



Semiannual Report

Office of Inspector General

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U.S. Department of
Health and Human Services



“Working Together to Promote, Preserve & Protect the Nation’s Well-Being”

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Message from the Inspector General

This report, submitted pursuant to the IG Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG) for the 6-month reporting period that ended September 30, 2004.

The OIG is responsible for detecting fraud, waste, and abuse and promoting the economy, efficiency and effectiveness of programs within the Department of Health and Human Services. As indicated in our previous semiannual report, this charge has been enlarged with the recent enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which represents some of the most significant changes to the Medicare program since its inception in 1965.

The MMA creates substantial new oversight responsibilities and contains a number of provisions that direct specific work be conducted by OIG. These include provisions related to audits of drug manufacturers and surveys of market prices of Medicare Part B drugs, safe harbor requirements, the effect of Medicare payments on the availability of certain drugs, and a number of additional mandated studies. Two mandated studies were completed during this reporting period, one regarding the pricing of oxygen equipment and the other on pricing of end-stage renal disease drugs. In addition, work has been initiated in several areas believed to contain the greatest potential vulnerabilities under the MMA.

With funding from the Health Care Fraud and Abuse Control (HCFAC) Program statutorily capped at the fiscal year 2003 spending level, balancing the work this office traditionally has done with new oversight responsibilities posed by the MMA presents a unique challenge. We must focus on setting priorities based on the added MMA requirements, even as work continues to uncover occurrences of fraud, waste, and abuse in other important Department programs. Examples presented in this semiannual report include significant investigations of fraud in the durable medical equipment industry, particularly power wheelchairs, record recoveries from investigations of pharmaceutical companies, and continued work in the area of nursing home quality of care.

Continued cooperation between this office, the Congress, the Department, and the health care industry are essential in order to fulfill our collective responsibilities under the MMA and to address current challenges. I am confident that this office will rise to the new challenges while continuing to produce the high impact, high quality work that has marked its success through the years.

As I begin my tenure as Acting IG, I want to thank Acting Principal Deputy Inspector General Dara Corrigan for her leadership during this transitional period for OIG. I also wish to express my appreciation for the accomplishments of all OIG employees and commend them for their continued professionalism and dedication.



Daniel R. Levinson
Acting Inspector General

Highlights

Summary of Accomplishments

For fiscal year 2004, the Office of Inspector General (OIG) reported savings of approximately \$30 billion: \$27.3 billion in implemented recommendations and other actions to put funds to better use, \$754.2 million in audit receivables, \$8.3 million in additional audit recoveries, and \$1.9 billion in investigative receivables. (For figures for this semiannual reporting period, see pp. 53, 58, and 61.)

Also for this fiscal year, OIG reported exclusions of 3,293 individuals and entities for fraud or abuse of Federal health care programs and/or their beneficiaries; 533 convictions of individuals or entities that engaged in crimes against departmental programs; and 268 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. (For figures for this reporting period, see pp. 20 and 22.)

Prescription Drugs

Pfizer Inc., Warner-Lambert Company LLC, and the Parke-Davis Division—Pfizer Inc. (Pfizer), Warner-Lambert Company LLC (Warner-Lambert), and the Parke-Davis Division entered a global settlement for \$430 million plus interest. As part of the settlement, Pfizer subsidiary Warner-Lambert pled guilty to violating the Food, Drug and Cosmetic Act, and Pfizer entered a 5-year corporate integrity agreement with OIG. The settlement resolved allegations that by marketing the drug Neurontin for off-label uses not approved by the Food and Drug Administration and by other conduct, Warner-Lambert caused the submission of false and/or fraudulent claims to Medicaid. (See p. 24.)

Rite Aid Corporation—Following three settlements with other companies for similar conduct, the United States settled an additional case with a major retail pharmacy chain related to allegations of improper billing to Federal health care programs. Rite Aid Corporation (Rite Aid) agreed to pay \$7 million to resolve civil and administrative liabilities for allegedly billing for full prescriptions when only portions of the medications were delivered. Rite Aid also entered settlements with affected States and entered a corporate integrity agreement with OIG designed to address prescription billing procedures and other compliance issues. (See p. 25.)

Reimbursement for End Stage Renal Disease (ESRD) Drugs—In an inspection mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, OIG found that, in 2003, the Medicare program paid significantly higher rates—between 5 and 68 percent higher—for 10 ESRD drugs than did dialysis providers and facilities. (See p. 3.)

