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Appendix A: Savings Achieved Through Implementation of Recommendations

After laws involving the Department of Health and Human Services (HHS) programs have been enacted, the Office of Inspector General (OIG) analyzes them to identify provisions that were supported by recommendations arising from OIG work. A similar process occurs with respect to administrative changes by HHS management through regulations or other directives.

For administrative changes, the savings estimates are developed by the pertinent HHS operating or staff division or by OIG. For legislative savings, we use estimates prepared by the Congressional Budget Office (CBO). As part of the process of informing Congress of the potential impact of legislation under consideration, CBO projects the annual Federal costs and savings that are expected to result from enacting legislation.

The savings estimates described annually in this appendix represent funds that will be available for better use as a result of actions taken, such as 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. Savings of this kind generally reflect not only OIG's recommendations, but also the contributions of others, such as HHS staff and operating divisions and the Government Accountability Office.

Total savings attributed to fiscal year (FY) 2010 as a result of legislative and administrative actions supported by OIG recommendations totaled $21,014 million ($21 billion).

OIG Recommendation	Implementing Action	Savings (millions)
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)		
State-Enhanced Payments Under Medicaid Upper Payment Limit Requirements. The Centers for Medicare & Medicaid Services (CMS) should move as quickly as possible to issue regulatory changes to the upper payment limit (UPL) rules governing enhanced payments to local government providers. The recommendation related to findings in OIG report number A-03-00-00216.	On January 12, 2001, CMS issued revisions to the 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.	$8,000

OIG Recommendation	Implementing Action	Savings (millions)
Medicaid Enhanced Payments to Local Providers. Reconsider capping the aggregate upper payment limit (UPL) at 100 percent for all facilities, rather than the 150-percent allowance for non-State-owned Government hospitals. The recommendation relates to findings in OIG report number A-03-00-00216.	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 the spring of 2002.	$3,200
Medicare Advantage Payments. Modify payment rates to a level fully supported by empirical data considering the effects of the multiple elements that impact total payments. The recommendation that MA payment rates should be fully supported by empirical data mirrors a body of past and continuing OIG work. The source report for this recommendation was A-14-00-00212.	Section 5301 of the DRA amended the Social Security Act, § 1853(k), to phase out risk adjustment budget neutrality in determining the amount of payments to Medicare Advantage (MA) organizations. The DRA defined the applicable amount in calculating benchmark amounts; codified the phase-out schedule for the budget neutrality adjustment; and identified the adjustments to be made to the budget neutrality calculation during the phase-out years. CBO scored the provision to save about $6.5 billon through FY 2010 with $2.9 billion attributed to FY 2010.	$2,900
Payment Reform for Part B Drugs and Biologicals. Reexamine drug reimbursement methodologies based on average wholesale price (AWP) with the goal of reducing payments in both Medicare and Medicaid. The recommendation relates to findings in the following OIG reports. 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	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, through December 31, 2004, unless they met certain exceptions. Since January 1, 2005, most drug prices have been based on the average sales price or competitive acquisition instead of AWP.	$1,900

OIG Recommendation	Implementing Action	Savings (millions)
Medicare Secondary Payer. Ensure sufficient resources and contractor training for retroactively examining paid claims to identify other payer sources and initiating recovery action on all related overpayments. The recommendation related to findings in the following OIG reports. A-02-98-01036 A-04-92-02057 A-09-89-00162 A-10-86-62005	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 Medicare Secondary Payer provisions. This section builds on other program improvements related to OIG's work that were implemented by the Balanced Budget Act (BBA), Omnibus Budget Reconciliation Act (OBRA) 1993, OBRA 1990, and OBRA 1989.	$1,000
Clinical Diagnostic Laboratory Tests. 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. The recommendation related to findings in the following OIG reports. A-09-89-00031 A-09-93-00056	Section 628 of the MMA froze annual updates for FY 2004 through FY 2008. This action builds on prior legislative actions in the BBA, OBRA 1993, OBRA 1990, and legislation in 1984 that were also responsive to OIG's recommendations to curb excessive clinical laboratory test reimbursements by Medicare.	$1,000
Payments for Durable Medical Equipment. Take steps to reduce payments for a variety of durable medical equipment (DME) and related supplies. The recommendation related to findings in the following OIG reports: 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	Section 302 of the MMA froze payments for certain DME items, including prosthetics and orthotics, effective January 1, 2004.	$900

