



Department of Health and Human Services

# Semiannual

Report to Congress

April 1, 2006-September 30, 2006



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 September 30, 2006.

OIG is dedicated to fighting fraud, waste, and abuse and promoting economy and efficiency in the Department's varied and important programs. Over the past 6 months, OIG has produced a significant body of accomplishments that result from our continued work on longstanding issues and new activities relating to implementation of Medicare Part D and our Medicaid integrity efforts pursuant to the Deficit Reduction Act of 2005. These accomplishments also reflect effective collaboration with the Department, as well as Federal, State, and local agencies and other important stakeholders.

I am pleased to report that OIG enforcement activities produced significant and noteworthy results. OIG obtained the largest-ever administrative recovery under its civil monetary penalty authority and its first settlement with a pharmacy benefits manager for soliciting and receiving kickbacks from pharmaceutical manufacturers and potential customers. In addition, OIG reviewed pricing of Medicare and Medicaid prescription drugs and testified before Congress regarding Medicare Part B drug pricing. OIG also completed a study of nursing home emergency preparedness and response to recent Gulf Coast hurricanes.

During this reporting period, OIG also issued final regulations that establish two new safe harbors under the Federal anti-kickback statute for arrangements involving the donation of certain prescribing and electronic health information technology and services. These regulations will help to further the President's and the Secretary's goal of widespread adoption of electronic health records technology by 2014.

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.



Daniel R. Levinson  
Inspector General



# Highlights

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## Summary of Accomplishments

For fiscal year (FY) 2006, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) reported savings and expected recoveries of nearly \$38.2 billion: \$35.8 billion in implemented recommendations and other actions to put funds to better use, \$789.4 million in audit receivables, and \$1.6 billion in investigative receivables.\*

Also for this FY, OIG reported exclusions of 3,425 individuals and entities for fraud or abuse involving Federal health care programs and/or their beneficiaries; 472 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 272 civil actions, which include False Claims Act (FCA) and unjust enrichment suits filed in Federal district court, Civil Monetary Penalties Law (CMPL) settlements, and administrative recoveries related to provider self-disclosure matters.

## Average Manufacturer Prices for Prescription Drugs

As required by the Deficit Reduction Act (DRA) of 2005, OIG reviewed the requirements for and manner in which calculations of average manufacturer prices (AMP) for prescription drugs are determined. The review, which included discussions with industry groups, determined that some AMP requirements were unclear and that manufacturers' calculation methods were inconsistent.

OIG recommended that the Secretary direct the Centers for Medicare & Medicaid Services (CMS) to (1) clarify requirements for determining certain aspects of AMPs, (2) consider addressing issues raised by industry groups, (3) issue guidance on the implementation of the AMP-related reimbursement provisions of the DRA, and (4) encourage States to analyze the relationship between AMPs and pharmacy acquisition costs. CMS agreed to address these issues in its proposed regulation.

## Nursing Home Emergency Preparedness and Response During Recent Hurricanes

An OIG report recommended that CMS strengthen Federal certification standards for nursing home emergency plans. OIG's study of emergency preparedness for selected nursing homes in five Gulf Coast States during the 2004 and 2005 hurricanes found that those facilities all experienced problems, whether evacuating or sheltering in place. Administrators and staff often did not follow their emergency plans, the plans were often missing suggested provisions, and a lack of collaboration between State and local emergency entities and nursing homes impeded emergency planning and response.

## Saint Barnabas Settlement

The Saint Barnabas Health Care System (SBHCS) agreed to pay \$265 million and enter into a 6-year corporate integrity agreement (CIA) to resolve its liability under the FCA and

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\*This figure represents HHS investigative receivables only; receivables on behalf of other Federal agencies, States, and others are not included here.

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other statutes and certain common law causes of action. SBHCS is the largest health care system in New Jersey, currently operating seven acute care hospitals and other ancillary health care providers. The United States alleged that SBHCS artificially inflated its cost-to-charge ratio, triggering the outlier payments to which it was not entitled.

### **Medicare Part B Drug Studies**

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established new mandates for OIG that required ongoing monitoring of manufacturer-reported average sales prices (ASP) compared to other pricing points. OIG conducted several evaluations that looked at various pricing comparisons and found that manufacturer-reported ASPs sometimes exceeded other prices available in the marketplace. Medicare could have saved between \$64 million and \$164 million a year had these other prices been used to set reimbursement.

While conducting the mandated price comparisons, OIG found that CMS's method for calculating a volume-weighted ASP was mathematically flawed because CMS did not consistently weight the number of units of a drug that were sold throughout its equation. As a result, many procedure codes had a reimbursement amount that was higher or lower than the amount that would have been calculated if the weighting had been applied consistently. The results of these studies and other OIG work in this area were presented at a hearing before the House Ways and Means Committee's Subcommittee on Health.

### **340B Drug Prices**

In a series of reports on 340B drug prices, OIG recommended that the Health Resources and Services Administration (HRSA) improve its oversight of the 340B Program to ensure that entities are charged at or below the 340B ceiling price. OIG found that in a single month in 2005, 14 percent of total purchases made by 340B entities exceeded 340B ceiling prices, resulting in total projected overpayments of \$3.9 million. The largest price discrepancies resulted from prices that were not in line with a HRSA policy that directs manufacturers, in very specific situations, to charge entities one penny per unit.

### **Couple Sentenced for Abuse of Mentally Ill Patients**

A Kansas couple was convicted of and sentenced on charges of involuntary servitude, forced labor, conspiracy, health care fraud, and mail fraud. Operating a group home for mentally ill patients, the social worker and his wife forced and coerced the patients to perform manual labor in the nude and participate in sexually abusive "therapy" sessions. The husband and wife were sentenced to respective prison terms of 30 years and 7 years.

### **Podiatrist Sentenced to Death for Murder of Witness**

An Illinois podiatrist received the death penalty for the murder of a woman who was expected to testify against the podiatrist before a grand jury about his scheme to defraud Medicare. The woman was expected to testify about the more than 70 foot surgeries billed to Medicare that never took place.

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## **Health Information Technology Safe Harbors**

OIG issued final regulations that establish two new safe harbors under the Federal anti-kickback statute for arrangements involving the donation of certain electronic health information technology and services. The final rule seeks to lower perceived barriers to the adoption of health information technology by finalizing safe harbors that promote the adoption of electronic prescribing technology and open, interconnected, interoperable electronic health record systems while safeguarding Federal programs and beneficiaries against undue risks of fraud and abuse.

## **AdvancePCS**

AdvancePCS, a pharmacy benefits manager (PBM), agreed to pay the Government \$137.5 million and enter into a 5-year CIA to resolve its liability for allegedly soliciting and receiving kickbacks from pharmaceutical manufacturers and paying kickbacks to potential customers to induce them to contract with the company. This settlement represents the first of its kind with a PBM.

## **Targeted Case Management Services**

Medicaid pays for targeted case management services to assess Medicaid beneficiaries' service needs, refer beneficiaries to needed services, and monitor the services. It does not pay for direct social services to which beneficiaries have been referred. However, Massachusetts included the costs for direct social services in the rates used to claim reimbursement for targeted case management services. OIG recommended that the State refund the resulting \$87 million Federal overpayment and work with CMS to determine the allowability of the remaining \$13.5 million Federal share claimed. The \$13.5 million claimed may have already been reimbursed under other Federal programs.

## **Lincare Settlement**

Lincare Holdings, Inc., and its subsidiary Lincare Inc. (collectively, Lincare) agreed to pay \$10 million to resolve allegations that Lincare paid illegal kickbacks and violated the Physician Self-Referral Law. OIG alleged that from January 1993 through December 2000, Lincare engaged in a nationwide scheme to pay physicians kickbacks to refer their patients to Lincare. The Lincare settlement represents OIG's largest administrative settlement to date.

## **Universities' Compliance With Select Agent Regulations**

In this summary report, OIG noted that 11 of the 15 universities reviewed did not fully comply with Federal requirements regarding securing and accounting for select agents. Select agents are materials that could pose a severe threat to public health and safety as a result of inadvertent, terrorist or other criminal acts. The Centers for Disease Control and Prevention agreed to resolve the recommendations in OIG's individual reports to the universities.

## **Food and Drug Administration Postmarketing Study Commitments**

An OIG evaluation identified vulnerabilities that raise concerns that the Food and Drug Administration is not able to readily identify whether or how timely postmarketing study commitments are progressing toward completion. After a drug has been approved for

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marketing, drug applicants can learn more about the risks, benefits, and optimal use of a drug by conducting postmarketing studies. About one-third of annual status reports were missing or incomplete, and others contained information that is of limited use.

# Office of Inspector General's Hurricane-Related Activities

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In response to the Gulf Coast hurricanes of 2005, the Office of Inspector General (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, which is coordinating the oversight activities of the various Inspectors General. OIG is taking the lead in developing information related to State and Local Liaisons as part of a comprehensive Hurricane Action Plan currently under development 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, evaluation, and investigative activities related to the oversight of U.S. Department of Health and Human Services (HHS) hurricane recovery efforts. These activities have been performed under existing appropriations. A list of ongoing and completed projects follows:

## **Department Accounting for Federal Emergency Management Agency Assignments**

As of June 30, 2006, the spending authority for HHS Federal Emergency Management Agency (FEMA)-requested mission assignments totaled \$315.4 million. This spending authority is contained within 121 individual mission assignments with different magnitudes and objectives. OIG's audits will determine whether HHS is appropriately accounting for these costs.

## **Nursing Home Emergency Preparedness and Response During Recent Hurricanes**

An OIG report recommended that the Centers for Medicare & Medicaid Services (CMS) consider strengthening Federal certification standards for nursing home emergency plans after OIG's study of emergency preparedness for homes in five Gulf Coast States found that the homes all experienced problems during the 2004 and 2005 hurricanes, whether evacuating or sheltering in place. Nursing home administrators and staff often did not follow their emergency plans, the plans were often missing suggested provisions, and a lack of collaboration between State and local emergency entities and nursing homes impeded emergency planning and response.

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

OIG will continue to be involved in hurricane-related investigations. Currently, OIG has 12 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 cases that include allegations of individuals fraudulently obtaining benefits based on false information.

## **Auditing Vulnerable Hurricane-Related Procurements**

OIG is auditing all hurricane-related contractual procurements over \$500,000. These audits will specifically focus 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 September 30, 2006, OIG had issued nine audit reports with an audited value of \$26.2 million. OIG is in the process of completing and issuing an additional 63 reports with an audited value of \$66.5 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 require enroute medical care and therefore cannot travel via commercial air or without medical assistance. It is estimated that 6,000 individuals may need to be transported. This contractor was awarded \$21 million to transport evacuees back to their medical facilities.

## **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 Inspector General (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.

## **Use of Emergency Preparedness Grants in Selected Gulf Coast States**

OIG is auditing the use of HHS emergency preparedness grant funding in selected Gulf Coast States to determine whether such funding, which is provided annually by the Centers for Disease Control and Prevention and the Health Resources and Services Administration, was used for approved purposes and whether items funded by these grants were effective in the hurricane response and recovery efforts. Reviews are being performed in Florida, Alabama, Louisiana, Texas, and Mississippi.

## **Implementation of National Response Plan Responsibilities**

OIG will audit HHS's implementation of its responsibilities under the National Response Plan, specifically, Emergency Support Function #8: Public Health and Medical Services. At appropriate departmental, operating division, and staff division levels, OIG will assess

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the handling of FEMA-requested mission assignments using established plans, objectives, and other pertinent benchmarks. The audit results will be critical for improving departmental processes for future public emergencies.

### **Use of Purchase Cards in Response to Hurricane Katrina**

OIG is analyzing the use of purchase cards by HHS personnel deployed in response to Hurricane Katrina. The study focuses on compliance with both established and emergency HHS and agency spending guidelines and procedures. This study builds on OIG's March 2003 report "International Merchant Purchase Authorization Card Program: Review of Calendar Year 2001 Transactions." That study found that 44 percent of sampled transactions did not fully comply with requirements for using the cards. These past findings, combined with the urgent nature of the responses to Hurricane Katrina, provide a useful opportunity to examine the use of HHS purchase cards during responses to large-scale public health emergencies.

### **Commissioned Corps's Deployment in Response to Hurricane Katrina**

OIG is evaluating the U.S. Public Health Service Commissioned Corps' responses to Hurricanes Katrina and Rita and identifying whether and how the Corps could improve its response to future public health emergencies. This deployment was one of the largest in the Corps' 207-year history and came at a time when the Corps was working toward the goal of being 100-percent deployable. In the weeks following Hurricane Katrina, more than 1,400 officers worked with State, local, and private agencies in seven Gulf Coast States; after 1 month, more than 700 remained in the Gulf Coast States and evacuee areas to provide relief services.

### **Hurricane Katrina-Related Medical Review Contract**

Because of the effects of Hurricane Katrina, 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 received needed health care, HHS used Section 1115 and 1135 waiver authorities to expand Medicaid coverage criteria. In this study, OIG describes the services and payments made under Section 1115 Medicaid waivers for victims of Katrina and determines the extent to which providers enrolled in Medicaid under the Section 1135 waiver authority.



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Please note: Numerical information in this report is rounded.

# **Centers for Medicare & Medicaid Services**

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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 either to 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.

The U.S. Department of Health and Human Services (HHS or the Department) Office of Inspector General (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

### Medicare's Program Safeguard Contractors: Performance Evaluation Reports

Program safeguard contractors (PSCs) are entities that are awarded benefit integrity task orders by CMS to detect and deter fraud and abuse in Medicare, as well as to undertake other projects. OIG found that CMS's most current performance evaluation report for each of the 17 benefit integrity task orders contained little or no information on results, especially quantitative results, regarding PSCs' detection and deterrence of fraud and abuse. OIG also found that 72 percent of performance evaluation reports for 1999–2004 were issued on time, while 28 percent were late.

OIG recommended that CMS include PSC results in its performance evaluation reports. For example, if PSC activities are saving money for the Medicare program, the activity and the amount of money saved should be included in the reports. OIG also recommended that CMS provide information about required fraud and abuse detection and deterrence activities in the reports. In addition, CMS should ensure that all draft and final reports are issued on time and should establish a means to track and save evaluation milestone dates. CMS concurred in part with OIG's recommendations, but expressed concern about how best to address results in PSC performance evaluation reports. CMS stated that quantifying PSC output could create the appearance of case quotas. (OEI-03-04-00050)

### Consultations in Medicare: Coding and Reimbursement

OIG found that Medicare allowed \$1.1 billion in improper payments in fiscal year (FY) 2001 for services billed as consultations. Medicare allowed approximately \$191 million for services that did not meet its definition of a consultation. Medicare and its beneficiaries overpaid an additional \$613 million for consultations that were billed as the incorrect type or level of complexity and \$260 million for undocumented consultations.

Consultations billed at the highest level (for the most complex services, which generate the highest reimbursements under the Medicare physician fee schedule) and follow-up inpatient consultations were particularly problematic: approximately 95 percent of each were miscoded or undocumented.

To reduce the incidence of improperly billed consultations, OIG recommended that CMS educate physicians and other health care professionals about the criteria and proper billing for all types and levels of consultations, emphasizing the highest billing levels and follow-up inpatient consultations. CMS agreed with the recommendations and outlined a plan to publish an article about consultations on its Web site. CMS also noted that codes for billing follow-up inpatient and confirmatory consultations have been eliminated from the reference text *Current Procedural Terminology*, effective January 1, 2006, which should reduce coding errors. (OEI-09-02-00030)

### **Medicare Advantage Marketing Materials for Calendar Year 2005**

This report determined whether Medicare Advantage marketing materials for 2005 met CMS's marketing requirements. OIG found that some marketing materials in its sample lacked CMS-required information concerning limitations to prescription drug benefits. In addition, some materials in the sample lacked elements required by CMS to ensure that beneficiaries can access plan information, and some marketing materials in the sample did not clearly convey information concerning other aspects of plan coverage. CMS's continued diligence in reviewing marketing materials is essential. OIG had no recommendations for CMS in this report. CMS concurred with the findings, stating that the report will help it improve its marketing materials review process. (OEI-01-05-00130)

### **Cost and Performance of Medicare's 2005 Chemotherapy Demonstration Project**

In an evaluation conducted at the request of the Senate Committee on Finance, OIG estimated the total cost of Medicare's chemotherapy demonstration by analyzing Medicare paid claims data through the end of 2005. To conduct an overall assessment of the demonstration, OIG interviewed staff at CMS and four oncology practices that participated in the demonstration to learn how they implemented the demonstration requirements.

This study estimated that Medicare and its beneficiaries would spend approximately \$275 million for the 2005 chemotherapy demonstration. Participation in the project was high; 90 percent of eligible providers took part, and approximately 85 percent billed the demonstration codes at 50 percent or more of eligible chemotherapy administration visits. Seven percent of paid demonstration claims did not comply with program rules or were paid incorrectly, resulting in \$17 million in overpayments. Furthermore, because the parameters of the demonstration were not sufficiently defined, OIG concluded that the data are unreliable. (OEI-09-05-00171)

### **Determining Average Manufacturer Prices for Prescription Drugs Under the Deficit Reduction Act of 2005**

The Medicaid drug rebate program requires manufacturers of prescription drugs to determine and report the average manufacturer prices (AMP)—generally the average prices paid to the manufacturer by wholesalers for drugs distributed to retail pharmacies. Manufacturers pay rebates to States based on AMPs and other factors. The Deficit Reduction Act (DRA) of 2005 changed the manner in which drug manufacturers determine the AMP and required that the AMP be used in setting Federal upper payment limits for certain drugs under the Medicaid program. The DRA also directed OIG to review the requirements for determining AMPs, and the way they are determined, to make recommendations based on this review.