State Financing Mechanisms

New York, Tennessee, and Alabama—OIG is continuing to look at the mechanisms some States use to maximize Federal Medicaid reimbursement. Most recently, OIG focused on intergovernmental fund transfers and their impact on public nursing homes and hospitals. In one report, OIG examined the impact of such State funding mechanisms on a nursing home in New York State. The State and the county required the home to return about 90 percent of its enhanced funding to the State. As a result, the home was unable to meet its operating costs and experienced a significant staffing shortage, which may have contributed to poor quality of care. Similarly, Tennessee’s public nursing homes were required to return all of their enhanced funding, and Alabama’s public hospitals were required to return 86 percent of the payments they received as reimbursement for serving disproportionate numbers of low-income people with special needs. In all of these cases, the Federal funds claimed by and paid to the States benefited the States more than the Medicaid beneficiaries. (See pp. 8 and 9.)

Durable Medical Equipment

Medicare Reimbursement for Power Wheelchairs—OIG published two related inspections on Medicare’s reimbursement for the wheelchairs. One report found that the program paid significantly higher rates for power wheelchairs compared with suppliers and consumers. The second inspection report, an analysis of power wheelchair reimbursement, found that Medicare is spending an estimated \$178 million for wheelchairs that do not meet Medicare’s coverage criteria. OIG recommended that CMS take steps to improve compliance with Medicare’s coverage criteria for power wheelchairs. (See pp. 4 and 5.)

Home Oxygen Equipment—A study on Medicare payment rates for home oxygen equipment found that the Federal Employees Health Benefits (FEHB) plans’ median payment rates were between 10 and 20 percent lower than median Medicare fee schedule allowances for stationary and portable equipment. Medicare could have saved \$499 million if payments had been based on the lowest FEHB rates.

OIG recommended that CMS use information collected by OIG to meet requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, reduce fee schedule payments for home oxygen equipment in 2005, and consider alternate methods to determine payment rates for this equipment. (See p. 4.)

Hospitals

Redding Medical Center—In its ongoing efforts to use its administrative authorities to safeguard Federal health care programs and their beneficiaries, OIG settled an exclusion case against Redding Medical Center (RMC), a 246-bed hospital in Redding, CA, formerly owned by Tenet Healthcare Corporation, Inc. (Tenet). OIG sought to exclude RMC because, from at least May 1999 through May 2002, RMC allegedly furnished or caused to be furnished to patients cardiac services that were medically unnecessary and of a quality that failed to meet professionally recognized standards of health care. Ultimately, Tenet and RMC agreed to settle the matter by divesting RMC, and the assets of RMC were sold to an unrelated party. (See p. 21.)

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Please Note: Figures in this document have been rounded for reporting purposes.

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare and Medicaid programs. Financed by the Federal Hospital Insurance Trust Fund, Medicare Part A provides hospital and other institutional insurance for persons aged 65 or older and for certain disabled persons. Medicare Part B (Supplementary Medical Insurance) is an optional program which covers most of the costs of medically necessary physician and other services and is financed by participants and general revenues.

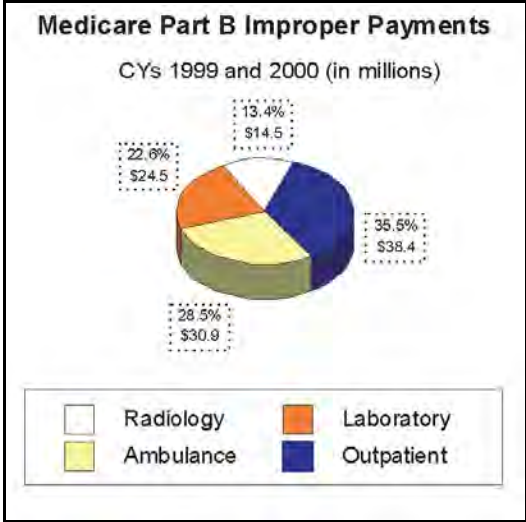
The Medicaid program provides funding to States for medical care and other support and services for low-income children, senior citizens, and people with disabilities. State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. The State Children's Health Insurance Program (SCHIP) expands health coverage to uninsured children whose families earn too much for Medicaid, but too little to afford private coverage.

The Office of Inspector General (OIG) devotes significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care; improved its quality; and reduced the potential for fraud, waste, and abuse. In addition, these efforts have often led to criminal, civil, and/or administrative actions against perpetrators of fraud and abuse.

