

U.S. Department of Health and Human Services
Office of Inspector General

Semiannual Report_{to} Congress

October 1, 2013 – March 31, 2014



OIG

OIG Organization

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) employs about 1,500 professional staff members who are deployed throughout the Nation in regional and field offices and in Washington, DC, headquarters. We collaborate with HHS and its operating and staff divisions, the Department of Justice (DOJ) and other executive branch agencies, Congress, and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds. Following are descriptions of our mission-based components. The components are supported by the Immediate Office of the Inspector General and the Office of Management and Policy.

OAS

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

OEI

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.

OI

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State and the District of Columbia, OI actively coordinates with DOJ and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, or CMPs.

OCIG

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the antikickback statute and other OIG enforcement authorities.

A Message From the Inspector General



Daniel R. Levinson
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), Department of Health and Human Services (HHS), for the 6-month period that ended March 31, 2014.

During this reporting period, OIG ramped up its oversight of the Department's efforts to implement the Affordable Care Act, including the Health Insurance Marketplaces. OIG has a substantial body of work underway focusing on core risk areas associated with the Marketplaces, such as eligibility systems, payment accuracy, contractor oversight, and data security. We have completed significant aspects of data collection for some audits and evaluations, and resulting reports will offer recommendations to address vulnerabilities and better ensure Marketplaces operate efficiently and effectively. During this reporting period, which covered the Marketplace open enrollment period, OIG coordinated closely with Federal and State law enforcement partners to monitor the Marketplaces for fraud against consumers.

OIG's commitment to ensuring the appropriate use of prescription drugs by Medicare and Medicaid beneficiaries continues. The misuse of prescription drugs has significant financial, safety, and quality of care consequences for the programs and patients. OIG's investigative results during this reporting period included the sentencing of a radiologic technician and drug addict who stole painkillers prepared for patients awaiting cardiac catheterizations. Court documents showed that the technician, who was infected by the potentially fatal virus hepatitis C, took syringes prefilled with the painkiller, injected himself, then refilled the syringes with saline, which was then administered unknowingly by nurses to patients using the tainted syringes. At least 45 patients were infected with the virus. Work highlighted in this report includes other significant cases of drug overutilization, fraud, and abuse that resulted in criminal or civil prosecutions in State and Federal courts and Federal health care program exclusions of individuals and entities; such cases play a vital role in protecting HHS programs and beneficiaries.

Our reports continue to identify vulnerabilities in, and recommendations for improving, the Centers for Medicare & Medicaid Services' (CMS) oversight of the contractors that administer more than a half trillion dollars in benefits each year. Reports generated during this reporting cycle identified Medicare Administrative Contractor performance shortcomings and highlighted issues that limit CMS's ability to effectively oversee Part C and Part D contractors. Many CMS contractors rely on medical records to conduct work aimed at ensuring program integrity, yet a new OIG report raises concerns about contractors' ability to identify improper payments and fraud using electronic medical records. Our reports offer recommendations to improve contractor performance and CMS oversight.

Grants oversight and management is a significant challenge facing the Department. For example, since 2012 we have performed a series of reviews of States' efforts to administer and implement the Child Care and Development Block Grant, which provides financial assistance for child care for approximately 1.6 million children each month. New OIG work highlighted in this semiannual report focuses on challenges related to monitoring the health and safety of children served by these block grants to ensure that grant funds are used effectively to improve the availability, quality, and affordability of child care.

Since its 1976 establishment, OIG has worked diligently with its partners to fight waste, fraud, and abuse in Medicare and more than 300 other HHS programs. Moreover, our partnership with other Federal, State, and local law enforcement entities as part of the Health Care Fraud Prevention and Action Team (HEAT) continues to produce strong results. I would once again like to express my appreciation to Congress and to the Department for their sustained commitment toward improving the efficiency and effectiveness of HHS programs.

Daniel R. Levinson
Inspector General

Highlights

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Semiannual Report to Congress* (Semiannual Report) describes 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) 2014 (October – March) and summarizes key accomplishments during the period.

Accomplishments

In the first half of FY 2014, OIG reported expected recoveries of more than \$3.1 billion consisting of nearly \$295 million in audit receivables and about \$2.83 billion in investigative receivables, which include about \$813.7 million in non-HHS investigative receivables resulting from our work in areas such as the States' shares of Medicaid restitution.

OIG reported 465 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 266 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. We also reported exclusions of 1,720 individuals and entities from participation in Federal health care programs;

Medicare Fraud Strike Force accomplishments

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and the Department of Justice (DOJ) to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse. HEAT has continued with increasing momentum to identify and hold accountable those who seek to defraud Medicare and Medicaid.

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. The 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. During this semiannual period, Strike Force efforts resulted in the filing of charges against 94 individuals or entities, 107 criminal actions, and \$294.1 million in investigative receivables. 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 suspected perpetrators, thereby immediately preventing losses from claims submitted by Strike Force targets.

Strike Force case example—Unnecessary services, therapy, and tests

New York – Irina Shelikhova managed the daily operations of three medical clinics. According to the indictment, the clinics submitted over \$71 million in false claims to Medicare, for which Medicare reimbursed approximately \$47 million. Shelikhova and her co-conspirators paid cash kickbacks to Medicare beneficiaries in return for receiving unnecessary physicians' services, physical therapy, and

diagnostic tests at the clinics. Shelikhova hired a medically unlicensed co-defendant to impersonate a physician and render phony medical care to such patients and she directed employees to create fake medical notes and to forge physicians' names on prescriptions and charts. Shelikhova, who was listed on HHS OIG's Most Wanted Fugitives web site until her capture in 2012, was sentenced to 15 years in prison and ordered to pay \$50.9 million in restitution, joint and several, for her involvement in the scheme. Shelikhova will face deportation from the United States at the conclusion of her prison term. A co-conspirator was sentenced to 2-and-a-half years in prison and was ordered to pay \$9.1 million in restitution, joint and several. Other co-conspirators were previously sentenced to a combined 22 years and 7 months in prison and ordered to pay more than \$60 million in restitution, joint and several.

Prescription drug issues

Medicare and Medicaid are major payers for prescription drugs. Our investigations and reviews find vulnerabilities at many levels, including pharmaceutical manufacturer noncompliance, retail pharmacy and prescriber schemes, and flawed reimbursement methodologies.

Allegations of promoting the sale of drugs for unapproved uses

Pennsylvania – In one of the largest health care fraud settlements in U.S. history, Johnson & Johnson (J&J) and its subsidiaries agreed to pay more than \$2.2 billion to resolve criminal and civil allegations relating to the prescription drugs Risperdal, Invega, and Natrecor. The allegations included promoting the drugs for uses not approved as safe and effective by the FDA and paying kickbacks to physicians and to the nation's largest long-term care pharmacy provider, Omnicare, Inc. According to court documents, sales representatives allegedly urged physicians and other prescribers who treated elderly dementia patients to prescribe the drug Risperdal to treat symptoms of anxiety, agitation, depression, hostility, and confusion. Written sales aids emphasized symptoms and minimized any mention of the FDA-approved use, which was for the treatment of schizophrenia. The company also provided incentives for off-label promotion and intended use by basing sales representatives' bonuses on total sales in their respective sales areas of Risperdal, not just the sales for FDA-approved uses. J&J entered into a corporate integrity agreement (CIA) with OIG that includes provisions designed to promote accountability and transparency.

Multi-million dollar conspiracy—illegal prescriptions and drug trafficking

Pennsylvania – During this semiannual period, 51 defendants were sentenced for their participation in a multi-million-dollar drug conspiracy involving illegal prescriptions, pseudo-patients, and multiple drug trafficking organizations. According to court records, pseudo patients were transported by the vanload to a medical practice to obtain prescriptions for oxycodone-based products. The pseudo patients paid cash for the office visits; used their Medicare, Medicaid, or private insurance cards and cash to pay for the filled prescriptions at various pharmacies; and, in exchange for payments, provided the filled prescriptions to members of six separate drug trafficking organizations to be resold on the street. Thus far, a total of 61 defendants have been sentenced to a combined 253 years in prison.

Pill mill operation—Physician Kermit Gosnell

Pennsylvania – According to the indictment, Physician Kermit Gosnell and his co-conspirators allegedly ran a "pill mill" out of Women's Medical Society. His customers, often referred to as drug "seekers,"

purchased prescriptions for controlled prescription drugs without any legitimate medical purpose. Investigators believe that Gosnell used his practice to distribute over 500,000 pills containing oxycodone, 400,000 pills containing alprazolam, and over 19,000 ounces of cough syrup containing codeine. Many of the illegal prescriptions were paid for by Pennsylvania Medicaid, Medicare Part D, and other insurers. Gosnell was sentenced to 30 years in prison and ordered to forfeit approximately \$200,000 and pay a \$50,000 fine.

Injections tainted with Hepatitis C virus

New Hampshire – David Kwiatkowski was a radiologic technician who was employed at 15 health care facilities in eight states. According to court documents, while employed at Hays Medical Center in Kansas in June 2010, Kwiatkowski became aware that he was infected with Hepatitis C. Notwithstanding that knowledge, Kwiatkowski injected himself with syringes of the anesthetic fentanyl, which were intended for patients who were undergoing medical procedures. He added saline to the same syringes, which were then administered unknowingly by nurses to the patients. Consequently, instead of receiving the prescribed dose of fentanyl, the patients received saline that was tainted with the Hepatitis C virus. Kwiatkowski repeated this pattern of behavior at other hospitals where he worked, which led to at least 45 patients' becoming infected with Hepatitis C. Some of these patients experienced very serious health complications, including one death in which Hepatitis C was a contributing factor. Kwiatkowski was sentenced to 39 years in prison and ordered to pay \$22,680 in restitution after pleading guilty to charges of tampering with a consumer product and fraudulently obtaining controlled substances.

Physician administered drugs—Herceptin

We reported that 77 percent of payments that Medicare contractors made to providers for full vials of Herceptin were incorrect and included overpayments of about \$24.2 million, or more than one-third of total dollars reviewed. Herceptin (trastuzumab) is a Medicare-covered drug used to treat breast cancer that has spread to other parts of the body. Herceptin is one of many drugs packaged in multiuse vials. Therefore, the problem of provider billing for full vials may exist with other such drugs. On nearly all of the incorrect line items, the providers reported the units of service for the entire content of 1 or more vial(s), each containing 440 milligrams of Herceptin, rather than reporting the units of service for the amount actually administered. [A-05-13-00024](#).

Oversight of contractors and information systems

CMS relies on contractors to administer the Medicare program and is responsible for overseeing the contractors' performance. Medicare contractors are responsible for administering more than a half trillion dollars in benefits each year. MACs process Parts A and B claims; Medicare Advantage (MA) plans provide managed care services under Part C; Part D plans provide prescription drug coverage under Part D; and various benefit integrity contractors serve to protect Medicare from fraud, waste, and abuse. CMS also oversees contractors' information systems to ensure they perform as intended.

Contractor performance and quality assurance

Given the billions of dollars awarded to MACs and the critical role they play in administering the Medicare program, effective oversight of MACs' performance is important to ensure that they are

adequately processing claims and performing other assigned tasks. We found that Medicare Administrative contractors (MACs) did not meet one-quarter of the quality assurance standards reviewed and MACs had not resolved issues with 27 percent of these unmet standards as of June 2012. MAC standards have stringent performance requirements; a number of standards require 100-percent performance compliance. CMS did not require action plans for 12 percent of unmet standards, and unmet standards without action plans were almost four times more likely to have issues that go unresolved. [OEI-03-11-00740](#).

CMS's use of data for oversight of Medicare Part C contractors.

We reported that CMS regularly reviews data that Medicare Advantage (MA) organizations submit pursuant to Part C reporting requirements, but its followup and uses of the data are limited. CMS has collected such data from MA organizations since 2009. The data are intended to serve as a resource for CMS to conduct oversight. [OEI-03-11-00720](#).

Part D sponsor reporting of fraud and abuse data

We reported that more than half of Part D sponsors did not voluntarily report data on potential fraud and abuse. CMS requires sponsors to conduct inquiries and implement corrective actions in response to incidents of potential fraud and abuse; however, 28 percent of Part D plan sponsors reported performing none of these actions between 2010 and 2012. Of those sponsors that did report data, more than one-third did not identify any incidents for at least one of their reporting years. Although CMS said that it conducted basic summary analyses of the sponsor-submitted data, it did not perform quality assurance checks on the data or use them to monitor or oversee the Part D program. [OEI-03-13-00030](#).

Electronic health records vulnerabilities and safeguards

Vulnerabilities. We reported that although electronic health records (EHR) technology may make it easier to commit fraud, CMS and its contractors have not adjusted their practices for identifying and investigating fraud in EHRs. Few contractors reviewed EHRs differently from paper medical records. Also, not all contractors reported being able to identify copied language or overdocumentation in medical records. Finally, CMS had provided limited guidance to Medicare contractors on EHR fraud vulnerabilities. [OEI-01-11-00571](#).

Safeguards. We determined the extent to which hospitals that received EHR Medicare incentive payments had implemented the recommended fraud safeguards. Findings included that only about one quarter of hospitals had policies on the use of the copy-paste feature in EHR technology, which, if used improperly, could pose a fraud vulnerability. [OEI-01-11-00570](#).

State Medicaid information systems vulnerabilities

We identified 79 findings in the 10 State Medicaid agencies whose information system general controls we audited between calendar years 2010 and 2012. Some primary objectives of general controls are to safeguard data, protect computer applications, prevent unauthorized access to system software, and ensure continued computer operations after unexpected interruptions. In some of the general control areas, we noted findings with similar vulnerabilities in different State agencies, which indicated that the vulnerabilities identified in these findings were systemic and pervasive. State officials pointed most frequently to resource constraints that made information system security a lower priority. Officials also

described a lack of formal policies and procedures when explaining the causes of the vulnerabilities. [A-07-14-00433](#).

Other Medicare and Medicaid reviews

Medicare Part A helps cover certain inpatient services, such as those provided in hospitals and skilled nursing facilities and some home health services. Part B helps cover certain other medical services, equipment, supplies, and drugs that Part A does not cover. Health care providers and suppliers bill Medicare for reimbursement. For the Medicaid program, States have considerable flexibility in designing and operating their programs; however, to receive a Federal share of Medicaid costs, applicable State and Federal requirements must be met. Health care providers and suppliers are paid by the States. The States then report the amounts to CMS to receive the Federal share.

Payments on behalf of unlawfully present, incarcerated, and deceased beneficiaries

Unlawfully present beneficiaries. We identified \$91.6 million in improper payments to unlawfully present beneficiaries in Part B during CYs 2009 through 2011. When CMS received untimely information indicating that unlawful presence overlapped with the dates of service on previously paid Medicare claims, CMS did not notify Medicare's contractors of this updated information, and the contractors did not detect and recoup improper payments. For the same period, we estimated \$29 million in gross drug costs associated with unlawfully present beneficiaries in Part D. [A-07-12-06038](#).

Incarcerated beneficiaries. We identified nearly \$33.6 million in uncollected improper payments on behalf of incarcerated beneficiaries in Part A and Part B during CYs 2009 through 2011. With certain exceptions, prisons (instead of Medicare) pay for the health care of incarcerated beneficiaries who are otherwise eligible for Medicare. CMS does not always receive timely updates regarding incarceration information before Medicare contractors pay providers on behalf of incarcerated beneficiaries. Similarly, we estimated that more than \$11.6 million in gross drug costs were associated with incarcerated beneficiaries in Part D for CYs 2006 through 2010. [A-07-12-06035](#).

Deceased beneficiaries. Prior OIG studies and audit reports have identified Medicare payments made on behalf of deceased beneficiaries. Although CMS has safeguards to prevent and recover Medicare payments made on behalf of deceased beneficiaries, it inappropriately paid \$23 million in 2011 for dates of service after beneficiaries' deaths. Part C accounted for 86 percent of the improper payments. Additionally, 11 percent of the improper payments resulted from the fact that dates of death were missing or incorrect. Further, we identified 251 providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths. [OEI-04-12-00130](#).

Hospitals—Inpatient payment policies: DRG Window

Expanding the window of time covered by Medicare's lump sum payments for inpatient care would result in cost savings. We reviewed outpatient services that the admitting hospitals provided during the 11 days prior to the existing window and found that in 2011, Medicare and its beneficiaries paid an estimated \$263 million for such services. OIG has previously recommended expanding the window, but CMS has not sought authority to do so. [OEI-05-12-00480](#).

Nursing homes—Harm to patients and questionable resident hospitalizations

Nursing home harm to patients. We reported that an estimated 22 percent of Medicare beneficiaries experienced adverse events during skilled nursing facility (SNF) stays. An additional 11 percent experienced temporary harm events during SNF stays. Physician reviewers determined that 59 percent of the adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of \$208 million in August 2011. This equates to \$2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011. Because many of the events that we identified were preventable, our study confirms the need and opportunity for SNFs to significantly reduce the incidence of resident harm events. [OEI-06-11-00370](#).

Nursing home resident hospitalization rates. We reported that in FY 2011, nursing homes transferred one-quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent \$14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions, with septicemia the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Hospitalizations are costly to Medicare, and research indicates that transfers between settings increase the risk of residents' experiencing harm and other negative care outcomes. High rates of hospitalizations by individual nursing homes could signal quality problems within those homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the CMS Five-Star Quality Rating System. [OEI-06-11-00040](#).

Medicaid residential habilitation services: New York

Payment rates for residential habilitation services provided at State-operated residences did not meet the Federal requirement that payment for services be consistent with efficiency and economy. For State fiscal year 2010, Federal Medicaid payments exceeded actual costs for providing these services by approximately \$320 million (57 percent more than actual costs). Further, the payment rate for supervised residential habilitation services at State-operated residences was more than double the average rate for privately operated residences that offered the same services. We also determined that if New York had used the prior year's actual costs in calculating payment rates for residential habilitation services, its State fiscal year 2011 reimbursement would have been approximately \$692 million (\$346 million Federal share) less than what it claimed. [A-02-13-01008](#).

Medicaid pediatric dental services: New York

We identified 23 general dentists and 6 orthodontists in New York with questionable billing. These providers are extreme outliers when compared to their peers. Medicaid paid the providers \$13.2 million for pediatric dental services in 2012. Our findings raise concerns that certain providers may be billing for services that are not medically necessary or were never provided. They also raise concerns about the quality of care provided to Medicaid children. Although some of the billing may be legitimate, providers who bill for extremely large amounts of services warrant further scrutiny. [OEI-02-12-00330](#).

Medicaid State stewardship—Excessive withdrawal of funds

The Maryland Medicaid program obtained Federal Medicaid funds for FYs 2009 through 2011 that were not supported by net expenditures. The State agency obtained \$12.9 billion in Federal Medicaid funds,

but CMS awarded the State agency only \$12.8 billion for Medicaid expenditures. Maryland inappropriately withdrew the difference of \$115.3 million. Also, Maryland did not always withdraw Federal funds from the appropriate Payment Management System (PMS) accounts because of fund deficiencies, a faulty procedure, and other errors. The withdrawals caused the balances in the accounts to be wrong. [A-06-12-00051](#).

Public health and human services reviews

Public health activities and programs represent the country's primary defense against acute and chronic diseases and disabilities and generally promote and enhance health. Other HHS-related reviews include human services programs and administrative functions.

World Trade Center program— Contractor compliance

Centers for Disease Control and Prevention (CDC). The World Trade Center Health Program (WTCHP) was established in January 2011. Under the WTCHP, CDC contracted with clinics to provide medical services and pharmacy benefits to eligible responders and survivors with health conditions related to the September 11, 2001, terrorist attacks on the World Trade Center. We found that CDC and the National Institute for Occupational Safety and Health (NIOSH) did not monitor and evaluate clinic compliance with contract terms and conditions, as required by Federal regulations. Also, contracting officials did not take timely or appropriate action when they learned of three instances of clinic contract noncompliance. Further, evaluations of contractor performance were not completed, as required, and were not always entered into the information systems. [A-02-11-02003](#).

340B Drug discount program—Entity compliance

Health Resources and Services Administration (HRSA). The 340B Drug Pricing Program requires drug manufacturers participating in Medicaid to provide discounted covered outpatient drugs to certain eligible health care entities, known as covered entities. These entities may contract with pharmacies to dispense drugs purchased through the program on their behalf. The majority of covered entities do not use contract pharmacies. Recent HRSA audits of covered entities have found program violations related to contract pharmacies. Our February 2014 report is a descriptive review of contract pharmacy arrangements and examines, under such agreements, how entities prevent drug diversion and duplicate discounts. We found complications with regard to both issues. We also found that most covered entities in our study do not conduct all of the oversight recommended by HRSA. [OEI-05-13-00431](#).

Child Care and Development Fund—State monitoring and compliance

Administration for Children and Families (ACF). We reported that all States complied with the Federal requirement to have health and safety requirements for licensed child care providers in three specified areas. However, States' monitoring requirements did not always meet the ACF recommendations for background screenings or the recommended standards for unannounced inspections. In selected States that we reviewed, monitoring of licensed providers was not conducted in accordance with States' own requirements. Moreover, ACF did little to monitor how States were overseeing CCDF providers. [OEI-07-10-00231](#).

OIG participation in congressional hearings

3-26-2014 **Brian Martens**, Assistant Special Agent in Charge, Miami Region, testified before the Senate Special Committee on Aging on preventing Medicare fraud—how we can best protect seniors and taxpayers. [Testimony](#).



Brian Martens, Assistant Special Agent in Charge, Miami

3-25-2014 **Gloria Jarmon**, Deputy Inspector General for Audit Services, testified before the House Committee on Education and Workforce, Subcommittee on Early Childhood, Elementary, and Secondary Education, on the foundation for success through strengthening the Child Care and Development Block Grant program. [Testimony](#).



Gloria Jarmon, Deputy Inspector General for Audit Services

3-04-2014 **Robert Vito**, Regional Inspector General for Evaluation and Inspections, testified before the House Committee on Energy and Commerce, Subcommittee on Health, about keeping the promise—how better managing Medicare can protect seniors. [Testimony](#).



