



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

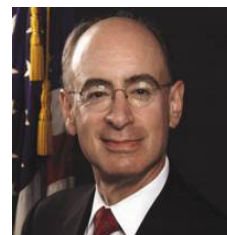
Office of
Inspector
General

Semiannual
Report
To **Congress**

October 1, 2011 – March 31, 2012

A Message From the Inspector General

This *Semiannual Report to Congress*, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS), for the 6-month period ending March 31, 2012.



Over the past 6 months, OIG has stepped up our focus on data analytics as a critical tool for enhancing our fraud, waste, and abuse activities. We are using advanced data analytics to help us conduct risk assessments; more effectively pinpoint our oversight efforts; and significantly reduce the time and resources required for audits, investigations, evaluations, and other program integrity activities. However, technology is not a silver bullet, and now more than ever, experienced professionals are integral to protecting Medicare and Medicaid. As program integrity efforts become more technology driven, so will health care fraud, and we must adapt to this evolving environment. Additionally, even the best fraud prevention technologies will be of little value if not effectively implemented and appropriately overseen.

OIG's data warehouse is a key component of our strategic use of information technologies. Among other things, the warehouse integrates data from Medicare Parts A, B, and D so we can develop a more comprehensive picture of beneficiaries' histories of medical care and providers' billing patterns. In addition to adding powerful analytic tools, the data warehouse has the potential for dramatically improving the timeliness and impact of our work.

OIG's new hospital compliance initiative illustrates the impact of technology on our ability to identify suspect claims and noncompliant billing practices. OIG has deployed resources toward testing and ensuring acute-care hospital compliance with program requirements. Instead of narrowly focusing our audits on specific risk areas, we are now more quickly and efficiently analyzing a vast array of hospital data to simultaneously identify multiple compliance risks.

As exemplified by the Medicare Fraud Strike Force, sophisticated data analysis, combined with field intelligence and traditional law enforcement techniques, enables us to more quickly identify fraud schemes and trends. The data-driven approach of the Strike Force pinpoints fraud hot spots through the identification of suspicious billing patterns and

targets criminal behavior as it occurs. This *Semiannual Report* highlights many of our Strike Force successes.

We also continue our focus on identifying waste in the operation of HHS programs. Reduction of waste is critical and necessary to achieve savings in Federal health care programs. Waste occurs in many forms, and work included in this report identifies outdated pricing methodologies for pharmaceuticals and durable medical equipment as well as payments for unnecessary and undocumented services. Identifying waste also requires diligent oversight by CMS to ensure that contractors are effectively identifying improper payments made to providers and suppliers. OIG work highlighted in this report provides information regarding our recommendations to CMS in the important area of contractor oversight.

The public health and welfare of HHS beneficiaries continues to be of paramount concern to our office. We completed work during this reporting period regarding adverse events in hospitals and regarding Head Start programs that did not comply with program requirements and therefore jeopardized the health and safety of children.

As we tackle an expanding mission to protect HHS's vital health and human service programs, I would like to express my appreciation to Congress and to the Department for their sustained commitment to supporting the important work of our Office.

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

Daniel R. Levinson
Inspector General

Highlights

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Semiannual Report(s) to Congress* (Semiannual Report) describe significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. This edition addresses work completed during the first half of fiscal year (FY) 2012 (October – March) and provides summary data on key accomplishments during the period. The [Semiannual Report](#) is one of OIG's three core publications. Our [Work Plan](#) describes work in progress and new projects that we plan to pursue during the fiscal year and beyond. Our [Compendium of Unimplemented Recommendations](#) describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.

Summary of Accomplishments

For the first half of FY 2012, we reported expected recoveries of about \$1.2 billion consisting of \$483.1 million in audit receivables and \$748 million in investigative receivables (which includes \$136.6 million in non-HHS investigative receivables resulting from our work in areas such as the States' shares of Medicaid restitution).

We reported exclusions of 1,264 individuals and entities from participation in Federal health care programs; 388 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 164 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters. Following are highlights of some of the significant problems, abuses, deficiencies, activities, and investigative outcomes that are included in the Semiannual Report for the first half of FY 2012.

Health Care Fraud Prevention and Enforcement Action Team

Medicare Strike Force Teams

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. These teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force began in March 2007 and is operating in nine major cities. The effectiveness of the Strike Force model is enhanced by interagency collaboration. For example, we refer credible allegations of fraud

to the Centers for Medicare & Medicaid Services (CMS) so that it can suspend payments to the perpetrators. During Strike Force operations, OIG and CMS work to impose payment suspensions that immediately prevent losses from claims submitted by Strike Force targets.

- **Strike Force Accomplishments** – During this semiannual period, Strike Force efforts resulted in the filing of charges against 101 individuals or entities, 96 criminal actions, and \$50.9 million in investigative receivables.
- **Arrests in the Northern District of Texas** – A physician and the office manager of his medical practice, along with five owners of home health agencies, were arrested February 28 on charges related to their alleged participation in a nearly \$375 million scheme involving fraudulent claims for home health services. The conduct charged in this indictment represents the single largest fraud amount orchestrated by one doctor in the history of HEAT and our Medicare Fraud Strike Force operations and the largest alleged home health fraud scheme ever committed. As a related matter, CMS announced the suspension of 78 home health agencies (HHA) associated with the physician based on credible allegations of fraud against them.

Strike Force Investigation Nets Imprisonment, \$6 Million in Restitution in Infusion and Injection Therapy Scheme

Michigan – Siblings [Clara Guilarte](#) and [Caridad Guilarte](#), along with previously captured and sentenced co-conspirator [Reynel Betancourt](#), submitted \$9.1 million in false and fraudulent claims. The trio recruited and paid cash and other inducements to Medicare beneficiaries to visit the Dearborn Medical Rehabilitation Center (DMRC), which the Guilartes owned and operated, and sign forms indicating that they received legitimate medical services, including injections and infusions of expensive medications that were not actually provided. The Guilartes then distributed the proceeds through a series of transactions involving shell corporations that served no purpose other than to conceal the nature, source, and location of the funds. After pleading guilty to conspiracy to commit health care fraud and conspiracy to commit money laundering, the Guilartes were each sentenced to serve 14 years in prison. They were also ordered to pay approximately \$6 million in restitution jointly and severally. The Guilartes, who were two of OIG's Top 10 most wanted fugitives, fled the United States to avoid capture. They were arrested by the Colombian National Police and transferred into the custody of U.S. officials. Sentenced occurred during this reporting period.

Payments Made to Nonoperational Comprehensive Outpatient Rehabilitation Facilities

Eighteen of the 101 South Florida Comprehensive Outpatient Rehabilitation Facilities (CORF) included in our analysis were not operational. Ten of the 18 CORFs were not at the locations on file with CMS, and 8 were not open during business hours. Medicare allowed \$2.2 million in 2010 for services billed by these nonoperational CORFs. This HEAT initiative review was limited to determining whether the CORFs were operational. In prior reviews at three South Florida CORFs, we estimated that each audited CORF received between \$720,000 and \$1.6 million for services that

did not meet Medicare reimbursement requirements. *South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities*. -OEI-05 10-00090. November 2011. [Web Summary](#). [Full Text](#). See also prior reports: [A-04-05-02009](#), [A-04-05-02010](#), and [A-04-05-02011](#).

New Provider Compliance Training Videos and Podcasts



OIG's online training continued to reach the health care community with our compliance message. We have developed comprehensive training materials for HEAT provider compliance training. The FY 2011 materials are available on our Web site.

The materials include [video Webcast modules](#) dividing the presentations by subject area. A series of [new videos](#) and corresponding [audio podcasts](#) are also available.

Prescription Drug Reviews and Investigations

State Medicaid agencies lack information about pharmacies' costs to purchase drugs and/or fail to use available information about whether drugs are eligible for payment. As a result, payments to pharmacies often significantly exceed pharmacies' costs for the drugs and/or are for drugs that are made ineligible for Medicaid reimbursement.

Multi-Tier Strategy To Avoid Waste in Medicaid Drug Pricing

States may be able to better align Medicaid payments with pharmacies' invoice prices of drugs by developing separate reimbursement methodologies for major categories of drugs. Numerous OIG reviews have found that the basis that States historically used for Medicaid drug reimbursements did not represent pharmacies' actual costs to acquire drug ingredients. As a result, States often have overreimbursed pharmacies for those costs.



Align Medicaid Reimbursements With Pharmacies' Costs

This review evaluated the relationships between three recognized pricing benchmarks and pharmacy invoice prices for Medicaid-reimbursed drugs and found variations depending on whether the drugs were brand-name or generic. *Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices*. A-06-11-00002. October 2011. [Web Summary](#). [Full Text](#).

State Controls Over Medicaid Drug Expenditures Inadequate

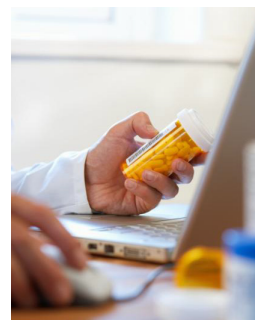
Neither CMS nor the 14 State agencies that we reviewed had adequate controls to ensure that all drug expenditures complied with Federal requirements. The 14 States generally did not use quarterly listings (called quarterly Medicaid drug tapes) that CMS provided to determine whether a drug was eligible for coverage and did not contact CMS to determine whether a drug was eligible for coverage if the drug was not on the tapes. The tapes indicate the drugs' termination dates, if applicable; specify whether the drugs are less than effective; and include information that the States use to claim rebates from manufacturers. The shortcomings we identified adversely affect the efficiency of the Medicaid outpatient prescription drug program. Cost savings to the Medicaid program can be realized by implementing several corrective actions we outlined in our report.

Multi-State Review of Centers for Medicare & Medicaid Services Medicaid Drug Expenditure Controls.

A-07-10-06003. October 2011. [Web Summary](#). [Full Text](#).

Pharmacist Sentenced for Health Care Fraud, Money Laundering

Indiana – John Love, controlling member and pharmacist for the Terre Haute Prescription Shop, input false prescriptions in the pharmacy's computer system, which bills the Indiana Medicaid Program. Love was sentenced to 4 years and 3 months of incarceration and ordered to pay over \$3.5 million in restitution for his role in the health care fraud and money laundering scheme.



Computer Billing Misuse

Patient Safety and Quality of Care

As a purchaser of health care, Medicare and Medicaid face challenges in ensuring quality of care for their beneficiaries. Despite increased attention to patient safety, problems persist.

States and CMS Responded Timely to Allegations of Serious Harm to Hospital Patients, but Missed Opportunities to Improve



State survey and certification agencies' (State agencies) responses on behalf of Medicare to allegations of serious harm to hospital patients were generally timely and found problems. However, State agencies often missed opportunities to incorporate patient safety principles. CMS often failed to inform the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) concerning complaints about the hospitals it accredits, thereby impeding the Joint Commission's oversight.

Safety principles incorporated by State agencies include assessing hospitals' performance improvement systems and governing bodies, monitoring hospitals for sustained improvements, and maximizing opportunities for hospitals to learn from alleged adverse events. Together, five types of in-hospital adverse events represented half or more of the complaints in our sample: sexual assault, medication error, physical abuse by hospital staff, restraint problems, and suicide. Investigations into these types of events led to most of the citations issued. State agencies conducted the investigations on behalf of Medicare. The hospitals' corrective actions resulted largely in training, coupled with policy and process changes. *Adverse Events in Hospitals: Medicare's Responses to Alleged Serious Events*. OEI-01-08-00590. October 2011. [Web Summary](#). [Full Text](#).

Medicare Improper Payments and Fraudulent Billings



Improper payments are a significant problem across Federal programs, costing billions of dollars annually.

Improper payments in Medicare and Medicaid commonly fall into four categories: unsupported services, medically unnecessary services, incorrect billings, and other noncovered cost or error types. Some of these core payment issues result from fraudulent behavior. Many claims are questioned and disallowed because providers do not maintain required documentation or sufficient documentation to support the services and amounts claimed.



Medical
Documentation

Outpatient Services, Medical Equipment, and Physical Therapy

- **Medicare Overpaid for Outpatient Services.** Payments exceeding charges for outpatient services were prone to errors and overpayments. We continue to review outpatient line items for which Medicare payments significantly exceeded billed charges (the prices that a provider sets for its services). Reports in this period revealed that providers often made errors, including submitting incorrect units of services and incorrect codes, or a combination of those; billing for unallowable services; and submitting inadequate supporting documentation, causing Medicare to overpay for the services. Millions of dollars in overpayments have occurred in part because key Medicare systems (the Fiscal Intermediary Standard System and the Common Working File (CWF)) did not have sufficient edits in place during our audit periods to prevent or detect the overpayments. See Part I (Medicare) of the Semiannual Report for overpayment amounts and links to 13 related reports issued in this semiannual period.
- **Multimillion-Dollar Durable Medical Equipment Fraud Results in Incarceration, Restitution in California.** Christopher Iruke, owner and operator of several fraudulent durable medical

equipment (DME) companies; his wife and co-conspirator Connie Ikpoh; and co-conspirators Aura Marroquin and others used fraudulent prescriptions and documents to bill Medicare for expensive high-end power wheelchairs and orthotics that were medically unnecessary or were never provided. Iruke and Ikpoh diverted most of the proceeds from their scheme to pay for business and personal expenses, including the leases on their Mercedes vehicles and home-remodeling expenses. Iruke was sentenced to 15 years of incarceration and ordered to pay \$6.7 million in restitution, jointly and severally with co-conspirators, for his role in the multimillion-dollar scheme. Ikpoh, Marroquin, and two other co-conspirators were also convicted for their roles in the scheme.

- **Nursing Services Operator, Others Conspired in Physical Therapy False Billings in Texas.** Umawa Oke Imo, owner and operator of City Nursing Services of Texas Inc. (City Nursing Services), and his co-conspirators fraudulently used City Nursing Services to pay kickbacks to Medicare beneficiaries and recruiters, provide physical therapy services to Medicare beneficiaries even though it did not employ any licensed or qualified physical therapists, and bill Medicare for physical therapy services that were not rendered. To mask this practice, City Nursing Services created false and fraudulent patient files. Imo was sentenced to 27 years and 3 months of incarceration and ordered to pay more than \$30.2 million in restitution, jointly and severally. Co-conspirators Joanne White and Christina Joy Clardy were also sentenced in the scheme, and other conspirators were indicted.

Oversight of Medicare Program and Benefit Integrity Contractors

CMS contracts with several entities, including Program Safeguard Contractors (PSC), Medicare Drug Integrity Contractors (MEDIC), Zone Program Integrity Contractors (ZPIC), and Recovery Audit Contractors (RAC), to perform many Medicare integrity functions. OIG work reveals persistent problems with oversight of this area.

Inadequate Data Limitations, Procedures Obstruct Oversight

CMS's systems and procedures and those used by its contractors were not sufficient to ensure effective oversight of contractor performance and resolution of known vulnerabilities.

- **Data deficiencies obstructed CMS's oversight of ZPICs.** The workload data that CMS uses to oversee ZPICs were not accurate or uniform, and inaccuracies and lack of uniformity in the ZPICs' data prevented us from making a conclusive assessment of ZPICs' activities. ZPICs are replacing CMS's PSCs and will perform Medicare Part A and Part B benefit integrity work in seven newly established geographical zones. The inaccuracies and lack of uniformity in ZPICs' data resulted from system issues in CMS's Analysis, Reporting, and Tracking System (CMS ARTS); ZPIC reporting errors; ZPICs' interpretations of workload definitions; and

inconsistencies in requests for information reports. ZPICs' performance evaluations contained few workload statistics, and data access issues affected ZPICs' program integrity activities. The conditions are serious obstacles to CMS's oversight of ZPIC operations and effectiveness. *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*. OEI-03-09-00520. November 2011. [Web Summary](#). [Full Text](#).

- **CMS did not resolve contractor-identified vulnerabilities.** CMS had not resolved, or taken significant action to resolve, 77 percent of vulnerabilities that its Medicare benefit integrity contractors reported in 2009. The estimated impact of vulnerabilities, such as those in claims coding and provider identifiers, which contractors reported inconsistently or not at all, was at least \$1.2 billion. Only two of the vulnerabilities reported in 2009 had been resolved as of January 2011. Although CMS has procedures to consistently track and review vulnerabilities, it lacks procedures to ensure that vulnerabilities are resolved. *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*. OEI-03-10-00500. December 2011. [Web Summary](#). [Full Text](#).

Medicare's Fee-for-Service Error Rate Calculations Could Be More Accurate

CMS's Comprehensive Error Rate Testing (CERT) program contractors collect and review documents supporting claims for payment, identify improper payments, and calculate a national Medicare fee-for-service error rate. We found issues in current CERT practices.

- **Impact of Appeals** – A CERT contractor's error rate calculations did not account for pending appeals. If the CERT statistical contractor had included overturned CERT claim payment denials in its error rate calculations, it would have decreased the estimated value of reported errors for FYs 2009 and 2010 by approximately \$2 billion each year. CMS could improve the accuracy of the reported estimate of improper payment error rates by including an adjustment for overturned CERT claim payment denials. *Review of CERT Errors Overturned Through the Appeal Process for FYs 2009 and 2010*. A-01-11-00504. March 2012. [Web Summary](#). [Full Text](#).
- **Impact of Documentation** – A CERT contractor did not initially obtain all necessary documentation. Additional documentation to overturn the claim payment denials used in the FY 2010 error rate calculation would have reduced the estimate of improper payments for FY 2010 by almost \$1 billion. *Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 CERT Program Audit*. A-01-11-00502. February 2012. [Web Summary](#). [Full Text](#).

Medicaid Reimbursements and Program Integrity



The Federal Government and States jointly administer, fund the cost of, and oversee the integrity of the Medicaid medical assistance program. At the

Federal level, CMS administers the program. At the State level, State agencies administer their Medicaid programs in accordance with broad Federal CMS-approved State plans.

States Improperly Claimed Federal Reimbursement for Unallowable Services

States have considerable flexibility in designing and operating their Medicaid programs; however, to receive a Federal share of Medicaid costs, applicable State and Federal requirements must be met.

- **New Jersey** – Personal Care Services (PCS) Claims. New Jersey improperly claimed an estimated \$145.4 million in Federal Medicaid reimbursement for PCS. The mixed deficiencies found in the claims we reviewed included no prior authorizations, no in-service education for personal care assistants, no nursing supervision, no documentation of services, no nursing assessments, and no certification of personal care assistants by the New Jersey Board of Nursing. New Jersey did not effectively monitor the PCS program for compliance with Federal and State requirements. *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey. A-02-09-01002. December 2011.* [Web Summary](#). [Full Text](#). For a quick view of OIG's PCS work, see the [Spotlight](#) article on PCS on our Web site.
- **New York State** – Continuing Day Treatment (CDT) Claims. More than half of the claims for CDT services that we reviewed did not comply with one or more of New York State's own requirements for payment. The deficiencies resulted in an estimated \$84.3 million in unallowable CTD claims. Providers did not properly document the type of CDT services billed, recipients' clinical progress, and/or recipients' contact with outpatient program staff. Although the State conducts periodic onsite monitoring, its monitoring program did not ensure that providers complied with all State requirements. *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State Audit. A-02-09-01023. October 2011.* [Web Summary](#). [Full Text](#).