OIG also reports on the audits of CMS financial statements—which presently account for almost 82 percent of Department of Health and Human Services (HHS) net costs. In addition to issuing an opinion on the statements, auditors assess compliance with Medicare laws and regulations and the adequacy of internal controls.

Skilled Nursing Facility Payments

This report points out that Medicare sometimes paid twice for the same service—once to a skilled nursing facility (SNF) under the Medicare Part A prospective payment system (PPS) and again to an outside supplier under Medicare Part B. Under current law, a SNF is reimbursed a prospective payment for SNF-covered services rendered to Medicare beneficiaries in a Part A stay. Under consolidated billing requirements, outside suppliers must bill the SNF (not Medicare Part B) for SNF services and supplies provided. The improper Medicare payments to Part B providers and suppliers identified in the report totaled \$108.3 million during 1999 and 2000. Moreover, the beneficiaries of these SNF services may have incurred unnecessary charges of \$33.1 million in coinsurance and deductibles. This problem occurred because SNFs and suppliers had not established adequate controls to prevent improper billing for Part B services included in the Part A SNF payment rate. Following OIG’s review period, CMS established edits in its claims processing systems to detect improperly billed Part B services.



OIG recommended that CMS recover the improper payments and instruct its Medicare contractors to encourage SNFs and suppliers to establish and/or enhance billing controls. CMS generally concurred with the recommendations. (A-01-02-00513)

Comprehensive Error Rate Testing Improvements ❖❖

During fiscal year (FY) 2003, CMS experienced a significant problem with providers that did not respond to requests for medical records for use in developing the Medicare payment error rate. The objective of this review was to evaluate CMS’s corrective actions to improve the Comprehensive Error Rate Testing process for obtaining medical records.

❖❖ Indicates performance measure. Details can be found in Appendix H.

CMS has implemented a number of such corrective actions. Based on OIG's review of data for the first three quarters of the FY 2004 error rate sample, these corrective actions appeared to have increased provider responsiveness to requests for medical records. However, as of April 8, 2004, providers had still failed to submit medical records supporting 2,239 of the 126,618 claims, despite repeated requests for the records. Therefore, OIG has initiated an indepth review to determine why providers failed to respond. Also, as part of a broader evaluation of the program, OIG will further assess the impact of CMS's corrective actions. (A-03-04-00005)

Classification of Provider Tax Refunds

The aim of this review was to determine whether Missouri hospitals properly claimed provider tax refunds on their Medicare cost reports from January 1, 1997 to August 1, 2000. This report points out that, contrary to Medicare regulations, 15 hospitals did not properly record the refund of provider tax expenses on their costs reports and that 4 hospitals included donations to the Missouri Hospital Association, which are unallowable expenses under Medicare regulations. Also, the fiscal intermediary, when settling cost reports, inconsistently applied Medicare rules. As a result, the hospitals received \$8.4 million in excess Medicare reimbursement.

OIG recommended that CMS instruct fiscal intermediaries to recover the excess reimbursement from the hospitals. OIG also recommended procedural improvements that should preclude this problem in the future. CMS concurred with these recommendations. (A-07-02-04006)

Reimbursement for End Stage Renal Disease Drugs

This inspection was required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. OIG found that in 2003, the 4 largest dialysis providers paid between 12 percent and 68 percent less than the current Medicare reimbursement amount for the 10 End Stage Renal Disease (ESRD) drugs reviewed. A sample of facilities not owned or managed by the 4 largest providers paid between 5 percent and 58 percent less than Medicare for the same 10 drugs. In 2003, average sales prices for the drugs under review were between 6 percent and 66 percent below the Medicare reimbursement amount. According to OIG projections, Medicare reimbursement for separately billable drugs will rise by 11 percent between 2003 and 2005, and CMS plans to use data from this report to set calendar year 2005 reimbursement rates for ESRD drugs. (OEI-03-04-00120)

Medicare Payment Rates for Home Oxygen Equipment

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to reduce fee schedule payment amounts for home oxygen equipment in 2005. The reduction will be based on the percentage difference between the Medicare fee schedule amounts for each State and the median prices paid by Federal Employees Health Benefits (FEHB) plans. This OIG inspection found that in 2002, FEHB plans' median payment rates for home oxygen equipment were between 10 and 20 percent lower than median Medicare fee schedule allowances for stationary and portable equipment. OIG also found that plans use alternative payment methods, including competitive bidding and capped rental arrangements, to lower their costs.