Robert Vito, Regional Inspector General for Evaluation and Inspections, Philadelphia

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<http://oig.hhs.gov>

Selected acronyms

ACF	Administration for Children and Families
Affordable Care Act	Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148
AFR	agency financial report and other accompanying information
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
CAH	critical access hospital
CBA	competitive bidding area
CCDF	Child Care and Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CCW	Community Care Waiver (program)
CDC	Centers for Disease Control and Prevention
CERT	Comprehensive Error Rate Testing
CFO Act	Chief Financial Officers Act of 1990, P.L. No. 101-576
Charge Card Act	Government Charge Card Abuse Prevention Act of 2012, P.L. No. 112-194
CHIP	Children's Health Insurance Program
CIA	corporate integrity agreement
CMP	civil monetary penalty
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
COR	contracting officer representative
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
DSH	disproportionate share hospital
DUA	data use agreement
EHR	electronic health record
EMTALA	Emergency Medical Treatment and Labor Act
ERRP	Early Retiree Reinsurance Program
ESRD	end stage renal disease
FCA	False Claims Act
FDA	Food and Drug Administration
FIR	financial information reporting
FISMA	Federal Information Security Management Act of 2002, P.L. No. 107-347
FY	fiscal year
HEAL	Health Education Assistance Loan
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
HIV	Human Immunodeficiency Virus
HRSA	Health Resources and Services Administration
IPERA	Improper Payments Elimination and Recovery Act of 2010, P.L. No. 111-204
IPIA	Improper Payments Information Act of 2002, P.L. No. 107-300

IRB	institutional review board
LCD	local coverage determination
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MCE	Medicaid managed care entities
MCSIS	Medicaid and Children’s Health Insurance Program State Information Sharing System
MFCU	Medicaid Fraud Control Unit
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173
MMIS	Medicaid Management Information System
MSN	Medicare Summary Notice
NCCI	National Correct Coding Initiative
NGS	National Government Services, Inc. (Medicare contractor)
NHS	Noridian Healthcare Solutions, LLC (Medicare contractor)
NIOSH	National Institute for Occupational Safety and Health
OASIS	Outcome and Assessment Information Set
OCR	Office for Civil Rights
OHRP	Office for Human Research Protections
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
PDE	prescription drug event
PEPFAR	President’s Emergency Plan for AIDS Relief
PI	principal investigator
PMS	Payment Management System
POD	physician-owned distributor
PRB	postretirement benefit
PSC	Program Support Center (HHS)
PT/OT	physical therapy/occupational therapy
QASP	quality assurance surveillance plan
RAC	Recovery Audit Contractor
SNF	skilled nursing facility
SOSI	statement of social insurance
SSA	Social Security Administration
TANF	Temporary Assistance to Needy Families
The Act	Social Security Act
TrOOP	true out-of-pocket (costs)
ZPIC	Zone Program Integrity Contractor

Centers for Medicare & Medicaid Services

CMS financial management and reporting

CMS financial report for fiscal year 2013

- *CMS Financial Report, Fiscal Year 2013. Audit Opinion Section. Daniel R. Levinson, Inspector General, Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2013 (pp. 108 - 109, 127, 134 - 135). [A-17-13-02013](#). 2013 DEC.*

The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the CMS financial statements in support of the U.S. Department of Health and Human Services (HHS) audit. We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to conduct the CMS audit. The findings and recommendations center on financial reporting and information system controls.

Financial reporting. The Centers for Medicare & Medicaid Services (CMS) relies on a decentralized organizational structure and complex financial management systems, not only within its central office and regional offices' processes, but also within many of the Medicare contractor organizations, to accumulate data for its financial reporting. Most recommendations were carried forward from past years. During fiscal year (FY) 2013, CMS improved its financial management performance in many areas and continues to focus on the remaining significant deficiencies.

Recommendations regarding financial reporting—CMS should continue to monitor State Medicaid draws of Federal funds; work with States to resolve issues and to report timely, accurately, and consistently on the funds drawn; determine the reasonableness of the methodology used to estimate accruals by establishing and performing claims-level detailed look-back analyses of Medicaid entitlement benefits due and payable; allow more time to analyze findings and develop remediation plans by continuing to improve the efficiency of the various error rate processes; implement an integrated financial management system to promote consistency and reliability in accounting and financial reporting; enhance its process for developing, documenting, and validating critical accounting matters; delegate to the centers or offices the responsibility to provide robust analyses on a routine and recurring basis; and continue to adhere to established policies and procedures to ensure that the statement of social insurance (SOSI) model methodology, related calculations, and estimates are consistently documented.

Information Systems Controls. CMS's information systems controls were considered a significant deficiency in the FY 2013 financial statement audit because CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights, and mitigating the potential impact on adequate segregation of duties. Also, there was inconsistent implementation planning and execution of CMS's overall directives and guidance over information security controls across the CMS enterprise, including the Medicare claims processing contractors.

Recommendations regarding information systems controls—CMS should ensure that systems are appropriately and timely certified, that related system security plans are complete and are prepared by all system owners and Medicare fee-for-service contractors, and that documentation of all interconnections between Medicare contractors is consistently prepared. To prevent excessive or inappropriate access, CMS should ensure that all application changes and interfaces to CMS systems, including Medicare fee-for-service shared systems, are documented and tested timely, adequately, and completely and ensure that appropriate segregation of duties is established for all systems that support CMS's programs, including Medicare fee-for-service claims and related financial processing at claims processing contractors and enterprise data centers.

CMS oversight of Medicare contractor performance

CMS relies on contractors to administer the Medicare program and is responsible for overseeing the contractors' performance. Medicare contractors are responsible for administering more than a half-trillion dollars in benefits each year. Medicare Administrative Contractors (MACs) process Parts A and B claims; Medicare Advantage (MA) plans provide managed care services under Part C; Part D plans provide prescription drug coverage under Part D; and various benefit integrity contractors serve to protect Medicare from fraud, waste, and abuse.

Contractor performance and quality assurance

■ *Medicare Administrative Contractors' Performance.* [OEI-03-11-00740](#). 2014 JAN.

MACs had not met one-quarter of the quality assurance standards reviewed and they had not resolved issues with 27 percent of the unmet standards as of June 2012. MAC standards have stringent performance requirements; a number of standards require 100-percent performance compliance. CMS did not require action plans for 12 percent of unmet standards, and unmet standards without action plans were almost four times more likely to have issues go unresolved. Recommendations—CMS should require action plans for all quality assurance standards not met, use the results of quality assurance reviews to help select award fee metrics for review, meet timeframes for completing quality assurance reports, meet timeframes for completing award fee determinations, establish reasonable timeframes for issuing contractor performance reports, and seek legislative change to increase the time between MAC contract competitions to give CMS more flexibility in awarding new contracts when MACs are not meeting CMS requirements.

Contractor payment error rate reduction plans

■ *Medicare Claims Administration Contractors' Error Rate Reduction Plans.* [OEI-09-12-00090](#). 2014 JAN.

We reported that most error rate reduction plans submitted by claims administration contractors included the required elements. However, corrective actions were not always relevant to claims administration contractors' Comprehensive Error Rate Testing program (CERT) results and varied substantially in number. The CERT program measures the improper payment rate (error rate) in the Medicare fee-for-service program. To reduce the error rate, CMS requires claims administration

contractors to submit error rate reduction plans. We found that CMS's oversight of error rate reduction plans is limited, and some of the sampled plans that CMS approved did not include five required elements or were for contracts with high error rates. We also found that limitations in CMS's administration of incentives for error rate reduction may reduce their effectiveness.

Recommendations—CMS should review its process for overseeing claims administration contractors' error rate reduction, ensure that contractors submit clear plans for reducing their error rates, provide additional guidance for contractors and CMS staff who review plans, and provide error rate reduction incentives that are aligned with the contracts' error rates and performance periods.

Contractor performance related to processing appeals.

- *The First Level of the Medicare Appeals Process, 2008–2012: Volume, Outcomes, and Timeliness. OEI-01-12-00150. 2013 OCT.*

In 2012, Medicare contractors processed 2.9 million first-level appeals (redeterminations). The redeterminations involved 3.7 million claims, an increase of 33 percent since 2008. Although 80 percent of all redeterminations in 2012 involved Part B services, redeterminations involving Part A services have risen more rapidly. By 2012, appeals involving Medicare's recovery audit contractors (RAC) accounted for 39 percent of all appealed Part A claims. Contractors who conduct redeterminations decided in favor of Part A appellants at a lower rate than that for Part B appellants. Also, the contractors largely met required timeframes for processing redeterminations and paying favorably appealed claims, but they fell short of meeting timeframes for transferring case files for second-level appeals. Moreover, Medicare contractors use information from redeterminations in a variety of ways to improve their operations and to educate providers. Finally, CMS employs multiple methods to improve contractors' processing of redeterminations, including fostering communication among contractors and implementing the Medicare Appeals System (MAS) for first-level appeals. Recommendations—CMS should use the MAS to monitor contractor performance, continue to foster information sharing among Medicare contractors, and monitor the quality of redeterminations data in MAS.

CMS's use of data for oversight of Medicare Part C contractors

- *CMS Regularly Reviews Part C Reporting Requirements Data but Its Followup and Use of the Data Are Limited. OEI-03-11-00720. 2014 MAR.*

We reported that CMS regularly reviews data that MA organizations submit pursuant to Part C reporting requirements, but its followup and uses of the data are limited. CMS has collected such data from MA organizations since 2009. The data are intended to serve as a resource for CMS to conduct oversight. Recommendations—CMS should determine whether outlier data values submitted by MA organizations reflect inaccurate reporting or atypical performance, use appropriate Part C reporting requirements data as part of its reviews of MA organizations' performance, and establish a timeline for releasing public use files for Part C reporting requirements data.

Part D sponsor reporting of fraud and abuse data

- *Less Than Half of Part D Sponsors Voluntarily Reported Data on Potential Fraud and Abuse.* [OEI-03-13-00030](#). 2014 MAR.

We reported that more than half of Part D sponsors did not voluntarily report data on potential fraud and abuse. CMS requires sponsors to conduct inquiries and implement corrective actions in response to incidents of potential fraud and abuse; however, 28 percent of Part D plan sponsors reported performing none of these actions between 2010 and 2012. Of those sponsors that did report data, more than one-third did not identify any incidents for at least one of their reporting years. Although CMS said that it conducted basic summary analyses of the sponsor-submitted data, it did not perform quality assurance checks on the data or use them to monitor or oversee the Part D program. Recommendations—CMS should amend regulations to require sponsors to report to CMS their identification of and response to incidents of potential fraud and abuse; provide sponsors with specific guidelines on how to define and count incidents, related inquiries, and corrective actions; review data to determine why certain sponsors reported especially high or low numbers of incidents, related inquiries, and corrective actions; and share sponsors' data on potential fraud and abuse with all sponsors and law enforcement.

Part D sponsors' tracking and transfer of true-out-of-pocket cost data

- *CMS Should Improve Oversight for the Transfer of True Out-of-Pocket Costs Between Part D Plans.* [A-05-12-00053](#). 2013 DEC.

We reported that the Federal Government and Medicare Part D enrollees could have saved approximately \$1.6 million in 2010 if CMS had provided adequate oversight to ensure the correct transfer of all true out-of-pocket (TrOOP) costs for enrollees who changed prescription drug plans during the 2010 coverage year. TrOOP costs are prescription drug costs paid by enrollees (or by specified third parties) that count toward the Part D annual out-of-pocket threshold that enrollees must meet before their catastrophic drug coverage begins. Part D sponsors are responsible for tracking and transferring enrollees' TrOOP costs as enrollees change plans during the coverage year. Effective January 1, 2009, sponsors must use the Financial Information Reporting (FIR) system to transfer TrOOP balances and gross covered drug costs whenever an enrollee makes an enrollment change. CMS and the TrOOP facilitator did not have adequate procedures to ensure these FIR transactions were initiated and were complete and PDE records were updated. Recommendations—CMS should transfer TrOOP costs in accordance with Federal requirements and implement controls to ensure the TrOOP facilitator initiates specific FIR transactions, compare FIR to prescription drug event (PDE) records to determine which FIR transactions are incomplete and require plan resubmission, and ensure subsequent plan sponsors are properly updating PDE records with reported FIR information.

Contractor pension assets and postretirement benefit assets

- *National Government Services, Inc., Understated Its Medicare Segment Pension Assets as of January 1, 2010.* [A-07-13-00408](#). 2013 OCT.

National Government Services, Inc. (NGS), a Medicare contractor, understated its Medicare segment pension assets by about \$1.2 million as of January 1, 2010. CMS reimburses a portion of the annual

contributions that Medicare contractors make to their pension plans. The Medicare segment pension assets are integral to calculating the allowable Medicare pension costs. CMS incorporated pension segmentation requirements into Medicare contracts beginning with FY 1988. Previous OIG reviews found that Medicare contractors did not always correctly identify and update the segmented pension assets. Recommendations—NGS should adjust the errors and establish controls to ensure compliance with Federal regulations and the Medicare contracts' pension segmentation requirements when allocating contributions and transferred prepayment credits, benefit payments, participant transfers, and investment earnings and expenses.

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- *Noridian Healthcare Solutions, LLC, Understated Its Medicare Segment Postretirement Benefit Assets as of January 1, 2011. [A-07-13-00420](#). 2014 MAR.*

Contract administration and costs—postretirement benefit assets. Noridian Healthcare Solutions, LLC (NHS), a Medicare contractor, understated the Medicare segment postretirement benefit plan assets by \$1.1 million as of January 1, 2011. CMS reimburses a portion of contractors' costs for postretirement benefit (PRB) plans. Medicare segment PRB assets are used in calculating the allowable Medicare PRB costs. NHS understated the Medicare segment PRB assets because it incorrectly identified Medicare segment participants and, therefore, incorrectly identified the Medicare segment contributions and prepayment credits. In addition, NHS lacked controls to ensure that it calculated the assets in accordance with requirements. Recommendations—NHS should adjust the errors and establish controls to ensure compliance with Federal regulations and the Medicare contracts' pension segmentation requirements when updating the Medicare segment PRB assets with contributions, income, claims paid, and expenses.

CMS records and information systems security and functionality

Protected records disclosure and accounting

- *Disclosure and Accounting of Protected Records by CMS Between 2006 and 2011. [OEI-09-11-00430](#). 2014 JAN.*

For at least 98 percent of all approved data requests in our sample, CMS's disclosures of records were consistent with the routine uses identified in the system of records notices. Five percent of all data files disclosed by CMS were not requested in the data use agreement (DUA) or updated DUAs. A DUA is a legally binding agreement that contains the written terms and conditions that govern each disclosure. Among other things, CMS uses DUAs to ensure that its disclosures are in compliance with the Privacy Act. CMS did not have the DUAs on file for 33 percent of all user agreement files. Recommendations—CMS should develop a process to ensure that the data requested are the ones disclosed to the entity; ensure that the DUA and DUA-related documents are in a user agreement file; ensure that entities submit the required documents to properly close their DUAs; use a standardized, documented process for requesting and approving DUA extensions; and ensure that expiration dates are consistent between the DUA and Data Agreement and Data Shipping Tracking System.

Information security at Medicare contractors

- *Review of Medicare Contractor Information Security Program Evaluations for Fiscal Year 2011. [A-18-13-30100](#). 2014 JAN.*

The evaluations of the Medicare contractor information security program were adequate in scope and were sufficient, but CMS should continue to ensure that all Medicare contractor findings are remediated. Each Medicare contractor must have its information security program evaluated annually by an independent entity. These evaluations must address the eight major requirements enumerated in the Federal Information Security Management Act of 2002 (FISMA). The Social Security Act (the Act) also requires evaluations of the information security controls for a subset of systems but does not specify the criteria for these evaluations. OIG must submit to Congress annual reports on the results of these evaluations, to include assessments of their scope and sufficiency. This report fulfills that responsibility for FY 2011.

Electronic health records vulnerabilities and safeguards

- *CMS and Its Contractors Have Adopted Few Program Integrity Practices To Address Vulnerabilities in EHRs. [OEI-01-11-00571](#). 2014 JAN.*
- *Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology. [OEI-01-11-00570](#). 2013 DEC.*

Vulnerabilities. We reported that though electronic health record (EHR) technology may make it easier to commit fraud, CMS and its contractors have not adjusted their practices for identifying and investigating fraud in EHRs. Few contractors reviewed EHRs differently from paper medical records. In addition, not all contractors reported being able to identify copied language or overdocumentation in a medical record. Finally, CMS had provided limited guidance to Medicare contractors on EHR fraud vulnerabilities. Recommendations—CMS should provide guidance to its contractors on detecting fraud associated with EHRs. Second, CMS should direct its contractors to use providers' audit logs. Audit log data distinguish EHRs from paper medical records and could be valuable to CMS's contractors when reviewing medical records.

Safeguards. We determined the extent to which hospitals that received EHR Medicare incentive payments had implemented the recommended fraud safeguards. We reported that nearly all hospitals followed recommendations for audit functions, data transfer safeguards, and user authorization and access controls. Almost half of hospitals had begun implementing recommended tools to include patient involvement in anti-fraud efforts. Finally, only about one quarter of hospitals had policies on the use of the copy-paste feature in EHR technology, which, if used improperly, could pose a fraud vulnerability. Recommendations—HHS should ensure that audit logs are operational whenever EHR technology is available for updates or viewing. ONC and CMS should strengthen their collaborative efforts to develop a comprehensive plan to address fraud vulnerabilities in EHRs. Finally, we recommend that CMS develop guidance on the use of the copy-paste feature in EHR technology.

Accuracy of data in CMS contractors' systems

- *Over Four Million Medicare Summary Notices Mailed to Beneficiaries Were Not Delivered in 2012.*
OEI-03-12-00600. 2014 JAN.

We reported that there continues to be a problem with incorrectly populated beneficiary addresses in the data systems that claims processors use to process Medicare summary notices (MSNs). We found that as a result, over 4 million MSNs that claims processors had mailed to beneficiaries were not delivered in 2012. Some of the undelivered MSNs reviewed were associated with compromised beneficiary or provider identification numbers. If MSNs go undelivered, beneficiaries do not have the opportunity to review the services or items billed to Medicare and report suspicious billing.

Recommendations—CMS should provide guidance to claims processors about whether and how to track and follow up on MSNs that are returned as undeliverable and ensure that the address information used by claims processors to print addresses on MSNs is complete and properly formatted.

<http://oig.hhs.gov>

Medicare payments, policies, and quality

Medicare improper claims and payments

Clinicians—High cumulative payments

- *Reviews of Clinicians Associated With High Cumulative Payments Could Improve Medicare Program Integrity Efforts.* [A-01-11-00511](#). 2013 DEC.

We identified 303 clinicians who were each responsible for more than \$3 million in Part B payments during calendar year (CY) 2009. We determined that MACs and Zone Program Integrity Contractors (ZPICs) had identified 104 of the 303 for improper payment reviews. As of December 31, 2011, the MACs and ZPICs had completed reviews of 80 of the 104 clinicians and had identified \$34 million in overpayments. Three of the clinicians had their medical licenses suspended, and two were indicted. The results of the reviews demonstrate that identifying clinicians who are responsible for high cumulative payments could be a useful means of identifying improper payments.

Recommendations—CMS should establish a cumulative payment threshold—taking into consideration costs and potential program integrity benefits—above which a clinician’s claims would be selected for review and implement a procedure for timely identification and review of clinicians’ claims that exceed the payment threshold.

Home health services—Payments in New England

- *Medicare Often Made Overpayments to New England Home Health Agencies for Claims Without Required Outcome and Assessment Information Set Data for Calendar Year 2010.* [A-01-12-00508](#). 2014 MAR.

We estimated that the regional home health intermediary for six New England States made approximately \$25.1 million in Medicare overpayments because it did not deny claims that home health agencies (HHAs) submitted without the required Outcome and Assessment Information Set (OASIS) data, which is a condition of payment. CMS uses OASIS data to help determine payment rates and for other purposes. Beginning January 1, 2010, CMS required HHAs to submit accepted OASIS data as a condition of payment and instructed that claims from HHAs that lacked OASIS data were not to be paid.

Overpayments occurred because HHAs often had inadequate controls for the submission of OASIS data. Further, Medicare payment controls were inadequate to prevent or detect payments to HHAs for claims that were missing accepted OASIS data. Recommendations—CMS should complete a process that would allow the claims processing system to interface with State survey agency systems to identify, on a prepayment basis, HHA claims without accepted OASIS data submissions and encourage its contractors to conduct periodic postpayment reviews of HHA claims, to include ensuring that OASIS data support claims, until sufficient prepayment controls are established. CMS also should adjust the overpayments identified, reopen nonsampled claims, and recover any additional overpayments found.

Hospitals—Outlier payments

- *Medicare Hospital Outlier Payments Warrant Increased Scrutiny.* [OEI-06-10-00520](#). 2013 NOV.

We reported that nearly all hospitals received outlier payments and that some received a much higher proportion of their Medicare reimbursements from outlier payments. The routine receipt of outlier payments for certain diagnoses at high-outlier hospitals raises concerns about why charges for similar patient-care cases vary substantially across hospitals. Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. In some cases, high charges could be the result of high costs because hospitals attract a disproportionate share of exceptionally costly patients or because they apply costly technologies and treatments. Recommendations—CMS should instruct its contractors to increase monitoring of outlier payments, include information about the distribution of outlier payments with other publicly reported hospital data, and examine whether diagnoses associated with high rates of outlier payments warrant coding changes or other adjustments.

Hospitals— Postacute care transfer policy

- *Noridian Healthcare Solutions, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 2.* [A-09-13-02035](#). 2013 NOV.

Medicare contractor Noridian Healthcare Solutions, LLC (NHS), inappropriately paid Medicare claims subject to the postacute care transfer policy; as a result Medicare made overpayments to 73 hospitals totaling \$1.1 million over 4 years. The overpayments occurred because the hospitals improperly coded claims as discharges to home or certain types of health care institutions rather than as transfers to postacute care. Another reason that the overpayments occurred was that Medicare's system edits related to postacute care transfers were not working properly. Also, the edits that were related to transfers to home health care erroneously calculated the number of days between the dates of service on the inpatient claim and the home health claim, an error that CMS corrected. Recommendations—NHS should educate hospitals in Jurisdiction 2 on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered; work with the system maintenance contractor to ensure that it receives the automatic adjustments identifying overpayments on inpatient claims; and recover the overpayments identified in our review.

Hospitals—Outpatient clinic visits

- *CMS Did Not Always Correctly Make Clinic Visit Payments to Hospitals.* [A-04-12-06154](#). 2014 MAR.

Medicare made an estimated \$7.5 million in incorrect outpatient payments to hospitals for established patients' clinic visits for 2010 and 2011. Medicare payments to hospitals for outpatient clinic visits vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a 3-year period. The hospitals attributed the incorrect payments to clerical errors, the fact that staff did not fully understand Medicare billing requirements for clinic visits, reliance on the code that the physician selected for the visit, or billing systems that could not

identify established patients. Also, Medicare does not have edits in place to identify Medicare payments for patients who were already registered at a facility. Recommendations—CMS should work with its MACs to provide additional guidance to hospitals on billing clinic visits for new or established patients, instruct hospitals on the need for stronger compliance controls that ensure proper billing of clinic visits, recover the incorrect payments identified in our sample, resolve the remaining line items, and recover any additional overpayments found.