OIG Recommendation	Implementing Action	Savings (millions)
Medicare Home Health Payments. Reduce the Home Health Agency (HHA) update factor 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. The recommendation related to findings in report number A-04-99-01194.	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 three quarters of 2004 equal to the market basket increase minus 0.8 percent.	$800
Payment for Services Furnished in Ambulatory Surgical Centers. 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. The recommendation related to findings in the following OIG reports. OEI-05-00-00340 OEI-09-88-01003 A-14-98-00400 A-14-89-00221	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, effectively reducing the payment advantage to ASCs for those procedure codes that are more highly paid in the surgical center compared to outpatient departments. Section 626 also mandated that CMS implement a new payment system that takes into account disparities in the costs of procedures performed in ASCs and the costs of procedures performed in hospital outpatient departments, which CMS implemented by regulation effective January 1, 2008.	$400
Capped Rental Durable Medical Equipment. Eliminate the semiannual maintenance payment allowed for capped rental DME, pay only for repairs when needed, eliminate the 15-month rental option, and convert rentals to purchases after the 13th month. The recommendation related to findings in report number OEI-03-00-00410.	Section 5101 of the Deficit Reduction Act of 2005 (DRA) revised the payment rules for capped rental DME to require that ownership of the item transfer to the beneficiary after the 13th month and that Medicare pay for maintenance services on a cost-reimbursement basis.	$200

OIG Recommendation	Implementing Action	Savings (millions)
Part B Drugs Average Sales Price. Adopt an alternate calculation of volume-weighted average sales price that is consistent with the results set forth in section 1847A(b)(3) of the Social Security Act. The recommendation related to findings in report number OEI-03-05-00310.	Section 112 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 establishes a revised calculation method for calculating volume weighted average sales prices for Medicare Part B drugs that comports with OIG's recommendation.	$200
Medicaid Third Party Liability. Determine whether legislation is needed to explicitly include pharmacy benefit management companies in the Medicaid definition of a third party, require third parties to match their eligibility files with Medicaid's eligibility files, and allow Medicaid up to 3 years to recover payments from liable third parties. The recommendation related to findings in report number OEI-03-00-00030.	Section 6035 of the DRA made several changes to strengthen Medicaid's third-party liability provisions, including clarification regarding pharmacy benefit managers. The section also includes requiring States to ensure that health insurers, as a condition of doing business in the State, provide requested coverage data; accept the State's right of recovery; and agree, conditionally, not to deny a claim solely on the basis of date of submission of the claim when the claim is submitted by the State within a 3-year period beginning on the date on which the item or service was furnished.	$190
Medicare Secondary Payer. Implement stronger follow-up procedures for employers who fail to respond to data requests, exercise civil monetary penalty authority, and seek necessary legislative authority for mandatory data reporting. A-02-98-01036; A-02-02-01037; A-02-02-01038; A-04-01-07002; A-09-89-00100.	Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 amended the Medicare secondary payer provisions of the Social Security Act, § 1862(b), to provide for mandatory reporting for various categories. CBO estimated that this provision would result in savings of $1.1 billion over 10 years, with $100 million attributed to FY 2010.	$100
Additional Rebates for Brand-Name Drugs With Multiple Versions. OIG recommended that CMS continue to seek legislative authority to modify the rebate formula calculation to ensure that manufacturers cannot circumvent additional rebates by bringing new	Section 2501(d) of the Patient Protection and Affordable Care Act, as amended by section 1206(a) of the Health Care and Education Reconciliation Act of 2010, addresses this issue. CBO estimated savings of $100 million attributed to the effect of the amendment in FY 2010.	$100

OIG Recommendation	Implementing Action	Savings (millions)
versions of existing brand-name drugs to market. A-06-09-00033.		
Medicaid Drug Rebates—Sales to Repackagers Excluded From Best Price Determinations. Require drug manufacturers that excluded sales to health maintenance organizations (HMO) 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. Medicaid rebates were lost because sales to HMOs were improperly excluded from drug manufacturers' best price determinations in FYs 1998 and 1999. The recommendation related to findings in report number A-06-00-00056.	CMS issued Medicaid Drug Rebate Program Release #47 in July 2000, reiterating that section 1927(c) of the Social Security Act requires that manufacturers include in the best price the lowest price available to, among other entities, any wholesaler, retailer, provider, and HMO. The release specifically stated that this includes sales to organized health care settings, such as HMOs.	$81
Rebates for Physician-Administered Drugs. Encourage States to take actions to collect rebates on physician-administered drugs, especially single-source drugs. States should either use National Drug Codes (NDC) instead of procedure codes or link procedure codes to NDCs for single source drugs. The recommendation related to findings in report number OEI-03-02-00660.	Section 6002 of the DRA requires States to provide for the collection and submission of utilization data needed to secure rebates for physician-administered drugs and provide that the utilization data for single source and specified multiple-source physician-administered drugs be submitted using NDC numbers (unless the Secretary specifies an alternative coding system).	$20