This report recommended that CMS use the pricing information OIG obtained to reduce the rates Medicare pays for home oxygen equipment in 2005. OIG also recommended that the agency consider alternative methods for determining future Medicare oxygen payment rates. The agency concurred with OIG's recommendations. (OEI-09-03-00160)

Payment for Power Wheelchairs

In 2001, Medicare and its beneficiaries paid \$513 million for all K0011 power wheelchairs. Payments for this procedure code have risen dramatically, increasing 43 percent from calendar year 2000 to 2001 alone. To determine whether K0011 power wheelchairs provided in 2001 met Medicare's coverage and documentation requirements, OIG selected a simple random sample of 300 claims. OIG then contacted the suppliers, ordering physicians, and beneficiaries associated with these claims, obtained relevant medical documentation, and provided that documentation to an independent contractor for a coverage review.

OIG found that almost one-third of the claims reviewed did not meet Medicare's coverage criteria for any type of wheelchair. An additional 45 percent of reviewed claims did not meet Medicare's coverage criteria for the K0011 power wheelchair but may have met criteria for a less expensive mobility device. Only 13 percent of reviewed claims actually met the coverage criteria for the power wheelchairs. Due to insufficient documentation, the reviewer could not determine whether the remaining 11 percent of reviewed claims met the coverage criteria for the K0011 power wheelchair. OIG's coverage review indicated that Medicare and its beneficiaries are spending an estimated \$178 million for wheelchairs that do not meet Medicare's criteria. OIG also identified a number of other problems with Medicare claims for the wheelchairs, including missing and incomplete supporting documentation, and equipment that is not used by Medicare

beneficiaries. OIG recommended that CMS improve compliance with Medicare's coverage criteria for power wheelchairs. OIG suggested that CMS require durable medical equipment regional carriers to revise current coverage policies for power wheelchairs; conduct frequent reviews of K0011 claims; and educate ordering physicians and beneficiaries about power wheelchair coverage criteria. CMS concurred with the recommendations. (OEI-03-02-00600)

Power Wheelchair Price Comparison

In this report, OIG found that the median purchase prices for both consumers and suppliers were lower than the Medicare reimbursement amount for K0011 power wheelchairs. While a wide range of prices was collected, 94 percent of the prices were less than the Medicare reimbursement amount. Medicare and its beneficiaries could have saved over \$224 million in 2002, if the K0011 power wheelchair reimbursement amount were set at the median prices available to consumers and suppliers.

In order for CMS to determine whether the Medicare reimbursement amount for K0011 power wheelchairs is appropriate, OIG recommended that CMS create a new coding system that accounts for the variety in models and prices for power wheelchairs and/or use the pricing information in this report to determine whether an inherent reasonableness review for K0011 power wheelchairs is appropriate. CMS believes OIG's recommendation regarding coding warrants further consideration and agreed with OIG's recommendation that it consider using its inherent reasonableness authority to reduce the reimbursement amount for K0011 power wheelchairs. (OEI-03-03-00460)

Payments to Ambulatory Surgery Centers for Intraocular Lenses

OIG found that the current \$150 per lens Medicare payment to ambulatory surgical centers (ASCs) for intraocular lenses (IOLs) is not "reasonable and related to the cost," as required by law. For the 12 months ending June 2002, 40 percent of IOL payments by Medicare and its beneficiaries were in excess of the ASC's IOL costs. Overall, IOL costs averaged \$90.30 per lens, \$59.70 below the \$150 Medicare payment. The IOL cost varied significantly by lens type (grouped by lens material), with the highest cost IOL averaging \$125 per soft acrylic lens, followed by an average \$69 per silicone lens, and an average \$39 per polymethyl methacrylate lens. The most frequently used lens type is the silicone lens at a \$69 average cost. This report estimated that Medicare and its beneficiaries could have achieved substantial savings through the use of alternative payment rates.

OIG recommended that CMS reduce Medicare payment to ASCs for IOLs in a manner that takes into account the different types and cost of IOLs. CMS agreed to take

into account OIG's recommendation and IOL cost data in developing the revised payment system for ASCs, which the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires be implemented beginning on or after January 1, 2006 and not later than January 1, 2008. (OEI-06-02-00710)

Long Term Care Hospitals-Within-Hospitals

An OIG evaluation found that 19 of 87 hospitals-within-hospitals exceeded the annual 5 percent threshold for readmissions from their host hospitals at least once during their fiscal years ending in September 2000 through December 2002. Currently, CMS lacks a system to detect readmissions over the 5 percent threshold. As Medicare's prospective payment system for long-term care hospitals is fully implemented, paying hospitals-within-hospitals that are over the 5 percent readmission level could result in increased costs to the Medicare program. In addition, CMS has no ongoing mechanism to determine whether hospitals-within-hospitals are financially and organizationally separate from their host hospitals.

