN: A-07-05-03069 MISSOURI UNDISTRIBUTABLE CHILD SUPPORT PAYMENTS, JUL 2006, \$457,128

CIN: A-03-04-00205 MEDICAID PROVIDER OVERPAYMENTS--DELAWARE, OCT 2004, \$437,592

CIN: A-03-06-03302 ESRD NETWORK #5 BID PROPOSAL RFP CMS-500-06-DMP, MAY 2006, \$437,008

CIN: A-01-04-00506 REVIEW OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS CLAIMED BY SAINT MARY'S HOSPITAL FOR FISCAL YEAR ENDING DECEMBER 31, 2002, MAY 2004, \$433,502

CIN: A-02-05-01017 REVIEW OF DURABLE MEDICAL EQUIPMENT PROVIDERS' MEDICAID CLAIMS FOR RESIDENTS OF ASSISTED LIVING PROGRAMS, SEP 2006, \$406,081

CIN: A-05-04-00081 REVIEW OF INDIANA COMMUNITY MENTAL HEALTH CENTER MEDICAID ADMINISTRATIVE COSTS, SEP 2006, \$328,151

CIN: A-02-06-02004 ACF REQUEST FOR ADMINISTRATIVE COSTS REVIEW - LONG ISLAND HEAD START, JUL 2006, \$325,861

CIN: A-05-01-00096 PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$319,355

CIN: A-06-06-00022 MEDICARE PRESCRIPTION DRUG CARD PROGRAM, SEP 2006, \$311,526

CIN: A-03-04-00204 SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPMP) - WEST VIRGINIA, DEC 2004, \$299,360

CIN: A-07-05-01013 PAYMENTS FOR M+C ORGANIZATION FOR INSTITUTIONAL BENEFICIARIES, OCT 2005, \$293,885

CIN: A-05-06-00048 EVALUATION OF ESRD NO. 9 PRE-AWARD AUDITS, MAY 2006, \$289,883

CIN: A-09-04-00068 REVIEW OF CALIFORNIA'S STATE AUTOMATED CHILD WELFARE INFORMATION SYSTEM (SACWIS) AT SANTA CLARA COUNTY, APR 2006, \$286,464

CIN: A-07-04-00175 REVIEW OF UNFUNDED PENSION COSTS AT VERITUS, INC., OCT 2004, \$266,052

CIN: A-07-03-02662 REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DEC 2002, \$258,112

CIN: A-05-05-00033 MICHIGAN-UNDISTRIBUTED CHILD SUPPORT COLLECTIONS, AUG 2006, \$257,859

CIN: A-03-04-00353 ACCOUNTABILITY OVER CDC BT FUNDS, JUN 2005, \$238,537

CIN: A-05-01-00094 PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCT 2002, \$229,656