ADMINISTRATION FOR CHILDREN AND FAMILIES		
OIG Recommendation	**Implementing Action**	**Savings (millions)**
Triennial Reviews of Child Support Orders and Medical Support by Parents. Ensure that more periodic reviews are initiated and take action to increase medical support by parents. OIG reviewed the effects of 1996 legislation that no longer required States to conduct periodic reviews and adjustments of child support orders (unless requested by a State agency or parent) and found that many States had, in effect, discontinued the reviews. The recommendations related to findings in report number OEI-05-98-00100.	Section 7302 of the DRA implemented our recommendation to increase periodic reviews by requiring States to adjust child support orders of families on the Temporary Assistance for Needy Families program every 3 years. CBO estimated net savings resulting from section 7302 as $20 million in 2010. Section 7307 of the DRA requires, for court orders that are issued or amended after enactment, that all States assess the ability of either or both parents to provide medical support for their children. CBO estimated savings from section 7307 as $3 million in FY 2010.	$23

Appendix B: Recommendations for Questioned Costs and Funds To Be Put to Better Use

The following statistical tables summarize the Office of Inspector General's (OIG) monetary recommendations and the Department of Health & Human Services' (HHS) responses to those recommendations. This information is provided in accordance with sections 5(a)(8) and (a)(9) of the Inspector General Act (5 U.S.C. App. §§ 5(a)(8) and (a)(9)) and the Supplemental Appropriations and Rescissions Act of 1980.

Table 1: Audit Reports With Questioned Costs

Questioned costs are those costs questioned by OIG audits because of an alleged violation of a provision of a law, regulation, contract, grant, or other agreement governing the expenditure of funds. Costs are questioned because the expenditure was not supported by adequate documentation or because the expenditure was unnecessary or unreasonable.

OIG includes those questioned costs that HHS program officials, in a management decision, have agreed should not be charged to the Federal Government, commonly referred to as disallowed costs, as part of the expected recoveries in the Accomplishments section at the beginning of the *Semiannual Report*. Superscripts indicate end notes.

Audit Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decision had been made by the beginning of the reporting period[1]	155	$1,096,110,000	$46,084,000
Reports issued during the reporting period	123	$171,342,000	$56,899,000
Total Section 1	278	$1,267,452,000	$102,983,000
Section 2			
Reports for which a management decision was made during the reporting period[2, 3, 4]			
Disallowed costs	138	$438,576,000	0
Costs not disallowed	8	$19,314,000	$13,831,000
Total Section 2	146	$457,890,000	$13,831,000
Section 3			
Reports for which no management decision had been made by the end of the reporting period			
Total Section 1 Minus Total Section 2	132	$809,562,000	$89,152,000

			Continued
Section 4			
Reports for which no management decision was made within 6 months of issuance[5]	64	$672,497,000	$32,253,000

Table 2: Funds Recommended To Be Put to Better Use (Audit Reports)

Recommendations from audit reports that funds be put to better use are recommendations that funds could be used more efficiently if management took action to implement an OIG recommendation through reductions in outlays, deobligation of funds, and/or avoidance of unnecessary expenditures. Table 2 reports HHS program officials' decisions to take action on these audit recommendations. Implemented recommendations are reported in Appendix A.

Audit Reports	Number of Reports	Dollar Value
Section 1		
Reports for which no management decision had been made by the beginning of the reporting period[1]	12	$3,956,885,000
Reports issued during the reporting period	10	$362,735,000
Total Section 1	22	$4,319,620,000
Section 2		
Reports for which a management decision was made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	1	$39,206,000
Based on proposed legislative action		
Value of recommendations not agreed to by management		$0
Total Section 2	1	$39,206,000
Section 3		
Reports for which no management decision had been made by the end of the reporting period[2]		
Total Section 1 Minus Total Section 2	21	$4,280,414,000

End Notes to Tables 1 and 2

Table 1 End Notes

[1] The opening balance was adjusted upward by $340.6 million primarily because of a reevaluation of previously issued non-Federal audit recommendations.

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

- A-01-02-00516, *Review of Potentially Excessive Medicare Payments-United Government Services*. CMS subsequently determined that several high-dollar claims were allowable and reversed its original management decision to disallow $1,382,206.
- A-07-05-04048, *Followup Audit of the Medicaid Drug Rebate Program in Colorado*. CMS originally agreed with the recommended refund of $1,925,367. Subsequently CMS determined that the net refund due from the State was $102,725.
- A-09-03-00042, *Review of Payments Made by United Government Services for Home Health Services Preceded by a Hospital Discharge*. CMS subsequently increased its original disallowance to reflect $1,445,138 in additional overpayments.