OIG recommended that CMS develop a system to monitor hospitals-within-hospitals' compliance with the five percent readmission rule, and require hospitals-within-hospitals to demonstrate their organizational and financial independence on a continuing basis. CMS supported the report's findings and the thrust of OIG's recommendations. (OEI-01-02-00630)

Managed Care Payments

Medicare+Choice organizations (MCO) are responsible for providing all Medicare-covered services, except hospice care, in return for a predetermined capitation payment. MCOs with plans for which payment rates increased under the Benefits Improvement Protection Act of 2000 were required to submit a revised proposal to show how they would use the increase during 2001. They were also required to use the additional amounts to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers. This review found that about \$5.2 million of the \$16.4 million increase in one MCO's revised proposal was not used in the required manner or its use was not adequately supported.

OIG recommended that the MCO refund the \$5.2 million to the Federal Government or, as an alternative, deposit this amount in a benefit stabilization fund for use in future years and ensure that estimated costs in future proposals are properly supported. The MCO did not agree. (A-06-02-00060)

Medicare+Choice Organizations' Related-Party Fees

OIG reviewed four MCOs in a nationwide chain. The MCOs reported to CMS more than \$100 million in “related-party” fees paid to their management company in return for administrative services. The review found that the MCOs failed to show that the related-party fees did not exceed the costs that would have been incurred with an unrelated party and that the MCOs did not have effective procedures to develop and allocate actual costs. OIG recommended that CMS take several steps, including applying administrative sanctions, if appropriate, to ensure that MCOs comply with related-party financial disclosure requirements. CMS did not fully agree with the recommendations.

(A-06-01-00033)

Terminated Medicare Contractors

Since its inception, Medicare has paid a portion of Medicare contractors' annual contributions to their pension plans. OIG reviewed three insurance companies that processed and paid Medicare fee-for-service claims until their contractual relationships with CMS were terminated.

- ▶ One company in New Jersey claimed more than \$3.8 million in excess pension assets. Federal regulations and the Medicare contracts provide that pension gains that exist when a Medicare segment of a pension plan closes are to be credited to the Medicare program. The company agreed in part with OIG's recommendation to remit the excess amount. (A-07-02-03028)
- ▶ Another company, located in North Carolina, claimed more than \$2 million in postretirement benefit costs. OIG determined that the entire amount was unallowable because the claim represented a retroactive change in the company's accounting basis and a request for reimbursement of unfunded costs. The company disagreed with OIG's recommendation to withdraw the claim. (A-07-04-00162)
- ▶ A third company, located in Texas, identified \$11.2 million in excess pension assets. OIG determined that this figure was materially accurate and recommended the company remit the excess to the Federal Government. The company agreed. In another audit, OIG determined that the same company had incorrectly calculated over \$3 million in pension costs and recommended that the company remit the overpayment to the Federal Government. The company disagreed. (A-07-02-03032, A-07-03-03046)

Fiscal Intermediary Administrative Costs

The objectives of this review were to determine whether a Medicare fiscal intermediary had effective controls over the accounting and reporting of administrative costs and whether the costs it claimed complied with Federal regulations and contract provisions. The report identified \$2.75 million in unallowable costs and recommended that the company make a financial adjustment and revise its procedures to ensure that its future proposals are accurate. The company generally disagreed with the recommendations. (A-01-02-00525)

Intergovernmental Transfers

OIG has continued to focus on States' use of intergovernmental transfers, a mechanism by which some States claim the Federal share of Medicaid funds for payments to public facilities and then require the facilities to return the funds to the State. In one report, OIG found that Tennessee used intergovernmental transfers to maximize Federal Medicaid reimbursement at little or no cost to the State. Moreover, Tennessee did not use the funds primarily for the benefit of public nursing homes, for which the program was designed. Also, Tennessee's upper-payment-limit calculations for State FYs 2001 and 2002 exceeded the Medicare upper payment limit (UPL) by \$23.7 million. Of this amount, \$21.8 million represented an overpayment, and the State had not yet claimed the balance of \$1.9 million.