Hospitals—Outpatient drugs

- *The Medicare Contractors for Jurisdiction E Overpaid Providers for Selected Outpatient Drugs.*
[A-09-13-02009](#). 2014 JAN.
- *The Medicare Contractor for Jurisdiction F Overpaid Providers for Selected Outpatient Drugs.*
[A-09-13-02003](#). 2014 JAN.
- *The Medicare Contractor for Jurisdiction 5 Overpaid Providers for Selected Outpatient Drugs.*
[A-07-13-04201](#). 2014 MAR.
- *Medicare Contractors for Jurisdiction 8 Overpaid Providers for Selected Outpatient Drugs.*
[A-05-13-00012](#). 2014 MAR.
- *The Medicare Contractors for Jurisdiction 11 Overpaid Providers for Selected Outpatient Drugs.*
[A-03-13-00011](#). 2014 FEB.
- *The Medicare Contractor for Jurisdiction 12 Overpaid Providers for Selected Outpatient Drugs.*
[A-03-13-00012](#). 2014 FEB.
- *Medicare Contractors for Jurisdiction 15 Overpaid Providers for Selected Outpatient Drugs.*
[A-05-13-00013](#). 2014 MAR

CMS pays Medicare claims through the Medicare administrative contractor or fiscal intermediary (Medicare contractor) in each Medicare jurisdiction. From July 1, 2009, through June 30, 2012, Medicare contractors nationwide paid hospitals \$11.5 billion for outpatient drugs, which include biologicals and radiopharmaceuticals. Previous OIG reviews of outpatient services have found that Medicare contractors overpaid providers for selected outpatient drugs. This series of reports focuses on payments for selected outpatient drugs. The objective of the reviews was to determine whether payments that the Medicare contractors for various jurisdictions made to providers for selected outpatient drugs were correct.

We have found several types of errors, including that providers reported incorrect units of service, reported a combination of incorrect units of service and incorrect standardized billing codes, did not provide supporting documentation, and billed separately for an outpatient drug for which payment was packaged with the primary service. Providers attributed the incorrect billings to clerical errors and to provider billing systems that could not prevent or detect the incorrect billing of outpatient drug services. The Medicare contractors overpaid these providers because insufficient edits were in place to prevent or detect the overpayments.

Our findings and recommendations are addressed to the subject Medicare contractors. Recommendations variously include that the contractors should use the results of the audits in their

ongoing provider education activities, recover identified overpayments, and verify the payment of identified underpayments.

Unlawfully present, incarcerated, and deceased beneficiaries

- *Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Unlawfully Present Beneficiaries During 2009 Through 2011. [A-07-12-06038](#). 2013 OCT.*

We identified \$91.6 million in improper payments to unlawfully present beneficiaries in Part B during CYs 2009 through 2011. When CMS received untimely information indicating that unlawful presence overlapped with the dates of service on previously paid Medicare claims, CMS did not notify Medicare's contractors of this updated information, and the contractors did not detect and recoup improper payments. For the same period, we estimated \$29 million in gross drug costs associated with unlawfully present beneficiaries in Part D. Recommendations—CMS should implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to unlawfully present beneficiaries and ensure that Medicare contractors recoup the improper payments we identified.

- *Medicare Improperly Paid Millions of Dollars for Prescription Drugs Provided to Incarcerated Beneficiaries During 2006 Through 2010. [A-07-12-06035](#). 2014 JAN.*

We identified nearly \$33.6 million in uncollected improper payments on behalf of incarcerated beneficiaries in Part A and Part B during CYs 2009 through 2011. With certain exceptions, prisons (instead of Medicare) pay for the health care of incarcerated beneficiaries who are otherwise eligible for Medicare. CMS does not always receive timely updates regarding incarceration information before Medicare contractors pay providers on behalf of incarcerated beneficiaries. Similarly, we estimated that more than \$11.6 million in gross drug costs were associated with incarcerated beneficiaries in Part D for CYs 2006 through 2010. Recommendations—Implement policies and procedures to detect and recoup improper payments made for Medicare services rendered to incarcerated beneficiaries; ensure that all claims with exception codes are processed consistently and pursuant to Federal requirements; work with other entities, including the Social Security Administration (SSA), to identify ways to improve the timeliness with which CMS receives incarceration information; ensure that Medicare contractors recoup the improper payments we identified; and identify improper payments made on behalf of incarcerated beneficiaries after our audit period and recoup those payments.

- *Medicare Payments Made on Behalf of Deceased Beneficiaries in 2011. [OEI-04-12-00130](#). 2013 OCT.*

Health care fraud schemes have involved the submission of fraudulent claims by providers or suppliers to Medicare, including claims for deceased beneficiaries, and prior OIG studies and audit reports have identified Medicare payments made on behalf of deceased beneficiaries. Our October 2013 report revealed that although CMS has safeguards to prevent and recover Medicare payments made on behalf of deceased beneficiaries, it inappropriately paid \$23 million in 2011 for dates of service after beneficiaries' deaths. Part C accounted for 86 percent of the improper payments. Additionally, 11 percent of the improper payments resulted from the fact that dates of death were missing or incorrect. Further, we identified 251 providers and suppliers that had high numbers of paid and/or

unpaid Part B claims with service dates after beneficiaries' deaths. Recommendations—improve existing safeguards to prevent future improper Medicare payments after beneficiaries' deaths, take appropriate action on improper Medicare payments made on behalf of deceased beneficiaries and correct inaccurate dates of death, monitor both paid and unpaid Part B claims with service dates after beneficiaries' deaths, and take appropriate action on providers and suppliers that had high numbers of paid and/or unpaid Part B claims with service dates after beneficiaries' deaths.

Lower limb prosthetics

- *National Government Services, Inc., Paid Unallowable Lower Limb Prosthetics Claims. A-07-13-05039. 2013 OCT.*

National Government Services, Inc. (NGS, operating in Indiana), paid \$1.5 million for 770 lines of service for lower limb prostheses from January 1, 2009, through September 30, 2012, that did not meet local coverage determination (LCD) requirements. Recommendations—NGS should continue to monitor the edits it developed and updated to ensure that they are functioning correctly and recover \$1.5 million in identified overpayments for lines of service for lower limb prostheses that did not meet LCD requirements.

Organ procurement payments

- *Medicare Could Have Saved Millions if Organ Procurement Organizations Had Correctly Reported Procurement of Double Lungs as Two Organs. A-09-12-02085. 2013 DEC.*

Organ procurement organizations (OPOs) are not-for-profit organizations that facilitate organ donation and transplantation. Because lungs are in pairs, they are procured as one or two organs and should be reported as such. When OPOs report the number of transplanted lungs incorrectly, Medicare costs may be misstated. Both independent and hospital-based OPOs incorrectly reported lung statistics because they relied on CMS's *Provider Reimbursement Manual*, which does not provide specific instructions on reporting double lungs. If the 44 OPOs had reported procurement of 1,721 double lungs correctly, the Medicare program could have saved an estimated net amount of \$8.9 million during the year. Recommendations—CMS should clarify instructions on how independent and hospital-based OPOs should report lung statistics in Medicare cost reports and work with the Medicare contractors to educate OPOs on the correct reporting of double lungs in Medicare cost reports.

Physician administered drugs—Herceptin

- *Medicare Contractors Nationwide Overpaid Millions to Providers for Full Vials of Herceptin. A-05-13-00024. 2013 NOV.*

We reported that 77 percent of payments that Medicare contractors made to providers for full vials of Herceptin were incorrect and included overpayments of about \$24.2 million, or more than one-third of total dollars reviewed. Herceptin (trastuzumab) is a Medicare-covered drug used to treat breast cancer that has spread to other parts of the body. Herceptin is one of many drugs packaged in multiuse vials. Therefore, the problem of provider billing for full vials may exist with other such drugs. On nearly all of the incorrect line items, the providers reported the units of service for the entire content of one or more

vial(s), each containing 440 milligrams of Herceptin, rather than reporting the units of service for the amount actually administered. The providers attributed the incorrect payments to clerical errors and to billing systems that could not prevent or detect the incorrect billing of units of service. The incorrect payments made by Medicare contractors during our audit period occurred because the pertinent systems did not have sufficient edits in place during this period to prevent or detect the overpayments.

Recommendations—CMS should require that Medicare contractors implement a Herceptin-specific system edit to identify for review claim lines billed with unit counts in multiples of 44 that represent billings equivalent to entire multiuse vial(s) and review other multiuse-vial drugs to determine whether system edits are needed to prevent incorrect billings. CMS should also ensure that Medicare contractors collect the identified overpayment amounts, review payments made to providers after our audit period ended for full vials of Herceptin, and recover any additional overpayments identified.

Polysomnography (sleep studies)

■ *Questionable Billing for Polysomnography Services.* [OEI-05-12-00340](#). 2013 OCT.

Medicare paid nearly \$17 million for polysomnography services (a type of sleep study) that did not meet one or more of three Medicare requirements. Payments for services with inappropriate diagnosis codes composed a majority of these payments. Eighty-five percent of claims with inappropriate diagnosis codes came from hospital outpatient departments. Inappropriate payments might have been averted with effective electronic edits that automatically deny claims or suspend them for manual review. Further, 180 providers exhibited patterns of questionable billing for polysomnography services. Most of these providers submitted an unusually high percentage of claims for beneficiaries with another polysomnography claim on the same day, which is questionable because beneficiaries can undergo only one polysomnography service in a day, as the process requires an overnight stay. **Recommendations**—CMS should implement or improve claims processing edits and consider using measures of questionable billing from this study to identify providers for further investigation. We also recommend that CMS take appropriate action regarding inappropriate payments and providers that exhibited patterns of questionable billing.

Medicare wasteful payments, policies, and practices

End stage renal disease—Payments for drugs

■ *Update: Medicare Payments for End Stage Renal Disease Drugs.* [OEI-03-12-00550](#). 2014 MAR.

As of January 2011, Federal law required CMS to bundle Medicare reimbursement for almost all end stage renal disease (ESRD) treatments—including drugs that were previously billed separately—into one payment rate. CMS is required to reduce the ESRD payment bundle's base rate for 2014 to reflect changes in utilization and should take into account recent drug sales and pricing data. Our findings show that acquisition costs for most of the drugs under review have decreased, but the costs for drugs that represented the majority of facilities' total drug costs have increased. This means that any savings resulting from a decrease in utilization may potentially be offset by the drugs' cost increase. In addition, although independent dialysis facilities could acquire the majority of ESRD drugs for less than Medicare

reimbursement, any reductions to the ESRD base rate could potentially harm hospital-based dialysis facilities because these facilities had difficulty purchasing ESRD drugs for less than reimbursement, in the aggregate.

Recommendations—CMS should rebase (i.e., redetermine the basis of) the ESRD base rate to reflect current trends in drug acquisition costs, as required by law; distinguish payments in the ESRD base rate between independent and hospital-based dialysis facilities; and consider updating the ESRD payment bundle using a factor that takes into account drug acquisition costs.

Part B drugs—Price substitution

- *Comparing Average Sales Prices and Average Manufacturer Prices for Medicare Part B Drugs: An Overview of 2012.* [OEI-03-13-00570](#). 2014 MAR.

When Congress established average sales price (ASP) as the basis for Medicare Part B drug reimbursement, it also provided a mechanism for monitoring market prices and limiting potentially excessive ASP-based payment amounts. Specifically, the ASP statute mandates that OIG compare ASPs with average manufacturer prices (AMPs) and directs CMS to lower reimbursement for certain drugs on the basis of OIG's findings. To comply with its statutory mandate, OIG has completed 29 quarterly pricing comparisons since the ASP reimbursement methodology for Part B drugs was implemented in January 2005. CMS began substituting payment amounts in April 2013 in accordance with a price substitution policy that is relatively limited in scope. Under this price substitution policy, 14 drug codes would have been subject to reimbursement reductions on the basis of data from 2012, saving Medicare and its beneficiaries an estimated \$1.8 million between the fourth quarter of 2012 and the third quarter of 2013. However, because CMS did not begin substituting prices until the second quarter of 2013, only eight drug codes were actually subject to reductions, generating an estimated \$819,000 in savings. If CMS had expanded its price substitution criteria, the agency could have generated a quarter of a million dollars in additional savings. Recommendations—CMS should expand the price substitution policy to include drug codes with complete AMP data in a single quarter and drug codes with partial AMP data.

Hospitals—Inpatient payment policies: DRG Window

- *Medicare and Beneficiaries Could Realize Substantial Savings If the DRG Window Were Expanded.* [OEI-05-12-00480](#). 2014 FEB.

Expanding the window of time covered by Medicare's lump sum payments for inpatient care would result in cost savings. We reviewed outpatient services that the admitting hospitals provided during the 11 days prior to the existing window and found that in 2011, Medicare and its beneficiaries paid an estimated \$263 million for such services. OIG has previously recommended expanding the window, but CMS has not sought authority to do so. Recommendations—CMS should seek legislative authority to expand the DRG window to include additional days prior to the inpatient admission and seek legislative authority to expand the DRG window to include other hospital ownership arrangements, such as affiliated hospital groups.

Hospitals—Characteristics of critical access hospitals

- *Services Provided at Critical Access Hospitals in 2011.* [OEI-05-12-00081](#). 2013 DEC.

In previous reports, OIG recommended that policymakers reevaluate which facilities are certified as critical access hospitals (CAHs). In addition, the Administration has proposed to decertify some CAHs and change how remaining CAHs are paid. For most services provided, Medicare reimburses CAHs at 101 percent of their costs rather than at the rates set by the prospective payment systems or fee schedules. In 2011, Medicare and beneficiaries paid approximately \$8.5 billion for services provided at CAHs. This report provides additional information for policymakers to consider while reassessing how CAHs should be certified and paid, including what types of services were provided at CAHs in 2011; how the types of services provided at CAHs in 2011 compared to the types of services provided at acute-care hospitals in 2011; and how much Medicare paid for services provided at CAHs in 2011. The report does not contain new recommendations.

Local coverage determinations—Effect on payments

- *Local Coverage Determinations Create Inconsistency in Medicare Coverage.* [OEI-01-11-00500](#). 2014 JAN.

We reported that in October 2011, over half of Part B procedure codes were subject to LCDs in one or more States. The presence of these LCDs was unrelated to the cost and utilization of items and services. Furthermore, LCDs limited coverage for these items and services differently across States. LCDs also defined similar clinical topics inconsistently. Although CMS has taken steps to increase consistency among LCDs, it lacks a plan to evaluate new LCDs for national coverage. Recommendations—CMS should establish a plan to evaluate new LCD topics for national coverage consistent with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requirements and continue efforts to increase consistency among existing LCDs. We also recommend that CMS consider requiring MACs to jointly develop a single set of coverage policies.

Vacuum erection systems

- *Medicare Payments for Vacuum Erection Systems Are More Than Twice as Much as the Amounts Paid for the Same or Similar Devices by Non-Medicare Payers.* [A-07-12-05024](#). 2013 DEC.

Medicare payment amounts for vacuum erection systems (VES) remain grossly excessive compared with non-Medicare reimbursement. Medicare pays suppliers more than twice as much for VES as the Department of Veterans Affairs and consumers over the Internet pay for these types of devices. Processes exist to remedy this imbalance by adjusting Medicare payment rates for VES. Use of the inherent reasonableness process would achieve cost savings. If the Medicare fee schedule amount for VES had been adjusted to approximate the amount paid for the same or similar devices by non-Medicare payers, the Federal Government would have saved an average of approximately \$14.4 million for each of the 6 years reviewed, and Medicare beneficiaries would have saved approximately \$3.6 million annually. Recommendations—CMS should either use its authority under the inherent reasonableness regulations to determine whether the payments for VES are grossly excessive and, if so, establish a special payment

limit or seek legislative authority to include VES in the Competitive Bidding Program and then implement a National Mail-Order Competitive Bidding Program for VES.

Physician-owned distributors—Spinal devices

- *Spinal Devices Supplied by Physician-Owned Distributors: Overview of Prevalence and Use. OEI-01-11-00660. 2013 OCT.*

This report responds to a congressional request to determine the extent to which physician-owned distributors (PODs) provide spinal devices to hospitals. PODs' physician-owners can include the surgeons who implant the PODs' devices; these owners have an opportunity to profit from using the devices their PODs sell. Critics of PODs claim that such ownership creates a conflict of interest that may affect physicians' clinical decision making. PODs assert that their devices cost less than devices provided by other spinal device companies. However, our findings raise questions about PODs' claim that their devices cost less than those of other suppliers. Surgeons performed more spinal surgeries at hospitals that purchased from PODs, and those hospitals experienced increased rates of growth in the number of spinal surgeries performed in comparison to the rate for all hospitals. In FY 2012, surgeons performed more spinal surgeries at hospitals in our sample that purchased from PODs than at those that did not purchase from PODs. Taken together, these factors may increase the cost of spinal surgery to Medicare over time. Hospitals' policies varied in whether they required physicians to disclose ownership interests in PODs to either the hospitals or their patients. Thus the ability of hospitals and patients to identify potential conflicts of interest among these providers is reduced.

Medicare quality of care

End stage renal disease grievance process

- *The ESRD Beneficiary Grievance Process. OEI-01-11-00550. 2013 DEC.*

Previous OIG work found that the ESRD beneficiary grievance process was unreliable in identifying and resolving quality-of-care concerns. Medicare regulations require that dialysis facilities implement a process for beneficiaries to file grievances without reprisal or denial of services. Beneficiaries also have the option of filing grievances with ESRD Network Organizations (networks), which are Medicare contractors that work with dialysis facilities. Dialysis facilities have latitude in what they record as a grievance, and two-thirds of facilities recorded five or fewer grievances in 2011.

Our December 2013 report revealed that the most common grievances recorded concerned the comfort or appearance of the physical environment and interactions with staff. Anonymous grievance processes can be difficult to implement, and fear of reprisal may be difficult for facilities to measure. ESRD networks' involvement with beneficiary grievances is constrained by limited data and reporting. They analyze grievances for trends, but the database they use is of limited utility. CMS is unable to readily provide network grievance and complaint data. Recommendations—CMS should define "grievance" for facilities, require that facilities report grievances regularly to their respective networks, provide guidance to facilities on what constitutes a robust process for anonymous grievances, work with the Agency for Healthcare Research and Quality (AHRQ) to add a question to the standardized satisfaction survey to

assess ESRD beneficiaries' fear of reprisal, and provide networks with better technical support for their grievance database.

Nursing homes—Harm to patients and questionable resident hospitalizations

- *Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries. OEI-06-11-00370. 2014 FEB.*

We reported that an estimated 22 percent of Medicare beneficiaries experienced adverse events during their skilled nursing facility (SNF) stays. An additional 11 percent experienced temporary harm events during their SNF stays. Physician reviewers determined that 59 percent of the adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care. Over half of the residents who experienced harm returned to a hospital for treatment; the estimated cost to Medicare was \$208 million in August 2011. This equates to \$2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.

Because many of the events that we identified were preventable, our study confirms the need and opportunity for SNFs to significantly reduce the incidence of resident harm events. Therefore, we recommend that AHRQ and CMS raise awareness of nursing home safety and seek to reduce resident harm through methods used to promote hospital safety efforts. This would include collaborating to create and promote a list of potential nursing home events—including events we found that are not commonly associated with SNF care—to help nursing home staff better recognize harm. CMS should also instruct State agency surveyors to review nursing home practices for identifying and reducing adverse events.

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- *Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring. OEI-06-11-00040. 2013 NOV.*

We reported that in FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions and that Medicare spent \$14.3 billion on these hospitalizations. Nursing home residents went to hospitals for a wide range of conditions; septicemia was the most common. Annual rates of Medicare resident hospitalizations varied widely across nursing homes. Nursing homes with the following characteristics had the highest annual rates of resident hospitalizations: homes in Arkansas, Louisiana, Mississippi, or Oklahoma and homes with one, two, or three stars in the CMS Five-Star Quality Rating System. Recommendations—CMS should develop a quality measure that describes nursing home resident hospitalization rates and instruct State survey agencies to review the proposed quality measure as part of the survey and certification process.

Medicaid payments, policies, and quality

Medicaid-related information systems security and functionality

Terminated providers—Federal and State information-sharing system

- *CMS System for Sharing Information About Terminated Providers Needs Improvement. OEI-06-12-00031. 2014 MAR.*

We reported that CMS's process for sharing information about providers that were terminated for cause needs improvement. Sharing terminated provider data among States prevents terminated providers in one State from enrolling in another State Medicaid program. The Patient Protection and Affordable Care Act (Affordable Care Act) required CMS to establish a process for sharing such information. Hence, CMS established a Web-based portal for States and Medicare to use for this purpose.

Recommendations—CMS should require each State Medicaid agency to report all terminated providers, ensure that the shared information contains only records that meet CMS's criteria for inclusion, and take action to improve the completeness of records shared through the process.

State information systems vulnerabilities

- *High-Risk Security Vulnerabilities Identified During Reviews of Information Technology General Controls at State Medicaid Agencies. A-07-14-00433. 2014 MAR.*

We identified 79 findings in the 10 State Medicaid agencies whose information system general controls we audited between calendar years (CYs) 2010 and 2012. Information system general controls are the structure, policies, and procedures that apply to an entity's overall computer operations. Some primary objectives of general controls are to safeguard data, protect computer applications, prevent unauthorized access to system software, and ensure continued computer operations after unexpected interruptions. In some of the general control areas, we noted findings with similar vulnerabilities in different State agencies, which indicated that the vulnerabilities identified in these findings were systemic and pervasive. State officials pointed most frequently to resource constraints that made information system security a lower priority. Officials also described a lack of formal policies and procedures when explaining the causes of the vulnerabilities. This review aggregates findings from the individual reports and is intended to provide information to assist those State agencies and the Centers for Medicare & Medicaid Services (CMS) in strengthening system security. It does not make new recommendations.

National correct coding initiative: Georgia

- *Georgia Did Not Pay Some Line Items on Medicaid Claims in Accordance With Its Medicaid National Correct Coding Initiative Methodologies.* [A-04-12-06159](#). 2013 DEC.

