Appendixes

Appendix A
Savings Achieved Through Implementation of Recommendations

After laws involving Department of Health & Human Services (HHS) programs are enacted, the Office of Inspector General (OIG) analyzes them to identify provisions that were supported by our recommendations and the associated cost savings. A similar process occurs with respect to administrative changes implemented by HHS management through regulations or other directives. The savings reported in this appendix generally reflect third-party estimates of funds made available for better use through reductions in Federal spending, deobligation of funds, and/or avoidance of unnecessary expenditures.

To identify administrative savings, we use estimates developed by or in consultation with HHS operating or staff divisions. To identify legislative savings, we use estimates that the Congressional Budget Office (CBO) prepared to inform Congress of the potential impact of legislation under consideration. CBO projects the annual increases and/or reductions in Federal spending that it expects would result from enacting legislation. Implemented legislative and administrative actions reflect not only OIG's recommendations, but also the contributions of others, such as HHS staff and operating divisions and the Government Accountability Office (GAO).

Savings estimated for fiscal year (FY) 2011 that were supported by OIG recommendations totaled $19,826 million ($19.8 billion).

Centers for Medicare & Medicaid Services

OIG Recommendation	Implementing Action	Savings (millions)
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.	In 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. Savings were projected through FY 2011.	$8,400
Medicaid Enhanced Payments to Local Providers. Reconsider capping the aggregate 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 2001 final rule that modified the Medicaid UPL provisions removed the 150-percent UPL for services furnished by non-State-owned or -operated hospitals. Savings were projected through FY 2011.	$3,300

OIG Recommendation	Implementing Action	Savings (millions)
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.	$2,200
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.	$1,100
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.	$1,100
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	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)
OEI-07-96-00221 OEI-03-96-00230 OEI-03-94-00021 OEI-06-92-00861 OEI-06-92-00866		
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.	$900
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.	$500
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 Medicare Advantage (MA) payment rates 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 Deficit Reduction Act of 2005 (DRA) amended the Social Security Act, § 1853(k), to phase out risk adjustment budget neutrality in determining the amount of payments to MA organizations. The DRA defined the applicable amount in calculating benchmark amounts, codified the phaseout schedule for the budget neutrality adjustment, and identified the adjustments to be made to the budget neutrality calculation during the phaseout years. CBO estimated the provision would reduce spending by about $6.5 billon through FY 2010 and projected $300 million in reduced spending for FY 2011.	$300

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 versions of existing brand-name drugs to market. The explanatory report for this recommendation was A-06-09-00033.	Section 2501(d) of the Patient Protection and Affordable Care Act (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 $300 million attributed to the effect of the amendment in FY 2011.	$300
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 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
Part B Drugs Average Sales Price. Adopt an alternate calculation of volume-weighted average sales price (ASP) 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.	$200

Medicare Secondary Payer. Implement stronger followup procedures for employers who fail to respond to data requests, exercise civil monetary penalty (CMP) authority, and seek necessary legislative authority for mandatory data reporting. Related reports include: 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 2011.	$100
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 action 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 provides 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 2011. Section 7307 of the DRA requires, for court orders 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 $5 million in FY 2011.	$25

Appendix B
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 them. 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), (a)(9)) and the Supplemental Appropriations and Rescissions Act of 1980.

Table 1: Audit Reports With Questioned Costs

Questioned costs are those 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 Accomplishment 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]	160	$1,171,671,000	$85,125,000
Reports issued during the reporting period	88	$339,552,000	$12,007,000
Total Section 1	248	1,511,223,000	$97,132,000
Section 2			
Reports for which a management decision was made during the reporting period[2, 3]			
Disallowed costs	120	$405,369,000	$6,753,000
Costs not disallowed	11	$408,076,000	$8,180,000
Total Section 2	131	$813,445,000	$14,933,000

Section 3			
Reports for which no management decision had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	117	$697,778,000	$82,199,000
Section 4			
Reports for which no management decision was made within 6 months of issuance[4]	55	$409,714,000	$70,192,000