OIG recommended that Tennessee refund the overpayment and improve its review procedures to ensure the accuracy of UPL calculations. Tennessee concurred with the recommendations. (A-04-02-02018)

Nursing Home Payments

This report found that Medicaid payments to a county nursing home in New York State were adequate to cover its operating costs, but that State requirements that the home return a portion of those payments left the home without adequate funding. During the 3 years that ended September 30, 2001, payments to the nursing home totaled \$132 million: \$41 million in Medicaid per diem payments and \$91 million in payments. In the same period, the home's operating costs were about \$70 million.

However, because the State and county required the nursing home to return about 90 percent of its UPL funding, the home was allowed to retain only about \$50 million—\$20 million less than its operating costs. The home was also significantly understaffed, which may have affected the quality of care provided to its residents. In fact, the home had received a rating from the State indicating that its residents were in immediate jeopardy.

The State's UPL funding approach benefited the State and the county more than the nursing home: the State received \$20 million more than it expended, and the county was fully reimbursed for its contribution. In effect, the Federal Government provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is a shared Federal-State responsibility.

In effect, the Federal Government provided almost all of the nursing home's Medicaid funding, contrary to the principle that Medicaid is a shared Federal-State responsibility.

OIG recommended that the State (1) seek necessary authority to calculate the nursing home's Medicaid per diem rate to more closely reflect operating costs and (2) allow the nursing home to retain sufficient funding so that it can attract, hire, and retain sufficient nursing staff to provide an adequate level of care to its residents. The State did not agree with the recommendations. (A-02-02-01020)

Disproportionate Share Hospital Payments

Medicaid requires States to make additional payments, called disproportionate share hospital (DSH) payments, to hospitals for the uncompensated costs of serving disproportionate numbers of low-income patients with special needs. OIG recently issued two DSH payment reports, one on Alabama and the other on Ohio.

- ▶ **Alabama**—OIG found that Alabama's DSH payments did not comply with the hospital-specific payment limits mandated by the Social Security Act. Consequently, hospitals participating in the managed care arrangement were overpaid about \$66 million (\$46 million Federal share) in FYs 1999 and 2000. Also, hospitals were required to transfer about 86 percent of their DSH payments back to the State via intergovernmental transfers. The State made DSH payments primarily to publicly owned hospitals because these hospitals could return the funds to the State. As a result, private hospitals were likely not reimbursed for all of their uncompensated care costs.

OIG recommended that the State refund the \$46 million, include an offset for all enhanced payments in its DSH calculations, calculate uncompensated care costs annually, and establish controls to ensure the reasonableness and allowability of future uncompensated care costs. The State disagreed. (A-04-01-02006)

- ▶ **Ohio**—This State’s DSH payments were in compliance with Federal requirements and CMS policies, with one exception: Ohio incorrectly included the 22- to 64-year-old patient age group in the Medicaid inpatient utilization rate calculation for its State-owned institutions for mental diseases (IMD). As a result, Ohio made approximately \$80 million (\$47 million Federal share) in DSH payments to seven IMDs that did not meet the Medicaid inpatient utilization rate requirements.

OIG recommended that Ohio revise its State plan to exclude the 22- to 64-year-old age group in calculating the Medicaid IMD inpatient utilization rate for future DSH reporting periods and refund the \$47 million in Federal payments. The State disagreed with the recommendations. (A-05-01-00058)

Variation in State Medicaid Drug Prices

OIG assessed the extent to which States vary in their Medicaid pharmacy reimbursement for the same drugs. This inspection found that the Medicaid program could benefit from substantial savings if all States reimbursed pharmacies at prices closer to the drug reimbursement prices paid by the lowest paying States. OIG analyzed fiscal year (FY) 2001 prescription drug reimbursement data for 28 drugs from 42 States. The highest paying State’s unit reimbursement price ranged from 12 to 4,073 percent more per drug than the lowest paying State for the 28 drugs. On average, the highest paying State paid almost \$200 more per package than the lowest paying State for these drugs. Medicaid could have saved \$86.7 million in FY 2001 if all States had reimbursed at the same price as the lowest paying State for each of the 28 drugs. Multiple factors contributed to the differences in drug prices across States. Even States with the same formula for estimating pharmacy acquisition costs demonstrated variation in their average annual reimbursement prices.