OIG found that some AMP requirements were unclear and that manufacturers' methods of calculating AMPs were inconsistent. Consistent with OIG's findings, industry groups also emphasized the need to clarify certain AMP requirements and raised additional issues related to the implementation of DRA provisions. OIG recommended that the HHS Secretary direct CMS to clarify requirements for determining certain aspects of

AMPs, including the definition of “retail class of trade,” and to clarify the treatment of pharmacy rebates and Medicaid sales. OIG also recommended that the Secretary direct CMS to (1) consider addressing issues raised by industry groups, (2) issue guidance that specifically addresses the implementation of the AMP-related reimbursement provisions of the DRA, and (3) encourage States to analyze the relationship between the AMP and pharmacy acquisition costs to ensure appropriate pharmacy reimbursement. CMS agreed to address each recommended area in its proposed regulation and to evaluate the need for additional guidance. (A-06-06-00063)

### **Medicare Beneficiary Access to Skilled Nursing Facilities and Home Health Care: 2004**

Two OIG evaluations assessed Medicare beneficiaries’ access to skilled nursing facilities (SNFs) and home health care since the implementation of the prospective payment system. These studies are the most recent in a series conducted by OIG on access to SNFs and home health care for Medicare beneficiaries since the Balanced Budget Act of 1997 required payments for these to be made on a prospective basis. The studies were based on structured interviews with 256 hospital discharge planners with experience placing Medicare beneficiaries in SNFs and home health care, and an analysis of 5 years of Medicare data for beneficiaries discharged from hospitals to either a SNF or home health care.

OIG found that most Medicare beneficiaries have access to both SNFs and home health care. In the first report, OIG also found that beneficiaries with certain medical conditions, such as those requiring expensive drugs or wound care, may experience delays being placed in a SNF. Similarly, in the report on home health care, OIG found that beneficiaries with certain medical conditions, such as those needing intravenous antibiotics and/or expensive drugs or complex wound care, may experience delays being placed in home health care.

OIG concluded that these findings are generally consistent with the findings in its prior reports, suggesting that, overall, the prospective payment system has not resulted in reduced access to SNF care or home health care. OIG encouraged CMS to continue to monitor access to skilled nursing care and home health care, particularly for beneficiaries with certain medical conditions or service needs who may experience delays in accessing such care. (OEI-02-04-00260; OEI-02-04-00270)

### **Medicare Drug Price Comparisons Mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003**

In 2005, Medicare began paying for most Part B drugs using a new methodology based on average sales price (ASP). Pursuant to section 1847A(d)(3) of the Social Security Act, OIG must notify the HHS Secretary if the ASP for a particular drug exceeds the average manufacturer price (AMP) or widely available market price (WAMP) by a threshold of 5 percent. If that threshold is met, section 1847A(d)(3) of the Act grants the Secretary authority to disregard the ASP and substitute the payment amount for the drug with the lesser of the WAMP (if any) for the drug or 103 percent of the AMP.

OIG recently completed the following three studies that compare ASP to AMP and WAMP:

■ **Monitoring Medicare Part B Drug Prices: A Comparison of Average Sales Prices to Average Manufacturer Prices**—OIG found that in the third quarter of 2004, 51 of the 364 procedure codes (14 percent) included in this review had an ASP that exceeded the AMP by at least 5 percent. If reimbursement amounts for these 51 codes had been lowered to 103 percent of the AMP, Medicare expenditures would have been reduced by an estimated \$164 million in 2005. In response, CMS stated that the information in the report was helpful in its continuing efforts to monitor payment adequacy under the ASP methodology. However, CMS noted that OIG’s review was conducted using data submitted during the initial implementation phase of the ASP methodology. Although CMS acknowledged the Secretary’s authority to adjust ASP payment limits when certain conditions are met, it believed that other factors should be considered, including the timing and frequency of pricing comparisons, stabilization of ASP reporting, the effective date and duration of rate substitution, and the accuracy of ASP and AMP data. (OEI-03-04-00430)

■ **Comparison of Fourth Quarter 2005 Average Sales Prices to Average Manufacturer Prices: Impact on Medicare Reimbursement for the Second Quarter of 2006**—OIG found that for 46 of the 341 procedure codes (13 percent) included in this review, ASPs exceeded AMPs by at least 5 percent in the fourth quarter of 2005. Twenty of these codes were identified in OIG’s previous report as having ASPs that exceeded AMPs by at least 5 percent in the third quarter of 2004. If reimbursement amounts for the 46 codes had been based on 103 percent of the AMP, OIG estimated that Medicare expenditures would have been reduced by \$64 million in 1 year. (OEI-03-06-00370)

■ **A Comparison of Average Sales Prices to Widely Available Market Prices: Fourth Quarter 2005**—For this analysis, OIG specifically selected a purposive sample of nine procedure codes for which OIG suspected that ASPs might exceed WAMPs by at least 5 percent. The purposive sample was based on the results of the September 2005 OIG report on adequacy of reimbursement for cancer drugs. OIG found that five of the nine procedure codes included in this review met or surpassed the 5-percent threshold defined by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). For these 5 codes, the ASPs exceeded the WAMPs by a range of 17 to 185 percent. OIG estimated that Medicare expenditures would be reduced by as much as \$67 million in 2006 if reimbursement amounts were lowered to the WAMPs for these five codes. In addition, the prices that physicians pay for these drugs may be even lower than the WAMPs that were calculated, as all of the responding distributors offered price discounts to physician customers that were not reflected in the calculation of WAMPs. (OEI-03-05-00430)

### **Nursing Home Emergency Preparedness and Response During Recent Hurricanes**

Federal regulations require that Medicare- and Medicaid-certified facilities maintain written plans and procedures to meet all potential emergencies and to train employees in emergency procedures. An OIG review examined the experiences of selected nursing

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homes in the five Gulf Coast States during recent hurricanes and the completeness of their emergency preparedness plans. The review found that while 94 percent of selected nursing homes met Federal standards for emergency plans and 80 percent had sufficient emergency training, all experienced problems whether they evacuated or sheltered in place. Nursing homes that evacuated faced problems such as transportation contracts that were not honored, lengthy travel times, host facilities that were unavailable or inadequately prepared, inadequate staffing, insufficient food and water, and difficult reentry to facilities. OIG also found that nursing home administrators and staff often did not follow their emergency plans, that the emergency plans often lacked provisions, and that a lack of collaboration between State and local emergency entities and nursing homes impeded emergency planning and response.

OIG recommended that CMS consider strengthening Federal certification standards for nursing home emergency plans by including requirements for specific elements of emergency planning, and that CMS encourage communication and collaboration among State and local emergency entities and nursing homes. CMS concurred with these recommendations and is exploring ways to strengthen Federal certification standards for emergency preparedness and to promote better coordination among Federal, State, and local emergency management entities. (OEI-06-06-00020)

### **Medicare Reimbursement for New End-Stage Renal Disease Drugs**

The MMA required that OIG conduct two studies on drugs used to treat end-stage renal disease (ESRD) patients. The first study reviewed ESRD drugs in existence when the MMA passed, and OIG issued its first report on this topic in May 2004. In this second study, OIG compared the Medicare reimbursement amount for new ESRD drugs to facility acquisition costs. For purposes of this study, new drugs were those for which a billing code did not exist before January 1, 2004.

OIG determined that just one new drug, darbepoetin alfa, was widely used in independent dialysis facilities during the time covered by this review. OIG found that independent dialysis facilities were able to purchase darbepoetin alfa at prices below the Medicare reimbursement amount in 2005. At that time, the average acquisition cost for the drug was \$2.59 per microgram, while Medicare reimbursement ranged from \$3.01 to \$3.54 per microgram. This report did not include recommendations for CMS. (OEI-03-06-00200)

### **Excessive Payments for Medicare Outpatient Services**

During calendar year (CY) 2003, a Medicare fiscal intermediary made 54 payments of \$50,000 or more each to providers for outpatient services. OIG found that 45 of the payments were incorrect because the providers inappropriately overstated the units of service. OIG recommended that the intermediary (1) inform OIG of the status of the recovery of the \$2.8 million in overpayments that the audit identified, (2) identify and recover additional overpayments made on high-dollar outpatient claims paid after CY 2003, and (3) use the results of the audit in its provider education activities. The intermediary agreed with the recommendations. (A-01-05-00514)

### **Medicare Contractor's Administrative Costs**

This audit found that a Medicare contractor's internal controls were largely effective in identifying administrative costs to be excluded from cost proposals. However, the contractor claimed nearly \$4.7 million in administrative costs that were not allowable for Medicare reimbursement.

OIG recommended that the contractor make a \$4.7 million adjustment, work with CMS to determine the allowability of \$2.1 million in reported forward-funding costs, and ensure that future cost proposals are calculated accurately. The contractor partially disagreed. (A-02-03-01020)

### **Medicare Contractor's Pension Segmentation Requirements**

Since its inception, Medicare has paid a portion of Medicare contractors' annual contributions to their pension plans. CMS requires that contractors' claims for pension costs comply with the Medicare contracts.

A Medicare contractor in Utah did not correctly identify the initial allocation of pension plan assets to the Medicare segment as of January 1, 1986, and did not comply with the Medicare contract's pension segmentation requirements for updating Medicare segment assets from January 1, 1986, to January 1, 1991. In addition, the contractor did not update the Medicare segment assets from January 1, 1991, to January 1, 1998.

OIG recommended that the contractor identify Medicare segment pension assets of more than \$2.1 million as of January 1, 1998. The contractor agreed. (A-07-05-00190)

### **Independent Diagnostic Testing Facilities' Claims for Medicare Services**

An independent diagnostic testing facility (IDTF) is an entity independent of a hospital or physician's office in which licensed or certified technicians perform diagnostic tests under physician supervision. Medicare requires that IDTF services be reasonable and necessary, ordered by a physician, and sufficiently documented. During the audit period, Medicare also required IDTFs to report any change in personnel, equipment, tests performed, ownership, or location to the Medicare carrier within 30 days of the change.

Based on a sample of services paid by 10 Medicare carriers, OIG identified approximately \$165,000 in overpayments and estimated that the carriers made improper Medicare payments of \$71.5 million to IDTFs. In addition, 191 IDTFs did not comply with enrollment update requirements.

OIG recommended that CMS require its carriers to recover the \$165,000, perform follow-up reviews to identify and recover the potential \$71.5 million in improper payments, and consider performing site visits to monitor IDTFs' compliance with update requirements if funding is available. CMS agreed with the first two recommendations subject to certain conditions. CMS stated that, because of funding limitations, it was not able to require Medicare carriers to conduct site visits to monitor compliance. (A-03-03-00002)

### **Medicare Claims for Outpatient Physical and Occupational Therapy Services**

Medicare covers outpatient physical and occupational therapy services provided by qualified therapists in private practice. Medicare requires that these services be reasonable and necessary for the treatment of a beneficiary's illness or injury and that they be provided according to an established plan of treatment reviewed by the beneficiary's physician.

OIG sampled 114 claims for outpatient physical and occupational therapy services performed by a California provider from 2000 through 2003 and found that none met Medicare reimbursement requirements. As a result, the provider received more than \$41,000 in unallowable Medicare payments. Projecting these results to the population, OIG estimated that at least \$10 million of the \$11.1 million that the provider received for outpatient physical and occupational therapy claims was unallowable.

OIG recommended that the provider refund \$10 million to the Medicare program and work with CMS to determine the allowability of services billed after 2003. The provider did not respond; the provider's Medicare carrier said that it would work with CMS to address the recommendations. (A-09-04-00069)

### **Medicare Payments to Community Mental Health Centers**

Partial hospitalization is an intensive outpatient program of psychiatric services that community mental health centers (CMHC) may provide to patients in lieu of inpatient psychiatric care. OIG conducted several reviews to determine whether Medicare payments to CMHCs for partial hospitalization services complied with reimbursement requirements.

■ A fiscal intermediary did not calculate payments to a CMHC in Louisiana in accordance with Medicare reimbursement requirements. The intermediary used incorrect cost report information, incorrectly entered information in its claim-processing system, and assigned an incorrect geographic wage index factor. As a result, the intermediary overpaid the CMHC almost \$8.2 million. OIG recommended that the intermediary collect the overpayment, review claims subsequent to the audit period, and implement controls to ensure that future payments are calculated correctly. The intermediary disagreed with most of the recommendations. (A-06-04-00032)

The intermediary made similar errors in calculating payments to the remaining 38 CMHCs in its service area. As a result, the CMHCs were overpaid almost \$8 million. OIG recommended that the intermediary collect the overpayments, review claims subsequent to the audit period and make any necessary financial adjustments, and implement controls to ensure that future payments are calculated correctly. Again, the intermediary generally disagreed. (A-06-04-00065)

■ Medical reviewers found that 95 of the 100 sampled claims submitted by a CMHC in Florida did not meet Medicare reimbursement requirements relating to initial certification/evaluation by a physician, recertification, and/or beneficiary eligibility. Based on the sample results, OIG estimated that the CMHC was overpaid \$4.8 million.

The CMHC disagreed with the findings, and OIG issued the report to CMS for resolution. OIG recommended that CMS determine the allowability of the claims that resulted in the \$4.8 million estimate of unallowable payments. (A-04-04-02003)

### **Inpatient Rehabilitation Facilities' Compliance With Medicare Transfer Regulation**

Medicare pays the full prospective payment to an inpatient rehabilitation facility (IRF) that discharges a beneficiary to home. In contrast, under its transfer regulation, Medicare pays a lesser amount if the IRF transfers the beneficiary to certain other types of facilities.

Nationwide, OIG identified 2,473 IRF claims coded and paid as discharges to home that potentially should have been paid as transfers during FY 2003. The IRFs that OIG contacted attributed the miscoded claims to clerical errors. Also, a key claim-processing system, the Common Working File, did not contain the necessary edits to compare the date a beneficiary was discharged from an IRF with the date the beneficiary was admitted to another provider. As a result, estimated overpayments to IRFs totaled almost \$12 million.

OIG recommended that CMS collect the overpayments, review claims paid after the audit period, and implement system edits to identify miscoded claims. CMS agreed with the recommendations. (A-04-04-00008)

### **Medicare Part B Payments for Radiology Services**

Under the inpatient prospective payment system, Medicare payments to hospitals cover outpatient radiology services provided to beneficiaries during inpatient hospital stays. During CYs 2001–2003, carriers inappropriately made Part B payments for more than 100,000 outpatient radiology services provided to hospital inpatients. Rather than billing the hospitals for these services, suppliers billed the carriers and received separate payments. As a result, Medicare overpaid an estimated \$20 million. In addition, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid approximately \$5.7 million in coinsurance and deductibles related to these potential overpayments. Neither CMS nor its carriers had established computerized edits or postpayment review procedures for identifying duplicate Part B payments.

OIG recommended that CMS instruct the Medicare carriers to recover the \$20 million in potential overpayments, establish prepayment controls to detect and prevent duplicate payments, and educate the Medicare carriers and radiology suppliers on the most common types of payment errors. CMS generally agreed. (A-01-04-00528)

### **Hospital Wage Data Used To Calculate Inpatient Prospective Payment System Wage Indexes**

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. The wage indexes are based on data that hospitals include in their Medicare cost reports. OIG determined whether several hospitals

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complied with Medicare requirements for reporting wage data in their Medicare cost reports.

■ A hospital in Illinois overstated its wage data by nearly \$4.4 million and 1,744 hours. OIG recommended that the hospital submit a revised FY 2003 Medicare cost report to the fiscal intermediary and implement procedural improvements. The hospital concurred with OIG's findings and adjustments but did not address the recommendations. (A-05-05-00022)

■ OIG reviewed two hospitals in New York. The first hospital overstated its wage data by more than \$3.1 million and more than 1,500 hours. The second hospital overstated its salaries by \$311,000 and understated its hours by 10,940. OIG recommended that the hospitals submit revised FY 2003 Medicare cost reports to the fiscal intermediaries and implement procedural improvements. The hospitals generally agreed. (A-02-05-01004; A-02-05-01008)

■ OIG also reviewed three hospitals in Florida. The first hospital understated its wage data by more than \$2.9 million and more than 175,000 hours. The second hospital overstated its wage data by \$2.4 million and 57,897 hours. The third hospital overstated its wage data by \$910,000 and 52,895 hours. OIG recommended that the hospitals submit revised FY 2003 Medicare cost reports to the fiscal intermediaries and implement procedural improvements. The hospitals generally agreed. (A-04-05-02003; A-04-05-02002; A-04-05-02001)

■ A hospital in California overstated wage data by approximately \$1.7 million and more than 473,000 hours. As a result of OIG's review, the hospital filed an amended FY 2004 Medicare cost report. However, nearly \$1.3 million of wages and approximately 27,000 related hours remained overstated. OIG recommended that the hospital submit another revised FY 2004 Medicare cost report to the fiscal intermediary and implement procedural improvements. The hospital agreed. (A-09-05-00040)

■ A hospital in New Jersey overstated its wage data by nearly \$312,000 and understated hours by 1,865. OIG recommended that the hospital submit a revised FY 2003 Medicare cost report to the fiscal intermediary and implement procedural improvements. The hospital concurred. (A-03-05-00005)

### **New Jersey's Controls for Preventing Duplicate Medicaid and State Children's Health Insurance Program Payments**

SCHIP enables States to provide health care coverage to uninsured children whose family incomes are too high to qualify for Medicaid but too low to afford private coverage. In this report, OIG examined whether New Jersey's controls were adequate to prevent Medicaid and SCHIP from duplicating payments for the same beneficiary. New Jersey's controls were adequate to prevent Medicaid and SCHIP from making duplicate provider payments and to prevent beneficiaries from enrolling in both programs. However, New Jersey overstated SCHIP payments by approximately \$1 million.

OIG recommended that New Jersey refund the Federal share, approximately \$600,000. New Jersey agreed with the findings regarding the overpayment, and it has implemented programming changes to prevent future overpayments. (A-02-04-01011)

### **Graduate Medical Education for Dental Residents**

The Medicare program makes payments to teaching hospitals to support graduate medical education (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 full-time equivalent (FTE) residents that the hospitals train. The Balanced Budget Act of 1997 permitted hospitals to count residents who train in nonhospital settings for purposes of indirect, in addition to direct, GME payments. In order to count FTE residents training in nonhospital settings, hospitals are required to incur all or substantially all the costs of the training programs in those sites. OIG reviewed hospitals in several States to determine whether they included the appropriate number of dental residents in their FTE counts when computing Medicare GME payments.