Not detailed are net reductions to previously reported disallowed costs totaling $84,229.

[3] Included are management decisions to disallow $353.7 million in questioned costs that were identified by non-Federal auditors in audits of States and local governments, colleges and universities, and nonprofit organizations receiving Federal awards conducted in accordance with OMB Circular A-133. By law, OIG is responsible for ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

[4] Because of administrative delays, some of which were beyond management control, resolution of the following 64 audits was not completed within 6 months of issuance of the report. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-06-07-00041	REVIEW OF AMP CALCULATION, MANUFACTURER A, MAR 2008, $268,000,000
CIN: A-06-07-00039	REVIEW OF AMP CALCULATION, MANUFACTURER C, MAR 2008, $101,000,000
CIN: A-03-07-00560	PENNSYLVANIA FOSTER CARE MAINTENANCE PAYMENTS, PHILADELPHIA, UNDER $300, MAY 2008, $56,513,439
CIN: A-09-06-00023	REVIEW OF LOS ANGELES COUNTY APPROVAL PROCESS OF RELATIVE FOSTER FAMILY HOMES, OCT 2009, $45,520,603
CIN: A-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, $33,318,976
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES, CONNECTICUT, MAY 2003, $32,780,146
CIN: A-06-07-00040	REVIEW OF AMP CALCULATION, MANUFACTURER B, MAR 2008, $27,700,000
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEP 2002, $14,165,950

CIN: A-03-06-00564	PA FOSTER CARE MAINTENANCE PAYMENT, PHILADELPHIA, OVER $300/DAY, DEC 2007, $11,693,989
CIN: A-03-05-00550	AUDIT OF PENNSYLVANIA FOSTER CARE MAINTENANCE PAYMENTS, CASTILLE SAMPLE, SEP 2007, $11,611,822
CIN: A-01-07-00013	REVIEW OF MEDICAID SUPPLEMENTAL PAYMENT TO UMASS MEMORIAL HEALTH CARE, INC., DEC 2009, $8,531,218
CIN: A-06-02-00034	COST REPORTS AND MEDICARE FEE-FOR-SERVICE PAYMENTS, SCOTT & WHITE, MAY 2003, $8,229,574
CIN: A-03-08-03000	REVIEW OF PROCUREMENTS MADE BY NIH FOR THE DEPARTMENT OF DEFENSE, MAY 2009, $6,300,000
CIN: A-04-08-03521	AUDIT OF UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS IN TENNESSEE FOR THE PERIOD OCTOBER 1, 1998 TO DECEMBER 31, 2007, FEB 2009, $5,768,243
CIN: A-01-08-00511	REVIEW OF SEPARATELY BILLED CLINICAL LABORATORY SERVICES PROVIDED TO ESRD BENEFICIARIES BY FMCNA, MAR 2010, $5,410,712
CIN: A-01-06-00007	REVIEW OF RHODE ISLAND'S MEDICAID ADMINISTRATIVE COST CLAIMS, FY 2004 - FY 2005, MAR 2008, $5,092,735
CIN: A-04-04-02003	MEDICARE OUTLIER PAYMENTS TO COMMUNITY MENTAL HEALTH CENTERS, APR 2006, $4,762,036
CIN: A-04-08-03523	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN FLORIDA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2009, $4,413,264
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR STATE FY 1998, SEP 2002, $3,776,054
CIN: A-06-04-00076	MEDICAL REVIEW OF SYNERGY'S PARTIAL HOSPITALIZATION SERVICES CLAIMS, MAR 2006, $3,098,296
CIN: A-10-96-00001	REVIEW OF GROUP HEALTH'S GHCPS REPORTING OF ESRD, APR 1997, $2,763,498
CIN: A-07-08-03114	REVIEW OF MISSOURI ACF TRAINING COSTS, AUG 2009, $2,556,099
CIN: A-03-08-00553	AUDIT OF PENNSYLVANIA TITLE IV-E FOSTER CARE CHILDREN OVER 19 YEARS OLD, NOV 2009, $1,641,903
CIN: A-04-06-01042	PAYMENTS TO VACCINE SUPPLIERS, MAR 2010, $962,998
CIN: A-07-09-03119	MISSOURI CLAIM FOR TITLE IV-E TRAINING COSTS FOR SALARIES AND BENEFITS, JUL 2009, $741,872
CIN: A-07-09-03121	MISSOURI TITLE IV-E TRAINING COSTS FOR RESIDENTIAL TREATMENT CENTERS AND FOSTER CARE PARENTING, SEP 2009, $569,663
CIN: A-05-09-00047	HEAD START MATCHING COSTS, COMMUNITY ACTION COMMITTEE OF LANCASTER FAIRFIELD COUNTY, JAN 2010, $547,019
CIN: A-05-06-00038	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, INDIANA, MAR 2007, $461,430
CIN: A-01-08-00014	AUDIT OF MEDICAID ADMINISTRATIVE COSTS CLAIMED BY THE COMMONWEALTH OF MASSACHUSETTS, OCTOBER 1, 2005 THROUGH SEPTEMBER 30, 2007, FEB 2010, $448,968
CIN: A-04-04-02010	REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION THERAPY SERVICES PROVIDED BY ABSOLUTE THERAPY INC., NOV 2006, $414,712