Table 2: Funds Recommended To Be Put to Better Use

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]	21	$3,612,138,000
Reports issued during the reporting period	9	$959,423,000
Total Section 1	30	$4,571,561,000
Section 2		
Reports for which a management decision was made during the reporting period[2]		
Value of recommendations agreed to by management		
Based on proposed management action	5	$239,842,000
Based on proposed legislative action		
Value of recommendations not agreed to by management[3]	2	$377,796,000
Total Section 2	7	$617,638,000

Section 3		
Reports for which no management decision had been made by the end of the reporting period[4] (Sec. 1 minus Sec. 2)	23	$3,953,923,000

End Notes to Tables 1 and 2

Table 1 End Notes

[1] The opening balance was adjusted upward by $50.1 million because of a reevaluation of previously issued recommendations.

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

- A-06-03-75545, *State of Louisiana*. In fiscal year (FY) 2007, the Centers for Medicare & Medicaid Services (CMS) disallowed $312,343,358 because the State claimed Federal financial participation (FFP) for disproportionate share hospital (DHS) payments to State hospitals in excess of the hospitals' actual uncompensated care costs for State FYs 1996 through 2006. In FY 2009, CMS amended its initial decision and increased its disallowance to $362,053,628. In August 2011, CMS provided a second amended decision reflecting a Departmental Appeals Board decision (Decision No. 2350 dated December 20, 2010), which reduced the disallowance to $239,639,169, including accrued interest.

- A-07-92-00608, *Denied Outpatient Claims at Blue Cross Blue Shield of Missouri*. CMS reversed a 1992 disallowance because it was unable to determine whether $960,615 in overpayments had been recovered. According to information provided by CMS, Blue Cross Blue Shield of Missouri left the Medicare program in 1992 and successor contractors were not able to provide information on recovered amounts.

Not detailed are net reductions to previously reported disallowed costs totaling $53,434.

[3] Included are management decisions to disallow $48.7 million in questioned costs that were identified by non-Federal auditors in audits of State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. The audits were conducted in accordance with Office of Management and Budget (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 55 audits was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations before the end of the next semiannual reporting period:

CIN: A-05-08-00098	REVIEW OF OHIO DEPARTMENT OF JOB AND FAMILY SERVICES CLAIMS FOR COSTS REPORTED BY THE HAMILTON COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, JAN 2011, $58,987,755
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-01-09-00507	NATIONWIDE REVIEW OF INPATIENT REHABILITATION FACILITIES PATIENT ASSESSMENT INSTRUMENTS, JUN 2010, $39,247,645
CIN: A-04-09-00059	REVIEW OF INPATIENT REHABILITATION CARE FACILITIES MEDICARE CLAIMS FOR COMPLIANCE WITH CMS TRANSFER CLASSIFICATION REQUIREMENTS FOR OCTOBER 1, 2003, THROUGH SEPTEMBER 30, 2007, JUN 2010, $34,051,807
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-03-08-00554	AUDIT OF PENNSYLVANIA TITLE IV-E FOSTER CARE ALLEGHENY COUNTY, JAN 2011, $28,307,142
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DSH PAYMENTS FOR FY 1998, SEP 2002, $14,165,950
CIN: A-03-06-00564	PENNSYLVANIA 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-03-09-00019	REVIEW OF MEMBERHEALTH'S 2006 AND 2007 DIRECT AND INDIRECT REMUNERATION REPORTS, OCT 2010, $9,339,013
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-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 NATE DSH PAYMENTS FOR SFY 1998, SEP 2002, $3,776,054
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-03-08-00552	RYAN WHITE PAYER OF LAST RESORT – PENNSYLVANIA, NOV 2010, $2,162,998
CIN: A-03-10-00011	REVIEW OF CAPITAL BLUE CROSS 2008 DIR, OCT 2010, $1,818,249
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-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	UNDISTRIBUTABLE 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 – 2008, JUL 2009, $124,046
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLORIDA 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-05-97-00017	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-01-10-02504	RCA OF THE COMMUNITY ACTION AGENCY OF NEW HAVEN, INC., FEB 2011, $90,851
CIN: A-05-01-00090	PAYMENTS TO AETNA U.S. HEALTHCARE PENNSYLVANIA FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, $87,516
CIN: A-03-08-00011	REVIEW OF DUPLICATE PAYMENTS TO PHARMACIES FOR MEDICARE PART D DRUGS – BARON DRUGS, SEP 2009, $79,489
CIN: A-02-06-01023	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION – NEW YORK, MAR 2008, $77,358
CIN: A-09-06-00039	MEDICARE INTEGRITY – AUDIT OF QUALITY IMPROVEMENT ORGANIZATION – WASHINGTON STATE, FEB 2008, $73,636
CIN: A-01-10-00600	REVIEW OF VERMONT'S COMPLIANCE WITH CMS REIMBURSEMENT OF MEDICARE PART D DRUG DEMONSTRATION PROJECT REQUIREMENTS, SEP 2010, $70,027
CIN: A-05-01-00086	PAYMENTS TO HMO OF NORTHEASTERN PENNSYLVANIA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
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, AZ.- 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 NUMBER OF REPORTS: 55
TOTAL AMOUNT: $409,714,000