Georgia did not pay some line items in accordance with its Medicaid National Correct Coding Initiative (NCCI) methodologies on claims that hospitals submitted from November 1, 2010, through September 30, 2011. The NCCI promotes correct coding of health care services provided to beneficiaries and prevents payment for improperly coded services. Overall, the State agency satisfied Federal and State requirements by implementing the Medicaid NCCI into the Georgia Medicaid Management Information System (GAMMIS). However, the Medicaid NCCI edits did not prevent all erroneous payments. The State agency made erroneous payments to providers totaling \$1.5 million (\$1 million Federal share). The State agency acknowledged that the Medicaid NCCI edits did not work as intended and that it paid line items in error. Recommendations—Georgia should ensure that the Medicaid NCCI edits were properly incorporated and are functioning as intended in the GAMMIS and refund the erroneous payments. Subsequent to our fieldwork, agency officials stated that all of the erroneous payments identified in our universe had been recovered from providers.

Improper State claims for Federal reimbursement

Laboratory Services—Maine

- *Maine Did Not Always Claim Federal Medicaid Reimbursement for Clinical Diagnostic Laboratory Services in Accordance With Requirements.* [A-01-13-00005](#). 2014 MAR.

We reported that Maine paid clinical diagnostic laboratory services providers more than they would have been paid under Medicare or more than the amounts allowed by State regulations. As a result, the Federal reimbursement that the State agency claimed exceeded the rates allowed by Federal and State requirements by \$3.5 million (\$2.5 million Federal share). The overpayments occurred because the State agency did not always follow its policies and procedures. Recommendations—Maine should follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services do not exceed the amounts that would be paid under Medicare (for out-of-State providers) or the amounts allowed by State regulations (for in-State providers) and refund the excessive Federal share to the Federal Government.

Assistive technology services: New York

- *New York Claimed Some Unallowable Costs for Assistive Technology Services Under the State's Developmental Disabilities Waiver Program.* [A-02-10-01039](#). 2013 NOV.

On the basis of a sample, we estimated that New York improperly claimed at least \$1.8 million of Federal reimbursement for assistive technology services that did not comply with certain Federal and State requirements. New York Medicaid covers a variety of assistive technology services performed under contracts, including services tailored to enable individuals to increase or maintain the ability to live independently and safely at home or in the community (e.g., installation of wheelchair ramps). Most

claims were unallowable because they were not provided pursuant to a required written plan of care. State policies and procedures did not adequately ensure that conditions were met and that contractors properly claimed reimbursement from the State. Recommendations—New York should ensure that the pertinent State agencies strengthen related policies and procedures, refund the overpaid amounts we identified, and work with CMS to resolve potentially unallowable amounts and refund any additional unallowable amounts.

Duplicate fee for service and managed care payments: New York

- *New York State Made Unallowable Medicaid Fee-for-Service Payments for Beneficiaries Also Enrolled in Medicaid Managed Care.* [A-02-12-01007](#). 2014 JAN.

New York State did not prevent separate Medicaid fee-for-service payments from being made for beneficiaries who were also enrolled in Medicaid managed care organizations. For all 107 inpatient admissions included in our sample, the State agency improperly claimed Federal Medicaid fee-for-service reimbursement for inpatient hospital services on behalf of beneficiaries for whom separate Medicaid managed care payments were made under a different Medicaid identification number. The improper payments occurred because the State agency operated two eligibility systems that did not identify beneficiaries with multiple Medicaid identification numbers. In addition, local departments of social services did not use all available resources within the systems to ensure that beneficiaries were not issued multiple Medicaid identification numbers. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$23.4 million in Federal Medicaid fee-for-service reimbursement for inpatient hospital services made on behalf of beneficiaries for whom separate Medicaid managed care payments were also made.

Recommendations—New York should use all available resources to ensure that no beneficiary is issued multiple Medicaid identification numbers or develop one eligibility system that could be used to determine whether applicants are enrolled in any medical or public assistance program throughout New York State. New York should refund \$23.4 million to the Federal Government.

Residential habilitation services: New York

- *Medicaid Rates for Residential Habilitation Services Provided at New York State-Operated Residences Are Excessive.* [A-02-13-01008](#). 2014 MAR.

Payment rates for residential habilitation services provided at State-operated residences did not meet the Federal requirement that payment for services be consistent with efficiency and economy. Specifically, for State fiscal year (FY) 2010, Federal Medicaid payments exceeded actual costs for providing these services by approximately \$320 million (57 percent more than actual costs). Further, the payment rate for these services was more than double the average rate for privately operated residences that offered the same services. We also determined that if New York had used the prior year's actual costs in calculating payment rates, its State FY 2011 total reimbursement would have been approximately \$692 million (\$346 million Federal share) less than what it claimed.

Payment rates for residential habilitation services were significantly higher because CMS did not adequately consider the appropriateness of the rate-setting methodology when it approved New York's waiver agreement. The application did not describe in detail the methodology used to calculate the

payment rates for State-operated residences. According to New York officials, that methodology used the prior year's adjusted payment rates, which were calculated using reimbursable costs rather than actual costs, to determine payment rates for the current year. Recommendations—CMS should work with New York to ensure that the methodology used to set payment rates for State-operated residences meets the Federal requirement that payment for services be consistent with efficiency and economy.

Pediatric dental services—Questionable billing: New York.

- *Questionable Billing for Medicaid Pediatric Dental Services in New York.* [OEI-02-12-00330](#). 2014 MAR.

We identified 23 general dentists and 6 orthodontists in New York with questionable billing. The providers are extreme outliers when compared to their peers. Medicaid paid these providers \$13.2 million for pediatric dental services in 2012. The general dentists and orthodontists—representing 3 percent of dental providers we reviewed—received extremely high payments per child; provided an extremely large number of services per child; or provided certain selected services, such as pulpotomies or extractions, to an extremely high proportion of children. Additionally, almost a third of the general dentists were associated with a single dental chain that had settled lawsuits for providing services that were medically unnecessary or that failed to meet professionally recognized standards of care to children. Our findings raise concerns that certain providers may be billing for services that are not medically necessary or were never provided. They also raise concerns about the quality of care provided to Medicaid children. Although some of the billing may be legitimate, providers who bill for extremely large amounts of services warrant further scrutiny.

Recommendations—New York should continue to monitor general dentists and orthodontists to identify patterns of questionable billing, ensure that the State employs adequate safeguards to monitor general dentists and orthodontists under managed care, and ensure appropriate followup on the general dentists and orthodontists identified as having questionable billing.

Other medical equipment and supplies

- *State Medicaid Program Efforts to Control Costs for Disposable Incontinence Supplies.* [OEI-07-12-00710](#). 2014 JAN.

We reported that all State Medicaid programs implemented cost-control measures—such as quantity limitations or reductions in fee-schedule amounts for incontinence supplies. Five States implemented competitive bidding programs. These programs reported savings of up to 50 percent. If States had paid suppliers at the median competitive bidding rate, they could have paid 23 percent less and saved \$62 million. Other positive outcomes resulted from competitive bidding, such as increased beneficiary access to supplies, increased product quality, and State control of providing supplies. However, States reported encountering initial challenges with their competitive bidding programs, and six States attempted to establish competitive bidding but did not fully implement it. Recommendation—CMS should encourage States to seek further cost savings for disposable incontinence supplies.

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- *The Minnesota Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment and Supplies.* [A-05-13-00015](#). 2014 JAN.

The Minnesota Medicaid program could have saved an estimated \$2.27 million by establishing a competitive bidding program for durable medical equipment (DME) and supplies to obtain pricing similar to pricing that Medicare obtained through its competitive bidding program. The competitive bidding program sets lower payment rates than conventional Medicare payment rates for selected items while ensuring beneficiary access to quality items and services. We determined that average Medicare payment rates obtained through competitive bids for the 42 selected items were significantly lower than Minnesota's average Medicaid payment rates. Recommendation—Minnesota should establish competitive bidding that functions similarly to Medicare's competitive bidding program for the purchase of the 42 selected DME items, which could have resulted in cost savings.

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- *The California Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment.* [A-09-13-02028](#). 2014 MAR.

The California Medicaid program (Medi-Cal) could have saved an estimated \$3.9 million for CY 2011 by establishing a competitive bidding program for reimbursement of standard power wheelchairs, oxygen systems, and oxygen concentrators similar to Medicare's competitive bidding program or by revising its reimbursement methodology to obtain pricing similar to the Medicare payment rates in California's competitive bidding area (CBA). For the three product types reviewed, we determined that Medicare payment rates in California's CBA were significantly lower than the Medi-Cal payment amounts. Recommendation—California should establish a competitive bidding program similar to Medicare's.

Physician administered drugs: Maryland

- *Maryland Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs.* [A-03-12-00200](#). 2013 NOV.

Maryland did not always comply with Federal Medicaid requirements for billing manufacturers for rebates for physician-administered drugs. Federal reimbursement for covered outpatient drugs administered by a physician is not available to States that do not comply with Federal requirements for capturing data to bill and collect rebates. Maryland paid \$9.4 million for claims received on paper forms but billed for rebates on only \$35,000. As a result, it improperly claimed Federal reimbursement for \$3.5 million of single-source and top-20 multiple-source drugs. Recommendations—Maryland should update its Medicaid Management Information System (MMIS) edits to require national drug codes for payment on all drug claims; establish and implement processes to ensure that all physician-administered drug claims, including claims submitted on paper forms, are processed for rebates; refund the unallowable Federal share; and work with CMS to determine whether other questionable amounts are unallowable and refund the Federal share.

Supported employment services: New Jersey

- *Most of New Jersey's Claims for Medicaid Supported Employment Services Were Unallowable. A-02-12-01009. 2013 DEC.*

Most of the New Jersey Department of Human Services' (State agency) claims for Federal Medicaid reimbursement for supported employment services in the community care waiver (CCW) program did not comply with certain Federal and State requirements. Supported employment services are ongoing support services and other appropriate services needed to support and maintain individuals with developmental disabilities in a work setting. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$6.9 million in Federal Medicaid reimbursement for unallowable supported employment services. The claims for unallowable services were made primarily because most providers did not ensure that supported employment services were documented or provided by approved personnel to eligible beneficiaries.

Recommendations—New Jersey should ensure that reimbursement is claimed only for documented supported employment services, that supported employment services are provided only to beneficiaries for whom there is a completed and approved care plan, that all job coaches meet qualifications, and that all beneficiaries approved for supported employment services have been assessed and certified to need the required level of care. New Jersey should refund any unallowable Federal share to the Federal Government.

Orthodontic services: New York City

- *New York Improperly Claimed Medicaid Reimbursement for Orthodontic Services to Beneficiaries in New York City. A-02-11-01003. 2013 OCT.*

New York claimed Federal Medicaid reimbursement for orthodontic services provided to beneficiaries in New York City that did not always comply with Federal and State requirements. Of the 100 beneficiaries in our random sample, the State agency improperly claimed Medicaid reimbursement for 43 beneficiaries with 1 or more services that were unallowable. On the basis of our sample results, we estimated that the State agency claimed at least \$7.8 million in unallowable Federal reimbursement. The deficiencies occurred because the State and providers did not ensure that cases were reviewed annually to determine the need for continuing care and that services were documented. Further, the State provided only limited guidance to providers on State regulations, and the State did not sufficiently educate providers regarding their responsibilities. Recommendations—New York should strengthen guidance and provider education activities related to authorizing continuing treatment and maintaining adequate documentation and refund the unallowable Federal share to the Federal Government.

Excessive disproportionate share hospital payments: New Jersey

- *New Jersey Claimed Excessive Medicaid Disproportionate Share Hospital Payments to Four Hospitals. A-02-10-01042. 2014 MAR.*

DSH payments may not exceed hospitals' uncompensated care costs for providing services to patients who are eligible for Medicaid or have no health insurance for services provided during the year (known

as the “hospital-specific limit”). New Jersey claimed reimbursement for DSH payments to four hospitals that exceeded the hospital-specific limit by \$44 million (\$22 million Federal share). The overpayments occurred because the State had not established procedures for reconciling and adjusting DSH payments. Recommendations—New Jersey should establish procedures for reconciling and adjusting DSH payments to hospital-specific limits and refund unallowable Federal share to the Federal Government.

State payment of Medicare Part B deductibles and coinsurance

■ *Michigan Claimed Improper Medicaid Reimbursement for Some Medicare Part B Premiums.* *A-05-12-00035. 2014 MAR.*

Michigan claimed Federal Medicaid reimbursement for some Medicare Part B premiums it paid on behalf of beneficiaries who were ineligible for the buy-in program. Participating State Medicaid agencies are allowed to pay the monthly Medicare Part B premiums and claim reimbursement for the Federal share for certain Medicaid beneficiaries who are entitled to both Medicare and Medicaid benefits. The premium payments are made in cooperation with CMS under what is known as the “buy-in program.” On the basis of our sample results, we estimated that Michigan improperly claimed at least \$517,000 (Federal share) in Medicare Part B premiums it paid for individuals ineligible for enrollment in the buy-in program for the quarters ended December 31, 2008, through March 31, 2010. In addition, for the quarters ended December 31, 2007, through September 30, 2008, Michigan claimed \$232.8 million (\$139.5 million Federal share) for Part B premiums it paid on behalf of beneficiaries it could not readily identify nor document as eligible for the buy-in program.

Recommendations—Michigan should strengthen coordination with CMS and Social Security Administration officials to ensure appropriate corrective action is taken in verifying changes reported in a beneficiary’s eligibility status. Michigan should refund the unallowable Federal share and work with CMS to determine the allowability of Part B premiums claimed for Medicaid reimbursement for which it had inadequate support and refund any unallowable amount claimed.

■ *Colorado Did Not Properly Pay Some Medicare Part B Deductibles and Coinsurance.* *A-07-13-03189. 2013 DEC.*

During FYs 2011 and 2012, Colorado did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance in accordance with Federal requirements and the approved State plan. For 30 of the 100 claims in our sample, the State agency did not limit payment of Medicare Part B deductibles and coinsurance by State Medicaid plan rates, as required under Colorado’s Medicaid State plan. Because Federal requirements provide that a State plan for medical assistance is mandatory upon the State and all of its political subdivisions, these 30 claims thus violated Federal requirements as well as the requirements of the State plan.

These errors occurred because the State agency did not compare the Medicare payment to the State Medicaid plan rate, as required by the State plan. The State agency did not make this comparison because it did not have policies and procedures requiring it to do so for all Medicare Part B crossover claims. On the basis of our sample results, we estimate that the State agency claimed unallowable Medicaid payments of at least \$3.1 million (\$1.7 million Federal share) during FYs 2011 and 2012.

We recommended that Colorado refund \$1.7 million to the Federal Government for unallowable Medicaid payments for Medicare Part B deductibles and coinsurance and develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate, as required by the State plan, to determine the allowable Medicare Part B deductibles and coinsurance for all crossover claims.

Medicaid wasteful policies and practices

Diabetic testing supplies

- *State Medicaid Agencies Can Significantly Reduce Medicaid Costs for Diabetic Test Strips.* [A-05-13-00033](#). 2014 MAR.

See also:

- *Results of Reviews at Three Suppliers of Diabetic Testing Supplies.* [A-09-13-02032](#). 2014 MAR.
- *OIG Spotlight* article on diabetic strips, available on our Web site (News Room).

We reported that home blood-glucose test strips (test strips) are available to CMS and certain State Medicaid agencies at a net cost well below that available to other State Medicaid agencies. We conducted audits in Illinois, Indiana, New Jersey, New York, and Ohio to determine whether opportunities exist for State Medicaid programs to achieve savings for test strips. In these audits, we found that the State Medicaid agencies had saved or could have saved \$56 million for the period we reviewed. This included \$17.9 million saved through the use of manufacturer rebates, \$29.7 million of potential savings through the use of manufacturer rebates or competitive bidding in the purchase of test strips, and \$8.3 million in additional savings in States that obtained pricing comparable to pricing under Medicare's national mail-order competition for diabetic supplies. One State Medicaid program initiated a competitive bidding program after the completion of our audit. Recommendations—CMS should work with State Medicaid agencies to determine whether the use of manufacturer rebates and lower provider reimbursement rates could achieve net savings for the purchase of test strips.

State stewardship—Excessive withdrawal of funds

- *Maryland Withdrew Excessive Federal Medicaid Funds for Fiscal Years 2009 Through 2011.* [A-06-12-00051](#). 2013 DEC.

The Maryland Department of Health and Mental Hygiene (State agency) obtained Federal Medicaid funds for FYs 2009 through 2011 that were not supported by net expenditures. The State agency obtained \$12.9 billion in Federal Medicaid funds, but CMS awarded the State agency only \$12.8 billion for Medicaid expenditures. The State agency inappropriately withdrew the difference of \$115.3 million, consisting of \$116.7 million that the State agency inappropriately withdrew from FY 2012 grant award funds because of errors that occurred during its quarterly reconciliations for FYs 2009 through 2011 and \$1.4 million owed to the State agency because it mistakenly returned more funds than necessary in an FY 2011 account that was originally overdrawn. Additionally, the State agency did not always withdraw Federal funds from the appropriate Payment Management System (PMS) accounts because of fund

deficiencies, a faulty procedure, and other errors. The withdrawals caused the balances in the accounts to be wrong.

Recommendations—Maryland should ensure that the amounts used in its quarterly reconciliations are accurate and that it makes reconciliation adjustments to return or obtain Federal funds, establish procedures in its quarterly reconciliations to account for adjustments to expenditures not included on the CMS-64 report but that affect the State agency's grant award amounts, monitor PMS accounts to anticipate fund deficiencies and determine whether to refund overdrawn amounts or to request a supplemental grant award, and ensure that it withdraws funds from the appropriate PMS account. Maryland should refund \$115.3 million to the Federal Government.

Medicaid quality of care and patient safety

State oversight of managed care credentialing

■ *State and CMS Oversight of the Medicaid Managed Care Credentialing Process.*
[OEI-09-10-00270](#). 2013 NOV.

States must establish uniform provider credentialing policies and include Federal credentialing provisions in contracts with Medicaid Managed Care Entities (MCEs). States must also monitor MCEs' compliance with these Federal provisions and any additional State credentialing requirements in contracts. We reported that five of six States reviewed did not monitor MCEs' compliance with the Federal provider nondiscrimination contract provision. This provision requires that MCEs not discriminate against providers that serve high-risk populations or that specialize in conditions requiring costly treatment (67 Fed. Reg. 40989, 41031 (June 14, 2002).) Also, CMS oversight to ensure compliance of State contracts was inconsistent. Our review of 32 checklists showed that CMS regional office staff did not indicate whether 25 percent of contracts met all Federal credentialing provisions and that many checklists were missing other required contract information. Recommendations—CMS should issue guidance to States on monitoring MCE compliance with the Federal provider nondiscrimination contract provision. We also recommend that CMS regional office staff accurately complete the checklist to ensure State compliance with the Federal credentialing provisions.

<http://oig.hhs.gov>

Legal and investigative activities related to Medicare and Medicaid

For this semiannual period, we reported 427 criminal and 266 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported \$2.02 billion in investigative receivables due to the U.S. Department of Health and Human Services (HHS) and \$811.9 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs.

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, when appropriate, under the False Claims Act (FCA). Depending on the types of fraud or other violations involved, OIG 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 (Semiannual Report)* and on our Web site at: <https://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Chart 1: All programs

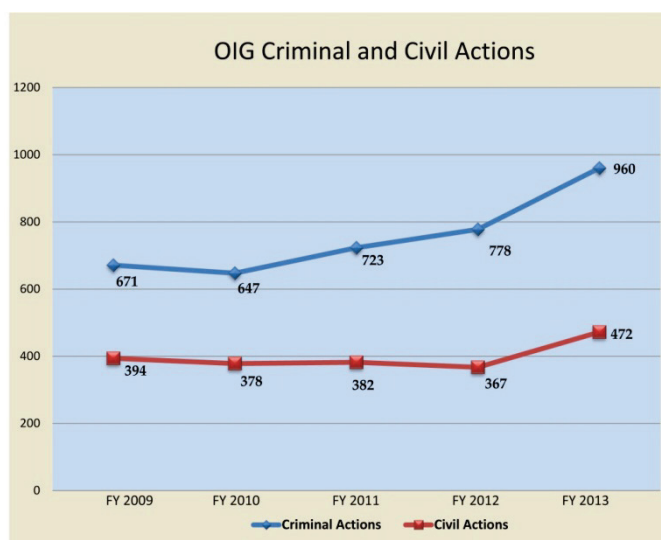
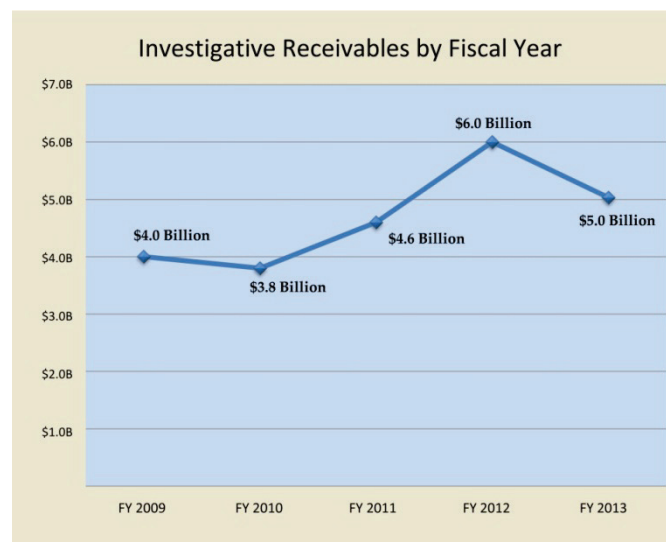


Chart 2: All programs



(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, § 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. From October 1, 2013, to March 31, 2014, OIG received 29 requests for advisory opinions and issued 9 opinions.

Health care fraud prevention and enforcement

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 initiative developed as part of HEAT in 2011 that

continues to reach the health care community with OIG's message of compliance and prevention via free, downloadable, comprehensive training materials and podcasts. OIG's provider compliance training resources can be accessed at http://oig.hhs.gov/newsroom/video/2011/heat_modules.asp.

Medicare Fraud Strike Force activities

The Medicare Fraud Strike Force (Strike Force) is a key component of HEAT. Strike Force was established in March 2007 and is 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 and investigative intelligence to quickly identify fraud and bring prosecutions. During this reporting period, Strike Force efforts resulted in the filing of charges against 94 individuals or entities, 107 criminal actions, and \$294.1 million in investigative receivables.