OIG recommended that CMS share average manufacturer price data with States, conduct further research on the factors that affect States’ drug prices, and annually review States’ reimbursement data to target technical assistance to higher paying States. CMS nonconcurred with the report due to concerns about the data but agreed with OIG that this report raises serious issues that warrant attention. (OEI-05-02-0068)

Medicaid Claims for Contractual Services

New Jersey contracted with a consulting firm to identify and submit to the Federal Government unclaimed State expenses. As a result of the firm's efforts, the State claimed \$110.4 million for contractual service costs under the Medicaid DSH program. OIG found that \$3.7 million (\$1.8 million Federal share) was not eligible for Federal reimbursement and that the State had not ensured the veracity of the claims prepared by the consulting firm. OIG recommended that New Jersey refund the \$1.8 million to the Federal Government, adhere to Federal and State guidelines when submitting future claims, and review its consultants' work. The State agreed. (A-02-03-01015)

Claims for Residents of Institutions for Mental Diseases

In two reports, OIG summarized its seven-State reviews of controls to preclude States from claiming Federal Medicaid funds for services provided to 21- to 64-year-old residents of IMDs. The first report, which focused on residents who were temporarily released to acute care hospitals for inpatient medical treatment, found that the seven States (California, Florida, Maryland, New Jersey, New York, Texas, and Virginia) generally had ineffective or no controls and, as a result, improperly claimed a total of \$21.1 million in Federal Medicaid funds. The second report, which covered other medical and ancillary services, noted that three States (Maryland, Texas, and Virginia) had no controls to prevent Federal funding from being claimed, one State (New Jersey) had ineffective controls, two States (New York and Florida) had generally adequate controls, and one State (California) had effective controls and made no improper claims. The remaining six States improperly claimed a total of almost \$2.5 million in Federal Medicaid funds.

OIG recommended that CMS (1) reinforce to States that Federal Medicaid funds may not be claimed for 21- to 64-year-old IMD residents, including those temporarily released to acute care hospitals for inpatient medical treatment, (2) instruct States to implement controls, where cost effective, to preclude such claims, and (3) advise States not included in OIG's reviews of the audit findings and encourage them to review their controls to prevent improper claims. CMS concurred with the recommendations. (A-02-03-01002; A-02-03-01030)

Hospital Patient Transfers Paid As Discharges

The objective of this review was to determine whether inpatient hospital claims for patients transferred from one hospital to another on the same day were properly coded and paid in accordance with North Carolina's Medicaid reimbursement requirements. OIG determined that 512 claims at 35 hospitals were for transfers incorrectly coded as discharges. OIG recommended that the State refund \$1.85 million in overpayments and establish procedures to prevent and detect coding errors. The State agreed and took appropriate corrective actions. (A-05-03-00041)

Selective Provider Contracting Program

A portion of California's Medicaid program operated under a Federal waiver known as the Selective Provider Contracting Program. The program allowed the State to contract with selected hospitals to provide inpatient Medicaid services at rates typically lower than those under traditional Medicaid rules. The State used the rates to project savings under the waiver and, based on those savings, made supplemental payments to hospitals.

As a result of errors in the methods that the State used to project program savings, the State's savings were overstated. Also, documentation did not adequately support projected savings. OIG recommended that the State revise its savings calculation methods; recalculate program savings; determine whether supplemental payments exceeded the recalculated savings and, if so, refund the Federal share; and maintain adequate documentation. The State disagreed. (A-09-02-00082)

Payments for Oxygen-Related Medical Equipment

This report consolidates audits of 9 States and an analysis of the 41 other States and the District of Columbia concerning Medicaid payments for oxygen-related durable medical equipment (DME) and supplies. Medicaid paid providers in six of the nine States approximately \$12.7 million (\$7.3 million Federal share) more than Medicare would have paid. Specifically, four States with a requirement that Medicaid rates for oxygen-related DME and supplies not exceed the Medicare rates overpaid Medicaid providers \$10 million (\$5.9 million Federal share). Two States without that requirement could have saved approximately \$2.7 million (\$1.4 million Federal share) if Medicaid rates had been limited to the Medicare-allowable amounts. In addition, OIG's analysis of data from the 41 other States and the District of Columbia determined that 22 States and the District of Columbia

could achieve significant savings by limiting Medicaid rates for oxygen-related DME and supplies to the Medicare-allowable amounts.

OIG recommended that CMS instruct those States that limit Medicaid rates to Medicare reimbursement levels to apply the payment limits correctly and in a timely manner and alert the remaining States to the opportunity to reduce Medicaid payments by limiting reimbursement rates to the Medicare-allowable amounts. CMS officials generally agreed. (A-05-03-00018)

School-Based Services

A 1988 amendment to the Social Security Act allows Medicaid coverage of school-based health services, including transportation, for children with disabilities or special needs. OIG reviewed two States to determine whether claims for school-based services were allowable for Federal reimbursement.