CIN: A-05-06-00049	EVALUATION OF ESRD NO. 10 PRE-AWARD AUDIT, MAY 2006, \$210,049
CIN: A-03-06-03301	ESDR NETWORK #4 BID PROPOSAL RFP CMS-500--06-NW4, MAY 2006, \$208,449
CIN: A-02-01-01019	DEMO BSWNY - CASH MANAGEMENT, OCT 2002, \$208,271
CIN: A-01-05-00509	REVIEW OF MEDICARE CONTRACT TERMINATION/SEVERANCE COSTS CLAIMED BY BLUE CROSS & BLUE SHIELD OF RHODE ISLAND, SEP 2005, \$205,384
CIN: A-05-06-00052	REVIEW OF SAMHSA GRANT, SEP 2006, \$203,112
CIN: A-01-06-00002	MEDICAID ACCOUNTS RECEIVABLE - VERMONT, SEP 2006, \$201,383
CIN: A-05-06-00021	DUPLICATE ELIGIBILITY IN MICHIGAN & OHIO - OHIO REPORT, JUN 2006, \$196,325
CIN: A-01-04-01501	NORTHEASTERN UNIVERSITY HHS GRANT COSTS GRANT #S 9274, 4000 AND 4111, JAN 2005, \$194,890
CIN: A-06-05-00066	MEDICARE PRESCRIPTION DRUG CARD PROGRAM, SEP 2006, \$168,782
CIN: A-07-05-00194	PENSION COSTS CLAIMED REVIEW AT ANTHEM INSURANCE COMPANIES - MAINE, OCT 2005, \$163,107
CIN: A-07-06-00216	PENSION COSTS CLAIMED AT BLUE CROSS BLUE SHIELD OF ARIZONA, AUG 2006, \$142,343
CIN: A-09-05-00077	REVIEW OF PACIFICARE'S USE OF ADDITIONAL CAPITATION UNDER THE MMA OF 2003, MAR 2006, \$135,000
CIN: A-05-06-00029	AUDIT OF COST-BASED HMOS FOR OVERPAYMENTS MADE TO CAPITATED PROVIDERS, SEP 2006, \$132,075
CIN: A-01-03-00010	MEDICAID SCHOOL-BASED HEALTH SERVICES ADMINISTRATIVE CLAIMING REVIEW - RHODE ISLAND, JUN 2004, \$123,010
CIN: A-04-06-83976	RANDOLPH COUNTY BOARD OF EDUCATION, SEP 2006, \$122,663
CIN: A-05-06-00031	AUDIT OF COST-BASED HMOS FOR OVERPAYMENTS MADE TO CAPITATED PROVIDERS, SEP 2006, \$122,130
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLORIDA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, \$121,023
CIN: A-05-05-00044	DUPLICATE MEDICARE PAYMENTS TO COST-BASED HMO PLAN- ARNETT HEALTH PLANS, INC. FOR FISCAL YEARS 2000, THROUGH 2003, SEP 2005, \$111,862
CIN: A-05-06-00018	WI-UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, MAY 2006, \$107,383
CIN: A-01-02-00527	REVIEW OF ANTHEM BLUE CROSS/BLUE SHIELD MEDICARE CONTRACT TERMINATION & SEVERANCE COSTS, SEP 2003, \$104,468
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MICHIGAN FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, \$100,692
CIN: A-04-04-01002	USE OF CDC BIOTERRORISM GRANT FUNDS, JUL 2005, \$98,929
CIN: A-05-02-00067	REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS & COST REPORTS AT WELBORN, JUN 2003, \$97,623
CIN: A-05-05-00042	DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLAN- DEAN HEALTH PLANS, INC. FOR FISCAL YEARS 2000, THROUGH 2003, AUG 2005, \$91,710
CIN: A-05-01-00090	PAYMENTS TO AETNA OF FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, \$87,516
CIN: A-05-05-00043	DUPLICATE MEDICARE PAYMENTS TO COST-BASED HMO PLAN - JOHN DEERE HEALTH PLANS, INC. FOR FISCAL YEARS 2000, THROUGH 2003, SEP 2005, \$78,799
CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCT 2002, \$77,000
CIN: A-04-05-02000	AUDIT OF HHA THERAPY BILLINGS, SEP 2005, \$63,425
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PENNSYLVANIA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$62,432

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CIN: A-05-02-00054 UNITED GOVERNMENT SERVICES, Y2K COSTS FY 1998 & 1999, APR 2003, \$49,923

CIN: A-03-02-00373 REVIEW OF US HELPING US, DEC 2003, \$45,558

CIN: A-01-03-01500 REVIEW OF CDC HIV PROGRAMS AT GREATER BRIDGEPORT ADOLESCENT PREGNANCY PROGRAM, JUL 2003, \$41,088

CIN: A-05-03-00105 AUDIT OF MEDICAID NURSING FACILITY ADMINISTRATIVE COSTS, OCT 2004, \$39,104

CIN: A-02-06-02010 ACF REQUEST FOR LIMITED REVIEW OF HEAD START GRANTEE - CONCERNED PARENTS, SEP 2006, \$32,490

CIN: A-08-03-73541 SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JAN 2003, \$28,573

CIN: A-07-06-00198 REVIEW OF UNFUNDED PENSION COSTS AT REGENCE BLUE CROSS BLUE SHIELD OF UTAH, APR 2006, \$27,292

CIN: A-07-02-00150 PAYMENTS TO COVENTRY--PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUN 2003, \$26,000

CIN: A-02-06-01018 REVIEW OF BID PROPOSAL SUBMITTED IN RESPONSE TO REQUEST FOR PROPOSAL #500-06-NW03 - NETWORK 3 - TRANS-ATLANTIC RENAL COUNCIL, INC., MAY 2006, \$21,865

CIN: A-05-01-00078 PAYMENTS TO HEALTH NET-TUCSON, ARIZONA. - FOR INSTITUTIONAL BENEFICIARIES, APR 2002, \$21,233

CIN: A-05-02-70624 STATE OF OHIO, JAN 2002, \$19,970

CIN: A-08-04-76779 COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, \$18,925

CIN: A-05-01-00100 PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, \$18,842

CIN: A-05-01-00095 PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, \$18,645