Strike force case—\$50.9 million in restitution

New York – Irina Shelikhova managed the daily operations of three medical clinics—Bay Medical Care PC, SVS Wellcare Medical PLLC, and SZS Medical Care PLLC. According to the indictment, the clinics submitted over \$71 million in false claims to Medicare, for which Medicare reimbursed approximately \$47 million. From March 2005 to July 2010, Shelikhova and her co-conspirators paid cash kickbacks to Medicare beneficiaries in return for receiving unnecessary physicians' services, physical therapy, and diagnostic tests at the clinics. Shelikhova hired a medically unlicensed co-defendant to impersonate a physician and render phony medical "care" to such patients. She also directed employees to create fake medical notes to support the false billings and to forge physicians' names on prescriptions and charts. Shelikhova, who was listed on HHS OIG's Most Wanted Fugitives web site until her capture in 2012, was sentenced to 15 years in prison and ordered to pay \$50.9 million in restitution, joint and several, for her involvement in the scheme. Shelikhova will face deportation from the United States at the conclusion of her prison term. A co-conspirator was sentenced to 2-and-a-half years in prison and was ordered to pay \$9.1 million in restitution, joint and several. Other co-conspirators were previously sentenced to a combined 22 years and 7 months in prison and ordered to pay more than \$60 million in restitution, joint and several.

Other strike force examples

New York – Dmitry Shteyman was the chief operating officer and vice president of Solstice Wellness Center, a medical clinic that purportedly provided physical therapy and diagnostic tests to Medicare beneficiaries. According to the indictment, Shteyman and his co-conspirators allegedly paid beneficiaries up to \$300 in kickbacks to be transported by ambulance to and from Solstice to receive physician services, physical therapy, and diagnostic tests. The services either were not provided or were medically unnecessary. Shteyman and his co-conspirators then submitted false claims to Medicare on behalf of Solstice for the services. Shteyman was sentenced to 8 years and 1 month of incarceration and ordered to pay \$1.4 million in restitution, joint and several, after pleading guilty to conspiracy to commit health care fraud.

California – Charles Agbu owned and operated the durable medical equipment (DME) company Bonfee, Inc. His daughter, Obiageli Agbu, owned and operated the DME company Ibon, Inc. According to the indictment, co-conspirators Candalaria Estrada and Alejandro Maciel acted as marketers who solicited

and obtained Medicare beneficiaries' information by offering them medically unnecessary medical equipment. The information was used by Dr. Emmanuel Ayodele and others to create fraudulent prescriptions and medical documents. Charles and Obiageli Agbu then used the information to submit or cause the submission of more than \$11 million in false claims to Medicare for power wheelchairs and other medical equipment that had not been provided or were medically unnecessary. Charles Agbu, Estrada, Maciel, and Ayodele pleaded guilty and were sentenced to a combined 14 years and 9 months of incarceration and were ordered to pay joint and several restitution of \$6.3 million. Obiageli Agbu was convicted at trial and is currently awaiting sentencing.

Florida – Miguel Guillermo Jimenez and Marina Sanchez-Pajon co-owned Flores Home Health Care, Inc., a home health agency that was located and operated in Miami-Dade County, Florida. From approximately October 2009 through June 2012, Flores Home Health Care billed Medicare and was paid approximately \$8 million for physical therapy and home health services that were not medically necessary and/or had not been provided. Jimenez and Sanchez-Pajon were sentenced to a combined 12 years in prison and ordered to pay \$8.4 million in joint and several restitution for their involvement in the fraud scheme.

Other criminal and civil enforcement activities

Special Assistant U.S. Attorney Program

During this reporting period, DOJ and OIG continued their participation in a program in which OIG attorneys, some of whom are Special Agents, serve as Special Assistant U.S. Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, including assignments to the Medicare Fraud Strike Force. 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 the fraudulent billing of medical equipment and supplies, infusion therapy, and physical therapy, as well as other types of Medicare and Medicaid fraud. Related case examples follow.

Michigan – Orlando Mena controlled and directed operations at two Detroit-area health care provider companies—World Health Care Medical Center, LLC (WHC) and Wyoming Medical Center, LLC (WMC). WMC was co-owned and operated by Reinaldo Orellana. According to court documents, Orlando Mena, Orellana, and co-conspirators Akim Mena and Xiomara Rodriguez allegedly offered and paid kickbacks and bribes, including cash and prescriptions for OxyContin, to Medicare beneficiaries in exchange for visiting the businesses. The conspirators then submitted false and fraudulent claims to Medicare for medically unnecessary office visits and various unnecessary tests. Between August 2008 and June 2010, the defendants caused the billing of more than 300,000 prescriptions for OxyContin. Orlando Mena, Akim Mena, and Rodriguez, all of whom were on HHS OIG's Most Wanted fugitives list until their captures in 2012, were sentenced to a combined 20 years and 10 months in prison and were ordered to pay more than \$3.7 million in restitution, joint and several, after pleading guilty to charges of conspiracy to commit health care fraud. Orellana, who hired marketers to recruit Medicare patients in the scheme, was sentenced to 4-and-a-half years of incarceration and was ordered to pay \$1.4 million in restitution, joint and several.

Tennessee – Husband and wife Woody Medlock, Sr., and Kathy Medlock owned and operated Murfreesboro Ambulance Service (MAS), an ambulance company that transported Medicare and Medicaid patients to and from dialysis treatments who were not qualified to receive ambulance transportation. According to evidence presented at trial, for more than a decade, the Medlocks submitted and caused MAS to submit about \$1.2 million in false claims to Medicare and Medicaid. The claims falsely represented that beneficiaries were on stretchers when, in fact, they were actually transported in the front seat of the ambulance or in a seat in the back of the ambulance and that patients were transported individually when, in fact, two patients were transported simultaneously in one ambulance. To conceal the fraud, the Medlocks and their co-conspirators allegedly omitted facts and/or provided vague descriptions on records that were used to falsely bill Medicare. The Medlocks were sentenced to a combined 12 years and 1 month of incarceration after being convicted by a jury on charges of conspiracy, Medicare fraud, making false statements related to health care matters, wire fraud, and aggravated identity theft. The Medlocks were also ordered to pay \$457,730 in restitution, joint and several.

Most wanted fugitives listed on OIG's Web site

The OIG Most Wanted Fugitives Web site continues to garner national and international attention and has greatly assisted in helping to capture fugitives charged with defrauding Federal health care programs and stealing millions of taxpayer dollars. The Most Wanted Fugitives Web site is continuously updated and features 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 English or Spanish, 24 hours a day, 365 days a year. The Most Wanted Fugitives list can be accessed at <https://oig.hhs.gov/fraud/fugitives>. During this reporting period, three fugitives were captured. Following are two examples.

Hector Hernandez – Most Wanted Fugitive Hector Hernandez was arrested on January 6, 2014, while traveling in a vessel toward the coast of Key West, Florida. In July 2009, Hernandez was indicted on charges of health care fraud and money laundering. Investigators believe that Hernandez, through his company, submitted approximately \$3.1 million in fraudulent Medicare claims for durable medical equipment (DME), such as sterile gauzes, appliance cleaners, urinary leg bags, and extension drainage tubings that were not prescribed by a doctor and had not been provided to Medicare beneficiaries. Medicare paid Hernandez's company, Complete Medical Center, Inc., approximately \$1.4 million in reimbursement for the false claims.

Carmen Gonzalez – Most Wanted Fugitive Carmen Gonzalez was captured and arrested in September 2013. Gonzalez was convicted at trial on charges of conspiracy to defraud the United States, conspiracy to cause the submission of false claims, conspiracy to pay health care kickbacks, and conspiracy to commit health care fraud. She was sentenced to 9 years in prison and ordered to pay more than \$8.2 million in joint and several restitution.

Because of the success of OIG's Most Wanted Fugitives Web site, OIG launched its Most Wanted Deadbeat Parents Web site at: <https://oig.hhs.gov/fraud/child-support-enforcement/index.asp>. The site identifies parents who fail to pay court-ordered child support for their children; as a result, an unnecessary strain is placed on the custodial parents and the children, as well as on agencies that enforce these matters. Examples are provided in the "Human Services Reviews" section of this Semiannual Report.

Recently completed actions and settlements

Pharmaceutical company

Pennsylvania – In one of the largest health care fraud settlements in U.S. history, Johnson & Johnson (J&J) and its subsidiaries agreed to pay more than \$2.2 billion to resolve criminal and civil allegations relating to the prescription drugs Risperdal, Invega, and Natrecor. The allegations included promoting the drugs for uses not approved as safe and effective by the Food and Drug Administration (FDA) and paying kickbacks to physicians and to the Nation's largest long-term care pharmacy provider, Omnicare, Inc. According to court documents, sales representatives for J&J subsidiary Janssen Pharmaceuticals Inc. (Janssen) allegedly urged physicians and other prescribers who treated elderly dementia patients to prescribe the drug Risperdal to treat symptoms of anxiety, agitation, depression, hostility, and confusion. Janssen allegedly created written sales aids for use by its ElderCare sales force that emphasized symptoms and minimized any mention of the FDA-approved use, which was for the treatment of schizophrenia. The company also provided incentives for off-label promotion and intended use by basing sales representatives' bonuses on total sales of Risperdal in their respective sales areas, not just the sales for FDA-approved uses. J&J agreed to pay a criminal fine, a forfeiture amount, and a civil settlement amount based on the False Claims Act. Also, Janssen pleaded guilty to one misdemeanor count of introduction of a misbranded drug (Risperdal) into interstate commerce. Finally, J&J entered into a CIA with OIG that includes provisions designed to promote accountability and transparency.

Prescription drug fraud

New Hampshire – David Kwiatkowski was a radiologic technician who was employed at 15 health care facilities in 8 states. According to court documents, while employed at Hays Medical Center in Kansas in June 2010, Kwiatkowski became aware that he was infected with Hepatitis C. Notwithstanding that knowledge, Kwiatkowski injected himself with syringes of the anesthetic fentanyl, which were intended for patients who were undergoing medical procedures. He added saline to the same syringes, which were then administered unknowingly by nurses to the patients. Consequently, instead of receiving the prescribed dose of fentanyl, the patients received saline that was tainted with the Hepatitis C virus. Kwiatkowski repeated this pattern of behavior at other hospitals where he worked, which investigators determined, caused least 45 patients to become infected with Hepatitis C. Some of these patients experienced very serious health complications, including one death in which Hepatitis C was a contributing factor. Kwiatkowski was sentenced to 39 years in prison and ordered to pay \$22,680 in restitution after pleading guilty to charges of tampering with a consumer product and fraudulently obtaining controlled substances.

Pennsylvania – During this semiannual period, 51 defendants were sentenced for their participation in a multi-million-dollar drug conspiracy involving illegal prescriptions, pseudo-patients, and multiple drug trafficking organizations. According to court records, pseudo patients were transported by the vanload to the medical practice of Dr. Norman Werther to obtain prescriptions for oxycodone-based products. The pseudo patients paid about \$150 in cash for the office visits; used their Medicare, Medicaid, or private insurance cards and cash to pay for the filled prescriptions at various pharmacies; and, in exchange for payments, provided the filled prescriptions to members of six separate drug trafficking organizations that would resell the drugs on the street. In return, the pseudo-patients were paid approximately \$300 to \$1,000 depending on the type of prescription they received. The operation resulted in the illegal distribution of more than 700,000 pills containing oxycodone. Werther was

previously sentenced to 20 years in prison and ordered to forfeit \$10 million, joint and several. Thus far, a total of 61 defendants have been sentenced to a combined 253 years in prison.

Pennsylvania – Physician Kermit Gosnell owned the practice entitled Family Medical Society, A Division of Women’s Medical Society, Inc. (Women’s Medical Society). According to the indictment, Gosnell and his co-conspirators allegedly ran a “pill mill” out of Women’s Medical Society. His customers, often referred to as drug “seekers,” purchased prescriptions for controlled prescription drugs without any legitimate medical purpose. Investigators believe that Gosnell used his practice to distribute over 500,000 pills containing oxycodone, 400,000 pills containing alprazolam, and over 19,000 ounces of cough syrup containing codeine. Gosnell allegedly saw customers in the evenings and until the early hours of the morning, at which time he sometimes provided a cursory physical examination before writing prescriptions for controlled substances. Many of the illegal prescriptions and some office visits were paid for by Pennsylvania Medicaid, Medicare Part D, and other insurers. Gosnell was sentenced to 30 years in prison and ordered to forfeit approximately \$200,000 and pay a \$50,000 fine.

Florida – Jose Teijeiro was the manager and registered agent of Greenwall Pharmacy Discount, Inc. (Greenwall Pharmacy). According to court records, Teijeiro and his co-conspirators paid recruiters to refer Medicare beneficiaries to Greenwall Pharmacy, where their Medicare numbers were used to file false claims for various health care benefits, primarily prescription drugs. Teijeiro also purchased false invoices from a pharmaceutical wholesaler. Medicare Part D plan sponsors paid Greenwall Pharmacy approximately \$6.8 million in reimbursement for the false claims. Teijeiro was sentenced to 5 years and 3 months of incarceration and ordered to pay \$6.8 million in restitution after pleading guilty to conspiracy to commit health care fraud.

Kentucky – National Respiratory Services, LLC (NRS), was a Louisville-based mail-order pharmacy. In July 2006, Medicare drastically reduced the reimbursement rate for compounded drugs to discourage companies from using those particular codes. On July 1, 2007, Medicare began denying all claims for inhalation compounded drugs, deeming them “medically unnecessary.” According to the indictment, NRS allegedly marketed directly to doctors who specialized in treating respiratory illnesses, and solicited business from these doctors to supply their patients with the drugs that the doctors prescribed to treat asthma, emphysema, and other respiratory illnesses. Between July 2006 and June 2008, NRS compounded drugs and then falsely represented that the drugs were FDA-approved when, in fact, these drugs were not FDA approved, were of various potencies, were non-sterile, and therefore were adulterated and misbranded. NRS was ordered to pay \$2 million in restitution, joint and several, after pleading guilty to health care fraud charges. NRS owner Chris Keegan, vice-president Johnny Perry, consultant/minority owner Jim Rives, and pharmacists Linda Schmidt and Leo Parrino were all sentenced in connection with this case.

Medical clinics

Texas – Sunday Joseph Edem controlled and operated several medical clinics in and around Houston, Texas, despite being excluded from participation in all Federal health care programs on the basis of an earlier health care fraud conviction in California. To conceal his involvement with the clinics, Edem registered the clinics in the names of other individuals, known as “straw owners,” including the mother of his child and employees at the clinics. According to court documents, Edem allegedly paid individuals to recruit Medicare beneficiaries, including some residing in homeless shelters, to visit the clinics to receive medically unnecessary diagnostic tests. Edem partnered with Donald Gibson II, who acted as the “medical director” of the clinics, though he did not see or evaluate patients. Edem and Gibson then

billed Medicare more than \$15 million for the unnecessary tests, using Gibson's Medicare provider number. Edem was sentenced to 6 years of incarceration and ordered to pay \$4.3 million in restitution, joint and several, after pleading guilty to conspiracy to commit health care fraud. Gibson was sentenced to 4 years and 4 months in prison and ordered to pay \$6.9 million in restitution.

Kentucky – Dr. Bryan Wood and Dr. Robin Peavler owned and operated a chain of addiction treatment clinics located in 12 Kentucky cities. After Wood and Peavler became owners of the clinical laboratory PremierTox 2.0 LLC (PremierTox), they allegedly began referring all drug screens completed at the clinics to PremierTox for additional comprehensive urine drug screening tests, which were often unnecessary and more expensive than suitable alternative tests. PremierTox allegedly submitted false claims that misidentified the class of drug that was tested for and, as a result, obtained greater reimbursement than it was entitled to receive. Wood, Peavler, PremierTox, and Addixion Recovery of Kentucky, LLC (d/b/a SelfRefind) collectively agreed to pay \$15.75 million to resolve civil allegations under the False Claims Act that they billed Federal health care programs for medically unnecessary and excessive urine tests. As part of the settlement, PremierTox agreed to enter into a 5-year CIA with OIG that obligates PremierTox to undertake substantial internal compliance reforms and commit to third-party reviews of claims submitted to Federal health care programs.

Dental practices

Connecticut – Gary Anusavice, who was excluded by OIG from participating in Federal health care programs (including Medicaid) partnered with a dentist to fraudulently open three dental practices in Connecticut. In the applications to enroll the entities as Medicaid providers, Anusavice failed to disclose that he had an ownership interest in the dental practices, that he was the subject of prior disciplinary and criminal actions, or that he was excluded from the Medicaid program. Anusavice concealed his involvement in the dental practices by having other licensed dentists, including his business partner, act as nominal heads of the clinics. Anusavice used the proceeds of this fraudulent scheme to purchase a mansion, boat, Mercedes Benz, and other personal items. From tax years 2008 through 2011, Anusavice did not file federal tax returns. Anusavice was sentenced to 8 years and 1 month in jail and ordered to pay \$5.2 million in restitution after pleading guilty to charges of health care fraud and tax evasion.

Home health care

Michigan – The owners of five home health companies created fictitious therapy files, appearing to document physical and occupational therapy services provided to Medicare beneficiaries when, in fact, no such services were provided. According to court documents, the owners hired patient recruiters, who offered cash and the promise of prescriptions drugs to Medicare beneficiaries in return for their Medicare identification numbers. Physical therapists and physical therapist assistants at the companies used the Medicare information to create false physical therapy files using blank, pre-signed forms to make it appear as if physical therapy services had been rendered. The forms were then used to bill Medicare nearly \$20 million for services that had not been rendered and were medically unnecessary. Nine individuals—Muhammad Shahab, Vishnu Meda, Mehran Javidan, Curtis Mallory, Jessica Vigil, Maira Suleman, Sherry Prescott, Tariq Chaudhary, and Faisal Chaudry—were sentenced to a combined 26 years and 11 months of incarceration and ordered to pay a combined \$29.9 million in restitution, joint and several, for their connections to the scheme.

Florida – Caring Nurse Home Health, Corp. and Good Quality Home Health, Inc., were Florida-based businesses that purportedly provided home health care and physical therapy services to eligible

Medicare beneficiaries. According to the indictment, the companies' presidents and co-conspirators allegedly paid kickbacks to individuals to recruit beneficiaries as patients. The companies then billed Medicare for home health services, including diabetic injections, skilled nursing visits, and physical therapy, which were not medically necessary and/or had not been provided. The defendants also sent patient recruiters and beneficiaries to doctors to obtain prescriptions for home health services that were not medically necessary. The two companies submitted about \$52.5 million in claims to Medicare for home health services purportedly provided to about 1,300 beneficiaries. During this reporting period, five patient recruiters (Elizabeth Monteagudo, Cristobal Gonzalez, Emilio Amador, Eduims Mora, and Jose Contreras) were sentenced to a combined 20 years and 4 months in prison and ordered to pay a combined \$30.6 million in restitution, joint and several. The presidents of the two companies were previously sentenced to a combined 13 years and 3 months in prison and ordered to pay \$35 million in restitution.

Hospice care

Pennsylvania – Dr. Eugene Goldman, aka Yevgeniy Goldman, served as the medical director of Home Care Hospice, Inc. (HCH), from 2000-2011. Evidence presented at trial showed that, from January 2004 to October 2008, Goldman received about \$228,773 in kickbacks for Medicare and Medicaid patient referrals to HCH. Goldman received up to \$400 for each new patient referral and \$150 per month for each patient that remained in hospice care. To conceal the illegal kickback arrangement, HCH and Goldman entered into a fictitious written contract to create the false appearance that all payments were for bona fide services rendered in Goldman's capacity as medical director. Goldman was sentenced to 4 years and 3 months of incarceration and was ordered to pay \$300,000 in fines after being convicted on charges of conspiracy to receive kickbacks and for receiving kickbacks for Medicare referrals.

Hospitals

Kentucky – Saint Joseph Health System, Inc. (d/b/a Saint Joseph London (SJL)), agreed to pay \$16.5 million to resolve allegations that it violated the anti-kickback statute, Stark Law, and False Claims Act. The Government alleged that SJL was aware that doctors working at its facility performed unnecessary invasive cardiac procedures on Medicare and Medicaid patients, including coronary stents, pacemaker implants, coronary artery bypass graft surgeries, and diagnostic catheterizations. SJL also allegedly entered into sham management agreements with two cardiologists who owned a medical practice that had entered into an exclusive arrangement with SJL to provide cardiology services to SJL's patients. As part of the settlement, SJL entered into a 5-year CIA with OIG that requires SJL to appoint physician executives to oversee medical staff quality-of-care matters, appoint a Medical Director of the Cardiac Catheterization Laboratory, and hire a Peer Review Consultant to evaluate SJL's peer review practices.

New York – John Reynolds was the former chief executive officer (CEO) of the Hospital for Special Surgery, Inc. (HSS). According to court documents, from approximately 1997 to 2006, Reynolds engaged in several fraudulent acts. For example, he solicited and received approximately \$420,000 in kickbacks from at least two different hospital vendors in return for using his position at the hospital to secure contracts for the vendors; he extorted nearly \$300,00 in annual bonus money from a hospital employee; and he solicited and received about \$670,000 in kickbacks from a health care organization in the United Kingdom in return for using his position to approve a clinical partnership between the hospital and the United Kingdom company. Through the schemes, Reynolds pocketed approximately \$1.4 million.

He deceived the hospital by making false statements and withheld information from the hospital's board of directors relating to his outside consulting arrangements. Reynolds also provided Federal agents with false information during interviews. Reynolds was sentenced to a year-and-a-half in jail and ordered to pay \$383,500 in restitution after pleading guilty to charges of wire fraud and making false statements to a Federal agent.

Identity theft

Amira Avendano-Hernandez, an undocumented alien, falsely used the identifying information of another person to obtain federally funded health care benefits and Social Security disability benefits. From 2004 to 2009, she received health care items and services, including a liver transplant, for which Medicaid and Medicare collectively paid a total of \$165,463. From 2005 through 2011, Avendano-Hernandez used the same false identity to fraudulently qualify for about \$66,457 in Social Security disability benefits, which she converted to her own use knowing she was not entitled to them. Avendano-Hernandez was sentenced to 6 months in prison and ordered to pay \$231,920 in restitution after pleading guilty to a charge of theft of Government funds.

Medical devices

Florida – Genzyme Corporation agreed to pay nearly \$22.3 million to resolve allegations that it improperly marketed and knowingly caused false claims to be submitted to Federal health care programs for use of its device, Seprafilm, in a form that was altered and untested and was therefore not reimbursable. Seprafilm is a Class III medical device approved by FDA as an adhesion barrier for open abdominal and pelvic surgery. From January 2003 through May 2010, Genzyme sales representatives allegedly taught doctors and other staff to cut the Seprafilm sheets into small pieces, add saline, and allow the pieces to dissolve until the desired consistency was reached. The resulting slurry was used in laparoscopic or "key hole" surgeries by inserting a catheter filled with the mixture into the patient's body and squirting it into the abdominal cavity.