CIN: A-06-06-00072	REVIEW OF COST FOR TEXAS MEDICAL FOUNDATION AUDITEE, MAY 2008, $403,581
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $319,355
CIN: A-07-09-03120	MISSOURI CLAIM FOR TITLE IV-E TRAINING COSTS FOR LONG TERM TRAINING, FEB 2010, $301,187
CIN: A-07-05-01013	PAYMENTS FOR M+C ORGANIZATION FOR INSTITUTIONAL BENEFICIARIES, OCT 2005, $293,885
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS, MICHIGAN, AUG 2006, $257,859
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCT 2002, $229,656
CIN: A-07-06-01035	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION, IOWA, OCT 2007, $208,974
CIN: A-09-05-00077	REVIEW OF PACIFICARE'S USE OF ADDITIONAL CAPITATION UNDER THE MMA OF 2003, MAR 2006, $135,000
CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THROUGH 2008, JUL 2009, $124,046
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, $121,023
CIN: A-04-07-01045	COSTS CLAIMED FOR ESRD NETWORK 6 OPERATIONS, AUG 2009, $116,728
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-05-97-00017	FHP, INC. HMO INSTITUTIONAL STATUS PROJECT, JUN 1998, $109,114
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MICHIGAN FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $100,692
CIN: A-05-02-00067	REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS AND COST REPORTS, WELBORN, JUN 2003, $97,623
CIN: A-05-01-00090	PAYMENTS TO AETNA U.S. HEALTHCARE PENNYLVANIA FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, $87,516
CIN: A-03-08-00011	REVIEW OF DUPLICATE PAYMENTS TO PHARMACIES FOR MEDICARE PART D DRUGS (PDE-DEMO): BARON DRUGS, SEP 2009, $79,489
CIN: A-02-06-01023	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION, NEW YORK, MAR 2008, $77,358
CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCT 2002, $77,000
CIN: A-09-06-00039	MEDICARE INTEGRITY, AUDIT OF QUALITY IMPROVEMENT ORGANIZATION, WASHINGTON STATE, FEB 2008, $73,636
CIN: A-04-05-02000	AUDIT OF HHA THERAPY BILLINGS, SEP 2005, $63,425
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PENNSYLVANIA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
CIN: A-01-08-00601	REVIEW OF COSTS CLAIMED BY RETIREE DRUG SUBSIDY PLAN SPONSOR BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC. FOR PLAN YEAR ENDED DECEMBER 31, 2006, APR 2009, $33,300

CIN: A-04-06-00023	REVIEW OF QUALITY IMPROVEMENT ORGANIZATIONS, TENNESSEE, JUL 2008, $30,654
CIN: A-08-03-73541	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JAN 2003, $28,573
CIN: A-07-02-00150	PAYMENTS TO COVENTRY, PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUN 2003, $26,000
CIN: A-05-01-00078	PAYMENTS TO HEALTH NET, TUCSON, ARIZONA - FOR INSTITUTIONAL BENEFICIARIES, APR 2002, $21,233
CIN: A-08-04-76779	COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, $18,925
CIN: A-05-01-00100	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $18,645
CIN: A-07-03-00151	REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUN 2003, $18,400
CIN: A-07-04-01011	PAYMENTS FOR UNITED HEALTHCARE FOR INSTITUTIONAL BENEFICIARIES, MAR 2005, $13,128
CIN: A-05-06-00043	REVIEW OF OHIO KEPRO, FEB 2008, $11,874
CIN: A-05-01-00070	PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, MISSOURI GROUP HEALTH PLAN, JAN 2002, $11,089
Total CINs:	64
Total Amount:	$672,497,323

Table 2 End Notes (Audits)

[1] The opening balance was adjusted downward by $1.6 million.