Concerns Found With Medicaid Integrity Contractors and Managed Care Oversight

- **Impact of Poor Data** – Medicaid Integrity Contractors' (MIC) performance was hindered by poor data. For the MICs that we reviewed, analytical assignments under the task orders did not result in recommendations of specific audit leads or identification of potential fraud leads. MICs identified problems with CMS's Information Technology Infrastructure data that limited their ability to accurately complete data analysis assignments. Because data were missing or inaccurate data, the MICs inaccurately identified potential overpayments and may have overlooked some potential overpayments. States invalidated more than one-third of the

potential overpayments in samples the MICs provided. CMS says that it has several initiatives underway to improve the data the MICs use. *Early Assessment of Review Medicaid Integrity Contractors*. OEI-05-10-00200. February 2012. [Web Summary](#). [Full Text](#).

- **Fraud Concerns Continue** – Medicaid managed care entities (MCE) reportedly took steps to oversee fraud and abuse safeguards but they remain concerned about the prevalence of fraud. CMS, States, and Medicaid MCEs expressed that services billed but not rendered are their primary concern with respect to fraud and abuse in Medicaid managed care. Other concerns include rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries. All MCEs in our sample reported taking steps to meet Federal program integrity requirements. *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*. OEI-01-09-00550. December 2011. [Web Summary](#). [Full Text](#).

Public Health and Human Services Reviews and Enforcement

Our public health and human services work reflects some of HHS's top management challenges related to administration of contracts and grants management, including grantee performance issues and fraud. OIG also plays a significant role in child support enforcement activities.

National Institutes of Health's Compliance With Appropriation Laws

We found time and amount issues in four contracts that potentially violated the Antideficiency Act and/or the bona fide needs rule. The Antideficiency Act prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by law. Federal statutes specify that a fiscal year appropriation may be obligated only to meet a legitimate (bona fide) need arising in or continuing to exist in the appropriation's period of availability. From November 2008 through February 2009, an HHS internal review group assessed 176 HHS contracts, including 21 National Institutes of Health (NIH) contracts. Our reviews of the NIH contracts assessed compliance with the purpose, time, and amounts requirements specified in appropriations statutes. We recommended making monetary adjustments and reporting Antideficiency Act violations as appropriate. (See the Public Health section in the body of this publication for report titles and numbers.)

Early Head Start Grantees' Management Deficiencies Affected Their Funding.

Of 83 Early Head Start program grant applicants that OIG assessed, 75 had problems with financial stability, inadequate systems to manage and account for Federal funds, inadequate organizational structures, inadequate procurement and property management procedures, and inadequate personnel policies and procedures. Using our findings, the Administration for Children and Families (ACF) awarded \$15 million in Recovery Act funds to the 8 applicants that had no

deficiencies; did not award \$31 million requested by 15 of the 75 deficient applicants; and awarded \$126 million to 60 of the 75 deficient applicants on the condition that they receive increased ACF oversight, training, and technical assistance. *Review of 83 Early Head Start Applicants Under the American Recovery and Reinvestment Act*. A-01-10-02501. November 2011. [Web Summary](#). [Full Text](#).

Head Start Grantees Found To Have Health and Safety Violations



Rake and machete on broken steps

Of the 24 Head Start grantees that we reviewed, none fully complied with Federal Head Start or State requirements to protect children from unsafe materials and equipment. Twenty-one of the grantees did not fully comply with Federal Head Start or State requirements to conduct criminal records checks, recurring background checks, checks of childcare exclusion lists, or checks of child abuse and neglect registries. The grantees also failed to properly document criminal records checks.

Review of 24 Head Start Grantees' Compliance With Health and Safety Requirements. A-01-11-02503.

December 2011. [Web Summary](#). [Full Text](#).

See also OIG's [Spotlight](#) on Head Start Health and Safety available on our Web site.

ACF Grantee Sentenced to Incarceration for Failure To Meet Grant Requirements

Florida – Jimmy D. Howard, Jr., executive director of Dream Builders of Tallahassee, Inc. (DBT), pleaded guilty to the charge of wire fraud related to an ACF grant. Howard was unable to find the non-Federal matching funds required by the grant award, and after approximately 2 years of failing to meet this requirement, he began submitting false statements to HHS indicating that his company had the requisite amount of matching non-Federal funds. Howard also allegedly used a portion of the grant money for personal expenses. DBT is a nonprofit organization established to help low-income individuals save money by providing funds to match monies that the participants proved they had saved. As part of the grant requirements, DBT was required to have an equal amount of non-Federal funds to match the money saved by the individuals. Howard was sentenced to 51 months of incarceration and ordered to pay \$307,075 in restitution.

OIG Launched Child Support Enforcement Web Page, Introduced “Most Wanted” List of Deadbeat Parents

OIG launched a new Child Support Enforcement Web page that enlists the public's help in continuing Federal efforts to bring fugitive deadbeat parents to justice. See <http://oig.hhs.gov/fraud/child-support-enforcement/>.

OIG Participation in Congressional Hearings

During this semiannual period, OIG witnesses testified at two hearings conducted by committees of Congress on aspects of waste, fraud, and abuse in Medicare and Medicaid. The full text of OIG's testimony before congressional committees is available on our Web site at: <http://www.oig.hhs.gov/testimony.asp>.

12-07-2011

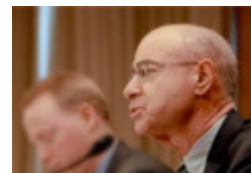
Gary Cantrell, Deputy Inspector General for Investigations, testified before the United States House of Representatives Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency and Financial Management, and Subcommittee on Health Care, District of Columbia, Census and the National Archives. Mr. Cantrell summarized OIG's efforts to combat Medicaid fraud. [Testimony](#)



*Gary Cantrell, Deputy
Inspector General for
Investigations*

11-30-2011

Daniel R. Levinson, Inspector General, testified before the United States Senate Special Committee on Aging. Mr. Levinson described OIG's work relating to the use of antipsychotic drugs in nursing homes. [Testimony](#)



*Daniel R. Levinson,
Inspector General*

Outline of Major Parts and Appendixes

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Part I

Medicare Program Reviews

Patient Safety and Quality of Care

Hospitals—States’ Responses to Allegations of Serious Harm to Hospital Patients

Although State survey and certification agencies’ (State agencies) responses on behalf of Medicare to allegations of serious harm to hospital patients were generally timely and found problems, the State agencies often missed opportunities to incorporate patient safety principles into the responses. Moreover, the Centers for Medicare & Medicaid Services (CMS) often failed to inform the Joint Commission of complaints about the hospitals it accredits, thereby impeding the Joint Commission’s oversight.

Safety principles include assessing hospitals’ performance improvement systems and governing bodies, monitoring hospitals for sustained improvements, and maximizing opportunities for hospitals to learn from alleged adverse events.

Together, five types of alleged in-hospital adverse events represented half or more of the complaints in our sample: sexual assault, medication error, physical abuse by hospital staff, restraint problems, and suicide. Investigations into these types of events led to the most citations for deficiencies. The hospitals’ corrective actions resulted largely in training, coupled with policy and process changes.

(Recommendations—CMS should require that State surveys evaluate compliance, ensure that States monitor hospitals’ corrective actions, amend guidance on State agency disclosure of the nature of complaints to hospitals, and improve communication with accreditors.) *Adverse Events in Hospitals: Medicare’s Responses to Alleged Serious Events*. OEI-01-08-00590. October 2011. [Web Summary](#). [Full Text](#).

Identifying and Reducing Improper Medicare Payments

Hospitals—Teaching Hospitals Overcounted Residents, Causing Excess Medicare Payments

Fifty of the 66 hospitals in our sample that over counted residents on their cost reports covering fiscal years (FY) 2006 and 2007 received \$1.9 million in excess Medicare reimbursement for graduate medical education (GME). The overpayments occurred because residents were claimed by more than one hospital for the same period and were counted in the Intern and Resident Information System (IRIS) as more than one full-time equivalent (FTE). There was no Federal requirement or procedure for Medicare's payment contractor to review IRIS data to determine whether a resident had overlapping rotational assignments at more than one hospital.

(Recommendations—The Medicare payment contractor should recover the excess GME payments, implement necessary adjustments and procedures, and identify and recover similar excess GME payments made outside the scope of our audit.) *Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to Highmark Medicare Services, Inc. A-02-09-01019.* January 2012.

[Web Summary.](#) [Full Text.](#)

Home Health Agencies—Data Reporting, Interim Sanctions for Noncompliance, and Documentation Reviews

Medicare beneficiaries who are generally confined to their homes may be eligible to receive certain medical services at home. Home health services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services. The services are provided by certified home health agencies (HHA).

- **Data Reporting Requirements** – HHAs did not properly submit required Outcome and Assessment Information Set (OASIS) data for 6 percent of claims filed in 2009, which represented over \$1 billion in Medicare payments. Among other important uses, States use OASIS data in the survey and certification of HHAs, which ensures that HHAs are meeting all Conditions of Participation (CoP) required by Medicare. CMS holds States accountable for ensuring that HHAs submit timely and accurate

OASIS data; however, it does not provide guidance on how States should oversee this process.

(Recommendations—CMS should identify all HHAs that failed to submit OASIS data and apply its 2-percent payment reduction authority, establish and implement enforcement actions for late submission of the data, and develop clear guidelines that delineate expectations regarding data accuracy and timeliness.) *Limited Oversight of Home Health Agency OASIS Data. OEI-01-10-00460.* February 2012. [Web Summary](#). [Full Text](#).

- **Intermediate Sanctions for Noncompliance** – CMS issued a Notice of Proposed Rulemaking (NPRM) in 1991 to implement intermediate sanctions for HHAs found to be noncompliant with Medicare’s CoP; however, CMS did not issue a final rule and withdrew the NPRM in August 2000. CMS said that legislative changes and other demands impeded promulgation of a final rule. Most recently, CMS said that it anticipates publishing a new NPRM by September 2012. Intermediate sanctions, such as civil money penalties, payment suspensions, and appointments of temporary management, will provide CMS with important tools to enforce compliance. We concluded that CMS should make HHA intermediate sanctions a high priority and complete their implementation as soon as possible. *Intermediate Sanctions for Noncompliant Home Health Agencies. OEI-06-11-00401.* March 2012. [Web Summary](#). [Full Text](#).
- **Documentation of Coverage Requirements** – HHAs usually documented Medicare’s coverage requirements in beneficiaries’ medical records. However, for the claims we reviewed, 22 percent were in error, resulting in \$432 million in improper payments. This review, which examined the medical records supporting a sample of HHA’s claims to Medicare, showed that HHAs’ records nearly always documented the information necessary to demonstrate compliance with key Medicare coverage requirements—that beneficiaries were homebound, needed skilled nursing care or therapy services, and were under the care of a physician. However, other Office of Inspector General (OIG) reviews and investigations, as well as joint efforts between the Department of Health and Human Services (HHS) and the Department of Justice (DOJ), have demonstrated that home health is an area at increased risk for fraud. We concluded that further reviews beyond the medical records are needed to determine whether beneficiaries are actually eligible, services are furnished, and Medicare requirements for payment are met. *Documentation of Coverage Requirements for Medicare Home Health Claims. OEI-01-08-00390.* March 2012. [Web Summary](#). [Full Text](#).

Portable X-Ray Suppliers—Questionable Billing Patterns

Medicare paid portable x-ray suppliers in our sample for questionable return trips to nursing facilities and paid for improper claims for services that were ordered by nonphysicians and therefore were not covered. Portable x-rays constitute a small portion of overall Medicare payments for diagnostic imaging services, but the questionable claims patterns we found raise concerns about the integrity of payments to certain suppliers.

(Recommendations—CMS should take action on the specific suppliers we referred, resolve and collect the portion of the \$12.8 million transportation component that was improper, collect \$6.6 million in overpayments ordered by nonphysicians, and implement procedures and controls to ensure that Medicare pays for portable x-ray services only when ordered by a physician.) *Questionable Billing Patterns of Portable X-Ray Suppliers*. OEI-12-10-00190. December 2011. [Web Summary](#). [Full Text](#).

Independent Diagnostic Testing Facilities—Questionable Billing Patterns

Twenty high-utilization geographic areas, called Core Based Statistical Areas (CBSA), accounted for 10.5 percent of Medicare Part B payments for independent diagnostic testing facilities (IDTF) services despite having only 2.2 percent of the total population of beneficiaries. IDTFs offer diagnostic services and are independent of physicians' offices or hospitals. Almost four times more beneficiaries in high-utilization CBSAs received IDTF services than beneficiaries in all other CBSAs. Nine percent of the IDTFs that served beneficiaries in high-utilization CBSAs provided 90.1 percent of IDTF services. Additionally, high-utilization CBSAs had twice as many claims with at least two questionable characteristics as all other CBSAs. IDTF services have historically been vulnerable to abuse.

(Recommendations—CMS should monitor IDTF claims for questionable characteristics, take appropriate action when IDTFs submit a high number of questionable claims, and assess whether to impose a temporary moratorium on new IDTF enrollments in CBSAs with high concentrations of IDTFs.) *Questionable Billing for Medicare Independent Diagnostic Testing Facility Services*. OEI-09-09-00380. March 2012. [Web Summary](#). [Full Text](#).

Outpatient Services—Payments Exceeding Charges Prone to Errors, Overpayments

Our review of outpatient line items for which Medicare payments significantly exceeded billed charges revealed frequent errors, including

incorrect units of services, incorrect codes, a combination of those, billing for unallowable services, and inadequate supporting documentation, causing Medicare to overpay for the services. Billed charges are the prices that a provider sets for its services. Medicare uses the outpatient prospective payment system (OPPS) to pay certain outpatient providers. Under the OPPS, the amount that Medicare pays the provider is generally less than the billed charges and the billed charges generally should not affect the current Medicare payment amounts.

This review focused on billings in which Medicare's payments significantly exceeded billed charges. Millions of dollars in overpayments have occurred in part because key Medicare systems (the Fiscal Intermediary Standard System and the Common Working File (CWF) did not have sufficient edits in place during our audit periods to prevent or detect the overpayments.

(Recommendations—Medicare's payment contractors should recover their overpayments, implement suggested system edits, and use the results of our audits in provider education activities.) Following are 13 reviews of this matter that we completed during this semiannual period.

- (Recommendation—Recover \$12 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period January 1, 2006, Through June 30, 2009. A-06-10-00045. January 2012. [Web Summary](#). [Full Text](#).
- (Recommendation—Recover \$6.3 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services, Inc., in Jurisdiction 6 - Illinois and Wisconsin for the Period January 1, 2006, Through June 30, 2009. A-05-10-00025. December 2011. [Web Summary](#). [Full Text](#).
- (Recommendation—Recover \$3.6 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 6 - Minnesota for the Period January 1, 2006, Through June 30, 2009. A-05-10-00020. September 2011. [Web Summary](#). [Full Text](#).
- (Recommendation—Recover \$ 2.2 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through June 30, 2009. A-06-10-00046. December 2011. [Web Summary](#). [Full Text](#).

- (Recommendation—Recover \$5.2 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services but Transitioned to Palmetto GBA, LLC, in Jurisdiction 11 for the Period January 1, 2006, Through June 30, 2009. A-03-10-00005. November 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$2.4 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TriSpan but Transitioned to Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through June 30, 2009. A-06-10-00048. October 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$847,000 in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by First Coast Service Options, Inc., in Jurisdiction 9 for the Period January 1, 2008, Through June 30, 2009. A-04-10-06128. November 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$1.9 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Cahaba Government Benefit Administrators, LLC, in Jurisdiction 10 for the Period January 1, 2008, Through June 30, 2009. A-04-10-06127. November 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$2.8 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Cahaba Government Benefit Administrators, LLC, in Jurisdiction 10 for the Period January 1, 2006, Through December 31, 2007. A-04-10-06121. November 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$4.7 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 11 for the Period January 1, 2006, Through June 30, 2009. A-03-10-00006. October 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$7.7 million in identified overpayments.)
Review of Select Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 13 for the Period January 1, 2006, Through June 30, 2009. A-02-10-01008. October 2011. [Web Summary.](#) [Full Text.](#)
- (Recommendation—Recover \$3.2 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by NHIC, Corp., in Jurisdiction 14 for the Period January 1, 2006,

Through June 30, 2009. A-01-10-00502. December 2011.

[Web Summary.](#) [Full Text.](#)

- (Recommendation—Recover \$5 million in identified overpayments.)
Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 15 for the Period January 1, 2006, Through June 30, 2009. A-05-10-00016. October 2011. [Web Summary.](#) [Full Text.](#)

Avoiding Waste in Part B Prescription Drug Pricing

Comparison of Drug-Pricing Points—Impact on Reimbursement

Since the implementation of the average sales price (ASP) prescription drug reimbursement methodology, OIG has issued 27 reports comparing ASPs to average manufacturer prices (AMP) and widely available market prices (WAMP). Twenty-five reports compared ASPs to AMPs and 2 reports compared ASPs to WAMPs. Federal law requires OIG to conduct the reviews. If OIG finds that the ASP of a drug exceeds either the AMP or the WAMP by a certain threshold (currently 5 percent), the Secretary of Health and Human Services may disregard the ASP for the drug when setting reimbursement amounts. Although CMS has yet to make any changes to Part B drug reimbursement as a result of these reviews, the agency published a final rule in November 2011 that specifies the circumstances under which AMP-based price substitutions will occur, effective January 2012. Reports issued during this semiannual period follow.

- **Comparison of ASP to AMP in the Second Quarter of 2011** – ASPs for 40 drug codes exceeded AMPs by at least 5 percent. Of these, 26 had complete AMP data. If reimbursement amounts for all 26 codes had been based on 103 percent of the AMPs in the fourth quarter of 2011, Medicare would have saved an estimated \$15.8 million in the fourth quarter. *Comparison of Second-Quarter 2011 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Fourth Quarter 2011. OEI-03-12-00020. January 2012. [Web Summary.](#) [Full Text.](#)*
- **Overview of 2010** – Medicare expenditures could have been reduced by an estimated \$13.2 million from the third quarter of 2010 through the second quarter of 2011. In a comparison of ASP to AMPs across

4 quarters in 2010, ASPs for 32 drug codes with complete AMP data exceeded AMPs by at least 5 percent in one or more quarters. If reimbursement amounts for these 32 codes had been lowered to 103 percent of the AMPs during the applicable quarter(s), Medicare expenditures would have been reduced by an estimated \$13.2 million from the third quarter of 2010 through the second quarter of 2011. This report summarized data across all four quarters of 2010.

(Recommendations—CMS should consider expanding the substitution policy to include drug codes with partial AMP data and seek legislative change requiring all manufacturers to submit ASPs and AMPs for Part B drugs.) *Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2010*. OEI-03-11-00410. November 2011. [Web Summary](#). [Full Text](#).

- **Comparison of ASP to WAMP** – This review was to compare ASPs to WAMPs for 14 drugs that have been identified in previous OIG reports as repeatedly exceeding the 5-percent ASP-AMP threshold. However, limitations and irregularities in sales data provided by the distributors and manufacturers called into question the data's accuracy and reliability.

The WAMPs we calculated varied widely from other pricing points; therefore, we could not accurately determine whether any of the drugs exceeded the ASP-WAMP threshold. The limitations and irregularities in the sales data provided by the distributors and manufacturers prevented us from measuring WAMPs against the threshold. Because of limitations in the distributor-reported data, most of the sales data we received did not reflect discounts and rebates that were passed on to providers. Further, the total number of units sold that were reported to us differed substantially from the number reported to CMS through quarterly ASP submissions, potentially causing our data to reflect an inaccurate number of sales.