Table 2 End Notes

[1] The opening balance was adjusted downward by $153,000 because of a reevaluation of previously issued audit recommendations.

[2] During the period, a previously reported management decision was revised:

A-04-09-04039, *Review of Jurisdiction C Medicare Payments for Selected Durable Medical Equipment Claims With the KX Modifier for Calendar Year 2007*. In October 2010, CMS agreed to consider implementing a prepay claims documentation edit proposed by CIGNA Government Services, the durable medical equipment (DME) Medicare contractor for Jurisdiction C, to improve the effectiveness of the KX modifier. The proposed edit was in response to an OIG finding that the KX modifier was not effective in ensuring that suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) had the required supporting documentation on file. In September 2011, CMS informed OIG that funds were not available to implement this edit and avoid costs estimated by OIG at $137 million. Because CMS acknowledged that the amount of potential savings from implementing this edit is substantial, we continue to recommend that CMS implement our recommendation when funds become available.

[3] A-07-10-01080, *Rollup Review of Impact on Medicare Program for Investment Income That Medicare Advantage Organizations Earned and Retained From Medicare Funds in 2007*. CMS did not concur with the OIG recommendation that it either (1) pursue legislation to adjust the timing of Medicare prepayments to Medicare Advantage Organizations (MAO) to account for the time that these organizations invest Medicare funds before paying providers for medical services or (2) develop and implement regulations that require Medicare Advantage (MA) organizations to reduce their revenue requirements in their bid proposals to account for anticipated investment income. OIG estimated that Medicare could have earned approximately $450 million of interest income in calendar year (CY) 2007 prepayments to MA plans if payments had been delayed until after the beginning of the beneficiary's coverage period by the same number of days that we estimated MA organizations held Medicare funds before using them to pay for services. Alternatively, OIG estimated that Medicare could have saved about $376 million had MA organizations reduced the revenue requirements in bid proposals to account for anticipated investment income. CMS nonconcurred with the OIG's recommendation and stated that it continued to believe that implementing either option recommended by OIG would cause most MA organizations to increase their bid proposals in order to recoup investment income that they would lose. CMS noted that if MA organizations were to increase their bid proposals to account for the proposed offsets, these higher costs would be recognized in the bid proposals and would result in a decrease in most or all of the estimated cost savings. OIG continues to recommend that CMS act on this recommendation in its *Compendium of Unimplemented Recommendations*.