[2] Because of administrative delays, some of which were beyond management control, resolution of the following 10 audits was not completed within 6 months of issuance of the report. The OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-06-09-00033	REVIEW OF ADDITIONAL REBATES OF NEW BRAND NAME DRUGS, MAR 2010, $2,500,000,000
CIN: A-06-07-00042	INDEXING THE REBATE FOR GENERIC DRUGS, OCT 2007, $966,000,000
CIN: A-02-07-02000	OPEN AND INACTIVE GRANTS ON THE PAYMENT MANAGEMENT SYSTEM, ACF, FEB 2009, $472,155,156
CIN: A-04-06-03508	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, FLORIDA, JAN 2008, $7,881,447
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS, MI, AUG 2006, $4,397,133
CIN: A-06-00-00073	MANAGED CARE ADDITIONAL BENEFITS, NYLCARE HEALTH PLANS OF THE SOUTHWEST, CY 2000, MAR 2002, $4,000,000
CIN: A-05-06-00038	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, INDIANA, MAR 2007, $871,677
CIN: A-05-01-00070	PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, MISSOURI GROUP HEALTH PLAN, JAN 2002, $98,689

CIN: A-05-06-00023	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, MINNESOTA, SEP 2006, $28,240
CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THROUGH 2008, JUL 2009, $17,764
TOTAL CINS:	10
TOTAL AMOUNT:	$3,955,450,106

Appendix C: Reporting Requirements of the Inspector General Act of 1978

The reporting requirements of the Inspector General Act of 1978, as amended, are listed in the following table along with the location of the required information. Page numbers in the table indicate pages in this report. The word "None" appears where there are no data to report under a particular requirement.

Section of the Act	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	Highlights section.
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout this report
(a)(3)	Prior significant recommendations on which corrective action has not been completed	See the *Compendium of Unimplemented Office of Inspector General Recommendations* : www.oig.hhs.gov/publications.html.
(a)(4)	Matters referred to prosecutive authorities	Legal and Investigative Section
(a)(5)	Summary of instances in which information was refused	None
(a)(6)	List of audit reports	Submitted to Secretary under separate cover
(a)(7)	Summary of significant reports	Throughout this report
(a)(8)	Statistical Table 1 – Reports With Questioned Costs	Appendix B

Section of the Act	Requirement	Location
(a)(9)	Statistical Table 2 – Funds Recommended To Be Put to Better Use	Appendix B
(a)(10)	Summary of previous audit reports without management decisions	Appendix B
(a)(11)	Description and explanation of revised management decisions	Appendix B
(a)(12)	Management decisions with which the Inspector General is in disagreement	None
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	To be reported annually in the spring *Semiannual Report*.
(a)(14)-(16)	Results of peer reviews of HHS-OIG conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by HHS-OIG of other OIGs.	Appendix F

Appendix D: Status of Public Proposals for New and Modified Safe Harbors to the Anti-Kickback Statute

Pursuant to the Health Insurance Portability and Accountability Act, § 205, the Inspector General is required to solicit proposals annually via a Federal Register notice for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b) and for developing special fraud alerts. The Inspector General is also required to report annually to Congress on the status of the proposals received related to new or modified safe harbors.

In crafting safe harbors for a criminal statute, it is incumbent upon the Office of Inspector General (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 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 not only to foster beneficial or innocuous arrangements but also to protect the Federal health care programs and their beneficiaries from abusive practices.

In response to the 2009 annual solicitation, OIG received the following proposals related to safe harbors:

Proposal	OIG Response
Create a Health Center Patient Incentive Safe Harbor that would protect incentives connected to a patient's condition or treatment plan that Federally Qualified Health Centers (FQHCs) or FQHC look-alikes would like to offer to encourage patients to either obtain medically necessary treatment, reward compliance with a treatment program, or reward achievement of treatment-related goals.	OIG is considering this suggestion.
Either clarify that free continuing medical education (CME) programs offered by hospitals do not violate the anti-kickback statute or establish a safe harbor to protect hospital CME programs.	OIG is not adopting the suggestion to establish a safe harbor for this purpose. The concept of "free programs" could vary greatly and should be addressed on a case-by-case basis, such as under the advisory opinion procedures.

Proposal	OIG Response
Establish a safe harbor for shared savings and gain-sharing arrangements.	OIG is considering this suggestion.
Establish a safe harbor for arrangements that support health care clinical innovation and/or payment reform models (e.g., pilot accountable care organizations, medical home, and joint ventures that support integration and care coordination).	OIG is considering this suggestion.