We will consider alternative methodologies that will allow us to conduct future ASP-WAMP pricing comparisons, including directly surveying providers to obtain accurate and complete sales data. *Comparison of Average Sales Prices to Widely Available Market Prices for Selected Drugs*. OEI-03-10-00280. January 2012. [Web Summary](#). [Full Text](#).

Preventing and Detecting Medicare Fraud

Comprehensive Outpatient Rehabilitation Facilities in South Florida—Several Facilities Not Located or Not Operational

Of 101 South Florida Comprehensive Outpatient Rehabilitation Facilities (CORF) included in our analysis, 18 were not operational. Ten of the eighteen CORFs were not at the locations on file with CMS and 8 were not open during business hours. Medicare allowed \$2.2 million in 2010 for services billed by the nonoperational CORFs. CORFs provide multidisciplinary outpatient rehabilitation services at a single location. In 2010, more than 25 percent of all CORFs nationwide were in South Florida.

This program integrity initiative review was limited to determining whether the CORFs could be located and were open during business hours. In prior reviews at three South Florida CORFs, we estimated that each audited CORF received between \$720,000 and \$1.6 million for services that did not meet Medicare reimbursement requirements. CMS contracts with State survey agencies to assess the prospective CORF's compliance with certain Federal regulations.

(Recommendations—CMS should continue to periodically conduct unannounced site visits to CORFs and implement additional program safeguards for CORFs.) *South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities*. OEI-05-10-00090. November 2011. [Web Summary](#). [Full Text](#). See also prior reports: [A-04-05-02009](#), [A-04-05-02010](#), and [A-04-05-02011](#).

Medical Equipment Suppliers—Some Newly Enrolled Suppliers Cause Program Integrity Problems for Medicare

CMS revoked billing privileges or placed on prepayment claims review 26 percent of high/medium-risk suppliers and 2 percent of low/limited-risk suppliers of medical equipment and supplies during their first year of enrollment in Medicare. Some suppliers received significant Medicare reimbursement before CMS took enforcement action.

A CMS contractor, the National Supplier Clearinghouse (NSC), reviews supplier enrollment applications, conducts unannounced site visits before and after enrollment, and assigns newly enrolled suppliers a risk rating based on an assessment of fraud risk. Many suppliers had omitted required information from their Medicare enrollment applications, demonstrating

that omitted information can remain undetected for more than a year despite NSC's processes.

(Recommendations—CMS should conduct earlier postenrollment site visits for the highest paid new suppliers, apply investigative techniques to identify unreported supplier owners or managers, and take appropriate action regarding suppliers that omit information from applications.) *Program Integrity Problems With Newly Enrolled Medicare Equipment Suppliers*. OEI-06-09-00230. December 2011. [Web Summary](#). [Full Text](#).

Medicare Program Oversight and Benefit Integrity Contractors

CMS contracts with several entities, including Program Safeguard Contractors (PSC), Medicare Drug Integrity Contractors (MEDIC), Zone Program Integrity Contractors (ZPIC), and Recovery Audit Contractors, to perform many Medicare integrity functions. OIG work continues to reveal persistent problems with CMS's program and benefit integrity contractors and ongoing vulnerabilities in CMS's oversight.

Inadequate Procedures, Data Limitations Obstruct Program Oversight

CMS's systems and procedures and those used by its contractors were not sufficient to ensure full collection of identified overpayments, resolution of known vulnerabilities, and effective oversight of contractor operations and performance.

- **Contractor-Identified Vulnerabilities** – CMS had not resolved, or taken significant action to resolve, 77 percent of vulnerabilities that its Medicare benefit integrity contractors reported in 2009. The estimated impact of the vulnerabilities, such as those in claims coding and provider identifiers, which contractors reported inconsistently or not at all, was at least \$1.2 billion. Only two of the vulnerabilities reported in 2009 had been resolved as of January 2011. Although CMS has procedures to consistently track and review vulnerabilities, it lacks procedures to ensure that vulnerabilities are resolved.

(Recommendations—CMS should determine the status of all unresolved vulnerabilities and take action to address them, require contractors to report monetary impact, and ensure that vulnerabilities are resolved by establishing formal written procedures.) *Addressing Vulnerabilities*

Reported by Medicare Benefit Integrity Contractors. OEI-03-10-00500.
December 2011. [Web Summary](#). [Full Text](#).

- **Data Deficiencies Obstructed CMS's Oversight of ZPICs** – The workload data that CMS uses to oversee ZPICs were not accurate or uniform, and inaccuracies and lack of uniformity in the ZPICs' data prevented us from making a conclusive assessment of ZPICs' activities. ZPICs are replacing PSCs and will perform Medicare Part A and Part B benefit integrity work in seven newly established geographical zones. The inaccuracies and lack of uniformity in ZPICs' data resulted from system issues in CMS's Analysis, Reporting, and Tracking System (CMS ARTS); ZPIC reporting errors; ZPICs' interpretations of workload definitions; and inconsistencies in requests for information reports. ZPICs' performance evaluations contained few workload statistics, and data access issues affected ZPICs' program integrity activities. The conditions are serious obstacles to CMS's oversight of ZPIC operations and effectiveness.

(Recommendations—CMS should clarify definitions in CMS ARTS; perform a timely review of data in CMS ARTS; and use and report ZPIC workload statistics in ZPIC evaluations.) *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*.

OEI-03-09-00520. November 2011. [Web Summary](#). [Full Text](#).

Fee-for-Service Error Rate Calculations Could Be More Accurate

CMS's Comprehensive Error Rate Testing (CERT) program contractors collect and review documents supporting claims for payment, identify improper payments, and calculate a national Medicare fee-for-service error rate. We found the following issues in current CERT practices.

- **Impact of Pending Appeals** – A CERT contractor's error rate calculations did not account for pending appeals. If the CERT statistical contractor had included overturned CERT claim payment denials in its error rate calculations, it would have decreased the estimated value of reported errors for FYs 2009 and 2010 by approximately \$2 billion each year. (Recommendation—CMS should improve the accuracy of the reported estimate of improper payment error rates by including an adjustment for overturned CERT claim payment denials.) *Review of CERT Errors Overturned Through the Appeal Process for FYs 2009 and 2010*. A-01-11-00504. March 2012. [Web Summary](#). [Full Text](#).
- **Impact of Insufficient Documentation** – A CERT contractor did not initially obtain all necessary documentation that would have overturned the claim payment denials used in the FY 2010 error rate calculation. Doing

so could have reduced the estimate of improper payments for FY 2010 by almost \$1 billion.

(Recommendations—CMS should continue to educate providers on the documentation required, assess the improper payments and overturned denials of claim payments to identify the population that would benefit from additional requests for medical records, and ensure that the CERT documentation contractor follows established procedures in seeking signature attestations.) *Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 CERT Program Audit.* A-01-11-00502. February 2012. [Web Summary](#). [Full Text](#).

Medicare Part A and Part B Contract Administration

Medicare Part B and End-Stage-Renal-Disease and Contractors

- **Medicare Part B Contractor's Administrative Costs** – Wisconsin Physicians Service Insurance Corporation (WPS), a Part B carrier under contract with CMS to process and pay claims submitted by health care providers, reported unallowable administrative costs for Medicare.

(Recommendations—decrease the FY 2007 Final Administrative Cost Proposal (FACP) by \$1.7 million and decrease the FY 2008 FACP by \$1.8 million to eliminate the unallowable costs identified in this report.) *Audit of Medicare Part B Administrative Costs for the Period October 1, 2006, Through September 30, 2008, at Wisconsin Physicians Service Insurance Corporation.* A-05-09-00096. November 2011. [Web Summary](#). [Full Text](#).

- **Medicare Part B contractor's Pension Costs** – HealthNow New York Inc. (HealthNow), which administers Medicare Part B and Durable Medical Equipment Regional Carrier operations under cost reimbursement contracts with CMS, overstated the pension costs it reported to Medicare. (Recommendations—HealthNow should revise the FACP for FYs 1995 through 2006 to reduce claimed Medicare pension costs by \$3.9 million or refund the amount to CMS.) *Review of Pension Costs Claimed for the Medicare Part B Segment by HealthNow New York Inc. for Fiscal Years 1995 Through 2006.* A-07-11-00364. March 2012. [Web Summary](#). [Full Text](#).

- **End-Stage-Renal-Disease (ESRD) Contractor's Travel, Other Direct Costs –** Southern California Renal Disease Council, Inc. (Council), one of 18 ESRD Network Organizations that contract with CMS to ensure the effective and efficient administration of ESRD program benefits, claimed for reimbursement unallowable travel and other direct costs.

(Recommendations—Council should refund \$19,996 for unallowable travel and other direct costs, work with CMS to resolve \$2.2 million set aside for further analysis and refund unallowable amounts, and strengthen controls over accountability.) *Southern California Renal Disease Council, Inc., Claimed Unallowable and Unsupported Costs Under Medicare Contract Number 500-03-NW18.* A-09-10-02045. March 2012. [Web Summary.](#) [Full Text.](#)

Medicare Part C and Part D Reviews

Medicare Advantage Organizations' Identification of Potential Fraud and Abuse Varies Widely

Of 170 Medicare Advantage (MA) organizations we reviewed, 33 (19 percent) did not identify any potential fraud and abuse incidents in 2009 in either their Part C health benefits or their Part D prescription drug benefits. Further, MA organizations that identified incidents varied significantly in the number of incidents reported, raising questions about whether MA organizations are implementing their program integrity programs effectively. The 137 organizations identified about 1.4 million incidents of potential Part C and Part D fraud and abuse in 2009. However, 95 percent of the 1.4 million incidents were identified by only 3 of the organizations.

Differences in the way the organizations defined and detected potential fraud and abuse may account for some of the variability in the number of incidents they identified. CMS does not require MA organizations to report, nor does CMS routinely review, the results of the organizations' fraud and abuse program efforts.

(Recommendations—CMS should ensure the implementation of MA organizations' fraud and abuse programs, determine the reasons for unusually high or low volumes of incidents reported, and develop specific guidance.) *Medicare Advantage Organizations' Identification of Potential*

Fraud and Abuse. OEI-03-10-00310. February 2012. [Web Summary](#). [Full Text](#).

Sponsors Lack Information To Ensure Part D Drugs Are Used Only for Medically Accepted Indications

Selected Prescription Drug Plan (PDP) sponsors were unable to systematically ensure that payments for Part D drugs were limited to drugs provided for medically accepted indications because their prepayment strategies are limited and their postpayment reviews do not focus on medically accepted indications.

To qualify for Medicare Part D reimbursement, the drugs provided must be used for medically accepted indications. Medically accepted indications include uses approved by the Food and Drug Administration (FDA) and uses supported by one or more of three compendia specified in the Social Security Act. The selected PDP sponsors did not routinely collect diagnosis information, except when using prior authorization.

In short, the sponsors lacked access to information necessary for appropriate reimbursement of Part D drugs. CMS's comments on the findings are available in the full text of the report. *Ensuring That Medicare Part D Reimbursement Is Limited to Drugs Provided for Medically Accepted Indication. OEI-07-08-00152. November 2011. [Web Summary](#). [Full Text](#).*

Stronger Controls Needed to Identify Prescriptions Written by Excluded Providers

For calendar years (CY) 2006 through 2008, Medicare accepted Prescription Drug Event (PDE) data with gross drug costs totaling \$15.1 million for prescriptions written by excluded providers (those who have been excluded by OIG from participating in Medicare, Medicaid and all Federal health care programs). Also, CMS accepted additional PDE data with gross drug costs of nearly \$2 million for prescriptions that also may have been written by excluded providers.

Federal law prohibits payment under Federal health care programs for prescriptions written by excluded providers when the person dispensing the prescription knows or has reason to know of the exclusion. CMS maintains a database of excluded providers, the Medicare Exclusion Database (MED). CMS accepted PDE data submitted by sponsors for prescriptions written by excluded providers because it had inadequate internal controls in place to prevent the errors.

(Recommendations—CMS should resolve the improper payments, revise its CY 2006–2008 final payment determinations, and implement several steps we proposed to strengthen its controls over PDE data and detecting excluded providers.) *Review of Excluded Providers in the Medicare Part D Program*. A-07-10-06004. December 2011. [Web Summary](#). [Full Text](#).

CMS's Mandatory and Discretionary Auditing of Medicare Part D Sponsors Could Be Improved

- **Mandatory Audits** – CMS did not fully comply with mandatory Federal requirements that it annually perform audits for a full one-third of its Part D prescription drug plan sponsors. CMS excluded certain contracts subject to audit because it interpreted the statutory requirement as allowing it to do so. CMS also had not updated its standard operating procedures for audit resolution to reflect actual practices and to ensure that sponsors reported corrective actions to CMS in a timely manner. This diminished CMS's ability to ensure that corrective action was taken as rapidly as possible.

(Recommendations—CMS should conduct the required audits and update its procedures.) *Review of the Centers for Medicare & Medicaid Services' Audits of Part D Sponsors' Financial Records*. A-03-10-00007. November 2011. [Web Summary](#). [Full Text](#).

- **Discretionary Audits** – CMS does not always conduct or follow through on discretionary audits of PDP sponsors. Of 125 unique sponsor contracts active during the first 4 years of the Part D program, 50 contracts, which covered 1.1 million beneficiaries, were never audited in any way. Of the 68 contracts that were active for all 4 years, 13 contracts were never audited. CMS did not complete any compliance plan audits during the 4-year period.

As part of its oversight responsibilities for Medicare Part D, CMS identified seven types of audits, other than financial audits, that it would use for reviewing stand-alone contracts in the first 4 years of the Part D program. CMS is not required by law to conduct any of these audits, and it has no directives regarding the number of audits it should conduct. CMS selects auditees on the basis of risk analysis and other factors. For the audits CMS did conduct, it did not always have evidence to show that all problems were addressed for certain audit types.

(Recommendations—CMS should establish a comprehensive Part D auditing strategy to ensure that each plan sponsor will be audited in some way within a certain timeframe and ensure that evidence is

available to show that corrective actions have been implemented.)
Audits of Medicare Prescription Drug Plan Sponsors. OEI-03-09-00330.
December 2011. [Web Summary](#). [Full Text](#).

Data About Physicians Opting Out of Medicare Insufficient for Program Oversight

Lack of Data Hinders Program Oversight of Physicians Opting Out of Medicare

CMS, Medicare Administrative Contractors (MACs), and legacy carriers (Medicare claims payment contractors that remain in jurisdictions not yet awarded to MACs) do not maintain sufficient data for analysis regarding physicians who opt out of Medicare. CMS issued guidance in 2011 that addresses the procedures that MACs and legacy carriers must have in place for maintaining data on physicians who opted out on or after January 1, 2009.

Monitoring the number of opted-out physicians and their specialties is important to ensure that Medicare beneficiaries have sufficient access to providers, including specialized providers. Additionally, having appropriate data on opted-out physicians is essential to ensuring that such physicians are not inappropriately receiving Medicare payments.

We sought to obtain data on opted-out physicians from CMS and from individual MACs and legacy carriers and were unable to answer our issue questions because no centralized data exist and the data that we received from MACs and legacy carriers were insufficient or were not provided at all. Specifically, we could not determine the characteristics of physicians who opt out of Medicare, the trend in the number of opted-out physicians, and the reason why physicians choose to opt out of Medicare.

We plan to conduct a full evaluation when a complete data source of opted-out physicians is available. *Lack of Data Regarding Physicians Opting Out of Medicare.* OEI-07-11-00340. January 2012. [Web Summary](#). [Full Text](#).

Part II

Medicaid Program Reviews

The Federal Government and States jointly administer, fund the cost of, and oversee the integrity of the Medicaid medical assistance program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. At the State level, State agencies administer their Medicaid programs in accordance with CMS-approved State plans.

Avoiding Waste in Medicaid Drug-Pricing and Payments

State Medicaid agencies lack information about pharmacies' costs to purchase drugs and/or fail to use available information about whether drugs are eligible for payment. As a result, payments to pharmacies often significantly exceed pharmacies' costs for the drugs and/or are made for drugs that are ineligible for Medicaid reimbursement.

Multitier Strategy Would Fine-Tune Medicaid Drug Pricing

States could better approximate pharmacies' invoice prices of drugs by developing separate reimbursement methodologies for major categories of drugs (single-source drugs, brand-name multiple-source drugs, and generic multiple-source drugs). Numerous Office of Inspector General (OIG) reviews have found that the basis that States historically used for Medicaid drug reimbursements did not represent pharmacies' actual costs to acquire drug ingredients (invoice prices), and as a result, States often have overreimbursed pharmacies for those costs. This review evaluated the relationships between three recognized pricing benchmarks and pharmacy invoice prices for Medicaid-reimbursed drugs and found variations depending on whether the drugs were brand-name or generic.

(Recommendations—CMS should share the results of this review with States to use when considering changes to their pharmacy reimbursement methodologies, including those for major categories of drugs.) *Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices.* A-06-11-00002. October 2011. [Web Summary](#). [Full Text](#).

State Controls Over Medicaid Drug Expenditures Inadequate

Neither CMS nor the 14 States that we reviewed had adequate controls to ensure that all drug expenditures complied with Federal requirements. Cost savings to Medicaid could be realized by implementing several corrective actions that we outlined in our report.

Federal Medicaid funding is generally available for covered outpatient drugs if the drug manufacturers have rebate agreements with CMS and pay rebates to the States. The agreements require manufacturers to provide a list of all covered outpatient drugs to CMS quarterly. CMS includes these drugs on a quarterly Medicaid drug tape (list), makes adjustments for any errors, and sends the tape to the States. Manufacturers did not always provide information timely.

We found that the States generally did not use the quarterly Medicaid drug tapes (quarterly listings) that CMS provided to determine whether a drug was eligible for coverage and did not contact CMS to determine whether a drug was eligible for coverage if the drug was not on the tapes. The drug tapes indicate the drugs' termination dates, if applicable; specify whether the drugs are less than effective; and include information that the States use to claim rebates from manufacturers. The shortcomings we identified adversely affect the efficiency of the Medicaid outpatient prescription drug program.

(Recommendations—CMS should instruct States to ensure compliance with Federal requirements, appropriately report terminated drug expenditures to States, require that States use the reports to ensure compliance; and follow up as necessary. CMS should also work with manufacturers to ensure that they collect and submit complete and accurate information and take appropriate action if they are not timely in providing the information.)

Multi-State Review of Centers for Medicare & Medicaid Services Medicaid Drug Expenditure Controls. A-07-10-06003. October 2011. [Web Summary](#). [Full Text](#).

Identifying and Reducing Improper State Claims for Federal Reimbursement

States have considerable flexibility in designing and operating their Medicaid programs; however, to receive a Federal share of Medicaid costs, applicable State and Federal requirements must be met.

Personal Care Services Improperly Claimed by the States of New Jersey and New Mexico

Federal law and regulations provide that personal care services (PCS) are generally furnished to individuals residing in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by each State. Other requirements may also apply based on State regulations.

- **New Jersey** – New Jersey improperly claimed an estimated \$145 million in Federal Medicaid reimbursement for PCS. Types of deficiencies in the claims we reviewed included lapses with authorizations, in-service education for personal care attendants, nursing supervision, documentation of services, nursing assessments, and certification of personal care attendants by the New Jersey Board of Nursing. New Jersey did not effectively monitor the PCS program for compliance with Federal and State requirements. (Recommendations—Refund \$145 million to the Federal Government and improve its monitoring of the PCS program to help ensure compliance with Federal and State requirements.) *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey*. A-02-09-01002. December 2011. [Web Summary](#). [Full Text](#).
- **New Mexico** – New Mexico improperly claimed about \$889,000 in Federal Reimbursement for PCS by a provider that did not always comply with certain Federal and State requirements. The deficiencies included lapses with attendant training, number of units claimed for attendant services, and prior approval for PCS provided by a legal guardian. (Recommendations—New Mexico should refund \$889,000 to the Federal Government and ensure that PCS providers maintain evidence that they comply with Federal and State requirements.) *Review of New Mexico Medicaid Personal Care Services Provided by Ambercare Home Health*. A-06-09-00062. March 2012. [Web Summary](#). [Full Text](#).