CIN: A-07-03-00151 REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUN 2003, \$18,400

CIN: A-01-02-01504 REVIEW OF CDC'S HIV PROGRAMS AT FENWAY COMMUNITY HEALTH CENTER, JUN 2003, \$18,028

CIN: A-07-06-00203 REVIEW OF MEDICARE SEGMENT ASSETS FOR NONQUALIFIED PLAN FOR HIGHMARK & PREDECESSORS, JAN 2006, \$13,533

CIN: A-07-04-01011 PAYMENTS FOR UNITED HEALTHCARE FOR INSTITUTIONAL BENEFICIARIES, MAR 2005, \$13,128

CIN: A-02-06-02007 ACF REQUEST FOR LIMITED REVIEW OF HEAD START PROGRAM - CAMDEN, NEW JERSEY, SEP 2006, \$13,106

CIN: A-02-06-01017 REVIEW OF BID PROPOSAL SUBMITTED IN RESPONSE TO REQUEST FOR PROPOSAL #500-CMS-ESRD-217DMP - NETWORK 2 - IPRO, MAY 2006, \$11,743

CIN: A-05-01-00070 PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JAN 2002, \$11,089

CIN: A-09-05-00058 WEDGE: HAWAII MEDICAID NURSING FACILITIES EXPENDITURES, FEB 2006, \$9,562

CIN: A-02-06-01019 REVIEW OF BID PROPOSAL SUBMITTED IN RESPONSE TO REQUEST FOR PROPOSAL #CMS-500-06-ESRD-217DMP FOR NETWORK 2 BY ESRD NETWORK OF NEW ENGLAND, INC., MAY 2006, \$9,526

CIN: A-06-06-00014 MEDICARE PRESCRIPTION DRUG CARD PROGRAM: ACCLAIM, SEP 2006, \$8,800

CIN: A-02-02-01035 EVALUATION OF BID PROPOSAL - MEDICARE HELP LINE, AUG 2002, \$3,760

CIN: A-03-03-00393 AUDIT OF CDC HIV/AIDS GRANT TO SEXUAL MINORITY YOUTH ASSISTANCE LEAGUE, OCT 2003, \$1,155

Total CINs: 150

Total Amount: \$1,142,520,617

Notes to Table 2

¹The opening balance was adjusted downward by \$10.9 million.

²Management decision has not been made within 6 months on 38 reports. Discussions with management are ongoing and it is expected that the following audits will be resolved by the next semiannual reporting period:

CIN: A-09-06-00026	UCLA - REVIEW OF WAGE INDEX DATA: PENSION AND POSTRETIREMENT BENEFITS, SEP 2006, \$90,020,211
CIN: A-07-04-04038	MEDICAID HOSPITAL OUTLIER PAYMENTS IN NORTH CAROLINA, JAN 2006, \$89,420,140
CIN: A-09-05-00039	UC SAN FRANCISCO - REVIEW OF WAGE INDEX DATA, SEP 2006, \$72,311,155
CIN: A-09-06-00024	UC DAVIS - REVIEW OF WAGE INDEX DATA: PENSION AND POSTRETIREMENT BENEFITS, SEP 2006, \$71,030,255
CIN: A-05-05-00053	REVIEW OF LAYERED GPOS -- ROLL-UP, JUN 2006, \$59,000,000
CIN: A-07-04-04031	MEDICAID HOSPITAL OUTLIER PAYMENTS IN ILLINOIS, MAY 2005, \$56,449,668
CIN: A-09-06-00027	UC SAN DIEGO - REVIEW OF WAGE INDEX DATA: PENSION AND POSTRETIREMENT BENEFITS, SEP 2006, \$47,773,319
CIN: A-01-02-00503	FURTHER EXPANSION OF THE DRG PAYMENT WINDOW, AUG 2003, \$37,000,000
CIN: A-09-06-00025	UC IRVINE - REVIEW OF WAGE INDEX DATA: PENSION AND POSTRETIREMENT BENEFITS, SEP 2006, \$31,373,369
CIN: A-05-02-00078	ROLLUP OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, FEB 2004, \$12,764,202
CIN: A-05-03-00019	PAYMENTS FOR SERVICES TO DECEASED RECIPIENTS - NEW YORK, OCT 2004, \$6,707,623
CIN: A-05-04-00073	ROLL-UP ON ADDITIONAL GPOS, MAY 2005, \$6,600,000
CIN: A-05-02-00077	MICHIGAN MEDICAID/SCHIP REVIEW, NOV 2003, \$5,908,350
CIN: A-03-02-00203	VIRGINIA - SCHIP/TITLE IV - D SURVEY, JUL 2004, \$5,402,491
CIN: A-05-05-00033	MICHIGAN - UNDISTRIBUTED CHILD SUPPORT COLLECTIONS, AUG 2006, \$4,397,133
CIN: A-06-00-00073	REV OF MGR CARE ADDTL BENEFITS FOR CY 00 OF NYLCAR, MAR 2002, \$4,000,000
CIN: A-02-05-01008	MEDICARE WAGE INDEX - NORTH SHORE, MAY 2006, \$3,119,582
CIN: A-01-05-02502	REVIEW OF CONNECTICUT'S TRAINING AND IV-E ADOPTION ASSISTANCE COSTS, JUL 2006, \$2,400,000
CIN: A-05-02-00075	INDIANA MEDICAID/SCHIP REVIEW, NOV 2003, \$1,885,708
CIN: A-05-04-00025	REVIEW OF MEDICARE PHYSICIAN PLACE OF SERVICE CODING FOR AMBULATORY SURGICAL AND RELATED PROCEDURES, OCT 2004, \$742,510
CIN: A-05-02-00082	BID PROPOSAL FOR 1-800 MEDICARE HOTLINE ADMINISTRATION, AUG 2002, \$609,950
CIN: A-05-03-00021	CIMRO PRO PRE-AWARD AUDIT FOR NEBRASKA, NOV 2002, \$504,650
CIN: A-05-06-00020	MEDICAID PAYMENTS FOR SERVICES TO BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN MICHIGAN AND OHIO - MICHIGAN REPORT, AUG 2006, \$467,317
CIN: A-04-06-07004	ESRD BID PROPOSAL BY NETWORK ORGANIZATION NO. 8, MAY 2006, \$415,630
CIN: A-07-04-01008	FAMILY PLANNING - FEE-FOR-SERVICE - COLORADO, JAN 2005, \$269,024
CIN: A-05-00-00006	MEDICAID MUTUALLY EXCLUSIVE CODES - MICHIGAN, JUN 2000, \$240,000

Appendix A

CIN: A-04-06-07003	ESRD BID PROPOSAL BY NETWORK ORGANIZATION NO. 7, MAY 2006, \$235,966
CIN: A-05-04-00023	HEAD START COMPENSATION REVIEW - CEOGC, JAN 2005, \$178,000
CIN: A-01-05-00512	REVIEW OF 2004 ACRP MODIFICATION SUBMITTED AS A RESULT OF MMA FOR THE FALLON COMMUNITY HEALTH PLAN, JAN 2006, \$154,970
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MAR 2003, \$144,909
CIN: A-05-03-00059	ESRD #9 PRE-AWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, \$139,816
CIN: A-04-03-08013	ESRD NETWORK COST PROPOSAL, MAY 2003, \$116,085
CIN: A-05-03-00060	ESRD #10 PREAWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, \$114,289
CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JAN 2002, \$98,698
CIN: A-04-06-07005	ESRD BID PROPOSAL FOR NETWORK ORGANIZATION NO. 17, MAY 2006, \$43,435
CIN: A-05-06-00023	MINNESOTA - UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, SEP 2006, \$28,240
CIN: A-02-04-01008	GME FOR DENTAL RESIDENTS - NYU, MAY 2006, \$10,783
CIN: A-05-04-00051	ALLOWABILITY OF CDC BIOTERRORISM COSTS - OHIO DEPARTMENT OF HEALTH, FEB 2005, \$4,154

Total CINs: 38

Total Amount: \$612,081,632

Reporting Requirements of the Inspector General Act of 1978, as Amended

The reporting requirements of the Inspector General Act of 1978, as amended, are listed on the following table along with the location of the required information. Where there are no data to report under a particular requirement, the word “None” appears.

A complete listing of audit and inspection reports is furnished to Congress under separate cover. Copies are available upon request.