Appendix E: Summary of Sanction Authorities

The Inspector General Act of 1978, as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to Congress. A selection of authorities appears below.

Program Exclusions

The Social Security Act, § 1128 (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. The Office of Inspector General (OIG) has the authority 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.

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) added another basis for the imposition of a permissive exclusion, that is, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program, including managed care programs under Medicare and Medicaid, as well as Medicare's prescription drug program.

Providers subject to exclusion are granted due process rights. These include a hearing before an administrative law judge and appeals to the Department of Health & Human Services Departmental Appeals Board and Federal district and appellate courts regarding the basis for the exclusion and the length of the exclusion.

Patient Dumping

The Social Security Act, § 1867 (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 (CMP) 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

The Civil Monetary Penalties Law (CMPL) of the Social Security Act, 1128A (42 U.S.C. § 1320a-7a), provides penalties, assessments, and exclusion from participation in Federal health care programs for engaging in certain activities. For example, a person who submits or causes to be submitted 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 and its implementing regulations also authorize 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)).

The Affordable Care Act added more grounds for imposing civil monetary penalties. These include, among other conduct, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program (including Medicare and Medicaid managed care programs and Medicare Part D) for which the Affordable Care Act authorizes a penalty of up to $50,000 for each false statement, as well as activities relating to fraudulent marketing by managed care organizations, their employees, or their agents.

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, in

order to induce or in return for (1) referring an individual to a person or an 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; 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 of the Social Security Act, § 1128B(b) (42 U.S.C. § 1320a–7b(b)).

Individuals and entities that engage in unlawful referral or kickback schemes may be subject to criminal penalties under the general criminal anti-kickback statute; a CMP under OIG's CMPL authority pursuant to the Social Security Act, § 1127(a)(7) (42 U.S.C. § 1320a–7a); and/or program exclusion under OIG's permissive exclusion authority under the Social Security Act, § 1128(b)(7) (42 U.S.C. § 1320a–7(b)(7)).

False Claims Amendments Act of 1986 – Under the Federal False Claims Amendments Act of 1986 (FCA) (31 U.S.C. §§ 3729–3733), a person or an 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 an entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid.

The FCA defines "knowing" to include not only the traditional definition but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a qui tam, or whistleblower, provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries. The FCA was again amended in 2009 in response to recent Federal court decisions that narrowed the law's applicability. Among other things, these amendments clarify the reach of the FCA to false claims submitted to contractors or grantees of the Federal Government.

Appendix F: Peer Review Results

The Inspector General Act of 1978, as amended, requires Offices of Inspector General (OIG) to report the results of peer reviews of their operations conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by the OIG of other OIGs in the semiannual period. Peer reviews are conducted by member organizations of the Council of the Inspectors General on Integrity and Efficiency (CIGIE).

The required information follows.

Office of Audit Services Peer Review Results

During this semiannual reporting period, no peer reviews were conducted by the Department of Health & Human Services (HHS) OIG's Office of Audit Services (OAS) and OAS did not conduct a peer review on other OIGs. Listed below is information concerning OAS's peer review activities during prior reporting periods.

Date	Reviewing Office	Office Reviewed	Findings
June 2009	U.S. Postal Service OIG	HHS OIG, OAS	The system of quality control for the audit organization of HHS OIG in effect for the year ending September 30, 2008, has been suitably designed and complied with to provide HHS OIG with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Federal audit organizations can receive a rating of pass, pass with deficiencies, or fail. HHS OIG received a peer review rating of pass.
December 2009	HHS OIG, OAS	U.S. Department of Defense (DoD) OIG	The system of quality control for the audit organization of DoD OIG in effect for the year ending March 31, 2009, has been suitably designed and complied with to provide DoD OIG with reasonable assurance of performing and reporting in

Date	Reviewing Office	Office Reviewed	Findings
			conformity with applicable professional standards in all material respects. Federal audit organizations can receive a rating of pass, pass with deficiencies, or fail. DoD OIG received a peer review rating of pass. HHS OIG recommended that DoD OIG continue to improve its system of quality control, including audit supervision, audit documentation, and report content, by ensuring compliance with audit standards and its policies and procedures. The DoD OIG indicated that it has completed the corrective actions to improve its quality control system that were underway at December 2009.

Office of Investigations Peer Review Results

During this semiannual reporting period, no peer reviews were conducted by HHS OIG's Office of Investigations (OI) and OI did not conduct a peer review of other OIGs. Listed below is information concerning OI's peer review activities during prior reporting periods.