Continuing Day Treatment Services Improperly Claimed by New York

More than half of the claims for continuing day treatment (CDT) services that we reviewed did not comply with one or more of New York State's requirements for payment, resulting in unallowable Federal reimbursements estimated at about \$84.4 million. CDT is a form of clinic services performed

by nonhospital providers that New York includes among its licensed outpatient programs.

Providers did not properly document the type of CDT services billed, recipients' clinical progress, and/or recipients' contacts with outpatient program staff. Although the State conducts periodic onsite monitoring, its monitoring program did not ensure that providers complied with all State requirements.

(Recommendations—Refund \$84.4 million to the Federal Government, work with the State Office of Mental Health to issue guidance to the provider community regarding State requirements for claiming Medicaid reimbursement for CDT services, and work with the State office to improve its monitoring of the CDT program to ensure compliance with State requirements.) *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State Audit*. A-02-09-01023. October 2011. [Web Summary](#). [Full Text](#).

Nonemergency Medical Transportation Services Improperly Claimed by New York

States are required to ensure necessary transportation for Medicaid beneficiaries to and from providers. Pursuant to New York State regulations, nonemergency medical transportation (NEMT) services may be delivered through the use of an ambulance, an ambulette, a taxicab, or livery service; prior authorization must be obtained; a medical practitioner's order justifying the beneficiary's use of NEMT services must be documented in the beneficiary's medical record; and a transportation provider must notify the New York Department of Motor Vehicles within 10 days of the date on which an ambulette driver commences employment.

- **New York** – New York improperly claimed an estimated \$13.5 million in Federal Medicaid reimbursement for NEMT services. The deficiencies occurred because New York State's policies, procedures, and mechanisms for overseeing the Medicaid program did not ensure that providers complied with Federal and State requirements for ordering, documenting, providing, and claiming such services.

(Recommendations—Refund \$13.5 million to the Federal Government; strengthen policies and procedures to ensure compliance with requirements for ordering, documenting, and claiming NEMT services; and require the New York State social services districts to strengthen their quality assurance mechanism to ensure that NEMT services are properly provided.) *Review of Medicaid Payments for Nonemergency*

Medical Transportation Services Claims Submitted by Providers in New York State. A-02-09-01024. February 2012. [Web Summary](#). [Full Text](#).

- **New York City** – During a 1-year period, New York improperly claimed Federal reimbursement for almost 1 million NEMT claims for services in New York City. We set aside for further analysis additional New York City NEMT claims that may also have been noncompliant. New York's policies and procedures did not ensure that providers complied with Federal and State requirements for ordering, documenting, and claiming NEMT services, and New York City's social services district's quality assurance mechanism did not ensure that NEMT services were properly provided. (Recommendations—Refund an estimated \$17 million to the Federal Government; resolve \$2.9 million set aside for further analysis; and strengthen policies, procedures, and quality controls.) *Review of Medicaid Payments for Nonemergency Medical Transportation Services Claims Submitted by Providers in New York City.* A-02-08-01017. November 2011. [Web Summary](#). [Full Text](#).

Family Planning Services Improperly Claimed by Oregon

Oregon improperly claimed \$1.7 million for unallowable Federal reimbursement for its Family Planning Expansion Project (Expansion Project) costs over a 3-year period.

States are required to furnish family planning services and supplies to individuals of childbearing age who are eligible under the Medicaid State plan and desire such services and supplies. Services include those that prevent or delay pregnancy or otherwise control family size and may also include infertility treatments. Oregon established the Expansion Project for certain categories of individuals who were not eligible for regular Medicaid under the State plan. Because Expansion Project clients are not eligible for the regular Medicaid program, services provided under the Expansion Project are unallowable for Federal reimbursement in their entirety.

(Recommendations—Refund an estimated \$1.7 million to the Federal Government, resolve \$3 million set aside for further analysis, limit income eligibility in accordance with Federal requirements, verify clients' incomes and Social Security numbers, and strengthen controls to prevent and detect duplicate claims.) *Oregon Improperly Claimed Federal Reimbursement for Medicaid Family Planning Services Provided Under the Family Planning Expansion Project.* A-09-11-02010. January 2012. [Web Summary](#). [Full Text](#).

Medicare Deductibles and Coinsurance for Dual Eligible Individuals Incorrectly Claimed by Nebraska

Various groups of low-income individuals who are entitled to Medicare are also eligible for full or partial Medicaid benefits. These individuals are referred to as “dual eligibles.” States may pay some or all of dual eligible individuals’ Medicare deductibles and copayments pursuant to Federal regulations and their Medicaid State Plans.

After the Medicare contractor pays a Medicare claim for a dual eligible individual and assesses the Medicare deductibles and coinsurance, the contractor forwards the claim information to the State’s Medicaid program. According to the guidelines in its State plan, the State determines whether to pay part or all of the Medicare deductibles and coinsurance and then pays the provider through the usual Medicaid payment system. The States claim the payments for Federal reimbursement.

- **Medicare Part A** – Nebraska did not follow the documented and approved State plan that was in effect during our audit period as a result, 60 of the 100 claims in our sample were improperly paid during FY 2009. These discrepancies occurred because the State did not compare the Medicare payments to the State Medicaid plan rate. (Recommendation—Refund an estimated \$5.5 million to the Federal Government.) *Review of Nebraska’s Medicaid Payments for Dual Eligible Individuals’ Medicare Part A Deductibles and Coinsurance.* A-07-11-03161. February 2012. [Web Summary](#). [Full-Text](#).
- **Medicare Part B** – For 68 of the 100 claims in our sample, Nebraska did not limit payment of Medicare Part B deductibles and coinsurance to State Medicaid plan rates as required under the State plan. These discrepancies occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so. (Recommendation—Refund an estimated \$5.6 million to the Federal Government.) *Nebraska Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance.* A-07-11-03168. February 2012. [Web Summary](#). [Full Text](#).

Medicaid Administrative Costs Improperly Claimed by New Jersey

Federal law permits States to claim Federal reimbursement for 50 percent of the costs of administrative activities necessary for the proper and efficient administration of the State Medicaid plan (Medicaid administration).

Allowable claims must be directly related to the Medicaid State plan or waiver services and may not include the overhead costs of a provider facility or the operating costs of an agency whose purpose is other than the administration of the Medicaid program. States' methodologies for distinguishing administrative activities eligible for Federal financial participation (FFP) should conform to CMS guidelines and the State's cost allocation plan.

- **FY 2007** – New Jersey's Medicaid administrative claim for Federal reimbursement exceeded the State's Medicaid administrative costs. New Jersey's Medicaid contractor included unallowable costs in the cost pool used to compute the claim. Also, the contractor performed a random moment time study (RMTS) that deviated from acceptable statistical sampling practices and applied Medicaid eligibility rates that were not documented by the State agency, affecting the accuracy of the costs claimed and the validity of the RMTS used to allocate the costs.

(Recommendations—Refund \$5 million to the Federal Government, resolve \$8 million in Medicaid administration costs set aside for further analysis, establish policies and procedures to follow acceptable statistical sampling practices, and maintain supporting documentation for rates used.) *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Year 2007*. A-02-07-01050. November 2011. [Web Summary](#). [Full Text](#).

- **FYs 2005 and 2006** – New Jersey included unallowable salaries and operating costs in the cost pool used to compute its Medicaid administrative claim. The State improperly claimed Federal Medicaid reimbursement for the cost of Medicaid administration activities performed by staff of contracted community mental health providers. In addition, the contractor that computed the Medicaid costs assigned Medicaid-reimbursable RMTS codes to workers' activities that were not allowable or could not be documented as related to Medicaid and performed an RMTS that deviated from acceptable statistical sampling practices. Also, New Jersey used Medicaid eligibility rates that could not be documented. These errors occurred because the State did not establish adequate policies and procedures to ensure compliance with Federal requirements.

(Recommendations—Refund \$22.5 million to the Federal Government, maintain supporting documentation for Medicaid-reimbursable activities, ensure that future calculations follow acceptable cost principles and CMS requirements, and maintain supporting

documentation for Medicaid eligibility rates used in computations.)
*Review of Medicaid Administrative Costs Claimed by New Jersey for State
Fiscal Years 2005 and 2006.* A-02-08-01009. March 2012.
[Web Summary.](#) [Full Text.](#)

Improper Claims for Therapy Services in Excess of State Limits Easily Preventable

A relatively low number of claims for therapy services were paid in excess of State limits; however, most of the errors that occurred were easily preventable. All of the eight States that we selected for indepth review had safeguards to prevent payments in excess of State limits. Despite the safeguards, we identified improperly paid therapy services claims totaling approximately \$744,000 in six of the eight States. Additional claims that were potentially improper were identified in three of the eight States. Several States reported improving their program integrity safeguards to address our findings.

(Recommendations—CMS should work with States to prevent Medicaid payments for therapy services in excess of State limits and follow up on the inappropriate claims identified in our review.) *Medicaid Payments for Therapy Services in Excess of State Limits.* OEI-07-10-00370. March 2012.
[Web Summary.](#) [Full Text.](#)

Problems With States' Reporting of Medicaid Overpayments and Collections

States have 60 days from the discovery of Medicaid overpayments to providers to recover, or attempt to recover, overpayments before the Federal share of the overpayments must be refunded to CMS. States must refund the Federal share of overpayments to CMS by the end of the 60-day periods following the dates of discovery, whether or not the States have recovered the overpayments from the providers. Providing appeal rights to providers does not extend the dates of discovery.

Pursuant to Federal law and the “applicable credit” provisions of Office of Management and Budget (OMB) Circular A-87, the Federal share of recovered overpayments or other collections must be credited to the Federal award in the quarter in which they are collected. The examples below demonstrate State errors in the reporting of uncollected overpayments (Illinois) and collected amounts (Oklahoma).

- **Illinois** – Illinois did not report 24 of the 27 overpayments we reviewed because of its unwritten policy of reporting overpayments not involving fraud or abuse when the provider appeals process was completed, rather than at the end of the 60-day period following discovery. (Recommendations—Include the unreported Medicaid overpayments we identified in its quarterly report to CMS, refund an estimated \$9 million to the Federal Government, and ensure that future Medicaid overpayments that are in the appeals process are reported in accordance with Federal requirements.) *Review of Illinois' Reporting of Fund Recoveries in the Appeals Process on the Form CMS-64.* A-05-11-00052. January 2012. [Web Summary](#). [Full Text](#).

- **Oklahoma** – Oklahoma did not properly report collections associated with probate amounts and with fraud and abuse collections. The State inappropriately subtracted probate collection amounts from its worksheet calculation because State officials incorrectly believed that probate collections were associated with adjusted claims and wanted to avoid duplicate reporting. Also, the State did not report the entire amount of its fraud and abuse collections. In other instances, the State underreported and overreported the Federal share of collections and applied incorrect share percentages.

(Recommendations—Refund an estimated \$14.8 million to the Federal Government; resolve \$435,000 in unsupported adjusted claims we set aside for further analysis; ensure that documentation requirements are met; and establish review procedures to ensure that collections are correctly compiled, assigned, and reported. *Review of Oklahoma Collections for the Medical Assistance Program for Calendar Years 2004 Through 2009.* A-06-10-00057. January 2012. [Web Summary](#). [Full Text](#).)

Oversight of Medicaid Integrity Contractors

CMS defined three types of Medicaid Integrity Contractors (MIC) to perform the program integrity activities mandated in the Deficit Reduction Act of 2005 (DRA) and to identify additional fraud, waste, and abuse—Review MICs, Audit MICs, and Education MICs. Review MICs review State Medicaid claims data and identify potential overpayments. Audit MICs audit specific providers and identify overpayments. Education MICs educate providers and beneficiaries on program integrity issues.

Poor Data and Audit Targeting Hinder Contractor Performance

- **Review MICs** – Performance was hindered by poor data. For the Review MICs that we examined, analytical assignments under the task orders did not result in recommendations of specific audit leads or identification of potential fraud leads. MICs identified problems with CMS's information technology infrastructure data that limited their ability to accurately complete data analysis assignments. Because data were missing or inaccurate, the MICs inaccurately identified potential overpayments and may have overlooked some potential overpayments. States invalidated more than one-third of the potential overpayments in samples the MICs provided. CMS reported several initiatives underway to improve the data the MICs use.

(Recommendations—CMS should improve the quality of data that Review MICs can access for conducting data analysis and require Review MICs to recommend specific audit leads.) *Early Assessment of Review Medicaid Integrity Contractors*. OEI-05-10-00200. February 2012. [Web Summary](#). [Full Text](#).

- **Audit MICs** – Performance was hindered because audit targets were poorly identified. Few of the audits assigned to Audit MICs from January through June 2010 identified overpayments. Of the 370 audits assigned to Audit MICs, 81 percent either did not identify overpayments or are unlikely to identify overpayments. Audit targets were misidentified because of data problems and because State program policies were applied incorrectly. The problematic audit targets caused MICs to duplicate efforts.

Audit MICs reported spending significant preaudit time evaluating algorithms, reanalyzing system data, and ensuring the accurate application of State policies during audit target selection. According to CMS's data, an average of 3 months elapsed between the date CMS assigned audits to Audit MICs and the date when Audit MICs began the audits.

(Recommendations—CMS should increase collaboration among Audit and Review MICs, CMS, and States to eliminate duplication of efforts and improve target selections in States that opt not to partner in collaborative audits.) *Early Assessment of Audit Medicaid Integrity Contractors*. OEI-05-10-00210. March 2012. [Web Summary](#). [Full Text](#).

Ensuring Program Integrity in Medicaid Managed Care

State Medicaid agencies contract with managed care entities (MCE) to provide comprehensive health services in return for capitated payments for each enrolled beneficiary. Two types of MCEs are subject to specific Federal program integrity requirements: managed care organizations (MCO) and prepaid inpatient health plans (PIHP). In 2000, CMS issued *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*. In the guidelines, CMS adapted general Medicaid definitions of "fraud" and "abuse" to the managed care environment and identified areas of concern.

Excluded Providers in Medicaid Managed Care Plans

We found that only a few of the providers that OIG had excluded from participation in Medicare were associated with the managed care provider networks we reviewed. We found 11 excluded providers enrolled in 4 of 12 Medicaid MCE provider networks. We recognize that the number of excluded providers that we identified is small. However, States may benefit from information regarding the failures that led to the inclusion of a few excluded providers in MCE provider networks. For example, two MCEs explained that excluded providers had joined their MCE networks through their acquisition of other MCEs or the providers had simply not been removed from the enrollment data when their last contracts expired or were terminated.

This report also describes the safeguards MCEs use to identify excluded providers. Federally funded programs, such as Medicaid managed care, are prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider or paying anyone who contracts with an excluded provider.

(Recommendation—CMS should periodically remind States of their obligation to ensure that no excluded providers receive Medicaid payments.) *Excluded Providers in Medicaid Managed Care Plans*. OEI-07-09-00630. February 2012. [Web Summary](#). [Full Text](#).

Fraud and Abuse Concerns Remain Despite Safeguards.

MCEs reportedly took steps to oversee fraud and abuse safeguards, but they remained concerned about the prevalence of fraud. CMS, States, and Medicaid MCEs expressed that services billed but not rendered are their

primary concern with respect to fraud and abuse in Medicaid managed care. Other concerns include rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries.

All MCEs in our sample reported taking steps to meet Federal program integrity requirements, and all States in our sample reported taking steps to oversee MCEs' fraud and abuse safeguards. Even so, they remained concerned about the prevalence of fraud.

(Recommendations—CMS should require that State contracts with MCEs include a method to verify with beneficiaries whether they received services billed by providers. CMS could require States to implement one of several options we described. We also recommend that CMS update guidance to reflect concerns expressed by MCEs and States and share best practices and innovative methods that States and MCEs have applied.) *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards.*

OEI-01-09-00550. December 2011. [Web Summary](#). [Full Text](#).

Part III

Legal and Investigative Activities Related to Medicare and Medicaid

Investigative Outcomes

For this semiannual period, we reported 346 criminal and 138 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported \$610.9 million in Department of Health and Human Services (HHS) investigative receivables and 130.8 million in non-HHS investigative receivables (such as those from our work related to the States' shares of Medicaid restitution) for health-care-related offenses.

The Office of Inspector General's (OIG) investigations often involve the combined efforts and resources of our office and other Federal and State law enforcement agencies. One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the False Claims Act Amendments of 1986 (FCA), as further amended in 2009.

Depending on the types of fraud or other violations involved, OIG's investigations may culminate in criminal or civil court judgments and decisions, administrative sanctions and decisions, and/or negotiated settlement agreements. Investigative outcomes take many forms, including incarceration, restitution, fines, penalties, forfeitures, assessments, and exclusion of individuals or entities from participation in all Federal health care programs. Frequently used exclusion and penalty authorities are described in Appendix D of this *Semiannual Report to Congress* and on our Web site at: <http://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Investigative work often requires more than a year to yield results. As a consequence, many of the cases summarized in this section reflect the results of our Medicare- and Medicaid-related work over several years that culminated in the first half of fiscal year (FY) 2012.

The following charts show the investigative outcomes that OIG reported for all HHS programs over a 5-year period.

Chart 1 – Actions: All HHS Programs

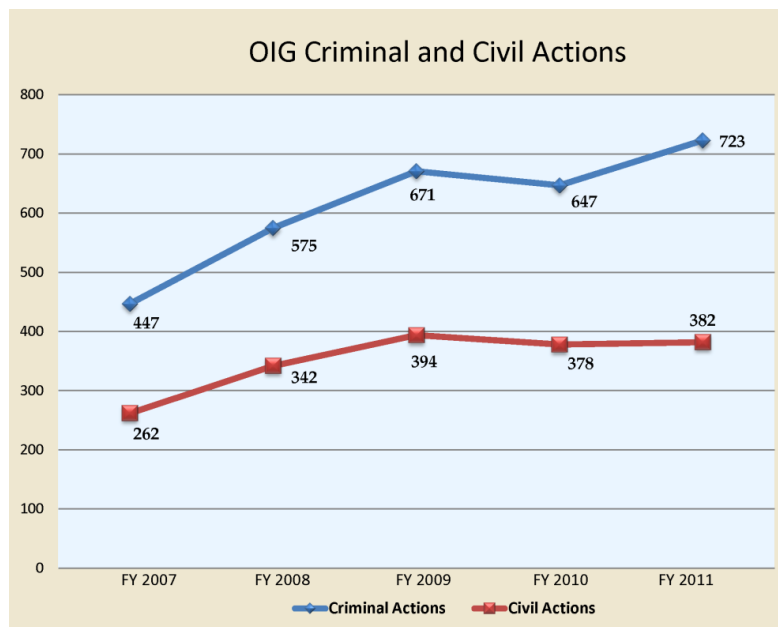
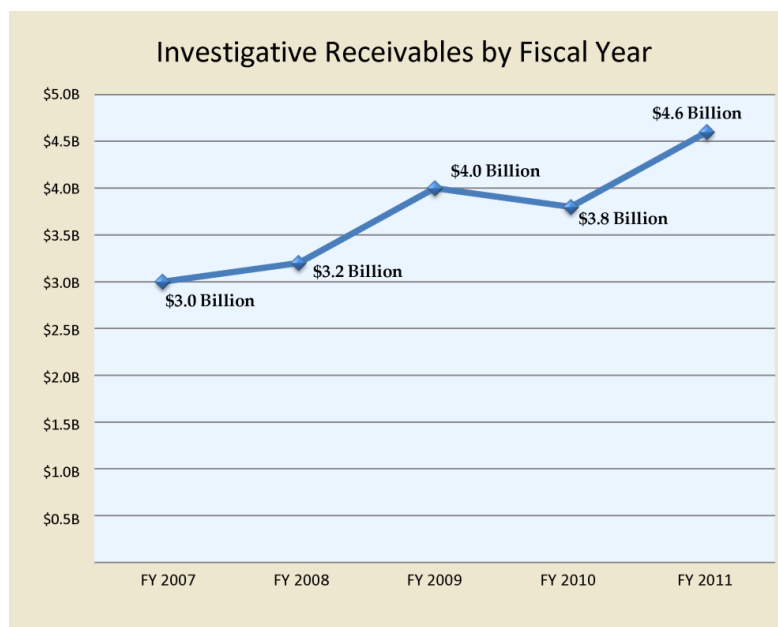


Chart 2 – Receivables: All HHS Programs

(Includes non-HHS receivables, e.g., States' share of Medicaid restitution.)