Minnesota – Boston Scientific Corporation and its subsidiaries, Guidant LLC, Guidant Sales LLC, and Cardiac Pacemakers, Inc. (collectively, Guidant), agreed to pay \$30 million to resolve allegations that Guidant knowingly sold defective heart devices to health care facilities that, in turn, implanted the devices into Medicare patients. Guidant manufactured and sold implantable defibrillators, which are used in patients at risk of cardiac arrest due to an irregular heartbeat. The Government alleged that two lines of Guidant's implantable cardiac devices contained a defect that would render them ineffective when implanted into patients' chests. Guidant allegedly learned that both lines of the devices were defective as early as April 2002 and November 2003, respectively. Although Guidant took corrective action to fix the defects, it allegedly continued to sell its remaining stock of the old, defective versions of the devices and took steps to hide the cause of the defect from patients, doctors, and FDA. In 2010, Guidant pleaded guilty to criminal charges of misleading FDA and failing to submit a labeling change to FDA relating to the defective devices.

Medical equipment and supplies

Texas – Emeka Daniel Orji owned and operated Spectrum Foundation, Inc. (Spectrum), a Texas business that purportedly provided Medicare and Medicaid beneficiaries with orthotics and other durable medical equipment (DME). According to the indictment, Orji and his co-conspirators used Spectrum to submit claims for DME items that were medically unnecessary or were not provided at all and claims for

DME that were intentionally miscoded. Spectrum then submitted claims to Medicare in excess of \$3.4 million for these and other items, including 157 unpaid claims on behalf of deceased beneficiaries. Orji also owned and operated an ambulance transportation company and submitted or caused the submission of claims to Medicare for ambulance services that had not been provided or for instances when the beneficiaries had been transported in a standard minivan. Orji was sentenced to 4 years in prison and ordered to pay nearly \$1.5 million in restitution following his conviction for conspiracy to commit health care fraud and health care fraud aiding and abetting.

Louisiana/Kansas – Robert Shea and Mark Franz were the owners of the mail-order diabetic supply companies Global Medical, Inc., and Global Medical Direct, LLC. Between April 2008 and January 2012, Shea and Franz allegedly caused the companies to enter into numerous marketing contracts with insurance brokerage and other companies with customer bases likely to have a high percentage of diabetes patients. Shea and Franz allegedly paid the companies on the basis of the number of patients referred for diabetic supplies, a violation of the anti-kickback statute. Shea and Franz agreed to pay \$7 million to resolve these allegations, which purportedly led to the submission of false claims to the Medicare and TRICARE programs. Both Shea and Franz also agreed to a 20-year period of exclusion from participation in Medicare, Medicaid, and all other Federal health care programs. In addition, Global Medical and Global Medical Direct agreed to pay \$5 million in proceeds from the sale of all of the companies' assets to settle civil allegations under the False Claims Act.

Personal care services

Illinois – “Operation Home Alone” was a joint law enforcement effort to crack down on individuals who exploited Illinois' Home Services Program and received Medicaid funds to which they were not entitled. This operation uncovered several personal care services fraud schemes, such as personal assistants' billing for services that could not have been performed because the personal assistants were in jail or out of town or because the beneficiaries were residing in hospitals or nursing homes, or were out of town. The investigations also revealed that personal assistants and/or beneficiaries had conspired to receive Medicaid payments for services not rendered and had split the Medicaid payments (see example below). As a result of Operation Home Alone, 11 defendants have been sentenced to more than 5 years in prison and 26 years of probation and 2 additional defendants have pleaded guilty and are awaiting sentencing.

Illinois – Lisa Luckett was a Medicaid beneficiary involved in a personal care services scheme. According to court documents, Luckett, who was receiving Medicaid disability benefits because she was on non-working disability,, completed an “Employment Agreement between Customer and Personal Assistant” form in which she falsely stated that her daughter was the personal care assistant for a Medicaid beneficiary who was living with Luckett. Luckett then submitted false home service time sheets to Medicaid, claiming that her daughter had performed more than 3,500 hours of personal assistant services. Luckett then pocketed the money reimbursed by Medicaid. When her daughter learned from the Internal Revenue Service (IRS) that her name was being used, she advised Luckett to stop using her name. Luckett then conspired with her neighbor, Henry Billups III, who agreed to have his name used in exchange for a portion of the amount reimbursed by Medicaid. According to published reports, Luckett ignored the beneficiary's serious and ongoing medical issues that should have led to hospitalization. Instead, she kept the beneficiary in the home and continued to receive payments from the State. The beneficiary died in Luckett's home as a result of malnutrition and sepsis due to neglect. Luckett and

Billups were each sentenced to 4 years and 6 months in prison, respectively, and were ordered to pay a combined \$99,301 in restitution after pleading guilty to charges of health care fraud.

Physical therapy

Florida – Rosina Cheverez was president of two companies that purportedly provided physical and occupational therapy (PT/OT) services for various Comprehensive Outpatient Rehabilitation Facilities (CORFs), Outpatient Rehabilitation Facilities (OPTs), and home health agencies that billed Medicare. According to the indictment, Cheverez partnered with Miami area PT/OT companies and recruited and hired therapists and therapist assistants to sign treatment forms falsely indicating that they had provided PT/OT services to Medicare beneficiaries when, in fact, these services had not been performed. These companies used the false treatment forms to bill Medicare for more than \$42 million in claims for PT/OT services that had not been provided. As a result, Medicare paid the companies \$18.6 million in reimbursements to which they were not entitled. Cheverez was sentenced to 10 years in prison and ordered to pay \$14.4 million in restitution, joint and several, after pleading guilty to conspiracy to commit health care fraud. Six other individuals were previously sentenced to a combined 15 years and 9 months of incarceration and ordered to pay a combined \$1.3 million in restitution, joint and several, for their connections to the scheme.

Missouri – Contract therapy providers RehabCare Group, Inc. and RehabCare Group East, Inc. (collectively, RehabCare); Rehab Systems of Missouri (RSM); and management company Health Systems, Inc. (HSI) agreed to pay \$30 million to resolve allegations that they violated the anti-kickback statute and the False Claims Act. The Government alleged that, between March 2006 and December 2011, RehabCare arranged with RSM to obtain RSM's contracts to provide therapy to Federal health care program beneficiaries residing in 60 nursing homes controlled by RSM's majority owner and managed by HSI. In exchange for this stream of referrals, RehabCare allegedly paid RSM prohibited remuneration in the form of an upfront payment of as much as \$600,000, plus a percentage of the revenue generated by each referral.

Physicians

New Jersey – Dr. Jose Katz owned two companies that purportedly provided cardiology, internal medicine, and other medical services to Medicare and Medicaid beneficiaries: Cardio-Med Services LLC (Cardio-Med) and Comprehensive Healthcare & Medical Services LLC (Comprehensive). According to published reports, Katz spent more than \$6 million in advertising on Spanish-language media to entice patients to visit Cardio-Med and Comprehensive. During the visits, Katz ordered and performed essentially the same diagnostic tests for nearly all the patients he treated, regardless of their symptoms. Katz also instructed his non-physician employees to order and perform diagnostic tests for patients of other doctors working at his companies, even though he had not examined those patients and the other physicians had not ordered the unnecessary tests. Katz admitted that he falsified patient charts and falsely diagnosed a majority of his patients with coronary artery disease and debilitating and inoperable angina to justify prescribing and administering unnecessary treatment, therefore subjecting them to serious risk of injury or death. Katz was sentenced to 6-and-a-half years in prison and ordered to pay \$19 million in restitution after pleading guilty to charges of attempt and conspiracy to commit health care fraud and false or fraudulent claims.

Skilled nursing facilities

California – Ensign Group, Inc. (Ensign), agreed to pay \$48 million to resolve civil allegations under the False Claims Act that it knowingly submitted false claims to Medicare for rehabilitation therapy services at six of its skilled nursing facilities. From January 1999 through August 2011, Ensign allegedly billed Medicare for levels of rehabilitation therapy services that had not been provided, were not medically necessary, and/or had been inflated on Minimum Data Set forms despite therapy logs that documented less therapy. The Government also alleged that the Ensign facilities in question had a corporate culture that improperly incentivized therapists and others to increase the amount of therapy provided to patients to meet allegedly planned targets for Medicare revenue that were set without regard to patients' individual therapy needs and could be achieved only by upcoding and/or providing unnecessary services. In addition to agreeing to pay the settlement amount, Ensign agreed to enter into a 5-year CIA with OIG covering all of its approximately 95 skilled nursing facilities.

Transportation fraud

California – Filyn Corporation (Filyn) owns and operates Lynch Ambulance, operating in and around southern California. According to court documents, from approximately 2001 through 2007, Filyn regularly billed Medicare and TRICARE for non-emergency, basic life support (BLS) transports of beneficiaries who were not "bed-confined" at the time of transport or whose transports were otherwise not medically necessary. Filyn agreed to pay more than \$3 million to resolve its civil liability under the False Claims Act. In addition, Filyn entered into a 5-year CIA with OIG.

California – Pacific Ambulance, Inc. (Pacific) and Bowers Companies, Inc. (Bowers) agreed to pay \$8 million to resolve their civil liability under the False Claims Act. Between 2004 and 2011, Pacific and Bowers allegedly entered into numerous below-cost contracts with skilled nursing facilities. The Government investigation determined that all these contracts constituted prohibited "swapping" arrangements, wherein Pacific and Bowers allegedly offered prices to the skilled nursing facilities that were below their total costs of providing ambulance transport services in return for referrals of future Medicare business.

State Medicaid Fraud Control Units

OIG oversight of State MFCUs

Medicaid Fraud Control Units (MFCUs or Units) are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. HHS OIG oversees MFCUs and administers grants that provide Federal funding for Unit operations. The Federal Government reimburses 75 percent of the costs of operating a Unit; the States contribute the remaining 25 percent. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities or board and care facilities.

MFCU funding and accomplishments in FY 2013

In FY 2013, combined Federal and State expenditures for the operation of 50 MFCUs (including 1 in Washington, DC), totaled about \$231.5 million. The MFCUs employed 1,912 individuals. Collectively, in FY 2013, MFCUs reported 15,590 investigations, of which 12,366 were related to Medicaid fraud and

3,224 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges against or indictments of 1,588 individuals, including 1,197 for fraud and 391 for patient abuse and neglect, including patient funds cases. In total, 1,341 criminal actions were reported in FY 2013, of which 991 were related to Medicaid fraud and 350 were related to patient abuse and neglect, including patient funds cases. Civil judgments and settlements for FY 2013 totaled 879 and monetary recoveries in civil cases totaled over \$1.5 billion. (*Medicaid Fraud Control Units FY 2013 Annual Report*. [OEI-06-13-00340](#). Appendix C. 2014 MAR.) See also Medicaid Fraud Control Units 2013 Statistics [Interactive Map](#) and [Chart](#) on our Web site.

OIG onsite reviews of MFCUs

OIG has developed 12 performance standards for use in assessing the operations of MFCUs. A copy of the [MFCU performance standards](#), most recently revised in June 2012, may be found on the OIG Web site. Periodically—approximately every 5 years—OIG conducts an in-depth onsite review of each Unit to evaluate its operations as related to the 12 performance standards and to assess compliance with laws, regulations, and OIG policy guidance. OIG issued reports of onsite reviews of the following MFCUs during the reporting period. The full reports are available on our Web site.

- *West Virginia State Medicaid Fraud Control Unit: 2013 Onsite Review.* [OEI-07-13-00080](#). 2013 OCT.
- *Montana Medicaid Fraud Control Unit: 2012 Onsite Review.* [OEI-09-12-00700](#). 2013 OCT.
- *Vermont State Medicaid Fraud Control Unit: 2013 Onsite Review.* [OEI-02-13-00360](#). 2013 DEC.
- *Nevada Medicaid Fraud Control Unit: 2012 Onsite Review.* [OEI-09-12-00450](#). 2013 OCT.
- *Michigan Medicaid Fraud Control Unit: 2013 Onsite Review.* [OEI-09-13-00070](#). 2014 JAN.
- *Minnesota State Medicaid Fraud Control Unit: 2013 Onsite Review.* [OEI-06-13-00200](#). 2014 MAR.

Joint investigations with MFCUs

Texas – Joint investigation with the FBI and Texas MFCU. Carla Herrera assisted in the operation of RGV DME, a durable medical equipment (DME) supplier based in McAllen, Texas. Herrera acted as marketing director, supervised the office manager, and provided training to employees. Beatriz Ramos was the office manager at RGV and was responsible for medical billing. According to court records, the defendants and their co-conspirators billed Medicare and Texas Medicaid for DME, including power wheelchairs, hospital beds, and diabetic supplies, which had not been prescribed or ordered by the beneficiaries' physicians, were not medically necessary, or had not been provided to the beneficiaries. The scheme included using "marketers" to solicit and obtain Medicare and Texas Medicaid beneficiaries' identification numbers and other information in exchange for gifts or other items of value. The defendants and co-conspirators submitted approximately 25,000 claims to Medicare and Texas Medicaid, totaling approximately \$11 million. Herrera and Ramos were sentenced to a combined 8 years and 8 months in prison and ordered to pay a combined \$9.5 million in restitution, joint and several. Two co-conspirators, including RGV's owner, were previously sentenced to a combined 23 years and 2 months in prison and ordered to pay \$6.1 million in restitution.

North Carolina – Joint investigation with the IRS, Federal Bureau of Investigation (FBI), and North Carolina MFCU. Linda Radeker was a licensed professional counselor who operated Wellness Training Associates, a company that purportedly provided mental health and substance abuse counseling. According to court documents, from approximately 2008 to 2011, Radeker claimed in her Medicaid billings that she was the attending clinician for behavioral and mental health services. Instead, Radeker “rented” her Medicaid provider number so others could bill Medicaid for services that had not been provided and/or for services that did not meet requirements. In return, Radeker received up to 50 percent of the fraudulent Medicaid reimbursement. As part of the Scheme, Radeker’s co-conspirators recruited and obtained the Medicaid numbers of children from the community whose parents thought they were enrolling their children in after-school programs. Radeker and her co-conspirators defrauded Medicaid of at least \$6.1 million in payments for sham behavioral and mental health services. Radeker was sentenced to 6 years of incarceration and ordered to pay \$6.1 million in restitution, joint and several, after pleading guilty to charges of conspiracy to commit health care fraud and money laundering and aiding and abetting.

Sanction authorities and other 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. Sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties (CMPs) 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 (EMTALA), also known as the patient dumping statute.

During this semiannual reporting period, OIG imposed 1,789 administrative 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. Exclusion and penalty authorities are described in Appendix D and on our Web site at <http://oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program exclusions

During this semiannual reporting period, OIG excluded 1,720 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. OIG is also responsible for reinstating providers who apply and have met the requirements of their exclusions. For a list of excluded individuals and entities, see: <https://exclusions.oig.hhs.gov/>. Case examples follow.

California – Physician Christine Daniel was excluded from Federal health care programs for a minimum period of 35 years on the basis of her conviction on counts of wire fraud, mail fraud, tax evasion, and witness tampering. Daniel was sentenced to 14 years of incarceration and her license to practice as a medical doctor was suspended indefinitely by the Medical Board of California. According to court documents, Daniel concocted a product that she labeled, described, and promoted under several different names. She and her employees falsely claimed that the product could cure or treat many human diseases and conditions, including cancer, and falsely represented that the product was made of herbs from around the world and that the product was manufactured according to the needs of each patient. Daniel caused the product to be shipped to customers throughout the United States, and

customers traveled to her facility to receive treatment. Depending on the purported product strength, Daniel charged between \$750 and \$4,270 for about a week's supply. In reality, Daniel's product did not have the represented cancer cure rate, was not made of herbs from around the world, and was not manufactured by Daniel in a laboratory for each patient. Daniel was also suspended indefinitely from participation in the California Medi-Cal program.

New York – HHS OIG captured fugitive Helene Michel, who owned and operated a DME company, was excluded for a minimum period of 35 years on the basis of her conviction for health care fraud and wrongful disclosure of individually identifiable health information. According to court documents, from about April 2003 to about March 2007, Michel submitted and caused the submission of claims to Medicare and Medicaid for medical supplies that were purportedly provided to patients in nursing homes. However, Michel knew that the supplies had not been provided. Michel was sentenced to 12 years of incarceration and ordered to pay \$4.4 million in restitution. She was also excluded from participation in the New York Medicaid program.

California – Vincent Rubio, the former chief financial officer at Tustin Hospital and Medical Center, was excluded for a minimum period of 20 years on the basis of his conviction for conspiracy to pay kickbacks for patient referrals. According to court documents, from about July 2003 to about September 2007, Rubio conspired with others to increase inpatient stays at the hospital by admitting homeless Medicare and Medi-Cal beneficiaries recruited by two individuals. Rubio, acting on behalf of the hospital, paid illegal remunerations to companies owned by the recruiters, knowing the hospital would bill Medicare and Medi-Cal for the services provided to the recruited beneficiaries, including services that were not medically necessary. Rubio was sentenced to 8 months of home detention and ordered to pay approximately \$10.6 million in restitution.

Pennsylvania – Physician Richard Minicozzi was excluded for a minimum period of 20 years on the basis of his conviction for conspiracy to distribute controlled substances and distribution of controlled substances. According to court documents, from about January 2005 to about September 2010, Minicozzi sold controlled substances and prescriptions for controlled substances to cash-paying customers outside the usual course of professional practice and with no legitimate medical purpose. Minicozzi purchased the controlled substances from pharmaceutical supply companies and had the drugs shipped to his office, where he packaged the drugs into small boxes for resale to his customers. Minicozzi falsified "medical" records to make it appear as if his customers received medical exams and treatment. Minicozzi was sentenced to 7 years of incarceration, and the Pennsylvania State Board of Medicine suspended his license to practice medicine for at least 10 years. Additionally, Minicozzi was indefinitely precluded from participating in the Pennsylvania Medicaid program.

Corporate integrity agreements

Many health care providers elect to settle their cases before litigation. As part of the settlements, providers often agree to enter into CIAs with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Under a CIA, a provider commits to establishing a program and taking other specified steps to ensure future compliance with Medicare and Medicaid rules. The compliance programs are designed, in part, to prevent future fraud. OIG monitors providers' compliance with these agreements. OIG may impose penalties on entities that fail to comply with the requirements of their CIAs.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties on 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 semiannual reporting period, OIG concluded cases involving more than \$18.7 million in CMPs and assessments. The following are case examples.

New York – Henry Schein, Inc., a medical and dental equipment supplier, agreed to pay more than \$1.1 million to resolve allegations under the CMPL provisions applicable to kickbacks. OIG alleged that Henry Schein, Inc., awarded customers, who were members of its Medical Privileges Program, points for every item purchased electronically through the company and allowed customers to redeem those points for an array of items, including travel, hotel stays, iPads, gift cards, toasters, toys, and medical office products and supplies. However, OIG alleged that this type of remuneration was improper and did not qualify as a “discount” or “rebate” under the anti-kickback statute.

Louisiana – Humana, Inc., agreed to pay \$1.8 million for allegedly violating the CMPL. OIG contended that Humana improperly submitted prescription drug event claims to the Medicare Part D program that included sales tax from Louisiana pharmacies, despite the fact that Medicare Part D drugs were not taxable under Louisiana law as of July 1, 2006. This case represents the first CMPL settlement with a Medicare Part D plan.

North Carolina – A diabetes supply company (Four Leaf Clover, Inc. (FLC)); a telemarketing company (Team Tech Solutions, Inc. (TTS)); and their owner-executives collectively agreed to pay \$472,000 for allegedly violating the CMPL. OIG contended that the companies and their executives paid and received kickbacks and caused the submission of false claims to Medicare for durable medical supplies as a result of illegal telemarketing. OIG alleged that FLC contracted with TTS to make unsolicited calls to Medicare beneficiaries and paid TTS for each Medicare beneficiary referred for diabetes supplies. FLC; its owner and President, William Sweeney; and its former co-owner and Chief Operating Officer, Michael Sweeney, agreed to be permanently excluded from participation in the Federal health care programs. TTS and its owner and President, Justin Ortiz, agreed to be excluded for 10 years.

Massachusetts – Ronald Goldberg, M.D., and his practice, Haverhill Family Practice (HFP), agreed to pay \$162,676 for allegedly violating the CMPL. OIG alleged that Goldberg and HFP improperly billed under Goldberg’s provider number for services rendered by nurse practitioners. Goldberg and HFP also allegedly submitted false claims for services that had not been provided to nursing home patients because the patients were in fact hospitalized or, because, in one case, the patient was deceased.

Patient Dumping

Some of the CMPL cases that OIG resolved between October 1, 2013, and March 31, 2014, were pursued under the Emergency Medical Treatment & Labor Act (EMTALA), a statute designed to prevent hospitals from denying emergency care to patients and to ensure patient access to appropriate emergency medical services. Examples follow.

North Carolina – Carolinas Medical Center (Carolinas) agreed to pay \$50,000 to resolve its liability under EMTALA. OIG alleged that Carolinas failed to provide an appropriate medical screening examination or stabilizing treatment to a patient who arrived at its emergency department with complaints of homicidal

ideation and acute depression. The patient also stated that he feared harming himself and his wife and that he had visual hallucinations. The patient had visited Carolinas approximately 2 weeks earlier with similar complaints, at which time Carolinas learned the patient had access to firearms. Following a cursory examination, the patient was discharged from the emergency department with a prescription for a mild anti-depressant, and, shortly after discharge, the patient killed his wife, two of his four children, and himself.

Tennessee – Regional Medical Center at Memphis (RMC) agreed to pay \$50,000 to resolve its liability under EMTALA. OIG alleged that RMC failed to provide a medical screening examination that was within the hospital's capability to a 6-year-old patient who arrived at its emergency department with a fractured arm, accompanied by her parents. The patient and her parents allegedly were refused entry into the emergency department and instead were instructed to walk to a nearby children's 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 protocol 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 were uncovered. The self-disclosure also allows 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. 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. 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 <https://oig.hhs.gov/compliance/self-disclosure-info/index.asp>.

During this reporting period, self-disclosure cases resulted in \$11.4 million in HHS receivables. The following are examples of provider self-disclosure settlements.

Texas – Seton Family of Hospitals (Seton) (d/b/a Towers Nursing Home (Towers)) self-disclosed to OIG that it submitted false claims to Medicare for post-hospital extended care services rendered at Towers, where the underlying certifications and recertifications did not meet applicable payment criteria. The certifications and recertifications contained several irregularities, including missing dates and physician signatures, errors in documenting the reasons for continued skilled nursing facility care, and signing of certifications by physicians who did not necessarily have knowledge about the patient's case. Seton agreed to pay \$1,139,789 for allegedly violating the CMPL.