■ **California**—A hospital in California inappropriately included a total of 153.88 direct GME FTEs and 159.69 indirect GME FTEs in its counts for FYs 2000 through 2002 without incurring all the costs of training dental residents in nonhospital sites for those years. As a result, the hospital overstated its direct and indirect GME claims by a total of \$3.9 million.

OIG recommended that the hospital refund \$3.9 million, establish procedures to ensure that the FTE counts for residents in nonhospital settings include only those FTEs for which the hospital has incurred all or substantially all of the training costs, and review subsequent Medicare cost reports and refund any overpayments. The hospital generally disagreed. (A-04-04-06012)

■ **Ohio**—A hospital in Ohio inappropriately included a total of 75.04 direct GME FTEs and 92.29 indirect GME FTEs in its counts for FYs 2000 through 2002 without incurring all the costs of training dental residents in nonhospital sites for those years. As a result, the hospital overstated its direct and indirect GME claims by a total of \$3.5 million.

OIG recommended that the hospital file an amended cost report, establish procedures to ensure that the FTE counts for residents in nonhospital settings include only those FTEs for which the hospital has incurred all or substantially all of the training costs, and review subsequent Medicare cost reports and refund any overpayments. The hospital generally disagreed. (A-04-04-06009)

■ **Virginia**—A hospital in Virginia appropriately computed and claimed GME payments in FYs 2001 and 2002. However, in FY 2000, the hospital inappropriately included 41.90 direct GME FTEs and 34.07 indirect GME FTEs in its counts without incurring all the costs of training dental residents in nonhospital sites that year. As a result, the hospital overstated its direct and indirect GME claims by approximately \$1.6 million.

OIG recommended that the hospital file an amended cost report, establish written procedures regarding FTE counts, and work with CMS to resolve FTEs corresponding to the didactic time of residents assigned to nonhospital settings. The hospital disagreed. (A-04-03-06019)

■ **New York**—A hospital in New York appropriately included dental residents in the FTE counts that it used to compute CYs 2000 and 2001 GME payments. However, for CY 2002, the hospital overstated the FTE counts for its dental residents. Contrary to Federal regulations, the hospital inaccurately recorded the number of resident days worked and inappropriately claimed the time of a resident who had exceeded his initial residency period. As a result, the hospital overstated its direct GME claims by nearly \$11,000.

OIG recommended that the hospital file an amended cost report, educate staff on the importance of accurately recording resident days, review subsequent Medicare cost reports, refund any overpayments, and work with CMS to resolve the FTEs corresponding to the didactic time of residents assigned to nonhospital settings. The hospital generally agreed. (A-02-04-01008)

### Medicaid Hospital Outlier Payments

Some States make outlier payments to hospitals when the cost of treating a Medicaid inpatient is extraordinarily high compared with the average cost of treating comparable conditions. OIG reported on two States' methods of computing outlier payments.

■ **New York**—New York's method of computing inpatient hospital cost outlier payments generally resulted in reasonable payments. However, New York did not use the most accurate cost-to-charge ratios to convert billed charges to costs. Had it done so, New York could have saved approximately \$21.5 million (\$10.75 million Federal share) in cost outlier payments between State FYs 1998 and 2002 at the three hospitals reviewed.

OIG recommended that New York amend its State plan to require retroactive adjustments of interim cost outlier payments based on cost report data for the year in which the inpatient discharge occurred. New York concurred with the recommendation but stated that implementation would require changes in State regulations and the applicable State plan. (A-02-04-01022)

■ **Texas**—Texas did not limit cost outlier payments to exceptionally high-cost cases. Specifically, the State (1) did not use current cost-to-charge ratios, (2) used noncovered charges in calculating the outlier payments, and (3) did not have sufficient policies and procedures in place to monitor cost outlier payments.

OIG recommended that Texas revise its method of computing cost outlier payments and develop policies and procedures to more closely monitor outlier payments. Texas disagreed with the first recommendation but agreed to review and update its processes. (A-06-04-00051)

### **Medicaid Disproportionate Share Hospital Payments**

Section 1923 of the Social Security Act, as amended, requires that States make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. This limit is known as the hospital-specific DSH limit.

DSH payments to a hospital in New Jersey exceeded the hospital-specific limits by \$171.4 million (\$85.7 million Federal share). The State's consultant erroneously included \$169.2 million of appropriations to a medical school in its calculations of the hospital's DSH limits. This amount was not DSH-eligible and should not have been included in the DSH limit calculations. In addition, the State claimed \$2.2 million of duplicate DSH expenditures.

OIG recommended that the State refund \$85.7 million to the Federal Government, adhere to Federal law and State plan requirements when submitting future DSH claims for Federal reimbursement, and review consultants' work to ensure the veracity of future Medicaid claims. The State partly agreed. (A-02-04-01004)

### **Resolution of Audit Findings on States' Beneficiary Eligibility Determinations for Medicaid and the State Children's Health Insurance Program**

The Office of Management and Budget (OMB) requires most non-Federal recipients of Federal awards to have periodic "single" audits, which are audits of all Federal awards given to an entity. Each Federal awarding agency is responsible for resolving audit findings that relate to its Federal awards by issuing a management decision on needed corrective actions. Departmental guidance requires CMS to resolve audit findings within 6 months. As of November 1, 2005, CMS had not resolved all single audit findings from FY 2002–2003 on States' Medicaid and SCHIP beneficiary eligibility determinations. CMS had not resolved the findings in 11 of the 22 FY 2002 audit reports, 25 of the 28 FY 2003 audit reports, or any of the 25 FY 2004 audit reports. As a result, CMS did not have reasonable assurance that States had corrected their deficiencies.

OIG recommended that CMS resolve its backlog of unresolved audit findings and resolve future findings within 6 months of receiving the audit reports. CMS substantially agreed with the recommendations and stated that it had already initiated a review of its audit resolution process. (A-07-06-03073)

### **Generic Drug Utilization in State Medicaid Programs**

Prescription drug costs are one of the largest- and fastest-growing Medicaid expenditures. Congress and CMS have expressed support for using generic drugs to contain prescription drug costs. OIG found that in 2004 Medicaid demonstrated high utilization of generic drugs. On average, generics were dispensed 89 percent of the time for multisource drugs (i.e., those for which generic substitutes were available). This compares favorably with a 90-percent private-sector benchmark. However, 41 percent of

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all prescriptions were for drugs that had no generic substitutes. Overall, on average, 54 percent of all drugs dispensed were generics. In light of these findings, OIG concluded that many States may have already achieved many of the gains possible in generic utilization through increased generic substitution. States may realize greater gains by encouraging the prescribing of drugs that have generic equivalents, rather than single-source drugs. Such efforts should be undertaken with caution to ensure that beneficiaries maintain access to appropriate treatment.

OIG suggested that CMS consider providing information and technical assistance to States that wish to increase generic drug utilization. In its comments, CMS indicated that it strongly encourages the dispensing of generic drugs as a cost-saving measure. CMS concurred with OIG's suggestion and noted that it would share this report with States and encourage States to review their generic drug use by therapeutic class. (OEI-05-05-00360)

### **Medicaid School-Based Health Claims in New Jersey**

Under Federal and State law and the Medicaid State plan, New Jersey schoolchildren who are eligible for the State's Medicaid school health program must receive a health professional's prescription or referral to receive speech, physical, or occupational therapy and nursing services. Individuals who provide such services must meet Federal qualification standards.

Of New Jersey's 150 school-based claims sampled, 109 did not comply with these requirements. Deficiencies occurred because the State did not provide guidance regarding Federal Medicaid requirements and school health providers failed to comply with other State guidance they had received. In addition, the State did not adequately monitor school health claims for compliance. OIG estimated that approximately \$51 million in Federal Medicaid funding to New Jersey was unallowable.

OIG recommended that New Jersey refund the \$51 million and emphasize to school districts the need to comply with Federal and State requirements. New Jersey did not concur with OIG's financial adjustment but agreed to work with CMS concerning approximately \$1 million in set-aside claims arising from the State's lack of guidance and/or compliance. (A-02-03-01003)

### **Medicaid School-Based Health Service Payment Rates in Kansas**

Kansas did not develop its payment rates for Medicaid school-based health services pursuant to Federal requirements and the State plan. Kansas used incorrect indirect cost rates and service utilization data to develop the payment rates. As a result, the payments to school districts for FYs 1998–2003 were incorrect, and Kansas received \$18.5 million of overpayments.

OIG recommended that Kansas refund \$18.5 million to the Federal Government, calculate and refund all overpayments that occurred subsequent to the audit period, and develop and implement adequate internal controls to ensure that future Federal claims for school-based services are consistent with Federal requirements and the State plan. Kansas concurred with two of the recommendations but did not address the

recommendation to calculate and refund overpayments subsequent to the audit period. (A-07-05-01018)

### **Montana's Accounts Receivable System for Medicaid Provider Overpayments**

An overpayment is a payment to a provider in excess of the allowable amount. Federal regulations require that State Medicaid agencies refund the Federal share of overpayments at the end of the 60-day period following discovery, whether or not the State has recovered the overpayment from the provider, unless the provider has filed for bankruptcy or gone out of business.

Montana did not report \$3.7 million (\$2.7 million Federal share) in Medicaid provider overpayments and delayed reporting \$1.3 million (\$944,000 Federal share) in overpayments during the period October 1, 2002, through September 30, 2004. OIG recommended that the State refund the \$2.7 million, determine and recover overpayments identified after the audit period, reduce overpayments only when it can support that providers are bankrupt or out of business, and ensure that overpayments are reported in accordance with Federal regulations. The State agreed. (A-07-05-03064)

### **Targeted Case Management Services Rendered by the Massachusetts Department of Social Services**

The Social Security Act authorizes State Medicaid agencies to provide case management services to Medicaid beneficiaries. CMS has defined such services to include an assessment of each beneficiary to determine service needs, development of a specific care plan, referral to needed services, and monitoring and followup of needed services. Specifically excluded are direct medical, educational, or social services to which the Medicaid-eligible person has been referred.

The Massachusetts Department of Social Services inappropriately included social workers' salaries for direct social services, such as child protection, in its monthly rates. Social Services used these rates to claim Medicaid reimbursement for targeted case management services. By excluding the unallowable costs from the rates, OIG determined that the State had overstated its claims by approximately \$171 million (approximately \$87 million Federal share). OIG was unable to express an opinion on the remaining \$26.6 million (\$13.5 million Federal share) claimed by the State. Although this amount related to services that may appear to be allowable as targeted case management, OIG found a significant risk that these services may have already been reimbursed under other Federal programs.

OIG recommended that Massachusetts refund approximately \$87 million, work with CMS to determine the allowability of the \$26.6 million, and establish procedures to ensure that rates used to claim Medicaid reimbursement do not include payment for direct medical, educational, or social services. Massachusetts disagreed. (A-01-04-00006)

### **Nursing Home Enforcement: Application of Mandatory Remedies**

The Omnibus Budget Reconciliation Act of 1987 established a certification process to maintain Federal standards in nursing homes participating in the Medicare and/or Medicaid programs. States that monitor the facilities must refer case information to CMS

for mandatory enforcement action. Enforcement action may include termination of the facility's Medicare contract and denial of payment for new admissions when a facility is noncompliant or exhibits deficiencies that place residents in immediate jeopardy.

OIG found that CMS failed to apply the mandatory remedy in 30 out of 55 cases (55 percent) requiring Medicare/Medicaid contract termination during CYs 2000–2002. Of these, OIG found that 23 cases failing to return to “substantial compliance” within 6 months were not terminated in a timely manner. Nor were the remaining seven facilities terminated, despite their unabated immediate jeopardy deficiencies. OIG recommended that CMS ensure facilities either reach compliance or are terminated within required timeframes. To accomplish this, OIG recommended that CMS encourage States to prioritize termination cases, ensure that mandatory remedies are properly applied, and strongly consider raising the standards for case referral. CMS agreed that timely enforcement and remedy of facility problems are important, but disagreed with OIG's recommendation regarding facility termination. (OEI-06-03-00410)

### **Nursing Home Complaint Investigations**

This report assessed whether State agencies investigate nursing home complaints in accordance with program requirements and evaluated the adequacy of CMS's monitoring of State agency performance in investigating nursing home complaints. OIG found that State agencies did not investigate some of the most serious nursing home complaints within the required timeframe, including 7 percent of complaints alleging immediate jeopardy and 27 percent of complaints alleging actual harm. In addition, while the Federal complaint tracking system, ASPEN Complaints/Incidents Tracking System (ACTS), shows potential for managing complaints, State agencies have not taken full advantage of this system. Finally, CMS oversight of nursing home complaint investigations is limited. OIG found that CMS conducts few Federal Oversight and Support Surveys (FOSS), which allow CMS's regional offices an opportunity to observe a State agency's complaint investigation process. CMS guidance states that State agencies should provide CMS with at least 2 weeks' advance notice of scheduled surveys, thus limiting the use of the FOSS for the most serious nursing home complaints.

OIG recommended that CMS require State agencies to meet the 10-day timeframe for investigating complaints involving actual harm, increase oversight of the State agencies, and offer additional ACTS training to its regional offices as well as State agencies. OIG also recommended that CMS remove the 2-week advance notice period for FOSSs. CMS concurred with OIG's first three recommendations, but did not concur that it should eliminate the 2-week advance notice for FOSSs. (OEI-01-04-00340)

### **Physical Therapy Billed by Physicians**

Claims for physical therapy under Medicare increased from \$353 million to \$509 million from CYs 2002 to 2004. In addition, the number of physicians billing for more than \$1 million in physical therapy more than doubled, from 15 to 38. Since OIG began reviewing Medicare rehabilitation therapy in 1994, it has found significant and persistent compliance and quality-of-care problems. These include overutilization of services, services rendered by unskilled staff, and billing for services that do not meet Medicare's coverage requirements. During the first 6 months of 2002, OIG found \$136 million

in improper payments for reasons including lack of medical necessity, lack of documentation, billing irregularities, and provision of services under incomplete medical care plans or medical care plans lacking information.

Despite a 2005 revision to the Social Security Act that allows unlicensed therapists to provide services under physician supervision, OIG believes that this represents a vulnerability and that all service providers should be licensed, whether they are independent or working under physician supervision. In addition, physical therapy billed “incident to” physicians’ professional services and rendered by unskilled and/or unlicensed personnel represent a vulnerability that could be placing beneficiaries at risk of receiving services that do not meet professionally recognized standards of care. OIG did not issue formal recommendations because CMS had already taken actions to address OIG findings. (OEI-09-02-00200)

## **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, 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 April 1 through September 30, 2006, OIG received 35 advisory opinion requests and issued 13 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://oig.hhs.gov> in the Fraud Prevention & Detection section under “Self-Disclosure Information.” Also, in an April 24, 2006, Open Letter to Providers, also available on the OIG Web site, the Inspector General discussed a new initiative to promote the use of the self-disclosure protocol to resolve civil monetary penalty liability under the physician self-referral and anti-kickback statutes for financial arrangements between hospitals and physicians.

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

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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 have resulted in \$4.3 million in HHS receivables. For example:

■ **Illinois**—To resolve a matter reported under OIG’s Provider Self-Disclosure Protocol, Concord Extended Care and its management company, Care Centers, Inc. (collectively, Care Centers) agreed to pay \$32,000 to resolve its Civil Monetary Penalties Law (CMPL) liability for employing an excluded individual. Care Centers alleged that it did not discover the employee’s excluded status until she reverted to using her maiden name. Through the investigation, it was determined that the employee had, in fact, disclosed both her maiden and married names, but that Care Centers failed to check the maiden name against the List of Excluded Individuals/Entities.

### 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 approximately \$263 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 1,923 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 G.

### Program Exclusions

During this reporting period, OIG excluded 1,885 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 York**—A dermatologist was excluded for a minimum period of 50 years based on his conviction in a health care fraud scheme involving unlawful distribution of prescription narcotic drugs. The dermatologist’s scheme caused the death of a patient. The patient, who visited the dermatologist approximately 24 times each month, died from a drug overdose. In March 2006, the dermatologist was sentenced to 20 years in prison

and ordered to pay approximately \$888,000 in restitution. His license to practice as a physician in the State of New York was revoked.

■ **Florida**—A medical clinic owner was excluded for a minimum period of 45 years based on her conviction related to a scheme to defraud the Medicare program. She was sentenced to 112 months in prison and ordered to pay \$14.5 million in restitution.

Also in Florida, a family practice physician was excluded for a minimum period of 30 years based on his conviction for Medicaid fraud and for controlled substance violations. He was sentenced to 25 years in prison and lost his license to practice medicine in the State.

■ **Virginia**—An owner of a home health agency (HHA) was excluded for a minimum period of 30 years based on his conviction for health care fraud and controlled substance violations. The HHA owner committed the fraud between January 2002 and January 2005. He was sentenced to 71 months' incarceration and ordered to pay \$2.5 million in restitution.

■ **Washington**—A nurse was excluded for a minimum period of 25 years based on his conviction for rape. While providing in-home care, the nurse engaged in sexual intercourse with a female patient incapable of giving consent. The victim is a quadriplegic who is developmentally disabled and suffers from spastic cerebral palsy. The nurse was sentenced to 102 months' incarceration and the State revoked his nursing license.

■ **Kansas**—A pharmacist was excluded for a minimum period of 5 years based on his conviction on multiple counts of battery. During a 15-month period, the pharmacist falsely represented that he was participating in a blood study. The pharmacist paid between \$10 and \$20 per blood sample, which he obtained from women in the community. The pharmacist drew their blood in the pharmacy after hours, in the pharmacy parking lot, in his home, or at the victims' homes.

### **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. The following is among the civil monetary penalties actions resolved during this reporting period:

■ **Florida**—Lincare Holdings, Inc., and its subsidiary, Lincare, Inc. (collectively, Lincare), agreed to pay the Government \$10 million and to enter into a 5-year company-wide corporate integrity agreement (CIA). The settlement resolves allegations that Lincare violated the anti-kickback provision of the CMPL and the Physician Self-Referral Law. OIG alleged that from January 1993 through December 2000, Lincare engaged in a nationwide scheme to pay remuneration to physicians to induce referrals of patients to Lincare for durable medical equipment (DME). OIG alleged that Lincare gave referring physicians items such as sporting and entertainment tickets, gift certificates, rounds of golf, golf equipment, fishing trips, meals, advertising expenses, office equipment, and medical equipment, as well as payments pursuant to purported consulting agreements.