Advisory Opinions and Other Industry Guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue [advisory opinions](#) and [other guidance](#) to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with the Department of Justice (DOJ), are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. During this period, we received 24 requests for advisory opinions. We issued eight new opinions, including one modification of an earlier opinion.

Health Care Fraud Prevention and Enforcement Action Team Activities

On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an interagency effort focused specifically on combating health care fraud. HEAT includes senior officials from DOJ and HHS who are strengthening programs, as well as investing in new resources and technologies, to prevent and combat fraud, waste, and abuse.

HEAT Provider Compliance Training

OIG provides free training on our Web site for health care providers, compliance professionals, and attorneys. OIG's Provider Compliance Training was an outreach initiative developed as part of HEAT. Following are links to various training resources:

- [Videos and Audio Podcasts](#)
- [Webcast](#)
- [Presentation Materials](#)

Medicare Fraud Strike Force Activities

The Medicare Fraud Strike Force is a key component of HEAT. The Strike Force began in March 2007 and is currently operating in nine cities—Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas. Strike Force teams coordinate joint law enforcement operations conducted by Federal, State, and local law enforcement entities.

These teams have a proven record of success in analyzing data to quickly identify fraud and prosecute the perpetrators. During this reporting period, Strike Force efforts have resulted in the filing of charges against 101 individuals or entities, 96 criminal actions, and \$50.9 million in investigative receivables.

(Correction to the Fall 2011 *Semiannual Report to Congress*: The number of Strike Force criminal actions for OIG for fiscal year 2011 was 181 instead of 184. The three cases were subsequently reassigned to other case categories.)

Strike-Force-Related Indictments, Arrests in Texas

In February 2012, the Medicare Fraud Strike Force attained another milestone with the indictment and arrest of a Texas physician and the office manager of his medical practice, along with five owners of home health agencies (HHA). The individuals were arrested on charges related to their alleged participation in a nearly \$375 million health care fraud scheme involving fraudulent claims for home health services—the single largest fraud orchestrated by one doctor in the history of HEAT and the Medicare Fraud Strike Force operation.

The indicted physician owned and operated an association of health care providers established to provide home health certifications and perform patient home visits. Between January 2006 and November 2011, the physician's association certified more Medicare beneficiaries for home health services and had more purported patients than any other medical practice in the United States.

The Government alleges that the physician and the involved HHAs certified patients that were not homebound and billed for more visits than occurred, resulting in more than \$350 million in fraudulent billing to Medicare and more than \$24 million in fraudulent billing to Medicaid. In addition, the Centers for Medicare & Medicaid Services (CMS) announced the suspension of 78 associated HHAs based on credible allegations of fraud. The indicted physician is awaiting trial.

Additional Examples of Strike Force Efforts

- **Michigan** – Two of OIG’s Top 10 most wanted fugitives, **Clara Guilarte** and **Caridad Guilarte** were each sentenced to 14 years of incarceration and ordered to pay over \$6 million in restitution, jointly and severally, after they pleaded guilty to charges related to a health care fraud and money laundering scheme. The pair owned and operated the **Dearborn Medical Rehabilitation Center** (DMRC), which purported to provide infusion and injection therapy to human immunodeficiency virus (HIV)-positive patients.

According to court documents, between November 2005 and March 2007, the Guilartes recruited and paid kickbacks to Medicare beneficiaries and billed Medicare for services not provided, while purchasing only a fraction of the medications billed to Medicare. The pair then distributed the proceeds through a series of transactions involving shell corporations that served no purpose other than to conceal the nature, source, and location of the funds.

The Guilartes, who fled the United States to avoid being apprehended, were arrested on March 14, 2011, by the Colombian National Police and transferred to the custody of U.S. officials.

- **Florida – Lisandra Alonso**, an office administrator, was sentenced to 78 months of incarceration after she pleaded guilty to charges of conspiracy to commit health care fraud. In addition, Alonso and co-conspirators **Farah Perez** and **Jose Ros** were ordered to pay \$15.3 million, \$118,000, and \$395,000, respectively, in restitution, jointly and severally, for their roles in the fraud scheme.

The trio was affiliated with **ABC Home Health, Inc.** (ABC), and Florida Home Health Care Providers, Inc., companies that purported to provide home health and physical therapy services to Medicare beneficiaries.

According to court documents, these companies existed for the purpose of defrauding Medicare. ABC fraudulently billed Medicare for home health services provided to beneficiaries who were not restricted to their homes and who had no medical necessity for the services. The scheme also entailed submitting false nursing notes for services not rendered and receiving money for recruited patients.

- **Michigan – Santiago Villa-Restrepo** was sentenced to 30 months of incarceration and ordered to pay restitution in the amount of \$2.9 million, jointly and severally, for his participation in a multimillion-dollar scheme to defraud Medicare. Villa-Restrepo and his

co-conspirators operated three purported medical clinics, **Blessed, Alpha & Omega**, and **Manuel**, all opened for the sole purpose of defrauding Medicare.

According to court documents, beginning approximately in 2007, Villa-Restrepo paid Medicare patients to undergo medically unnecessary diagnostic tests at the three clinics. In exchange for illegal kickbacks, the Medicare beneficiaries signed documents indicating they had received the services billed to Medicare.

The clinics involved in the fraud scheme subsequently billed Medicare for expensive and medically unnecessary diagnostic tests and diverted the proceeds to the clinic owners and co-conspirators for their personal use. Villa-Restrepo's co-conspirators are awaiting sentencing for their roles in the scheme.

Other Criminal and Civil Enforcement Activities

Special Assistant United States Attorney Program

During this reporting period, DOJ and OIG continued their participation in a program in which OIG attorneys, some of which are Special Agents, serve as Special Assistant United States Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, such as assignments to the Medicare Fraud Strike Force described above. Other attorneys prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the Departments in their efforts to fight fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to durable medical equipment (DME), infusion therapy, physical therapy, and other types of Medicare and Medicaid fraud.

Most Wanted Fugitives Listed on OIG's Web Site

During the last FY, OIG launched the Most Wanted Fugitives list on its Web site. The list is continuously updated and involves the public in helping to capture fugitives charged with defrauding Federal health care programs and taxpayers of millions of dollars. The list features a photograph, a profile, and statistics for each fugitive, as well as an online tip form and a hotline number for individuals to report fugitive-related information to OIG in either English

or Spanish, 24 hours a day, 365 days a year. The Most Wanted Fugitives list is accessed at <http://oig.hhs.gov/fraud/fugitives/>.

In addition to captures during this semiannual period with the help of third-party visitors to our Web site, one fugitive contacted OIG after seeing himself on the online list. The Government alleges that between July 2003 and March 2007, the fugitive and his accomplices committed health care fraud by paying Medicare beneficiaries to sign Medicare reimbursement forms and by paying doctors and therapists to sign fictitious files for treatment and services that were never rendered; they then submitted the fraudulent claims to Medicare.

Recently Completed Cases and Settlements

The following represent various types of cases concluded during this semiannual period. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Pharmaceutical Companies

- **California – Scios, Inc.** (Scios), a subsidiary of the pharmaceutical company Johnson & Johnson, pleaded guilty to a violation of the Food, Drug, and Cosmetic Act of 1938 (FDCA) and agreed to pay a criminal fine in the amount of \$85 million. Scios, based in Fremont, California, introduced its heart failure drug, Natrecor, into interstate commerce for a use not approved by the Food and Drug Administration (FDA). The FDA approved Natrecor for the treatment of acutely decompensated congestive heart failure with dyspnea (shortness of breath) at rest or with minimal activity. The approved labeling for Natrecor did not list any other use, and the drug was not approved by FDA for any other use.

Scios admitted that it intended Natrecor to be used off-label for infusing chronic (nonacute) congestive heart failure patients on a scheduled, serial basis, even though the company understood that this was not an approved use of the drug. Scios also admitted the FDA-approved labeling for Natrecor did not contain any directions for this scheduled, serial use to treat chronic patients.
- **Michigan – GE Healthcare, Inc.** (GEHC), agreed to pay \$30 million plus interest to resolve allegations that an acquired entity previously known as **Amersham Health, Inc.** (Amersham), violated the FCA. Specifically, the Government alleged that Amersham knowingly provided false or

misleading information to CMS and its contractors from January 2000 through December 2003 regarding Myoview, a radiopharmaceutical product used in certain cardiac diagnostic imaging procedures. The Government contended that the false and misleading information Amersham provided caused the Medicare program to reimburse certain claims for Myoview at artificially inflated rates.

- **Pennsylvania** – Four individuals each pleaded guilty, as responsible corporate officers, to one misdemeanor count of shipping an adulterated and misbranded medical device in interstate commerce. **Michael D. Huggins**, former President of Synthes North America, a subsidiary of **Synthes, Inc.** (Synthes); **Thomas B. Higgins**, former President of Synthes's Spine Division; **Richard E. Bohner**, former Vice-President of Operations for Synthes, and **John J. Walsh**, former Director of Regulatory and Clinical Affairs for Synthes's Spine Division, participated in the criminal conduct. Huggins was sentenced to 9 months of incarceration; Higgins was sentenced to 9 months of incarceration; Bohner was sentenced to 8 months of incarceration; and Walsh was sentenced to 5 months of incarceration.

In connection with this case, associated companies, Synthes and its former subsidiary, **Norian Corporation** (Norian), which develop, manufacture, distribute, market, and sell medical devices, entered into a global resolution with the United States to resolve liability with respect to allegations of conducting unauthorized clinical trials of Synthes' medical devices, Norian XR and Norian SRS. The devices were allegedly used in surgeries to treat vertebral compression fractures of the spine, a painful condition commonly suffered by elderly individuals.

Many of these procedures were performed on Medicare and other Federal health care program beneficiaries, and the procedures were conducted despite a warning on the label for Norian XR against this use and despite serious medical concerns about the safety of the devices when used in the spine.

Prescription Drugs

- **Indiana – John Love**, controlling member and pharmacist for the **Terre Haute Prescription Shop** (THPS), was sentenced to 4 years and 3 months of incarceration and ordered to pay \$3.5 million in restitution for his role in a health care fraud and money laundering scheme. Between January 2006 and September 2010, Love used his position at the pharmacy to carry out a scheme to defraud the Indiana Medicaid Program. Love

entered false prescriptions in the THPS computer billing system which, in turn, billed the Indiana Medicaid Program.

- **Massachusetts – Ernest Melvin McGee**, assistant pharmacist of **Codman Square Pharmacy** (Codman), along with Codman's owner, **Amadiogwu Onujiogu**, solicited paper prescriptions from customers in exchange for illegal kickbacks and submitted false claims to Medicare and Medicaid. McGee and Onujiogu targeted customers with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and/or psychiatric disorders, such as depression and bipolar disorder—conditions that require expensive prescriptions. Many of the beneficiaries they recruited were drug addicts or homeless persons. McGee was sentenced to 12 months and 1 day of incarceration and was ordered to pay restitution in the amount of \$292,635 and \$60,037 to Medicaid and Medicare, respectively, for his role in the health care fraud scheme. Onujiogu was previously convicted on the same charge and sentenced to 15 months of incarceration.
- **Florida – Paul Wagner Jr.**, a private citizen, was sentenced to 7 years and 2 months of incarceration for possession with intent to distribute, as well as for distributing the Schedule II drug Oxycodone. Wagner was part of a fraud scheme that entailed obtaining paper Oxycodone prescriptions from a local physician who prescribed the controlled substances to Medicare and Medicaid beneficiaries, despite lack of medical necessity. Wagner then assisted in filling the prescriptions and trafficking the drugs to street dealers.

Hospitals

Georgia – Satilla Health Services, Inc., d/b/a **Satilla Regional Medical Center** (Satilla) agreed to pay \$840,000 to resolve its liability under the FCA. The agreement resolves allegations that Satilla submitted claims to Medicare and Medicaid for medically unnecessary and dangerous endovascular procedures performed by a physician for the medical center's heart center that caused serious injury to 37 patients. In addition, Satilla has entered into an agreement with another company to purchase Satilla, which will result in a new board of directors, new administrators, and a new compliance program at Satilla.

Home Health Agencies

Virginia – Health Care of Virginia, LLC (HCV), an HHA, was ordered to pay \$323,420 in restitution for health care fraud. The company allegedly

submitted claims to the Virginia Medicaid program for services rendered by untrained personal care aides. The investigation indicated that HCV falsified training certificates and patient assessments. Two other defendants pleaded guilty for their roles in the fraud scheme and have been sentenced.

Hospice Care

- **Wisconsin - Odyssey Healthcare, Inc.** (Odyssey), a subsidiary of Gentiva Health Services, Inc., agreed to pay \$25 million to resolve allegations that between January 2006 and January 2009, Odyssey submitted claims for hospice services that were medically unnecessary. The investigation found Odyssey billed Medicare for continuous or crisis care services when the patients were not experiencing a crisis. Continuous or crisis care is reimbursed by Medicare at a higher rate than routine care. As part of the settlement, Odyssey entered into a 5-year corporate integrity agreement (CIA) with OIG.
- **Arkansas – Hospice Home Care, Inc.** (HHC), agreed to pay \$2.7 million to resolve its liability under the FCA for allegedly submitting false claims to Medicare. Between January 2002 and December 2004, HHC allegedly billed Medicare for general inpatient services when the patients received only routine care, which has a lower reimbursement rate.

Nursing Homes

Tennessee – Vanguard Healthcare Ancillary Services, LLC; Vanguard Healthcare, LLC; and Vanguard Healthcare Services, LLC (collectively, Vanguard), agreed to pay \$2 million as a part of a settlement agreement to resolve allegations of false claims and illegal kickbacks. Between March 1998 and September 2008, Vanguard allegedly submitted claims to Medicare for enteral (nutrition) therapy goods and services that were also billed to the Tennessee and Mississippi Medicaid programs.

Vanguard allegedly failed to disclose the relationship between its long-term-care (LTC) facilities (which billed Tennessee and Mississippi Medicaid for the enteral therapy goods and services) and Vanguard Healthcare Ancillary Services (which billed Medicare Part B for the same enteral therapy goods and services). Vanguard also allegedly submitted claims to Medicare for certain free items, namely pumps used to deliver nutritional products and intravenous poles used in the administration of enteral therapy that Vanguard had received at no cost from a third party supplier in order to induce referrals.

Clinics

- **Texas – Umawa Oke Imo**, owner and operator of **City Nursing Services of Texas Inc.** (City Nursing Services), and his co-conspirators, fraudulently used City Nursing Services to pay kickbacks to Medicare beneficiaries and recruiters; provide physical therapy services to Medicare beneficiaries even though it did not employ any licensed or qualified physical therapists; and bill Medicare for physical therapy services that were not rendered. To mask this practice, City Nursing Services created false and fraudulent patient files.

Imo was sentenced to 27 years and 3 months of incarceration and ordered to pay more than \$30.2 million in restitution, jointly and severally, after being convicted on charges of conspiracy to commit health care fraud, health care fraud, and aiding and abetting. Co-conspirators **Joanne White** and **Christina Joy Clardy** were also sentenced in the scheme. White was sentenced to 3 years and 10 months of incarceration and ordered to pay more than \$25.5 million in restitution, jointly and severally. Clardy was sentenced to 11 years and 3 months of incarceration and ordered to pay more than \$15.6 million in restitution, jointly and severally. Other conspirators were indicted.

- **New Jersey –The Center for Lymphatic Disorders**, LLC (CLD), was ordered to pay \$3 million in restitution as a result of a guilty plea to third-degree health care claims fraud by office manager **Farah Houtan**. Between January 2004 and June 2007, Houtan billed Medicare and Medicaid for services not provided to patients. CLD staff allegedly submitted claims for surgical procedures but, in fact, provided physical therapy services, which has a lower reimbursement rate.
- **Nevada – Dennis Falls**, former owner and sole practitioner for **Nevada Pulmonary and Sleep Diagnostics** (NPSD), was sentenced to 2 years and 3 months of incarceration and ordered to pay \$226,539 in restitution after he pleaded guilty to health care fraud. Falls caused claims to be submitted to Medicare for sleep studies and pulmonary stress tests that were neither requested by referring physicians nor performed. The investigation revealed that more than 50 percent of NPSD's sleep studies were conducted at the homes of beneficiaries, which is not covered by Medicare, but were billed as though they were performed in the office.
- **California – North Valley Radiation Oncology Medical Group** (NVRONG), a medical practice that provides oncology services to patients in northern California, agreed to pay \$46,220 to resolve its liability under the FCA for

submitting false claims to Medicare. Between January 2003 and February 2010, NVRONG allegedly billed Medicare for radiation services improperly coded with the place of service as their physician offices, when in fact the services were provided on the premises of a hospital's clinic. Medicare pays physicians a higher reimbursement for certain categories of services that are provided at their offices rather than in a hospital setting.

Practitioners and Other Suppliers

- **Michigan – Gwendolyn Washington**, a family practice physician, was sentenced to 10 years of incarceration and ordered to pay \$5.4 million in restitution for receiving kickbacks and fraudulently billing for diagnostic tests and services that were not medically necessary. During the investigation, CMS placed Washington on a prepayment review, which upon evaluation, resulted in a suspension of Washington's Medicare payments.
- **Maryland – Larry Bernhard**, a Maryland podiatrist, was sentenced to 4 years and 6 months of incarceration and ordered to pay \$1.1 million in restitution for his scheme to defraud Medicare Advantage (Part C) plans. Bernhard pleaded guilty to fraudulently billing Medicare for services to patients he had never seen. Additionally, Bernhard used the names and other personally identifiable information of approximately 200 nursing home patients to submit false claims for podiatry care he never provided.