[4] Management decisions were not made within 6 months on 11 reports. Discussions with management are continuing, and it is expected that the following audits will be resolved by 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-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-03-10-03121	TIGER TEAM – CONTRACT HHSN278-2008-00012C, NOV 2010, $3,460,879

CIN: A-09-09-00055	MEDICAID – REVIEW OF CALIFORNIA DRUG EXPENDITURES (MANUAL CLAIMS), JUN 2010, $1,096,464
CIN: A-05-06-00038	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS – IN, 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 – MN, SEP 2006, $28,240
CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, $17,764

TOTAL NUMBER OF REPORTS: 11
TOTAL AMOUNT: $2,994,007,449

Appendix C
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 another OIG organization on 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 describes 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 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

Date	Reviewing Office	Office Reviewed	Findings
			actions to improve its quality control system that were underway during December 2009.

Office of Investigations Peer Review Results

During this semiannual reporting period, no peer reviews were conducted by another OIG organization on HHS OIG's Office of Investigations (OI). OI conducted one peer review on another OIG. Listed below is information concerning OI's peer review activities during the current and 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.
January 2010	HHS-OIG, OI	U.S. Department of Justice (DOJ) 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.
January 2011	HHS-OIG, OI	U.S. Department of Housing and Urban Development (HUD) OIG	The system of internal safeguards and management procedures for the investigative function of HUD-OIG in effect through February 2011 was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.
July 2011	HHS-OIG, OI	DOD-OIG	The system of internal safeguards and management procedures for the investigative function of DOD-OIG in effect through July 2011 were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Appendix D
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 other 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 (HHS) 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 goes 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 law 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 CMPs. 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, 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 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 E
Reporting Requirements

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	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	Part IV, Other HHS-Related Issues.
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 OIG Compendium of Unimplemented Recommendations
(a)(4)	Matters referred to prosecutive authorities	Part III: Legal and Investigative Activities
(a)(5)	Summary of instances in which information was refused	None
(a)(6)	List of audit reports	Submitted to the Secretary under separate cover
(a)(7)	Summary of significant reports	Throughout this report
(a)(8)	Statistical Table 1 – Reports With Questioned Costs	Appendix B
(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

Section	Requirement	Location
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	Reported annually in the spring Semiannual Report to Congress.
(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 C

Other Reporting Requirements

Section	Requirement	Location
§ 845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for FY 2008 (P.L. No. 110-181), § 845.	Part IV: Other HHS-Related Issues
§205	Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), (P.L. No. 104-191) § 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.	Appendix F

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

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), § 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 (DOJ), 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 2010 annual solicitation, OIG received the following proposals related to safe harbors:

Proposal	OIG Response
New safe harbor that parallels the exemption to the civil monetary penalties (CMP) statute for remuneration "which promotes access to care and poses a low risk of harm to patients and Federal health care programs."	OIG is not adopting this suggestion at this time. The CMP and anti-kickback statutes are different in nature and scope, and it may not be appropriate to promulgate a safe harbor that mirrors this CMP exception.
New safe harbor that parallels the exemption to the CMP statute for coupons, rebates, or other rewards by a retailer that are offered or transferred on equal terms to the general public and are not tied to the provision of other items or services reimbursed in whole or in part by the program under a Federal health care program.	OIG is considering this suggestion.
Modify the existing safe harbor for electronic prescribing items and services to: (1) include the provision of electronic prescribing items and services by a community health clinic to its employees and contractors; and (2) require that the items and services meet the standards and certifications issued by the Office of the National Coordinator for Health Information Technology (ONC) that are required for participation in the Medicare and Medicaid electronic health records (EHR) program.	OIG is not adopting these suggestions. The scope of the safe harbor for electronic prescribing items and services is consistent with the scope mandated by statute.