OIG also alleged that Lincare violated the Physician Self-Referral Law by accepting referrals from parties to the purported consulting agreements.

### Patient Dumping

Of the total civil monetary penalties OIG collected between April 1 and September 30, 2006, \$335,000 represents collections from 7 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:

■ **Missouri**—Citizens Memorial Hospital (CMH), a 74-bed hospital, agreed to pay \$75,000 (the maximum penalty) to resolve allegations of three patient dumping incidents. OIG alleged that CMH failed to provide appropriate medical screenings and/or stabilizing treatment for three patients who presented to CMH's emergency department (ED) with emergency medical conditions: a baby with life-threatening acute bronchitis and exacerbated asthma; a woman whose intestines were protruding from a loose cesarean section incision; and a teenage boy who complained that he could not move, stand, walk, or feel his limbs. The baby was refused treatment because CMH did not accept Medicaid and the mother did not have \$100 cash for her son to be seen. The woman who had had the recent cesarean section was directed to her doctor's office without any evaluation. The doctor subsequently sent her back to the hospital via ambulance for emergency surgery. The teenage boy's allegations of paralysis were not believed and CMH sent him home despite objective signs that he could not move. His CT scan was reevaluated the next day and showed a vertebral fracture. He was brought back to the hospital in a worsened condition and is now a quadriplegic.

■ **New York**—Queens Hospital Center agreed to pay \$75,000 to resolve allegations of patient dumping involving two individuals. A 9-year-old girl presented to the ED complaining of fainting, vomiting, and headaches. She was given a cursory examination by a doctor and discharged. She died of a brain tumor while still in the ED. The other individual arrived via ambulance with an abnormal electrocardiogram reading and died of a heart attack in the ED after waiting 1 hour without receiving a screening examination.

■ **Colorado**—Poudre Valley Hospital (PVH) agreed to pay \$55,000 to resolve allegations of patient dumping. OIG alleged that PVH failed, twice on the same day, to provide an appropriate medical screening examination for a deaf, nonverbal, and developmentally disabled male. The patient went to a neighbor's house in distress. The neighbor called an ambulance that was owned and operated by PVH. The patient complained of severe stomach pain and discomfort by writing notes and constantly motioning to his stomach. The paramedics refused to transport him to the ED. Instead, the neighbor transported him. The ED nurse allegedly reported that he had been to the ED three times and that he was only hungry. A social worker gave him crackers and called a taxi to take him home. Two days later he died of hypovolemic shock caused by gastritis with erosion, ulcers, and gastric hemorrhage.

■ **Illinois**—The University of Chicago Hospitals (UCH) agreed to pay \$35,000 to resolve one allegation of patient dumping. OIG alleged that UCH failed to accept an appropriate

transfer of a 61-year-old man who presented to another hospital's ED with a large dissecting aortic aneurysm that required care that the transferring hospital was not equipped to provide. UCH had the specialized capabilities to treat and stabilize the patient's emergency medical condition, but allegedly refused to accept the transfer after learning the patient did not have insurance. UCH later agreed to accept transfer of the patient only if he provided proof of substantial funds in a bank account. The patient was transferred to another hospital where he died.

### **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 the civil False Claims Act (FCA) and, in appropriate cases, under Federal and State criminal statutes. A description of those enforcement authorities can be found in Appendix G. The successful resolution of such matters often involves the combined investigative efforts and resources of OIG, the Federal Bureau of Investigation, Medicaid Fraud Control Units (MFCUs), and a variety of 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.

In the fiscal year ending September 30, 2006, 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**

■ **New Jersey**—The Saint Barnabas Health Care System (SBHCS) agreed to pay \$265 million and enter into a 6-year CIA to resolve its liability under the FCA and other statutes, and certain common law causes of action. SBHCS is the largest health care system in New Jersey, currently operating seven acute care hospitals and other ancillary health care providers. The Government alleged that beginning in 1995, SBHCS falsely billed Medicare and the Department of Defense health care program TRICARE for excessive inpatient and outpatient outlier payments. Specifically, the United States alleged that SBHCS artificially inflated its cost-to-charge ratio, triggering the outlier payments to which it was not entitled. The investigation determined that SBHCS's conduct continued through August 2003.

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■ **South Carolina**—Marion Regional Health Care System (MRHS) agreed to pay the Government \$3.75 million and to enter into a 5-year CIA. The settlement resolves allegations that MRHS violated the Physician Self-Referral Law and upcoded in violation of the False Claims Act. Specifically, MRHS employed a family practitioner in its family practice and paid him above fair market value. In addition, the doctor routinely upcoded his claims for initial patient visits when his patients were hospitalized.

■ **Florida**—Mount Sinai Medical Center of Florida agreed to pay the Government \$3.4 million and to enter into a 5-year CIA. The settlement resolves cost report fraud allegations. Mount Sinai allegedly overstated its allowable costs by failing to reduce the costs claimed on several cost reports of a management fee that it paid to a cancer center to manage its outpatient cancer centers by the amounts of several rebate checks that Mount Sinai received from the cancer center.

■ **New York**—Harlem Hospital Center agreed to pay \$2.3 million to resolve its civil liability for allegedly double-billing the Medicare program for outpatient services from January 1992 through June 2001. The Government alleged that the fiscal intermediary directed Harlem to stop double-billing Medicare; however, the hospital continued to submit false claims to Medicare.

■ **Missouri**—McCune Brooks Hospital agreed to pay \$238,000 and enter into a 5-year CIA to settle allegations of submitting false claims to Medicare and Medicaid for services provided at its off-site cardiac rehabilitation unit facility. The Government alleged that McCune Brooks submitted claims for services provided by nonphysician personnel when no physician was present to supervise the service rendered, a violation of Medicare's "incident to" billing rules.

### Prescription Drugs

**Pennsylvania**—AdvancePCS, a pharmacy benefits manager (PBM), agreed to pay the Government \$137.5 million to settle allegations of entering into kickback arrangements for referrals of Federal Employees Health Benefits Program, Medicare+Choice, and Indian Health Service program business. Among the allegations, AdvancePCS allegedly solicited and received payments from drug manufacturers in the form of administrative fees and agreements for products and services such as medical data, research studies, and consultations that exceeded the value of the products and services provided. The company also allegedly solicited and received payments from certain drug manufacturers in the form of flat-fee rebate contracts in exchange for favorable treatment of those manufacturers' drugs and allegedly offered and paid remuneration to Federal health care program insurance carriers to induce them to enter into PBM contracts. AdvancePCS agreed to enter into a 5-year CIA that focuses on review of its contracts and other arrangements for potential kickback violations. AdvancePCS will also enter into a consent order with the U.S. Attorney's Office that includes detailed provisions governing the company's dealings with manufacturers, customers, pharmacists, and physicians. AdvancePCS was acquired by Caremark Rx, Inc., in March 2004.

## Practitioners

■ **Texas**—A physician was sentenced to 11 years and 3 months in prison and ordered to pay \$14.4 million in joint and several restitution for his role in defrauding the Medicare and Medicaid programs. Beginning in August 1999, the physician caused the submission of false claims to Medicare for physical therapy evaluations and services. As part of the scheme, the physician received payments for signing patient charts so clinic owners could fraudulently bill Medicare and Medicaid. In 2001, the physician became involved in another scheme related to the submission of claims for services he provided to beneficiaries who were unlawfully referred to him for motorized wheelchairs. The beneficiaries were transported to his clinic for the purpose of having motorized wheelchairs authorized. The physician performed medical services, many of which were unnecessary, then prepared and signed certificates of medical necessity (CMNs) authorizing the motorized wheelchairs. Some beneficiaries never saw the physician or qualified for wheelchairs.

A DME company owner involved in the wheelchair scheme was sentenced to 5 years and 3 months incarceration, ordered to pay \$478,000 in restitution to the Medicaid program, and held jointly responsible for paying \$4.2 million of the joint and several restitution figure. In addition, two individuals paid to recruit Medicare and Medicaid beneficiaries were sentenced for their roles in the scheme. One was sentenced to 12 months and 1 day in prison, and the other was sentenced to 6 months home detention.

Also in Texas, an osteopathic physician licensed in Oklahoma was sentenced to 10 years in prison and ordered to pay \$7.9 million for health care fraud and conspiracy. The physician accepted cash payments for signing preprinted prescriptions and CMNs for motorized wheelchairs for beneficiaries she never examined. Investigation revealed that more than 60 DME companies throughout the country received Medicare and Medicaid payments based on the fraudulent prescriptions. In addition to the prison sentence, the physician was ordered not to practice medicine again without written permission of the court.

■ **Illinois**—A podiatrist was condemned to death for the murder of a grand jury witness, sentenced to 78 months in prison for health care fraud, and ordered to pay \$1.8 million in restitution. A jury convicted and condemned the podiatrist to death for murdering a woman days before she was expected to testify before the grand jury about the more than 70 foot surgeries that were not performed that the podiatrist billed to Medicare. The woman was found shot six times. Also sentenced in this case was an elderly Medicare beneficiary who allowed the podiatrist to use his personal information in order to fraudulently bill Medicare for services never performed.

■ **California**—An audiologist was sentenced to 78 months in prison and ordered to pay \$868,000 in restitution for her scheme to defraud the Government. From January 1997 through July 2003, the audiologist billed Medicare and Medi-Cal for hearing aids, speech therapy, and other related services without being licensed to dispense or render the service and in most cases, without a prescription from a referring physician. In addition, the audiologist billed services purportedly provided to deceased beneficiaries.

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■ **Kansas**—A couple was convicted on Federal charges for involuntary servitude, forced labor, conspiracy, health care fraud, and mail fraud. The social worker and his wife, a nurse, were sentenced to 30 years and 7 years in prison, respectively, and ordered to pay approximately \$500,000 in joint and several restitution. In addition, the jury ordered the couple to forfeit approximately \$85,000 and four properties. For over 24 years, the couple operated a group home that provided “therapy” for mentally ill patients. The investigation revealed that the social worker forced and coerced his patients to perform manual labor in the nude and participate in therapy sessions that involved sexually explicit acts. The man’s wife helped enforce house rules and fraudulently billed Federal health care programs for the therapy provided.

■ **Ohio**—A psychiatrist agreed to pay the Government \$400,000 and to be permanently excluded from participating in Federal health care programs. The settlement resolves allegations that the psychiatrist improperly billed Medicare by misrepresenting that he provided therapy sessions generally requiring 30 or 60 minutes of face-to-face time with the patient, and claimed payment for the sessions, when he had only provided medication checks for 15 minutes or less. The psychiatrist also misrepresented that he had provided therapy sessions, for which he claimed payment, when in fact a nonlicensed individual had conducted the sessions. In addition, the psychiatrist claimed payment for therapy sessions when the patients had cancelled or failed to appear for the appointments.

### Durable Medical Equipment Suppliers

■ **Virginia**—Matria Women’s and Children’s Health, LLC, formerly known as Matria Healthcare, Inc. (Matria), and Diabetes Self Care, Inc. (DSC) agreed to pay \$9 million to resolve their liability for alleged improper billing practices for mail-order DME. The Government alleged that from January 1998 through December 2003, Matria and/or DSC submitted claims to Medicare for DME prior to obtaining valid physician orders, valid assignment of benefits, and/or valid CMNs. Among other things, the Government alleged that Matria and/or DSC also failed to credit Medicare for returned DME.

■ **West Virginia**—Group II Medical Supports, LLC (Group II), was ordered to pay \$8.4 million pursuant to its guilty plea to false statements relating to health care matters. Group II provided powered pressure-reducing air mattresses almost exclusively to beneficiaries residing in assisted living facilities. During the investigation, it was revealed that from 1998 to 2004, Group II billed Medicare and Medicaid for a type of mattress intended to treat Stage II decubitus ulcers regardless of whether the beneficiary met the coverage criteria for the mattress. In addition, Group II employees created false documents to support the false claims, and routinely misled assisted living facility personnel and physicians when marketing and servicing the mattresses.

In addition to the guilty plea, Group II, one of its former owners, a current owner, and a national sales manager entered into settlement agreements to resolve their alleged liability related to the improper claims submitted to Medicare and Medicaid. Group II and its current owner agreed to pay the Government \$1 million; the former owner and the sales manager agreed to pay the Government \$525,000 and \$50,000, respectively.

■ **Texas**—A DME company owner was sentenced to 63 months in prison and ordered to pay \$669,000 in restitution for conspiracy and health care fraud. Through his company, the man billed Medicare and Medicaid for motorized wheelchairs, wheelchair accessories, and alternating-pressure mattresses. However, patients received less-expensive or used equipment or no equipment at all.

### Clinic

■ **Massachusetts**—Cardiac Rehabilitation of Cape Cod, Inc. (CRCC), and its owner entered into a settlement with the Government to resolve their FCA liability. The owner, who is a physician, agreed to pay \$1.9 million and to enter into a 5-year Integrity Agreement (IA). The Government alleged that Medicare was billed for cardiovascular stress tests when cardiac rehabilitation services were actually performed. Cardiovascular stress tests have a significantly higher reimbursement rate. The IA will cover the physician and his new cardiology practice so that OIG can, among other things, monitor his compliance with Medicare billing guidelines. CRCC closed in 2001.

### Home Health Agency

■ **Kentucky**—Nurses' Registry and Home Health, Inc. (Nurses' Registry), agreed to pay the Government \$1.6 million and to enter into a 3-year CIA. The settlement resolves allegations that Nurses' Registry submitted claims for unallowable expenses related to advertising, community education, rental expenses and liaison salaries, benefits, and meals. The settlement also settles allegations that Nurses' Registry upcoded claims under the prospective payment system for home health services.

### Nursing Home Company

■ **Missouri**—American Healthcare Management, Inc. (AHM), its individual owners, and three affiliated nursing homes agreed to pay the Government \$1.25 million to settle allegations of submitting false and fraudulent nursing home billings to Medicare and Medicaid for poor quality of care. From January 1998 through June 2001, the Government alleged that due to staffing limitations, numerous residents of the nursing homes suffered from dehydration and malnutrition, went for extended periods of time without cleaning or bathing, and contracted preventable pressure sores. In addition, the Government alleged that instances of elopements of residents from the facilities occurred, a resident was found covered with ants, and a resident was physically abused by a staff member. As part of the settlement, AHM and the three nursing homes agreed to permanent exclusions, and the principal owner agreed to a 20-year exclusion. The other owner agreed to certify annually that he had no involvement in Medicare or Medicaid, and that if he did opt to bill those programs, he agreed that he would enter a CIA at that time.

### Laboratory

■ **Tennessee**—A diagnostic testing facility owner was sentenced to 37 months in prison and ordered to pay \$243,000 in joint and several restitution for billing Medicare and a

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private insurer for carotid artery ultrasound diagnostic tests that were not necessary or were not ordered by the patient's treating physician. The diagnostic tests, which were mainly marketed in senior citizen centers, are covered by Medicare when ordered by the treating physician for use in managing a beneficiary's specific medical problem. To facilitate the scheme, the owner paid a physician to sign test orders as if he were the treating physician. The marketing representative was sentenced and is held responsible for \$19,000, a portion of the joint restitution figure. The physician was found guilty at the conclusion of his jury trial for his involvement in the scheme. He was sentenced and is held responsible for paying \$151,000 of the joint restitution amount.

### Theft of Health Care Services

■ **Nevada**—A woman was ordered to pay \$23,000 in restitution for false statements relating to health care matters. The woman stole the identity of her sister, a Medicare beneficiary, and used it to obtain medical services for which Medicare paid.

### Medicaid Fraud Control Units

Currently, 48 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. In FY 2006, OIG provided oversight for and administration of approximately \$161 million in Federal grant funds to the units.

Examples of cases worked jointly by OIG with MFCUs during this semiannual period include:

■ **Tennessee**—An oncologist found guilty by a Federal jury was sentenced to 15 years and 8 months in jail and ordered to pay \$432,000 in restitution for her scheme to provide partial doses of medications to chemotherapy patients and for lying to a Federal agent about the scheme. An investigation and comprehensive analysis of records revealed that the oncologist billed for substantially more chemotherapy and chemotherapy side-effect medications than she actually purchased from manufacturers. The oncologist instructed her staff to give partial doses of Procrit but to indicate on patients' charts that full doses were provided. Diluted doses of Taxol and Camptosar were also administered to patients. This investigation involved OIG and the Tennessee MFCU.

■ **Texas**—A couple who owned and operated a DME company was sentenced for billing Medicare and Medicaid for power wheelchairs and other equipment that were not prescribed by a doctor or provided to patients. The wife pled guilty and was sentenced to 30 months in prison for health care fraud. The husband contended that he had no knowledge of the scheme, but was convicted after a 4-day trial. He was sentenced to 33 months in prison. The couple was also ordered to pay \$286,000 in joint and several restitution. This investigation involved OIG and the Texas MFCU.

■ **West Virginia**—A family practice physician was sentenced to 6 months' home detention and ordered to pay \$214,000 in restitution for health care fraud and for obtaining controlled substances by fraud. The physician submitted claims to Medicare

and Medicaid for initial hospital care services that he did not provide. The services were either not provided at all or were provided by physician assistant students. In addition, the physician used the names of family members to fraudulently obtain controlled substances. The investigation involved OIG and the West Virginia MFCU.

■ **Virginia**—A man who operated a transportation service was sentenced to 10 months' home confinement and ordered to pay \$77,000 in restitution for health care fraud and mail fraud. The man fraudulently billed Medicaid for nonambulatory transports when the patients were ambulatory and billed for excessive wait time. This investigation involved OIG, the Virginia MFCU, and the U.S. Postal Inspection Service.



## Public Health Agencies

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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

#### Review of 340B Drug Prices

Section 340B of the Public Health Service Act created the 340B Drug Discount Program (340B Program) to lower drug prices for more than 12,300 entities, including community health centers, public hospitals, and various Federal grantees. Pharmaceutical manufacturers calculate 340B Program ceiling prices using a specified formula and must sell their products at or below these prices to continue to receive reimbursement from the Medicaid program.