Durable Medical Equipment

- **Minnesota – Medtronic, Inc.**, a DME manufacturer, agreed to pay \$23.8 million plus interest to resolve allegations that it violated the FCA. The Government alleged that Medtronic used postmarket studies and device registries as vehicles to pay physicians illegal kickbacks to induce them to implant Medtronic pacemakers and defibrillators. It was also alleged that Medtronic solicited physicians for the studies and registries to convert their business from a competitor's product and persuade physicians to continue using Medtronic products.
- **California – Christopher Iruke**, owner and operator of several fraudulent DME companies; his wife and co-conspirator **Connie Ikpoh**; and co-conspirators **Aura Marroquin** and others used fraudulent prescriptions and documents to bill Medicare for expensive high-end power wheelchairs and orthotics that were medically unnecessary or were

never provided. Iruke and Ikpoh diverted most of the proceeds from their scheme to pay for business and personal expenses, including the leases on their Mercedes vehicles and home-remodeling expenses. Iruke was sentenced to 15 years of incarceration and ordered to pay \$6.7 million in restitution, jointly and severally with co-conspirators, for his role in the multimillion-dollar scheme. Iruke's sentence is one of the longest health care fraud sentences ever imposed in the Central District of California. Ikpoh, Marroquin, and two other co-conspirators were also convicted for their roles in the scheme.

- **Texas – James Reese, Lia St. Junius, Brenda Lopez, Lily Johnson**, and others of **The Mobility Store** (TMS), a DME company, took part in a scheme that fraudulently billed braces to Medicare and Medicaid as orthotic devices. As a result, Medicare reimbursed TMS at a rate many times the actual cost of the braces. Reese, Junius, Lopez, and Johnson were sentenced to 15 years, 11 years and 3 months, 3 years and 7 months, and 2 years and 9 months of incarceration, respectively, for their roles in the scheme. Additionally, Johnson was ordered to pay \$4 million in restitution, jointly and severally, and Lopez, Reese, and St. Junius were each ordered to pay \$8.6 million, jointly and severally.
- **Florida – Benjamin Bane** (B. Bane), owner and operator of two DME companies that provided oxygen therapy in central and west Florida, and two associated managers, **Greg Bane** (G. Bane) and **Tracy Bane** (T. Bane), were sentenced to incarceration and ordered to pay restitution for participating in a scheme to defraud Medicare and Medicaid.

Although DME companies are expressly prohibited by Medicare regulations from performing the qualifying tests to establish medical necessity for home oxygen, B. Bane allegedly instructed his employees to perform such tests; falsify test results; and alter information on office computers, such as the beneficiary's name and the procedure date. The qualifying test results were then provided to either one of two pulmonary diagnostics companies to appear as though they had been performed by an independent diagnostic testing facility in accordance with Medicare regulations and were therefore eligible for reimbursement.

B. Bane was sentenced to 12 years of incarceration and ordered to pay \$7 million in restitution, jointly and severally. G. Bane and T. Bane were sentenced to 3 years and 6 months of incarceration for their roles in the scheme, respectively, and both were ordered to pay \$7 million, jointly and severally, in restitution.

California – Mariya Bagdasaryan, owner of **Goldberg Medical Supply**, was sentenced to 3 years and 1 month of incarceration and ordered to pay \$576,803 in restitution for one count of health care fraud. Between October 2007 and December 2008, Bagdasaryan defrauded the Medicare and Medi-Cal programs by paying kickbacks to marketers to solicit beneficiary information with promises of free DME. Bagdasaryan then sold the beneficiary information to a Medicare billing service, which, in turn, sold some of the information to a fraudulent DME company called **True Care Medical Supply** (True Care). True Care then submitted claims to Medicare falsely representing that it had supplied DME to the Medicare beneficiaries.

Bagdasaryan received the longest possible prison term partly because of a conviction in 2002 for the same offense. In January 2011, the True Care owner, **Edgar Srapyan**, was sentenced to 37 months of incarceration and ordered to pay over \$330,000 in restitution.

Transportation Fraud

Rhode Island – John Almon, president and owner of **Med Care Ambulance LLC** (Med Care), was sentenced to 2 years of incarceration and ordered to pay \$704,117 in restitution for health care fraud. Between March and December 2008, Almon submitted fraudulent claims to Medicare and Blue Cross and Blue Shield by billing routine dialysis transports as specialty care transports (SCT), even though Med Care did not have the proper equipment or personnel to provide SCTs. This upcoded billing, which should have been billed as basic life support, resulted in a higher reimbursement rate. Almon also instructed his employees to alter the trip sheets to ensure that the transports qualified as SCTs.

Private Citizens

Florida – Joel Martinez-Hernandez, Eliezer Lazo, and Emilio Bezanilla were sentenced to 7 years, 5 years and 3 months, and 3 years and 1 month of incarceration, respectively. Between December 2007 and February 2008, Martinez-Hernandez, along with co-conspirators Lazo, Bezanilla, and others, laundered fraudulent proceeds from five pharmacies and DME companies. Martinez-Hernandez was charged with 15 counts of money laundering and 2 counts of structuring to avoid reporting requirements and was ordered to pay \$250,000 in restitution following his jury trial conviction. After the convictions of these individuals and with cooperation from other defendants, the owner of the pharmacies and DME companies was indicted for

allegations of crimes, including health care fraud and aggravated identity theft.

Medicaid Fraud Control Units

Funding and Accomplishments

Medicaid Fraud Control Units (MFCU) are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In FY 2011, HHS awarded \$156.7 million in Federal grant funds to 50 MFCUs (including 1 in Washington, DC), which employed a total of 1,833 individuals. Collectively, in FY 2011, MFCUs reported 14,819 investigations, of which 10,685 were related to Medicaid fraud and 4,134 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges against or indictments of 1,408 individuals, including 1,011 for fraud and 397 for patient abuse and neglect, including patient funds cases. In total, 1,230 convictions were reported in FY 2011, of which 824 were related to Medicaid fraud and 406 were related to patient abuse and neglect, including patient funds cases.

Joint Investigations

- **Minnesota – John Alemoh Momoh**, owner and operator of **Hopecare Service, Inc.** (Hopecare), was sentenced to 2 years of incarceration and ordered to pay \$656,876 in restitution to Medicaid for claims submitted for personal care assistant (PCA) services. Between May 2007 and March 2008, Momoh submitted false claims with respect to the number of PCA service hours provided to Medicaid beneficiaries. Momoh also submitted false claims to Medicaid for services that were not rendered, were provided by an unqualified individual, and were not medically necessary.
- **Pennsylvania – Octavia Durham** (Durham) and her daughter, **Anneikkia Durham Smith** (Smith), were sentenced for their roles in a Medicaid fraud scheme. A relative of the pair who was a Medicaid beneficiary received attendant care services from Durham pursuant to the Medicaid Commerce Waiver Program.

An initial investigation by the Pennsylvania MFCU revealed that the beneficiary suffered from ulcers, bed sores, dehydration, and malnutrition and had missed numerous medical appointments.

A doctor who examined him in June 2009 recommended that the beneficiary be immediately transported to an emergency room. On a number of Durham's attendant timesheets, Smith signed on behalf of the beneficiary, verifying Durham's hours and services provided. Numerous timesheets and claims submitted to Medicaid included hours that Durham allegedly provided care when in fact Durham was employed elsewhere or was out of town or when the beneficiary was hospitalized or was in a nursing home.

Durham was sentenced to between 11½ months to 23 months of incarceration and ordered to pay \$128,000 in restitution. Smith was ordered to pay \$38,614 of this amount, jointly and severally with Durham and was sentenced to a 7-year term of probation. This was a joint investigation with the MFCU of the Pennsylvania Attorney General's Office and the Montgomery County District Attorney's Office.

Sanction Authorities and Related Administrative Actions

Various Federal laws provide authorities to impose administrative sanctions for fraud and abuse as well as other activities that pose a risk to Federal health care programs and their beneficiaries. (See Appendix D for a summary of frequently used sanction authorities.)

Sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties (CMP) for submitting false and fraudulent claims to a Federal health care program or for violating the anti-kickback statute; the Stark Law; or the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), also known as the anti-patient-dumping law.

During this reporting period, OIG administered 1,304 sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. OIG is also responsible for reinstating providers who apply and have met the requirements of their exclusions. Exclusion and penalty authorities are described in Appendix D and on our Web site at: <http://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program Exclusions

During this semiannual reporting period, OIG excluded 1,264 individuals and entities from Medicare, Medicaid, and other Federal health care programs.

Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. For a list of excluded individuals and entities, see <http://exclusions.oig.hhs.gov/>.

For example:

- **Iowa – Kenneth Brown**, who was a certified medication aide at a residential facility, was excluded for 20 years for his conviction on two counts of dependent adult abuse. He sexually exploited two dependent adults and caused them to suffer mental injuries and increased symptoms regarding their mental health problems. Mr. Brown also has a prior criminal history that includes convictions for driving with a suspended license; assault with intent to cause pain or injury; theft in the fifth degree; driving while barred – habitual offender; and possession of a controlled substance. Additionally, the Iowa Director Care Worker Registry placed a finding of abuse on its registry regarding Brown.
- **Florida – Reinaldo Guerra**, the owner of durable medical equipment companies, was excluded for 95 years on the basis of his conviction of health care fraud and conspiracy to commit health care fraud. From 2002 to about August 2004, Guerra and his conspirators submitted false and fraudulent Medicare claims on behalf of the companies seeking reimbursement for DME that was neither ordered by a physician nor provided to the beneficiary. The court ordered Guerra to pay \$35.1 million in restitution and to serve 168 months of incarceration.
- **Ohio – Robert Scott Blankenburg**, a pediatrician, was excluded for 50 years on the basis of his conviction of unlawful sexual conduct with a minor, bribery, complicity to deception to obtain dangerous drugs, and compelling prostitution. From about March 1992 to about December 2008, Blankenburg provided prescriptions for controlled substances or money to patients in return for sexual favors. The court sentenced him to 13 years of incarceration. The Ohio State Board of Medicine permanently revoked his license to practice medicine.

Corporate Integrity Agreements

OIG assists DOJ in bringing and settling cases under the FCA. Many providers elect to settle their cases prior to litigation. As part of their

settlements, providers often agree to enter into CIAs with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Such agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct. During this period, 14 CIAs were executed. [More information on CIAs](#) is available on our Web site.

Example of CIA Violation – On November 23 and December 30, 2011, OIG imposed penalties totaling \$57,500 on [The SCOOTER Store, Inc.](#) (SCOOTER Store), for failure to submit timely reports, as required under its CIA. On February 17, 2012, OIG sent a Notice of Material Breach and Intent to Exclude the SCOOTER Store based on its failure to repay an identified overpayment.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits, or causes to be submitted, claims to a Federal health care program that the person knows or should know are false or fraudulent. During this reporting period, OIG concluded cases involving more than \$6.1 million in CMPs and assessments. The following are among the CMP actions resolved during this reporting period:

- [New Jersey – Sandoz Inc.](#) (Sandoz), a pharmaceutical manufacturer, agreed to pay \$230,000 to resolve its potential liability under the CMPL. Specifically, the Government contended that Sandoz failed to timely submit pricing data required under the Medicaid Drug Rebate Program.
- [Iowa – Buchanan County Health Center](#) (BCHC), a primary care community hospital, agreed to pay \$406,030 to resolve its potential liability under the CMPL for employing an excluded individual from 2007 to May 2011. The individual's exclusion was based on a conviction relating to a controlled substance violation. The Government contended that BCHC knew or should have known that the individual was excluded.
- [Mississippi](#) – OIG reached settlements with eight physicians who violated the CMPL by causing the submission of false claims to Medicare from physical medicine companies. Specifically, the physicians reassigned their Medicare payments to various physical medicine companies in exchange for medical directorship positions. The physicians did not personally render or directly supervise any physical therapy or related health care services.

As a result, unlicensed individuals with little or no medical background provided unsupervised in-home physical therapy services to Medicare beneficiaries. The physical medicine companies falsely billed Medicare using the physicians' reassigned provider numbers as if the physicians had personally rendered the services or directly supervised individuals rendering the services.

The eight physicians have collectively paid \$604,874 to resolve their CMPL liability. These administrative CMPL cases were collateral investigations associated with criminal cases prosecuted by the U.S. Attorney's Office for the Southern District of Mississippi. Several owners and operators of the physical medicine companies were criminally prosecuted in Federal court for their roles in these schemes.

Patient Dumping

Some of the CMPL cases that OIG resolved between October 1, 2011, and March 31, 2012, were pursued under EMTALA, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements under this statute:

- **Alabama – Princeton Baptist Medical Center** (Princeton Baptist) agreed to pay \$170,000 to resolve its potential liability under EMTALA. The Government alleged that Princeton Baptist failed to provide neurosurgical care, within its capabilities, to four individuals suffering from unstable emergency medical conditions.
- **Georgia – Piedmont Hospital** (Piedmont) agreed to pay \$50,000 to resolve its potential liability under EMTALA. The Government alleged that Piedmont failed to provide an appropriate medical screening exam and stabilizing treatment for an individual who presented to Piedmont's Emergency Department for evaluation and treatment of an emergency medical condition. The individual made repeated requests for treatment for approximately 8 hours without success. The individual left Piedmont, went to another hospital, and was diagnosed and treated for deep vein thrombosis and pulmonary embolus.
- **Tennessee – Vanderbilt University Medical Center** (Vanderbilt) agreed to pay \$45,000 to resolve its potential liability under EMTALA. The Government alleged that Vanderbilt refused to accept the appropriate transfer of a 66-year-old patient suffering from a large subdural hematoma on the brain with a midline shift. The patient had an unstable emergency medical condition that required the specialized capabilities available at Vanderbilt. Matthew Pearson, M.D., the neurosurgeon on call

at Vanderbilt, agreed to pay \$35,000 to resolve his potential liability as a responsible physician under EMTALA for refusing to accept an appropriate transfer of an individual with an unstable emergency medical condition that required the services of a neurosurgeon. The patient died a few hours later at another hospital.

Provider Self-Disclosure Protocol

OIG is committed to assisting health care providers and suppliers in detecting and preventing fraud and abuse. Since 1998, we have made available comprehensive guidelines describing the process for providers to voluntarily submit to OIG self-disclosures of fraud, waste, or abuse. The Provider Self-Disclosure Protocol gives providers an opportunity to minimize the potential costs and disruption that a full-scale OIG audit or investigation might entail if fraud is uncovered. In doing so, the self-disclosure also enables the provider to negotiate a fair monetary settlement and potentially avoid being excluded from participation in Federal health care programs.

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments).

After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG Web site at <http://www.oig.hhs.gov/fraud/selfdisclosure.asp>

During this reporting period, self-disclosure cases resulted in \$15.4 million in HHS receivables. The following are examples:

- **Illinois – Resurrection Health Care, Inc.** (Resurrection), agreed to pay \$2.8 million to resolve its potential liability under the CMPL. Resurrection voluntarily disclosed multiple personal service and lease arrangements, which created potential liability under the Physician Self-Referral Law (Stark Law) and the anti-kickback statute, along with three arrangements with excluded individuals. Resurrection disclosed the conduct through the Self-Disclosure Protocol.

- **New York – New York City Health and Hospitals Corporation (HHC)** agreed to pay \$442,909 to resolve HHC's potential liability under the CMPL for employing excluded individuals. HHC disclosed that it employed eight excluded individuals from August 1999 through October 2010. HHC voluntarily disclosed the conduct through the Self-Disclosure Protocol.
- **Wisconsin – Westfields Hospital** (Westfields) agreed to pay \$204,150 to resolve its potential liability under the CMPL for violating the anti-kickback statute. Westfields voluntarily disclosed the provision of space, services, and supplies to certain physician group practices without entering into a formal written contract and without collecting payment. Westfields disclosed the conduct through the Self-Disclosure Protocol.
- **West Virginia – West Virginia University Hospitals - East, Inc.; City Hospital, Inc.; and The Charles Town General Hospital d/b/a Jefferson Memorial Hospital** (collectively the hospitals) agreed to pay \$949,595 to resolve their potential CMPL liability for violating the Anti-Kickback Statute. Specifically, the hospitals voluntarily disclosed that they failed to collect rental payments under physician arrangements, paid costs and expenses pursuant to recruitment agreements in excess of actual additional incremental costs, paid student loans without written recruitment agreements, and paid costs and expenses pursuant to unwritten extensions of recruitment agreements. The hospitals voluntarily disclosed the conduct through the Self-Disclosure Protocol.

Part IV

Public Health, Human Services, and Other HHS-Related Reviews

The Office of Inspector General's (OIG) public health and human services work reflects the Department of Health and Human Services' (HHS) top management challenges related to safety of the Nation's food supply (including facility inspections); contract administration; and grants management, including grantee performance issues and fraud.

In the human services area, we also have a significant role in child support enforcement. Other HHS-related issues reported in this section include reviews that do not pertain directly to programs addressed in prior sections and to subjects that cross-cut HHS agencies, programs, management, and operations.

Public Health Reviews

Public Health Agencies' Management and Oversight

Selected organizational abbreviations used in this section:

CDC	Centers for Disease Control and Prevention
FDA	Food and Drug Administration
HRSA	Health Resources and Services Administration
NIH	National Institutes of Health
SAMHSA	Substance Abuse and Mental Health Services Administration

Local Public Health Preparedness for Radiological and Nuclear Incidents

CDC – Public health planning for radiological and nuclear (RN) incidents did not always correspond to prioritized threats identified in localities' risk assessments. Though specific RN plans are not required, according to the 2010 National Security Strategy, the American people face no greater or more urgent danger than a terrorist attack with a nuclear weapon. Thirty-six of the 40 localities we selected from the Nation's most populous metropolitan statistical areas had conducted risk assessments; however, only 4 had categorized RN incidents as a high-priority threat, and only 1 of

the 4 had developed RN-specific plans. For the five public health areas of responsibility we examined, localities' planning varied. Localities' coordination with Federal, State, and local partners for RN-specific public health planning also varied. Most State and local officials were aware of Federal guidance but requested more comprehensive and specific planning tools.

(Recommendations—CDC should work with selected localities to more closely align incident-specific planning with risk assessments, provide more guidance on RN-incident planning and coordination with other entities, and provide more training to selected localities about the unique aspects of RN incidents. *Local Public Health Preparedness for Radiological and Nuclear Incidents*. OEI-04-10-00250. January 2012. [Web Summary](#). [Full Text](#).)

FDA's Oversight of Food Facility Inspections

FDA – Although FDA has increasingly relied on States to inspect food facilities, our report identified significant weaknesses in FDA's oversight of such inspections.

Notably, in some States, FDA failed to ensure that the required number of inspections was completed. Moreover, FDA paid for many inspections that were incomplete. FDA did not ensure that all inspections were properly classified or that all inspection violations were remedied.

An “official action indicated” (OAI) classification is generally assigned when the most serious violations are identified. Officials responsible for several States reported that they would not assign OAI classifications to State inspections under any circumstances, contrary to FDA guidance. Other issues centered on deficiencies in the number of required audits conducted and lack of oversight of corrective actions.

(Recommendations—FDA should ensure that contract inspections are completed, properly documented, and appropriately paid for and contract inspections are properly classified. FDA should routinely track all actions taken to correct violations, meet the minimum audit rate in all States, and address any systemic problems identified by audits.) *Vulnerabilities in FDA's Oversight of State Food Facility Inspections*. OEI-02-09-00430. December 2011. [Web Summary](#). [Full Text](#).)

HRSA-Funded Health Centers' Quality Assurance and Care

HRSA – Almost all health centers we reviewed had quality assurance programs, and health services were appropriate for most health center patients. However, insufficient documentation prevented detailed

assessments of some medical records. HRSA's oversight and review activities provided only limited information about the extent to which individual health center patients received required primary health services.

Although HRSA's requirements specify which services health centers must make available to patients, they do not establish specific quality standards for the services. In 2008, health centers funded by HRSA grants provided care to 17.1 million patients in medically underserved urban or rural areas or in medically underserved populations.