Michigan – The Guidance Center (TGC) self-disclosed to OIG that it submitted claims for multiple developmental disability services provided simultaneously to Medicaid patients when only one service was eligible for payment. OIG alleged that TGC obtained greater reimbursement than it was entitled to receive by knowingly making or using a false record or statement that was material to a false or fraudulent claim for payment for services furnished under the Michigan Medicaid program. TGC agreed to pay \$742,398 for allegedly violating the CMPL.

Arizona – Havasu Regional Medical Center (HRMC) self-disclosed to OIG that it had a potentially problematic lease arrangement in place between its surgery center and a physician who served as an anesthesiologist and medical director at the surgery center. Under the arrangement, HRMC permitted the physician to rent office space at a rate below fair market value and inappropriately provided the physician with two employees. HRMC agreed to pay \$510,179 for allegedly violating the CMPL provisions applicable to physician self-referrals and kickbacks.

<http://oig.hhs.gov>

Public health agencies and enforcement activities

Office of the Assistant Secretary for Health

Protection of human subjects

- *Biospecimen Research: Meeting Basic Human Subjects Protection Requirements and Communicating Informational Risks.* [OEI-01-11-00520](#). 2013 NOV.

Researchers and bioethicists have identified human subjects' potential loss of privacy and confidentiality as a challenge to research that involves biospecimens. We reported that informed consent documents for biospecimen research contained required information on human subjects protections but varied in their substance and form. Biospecimen research must comply with Federal regulations governing research on human subjects. An institutional review board (IRB) must review and approve the research, and the principal investigator (PI) must obtain informed consent from all potential subjects unless the IRB waives the requirement for informed consent. IRBs and PIs identified challenges in conducting and overseeing research involving biospecimens, such as determining how much information to share with human subjects, determining how biospecimens should be stored for future use, and dealing with the slow pace of change for regulations governing this type of research. We found that some IRBs and PIs took steps to address the informational risks of collecting biospecimens and storing them for future research. Recommendation—The Office for Human Research Protections (OHRP), which reports to the Assistant Secretary for Health, should provide a forum to IRBs and PIs to discuss informational risks to human subjects.

Centers for Disease Control and Prevention

World Trade Center program—Contractor compliance

- *World Trade Center Health Program: CDC Should Strengthen Efforts To Monitor and Evaluate Clinic Compliance With Contract Terms.* [A-02-11-02003](#). 2014 JAN.

The World Trade Center Health Program (WTCHP) was established in January 2011. Under the WTCHP, the Centers for Disease Control and Prevention (CDC) contracted with clinics to provide medical services and pharmacy benefits to eligible responders and survivors with health conditions related to the September 11, 2001, terrorist attacks on the World Trade Center. We found that CDC and the National Institute for Occupational Safety and Health (NIOSH) did not monitor and evaluate clinic compliance with contract terms and conditions, as required by Federal regulations. Specifically, CDC contracting officers (COs) did not ensure that NIOSH contracting officer representatives (CORs) used the surveillance methodology established in the quality assurance surveillance plans (QASPs) developed to monitor clinic contract performance. In addition, contracting officials did not take timely or appropriate action when

they learned of three instances of clinic contract noncompliance. Further, evaluations of contractor performance were not completed, as required, and were not always entered into the information systems.

These inadequacies occurred because CDC and NIOSH did not consider the QASP surveillance methodology to be mandatory or the QASP performance standards to be realistic or attainable for the clinics and have standard operating procedures to ensure that required performance evaluations were conducted in a timely manner. We recommended that CDC monitor clinics' performance in accordance with contract terms, address clinics' noncompliance with contract terms, and follow Federal Acquisition Regulation section 42.1503 by developing and implementing standard operating procedures for evaluating contract performance.

President's Emergency Plan for AIDS Relief program

- *The University Teaching Hospital (in Zambia) Generally Managed the President's Emergency Plan for AIDS Relief Funds and Met Program Goals in Accordance With Award Requirements.* [A-04-13-04005](#). 2014 MAR.

Through its Global HIV/AIDS Program, CDC implemented the President's Emergency Plan for AIDS Relief (PEPFAR) to combat HIV/AIDS by strengthening health systems and building sustainable human immunodeficiency virus/acquired immunodeficiency virus syndrome (HIV/AIDS) programs in more than 75 countries. Through a 5-year cooperative agreement, CDC awarded President's Emergency Plan for AIDS Relief (PEPFAR) funds totaling \$4.9 million to the University Teaching Hospital (the Hospital) in Zambia for the budget period September 30, 2010, through September 29, 2011. We reported that the Hospital generally managed PEPFAR funds and met program goals in accordance with award requirements. However, the Hospital did not always follow its policies and procedures, and the Hospital did not submit an annual progress report to CDC. It did submit an annual program results report, but the report did not show progress on 8 of the Hospital's 21 goals included in its approved cooperative agreement. Recommendations—The Hospital should work with CDC to resolve whether a specified expenditure was allowable; work with the Zambian Government for a value-added taxes exemption and refund; and enhance its internal controls by updating its policies and procedures to include detailed steps to account for and report PEPFAR funds.

Health Resources and Services Administration

HRSA 340B Drug discount program—Contract Pharmacy Arrangements

- *Contract Pharmacy Arrangements in the 340B Program.* [OEI-05-13-00431](#). 2014 FEB.

The 340B Drug Pricing Program requires drug manufacturers participating in Medicaid to provide discounted covered outpatient drugs to certain eligible health care entities, known as covered entities. These entities may contract with pharmacies to dispense drugs purchased through the program on their behalf. The majority of covered entities do not use contract pharmacies. Recent Health Resources and Services Administration (HRSA) audits of covered entities have found program violations related to contract pharmacies. Our February 2014 report is a descriptive review of contract pharmacy

arrangements and examines, under such arrangements, how entities prevent drug diversion and duplicate discounts. We found complications with regard to both issues. We also found that most covered entities in our study do not conduct all of the oversight recommended by HRSA. Although almost all covered entities reported monitoring their contract pharmacy arrangements, the extent of such monitoring varied. For example, few covered entities reported retaining independent auditors for their contract pharmacy arrangements, as recommended in HRSA guidance.

HRSA health centers—Electronic health records

■ *Progress in Electronic Health Record Implementation Through HRSA Grants to Health Center Controlled Networks. [OEI-09-11-00380](#). 2014 JAN.*

We reported that most health centers had established a capability for capturing data electronically. However, fewer health centers established a capability for sharing data electronically. Establishing data-sharing capabilities often requires health centers to incur additional electronic health record (EHR)-related costs. Although 76 percent of health centers reported facing financial sustainability challenges, grantee progress reports contained limited information related to the financial sustainability of EHR systems at health centers. Recommendations—HRSA should use data to understand progress toward meaningful use objectives (for capturing and sharing data) and to provide guidance and technical assistance to health centers, ensure that health center- controlled networks grantees provide information on the financial sustainability of EHR systems at health centers, and examine the feasibility of collecting information directly from health centers regarding the financial sustainability of their EHR systems.

Public-Health-Related Legal Actions and Investigations

Health Education Assistance Loan Program

The Office of Inspector General (OIG) excludes individuals who have defaulted on Health Education Assistance Loan (HEAL) loans from participation in Federal health care programs.

Under the HEAL program, which stopped making loans in 1998, 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 graduate and begin 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 of such individuals from Medicare, Medicaid, and all other Federal health care programs for nonpayment of the loans.

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

HEAL Exclusions

During this semiannual reporting period, 37 individuals and related entities were excluded as a result of PSC referral of their cases to OIG. Individuals who have been excluded as a result of default may enter into settlement agreements, whereby the 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 debt is repaid, and they may not appeal the exclusions.

After being excluded for nonpayment of their HEAL debts, 2,502 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 22 individuals who entered into such settlement agreements or completely repaid their debts during this semiannual reporting period. More than \$190 million is being repaid through settlement agreements or through complete repayment. Of that amount, \$4.3 million is attributable to this semiannual reporting period.

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

- New Jersey – Medical doctor (\$323,257)
- Tennessee – Dentist (\$292,591)
- Ohio – Osteopath (\$155,087)
- California – Dentist (\$136,961)
- Louisiana – Medical doctor (\$101,275)

Human services agencies and enforcement activities

Administration for Children and Families

Adoption assistance—Connecticut

- *Connecticut Often Did Not Comply With Federal Adoption Assistance Requirements.*
[A-01-12-02507](#). 2013 NOV.

We reported that Connecticut did not always comply with Federal requirements in claiming adoption assistance payments for Federal reimbursement and did not always comply with Federal and State requirements for performing adoption assistance program background checks. We estimated unallowable payments of at least \$17.5 million for the review period. With regard to whether required background checks had been performed, we estimated that the safety of 2,862 children may have been at risk. Connecticut claimed ineligible adoption assistance payments because it did not always follow its established procedures for ensuring that claims met Federal requirements. Also, the State agency did not have adequate controls in place to ensure that the required background checks were completed or to ensure that supporting documentation was retained. Recommendations—Connecticut should strengthen and implement controls to ensure full compliance with financial and other eligibility requirements; strengthen and implement controls, such as but not limited to, accurate and appropriate checklists to ensure full compliance with background check requirements; discontinue claiming the Title IV-E adoption assistance we specified; and refund to the Federal Government the unallowable payments that were claimed without adequate documentation.

Head Start program

- *The Council on Rural Service Programs, Inc., Claimed Unallowable Head Start Costs.*
[A-05-12-00089](#). 2013 NOV.

Of the \$6.7 million in Head Start costs that we reviewed, the Council on Rural Service Programs, Inc. (the grantee), claimed \$1.4 million that was allowable under applicable Federal regulations and the terms of the grants. Of the remaining \$5.4 million, the grantee claimed other unallowable costs of \$1.1 million. We could not determine the allowability of the remaining \$4.3 million in executive and administrative salary and fringe benefit costs that the grantee claimed under its Head Start grants because the grantee did not adequately support, with personnel activity reports, the distribution of salaries and wages. Recommendations—The grantee should refund unallowable less-than-arm's-length lease payments totaling \$945,000; refund unallowable classroom rental payments totaling \$59,000; refund costs totaling \$70,000 for gift cards and other costs that did not benefit the Head Start program; and either refund \$4.3 million to the Federal Government for inadequately supported executive and administrative salary and fringe benefit costs, of which as much as \$1 million could have been for non-Head Start costs, or

work with ACF to determine what portion of the costs was allowable; and take corrective actions to ensure that it complies with Federal regulations.

Child Care and Development Fund—State monitoring and compliance

- *Child Care and Development Fund: Monitoring of Licensed Child Care Providers.*
OEI-07-10-00230. 2013 NOV.

We reported that all States complied with the Federal requirement to have health and safety requirements for licensed child care providers in three specified areas. However, States' monitoring requirements did not always meet Administration for Children and Families (ACF) recommendations for background screenings or the recommended standards for unannounced inspections. In selected States that we reviewed, monitoring of licensed providers was not conducted in accordance with States' own requirements. Moreover, ACF did little to monitor how States were overseeing Child Care and Development Fund (CCDF) providers. ACF administers the CCDF grant program, which provides financial assistance with child care for approximately 1.6 million children each month. Federal law requires States to have health and safety requirements in three areas: the prevention and control of infectious diseases, building and physical premises safety, and minimum health and safety training. Recommendations—ACF should seek authority to develop health and safety standards and ensure that States' requirements meet them, develop requirements for States to conduct mandatory background screenings and periodic unannounced inspections, conduct periodic reviews of States' compliance with their own licensing requirements related to minimum health and safety standards, and ensure that State plans comply with health and safety requirements. Many of our concerns are addressed in ACF's Notice of Proposed Rulemaking issued on May 20, 2013.

- *Ohio Exceeded the 5-Percent Limit for Claiming Child Care Development Fund Administrative Expenditures* *A-05-13-00014. 2013 NOV.*

Federal regulations limit the amount of CCDF funds that a State agency may claim for administrative expenditures to 5 percent of the total amount of discretionary, mandatory, and matching funds expended in a fiscal year. From fiscal year (FY) 2007 through FY 2011, Ohio exceeded the 5-percent limit for claiming CCDF administrative expenditures by \$3.2 million (Federal share). The State agency misclassified \$9 million (\$8.3 million Federal share) as quality activities expenditures when they should have been classified as administrative expenditures. The State agency's review of cost pool allocations did not identify the improper classification of administrative expenditures. Recommendations—Ohio should refund \$3.2 million in cost pool expenditures that exceeded the 5-percent CCDF administrative limit and take corrective actions to ensure that cost pool expenditures are properly claimed.

Child support enforcement activities

OIG investigations

IG investigates noncustodial parents who fail to pay court-ordered child support. OIG works with the Office of Child Support Enforcement; the Department of Justice; U.S. Attorneys' Offices; the U.S.

Marshals Service; and Federal, State, and local partners to address the most egregious child support enforcement cases with appropriate law enforcement and prosecutorial action. OIG investigations of child support enforcement cases nationwide resulted in 32 criminal actions and court-ordered restitution and settlements of \$2.1 million during this semiannual reporting period. The following are examples of child support enforcement cases:

South Dakota – Child support enforcement Most Wanted Fugitive Dennis Thomas was sentenced to 5 years of probation and ordered to pay \$67,122 in restitution after pleading guilty to a charge of failure to pay child support. In January 2013, OIG agents, along with members of the Great Falls Police Department in Montana, took Thomas into custody on his outstanding Federal arrest warrant issued in the District of South Dakota. Thomas was originally indicted in December 2009 for failure to pay legal child support and has been a Federal fugitive since 2009.

Vermont – Lee Godden was sentenced to 2 months of imprisonment and ordered to pay more than \$100,000 in restitution following his guilty plea to two counts of failure to pay child support. In 2004, Godden was ordered by a court to pay child support to the custodial parent of his two children. However, despite being gainfully employed, Godden made few or no child support payments since 2004.

Idaho – David Cox was sentenced to 5 years of probation and ordered to pay \$62,277 in restitution after being convicted on three counts of failure to pay legal child support. Cox had been ordered to pay child support for his three minor children from three women. At trial, it was revealed that Cox owed approximately \$61,000 in past due child support obligations.

Engaging the public in capturing deadbeat parents

Because of the success of OIG's Most Wanted Fugitives Web site, OIG launched its Most Wanted Deadbeat Parents Web site. The site identifies parents who fail to pay court-ordered child support for their children and thereby put an unnecessary strain on the custodial parents and the children, as well as on agencies that enforce these matters. The site, which is updated frequently, includes information on OIG's role in pursuing parents who fail to pay court-ordered child support and has a reporting button to turn in deadbeat parents.

OIG's Most Wanted Deadbeat Parents Web site is at:
<https://oig.hhs.gov/fraud/child-support-enforcement/index.asp>.

<http://oig.hhs.gov>

Other HHS-related reviews

Financial reporting and improper payment reduction

HHS financial report for FY 2013

- *Department Health and Human Services Fiscal Year 2013 Agency Financial Report. Section II. Daniel R. Levinson, Inspector General, OIG Report on the Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2013 (pp. 43, 44, 53, 56, 57, and 63). A-17-13-00001. 2013 DEC.*

The Chief Financial Officers Act of 1990, as amended (CFO Act), requires OIG or an independent external auditor, as determined by OIG, to audit HHS financial statements in accordance with applicable standards. We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to conduct the audit. The FY 2013 financial statement audit noted that HHS continued to make strides to improve controls within the Information Technology infrastructure that supports the financial application system. HHS continued to address and implement the existing governance, financial process and practices, and system tools needed to enhance controls over application information security and contingency planning. The audit noted a focused effort is still needed to more completely remediate long outstanding deficiencies to a level that supports an auditor's reliance on controls within the financial systems. Deficiencies were noted over controls related to segregation of duties, change management, and access to HHS financial systems.

The FY 2013 financial statement audit also noted internal control weaknesses in financial systems and processes, including the lack of integrated financial management systems and insufficient analysis of certain accounts that impaired the abilities of HHS and its operating divisions to adequately support and analyze account balances in a timely fashion. HHS's financial management systems still did not substantially comply with Federal financial management systems requirements.

Recommendations—HHS should continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity and continue to focus on remediating the remaining financial management system deficiencies.

Improper Payments Information Act of 2002

- *U.S. Department of Health and Human Services Met Many Requirements of the Improper Payments Information Act of 2002 But Was Not Fully Compliant. A-17-13-52000. 2013 MAR.*

OIG is required to review and report on HHS's annual *Agency Financial Report and Other Accompanying Information* (AFR) 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). (The acronym "IPIA" will refer to IPIA as amended by the IPERA.)

We reported that although HHS met many of the IPIA requirements, it did not fully comply with the IPIA and Office of Management and Budget (OMB) guidance. We evaluated the accuracy and completeness of the Department's reporting and did not identify any inaccuracies or gaps in the information reported for three programs (i.e., Medicaid, Head Start, and Foster Care). Other findings included that for four programs (i.e., Child Care Development Funds, Medicare Fee-for-Service, Medicare Advantage, and Medicare Prescription Drugs), we identified inaccuracies, and for two programs (i.e., the Children's Health Insurance Program (CHIP) and Temporary Assistance for Needy Families (TANF)), we identified incomplete information. We also found that the Department has achieved some success in reducing improper payment rates.

Recommendations—HHS should improve its compliance with the IPIA by assessing the need for additional actions to meet improper payment rate reduction targets, developing and reporting improper payment rate reduction targets and corrective action plans for CHIP, ensuring that amounts used in the computations for reporting overpayments recaptured are accurate and complete, and ensuring data are retained in accordance with program requirements.

Grants and Contracts

Hurricane Sandy grant and contract vulnerabilities

Hurricane Sandy struck the United States near Atlantic City, New Jersey, on October 29, 2012. It was the second-costliest hurricane in U.S. history and caused immense devastation. The storm affected 24 States and caused an estimated \$71 billion in damage. Disaster areas were declared from the Northeast, to the mid-Atlantic, and as far west as Wisconsin, a total of 12 states, and Washington D.C. The storm ravaged over 150,000 homes and destroyed businesses and public assistance facilities. Vital services rendered by some HHS programs were disrupted by the hurricane. Additionally, various research facilities for the National Institutes of Health with a physical presence on the east coast were damaged by the storm. Our goal is to make sure people who need health and human services get the best care and resources to recover from disasters. We have to make sure the recovery money goes to the right people. And after any major disaster like Hurricane Sandy, we must try to prevent fraud, waste, and abuse by ensuring that limited resources are used properly.

As part of our oversight with regard to Hurricane Sandy, we developed a series of videos that provide important guidance to HHS grant and contract officers, informing them of their roles and responsibilities, as well as risk areas when making awards to grantees or contractors. The videos also provide tips to help grantees and contractors use funds effectively and appropriately. The videos are available on our Web site at <http://oig.hhs.gov/newsroom/podcasts/2014/sandy/>.

Small Business Innovative Research Program

The National Defense Authorization Act for Fiscal Year 2012, § 5143, requires OIG to annually report on the number of cases that were referred to it related to fraud, waste, or abuse in the Small Business Innovative Research / Small Business Technology Transfer (SBIR/STTR) program; the actions taken in each case; justification for not taking action on a case; and an accounting of funds used to address waste, fraud, and abuse in this program. In our December 2013 report delivered to the three Congressional oversight committees, we reported that OIG spent approximately \$295,504 in salaries on oversight related to the SBIR/STTR program. HHS referred two new SBIR/STTR cases to OIG in FY 2013.

Recovery Act retaliation complaint investigations

The Recovery Act, § 1553, prohibits non-Federal employers that have received Recovery Act funding from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds. OIGs are required 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.

Contract Audits

Pursuant to the National Defense Authorization Act for FY 2008, § 845, Inspectors General appointed under the Inspector General Act of 1978 are required to submit, as part of their *Semiannual Reports to Congress*, information on final, completed contract audit reports issued during the period to the contracting activity containing significant audit findings. OIG did not issue final reports meeting § 845 criteria during this semiannual period.

OIG reviews of non-Federal audits

OIG reviews audits conducted by non-Federal auditors of entities receiving Federal awards. In this semiannual period, OIG's National External Audit Review Center reviewed 1,506 reports covering \$468.8 billion in audited costs. Federal dollars covered by these audits totaled \$111 billion, of which about \$45.1 billion were HHS funds.

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 organization-wide "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.

OIG's reports on non-Federal audits reviewed during this reporting period are categorized in the following table.

Non-Federal Audits, October 1, 2013, through March 31, 2014

Number of Non-Federal Audits:		
■	<i>Not requiring changes or having minor changes</i>	1,359
■	<i>Requiring major changes</i>	139
■	<i>Having significant technical inadequacies</i>	8
Total		1,506

The 1,506 reports included 3,219 recommendations for improving management operations. In addition, these audit reports provided information for 61 OIG special memorandums that identified concerns for increased monitoring by management.

Other reporting requirements and reviews

Health Insurance Portability and Accountability Act Security Rule

- *The Office for Civil Rights Did Not Meet All Federal Requirements in Its Oversight and Enforcement of the Health Insurance Portability and Accountability Act Security Rule.*
[A-04-11-05025](#). 2013 NOV.

HHS's Office for Civil Rights (OCR), a staff division of the Office of the Secretary, did not meet certain Federal requirements critical to the oversight and enforcement of the Health Insurance Portability and Accountability Act Security Rule (Security Rule). OCR had not assessed risks, established priorities, or implemented controls for its Federal requirements to provide for periodic audits of covered entities to ensure their compliance with Security Rule requirements. Also, OCR's Security Rule investigation files did not contain required documentation supporting key decisions made because management had not implemented sufficient controls, including supervisory review and documentation retention, to ensure that investigators follow policies and procedures for properly initiating, processing, and closing Security Rule investigations. Further, OCR had not fully complied with Federal cybersecurity requirements for its information systems used to process and store investigation data because it focused on system operability to the detriment of system and data security.

Recommendations—OCR should assess risks, establish priorities, and implement controls for its auditing requirements pursuant to the Health Information Technology for Economic and Clinical Health Act (HITECH); provide for periodic audits in accordance with HITECH to ensure Security Rule compliance at covered entities; implement sufficient controls, such as supervisory reviews and documentation retention, to ensure that policies and procedures for Security Rule investigations are followed; and

implement the National Institute of Standards and Technology Risk Management Framework for systems used to oversee and enforce the Security Rule.