OIG found that in a single month in 2005, 14 percent of purchases made by 340B Program entities exceeded 340B Program ceiling prices, resulting in total projected overpayments of \$3.9 million. The largest price discrepancies in OIG's sample resulted from prices that were not in line with a HRSA policy that directs manufacturers, in very specific situations, to charge entities a penny per unit. Additionally, patterns in OIG's sample suggest that overpayments varied by the volume of 340B Program purchases or sales associated with the entities, manufacturers, and wholesalers. Finally, inaccuracies in HRSA's calculations of the 340B Program ceiling prices continue to limit its ability to monitor 340B Program compliance.

OIG recommended that HRSA improve its oversight of the 340B Program to ensure that entities are charged at or below the 340B Program ceiling price. In addition, HRSA should provide technical assistance regarding 340B Program implementation to all participating entities, manufacturers, and wholesalers. HRSA should also publish guidance regarding its penny price policy, from which the largest price discrepancies in the sample resulted. Finally, OIG recommended that HRSA obtain consistent unit of measure and package size data to accurately calculate 340B Program ceiling prices. HRSA concurred with the recommendations. (OEI-05-02-00073)

#### Use of the Departmental Alert List by the Health Resources and Services Administration

The Departmental Alert List, posted on the Department's Web site, contains a record of grantees that have been designated "high risk" or have raised concerns for reasons such as inexperience in handling Federal funds, financial instability, inadequate management systems, or a history of poor programmatic performance. To determine the extent to which HRSA is adhering to policies for reporting to, maintaining, and consulting the Alert List, OIG reviewed the files of 56 HRSA grantees on the March 24, 2003, Alert List and conducted interviews with HRSA grants staff. OIG found that HRSA does not consistently follow Alert List policies, failing to (1) place all grantees that are designated "high risk" on the Alert List; (2) check the Alert List prior to awarding a grant; (3) consult with the placing agency to determine the reason for placement; (4) document the monitoring of grantees on the Alert List; and (5) remove grantees in a timely manner or justify retaining a grantee that appears on the Alert List for more than 2 years. In addition, OIG found that grants officers do not use the information on the Alert List to make grant decisions and some of them report concerns about whether the information on the Alert List is current or complete.

OIG recommended that HRSA ensure that grants officers follow Alert List policies and that HRSA develop methods to ensure that grants officers follow these policies. HRSA concurred with OIG's recommendations. HRSA reported taking corrective actions, including working closely with grants officers to support efforts to follow Alert procedures as recommended and having HRSA staff attend a Department Alert List training session. (OEI-02-03-00011)

### **The Food and Drug Administration's National Drug Code Directory**

An OIG study of FDA's National Drug Code (NDC) Directory of currently marketed prescription drug products found that the directory is neither complete nor accurate. An estimated 9,187 prescription drug products are missing, while another 5,150 have not cleared the listing process. Further, an estimated 34,257 drug products listed are no longer on the market, or are listed in error. Problems are due primarily to drug firms' failing to report when drugs are placed on or taken off the market and failing to provide sufficient and accurate information to complete the listing process.

To resolve issues of completeness and accuracy of the directory, this study recommended that FDA (1) finalize draft listing instructions referenced on its Web site, (2) provide greater control over the assignment of NDCs, (3) continue efforts to implement electronic submission of listing forms by firms, (4) implement a mechanism to routinely identify drug product omissions and inaccuracies, (5) resolve the status of currently pending drug product listings, (6) enhance communication with drug firms to facilitate accurate and complete reporting of drug products, and (7) identify and take appropriate action against drug firms that consistently fail to list drug products and update information. FDA concurred with OIG's recommendations, and has identified a number of steps it plans to take to address the issues identified in the report. (OEI-06-05-00060)

### **Monitoring of Postmarketing Study Commitments**

FDA requires all new drugs to undergo clinical testing to demonstrate their safety and efficacy prior to approval for sale in the United States. After a drug has been approved for sale, drug applicants can learn more about the risks, benefits, and optimal use of a drug by conducting postmarketing studies. Between fiscal years 1990 and 2004, 48 percent of new drug applications included at least one postmarketing study commitment. OIG identified vulnerabilities that raise concerns that FDA is not able to readily identify whether or how timely postmarketing study commitments are progressing toward completion. OIG found that about one-third of required annual status reports (ASRs) were missing or incomplete, and that ASRs contain information of limited use. OIG also found limitations associated with FDA's management information system for monitoring postmarketing study commitments. Finally, OIG found that monitoring postmarketing study commitments is not a top priority at FDA.

To address these vulnerabilities, FDA should (1) instruct drug applicants to provide additional, meaningful information in their ASRs; (2) improve the management information system for monitoring postmarketing study commitments; and (3) ensure that postmarketing study commitments are being monitored and that ASRs are being validated. FDA concurred with the second and third recommendation and has taken steps to address them. FDA did not concur with the first recommendation. (OEI-01-04-00390)

### **Agency for Healthcare Research and Quality: Monitoring Patient Safety Grants**

In fiscal years 2001–2003, AHRQ awarded 120 patient safety grants totaling \$128 million to conduct research on improving patient safety and reducing medical errors. Among 39 sampled grants, OIG found that 30 percent of required financial status reports were not received and 43 percent were late, representing a combined total of \$50.6 million in dispensed grant funds. Ninety-seven percent of the sampled grants had their most recent annual performance reports in the file, and 94 percent of the reports were received timely. Of the sampled grants, seven official grant files were eligible for closeout; however, three of these were not closed in accordance with Federal requirements. Two of the seven grants scheduled for closeout had the required documents; however, AHRQ staff did not finalize the closeout process.

OIG recommended that AHRQ require submission of interim financial information accounting for prior-year expenditures before future funding is authorized, establish a tracking system for financial status reports, require grantees with no-cost extensions to submit financial status reports in compliance with Federal requirements, and ensure that grants awaiting closeout are closed promptly. AHRQ's comments suggested general agreement with the recommendations and described actions to address some of OIG's specific recommendations. (OEI-07-04-00460)

### **Superfund Financial Activities at the National Institute of Environmental Health Sciences for Fiscal Year 2005**

OIG found that Superfund costs recorded by the National Institute of Environmental Health Sciences (NIEHS) from October 1, 2004, through September 30, 2005, were allowable, allocable, and reasonable in accordance with applicable laws and regulations. In addition, NIEHS took appropriate action to ensure that its Superfund grantees submitted required audit reports. Because this report contained no recommendations, no response was necessary. (A-04-06-01023)

### **Universities' Compliance With Select Agent Regulations**

OIG reviewed 15 universities' compliance with select agent regulations for the period November 2003 to November 2004. Select agents are materials that have the potential to pose a severe threat to public health and safety if they are misused as a result of inadvertent, terrorist, or other criminal acts. OIG issued detailed reports to each university and to CDC.

In this summary report, OIG pointed out that 11 universities had weaknesses in at least one of the following control areas: accountability for select agents, restricted access to select agents, security plans, training, and emergency response plans. OIG recommended that CDC resolve the recommendations in the individual reports. CDC is addressing OIG's concerns. (A-04-05-02006)

### **HIV Prevention Grants**

CDC entered into several cooperative agreements with an organization in the District of Columbia to advise community groups on HIV prevention training and intervention.

This review, conducted at CDC's request, found that during CYs 2003 and 2004, the organization spent approximately \$703,000 of CDC funds on unallowable costs, including \$379,000 on expenses such as lobbying and fundraising and \$324,000 on expenses that occurred in a prior period. The organization ceased operations and filed for bankruptcy without completing its cooperative agreement obligations. OIG recommended that CDC follow up with the U.S. Bankruptcy Court regarding repayment of the funds. (A-03-05-00351)

### **Select Agents at Private, State, and Local Laboratories**

Following its reviews of compliance with select agent regulations at universities, OIG conducted similar work at State, local, and nonprofit institutions and issued seven restricted final reports during this semiannual reporting period. The reports noted problems similar to those at the universities. OIG plans to issue a summary report that will be available to the public in FY 2007.

### **Financial Statement Audit**

To support its audit of the Department's FYs 2004 and 2005 financial statements, OIG contracted with independent certified public accounting firms to audit the financial statements of the major public health operating divisions. During this reporting period, an accounting firm issued an unqualified opinion on FDA's FY 2004 financial statements, which means that the statements were reliable and fairly presented. However, the firm was unable to obtain sufficient support for the amounts presented in the FY 2005 financial statements. The firm also noted two material weaknesses: financial systems and analysis and payroll processing. (A-17-05-00003)

### **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, 36 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.

## Public Health Agencies

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After being excluded for nonpayment of their HEAL debts, a total of 2,032 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. That figure includes the 43 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 totals \$144.3 million. Of that amount, \$3.57 million is attributable to this reporting period.

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

**A Puerto Rico physician**—\$530,000

**A Georgia dentist**—\$254,000

**A Florida chiropractor**—\$139,000

**A Colorado chiropractor**—\$118,000

## 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:

■ **Vermont**—A former professor and researcher at the University of Vermont was sentenced to 1 year and 1 day in prison for falsifying and fabricating research data used in his applications for NIH grants. The false and fabricated research data were also used in research papers and presentations related to several topics, including his study of the impact of the menopause transition on women’s metabolism, his study on the impact of aging in older men and women on a wide range of physical metabolic measures, and his proposal to study the impact of hormone replacement therapy on obesity in postmenopausal women. The researcher previously had agreed to pay \$196,000, had agreed to lifetime exclusion, and had written letters of retraction to medical journals that had published his papers.

# **Administration for Children and Families and Administration on Aging**

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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 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 a child support obligation. 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**

### **Aid to Families With Dependent Children in Connecticut**

Aid to Families with Dependent Children (AFDC) was replaced by the TANF program in 1996 as a part of welfare reform. Both programs were designed to help low-income families support their dependent children. Federal regulations require States to pursue and recover AFDC overpayments as long as outstanding overpayments remain, turning over the Federal share of such payments.

OIG determined that for 1 of the 16 quarters reviewed, Connecticut did not reimburse the Federal share of AFDC overpayment collections in a timely manner. As a result of internal control weaknesses, Connecticut could not verify whether its Federal refund checks had been received or cashed.

OIG recommended that Connecticut strengthen its internal controls so that it can verify that the Federal Government receives its share of future AFDC overpayment collections. Connecticut agreed. (A-01-05-02501)

### **Undistributable Child Support Collections**

ACF's Office of Child Support Enforcement (OCSE) requires States to offset Child Support Enforcement program costs by recognizing and reporting program income from undistributable child support collections and interest earned on program funds. OIG evaluated three States' handling of undistributable child support collections.

■ **Michigan**–Michigan did not recognize \$6.7 million in program income for unclaimed collections that should have been considered abandoned and transferred to the State treasurer. The State did not report \$391,000 in program income for undistributable child support collections that were transferred to the State treasurer. Furthermore, the State could not provide documentation to support resolution of a prior OCSE finding and recommendation regarding undistributable collections totaling \$1.1 million that were not reported as program income.

OIG recommended that Michigan make financial adjustments, improve its procedures, and work with OCSE to resolve the outstanding recommendation. The State generally disagreed. (A-05-05-00033)

■ **Missouri**–Missouri did not recognize and report program income totaling an estimated \$693,000. OIG recommended that Missouri make financial adjustments, revise its policies and procedures, and provide training to its personnel. The State agreed. (A-07-05-03069)

■ **Wisconsin**–Wisconsin did not recognize and report program income of \$163,000. OIG recommended that Wisconsin make financial adjustments and implement adequate program policies and procedures. The State agreed. (A-05-06-00018)

### **Costs Claimed for the Statewide Automated Child Welfare Information System in California**

ACF requested that OIG audit the costs claimed by Santa Clara County, California, for the Statewide Automated Child Welfare Information System (SACWIS). SACWIS is a comprehensive case management tool that supports social workers' foster care and adoption assistance case management.

OIG found that approximately \$573,000 (\$286,500 Federal share) of the county's claims for January 1, 1999, through June 30, 2003, was not allowable under Federal and State regulations. OIG was unable to determine whether the remaining \$6.1 million (\$3.1 million Federal share) claimed was allowable because the county did not allocate these costs to all child welfare service system applications.

OIG recommended that the State refund the \$286,500 Federal share of unallowable costs, work with ACF to determine what portion of the remaining \$6.1 million is reimbursable, and instruct the county to strengthen its internal controls. The State generally agreed. (A-09-04-00068)

### **Title IV-E Training Costs**

Pursuant to Title IV-E of the Social Security Act, the Federal Government shares in the costs of training State caseworkers who serve foster and adoptive children meeting Federal eligibility requirements. OIG evaluated the allowability of three States' claims for Title IV-E training costs.

■ **Connecticut**—Connecticut lacked established procedures to ensure that only allowable and qualified training expenses were claimed at the enhanced rate. As a result, the State overstated its Federal claims by \$2.4 million during 2001–2004. OIG recommended that Connecticut make a financial adjustment, ensure that only qualified training expenses are claimed at the enhanced rate, and review subsequent claims to ensure compliance with Federal requirements. The State agreed. (A-01-05-02502)

■ **Kentucky**—Kentucky did not always follow Federal regulations regarding allowability of training costs. As a result, Kentucky overstated its Federal claims by at least \$1 million during 2001–2003. OIG recommended that Kentucky make a financial adjustment, work with ACF to determine the allowable portion of costs set aside, and develop additional procedures. Kentucky generally agreed. (A-04-03-00022)

■ **Missouri**—Missouri did not always follow Federal regulations regarding allowability of costs. As a result, Missouri overstated its Federal claims by \$15.3 million during 1999–2002. OIG recommended that Missouri make a financial adjustment, review subsequent claims to identify any further overpayments, work with ACF to determine whether some costs could be claimed at a different rate, and ensure that it claims only allowable costs in the future. Missouri disagreed with the recommendations. (A-07-02-02002)

### **Administration on Aging-Related Reports**

#### **Cost Sharing for Older Americans Act Services**

In this evaluation, OIG assessed the extent to which States have implemented cost sharing under the Older Americans Act (OAA) and whether States implementing cost sharing do so in accordance with requirements designed to protect low-income individuals' access to services. OIG found that 12 States have implemented cost sharing for at least one OAA service in at least one part of their State. States that have implemented cost sharing do not always follow 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 AoA's participation data cannot be used to determine the impact of cost sharing on participation rates. OIG based this study on data gathered from a written survey completed by State representatives from all 50 States, Puerto Rico, and the District of Columbia; a review of relevant State documents; a review of AoA's participation data; and structured interviews with State Unit on Aging representatives, area agency officials, and State data officials.

OIG recommended that AoA ensure that States' cost sharing practices comply with requirements designed to protect low-income individuals' access to services; provide additional guidance to States about implementing cost sharing in accordance with the OAA; and improve the quality of its data so that any effects of cost sharing can be measured. AoA agreed with OIG's findings that cost sharing is limited and that States are confused about cost sharing. However, AoA did not agree with the finding that AoA has provided limited guidance to States. In addition, AoA also disagreed with the finding and recommendation regarding the National Aging Program Information System/State Program Reports (NAPIS/SPR). AoA stated that it will follow up on OIG's observations, correct instances of noncompliance with the provisions of the OAA, and will provide additional guidance to States. (OEI-02-04-00290)

#### **Performance Data for the Senior Medicare Patrol Projects: April 2006 Performance Report**

The Senior Medicare Patrol Projects receive grants from AoA to recruit retired professionals to serve as educators and resources to assist beneficiaries in detecting and reporting fraud, waste, and abuse in the Medicare program. In the 6 months from July through December 2005, the 64 projects educated about 290,500 beneficiaries in more than 96,000 group and one-on-one training sessions. In total, the projects documented more than \$103,000 recouped to the Medicare program. The projects also reported more than \$59,000 in savings to beneficiaries. All these projects provided descriptions of out-of-pocket expenses being returned to beneficiaries and savings due to resolution of billing errors. Additionally, one project's referral led to the removal of 11 providers from the Medicare program. OIG had no recommendations. (OEI-02-04-00363)

#### **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, 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 3,189 investigations of child support cases nationwide, resulting in 1,225 convictions and court-ordered restitution and settlements of \$64.7 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 10,800 cases from the States. As a result of the work of the task forces, 625 Federal arrests have been made and 601 individuals have been sentenced. The total ordered amount of restitution related to Federal investigations is \$27.2 million. There have been 409 arrests at the State level and 396 convictions or civil adjudications to date, resulting in \$21 million in restitution being ordered as a result of State investigations. In addition, of the court-ordered restitution, over \$31 million has actually been collected and distributed to families.

### Investigations

Nationwide, OIG investigations of child support cases resulted in 60 convictions and court-ordered restitution and settlements of \$3.8 million during this semiannual period. Examples of OIG’s enforcement results for failure to pay child support include the following:

■ **Colorado**—A man was sentenced to time served of 7 days and ordered to pay \$449,000 for failure to pay child support. The man, who worked internationally as a journalist, was arrested as he entered the United States from Mexico. The warrant for his arrest had been outstanding for nearly 2 years.

■ **California**—A man was sentenced to 1 year of home detention, 5 years’ probation, 100 hours of community service, and ordered to pay \$186,000 in restitution for failure to pay child support. The man, who attempted to win custody of his two children in 1987, has only made a single \$660 payment. Even after the custodial parent’s suicide in 2001, he failed to provide any financial support for his children. In November 2003, the man’s daughter assumed legal guardianship of her brother.

■ **Washington**—A former cancer researcher was sentenced to 5 years’ probation, 100 hours of community service, and ordered to pay \$166,000 in restitution for failure to pay child support. He was also ordered to enroll in a mental health program. Investigation revealed that, although the former researcher has not worked in the last

## **Administration for Children and Families and Administration on Aging**

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year, he has earned up to \$3 million a year. In addition, he liquidated \$15 million from his children's trust fund to buy fine art.