(Recommendations—HRSA should specify elements to be included in grantees' quality assurance programs, provide more guidance about how to conduct periodic assessments of services, and provide more guidance about patient records requirements and more specificity about patients' receipt of required primary health services. HRSA should also establish procedures to independently assess patients' receipt of primary health services and the adequacy of patients' records.) *Quality Assurance and Care Provided at HRSA-Funded Health Centers*. OEI-09-06-00420. March 2012.

[Web Summary](#). [Full Text](#).

NIH's Compliance With Appropriations Laws

NIH – We found time and amount issues in four contracts that potentially violated the Antideficiency Act and/or the bona fide needs rule. The Antideficiency Act prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by law.

Federal statutes specify that a fiscal year (FY) appropriation may be obligated only to meet a legitimate (bona fide) need arising in or continuing to exist in the appropriation's period of availability. From November 2008 through February 2009, an HHS internal review group assessed 176 HHS contracts, including 21 NIH contracts.

Our reviews of the NIH contracts assessed compliance with the purpose, time, and amounts requirements specified in appropriations statutes. Recommendations included making monetary adjustments and reporting Antideficiency Act violations as appropriate.

- **Charles River Laboratories, Inc.** – (Recommendations—Record the correct obligation for each program year against the appropriate FY appropriations, record expenditures for each program year against the appropriate FY appropriations, report an Antideficiency Act violation for expending FY 2007 funds in advance of an appropriation, report an Antideficiency Act violation if adequate FY 2009 and subsequent year

funds are unavailable to cover obligations for subsequent program years, return funds that were not required for program years 1 and 2; and reverse the expenditure to the contract for the \$111,000 erroneous payment and charge the correct contract accordingly.) *Appropriations Funding for National Institute on Drug Abuse Contract HHSN271-2007-00009C With Charles River Laboratories, Inc.* A-03-10-03104. October 2011. [Web Summary](#). [Full Text](#).

- **The EMMES Corporation** – (Recommendations—Record the correct obligation for each program year against the appropriate FY appropriations, record expenditures for each program year against the appropriate FY appropriations, report an Antideficiency Act violation for obligating FY 2008 funds in advance of an appropriation, report an Antideficiency Act violation if adequate FY 2009 and appropriate subsequent year funds are unavailable to cover obligations for subsequent program years, and return funds that were not required for program year 1 if it is determined that they are no longer needed during their period of availability.) *Appropriations Funding for National Institute of Allergy and Infectious Diseases Contract HHSN272-2008-00013C With The EMMES Corporation.* A-03-10-03115. October 2011. [Web Summary](#). [Full Text](#).
- **University of South Florida** – (Recommendations—Deobligate \$10.5 million of FY 2008 funds, deobligate any additional funds appropriated for years other than FY 2007 that the National Institute of Diabetes and Digestive and Kidney Diseases may have obligated after our audit, record the remaining \$123.2 million of the \$169.4 million contract obligation against FY 2007 funds, report an Antideficiency Act violation if FY 2007 funds are not available, and obtain a refund for the duplicate payment of \$28,000.) *Appropriations Funding for National Institute of Diabetes and Digestive and Kidney Diseases Contract HHSN267-2007-00014C With the University of South Florida.* A-03-10-03110. October 2011. [Web Summary](#). [Full Text](#).
- **Westat, Inc.** – (Recommendations—Deobligate \$33.2 million of FY 2004 funds and \$33.3 million of FY 2005 funds and return the canceled funds to the Treasury; deobligate \$33.5 million of FY 2006 funds and \$33.7 million of FY 2007 funds; record the remaining \$133.7 million of the \$164.7 million contract obligation against current FY appropriations; report an Antideficiency Act violation if sufficient current year appropriations are not available; and report, in accordance with 31 U.S.C. § 1554, the adjustment to the Contract using current FY appropriations.)

Appropriations Funding for Eunice Kennedy Shriver National Institute of Child Health and Human Development Contract HHSN275-03-3345 With Westat, Inc. A-03-10-03106. October 2011. [Web Summary](#). [Full Text](#).

NIH's Administration of the Clinical and Translational Science Awards Program

NIH – Staff of NIH's Clinical and Translational Science Awards Program (CTSA) did not properly document awardees' progress under their cooperative agreements. CTSA program staff documented a comparison of accomplishments to research objectives for only 1 of 38 awardees throughout the review period (FYs 2006 through 2008). Although reviews for six awardees' files mentioned an inability to fulfill goals, only one file included a note from CTSA program staff regarding resolution. Also, most progress reports and half of financial status reports were late, yet the files contained no evidence that CTSA program staff took action to address timeliness of reports. CTSA program staff did not maintain files in accordance with HHS policy.

Finally, awardees' files contained little or no evidence that CTSA program staff or CTSA-assigned project scientists provided substantial involvement to awardees in accordance with Federal regulations and NIH policy.

(Recommendations—NIH should ensure that CTSA program staff document their monitoring of awardee progress; ensure timely submission of required reports; maintain official files in accordance with Federal policy; and, as required for cooperative agreements, provide substantial involvement to CTSA awardees.) *NIH Administration of the Clinical and Translational Science Awards Program*. OEI-07-09-00300. December 2011. [Web Summary](#). [Full Text](#).

SAMHSA's Management of Grant Files and Grantee Communications

SAMHSA – Our review concluded that SAMHSA maintains grant files in accordance with Federal requirements, and most SAMHSA staff and grantee project directors reported positive interactions with one another. We were able to follow the grant "paper trail" and identify required documents; however, a few grant files were missing initial applications, continuation applications, and Financial Status Reports. Some SAMHSA staff and grantee project directors identified obstacles to communication. In 2009, the period of our review, SAMHSA administered 2,281 discretionary grants, which

ranged from approximately \$17,000 to \$7 million for a total of \$906.8 million.

Given the overall completeness and quality of the grant files and the low incidence of identified problems, we did not make formal recommendations to SAMHSA. Still, we encouraged SAMHSA to obtain and maintain all required documents. Also, we suggested using the information from this report to improve interactions between SAMHSA staff and the grantee project directors. *SAMHSA's Administration of Grants*. OEI-07-10-00220. February 2012. [Web Summary](#). [Full Text](#).

Public Health-Related Legal Actions and Investigations

Health Education Assistance Loan Program

Under the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking education in health-related fields. The students are allowed to defer repayment of the loans until after they have graduated and begun to earn income. Although HHS's Program Support Center (PSC) takes steps to ensure repayment, some loan recipients do not resolve their indebtedness. After PSC has exhausted efforts to secure repayment of a debt, it declares an individual in default. Thereafter, the Social Security Act permits exclusion from Medicare, Medicaid, and all other Federal health care programs for nonpayment of these loans.

Exclusion means that the individual may not receive reimbursement under these programs for professional services rendered nor can any other provider receive reimbursement for services ordered or prescribed by the individual. OIG is responsible for excluding individuals who have defaulted on HEAL loans from participation in Federal health care programs.

HEAL Exclusions

During the period covered by this report, 55 individuals and related entities were excluded as a result of PSC referrals of their cases to OIG. Individuals who have been excluded as a result of default may enter into settlement agreements whereby the exclusions are stayed while they pay specified amounts each month to satisfy their debts. If they default on these settlement agreements, they may be excluded until the entire debts are repaid and they may not appeal the exclusions.

After being excluded for nonpayment of their HEAL debts, 2,393 individuals have chosen to enter into settlement agreements or completely repay their debts. That figure includes the 35 individuals who have entered into such settlement agreements or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment is \$181,767,939. Of that amount, \$3,730,061 is attributable to this reporting period.

Practitioners in the following States entered into settlement agreements to repay the amounts indicated:

- Tennessee podiatrist, \$269,961
- Missouri chiropractor, \$57,337
- California psychologist, \$56,673
- California medical doctor, \$16,147

Human Services Reviews

Head Start Program

Head Start Grantees' Health and Safety Violations

Head Start – Of the 24 Head Start grantees that we reviewed, none fully complied with Federal Head Start or State requirements to protect children from unsafe materials and equipment. Twenty-one of the grantees did not fully comply with Federal Head Start or State requirements to conduct criminal records checks, recurring background checks, checks of childcare exclusion lists, or checks of child abuse and neglect registries. The grantees also failed to properly document criminal records checks.

We selected the 24 grantees on the basis of OIG's risk assessment and the Administration for Children and Families (ACF), Office of Head Start (OHS), most recent monitoring reviews that identified grantee's health and safety citations. Of the 24 grantees that were reviewed from May 2009 through October 2010, 3 were terminated and 21 corrected their violations.

(Recommendations—ACF should ensure through onsite monitoring that Head Start grantees comply with health and safety regulations; perform an analysis to determine whether it should seek a legislative amendment of

Federal health and safety requirements that would require periodic background checks for all Head Start employees; and amend current policy and regulations to require that any prospective or current employee be disqualified for or terminated from employment with a Head Start grantee if the individual has been convicted of sexual abuse of a child, other forms of child abuse and neglect, or a violent felony.) *Review of 24 Head Start Grantees' Compliance With Health and Safety Requirements*. A-01-11-02503. December 2011. [Web Summary](#). [Full Text](#). See Also OIG's [Spotlight on Head Start Health and Safety](#) available on our Web site.

Impact of Early Head Start Grantees' Management Deficiencies Funding

Early Head Start – Of 83 Early Head Start program grant applicants that OIG assessed, 75 had problems with financial stability; inadequate systems to manage and account for Federal funds; and inadequate organizational structures, procurement and property management procedures, and personnel policies and procedures. Using our findings, ACF awarded \$15 million in American Recovery and Reinvestment Act of 2009 (Recovery Act) funds to the 8 applicants that had no deficiencies; did not award \$31 million requested by 15 of the 75 deficient applicants; and awarded \$126 million to 60 of the 75 deficient applicants on the condition that they receive increased ACF oversight, training, and technical assistance.

(Recommendations—ACF should use the information in this report as part of its application-review process and in its monitoring and oversight of the 60 funded applicants identified in this report.) *Review of 83 Early Head Start Applicants Under the American Recovery and Reinvestment Act*. A-01-10-02501. November 2011. [Web Summary](#). [Full Text](#).

Child Support Enforcement

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

Child Support Task Forces

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

Investigative Outcomes

OIG investigations of child support cases nationwide resulted in 26 convictions and court-ordered restitution and settlements of \$1.2 million during this semiannual period. Examples of OIG's enforcement results for failure to pay child support included the following:

- **Idaho –** One of OIG's most wanted fugitive deadbeat parents, **Rusty Donnie Gene Haile**, was sentenced to 5 years of probation and ordered to pay \$119,700 in restitution for failure to pay a lawful child support order with respect to his four minor children. Since 2006, Haile had been residing and working in Bermuda. Haile returned to the United States in March 2011 and was arrested in Atlanta, Georgia, upon arrival. On November 2011, Haile pleaded guilty and, as part of the plea agreement, deposited \$30,000 with the court as a payment on his child support arrearage.
- **California – John Clay, Jr.**, was sentenced to 3 years of probation and ordered to pay restitution in the amount of \$80,595 for failure to pay child support. Clay was in the military and has held many private sector jobs. In addition, he has moved several times, living in Washington; Georgia; Ohio; Kentucky; and most recently, Texas. Clay has made sporadic voluntary and involuntary payments. On January 11, 2011, Clay pleaded guilty and was sentenced on October 26, 2011.
- **New Jersey – Richard Davis** was sentenced to 1 year of supervisory release with 5 months of home confinement and ordered to pay \$56,914 in restitution for failure to pay child support. Investigators determined that Davis, who was living and working in Florida, failed to pay child support to his child's custodian, who was living in New Jersey. On

January 10, 2012, Davis was sentenced in the District of New Jersey to time served (he had been held in custody for 3 months prior to being released on bond.)

- **South Dakota – Michael C. Hutchinson** was sentenced to 5 years of probation and ordered to pay restitution in the amount of \$49,905 for failure to pay child support. Hutchinson was indicted for failing to pay past child support to two separate custodial parents. Records indicate that Hutchinson, who was residing in New York, was aware of his legal child support obligations and had the ability to pay them.
- **South Dakota – Karla R. Atkins** was sentenced to 5 years of probation and ordered to pay \$34,368 in restitution for failure to pay child support. In March 1997, Atkins was ordered to pay \$216 per month in child support and failed to comply with the order. Atkins was subsequently arrested at a border crossing in San Diego, California, by Immigration and Customs Enforcement agents because of her outstanding warrant for failure to pay child support.

Highlights of recent enforcement actions to which OIG has contributed are posted on OIG's Web site at:

<http://www.oig.hhs.gov/fraud/enforcement/criminal/>.

Engaging the Public in Capturing Fugitive Deadbeat Parents

OIG launched its new Child Support Enforcement Web Page during this reporting period to enlist the public's help in bringing some of OIG's most wanted child support fugitives to justice. The new site includes photographs and other helpful information on these deadbeat parents and allows for individuals to report helpful tips and information to OIG online.

The site also includes an online fugitive tip form and OIG's hotline number (1-888-476-4453) to report fugitive-related information in either English or Spanish, 24 hours a day, 365 days a year. The Web page is at:

<http://oig.hhs.gov/fraud/child-support-enforcement/>

Other HHS-Related Reviews

Departmental Financial Statement Audit

The Chief Financial Officers Act of 1990 (CFO Act), as amended, requires OIG or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards. Independent external auditors provided an unqualified opinion on the FY 2011 HHS financial statements. This means that for the 13th consecutive year, the statements were reliable and were fairly presented. However, the report on internal controls noted one significant deficiency related to financial reporting systems, analyses, and oversight and one material weakness related to financial information systems, and the report on compliance with laws and other matters noted noncompliance with Federal Financial Management Improvement Act of 1996 (FFMIA).

Financial Reporting Systems, Analyses, and Oversight

FFMIA requires Federal agencies to have integrated financial management systems that provide effective and efficient interrelationships involving software, hardware, personnel, procedures, controls, and data in the systems and that are in compliance with the United States Standard General Ledger at the transaction level and applicable Federal accounting standards. HHS's lack of an integrated financial management system continues to impair its ability to support and analyze account balances reported.

Because of continued weaknesses in the financial management systems, management must compensate for the weaknesses by implementing and strengthening additional controls to ensure that errors and irregularities are detected in a timely manner.

The review of internal controls disclosed a series of weaknesses that affect HHS's ability to report accurate financial information on a timely basis. Internal control weaknesses still existed in financial systems and the overall processes for producing financial statements. For example, HHS did not perform sufficient analysis of certain accounts; as a result, HHS's ability to report timely financial information was affected.

In FY 2011, HHS made many improvements in its ability to report accurate and timely financial information. The major improvement was the full implementation of the new Consolidated Financial Reporting System

(CFRS). For the first time, HHS could automatically and consistently consolidate financial information from its three financial systems, the Unified Financial Management System (UFMS), the National Institutes for Health Business System, and the Healthcare Integrated General Ledger Accounting System. Other improvements include more detailed analysis of financial data at the HHS level and more timely closeout of older obligations.

Financial Information Systems

Issues in the design and the operation of key controls in both general and application controls were noted. In particular, weaknesses were identified in information security program and application configuration management. For example, external and internal system vulnerabilities, such as weak password configurations, insecure system configuration, and unnecessary system services, continue to exist and pose a significant risk. Change-management procedures were insufficient to ensure that only properly authorized changes were implemented in production systems. In addition, deficiencies warranting attention were identified in audit log monitoring and contingency management.

HHS expects to have the issues identified for Financial Management Information Systems corrected by September 30, 2012. HHS is currently updating its agency wide corrective action plan to address noncompliance with FFMIA.

See Department of Health & Human Services Fiscal Year 2011 Agency Financial Report, section II. Daniel R. Levinson, Inspector General, Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2011. A-17-11-00001. November 2011. (pp. II-5, II-10, II-16, II-24-25, II-42).

Non-Federal Audits

In this semiannual period, OIG's National External Audit Review Center reviewed 1,952 reports covering \$584.8 billion in audited costs. Federal dollars covered by these audits totaled \$140.6 billion, about \$50 billion of which was HHS money.

Office of Management and Budget (OMB) Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities must conduct annual organizationwide "single audits" of all

Federal money they receive. These audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entities' management of Federal funds. OIG's oversight of non-Federal audit activity informs Federal managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs for resolution or followup.

We identify entities for high-risk monitoring, alert program officials to any trends that could indicate problems in HHS programs, and profile non-Federal audit findings of a particular program or activity over time to identify systemic problems. We also provide training and technical assistance to grantees and members of the auditing profession. OIG maintains a process to assess the quality of the non-Federal reports received and the audit work that supports the selected reports. The non-Federal audit reports reviewed and issued during this reporting period are categorized in the following table.

Table – Non-Federal Audits, October 1, 2011, Through March 31, 2012

OIG reports issued:	
Not requiring changes or with minor changes	1,788
Requiring major changes	156
Having significant technical inadequacies	8
Total	1,952

The 1,952 reports included 4,434 recommendations for improving management operations. In addition, these audit reports provided information for 28 special memorandums that identified concerns for increased monitoring by management.

Affordable Care Act

CLASS—Community Living Assistance Services and Supports Program

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) requires OIG to submit an annual report to the Secretary and Congress on the overall progress of the Community Living Assistance Services and Supports (CLASS) program and the existence of waste, fraud, and abuse in

the program. HHS has suspended program implementation activities. On October 14, 2011, the Secretary informed Congress that HHS had not identified a benefit plan for the CLASS program for long-term insurance that is both actuarially sound for the next 75 years and consistent with the requirements of Title VIII of the Affordable Care Act. Because the Secretary suspended the program, we have no recommendations. *Community Living Assistance Services and Supports Program: 2011 Report to Congress*. OEI-04-11-00450. December 2011. [Web Summary](#). [Full Text](#).

National and State Background Checks for Long-Term-Care Employees

Employee Background Checks – The Affordable Care Act mandates that OIG submit a report to Congress evaluating the Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long Term-Care Facilities and Providers not later than 180 days after the program's completion. We plan to use the baseline information from this survey in the mandated report to assess the effects of background checks on the availability of long- term-care (LTC) workers.

Our survey of LTC provider administrators revealed that nearly all administrators conduct background checks on prospective employees and that current background check procedures do not appear to greatly reduce the available workforce. Only 4 percent of the administrators encountered individuals who were unwilling to undergo a background check. Twenty-three percent of administrators believed that their organizations' current background check procedures reduced the number of applicants in the pool of prospective employees.

Overall, 81 percent of administrators believed that there is a sufficient number of persons in the pool of qualified applicants for job vacancies. However, survey results indicate that 9 percent of administrators did not receive applications from qualified individuals for at least some job vacancies. *Nationwide Program for National and State Background Checks for Long-Term-Care Employees—Results of Long-Term-Care Provider Administrator Survey*. OEI-07-10-00421. January 2012. [Web Summary](#). [Full Text](#).

Recovery Act Retaliation Complaint Investigations

Section 1553 of the Recovery Act prohibits non-Federal employers that have received funding from the Recovery Act from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds. Section 1553 also requires OIGs to include in their semiannual reports to Congress the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. OIG did not discontinue or decline to conduct any Recovery Act whistleblower retaliation complaint investigations during this reporting period.

Improper Payments in HHS Programs

Noncompliance With Improper Payment Reporting Requirements

Improper Payments – HHS did not meet one or more requirements in the Medicare Advantage (MA), Children’s Health Insurance (CHIP), Temporary Assistance for Needy Families (TANF), and Child Care Development Fund programs. In addition, the accuracy and completeness of the financial reporting could be improved.