Section of the Act	Requirement	Location
Section 4(a)(2)	Review of legislation and regulations	p. 44
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	See <i>Red Book</i> and <i>Orange Book</i> at http://www.oig.hhs.gov/publications.html . <i>Please note:</i> The soon to be released <i>Compendium of Unimplemented Office of Inspector General Recommendations</i> will replace the <i>Red Book</i> and <i>Orange Book</i> .
(a)(4)	Matters referred to prosecutive authorities	p. 45
(a)(5)	Summary of instances in which information was refused	None
(a)(6)	List of audit reports	Under separate cover
(a)(7)	Summary of significant reports	Throughout
(a)(8)	Statistical Table 1—Reports With Questioned Costs	p. 42
(a)(9)	Statistical Table 2 - Funds Recommended To Be Put to Better Use	p. 43
(a)(10)	Summary of previous audit reports without management decisions	Appendix A
(a)(11)	Description and explanation of revised management decisions	Appendix A
(a)(12)	Management decisions with which the Inspector General is in disagreement	None

Summary of Sanction Authorities

The Inspector General Act of 1978 (Public Law 95-452), as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to Congress. A selection of other authorities appears below.

Program Exclusions

Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7) provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs. Exclusions are required for individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felonies for other health care fraud; and (4) felonies for illegal manufacture, distribution, prescription, or dispensing of controlled substances. OIG has the discretion to exclude individuals and entities on several other grounds, including misdemeanors for other health care fraud (other than Medicare or Medicaid) or for illegal manufacture, distribution, prescription, or dispensing of controlled substances; suspension or revocation of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; or engaging in unlawful kickback arrangements.

Providers subject to exclusion are granted due process rights (including a hearing before an HHS administrative law judge and appeals to the HHS Departmental Appeals Board and Federal district and appellate courts) regarding whether the basis for the exclusion exists and the length of the exclusion is reasonable.

Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. § 1395dd) provides that when an individual presents to the emergency room of a Medicare-participating hospital, the hospital must provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide either treatment to stabilize the condition or an appropriate transfer to another medical facility.

If a transfer is ordered, the transferring hospital must provide stabilizing treatment to minimize the risks of transfer and must ensure that the receiving hospital agrees to the transfer and has available space and qualified personnel to treat the individual. In addition, the transferring hospital must effect the transfer through qualified personnel and transportation equipment. Further, a participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who needs services if the hospital has the capacity to treat the individual.

OIG is authorized to collect civil monetary penalties of up to \$25,000 against small hospitals (fewer than 100 beds) and up to \$50,000 against larger hospitals (100 beds or more) for each instance in which the hospital negligently violated any of the section 1867 requirements. In addition, OIG may collect a penalty of up to \$50,000 from a responsible

physician for each negligent violation of any of the section 1867 requirements and, in some circumstances, may exclude a responsible physician.

Civil Monetary Penalties Law

Under the Civil Monetary Penalties Law (CMPL), section 1128A of the Social Security Act (42 U.S.C. § 1320a-7a), a person is subject to penalties, assessments, and exclusion from participation in Federal health care programs for engaging in certain activities. For example, a person who submits to a Federal health care program a claim for items and services that the person knows or should know is false or fraudulent is subject to a penalty of up to \$10,000 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion.

For the purposes of the CMPL, “should know” is defined to mean that the person acted in reckless disregard or deliberate ignorance of the truth or falsity of the claim. The CMPL also authorizes actions for a variety of other violations, including submission of claims for items or services furnished by an excluded person; requests for payment in violation of an assignment agreement; violations of rules regarding the possession, use, and transfer of biological agents and toxins; and payment or receipt of remuneration in violation of the anti-kickback statute (42 U.S.C. § 1320a-7b(b)).

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

■ **The Anti-Kickback Statute** – The anti-kickback statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers, or pays remuneration, in cash or in kind, to induce or in return for (1) referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Federal health care programs; or (2) purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing, or ordering of any good, facility, service, or item payable under the Federal health care programs (Section 1128B(b) of the Social Security Act, 42 U.S.C. § 1320a-7b).

Individuals and entities that engage in unlawful referral or kickback schemes may be subject to criminal penalties under the general criminal anti-kickback statute, civil monetary penalties under OIG’s CMPL authority (Section 1128A(a)(7) of the Social Security Act, 42 U.S.C. § 1320a-7a), and/or program exclusion under OIG’s permissive exclusion authority (Section 1128(b)(7) of the Social Security Act, 42 U.S.C. § 1320a-7(b)(7)).

■ **False Claims Amendments Act of 1986** – Under the Federal civil False Claims Amendments Act of 1986 (FCA) (31 U.S.C. §§ 3729-3733), a person or entity is liable for up to treble damages and a penalty between \$5,500 and \$11,000 for each false claim it knowingly submits or causes to be submitted to a Federal program. Similarly, a person or entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid.

The FCA defines “knowing” to include not only the traditional definition but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a qui tam, or whistleblower, provision that allows a private individual to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries.



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Office of Inspector General

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