■ **Idaho**—A man was sentenced to 10 months' incarceration, 1 year supervised release and ordered to pay \$106,000 in restitution for failure to pay child support. Although ordered to pay child support in 1989, he never made a voluntary payment. Payments were made by way of garnishments or were made in order to avoid confinement and contempt charges.

■ **Illinois**—A woman received a \$50,000 payment for support of her son after the noncustodial parent, a Washington, DC, area dentist, was notified of a pending OIG investigation into his failure to pay child support. The amount that the man paid covered his arrearage amount plus future amounts owed through June 2006, the date the child reached emancipation. The woman appeared in court with proof that the man had satisfied his obligation, and the State was ordered to update its records.

■ **South Dakota**—A man was sentenced to 5 years' probation and ordered to pay \$47,000 in restitution for failure to pay child support. The restitution amount included \$22,000 that was incorporated into the sentencing order for his children's health care expenses.

### **Misuse of ACF Grant Funds**

OIG also investigates cases involving the misuse of ACF grant funds. Resolution of charges involving the improper use of these funds occurred in the following example during this reporting period:

■ **Washington**—A former State government social worker and his wife were sentenced for their scheme to defraud the Federal Government. The man was sentenced to 46 months in prison and ordered to pay \$136,000 in joint and several restitution; his wife received a 30-day sentence. Between March 1998 and December 2004, the defendants diverted money from a federally funded program designed to help developmentally disabled foster care children and their families. As part of the scheme, phony invoices were submitted through the man's nonexistent business purportedly for services provided to children.

## General Oversight

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The Office of the Assistant Secretary for Resources and Technology (previously called the Office of the Assistant Secretary for Budget, Technology, and Finance) is responsible for developing and executing the Department of Health and Human Services (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.

### 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 2006, OIG's National External Audit Review Center reviewed 1,184 reports that covered \$1.2 trillion in audited costs. Federal dollars covered by these audits totaled \$415 billion, about \$186 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:

<b>Reports issued:</b>	
<b>Without changes or with minor changes</b>	<b>1,047</b>
<b>With major changes</b>	<b>97</b>
<b>With significant inadequacies</b>	<b>40</b>
<b>Total</b>	<b>1,184</b>

The 1,184 reports included recommendations for HHS program officials to take action on cost recoveries totaling \$1.5 million, as well as 5,577 recommendations for improving management operations. In addition, these audit reports provided information for 126 special memorandums that identified concerns for increased monitoring by departmental 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\***

<b>Reports</b>	<b>Number of Reports</b>	<b>Dollar Value Questioned</b>	<b>Dollar Value Unsupported</b>
<b>Section 1</b>			
For which no management decision had been made by the beginning of the reporting period <sup>1</sup>	466	\$2,387,426,000	\$252,642,000
Issued during the reporting period	85	\$518,918,000	\$17,028,000
<b>Total Section 1</b>	551	\$2,906,344,000	\$269,670,000
<b>Section 2</b>			
For which a management decision was made during the reporting period <sup>2,3</sup>			
Disallowed costs	254	\$501,371,000	\$1,688,000
Costs not disallowed	30	\$9,053,000	\$875,000
<b>Total Section 2</b>	284	\$510,424,000	\$2,563,000
<b>Section 3</b>			
For which no management decision had been made by the end of the reporting period			
<b>Total Section 1 minus Total Section 2</b>	267	\$2,395,920,000	\$267,107,000
<b>Section 4</b>			
For which no management decision was made within 6 months of issuance <sup>4</sup>	187	\$1,942,622,000	\$194,262,000

\* Details concerning footnotes can be found in Appendix D.

## General Oversight

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

<b>Reports</b>	<b>Number of Reports</b>	<b>Dollar Value</b>
<b>Section 1</b>		
For which no management decision had been made by the beginning of the reporting period <sup>1</sup>	35	\$592,774,000
Issued during the reporting period	21	\$401,188,000
<b>Total Section 1</b>	56	\$993,962,000
<b>Section 2</b>		
For which a management decision was made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	4	\$1,102,000
Based on proposed legislative action		
Value of recommendations not agreed to by management		\$0
<b>Total Section 2</b>	4	\$1,102,000
<b>Section 3</b>		
For which no management decision had been made by the end of the reporting period <sup>2</sup>		
<b>Total Section 1 minus Total Section 2</b>	52	\$992,860,000

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\* Details concerning footnotes can be found in Appendix D.

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## 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 FY 2006, OIG was involved in the review and clearance of the implementing regulations and other policy guidance resulting from the various provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005 (DRA). Among other things, OIG reviewed and provided comments on the final rules addressing Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships; Electronic Prescribing and Health Records Arrangements.

### 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:

- Published in the *Federal Register* final rulemaking addressing new safe harbors under the anti-kickback statute for arrangements involving the donation of certain electronic health information technology and services. The final rule seeks to lower perceived barriers to the adoption of health information technology by finalizing safe harbors that promote the adoption of electronic prescribing technology and open, interconnected, interoperable electronic health record systems, while safeguarding the Federal programs and beneficiaries against undue risks of fraud and abuse. As required by the MMA, the first safe harbor establishes the conditions under which certain individuals may donate to specific recipients' hardware, software, or information technology and training services necessary and used solely for electronic prescribing. The second safe harbor establishes conditions under which a broader category of individuals may donate to a broader category of recipients interoperable electronic health records software, information technology, and training services. (71 FR 45110; August 8, 2006).
- Continued to develop new proposed rulemaking addressing the reorganization of and revisions to 42 CFR part 1003, which sets forth OIG's regulatory authorities for imposing civil money penalties and assessments.

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

## General Oversight

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- In accordance with section 6031 of DRA, published a *Federal Register* notice setting forth specific criteria and standards for determining whether a State False Claims Act meets the requirements of section 1909(b) of the Social Security Act (71 FR 48552; August 21, 2006).
- Continued to develop 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.

## 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 example:

- **South Dakota**—A former Indian Health Service employee was ordered to pay \$4,000 in restitution following her guilty plea to larceny. Pursuant to an OIG investigation, the employee allegedly caused the intentional destruction of Government records to conceal payments made to contractors that were fraudulent. During the investigation, it was revealed that she stole funds from the Rosebud Public Health Service Employee Association through her capacity as treasurer.

## Prosecutions

During this semiannual reporting period, OIG investigations resulted in 246 successful criminal actions. Also during this semiannual period, 642 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 238 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, \$870.1 million was ordered to be returned, or was returned, as a result of OIG investigations during this reporting period. That figure includes civil settlements from investigations resulting from audit findings.

# APPENDIXES

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## Appendix A: Savings Achieved Through Implementation of Recommendations in Audits and Evaluations for the Period October 1, 2005, Through September 30, 2006

The Congressional Budget Office (CBO) estimates annual Federal savings expected to result from the enactment of legislation as part of the process of informing Congress of the potential impact of legislation under consideration. After laws involving HHS programs have been enacted, OIG analyzes them to identify provisions that were recommended in OIG-issued reports. A similar process occurs with respect to administrative changes recommended by OIG and implemented by HHS's operating or staff divisions. In the latter cases, the savings estimated to accrue are developed by the relevant HHS operating or staff division or by OIG.

Savings of this kind depend greatly on the contributions of others, such as other HHS divisions and the Department of Justice. The amounts claimed represent funds that will be available for better use as a result of documented actions taken, including reductions in budget outlays, deobligations of funds, reductions in costs incurred, preaward grant reductions, and reductions and/or withdrawal of the Federal portion of interest subsidy costs of loans or loan guarantees, insurance, or bonds.

Total estimated savings from implemented recommendations and other actions to put funds to better use were \$35,806.7 million (\$35.8 billion) for the fiscal year (FY) that ended September 30, 2006.

OIG Recommendation	Implementing Action	Savings (millions)
<b>Centers for Medicare &amp; Medicaid Services</b>		
<p><b>Medicare Home Health Payments:</b>            CMS should restructure the payment system for home health care to eliminate inappropriate incentives that unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services.            (OEI-04-93-00260; OEI-09-96-00110; A-04-96-02121)</p>	<p>Chapter 1 of Subtitle G of the Balanced Budget Act of 1997 (BBA) (as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998), which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in FY 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminates periodic interim payments to home health agencies (HHAs).</p>	\$7,330

## Appendix A

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<p><b>State-Enhanced Payments Under Medicaid Upper Payment Limit Requirements:</b> States are allowed to make enhanced payments to local government providers as long as aggregate State payments for each class of service do not exceed the amount that would have been paid under Medicare cost principles. OIG found that States' use of intergovernmental transfers maximized Federal Medicaid reimbursements. OIG also found that enhanced payments were not based on the cost of providing the service, nor did OIG find a direct relationship in the use of these funds to increase the quality of care. (A-03-00-00216)</p>	<p>On January 12, 2001, CMS issued revisions to the upper payment limit (UPL) regulations that, among other things, created new payment limits for local government-owned providers. This final rule significantly affects a State's ability to reap windfall revenues by reducing the available funding pool from which to make enhanced payments to local government-owned providers.</p>	<p>\$5,800</p>
<p><b>Medicare Part A Payments for Skilled Nursing Facilities:</b> Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and legislation should prohibit entities other than skilled nursing facilities (SNFs) from seeking payment on behalf of persons in Part A-covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a prospective payment system and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; A-17-95-00096; A-14-98-00350)</p>	<p>Section 4432 of the BBA (as amended by the Balanced Budget Refinement Act of 1999, or BBRA) established a prospective payment for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.</p>	<p>\$4,990</p>
<p><b>Medicare Indirect Medical Education:</b> CMS should base the indirect medical education adjustment factor on the level supported by CMS's empirical data. (A-07-88-00111)</p>	<p>Section 4621 of the BBA (as amended by the BBRA) reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7 percent in FY 1998, 6.5 percent in FY 1999, 6 percent in FY 2000, and 5.5 percent in FY 2001 and thereafter.</p>	<p>\$2,680</p>
<p><b>Medicaid Enhanced Payments to Local Providers:</b> CMS should reconsider capping the aggregate UPL at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned government hospitals. (A-03-00-00216)</p>	<p>CMS issued a final rule that modified the Medicaid UPL provisions to remove the 150-percent UPL for services furnished by non-State-owned or -operated hospitals. The rule became effective in spring 2002.</p>	<p>\$2,600</p>

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<p><b>Medicare Secondary Payer Extensions:</b>            CMS should establish a centralized database of information about private insurance coverage of Medicare beneficiaries. Extend the Medicare secondary payer (MSP) provision to include end-stage renal disease (ESRD) beneficiaries as long as the individual has employer-based coverage available. (OEI-07-90-00760; OEI-03-90-00763; A-10-86-62016; A-09-89-00100; A-09-91-00103; A-14-94-00391; A-14-94-00392)</p>	<p>The database capacity was achieved through the authorization of a data exchange between the Social Security Administration and the Centers for Medicare &amp; Medicaid Services (CMS) and between the Internal Revenue Service and CMS. Section 4631 of the BBA permanently extended current MSP policies for beneficiaries who are disabled and have ESRD.</p> <p>For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.</p>	<p>\$2,460</p>
<p><b>Medicare Outlier Payments:</b>            To prevent future inappropriate outlier payments, CMS should focus its attention on the following: (1) determining how to limit, if not eliminate, the policy that allows for the use of the statewide rate in place of a hospital-specific rate; (2) dramatically reducing the timelag between the payment of outliers and the actual closing of a specific hospital's cost report, particularly with regard to the hospitals that the fiscal intermediary identifies as having significantly increased their charges; and (3) eliminating the hospitals' ability to construct and manipulate charges to determine whether an outlier payment is warranted in a specific medical case without regard to the actual costs involved in that case. (A-07-02-04007)</p>	<p>CMS issued new regulations in summer 2003. As a result of these regulations, it is estimated that the Medicare program will save at least \$9 billion from 2004 to 2008.</p>	<p>\$1,800</p>
<p><b>Capital-Related Costs of Hospital Services:</b>            CMS should extend congressionally mandated reductions in capital-related hospital costs. OIG believes that CMS should seek legislative authority to continue mandated reductions in capital payments; excess capacity was not considered in the capital cost policy. (A-09-91-00070; A-07-95-01127)</p>	<p>Section 4402 of the BBA provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.</p>	<p>\$1,200</p>
<p><b>Medicare Payments for Oxygen:</b>            CMS should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00710; OEI-03-91-00711)</p>	<p>Section 4552(a) of the BBA reduced Medicare reimbursement for oxygen by 25 percent until 1999 and by 30 percent for each subsequent year.</p>	<p>\$1,000</p>

## Appendix A

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<p><b>Payment Reform for Part B Drugs and Biologicals:</b>            CMS should reexamine drug reimbursement methodologies based on average wholesale price (AWP) with the goal of reducing payments in both Medicare and Medicaid. (Multiple reports and testimony, including OEI-03-96-00420; OEI-03-97-00290; OEI-03-00-00310; OEI-03-97-00293; A-06-00-00023; A-06-01-00053; A-06-02-00041)</p>	<p>Sections 303 through 305 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) revised the current payment methodology for Part B-covered drugs and biologicals that were not paid on a cost or prospective payment basis. Under the MMA, most drugs were to be paid at 85 percent of the April 1, 2003, AWP effective January 1, 2004, unless they meet certain exceptions. CBO specifically attributed the FY 2004 savings to sections 304 and 305. After 2004, most drug prices are based on the average sales price or competitive acquisition instead of AWP.</p>	\$900
<p><b>Medicare Laboratory Reimbursements:</b>            In 1989, OIG recommended that CMS take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In 1990, OIG recommended that CMS seek legislation to allow across-the-board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices that laboratories charge physicians in a competitive marketplace. In a 1996 followup, OIG found that Medicare continued to pay more to clinical laboratories than to physicians for the same tests. Although the Omnibus Budget Reconciliation Act (OBRA) of 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that CMS periodically evaluate the national fee schedule to ensure that it is in line with the prices that physicians pay for the same clinical laboratory services. (OEI-02-89-01910; A-09-89-00031; A-09-93-00056)</p>	<p>Section 4553 of the BBA provided for reducing fee schedule payments by lowering the cap to 74 percent of the median for payment amounts, with no inflation update for 1998 through 2002. The MMA mandated that the annual adjustment to the clinical laboratory fee schedule for 2007 through 2008 will be 0 percent.</p>	\$900
<p><b>Medicare Secondary Payer:</b>            CMS should ensure sufficient resources and contractor training for retroactively examining paid claims to identify other payer sources and initiating recovery action on all related overpayments. (Multiple reports and testimonies, including A-02-98-01036; A-04-92-02057; A-09-89-00162; A-10-86-62005)</p>	<p>Section 301 of the MMA clarifies the Secretary's authority to make certain reimbursable conditional payments and to take recovery actions against all responsible entities, including collection of damages, under MSP provisions. This builds on other program improvements related to OIG's work that were implemented by the BBA of 1997, OBRA of 1993, OBRA 1990, and OBRA 1989.</p>	\$800

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<p><b>Graduate Medical Education Payments:</b>            CMS should reevaluate Medicare’s policy of paying graduate medical education (GME) costs for all physician specialties and consider backing legislation to reduce Medicare’s investment in GME for a more accurate and representative sharing of GME costs. (A-06-92-00020)</p>	<p>Sections 4623 and 4626 of the BBA provided for limits in the number of residents counted for purposes of Medicare GME payments and offered payments for voluntary reductions in the number of residents to limit Medicare’s share of GME costs.</p>	<p>\$700</p>
<p><b>Payments for Durable Medical Equipment:</b>            CMS should take steps to reduce payments for a variety of durable medical equipment (DME) and related supplies. (Multiple reports, including OEI-03-01-00680; OEI-03-02-00700; OEI-07-96-00221; OEI-03-96-00230; OEI-03-94-0021; OEI-06-92-00861; OEI-06-92-00866)</p>	<p>Section 302 of the MMA froze payments for certain DME items, including prosthetics and orthotics, effective January 1, 2004.</p>	<p>\$600</p>
<p><b>Payments for Durable Medical Equipment:</b>            Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment, and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)</p>	<p>Section 4551(b) of the BBA froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002 and simplified the process used to reduce inherently unreasonable prices by 15 percent.</p>	<p>\$500</p>
<p><b>Medicare Home Health Payments:</b>            The HHA update factor should be reduced to account for the high error rate found in OIG’s review. The annual update was defined as the home health market basket percentage increase. (A-04-99-01194)</p>	<p>Section 701 of the MMA changed the updates of home health rates from fiscal year to calendar year beginning in 2004, with the update for the last 3 quarters of 2004 equal to the market basket increase minus 0.8 percent.</p>	<p>\$400</p>
<p><b>Clinical Diagnostic Laboratory Tests:</b>            CMS should seek legislation to allow across-the-board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices that laboratories charge physicians in a competitive marketplace; and periodically evaluate the national fee schedule levels. (A-09-89-00031; A-09-93-00056)</p>	<p>Section 628 of the MMA froze annual updates for FY 2004 through FY 2008. This action builds on prior legislative action in the BBA of 1997, OBRA 1993, OBRA 1990, and legislation in 1984 that was also responsive to OIG’s recommendations to curb excessive clinical laboratory test reimbursements by Medicare.</p>	<p>\$400</p>
<p><b>Medicare Payments to Hospitals for Bad Debt:</b>            CMS should seek legislative authority to modify the bad debt payment policy. (A-14-90-00039)</p>	<p>Section 4451 of the BBA reduced bad debt payment to providers by 25 percent in FY 1998, 40 percent in FY 1999, and 45 percent in later years. The Benefits Improvement and Protection Act of 2000 subsequently reduced further to 30 percent.</p>	<p>\$160</p>
<p><b>Payment for Services Furnished in Ambulatory Surgical Centers:</b>            CMS should set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and establish parity among ambulatory surgical centers (ASC) and outpatient departments. (OEI-05-00-00340; OEI-09-88-01003; A-14-98-00400; A-14-89-00221)</p>	<p>Section 626 of the MMA limited the ASC update starting April 1, 2004, then froze updates for a period beginning the last quarter of FY 2005.</p>	<p>\$100</p>