Modify the safe harbor for EHR arrangements to remove the sunset provisions and make it a permanent safe harbor.	OIG is considering this suggestion.
Modify the EHR safe harbor to remove laboratories as protected donors.	OIG is considering this suggestion.
New safe harbor protecting shared savings and gainsharing arrangements.	OIG is considering this suggestion.
New safe harbor protecting free continuing medical education programs offered by hospitals to physicians.	OIG is not adopting this suggestion. The concept of "free programs" could vary greatly and should be addressed on a case-by-case basis, such as under the advisory opinion process.
New waivers or safe harbors to the anti-kickback statute regarding the organization of accountable care organizations (ACO). New safe harbors to antitrust laws regarding the organization of ACOs.	OIG, in conjunction with the Centers for Medicare & Medicaid Services (CMS), issued an interim final rule with comment period establishing waivers of the anti-kickback statute and certain other laws to specified arrangements involving ACOs under the Medicare Shared Savings Program. See 76 Fed. Reg. 67,992 (Nov. 2, 2011). OIG is considering the suggestion for waivers with respect to the application of the anti-kickback statute for CMS Innovation demonstration programs. OIG is also considering the suggestion to issue safe harbors to the anti-kickback statute regarding ACOs. OIG has no authority to promulgate a safe harbor related to the antitrust laws.

Appendix G
Acronyms and Abbreviations

Following are selected acronyms and abbreviations commonly used in the *Semiannual Report(s) to Congress*. Public laws are listed at the end of the appendix.

Terms, Titles, and Organizations

340B	340B drug pricing program (section 340B of the Public Health Service Act)
ACF	Administration for Children and Families
ADAP	AIDS Drug Assistance Program
AHRQ	Administration for Healthcare Research and Quality
AIDS	acquired immunodeficiency syndrome
AMP	average manufacturer price
AoA	Administration on Aging
ASC	ambulatory surgical center
ASP	average sales price
CDC	Centers for Disease Control and Prevention
CDPAP	Consumer Directed Personal Assistance Program
CERT	Comprehensive Error Rate Testing (program)
CHIP	Children's Health Insurance Program
CIA	corporate integrity agreement
CMP	civil monetary penalty
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
CY	calendar year
DEA	Drug Enforcement Administration
DME	durable medical equipment
DOJ	Department of Justice
FAR	Federal Acquisition Regulation
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FEHB	Federal Employees Health Benefits (program)
FMAP	Federal medical assistance percentage
Form CMS-64	Medicaid Statement of Expenditures for the Medical Assistance Program
FY	fiscal year
HAC	hospital-acquired condition
HCPCS	Healthcare Common Procedure Coding System
HEAL	Health Education Assistance Loan
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Department of Health & Human Services
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IRS	Internal Revenue Service
MA	Medicare Advantage

MAC	Medicare administrative contractor
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
NDC	National Drug Codes (Directory)
NIH	National Institutes of Health
OCSE	Office of Child Support Enforcement
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPPS	outpatient prospective payment system
PDE	prescription drug event
P.L.	Public Law
PERM	Payment Error Rate Measurement (program)
PPI	Producer Price Index
PSC	Program Support Center
QIO	Quality Improvement Organization
RUG	resource utilization group
SNF	skilled nursing facility
U.S.C.	United States Code

Public Laws

ACA	See Affordable Care Act below.
Affordable Care Act	Patient Protection and Affordable Care Act of 2010, P.L. No. 11-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-52
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act of 1990, P.L. No. 101-381
CFO Act	Chief Financial Officer Act of 1990, P.L. No. 101-576
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 (Updated in P.L. No. 111-203)
FDCA	Federal Food, Drug, and Cosmetic Act of 1938, P.L. No. 75-717
FFMIA	Federal Financial Management Improvement Act of 1996, P.L. No. 110-181
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
IG Act	Inspector General Act of 1978, as amended by P.L. No. 111-25, 5 U.S.C. App.
MIPPA	Medicare Improvements for Patients and Providers Act, P.L. No. 110-275
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173

PHS Act	Public Health Service Act of 1944
Recovery Act	American Recovery and Reinvestment Act of 2009, P.L. No. 111-5