Date	Reviewing Office	Office Reviewed	Findings
March 2009	U.S. Department of Labor OIG	HHS OIG, OI	The system of internal safeguards and management procedures for the investigative function of HHS OIG in effect for the year ending September 30, 2008, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Date	Reviewing Office	Office Reviewed	Findings
January 2010	HHS OIG, OI	U.S. Department of Justice OIG	The system of internal safeguards and management procedures for the investigative function of DOJ OIG in effect for the year ending September 30, 2009, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Appendix G: Acronyms and Abbreviations

Following are selected acronyms and abbreviations used in this publication.

Terms, Titles, and Organizations

ACF	Administration for Children & Families
ADAP	AIDS Drug Assistance Program
AIDS	acquired immunodeficiency syndrome
AMP	average manufacturer price
AoA	Administration on Aging
ASP	average sales price
BLS	Bureau of Labor Statistics
CCA	certification of compliance agreement
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing (program)
CHIP	Children's Health Insurance Program
CIA	corporate integrity agreement
CLAS	Culturally and Linguistically Appropriate Services in Health Care
CMP	civil monetary penalty
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
CY	calendar year
DEA	Drug Enforcement Administration
DME	durable medical equipment
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
DOJ	Department of Justice
DPNA	denial of payment for new admissions
DSH	disproportionate share hospital
EBNHC	East Boston Neighborhood Health Center
ENT	enteral nutrition therapy
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESPNS	Elder Service Plan of the North Shore
ESRD	end stage renal disease
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFP	Federal financial participation
FFS	fee for service
FHH	Fort Hamilton Hospital
FI	fiscal intermediary

FISS	Fiscal Intermediary Shared System
FMAP	Federal medical assistance percentage
FUL	Federal upper limit
FY	fiscal year
HCPCS	Healthcare Common Procedure Coding System
HEAL	Health Education Assistance Loan
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHA	home health agency
HHS	Department of Health & Human Services
HIPDB	Health Care Integrity and Protection Data Bank
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration
ICD	implantable cardioverter defibrillator
IHS	Indian Health Service
IMD	institutions for mental disease
IPF	inpatient psychiatric facility
IRF	inpatient rehabilitation facility
LCD	local coverage determination
LEP	limited English proficiency
MAC	Medicare administrative contractor
MEBH	MultiEthnic Behavioral Health Services, Inc.
MFCU	Medicaid Fraud Control Unit
NIEHS	National Institute of Environmental Health Sciences
NIH	National Institutes of Health
NLM	National Library of Medicine
NPI	national provider identifier
OAI	official action indicated
OCSE	Office of Child Support Enforcement
OIG	Office of Inspector General
OCR	Office for Civil Rights
OMB	Office of Management and Budget
OMH	Office of Minority Health
ORF	Office of Research Facilities Development and Operations
PDE	prescription drug event
P.L.	Public Law
PERM	Payment Error Rate Measurement (program)
PPI	Producer Price Index
PPS	prospective payment system
PSC	program safeguard contractor
PSC	Program Support Center
SLV	School-Located Vaccination (program)
SNF	skilled nursing facility

THA	The Health Alliance of Greater Cincinnati
TUH	The University Hospital
UCCP	uncompensated care pool
UIMA	University Internal Medicine Associates
UPIN	unique physician identifier number
U.S.C.	United States Code
ZPIC	Zone Program Integrity Contractor

Public Laws

Affordable Care Act	Patient Protection and Affordable Care Act of 2010, P.L. No. 11-148, as amended by the Health Care and Educaton Reconciliation Act of 2010, P.L. No. 111-52
ACA	(See Affordable Care Act above.)
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act of 1990, Public Law (P.L.) No. 101-381
CERCLA	Comprehensive Environmental Response, Compensation, and Liability Act of 1980, P.L. No. 96-510
DRA	Deficit Reduction Act of 2005, P.L. No. 109–171
EMTALA	Emergency Medical Treatment and Labor Act of 1986, P.L. No. 99-272
FCA	False Claims Act Amendments of 1986, P.L. No. 99-562
FDCA	Federal Food, Drug, and Cosmetic Act of 1938, P.L. No. 75-717
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
IDEA	Individuals with Disabilities Education Act of 2004, P.L. No. 108-446
IG Act	Inspector General Act of 1978 (IG Act), as amended by P.L. No. 111-25, 5 U.S.C. App.
IPIA	Improper Payment Information Act of 2002, P.L. No. 107-300
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173
Recovery Act	American Recovery and Reinvestment Act of 2009, P.L. No. 111-5