## Appendix A

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<p><b>Hospice Certification:</b> CMS should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; A-05-96-00023)</p>	<p>Sections 4441–4449 of the BBA contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60-day benefit periods (each requiring recertification).</p>	<p>\$90</p>
<p><b>Rural Health Clinics:</b> The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent clinics more equitable.</p> <p>In addition, the certification process should be modified to increase State involvement in the placement of the clinics. Recertification should be required within a specific time limit (for example, 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)</p>	<p>Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.</p>	<p>\$90</p>
<p><b>Medicaid Drug Rebates—Sales to Repackagers Excluded From Best Price Determinations:</b> Medicaid rebates were lost because sales to health maintenance organizations (HMO) were improperly excluded from drug manufacturers’ best price determinations in FYs 1998 and 1999.</p> <p>CMS should require drug manufacturers who excluded sales to HMOs from their best price calculations to repay the rebates and evaluate the policy guidance relating to exclusion of sales to other (non-HMO) repackagers from best price determinations. (A-06-00-00056)</p>	<p>CMS issued Medicaid Drug Rebate Program Release #47 in July 2000 to make it clear that manufacturers should not exclude other prices from best prices, as required by section 1927 of the Social Security Act.</p>	<p>\$81</p>

<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<p><b>Fraud and Abuse Provisions of the Balanced Budget Act:</b>            CMS should require DME suppliers and HHAs to provide Social Security numbers and employee identification numbers; refuse to enter into a provider agreement with any HHA whose owners or principals have prior criminal records or are the relatives of owners of a provider that has defrauded Medicare; apply “inherent reasonableness” provisions when assessing the appropriateness of Medicare payments; and authorize competitive bidding as a means of providing Medicare services.</p> <p>Moreover, CMS should clarify which general, administrative, and fringe benefit costs at hospitals and HHAs are related to patient care. Specifically, CMS should distinguish between employee benefits and/or prerequisites to entertainment and patient care; and specify that the cost of entertainment, goods, or services for personal use, and alcohol, all fines, penalties and associated interest, dues, and membership costs associated with civic and community organizations are not allowable. (OEI-04-96-00240; OEI-09-96-00110; OEI-09-96-00110; OEI-03-94-00392; OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; A-03-92-00017; A-04-93-02067)</p>	<p>A number of provisions in Subtitle D of the BBA corresponded to and were supported by OIG work. For example, the BBA authorized the HHS Secretary to collect Social Security numbers and employer identification numbers from entities under Medicare, Medicaid, and Title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized CMS to make inherent reasonableness adjustments of up to 15 percent to all Part B services except physician services; authorized up to five demonstration projects to be completed by December 31, 2002 (one must be oxygen and oxygen equipment), which can have multiple sites, to allow competitive bidding; and prohibited “reasonable cost” payments for items such as entertainment, gifts and donations, education expenses, and personal use of automobiles.</p>	<p>\$80</p>
<p><b>Hospital Sales:</b>            CMS should eliminate the requirement that Medicare adjust for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)</p>	<p>Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.</p>	<p>\$70</p>
<p><b>Medicare Payments for Prescription Drugs:</b>            CMS should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)</p>	<p>Section 4556 of the BBA reduced Medicare payments for drugs that are paid based on the average wholesale price.</p>	<p>\$50</p>
<p><b>Payments for Ambulance Services:</b>            CMS should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)</p>	<p>Section 4531 of the BBA made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. The fee schedule was to be set so that aggregate payments would be reduced by 1 percent.</p>	<p>\$20</p>

## Appendix A

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<b>OIG Recommendation</b>	<b>Implementing Action</b>	<b>Savings (millions)</b>
<b>ADMINISTRATION FOR CHILDREN AND FAMILIES</b>		
<b>Availability of Health Insurance for Title IV-D Children:</b> Connecticut should either implement policies and procedures to require noncustodial parents to pay all or part of the Medicaid costs for their dependent children or establish a statewide health insurance plan that provides reasonably priced, comprehensive coverage for children, with costs paid by noncustodial parents. (A-01-97-02506)	The BBA established the State Children's Health Insurance Program to enhance Medicaid coverage provided to children and to allow States to create insurance options for families who exceed Medicaid resource and income limits. Under Connecticut law, applicants include noncustodial parents ordered to provide health insurance.	\$5.7

## **Appendix B: Unimplemented Office of Inspector General Recommendations To Put Funds to Better Use**

OIG issues a publication called the *Red Book* that outlines the potential annual savings or onetime recoveries that could be realized if OIG recommendations were enacted by Congress or the Department through legislation, regulation, or management action.

Previous editions of the semiannual report included a table (Appendix B) that duplicated information found in the *Red Book*. Starting with this edition, the semiannual report will no longer repeat information from the *Red Book*. Instead, the reader may refer to the *Red Book* itself, which is available in its entirety at <http://oig.hhs.gov>.

Historically, OIG issued two publications, the *Red Book* and *Orange Book*, which, respectively, detailed the significant unimplemented monetary and nonmonetary recommendations made by OIG. In 2006, these two publications will be combined into a single publication titled *Unimplemented OIG Recommendations*.



## **Appendix C: Unimplemented Office of Inspector General Program and Management Improvement Recommendations**

OIG issues a publication called the *Orange Book* that outlines the potential improvements in Department programs and operations that could be realized if OIG's nonmonetary recommendations were enacted by Congress or the Department through legislation, regulation, or management action.

Previous editions of the semiannual report included a table (Appendix C) that duplicated information found in the *Orange Book*. Starting with this edition, the semiannual report will no longer repeat information from the *Orange Book*. Instead, the reader may refer to the *Orange Book*, which is available in its entirety at <http://oig.hhs.gov>.

Historically, OIG issued two publications, the *Red Book* and *Orange Book*, which, respectively, detailed the significant unimplemented monetary and nonmonetary recommendations made by OIG. In 2006, these two publications will be combined into a single publication titled *Unimplemented OIG Recommendations*.



## Appendix D: Notes to Tables 1 and 2

### Notes to Table 1

<sup>1</sup>The opening balance was adjusted upward \$ 54.2 million.

<sup>2</sup>During the period, revisions to previously reported management decisions included:

Central Identification Number (CIN): A-04-98-00126 REVIEW OF FOSTER CARE PAYMENTS – ACF and the State arrived at a settlement agreement whereby ACF would accept \$5.6 million as full and complete payment on the \$11.7 million that ACF disallowed.

CIN: A-07-04-04034 REVIEW OF MEDICARE OUTLIER PAYMENTS TO THE QUITMAN CLINIC – Questioned costs were revised from \$12.5 million to \$7.8 million based on the fiscal intermediary’s Statistical Valid Random Sample review.

CIN: A-08-00-64575 STATE OF COLORADO – Estimated questioned costs were revised from \$11.2 million to the actual amount collected and returned to CMS by a State totaling \$2.5 million.

Not detailed are revisions to previously disallowed management decisions totaling \$19 million.

<sup>3</sup>Included are management decisions to disallow \$69 million that was identified in nonfederal audit reports.

<sup>4</sup> A. Due to administrative delays, many of which are beyond management control, resolution of the following 187 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-02-02-01029	REVIEW OF SPEECH SCHOOL HEALTH CLAIMS - NYCDE, JUN 2005, \$435,903,456
CIN: A-02-02-01030	REVIEW OF SPEECH SCHOOL HEALTH CLAIMS - REST OF STATE, FEB 2004, \$172,553,831
CIN: A-05-01-00099	U OF I HOSPITAL-DSH PAYMENT LIMITS, OCT 2004, \$140,281,912
CIN: A-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, \$128,269,448
CIN: A-02-03-01023	REVIEW OF TRANSPORTATION SCHOOL HEALTH CLAIMS - NYC DEPT. OF EDUCATION, SEP 2005, \$108,241,199
CIN: A-04-99-05561	AUDIT ADMIN COST PROPOSALS FY95-98, BCBSFL, JAX, JUL 2002, \$101,671,328
CIN: A-09-02-00071	AUDIT OF CA DSH 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 MEDICAID POSTACUTE CARE TRANSFER POLICY - FY 01 & 02, APR 2005, \$72,369,964
CIN: A-02-03-01008	REVIEW OF TRANSPORTATION SCHOOL HEALTH CLAIMS - REST OF STATE, AUG 2004, \$53,037,302
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 DSH PAYMENT LIMITS, JUN 2004, \$47,000,000

## Appendix D

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CIN: A-04-01-02006	MEDICAID DISPROPORTIONATE SHARE PAYMENTS IN ALABAMA, JUN 2004, \$45,763,327
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 - CT, MAY 2003, \$32,780,146
CIN: A-04-03-06003	MEDICAID ACCOUNTS RECEIVABLE OVERPAYMENTS IN FLORIDA, OCT 2005, \$31,900,000
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-03-01-00224	MEDICAID SCHOOL-BASED SERVICES/MARYLAND, MAR 2003, \$19,954,944
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEP 2002, \$19,446,435
CIN: A-01-02-00509	REVIEW OF MEDICARE ADMINISTRATIVE COSTS - PART A & B - UNITED HEALTHCARE INSURANCE COMPANY, MAR 2005, \$12,991,420
CIN: A-02-03-01019	UPPER PAYMENT LIMIT CALCULATIONS - NEW JERSEY, MAR 2005, \$10,698,309
CIN: A-06-03-00027	REVIEW OF HUMANA'S BIPA MODIFICATIONS, JUL 2005, \$10,500,000
CIN: A-06-02-00034	REV OF COST REPORTS & MEDICARE FEE-FOR-SERVICE PYMTS @ SCOTT & WHITE, MAY 2003, \$8,229,574
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEP 2002, \$7,999,212
CIN: A-09-97-44262	STATE OF CALIFORNIA, APR 1997, \$7,300,000
CIN: A-07-02-03033	CAREFIRST SEGMENTATION AUDIT, MAY 2003, \$6,788,644
CIN: A-02-04-01009	MEDICAID PROVIDER OVERPAYMENTS - NEW JERSEY, JAN 2006, \$6,621,210
CIN: A-05-02-00049	MEDICAL SERVICE COSTS UNDER ILLINOIS SCHOOL-BASED MEDICAID, DEC 2003, \$6,067,669
CIN: A-03-03-00562	DELAWARE TITLE IV-E TRAINING AND ADMIN COSTS, JUL 2005, \$5,912,733
CIN: A-01-04-00525	REVIEW OF INTERRUPTED STAYS AT INPATIENT REHABILITATION FACILITIES, DEC 2005, \$5,868,697
CIN: A-04-00-02161	MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOV 2001, \$5,344,160
CIN: A-01-02-00016	MEDICAID SCHOOL-BASED HEALTH SERVICE ADMINISTRATIVE CLAIMING REVIEW-MASSACHUSETTS, SEP 2004, \$5,312,447
CIN: A-09-03-00042	REVIEW OF HHA PRECEEDING 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-04-04-06003	GME FOR DENTAL RESIDENTS - MA, MAR 2006, \$4,927,121
CIN: A-07-05-00187	PENSION COSTS CLAIMED REVIEW AT ANTHEM INSURANCE COMPANIES - ADMINISTAR FEDERAL, DEC 2005, \$4,833,704
CIN: A-09-03-00051	REVIEW OF BLUE SHIELD CALIFORNIA BIPA MODIFICATIONS TO CY 2001 ACRP, OCT 2004, \$4,555,992

CIN: A-05-01-00102	MT. SINAI HOSPITAL-DSH PAYMENT LIMITS, OCT 2004, \$4,516,112
CIN: A-02-00-01047	DEMO BSWNY - FINANCIAL, MAR 2002, \$4,505,051
CIN: A-01-02-00015	REVIEW OF MA MEDICAID USE OF REVISED FEE SCHEDULES FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES, JAN 2004, \$4,100,000
CIN: A-07-04-03053	REVIEW OF CAHABA'S UNFUNDED PENSION COSTS, FEB 2004, \$4,006,541
CIN: A-03-01-00225	VIRGINIA IMD UNDER 21, MAR 2004, \$3,948,532
CIN: A-09-03-00053	AUDIT OF ORGAN ACQUISITION COSTS AT CPMC, JAN 2005, \$3,731,752
CIN: A-01-02-00525	MAINE ANTHEM BCBS - MEDICARE ADMINISTRATIVE COSTS, APR 2004, \$3,389,716
CIN: A-05-03-00068	REVIEW OF INDIANA MEDICAID UPPER PAYMENT LIMIT CALCULATIONS, SEP 2005, \$3,173,161
CIN: A-06-04-00076	MEDICAL REVIEW OF SYNERGY'S PHP CLAIMS, MAR 2006, \$3,098,296
CIN: A-04-01-00005	MEDICAID FFS PAYMENTS TO LEA'S IN NORTH CAROLINA, MAY 2004, \$3,066,806
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-09-98-50183	STATE OF CALIFORNIA, MAR 1998, \$3,000,000
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-07-05-03064	MEDICAID PROVIDER OVERPAYMENTS IN MONTANA, MAR 2006, \$2,731,303
CIN: A-01-04-78839	STATE OF NEW HAMPSHIRE, JUN 2004, \$2,631,648
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-06-02-00051	LAPORTE ADMIN COST CLAIMED FOR MEDICAID SCHOOL-BASED SERVICES, JAN 2006, \$2,408,218
CIN: A-09-02-72300	STATE OF CALIFORNIA, JUL 2002, \$2,400,000
CIN: A-07-04-03050	PENSION SEGMENTATION REVIEW AT HIGHMARK, INC. OF PA, 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-04-03-06019	GRADUATE MEDICAL EDUCATION FOR DENTAL RESIDENTS - VA, MAR 2006, \$2,117,401
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-07-05-04048	MEDICAID DRUG REBATE FOLLOW-UP - COLORADO, NOV 2005, \$1,925,367

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CIN: A-01-02-00516	REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES UNITED GOVERNMENT SERVICES, MAR 2003, \$1,768,783
CIN: A-01-05-02500	REVIEW OF NEW HAMPSHIRE'S TRAINING AND IV-E ADOPTION ASSISTANCE COSTS, JAN 2006, \$1,760,000
CIN: A-03-01-00228	PENNSYLVANIA IMD UNDER 21, JUL 2005, \$1,694,148
CIN: A-02-04-01010	REVIEW OF PHYSICIAN PLACE OF SERVICE CODING FOR AMBULATORY SURGICAL AND RELATED PROCEDURES, JAN 2005, \$1,467,318
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 CT - 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-04-03-01000	REVIEW OF HOME HEALTH SERVICES CLAIMED BY LIFELINE HEALTH GROUP, INC, JUN 2004, \$1,173,330
CIN: A-09-94-01010	CLOSEOUT AUDIT-CONT NO. N01-ES-75196 (STRATAGENE), MAR 1994, \$983,208
CIN: A-05-05-00018	REVIEW OF MICHIGAN'S MEDICAID REIMBURSEMENT TO TEACHING HOSPITALS FOR GRADUATE MEDICAL EDUCATION, FEB 2006, \$955,060
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-05-04-77356	TRI-VALLEY OPPORTUNITY COUNCIL INC., FEB 2004, \$866,666
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-05-05-00032	MEDICAID GME IN OHIO, MAR 2006, \$823,883
CIN: A-06-03-00013	MEDICARE ADMINISTRATIVE COST PROPOSAL-ARKANSAS BCBS, OCT 2003, \$759,748
CIN: A-05-02-00041	INDIANA MEDICAID HOSPITAL PATIENT TRANSFERS, JAN 2003, \$730,061
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-06-03-00032	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-04-04-06002	GME FOR DENTAL RESIDENTS - PA, JAN 2006, \$579,977

CIN: A-02-03-01024	MEDICAID DRUG REBATE COLLECTIONS - NEW JERSEY, OCT 2004, \$567,186
CIN: A-05-04-00054	STATE AGENCY USE OF CONTRACTED SERVICES - OHIO, MAY 2005, \$560,249
CIN: A-07-02-03015	BCBS OF MN 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-01-04-00008	AUDIT OF MEDICAID PAYMENTS FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL REIMBURSED AT ENHANCED RATES OCTOBER 1, 2002 THROUGH SEPTEMBER 30, 2003 OFFICE OF VERMONT HEALTH ACCESS, MAR 2005, \$534,438
CIN: A-03-92-16229	STATE OF PENNSYLVANIA, MAR 1992, \$496,876
CIN: A-02-02-01004	MEDICAID PPS TRANSFERS, MAY 2003, \$493,158
CIN: A-03-04-00205	MEDICAID PROVIDER OVERPAYMENTS-DELAWARE, OCT 2004, \$437,592
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-05-03-00053	ESRD PRICING ERRORS AT INDEPENDENT FACILITIES, NOV 2003, \$407,300
CIN: A-10-04-00003	MEDICAID OVERPAYMENTS IN WASHINGTON, SEP 2005, \$396,941
CIN: A-02-01-67912	STATE OF NEW YORK, MAR 2001, \$389,536
CIN: A-04-04-06011	GRADUATE MEDICAL EDUCATION FOR DENTAL RESIDENTS - IOWA, FEB 2006, \$338,490
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$319,355
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-01-04-00522	THE MID COAST HOSPITAL IN MAINE DSH PAYMENT, SEP 2004, \$289,936
CIN: A-01-04-00003	APPLICATION CONTROLS AT NEW HAMPSHIRE MEDICAID STATE AGENCY, FEB 2005, \$274,370
CIN: A-01-05-00520	REVIEW OF FISCAL YEAR-END BILLING FOR INPATIENT REHABILITATION CLAIMS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ADMINISTAR FEDERAL FOR 2002, MAR 2006, \$272,564
CIN: A-09-94-30178	STATE OF ARIZONA, JUN 1994, \$267,021
CIN: A-07-04-00175	REVIEW OF UNFUNDED PENSION COSTS AT VERITUS, INC., OCT 2004, \$266,052
CIN: A-05-02-00047	UNITED GOVERNMENT SERVICES, MEDICARE PART A ADMIN. COSTS FY 1999-2001, JUN 2003, \$260,831
CIN: A-07-03-02662	REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DEC 2002, \$258,112
CIN: A-01-05-00508	REVIEW OF FISCAL YEAR-END BILLING AT MAINE GENERAL MEDICAL CENTER, AUG 2005, \$254,915