Of nine HHS programs that were deemed by OMB to be susceptible to significant improper payments, four did not meet one or more statutory requirements pertaining to improper payments in FY 2011. To improve accountability of Federal agencies’ administration of funds, Federal OIGs, including the HHS OIG, are required to review and report on agencies’ annual financial reports and accompanying material to determine compliance with the Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

(Recommendations—HHS should address payment errors, develop improper payment estimates, produce error rates, and develop adjustments as outlined in our report.) *U.S. Department of Health and Human Services Did Not Fully Comply With Federal Requirements for Reporting Improper Payments*. A-17-12-52000. March 2012. [Web Summary](#). [Full Text](#).

Grant Fraud

HHS is the largest grant-making organization in the Federal Government, and its funding of health and human services programs touches the lives of almost all Americans. Increased concerns by Congress and the Administration regarding transparency of and accountability for agency expenditures is creating heightened scrutiny over the administration of grant and contract dollars.

Florida – Jimmy D. Howard, Jr., executive director of **Dream Builders of Tallahassee, Inc.** (DBT), was sentenced to 51 months of incarceration and ordered to pay \$307,075 in restitution for one count of wire fraud related to an ACF grant. DBT is a nonprofit organization established to help individuals with low incomes save money by providing funds to match monies that the participants proved they had saved.

The company received a grant from ACF in 2004 for the purpose of matching the money saved by those enrolled in the program. The funds were to be used to help the enrollees purchase homes, continue their education, or grow small businesses. The grant also required DBT to have an equal amount of non-Federal funds to match the money saved by the individuals. Howard was unable to find matching non-Federal funds and, after approximately 2 years of failing to meet this requirement, began submitting false statements to HHS indicating that his company had the requisite amount of matching non-Federal funds. Howard also allegedly used a portion of the grant money for personal expenses.

Contract Audits

The National Defense Authorization Act for FY 2008, § 845, requires each Inspector General appointed under the Inspector General Act of 1978 to submit, as part of the semiannual report submitted to Congress pursuant to § 5 of such Act, information on final, completed contract audit reports issued to the contracting activity containing significant audit findings issued during the period covered by the semiannual report concerned.

We found time and amount issues in four NIH contracts that potentially violated the Antideficiency Act and/or the bona fide needs rule. The Antideficiency Act prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by

law. Details of the audits begin on page IV-3 of this document (NIH's Compliance With Appropriation Laws).

- *Appropriations Funding for National Institute on Drug Abuse Contract HHSN271-2007-00009C With Charles River Laboratories, Inc.* A-03-10-03104. October 2011. [Web Summary](#). [Full Text](#).
- *Appropriations Funding for National Institute of Allergy and Infectious Diseases Contract HHSN272-2008-00013C With The EMMES Corporation.* A-03-10-03115. October 2011. [Web Summary](#). [Full Text](#).
- *Appropriations Funding for National Institute of Diabetes and Digestive and Kidney Diseases Contract HHSN267-2007-00014C With the University of South Florida.* A-03-10-03110. October 2011. [Web Summary](#). [Full Text](#).
- *Appropriations Funding for Eunice Kennedy Shriver National Institute of Child Health and Human Development Contract HHSN275-03-3345 With Westat, Inc.* A-03-10-03106. October 2011. [Web Summary](#). [Full Text](#).

Employee Misconduct

Washington, DC – Cheng Yi Liang, a former chemist for the FDA Office of New Drug Quality Assessment, was sentenced to 5 years of incarceration for securities fraud and making false statements. Between approximately July 2006 and March 2011, Liang engaged in insider trading with information he had obtained about new drugs while working as an FDA scientist, including experimental drug information submitted to FDA by pharmaceutical companies for review.

According to the investigation, Liang wrongfully used FDA's internal tracking system to access material, nonpublic information relating to the progression of experimental drugs through FDA's drug approval process. He then used this information to trade pharmaceutical company securities in the stock market using the accounts of acquaintances and relatives, including his son.

In addition to receiving a prison sentence, Liang was ordered to forfeit \$3.77 million in proceeds from the scheme. This investigation was a joint effort with the Government-wide Financial Fraud Enforcement Task Force, which coordinates proactive efforts to investigate and prosecute financial crimes.

Legislative and Regulatory Reviews

The Inspector General Act requires us to review existing and proposed legislation and regulations relating to HHS's programs and operations and make recommendations concerning their impact on economy and efficiency or the prevention and detection of fraud and abuse. Most audits and other reviews that we conduct are designed to test compliance with and/or assess the administration and oversight of existing laws and regulations. Our reports of such reviews describe findings, which include questioned costs, inefficiencies, vulnerabilities to fraud, inconsistencies, errors in application, or weaknesses in oversight or supporting systems. Our corresponding recommendations tell HHS and its pertinent operating or staff divisions what administrative, regulatory, or legislative actions we believe are needed to effectively respond to the findings.

Our regularly published core publications reflect the relationship between our work and laws and regulations.

- Our [Semiannual Report to Congress](#) describes findings and recommendations from recently completed reviews, many of which focus on existing laws and regulations.
- Our [Compendium of Unimplemented Recommendations](#), which is published annually, describes priority findings and recommendations from past periods that remain to be implemented, along with pertinent citations of existing laws and regulations.
- Our annual [Work Plan](#), which is published at the start of each fiscal year, provides citations to laws and regulations that are the subject of ongoing or future reviews.

We also review proposed legislation and regulations related to HHS programs and operations. HHS routinely involves us and its other operating and staff divisions in the review and development of HHS regulations through a well-established HHS process. Our audits, evaluations, and investigations are sometimes cited in regulatory preambles as influencing HHS regulations. In addition, we provide independent, objective technical assistance on a bipartisan, bicameral basis to congressional committees and members who request it.

List of Appendixes

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Appendix A 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	<i>OIG Compendium of Unimplemented Recommendations</i>
(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

Section	Requirement	Location
(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 disagrees	None
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	Reported annually in the spring <i>Semiannual Report to Congress</i> , Part IV, Other HHS-Related Issues.
(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 fiscal year 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 <i>Federal Register</i> 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.	Reported annually in the fall Semiannual Report

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 and Human Services (HHS) responses to them. This information is provided in accordance with the Inspector General Act, §§ 5(a)(8) and (a)(9), (5 U.S.C. App. §§ 5(a)(8), (a)(9)) and the Supplemental Appropriations and Rescissions Act of 1980.

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.

In addition to issuing the audit reports noted in Table 1 below, OIG issued an evaluation report during the reporting period with \$6,600,000 in questioned costs. (Questionable Billing Patterns of Portable X-Ray Suppliers. OEI-12-10-00190. December 2011.)

Table 1 follows.

Table 1 – Audit Reports With Questioned Costs

	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	189	\$732,134,000	\$82,199,000
Reports issued during the reporting period	110	\$456,019,000	\$2,372,000
Total Section 1	299	\$1,188,153,000	\$84,571,000
Section 2			
Reports for which a management decision was made during the reporting period ^{2,3}			
Disallowed costs	172	\$483,145,000*	\$32,973,000
Costs not disallowed	2	\$211,000	\$0
Total Section 2	174	\$483,356,000	\$32,973,000
Section 3			
Reports for which no management decision had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	125	\$704,797,000	\$51,598,000
Section 4			
Reports for which no management decision was made within 6 months of issuance ⁴	53	\$385,319,000	\$49,270,000

* Audit receivables (expected recoveries).

Audit Reports With Funds Recommended To Be Put to Better Use

Recommendations that funds be put to better use mean 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 annually in the fall *Semiannual Report*.

Table 2 – Audit Reports With Funds To Be Put to Better Use

	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	\$3,553,001,000
Reports issued during the reporting period	7	\$225,144,000
Total Section 1	28	\$3,778,145,000
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	8	\$2,756,006,000
Based on proposed legislative action		\$0
Value of recommendations not agreed to by management	3	\$278,515,000
Total Section 2	11	\$3,034,521,000
Section 3		
Reports for which no management decision had been made by the end of the reporting period ⁴ (Sec. 1 minus Sec. 2)	17	\$743,624,000

End Notes

Table 1 End Notes

¹ The opening balance was adjusted upward by \$34.4 million because of a reevaluation of previously issued recommendations.

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

- A-01-09-91072, *State of New Hampshire*. The Centers for Medicare & Medicaid Services (CMS) reversed its decision to disallow costs associated with this non-Federal audit because it determined that it had already disallowed \$35,325,468 in Medicaid disproportionate share hospital (DSH) payments that did not comply with the hospital-specific DSH limits imposed by Federal regulations and the State plan in its

resolution of A-01-05-00001, *Review of New Hampshire's Medicaid Disproportionate Share Hospital Payments During Federal Fiscal Year 2004*.

- A-07-01-02093, *Review of Disproportionate Share Hospital Costs Claimed by the State of Missouri for Fiscal Year Ended June 30, 1999*. The Departmental Appeals Board reduced CMS's disallowance of \$36,200,000 to \$21,361,339.
- A-01-04-00513, *Medicare Part B Payments for Ambulance Services Rendered to Beneficiaries During Inpatient Stays: 2001 Through 2003*; A-01-07-00522, *Review of Separately Billed Laboratory Tests Paid by National Government Services, Inc., for Medicare Beneficiaries with End-Stage Renal Disease*; and A-02-07-01044, *Review of High-Dollar Payments for Medicare Part B Claims Processed by National Government Services for New Jersey Providers for the Period January 1, 2003, Through December 31, 2005*. CMS determined that it could not recoup its original disallowances totaling \$20,345,830 associated with these audits because Federal regulations at 42 CFR 405.980(b) prevented it from reopening claims beyond 4 years after its initial determination.
- A-01-05-00004, *Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003*. CMS reached an agreement with the State to settle targeted case management disallowances. As a result of this settlement, CMS agreed not to pursue recovery of \$8,327,896 in costs that it had originally disallowed.
- A-05-07-00019, *Review of Medicaid Outpatient Drug Expenditures in Illinois for the Period October 1, 2003, Through September 30, 2005*. After reviewing additional information from the State that showed that some expenditure were eligible for Medicaid coverage, CMS reduced its original disallowance by \$3,227,955.
- A-05-10-12004, *Michigan Department of Human Services*. After reviewing additional information provided by the State, the Administration for Children and Families (ACF) reversed its February 2011 decision to disallow \$4,446,704 in costs charged to the Social Services Block Grant.

Not detailed are net reductions to previously reported disallowances totaling \$2,076,828.

³ Included are management decisions to disallow \$9.95 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 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 53 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	PA FOSTER CARE MAINTENANCE PAYMENTS – PHILADELPHIA – UNDER \$300/DAY, 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-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL-BASED HEALTH SERVICES - CT, 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-04-09-03524	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN GEORGIA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2011, \$22,212,932
CIN: A-01-10-00513	NATIONWIDE REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED

	BY PART B CONTRACTORS FOR CY 2008, SEP 2011, \$19,270,689
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 PA FOSTER CARE MAINTENANCE PAYMENTS – CASTILLE SAMPLE, SEP 2007, \$11,611,822
CIN: A-01-10-00516	NATIONWIDE REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY PART B CONTRACTORS FOR CY 2009, SEP 2011, \$9,501,422
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 TN 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 FRESENIUS MEDICAL CARE NORTH AMERICA'S FACILITIES, MAR 2010, \$5,410,712
CIN: A-07-11-00347	REVIEW OF PENSION SEGMENTATION AT A TERMINATED CONTRACTOR, MUTUAL OF OMAHA, APR 2011, \$4,564,338
CIN: A-04-08-03523	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN FL FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2009, \$4,413,264
CIN: A-01-11-02500	REVIEW OF MASSACHUSETTS' TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, AUG 2011, \$4,242,540
CIN: A-07-11-00359	REVIEW OF POST RETIREMENT HEALTH BENEFITS AT BLUE CROSS BLUE SHIELD OF MISSISSIPPI, MAY 2011, \$4,198,848

CIN: A-10-96-00001	REVIEW OF GROUP HEALTH COOPERATIVE OF PUGET SOUND REPORTING OF ESRD, APR 1997, \$2,763,498
CIN: A-07-10-02752	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN TENNESSEE FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, APR 2011, \$2,078,774
CIN: A-03-10-00011	REVIEW OF CAPITAL BLUE CROSS 2008 DIR, OCT 2010, \$1,818,249
CIN: A-07-09-03121	MO TITLE IV-E TRAINING COSTS FOR RESIDENTIAL TREATMENT CENTERS AND FOSTER CARE PARENTING, SEP 2009, \$569,663
CIN: A-09-10-02017	REVIEW OF OREGON'S MEDICAID MANAGEMENT INFORMATION SYSTEM EXPENDITURES CLAIMED FOR THE 24-MONTH PERIOD ENDED SEPTEMBER 30, 2009, AUG 2011, \$565,727
CIN: A-05-09-00047	HEAD START MATCHING COSTS – COMMUNITY ACTION COMMITTEE OF LANCASTER FAIRFIELD COUNTY, JAN 2010, \$547,019
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-07-05-01013	PAYMENTS FOR M+C ORGANIZATION FOR INSTITUTIONAL BENEFICIARIES, OCT 2005, \$293,885
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW AT CTE, INC., MAY 2011, \$293,870
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MI, 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 THRU 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-05-97-00017	FHP, INC. - HMO INSTITUTIONAL STATUS PROJECT, JUN 1998, \$109,114
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, \$100,692
CIN: A-01-10-02503	RESULTS OF LIMITED SCOPE REVIEW AT THE COMMUNITY ACTION COMMITTEE OF DANBURY, INC., APR 2011, \$98,806
CIN: A-05-01-00090	PAYMENTS TO AETNA U.S. HEALTHCARE PA 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	REVIEW OF QUALITY IMPROVEMENT ORGANIZATION IN NEW YORK STATE, MAR 2008, \$77,358
CIN: A-09-06-00039	MEDICARE INTEGRITY – AUDIT OF QUALITY IMPROVEMENT ORGANIZATION – WASHINGTON STATE, FEB 2008, \$73,636
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA 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-07-04-01011	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
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TOTAL NUMBER OF REPORTS: 53
TOTAL AMOUNT: \$385,319,455

Table 2 End Notes

¹ The opening balance was adjusted downward by \$400.9 million resulting primarily from a series of contract reviews to determine whether an HHS agency was in compliance with the purpose, time, and amount requirements specified in appropriations statutes.

² Because of administrative delays, some of which were beyond management control, resolution of the following eight 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-02-07-02000	OPEN AND INACTIVE GRANTS ON THE PAYMENT MANAGEMENT SYSTEM – ACF, FEB 2009, \$472,155,156
CIN: A-03-10-03117	CONTRACT NO 1 –A-3-0052, SEP 2011, \$31,300,000
CIN: A-07-10-02752	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN TENNESSEE FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, APR 2011, \$7,502,017
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MI, AUG 2006, \$4,397,133
CIN: A-04-09-03524	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN GEORGIA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2011, \$2,842,653
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, JULY 2009, \$17,764

TOTAL NUMBER OF REPORTS: 8

TOTAL AMOUNT: \$518,341,652

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, two peer reviews involving the Office of Audit Services (OAS) were started and were still in progress as of March 31, 2012. The table below lists the reviews in progress and describes OAS's peer review activities during prior reporting periods.

Table 1 – Office of Audit Services

Date	Reviewing Office	Office Reviewed
2012 In Progress	HHS-OIG	Environmental Protection Agency (EPA) OIG

OAS is reviewing the Environmental Protection Agency for the 3 years ending Sept. 30, 2011. The review was in progress at March, 31, 2012.

Date	Reviewing Office	Office Reviewed
2012 In Progress	Department of Homeland Security (DHS) OIG	HHS-OIG

OAS is being reviewed by the Department of Homeland Security for the 3 years ending Sept. 30, 2011. The review was in progress at March 31, 2012.

Table 1 – Office of Audit Services (continued)

Date	Reviewing Office	Office Reviewed
2009 December	HHS-OIG, OAS	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. DoD-OIG indicated that it has completed the corrective actions to improve its quality control system that were underway during December 2009.

Date	Reviewing Office	Office Reviewed
2009 June	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.

Office of Investigations Peer Review Results

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

Table 2 – Office of Investigations

Date	Reviewing Office	Office Reviewed
2011 July	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.

Date	Reviewing Office	Office Reviewed
2011 January	HHS-OIG, OI	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.

Date	Reviewing Office	Office Reviewed
2010 January	HHS-OIG, OI	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.

Table 2 – Office of Investigations (continued)

Date	Reviewing Office	Office Reviewed
2009 March	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.

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 and Human Services (HHS) Departmental Appeals Board and Federal district and appellate courts regarding the basis for the exclusion and the length of the exclusion.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) of the Social Security Act, 1128A (42 U.S.C. § 1320a-7a), imposes 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.

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.

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

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

ACF	Administration for Children and Families
AHRQ	Administration for Healthcare Research and Quality
AIDS	acquired immunodeficiency syndrome
AMP	average manufacturer price
ASP	average sales price
CBSA	Core Based Statistical Area
CDC	Centers for Disease Control and Prevention
CDT	continuing day treatment
CERT	Comprehensive Error Rate Testing (program)
CFRS	Consolidated Financial Reporting System
CHIP	Children’s Health Insurance Program
CIA	corporate integrity agreement
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CLASS	Community Living Assistance Services and Supports Program
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CoP	conditions of participation
CORF	Comprehensive Outpatient Rehabilitation Facility
CTSA	Clinical and Translational Science Awards (program)
CWF	Common Working File
CY	calendar year
DME	durable medical equipment
DoD	Department of Defense
DOJ	Department of Justice
DSH	disproportionate share hospital
ESRD	end stage renal disease
FACP	final administrative cost proposal
FDA	Food and Drug Administration
FFP	Federal financial participation

Form CMS-64	Medicaid Statement of Expenditures for the Medical Assistance Program
FTE	full-time equivalent
FY	fiscal year
GME	graduate medical education
HEAL	Health Education Assistance Loan
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHA	home health agency
HHS	Department of Health & Human Services
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IDTF	independent diagnostic testing facility
IRIS	Intern and Resident Information System
IRS	Internal Revenue Service
LTC	long-term care
MA	Medicare Advantage (Part C)
MAC	Medicare administrative contractor
MED	Medicare Exclusion Database
MCE	managed care entity
MCO	Managed Care Organization
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
NEMT	nonemergency medical transportation
NIH	National Institutes of Health
NPRM	notice of proposed rulemaking
NSC	National Supplier Clearinghouse
OAI	official action indicated
OASIS	Outcome and Assessment Information Set
OCSE	Office of Child Support Enforcement
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
PCS	personal care services
PDE	prescription drug event
PDP	prescription drug plan
PIHP	prepaid inpatient hospital plan
P.L.	Public Law

PPI	Producer Price Index
RAC	Recovery Audit Contractor
RMTS	random moment time study
RN	radiological and nuclear
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families
U.S.C.	United States Code
WAMP	widely available market price
ZPIC	Zone Program Integrity Contractor

Public Laws

ACA	See Affordable Care Act
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
CFO Act	Chief Financial Officer Act of 1990, P.L. No. 101-576
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 (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.
IPERA	Improper Payments Elimination Act of 2010, P.L. 111-204
IPIA	Improper Payments Information Act of 2002, P.L. 107-300
MIPPA	Medicare Improvements for Patients and Providers Act, P.L. No. 110-275
MMA	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