Government Charge Card Abuse Prevention Act

- *Letter to Office of Management and Budget Director to Meet Requirements of Government Charge Card Abuse Prevention Act of 2012 Regarding Agency Progress Implementing Recommendations on Charge-Card-Related Findings.* [A-04-14-06173](#). 2014 JAN.

This letter report describes the progress that HHS has made in implementing previous purchase and travel card audit recommendations and the status of OIG's annual risk assessment. The letter was issued to meet the requirements of the Government Charge Card Abuse Prevention Act of 2012 (P.L. No. 112-194) (Charge Card Act) to report to OMB director on agency progress in the implementation of recommendations on charge-card-related findings. In addition, while not required for this report, we also explain how we intend to conduct required annual risk assessments of agency purchase cards.

Legislative and regulatory reviews

Pursuant to the Inspector General Act, § 4(a)(2), OIG is required 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 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 Priority Recommendations](#) describes priority findings and recommendations from past periods that remain to be implemented.
- Our annual [Work Plan](#) 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 operating and other 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.

Affordable Care Act implementation

OIG continues to perform reviews on the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act). The Affordable Care Act made changes to HHS programs and enacted a range of new programs that affect the Department, such as the Early Retiree Reinsurance Program (ERRP). The roll-out of the Health Insurance Exchanges (marketplaces) is a substantial management challenge to HHS. OIG's current focus is on areas such as eligibility systems, payment accuracy, contractor oversight, data security, and consumer protection. Our substantial body of work underway was developed in coordination with the Government Accountability Office (GAO) and other Federal and State oversight agencies. It is focused on identifying risks and vulnerabilities to the marketplaces to ensure efficient and effective operation and to minimize waste and abuse of funds. Our work has and will continue to encompass other aspects of Affordable Care Act implementation such as Medicaid expansion, use of State establishment grants, and the use of start-up and solvency loans for Consumer Operated and Oriented Plan Loans.

Following is an example of a recent Affordable Care Act review.

Early Retiree Reinsurance Program: Jersey City

■ *Jersey City, New Jersey, Did Not Always Comply With Early Retiree Reinsurance Program Requirements. [A-05-12-00039](#). 2014 JAN.*

Jersey City, New Jersey (the City), incorrectly requested and received \$130,000 in ERRP reimbursements on the basis of claims that were not in compliance with Federal requirements and the Center for Consumer Information and Insurance Oversight (CCIIO) guidance. The City, the plan sponsor, offered self-funded health benefits to eligible employees, retirees, and their dependents. The City did not have adequate policies and procedures to ensure that it submitted claims for reimbursement of only allowable costs incurred for individuals who met the definition of an early retiree and their spouses and dependents. Recommendations—The City should develop and implement policies and procedures to help ensure that the City claims only allowable health benefit costs incurred for individuals who meet the definition of an early retiree, refund \$130,000 in incorrectly requested and received ERRP reimbursements, and work with CCIIO to correct any subsequent ERRP reimbursement requests that did not comply with Federal requirements and CCIIO guidance.

Appendixes

Appendix A – Reporting requirements

Appendix B – Questioned costs and funds put to better use

Appendix C – Peer reviews

Appendix D—Sanction authorities

<http://oig.hhs.gov>

Appendix A: Reporting requirements in 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.

Section	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations.	“Other HHS-Related Issues” section.
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies.	Throughout this report.
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies.	Throughout this report.
(a)(3)	Prior significant recommendations on which corrective action has not been completed.	<i>OIG Compendium of Unimplemented Recommendations.</i>
(a)(4)	Matters referred to prosecutive authorities	“Legal and Investigative Activities” section
(a)(5)	Summary of instances in which information requested by OIG was refused.	None.
(a)(6)	List of audit reports.	Submitted to the Secretary under separate cover.
(a)(7)	Summary of significant reports.	Throughout this report.
(a)(8)	Statistical Table 1 – Reports With Questioned Costs.	Appendix B.
(a)(9)	Statistical Table 2 – Funds Recommended To Be Put to Better Use	Appendix B.
(a)(10)	Summary of previous audit reports without management decisions.	Appendix B.

Section	Requirement	Location
(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> , “Other HHS-Related Issues” section.
(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	National Defense Authorization Act for fiscal year 2008 (P.L. No. 110-181), § 845. Report significant contract audits.	“Other HHS-Related Issues” section.
205	Health Insurance Portability and Accountability Act, § 205. Annually solicit via a Federal Register notice proposals for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b) and proposals for developing special fraud alerts. Annually report annually to Congress on the status of the proposals received related to new or modified safe harbors.	Reported annually in the fall <i>Semiannual Report</i> , Appendix F.
1553	American Recovery and Reinvestment Act of 2009, § 1553. Report to Congress the retaliation complaint investigations OIG decided not to conduct or continue during the period.	“Other HHS-Related Issues” section.

Appendix B: Questioned costs and funds to be put to better use

The following 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) and (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 decisions, 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.

Table 1 – Audit Reports With Questioned Costs

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period ¹	195	\$802,141,000	\$26,182,000
Reports issued during the reporting period	84	\$476,484,000	\$139,500,000
Total Section 1	279	\$1,278,625,000	\$165,682,000
Section 2			
Reports for which management decisions were made during the reporting period ^{2,3}			
Disallowed costs	139	\$294,978,000*	\$0
Costs not disallowed	5	\$16,631,000	\$1,044,000
Total Section 2	144	\$311,609,000	\$1,044,000

*Audit receivables (expected recoveries).

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 3			
Reports for which no management decisions had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	135	\$967,016,000	\$164,638,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance ⁴	64	\$505,679,000	\$25,138,000

Audit Reports With Funds Recommended To Be Put to Better Use

The phrase “recommendations that funds be put to better use” means 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.

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

	Reports	Dollar Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period ¹	17	\$1,345,668,000
Reports issued during the reporting period	7	\$388,155,000
Total Section 1	24	\$1,733,823,000
Section 2		
Reports for which management decisions were made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	7	\$49,411,000
Based on proposed legislative action		0
Value of recommendations not agreed to by management	3	\$2,664,000
Total Section 2	10	\$52,075,000

	Reports	Dollar Value
Section 3		
Reports for which no management decisions had been made by the end of the reporting period ² (Sec. 1 minus Sec. 2)	14	\$1,681,748,000

End Notes

Table 1 End Notes

¹ The opening balance was adjusted upward by \$42 million because of a reevaluation of previously issued recommendations.

² Revisions to previously reported management decisions:

- A-02-03-01003 *Review of Medicaid Claims for School-Based Health Services in New Jersey*. The Departmental Appeals Board issued a favorable ruling for CMS upholding \$42,229,773 of the disallowance. Subsequent documentation provided by the state reduced disallowed cost by \$7,127,694.
- A-03-05-00203 *Review of Medicaid Reimbursement Rates for School-Based Services in West Virginia*. The Departmental Appeals board issued a favorable ruling for the State. As a result of the appeal by the State, the \$22,806,230 was determined to be allowable cost.
- A-04-09-03046 *Review of Concurrently Enrolled State Children's Health Insurance Program and Medicaid Beneficiaries in Florida from April 1, 2007, Through March 31, 2008*. CMS accepted The State of Florida's request for reconsideration of the disallowed cost totaling \$5,348,853 pursuant to section 1116(e) (1) of the Social Security Act. Subsequent review by CMS reduced disallowed cost by \$4,505,239.
- A-05-10-95134 *State of Indiana*. CMS subsequent review of additional information provided by the State, determined that the cost error was specific to the State's accounting system which was not the source for the preparation of the CMS 64. As a result, the identified cost totaling \$9,415,799 was determined to be allowable.

CMS's subsequent review of additional information obtained and confirmed with the State Board of Accounts determined that the identified cost totaling \$13,998,978 was allowable.

- A-10-10-95482 *State of Oregon*. Subsequent review by CMS determined that the premium assistance program operating under a CMS Waiver, was not required to provide coverage based upon services in the Medicaid State Plan. The \$9,400,000 was determined to be allowable cost.
- Not detailed are net reductions to previously disallowed management decisions totaling \$3,348,973.

³ Included are management decisions to disallow \$31.6 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 Circular A-133. By law, OIG is responsible for ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

⁴ Because of administrative delays, some of which were beyond management control, resolution of the following 64 audits was not completed within 6 months of issuance of the 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-01-13-00505	REVIEW OF DUPUY ORTHOPAEDICS' PROPOSED GLOBAL PAYMENT TO MEDICARE FOR REVISION SURGERIES RELATED TO THE DUPUY ASR HIP RECALL, JUL 2013, \$98,200,000.
CIN: A-07-12-01116	REVIEW OF MEDICARE PAYMENTS FOR UNLAWFULLY PRESENT BENEFICIARIES, JAN 2013, \$91,620,548.
CIN: A-02-10-01043	NEW YORK'S CLAIMS FOR MEDICAID SERVICES PROVIDED UNDER ITS TRAUMATIC BRAIN INJURY WAIVER PROGRAM DID NOT COMPLY WITH CERTAIN FEDERAL AND STATE REQUIREMENTS, MAY 2013, \$54,265,195.
CIN: A-09-06-00023	REVIEW OF LOS ANGELES COUNTY APPROVAL PROCESS OF RELATIVE FOSTER FAMILY HOMES, OCT 2009, \$45,520,603.
CIN: A-07-12-01113	REVIEW OF MEDICARE PAYMENTS FOR INCARCERATED BENEFICIARIES, JAN 2013, \$33,587,634.
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES - CT, MAY 2003, \$32,780,146.
CIN: A-02-11-01008	REVIEW OF NYS MEDICAID HOME HEALTH CLAIMS MADE BY REST OF STATE PROVIDERS, SEP 2013, \$31,482,913.
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, \$30,595,545.
CIN: A-07-10-06004	REVIEW OF PART D DRUGS PRESCRIBED BY EXCLUDED PROVIDERS, DEC 2011, \$15,079,608.
CIN: A-02-11-01038	REVIEW OF MEDICAID CLAIMS MADE BY HOSPITAL BASED CONTINUING DAY TREATMENT PROVIDERS IN NEW YORK STATE, SEP 2013, \$8,281,766.
CIN: A-09-12-02066	AUDIT OF MEDICARE PAYMENTS FOR INPATIENT CLAIMS THAT REQUIRE 96+ HOURS OF MECHANICAL VENTILATION, SEP 2013, \$7,714,825.
CIN: A-01-11-00534	NATIONWIDE REVIEW OF INPATIENT REHABILITATION FACILITIES PATIENT ASSESSMENT INSTRUMENTS FOR CALENDAR YEARS 2009 AND 2010, SEP 2012, \$7,700,700.
CIN: A-01-10-00508	REVIEW OF PAYMENTS TO HOSPITALS FOR NONPHYSICIAN OUTPATIENT SERVICES UNDER THE I/P PROSPECTIVE PAYMENT SYSTEM, JUN 2012, \$6,100,000.
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-03-12-00004	REVIEW OF HORIZON'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$4,344,417.
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-07-12-03175	REVIEW OF CCDF TARGETED FUNDS IN NEBRASKA, APR 2013, \$2,965,913.

CIN: A-03-11-00002	REVIEW OF NEW ENGLAND JOINT ENTERPRISE 2009 DIR REPORTS, APR 2012, \$2,710,732.
CIN: A-03-12-00006	REVIEW OF TAHMO'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$2,355,532.
CIN: A-03-12-00007	REVIEW OF ARCADIAN'S 2009 AND 2010 BONA FIDE SERVICE FEES, FEB 2013, \$2,048,967.
CIN: A-03-12-00005	REVIEW OF WINDSOR'S 2009 AND 2010 BONA FIDE SERVICE FEES, JAN 2013, \$1,948,737
CIN: A-05-12-00021	REVIEW OF CDC'S OVERSIGHT OF PEPFAR FUNDS PROVIDED TO AURUM IN SOUTH AFRICA FOR 2009-10, AUG 2013, \$1,690,605.
CIN: A-02-11-02007	LONG ISLAND CHILD AND FAMILY DEVELOPMENT SERVICES, INC.'S FINANCIAL MANAGEMENT SYSTEM DID NOT ACCURATELY DISCLOSE HEAD START PROGRAM RESULTS, MAY 2012, \$1,489,093.
CIN: A-07-11-06013	INDIRECT COSTS CLAIMED AS DIRECT COSTS - UNIVERSITY OF COLORADO DENVER, JUN 2013, \$1,419,524.
CIN: A-03-12-00008	REVIEW OF XL HEALTH DIR, JAN 2013, \$1,410,342.
CIN: A-01-12-02500	REVIEW OF CONNECTICUT'S TITLE IV-E ADMINISTRATIVE/TRAINING COSTS AND MAINTENANCE PAYMENTS, DEC 2012, \$1,316,684.
CIN: A-01-12-01501	REVIEW OF SAMHSA COSTS CLAIMED AT LATIN AMERICAN HEALTH INSTITUTE, BOSTON, MA, APR 2013, \$1,261,328.
CIN: A-09-11-01006	REVIEW OF CENTER FOR COMMUNITY & FAMILY SERVICES HEAD START FUNDS, JUN 2013, \$967,387.
CIN: A-02-11-02005	LIMITED HEAD START REVIEW OF INCLUDED EDUCATIONAL SERVICES, JUL 2012, \$588,830.
CIN: A-02-10-01025	REVIEW OF NEW JERSEY'S MEDICAID BUY-IN PROGRAM FOR MEDICARE BENEFICIARIES, AUG 2013, \$523,919.
CIN: A-09-11-01007	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR HCAP, FEB 2013, \$513,649.
CIN: A-03-09-00003	REVIEW OF RISK ADJUSTMENT DATA FOR BRAVO HEALTH, SEP 2013, \$422,409
CIN: A-01-11-02505	NEON - HEAD START LIMITED SCOPE REVIEW - ALLOCATING OF COSTS - ARRA, JAN 2012, \$406,434.
CIN: A-01-11-02510	REVIEW OF CT CSBG RECOVERY ACT COSTS CLAIMED, APR 2013, \$314,605.
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, \$293,870.
CIN: A-06-11-00055	REVIEW OF NEIGHBORHOOD CENTERS, INC., SEP 2013, \$287,571.
CIN: A-02-11-02015	REVIEW OF INSEC, INC. CSBG ARRA COSTS CLAIMED BY THE COMMONWEALTH OF PUERTO RICO, APR 2013, \$285,412.
CIN: A-04-12-04019	REVIEW OF NAMIBIA MOH FY 09 PEPFAR COOP AGREEMENT 5UGPS001094-2, JAN 2013, \$242,653.
CIN: A-05-12-00023	REVIEW OF CDC'S OVERSIGHT OF PEPFAR FUNDS PROVIDED TO SOUTHERN AFRICAN CATHOLIC BISHOPS' CONFERENCE FOR JUNE 1, 2009 TO MAY 31, 2010, JUL 2013, \$235,130.
CIN: A-09-09-00045	RISK ADJUSTMENT DATA VALIDATION OF PAYMENTS MADE TO PACIFICARE OF CALIFORNIA FOR CALENDAR YEAR 2007 (CONTRACT H0543), NOV 2012, \$224,388.
CIN: A-05-09-00044	RISK ADJUSTMENT DATA VALIDATION OF PAYMENTS MADE TO PARAMOUNT CARE INC. FOR CALENDAR YEAR 2007 (CONTRACT NUMBER H3653), SEP 2012, \$205,534
CIN: A-05-12-00012	REVIEW OF IL CSBG RECOVERY ACT COSTS CLAIMED - ROCKFORD, JUL 2013, \$205,296

CIN: A-05-12-00024	NATIONAL HEALTH LABORATORY SERVICE DID NOT ALWAYS MANAGE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS OR MEET PROGRAM GOALS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2013, \$185,768.
CIN: A-06-09-00012	RISK ADJUSTMENT DATA VALIDATION - PACIFICARE H4590, MAY 2012, \$183,247.
CIN: A-04-11-01004	NORTHEAST FLORIDA COMMUNITY ACTION AGENCY, INC.'S CSBG FUNDS AWARDED UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, SEP 2012, \$165,795.
CIN: A-04-11-01008	FLORIDA'S ADMINISTRATION OF CSBG RECOVERY ACT PROGRAM AND COSTS CLAIMED BY CENTRAL FLORIDA COMMUNITY ACTION AGENCY, INC., APR 2013, \$160,404.
CIN: A-07-10-01082	RISK ADJUSTMENT VALIDATIONS - CIGNA HEALTHCARE OF ARIZONA, INC. H0354, MAY 2013, \$151,453.
CIN: A-04-11-03538	HEAD START HIGH RISK GRANTEE - MOBILE COMMUNITY ACTION AGENCY, INC., DEC 2011, \$147,587.
CIN: A-07-11-02766	REVIEW OF WY CSBG RECOVERY ACT COSTS CLAIMED - CARBON COUNTY, AUG 2013, \$143,588.
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-09-11-01013	REVIEW OF OREGON'S HOUSING AND COMMUNITY SERVICES DEPARTMENT, APR 2013, \$115,911.
CIN: A-06-11-00058	REVIEW OF CSBG ARRA COSTS CLAIMED BY CROWLEY'S RIDGE DEVELOPMENT COUNCIL, AUG 2012, \$115,420.
CIN: A-07-12-02779	REVIEW OF NATRONA COUNTY CSBG RECOVERY ACT COSTS CLAIMED, JUN 2013, \$104,971.
CIN: A-03-11-03300	AUDIT OF INDIRECT ADMIN COSTS CHARGED AS DIRECT COSTS AT THOMAS JEFFERSON UNIVERSITY, JUN 2013, \$93,102.
CIN: A-05-12-00022	THE SOUTH AFRICAN NATIONAL DEPARTMENT OF HEALTH DID NOT ALWAYS MANAGE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS OR MEET PROGRAM GOALS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2013, \$77,790.
CIN: A-04-11-01010	FLORIDA'S ADMINISTRATION OF CSBG RECOVERY ACT PROGRAM AND COSTS CLAIMED BY THE AGRICULTURAL AND LABOR PROGRAM INC., FEB 2013, \$58,437.
CIN: A-06-11-00057	AUDIT DEVELOPMENT - VIETNAM PEPFAR REVIEWS, JUN 2013, \$47,708.
CIN: A-05-11-00083	REVIEW OF IL CSBG RECOVERY ACT COSTS CLAIMED (CITY OF CHICAGO), MAR 2013, \$40,247.
CIN: A-09-12-01000	REVIEW OF CSBG RECOVERY ACT ADMINISTRATIVE COSTS CLAIMED BY HI OFFICE OF COMMUNITY SERVICES, JUN 2012, \$34,861.
CIN: A-03-10-03110	TIGER TEAM - CONTRACT HHSN267-2007-00014C, OCT 2011, \$27,707.
CIN: A-02-11-02000	DIRECT COST REVIEW - SUNY ALBANY, OCT 2011, \$27,384.
CIN: A-09-11-01014	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR THE HAWAII COUNTY ECONOMIC OPPORTUNITY COUNCIL, JUL 2012, \$22,602.
CIN: A-02-11-02008	DIRECT COST REVIEW - SUNY STONY BROOK, AUG 2012, \$18,254.
CIN: A-05-11-00053	THE COLUMBUS URBAN LEAGUE CLAIMED SOME UNALLOWABLE COSTS TO HEAD START, SEP 2012, \$13,102.

TOTAL NUMBER OF REPORTS: 64
TOTAL AMOUNT: \$505,679,000

Table 2 End Notes

¹The opening balance was adjusted upward by \$ 2.3 million because of reevaluation of previously issued recommendations.

² Because of administrative delays, some of which were beyond management control, 7 of the 14 audits open at the end of the period were not resolved within 6 months of issuance of reports. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-01-12-00507	ACUTE-CARE INPATIENT HOSPITAL TRANSFERS TO INPATIENT HOSPICE CARE, MAY 2013, \$602,519,187.
CIN: A-01-12-00522	REVIEW OF ERYTHROPOIESIS STIMULATING AGENTS (ESA) UTILIZATION UNDER THE ESRD PPS, MAY 2013, \$529,645,050.
CIN: A-07-11-05017	NATIONWIDE REVIEW OF PART D INVESTMENT INCOME, APR 2013, \$111,244,413.
CIN: A-06-10-00059	REVIEW OF HOSPICE COVERED DRUGS NATIONWIDE, JUN 2012, \$33,638,137.
CIN: A-09-12-02066	AUDIT OF MEDICARE PAYMENTS FOR INPATIENT CLAIMS THAT REQUIRE 96 OR MORE HOURS OF MECHANICAL VENTILATION, SEP 2013, \$6,000,000.
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 THROUGH 2008, JUL 2009, \$17,764.

TOTAL NUMBER OF REPORTS: 7
TOTAL AMOUNT: \$1,283,092,791

<http://oig.hhs.gov>

Appendix C: Peer review results

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

Office of Audit Services peer review results

During this semiannual reporting period, no peer reviews involving the Office of Audit Services (OAS) were completed. Listed below is information concerning OAS's peer review activities during prior reporting periods.

OAS	Date	Reviewing Office	Office Reviewed
	June 2012	Department of Homeland Security	HHS OIG, OAS

The system of quality control for the audit organization of HHS OIG in effect for the year ending September 30, 2011, 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.

OAS	Date	Reviewing Office	Office Reviewed
	May 2012	HHS OIG, OAS	U. S. Environmental Protection Agency (EPA)

The system of quality control for the audit organization of EPA OIG in effect for the year ending September 30, 2011, has been suitably designed and complied with to provide EPA 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. EPA OIG received a peer review rating of pass.

(Peer Review Results continued next page)

Office of Investigations peer review results

During this semiannual reporting period, the U.S. Postal Service (USPS) Office of Inspector General conducted a peer review of HHS OIG's Office of Investigations (OI). OI did not conduct a peer review of another OIG during this reporting period. Listed below is information concerning OI's peer review activities during this and prior reporting periods.

OI	Date	Reviewing Office	Office Reviewed
	August 2012	USPS-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, 2012, were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.			
OI	Date	Reviewing Office	Office Reviewed
	July 2011	HHS-OIG, OI	DoD-OIG
The system of internal safeguards and management procedures for the investigative function of DoD-OIG in effect through July 2011 were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.			
OI	Date	Reviewing Office	Office Reviewed
	January 2011	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.			

Appendix D:

Summary of Sanction authorities

The Inspector General Act of 1978, as amended, specifies 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) is authorized 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 imposing 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 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 civil monetary penalties (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); 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 CMPs 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, or ordering, or arranging for or recommending the purchasing, leasing, or ordering, of any good, facility, service, or item payable under the Federal health care programs 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.