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CIN: A-06-05-00039 REVIEW OF ARKANSAS' ACCOUNTS RECEIVABLE SYSTEM FOR MEDICAID PROVIDER OVERPAYMENTS, JAN 2006, \$238,928

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-02-01-01019 DEMO BSWNY - CASH MANAGEMENT, OCT 2002, \$208,271

CIN: A-05-04-00058 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC., JUL 2004, \$206,495

CIN: A-01-05-00509 REVIEW OF MEDICARE CONTRACT TERMINATION/SEVERANCE COSTS CLAIMED BY BLUE CROSS & BLUE SHIELD OF RHODE ISLAND (RIBCBS), SEP 2005, \$205,384

CIN: A-01-04-01501 NORTHEASTERN UNIVERSITY DHHS GRANT COSTS GRANT #S 9274, 4000 AND 4111, JAN 2005, \$194,890

CIN: A-07-01-02094 SURVEY OF OUTPATIENT OBSERVATION SERVICES, OCT 2002, \$165,125

CIN: A-07-05-00194 PENSION COSTS CLAIMED REVIEW AT ANTHEM INSURANCE COMPANIES - MAINE, OCT 2005, \$163,107

CIN: A-09-05-00077 REVIEW OF PACIFICARE'S USE OF ADDITIONAL CAPITATION UNDER THE MMA OF 2003, MAR 2006, \$135,000

CIN: A-07-04-03051 MEDICAID PROVIDER OVERPAYMENTS IN UTAH, AUG 2004, \$132,749

CIN: A-05-03-00067 ADMINISTRATIVE COSTS - WI MEDICAID WAIVERS, JUN 2004, \$129,663

CIN: A-01-03-00010 MEDICAID SCHOOL-BASED HEALTH SERVICES ADMINISTRATIVE CLAIMING REVIEW - RHODE ISLAND, JUN 2004, \$123,010

CIN: A-05-01-00091 PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, \$121,023

CIN: A-02-96-02001 INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JAN 1998, \$114,631

CIN: A-05-05-00044 DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLAN-ARNETT HEALTH PLANS, INC. FOR FISCAL YEARS 2000, THROUGH 2003, SEP 2005, \$111,862

CIN: A-01-02-00527 REVIEW OF ANTHEM BLUE CROSS/BLUE SHIELD MEDICARE CONTRACT TERMINATION AND SEVERANCE COSTS, SEP 2003, \$104,468

CIN: A-05-01-00079 PAYMENTS TO BLUE CARE MID-MI 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 @ WELBORN, JUN 2003, \$97,623

CIN: A-10-05-80407 FIRST A.M.E. CHILD & FAMILY CENTER, MAR 2005, \$96,803

CIN: A-09-97-00066 WALTER MCDONALD - INDIRECT COST RATE AUDIT, MAR 1998, \$95,733

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-05-02-00074 IL PARTNERSHIP PLAN - TRANSPORTATION DURING AN INPATIENT STAY, APR 2003, \$89,147

CIN: A-05-01-00090 PAYMENTS TO AETNA OF FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, \$87,516

CIN: A-01-04-77722 STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS, JAN 2004, \$86,792

CIN: A-05-05-00043 DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLAN - JOHN DEERE HEALTH PLANS, INC.FOR FISCAL YEARS 2000 THROUGH 2003, SEP 2005, \$78,799

CIN: A-05-04-00061 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF BLUE CROSS BLUE SHIELD OF NEBRASKA, DEC 2004, \$78,352

CIN: A-05-01-00089 ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCT 2002, \$77,000

CIN: A-01-03-75448 STATE OF NEW HAMPSHIRE, APR 2003, \$65,917

CIN: A-04-05-02000 AUDIT OF HHA THERAPY BILLINGS, SEP 2005, \$63,425

CIN: A-05-01-00086 PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$62,432

CIN: A-09-04-00029 REVIEW OF AIR AMBULANCE SERVICES FOR CALENDAR YEAR 2002, JUL 2005, \$62,408

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

CIN: A-02-99-58263 PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD, JUL 1999, \$49,684

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-07-04-04035 REVIEW OF MEDICARE OUTLIER PAYMENTS TO FOUNDATION CMHC, APR 2005, \$36,000

CIN: A-02-00-65502 ABYSSINIAN DEVELOPMENT CORP., AUG 2000, \$34,737

CIN: A-05-02-69155 STATE OF WISCONSIN, DEC 2001, \$30,900

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

CIN: A-03-98-03301 AAUAP - INCURRED COST REVIEW - HHS 105-95-7011, APR 1998, \$28,289

CIN: A-05-03-00097 MEDICARE OUTPATIENT CARDIAC REHAB - NORTHFIELD HOSPITAL, NOV 2003, \$27,013

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

CIN: A-01-04-78952 STATE OF CONNECTICUT, AUG 2004, \$24,457

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

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

CIN: A-04-01-67441 CATAWBA INDIAN NATION, APR 2001, \$19,204

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

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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-10-04-76879	STATE OF ALASKA, DEC 2003, \$18,226
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-03-04-00001	RAYTEL CARDIAC SERVICES- OCIG ASSIST, JAN 2006, \$12,315
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-05-04-00030	PAYMENTS FOR SERVICES TO DECEASED MEDICAID BENEFICIARIES - MASSACHUSETTS, FEB 2005, \$4,696
CIN: A-04-03-01006	OUTPATIENT CARDIAC REHAB SERVICES AT MORTON PLANT HOSPITAL, JAN 2004, \$4,426
CIN: A-06-04-00092	REVIEW OF ARTERIAL STENTS - MUTUAL OF OMAHA CLAIMS, DEC 2005, \$4,109
CIN: A-02-02-01035	EVALUATION OF BID PROPOSAL - MEDICARE HELP LINE, AUG 2002, \$3,760
CIN: A-05-03-00084	MEDICARE OUTPATIENT CARDIAC REHAB - NORTHERN MICHIGAN HOSPITAL, OCT 2003, \$3,738
CIN: A-03-95-03318	TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996, \$3,016
CIN: A-04-95-33088	STATE OF NORTH CAROLINA, APR 1995, \$2,734
CIN: A-04-03-01002	OUTPATIENT HOSPITAL CARDIAC REHAB - MEMORIAL HOSPITAL JACKSONVILLE, NOV 2003, \$2,123
CIN: A-04-03-01005	OUTPATIENT CARDIAC REHAB SERVICES CENTRAL FL REGIONAL HOSPITAL, NOV 2003, \$2,003
CIN: A-02-03-01026	MEADOWLANDS HOSPITAL MEDICAL CENTER CARDIAC REHAB SERVICES, JAN 2004, \$1,703
CIN: A-06-02-00032	CMS FY 01 MEDICARE ERROR RATE - ARK BC/BS REPORT, NOV 2002, \$1,311
CIN: A-05-03-00070	MEDICARE OUTPATIENT CARDIAC REHAB - ST.CHARLES MERCY HOSP, OCT 2003, \$1,158
CIN: A-03-03-00393	AUDIT OF CDC HIV/AIDS GRANT TO SEXUAL MINORITY YOUTH ASSISTANCE LEAGUE, OCT 2003, \$1,155

**Total CINs: 187**

**TOTAL AMOUNT: \$1,942,621,749**

B. The following audit is open pending the resolution of the contractors' termination audit-related termination agreements and pending lawsuits:

CIN: A-04-01-67441 CATAWBA INDIAN NATION. UNABLE TO DETERMINE WHEN THE REPORT WILL BE CLOSED. THE REPORT HAS 1 MONETARY FINDING FOR \$19,204, MAY 2001.

**Notes to Table 2**

<sup>1</sup>The opening balance was adjusted downward by \$10 million.

<sup>2</sup>Management decision has not been made within 6 months on 32 reports.

A. Discussions with management are ongoing and it is expected that the following audits will be resolved by the next semiannual reporting period:

CIN: A-06-01-00041 AUDIT OF THE TX DISPROPORTIONATE SHARE HOSP PROG PAYMENT METHODOLOGY, FEB 2003, \$319,200,000

CIN: A-07-04-04038 MEDICAID HOSPITAL OUTLIER PAYMENTS IN NORTH CAROLINA, JAN 2006, \$89,420,140

CIN: A-07-04-04031 MEDICAID HOSPITAL OUTLIER PAYMENTS IN ILLINOIS, MAY 2005, \$56,449,668

CIN: A-01-02-0050 FURTHER EXPANSION OF THE DRG PAYMENT WINDOW, AUG 2003, \$37,000,000

CIN: A-05-04-00064 OHIO MEDICAID HOSPITAL OUTLIER PAYMENTS, MAR 2006, \$24,700,000

CIN: A-05-02-00078 ROLLUP OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, FEB 2004, \$12,764,202

CIN: A-03-04-00211 MEDICAID HOSPITAL OUTLIER PAYMENTS - PENNSYLVANIA, NOV 2005, \$11,420,000

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-05-05-00022 REVIEW OF RIVERSIDE MEDICAL CENTER'S WAGE DATA USED FOR CALCULATING INPATIENT PROSPECTIVE PAYMENT SYSTEM WAGE INDICES, MAR 2006, \$4,388,324

CIN: A-06-00-00073 REV OF MGR CARE ADDTL BENEFITS FOR CY 00 OF NYLCAR, MAR 2002, \$4,000,000

CIN: A-01-04-02503 REVIEW OF MAINE'S ADOPTION ASSISTANCE SUBSIDY PAYMENTS, APR 2005, \$1,900,000

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-05-04-00030 PAYMENTS FOR SERVICES TO DECEASED MEDICAID BENEFICIARIES - MASSACHUSETTS, FEB 2005, \$503,715

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CIN: A-05-04-00054	STATE AGENCY USE OF CONTRACTED SERVICES - OHIO, MAY 2005, \$277,243
CIN: A-07-04-01008	FAMILY PLANNING - FEE-FOR-SERVICE - COLORADO, JAN 2005, \$269,024
CIN: A-05-00-00006	MEDICAID MUTUALLY EXCLUSIVE CODES - MI, JUN 2000, \$240,000
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-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JAN 1998, \$90,528
CIN: A-05-02-00084	MEDICARE OUTPATIENT CARDIAC REHAB - ST. LUKE'S MEDICAL CENTER, JUL 2003, \$47,247
CIN: A-05-04-00051	ALLOWABILITY OF CDC BIOTERRORISM COSTS - OHIO DEPARTMENT OF HEALTH, FEB 2005, \$4,154

**Total CINs: 32**

**TOTAL AMOUNT: \$591,982,294**

## Appendix E: 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 below with reference to the page in the semiannual report on which each is addressed. Where there are no data to report under a particular requirement, the word “None” appears in the column. A complete listing of audit and inspection reports is being furnished to Congress under separate cover. Copies are available upon request.

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	p. 45
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 the <i>Red Book</i> and <i>Orange Book</i> at <a href="http://oig.hhs.gov">http://oig.hhs.gov</a> .
(a)(4)	Matters referred to prosecutive authorities	p. 46
(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. 43
(a)(9)	Statistical Table 2—Funds Recommended To Be Put to Better Use	p. 44
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	None



## Appendix F: Status of Public Proposals for New and Modified Safe Harbors to the Anti-Kickback Statute Pursuant to Section 205 of the Health Insurance Portability and Accountability Act of 1996

Pursuant to section 205 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, the Inspector General (IG) is required to solicit proposals annually via *Federal Register* notice for developing new and modifying existing safe harbors to the anti-kickback statute and for developing special fraud alerts. The IG is also required to report to Congress annually on the status of the proposals.

In crafting safe harbors for a criminal statute, it is incumbent upon OIG to engage in a complete and careful review of the range of factual circumstances that may fall within the proposed safe harbor subject area, so as to uncover all potential opportunities for fraud and abuse by unscrupulous providers. Having done so, OIG must then determine, in consultation with the Department of Justice, whether it can develop effective regulatory limitations and controls that will permit beneficial or innocuous arrangements, but also protect the Federal health care programs and their beneficiaries from abusive practices.

In response to the 2005 annual solicitation, OIG received the following proposals related to safe harbors:

<b>Proposal</b>	<b>OIG Response</b>
New safe harbor to protect intellectual property royalty payments to medical innovators.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.
Modification of existing group purchasing organization (GPO) safe harbor to clarify: (i) the application of the safe harbor to pharmacy benefit managers; (ii) the application of the “wholly owned” standard; and (iii) the treatment of administrative fees distributed by a GPO to its members.	These suggestions require further study.
Modification of discount safe harbor with respect to Medicare Part D plans to incorporate documentation and disclosure standards for manufacturers, Part D plans, and certain other business relationships.	This suggestion requires further study.
Modification of discount safe harbor to update disclosure requirements and standardize requirements for offerors and sellers.	These suggestions require further study.
New safe harbor applying to investment interests of physicians in specialty hospitals that receive their patient referrals.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures. Depending on the facts, existing safe harbors may be applicable.
New safe harbor specifying conditions under which Medicare patients could receive different types of services (e.g., educational services, home environment assessment) from home care providers prior to scheduled hospital procedures.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.

## Appendix F

Proposal	OIG Response
New safe harbor for assisting physicians with the adoption of electronic health records technology. This safe harbor should complement the previously announced proposed safe harbor for e-prescribing technology.	OIG published a final rule regarding new electronic prescribing and electronic health records safe harbors. See 71 FR 45110 (August 8, 2006).

In addition to the proposals in the preceding table (some of which duplicate proposals from past years), OIG has had under consideration a number of suggestions reported in prior years. The following table updates the status of those suggestions:

Proposal	OIG Response
New safe harbor for implementation of electronic health record systems between hospitals, health systems, and multi-specialty group practices and for the provision of standardized software and hardware to physicians without charge.	OIG published a final rule regarding new electronic prescribing and electronic health records safe harbors. See 71 FR 45110 (August 8, 2006).
New safe harbor for implementation of a “community wide” health information network.	OIG has solicited comments regarding this suggestion. See 70 FR 59015 at 59024 (October 11, 2005).
Modification of existing safe harbor for obstetrical malpractice insurance subsidies to include (i) additional types of physicians and (ii) subsidies where there is documented need and the subsidy amount is limited in scope and duration.	This suggestion requires further study.
New safe harbor for manufacturer donations to charitable organizations that provide items or services to financially needy patients, including copayment assistance.	This issue has been addressed in OIG’s Special Advisory Bulletin on Patient Assistance Programs for Medicare Part D Enrollees, issued on November 7, 2005, and in several advisory opinions. OIG continues to consider this suggestion.
Modification of the discount safe harbor to clarify its application to the additional entities with which pharmaceutical manufacturers may contract under MMA (e.g., discount drug card sponsors, pharmacy benefits managers, retail pharmacies, and Part D drug plan sponsors).	This suggestion requires further study.
New safe harbor for certain practices related to “economic credentialing” of physicians by hospitals.	This issue was addressed in the OIG Supplemental Compliance Program Guidance for Hospitals, issued on January 31, 2005. Public comments previously received variously suggest issuance of different types of guidance; some comments suggest that OIG take no action. OIG is reviewing the comments and studying the issue.
Modification of the Medicare SELECT safe harbor to cover (i) coinsurance waivers for inpatient services negotiated between a hospital and an Employee Retirement Income Security Act employee welfare benefit plan that covers retirees and (ii) Part B waivers for employer group plans.	These suggestions require further study. In September 2002, OIG issued a notice of proposed rulemaking to make certain modifications to the safe harbor. The public comments to that rulemaking are under review.
New anti-kickback safe harbor for inducements offered to beneficiaries that fit in an exception to the beneficiary inducements civil monetary penalties statute at 42 U.S.C. §1320a-7a(a)(5).	OIG is considering this suggestion.
Modification of the existing shared risk exception to cover (i) second tier contractors of Federally qualified	OIG is considering these suggestions.

Proposal	OIG Response
health centers (FQHCs) and (ii) the TRICARE program.	
New safe harbor for certain fee-for-service arrangements between FQHCs and other providers, practitioners, and suppliers.	OIG published a proposed rule regarding FQHC arrangements. See 70 FR 38081 (July 1, 2005). The public comments are under review.
Modification of the discount safe harbor to include a discount obtained by a commercial health plan that does not file claims with the Federal health care programs, where the discount otherwise meets the safe harbor conditions.	OIG is considering this suggestion.
Modification of the discount safe harbor to clarify its application to discounts applied to a manufacturer's full product line.	This suggestion requires further study.
Modification of the discount safe harbor's reporting requirements.	This suggestion requires further study.
Modification of the existing safe harbors to conform them to the final regulations under the physician self-referral statute published by the Centers for Medicare & Medicaid Services (CMS), and new safe harbors analogous to the new self-referral exceptions created by the CMS regulations.	OIG is considering making some conforming changes with respect to the group practice safe harbor. With respect to other safe harbors, the statutes generally serve somewhat different purposes, and conforming the safe harbors to the self-referral exceptions may not be appropriate.
Modification of the ambulatory surgical centers (ASC) safe harbor to address protection of start-up multi-specialty ASCs that otherwise comply with the current safe harbor conditions.	OIG is considering this suggestion.
Modification of the safe harbor for ASCs jointly owned by hospitals and physicians to add conditions under which a hospital would not be in a position to make or influence referrals.	OIG is considering this suggestion.
Modification of the ASC safe harbor to indicate whether an ASC can require investors to comply with safe harbor conditions.	OIG is considering this suggestion.
Modification of the ASC safe harbor to clarify (i) the use of "pass-through" entities to hold ownership interests and (ii) the treatment of physician investors who invest at different times.	OIG is considering this suggestion.
New safe harbor for rural health networks operating pursuant to the Medicare Rural Hospital Flexibility Program.	This suggestion requires further study.
New safe harbor for arrangements that comply with section 513 of the IRS Code pertaining to the provision of certain supporting goods and services by tax-exempt hospitals to other tax-exempt hospitals.	This suggestion requires further study.



## **Appendix G: 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 Act**—Under the Federal civil False Claims Act (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 of the truth or falsity of the information or in 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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