- ▶ ***New York***—Of 110 transportation claims sampled in this State, 97 did not comply with Federal and State requirements and 96 had more than 1 deficiency. The deficiencies occurred because the State provided to its schools and preschools improper guidance about CMS’s requirement for documentation, school health providers did not comply with other guidance they had received, and the State did not adequately monitor transportation claims from providers. As a result, over \$17.2 million in Federal funding was unallowable, and nearly \$35.8 million was set aside for further review.

OIG recommended that New York refund \$17.2 million to the Federal Government, work with CMS to resolve the set-aside claims, and improve its guidance and oversight of school-based transportation claims. New York disagreed with the recommendations. (A-02-03-01008)

- ▶ ***North Carolina***—Of 200 sampled claims in North Carolina, 146 did not meet Federal and State reimbursement requirements. The State did not provide sufficient guidance to local education agencies, have adequate policies to support Medicaid billing rates, monitor local education agencies to ensure that the State share was met, or have adequate controls to prevent improper payments for school-based services.

OIG recommended that North Carolina refund \$2.8 million to the Federal Government and implement procedures to prevent improper payments. North Carolina generally disagreed with the recommendations. (A-04-01-00005)

Rehabilitative Treatment Services

At the request of CMS, OIG reviewed Iowa's Rehabilitative Treatment Services Group Care program, which provides behavioral, psychological, and psychosocial treatment in a group care setting for Medicaid recipients age 20 or under. Of the 100 claims sampled, 46 did not meet Medicaid reimbursement requirements. Based on the sample, OIG estimated that \$3.3 million of the \$14.4 million in Federal funds claimed for FY 2001 was unallowable.

OIG recommended that the State refund the \$3.3 million and strengthen its policies and procedures. The State disputed some of the questioned claims. After reviewing the State's additional documentation, OIG agreed that certain claims were allowable and modified the refund recommendation. (A-07-02-03026)

Medicaid Fee-for-Service Payments for Medicare Managed Care Enrollees

This audit found that Ohio made unallowable Medicaid fee-for-service payments for beneficiaries enrolled in Medicare managed care organizations. Based on a statistical sample, OIG estimated that the unallowable Medicaid payments totaled \$4.6 million (\$2.7 million Federal share) during the fiscal year ended June 30, 2001. The State's system for processing Medicaid claims did not have controls to prevent such improper payments.

OIG recommended financial adjustments and improvements in internal controls. State officials did not concur. (A-05-02-00085)

Physician Drug Rebates

OIG found that from 1997 to 2000, Medicaid spending for outpatient prescription drugs grew twice as fast as total Medicaid spending. In 2000, Medicaid expenditures for these drugs were \$21 billion. Under the Medicaid drug rebate program, manufacturers are required to provide rebates on drugs paid for by a State. To receive rebates, States must identify the drugs by their national drug code. Most States, however, use procedure codes to identify physician-administered drugs and have not developed "crosswalks," which identify the national drug codes that match procedure codes. States that had crosswalks as of 2001 and were able to provide data requested \$23 million in rebates on these drugs. OIG found that in 2001, Medicaid could have added millions to its rebate savings,

primarily from single-source drugs, if every State had collected rebates for all single-source and 40 multiple-source, physician-administered drugs. The majority of savings was from the single-source drugs. As of March 2003, 24 States still did not collect rebates on physician-administered drugs. The study indicates a State's savings in a single year could exceed the one-time costs of implementing system changes in order to collect rebates for these drugs.

OIG recommended that CMS continue to encourage States to collect rebates for physician-administered drugs, especially single-source drugs. To facilitate rebate collection, CMS should encourage cooperation and information sharing between States that collect rebates for these drugs and States that do not. CMS could also inform States of the availability of the Medicare program's crosswalk, which States could use to reduce the administrative costs of creating and/or updating their own crosswalks. CMS concurred with the recommendations. (OEI-03-02-00660)

OIG found that from 1997 to 2000, Medicaid spending for outpatient prescription drugs grew twice as fast as total Medicaid spending. In 2000, Medicaid expenditures for these drugs were \$21 billion.

New York's Drug Rebate Program

Under the Medicaid drug rebate program, State Medicaid agencies bill manufacturers for rebates based on the States' records of drugs dispensed during the quarter. The States are required to report their rebate activity and outstanding rebate amounts to CMS. This audit found that New York State could achieve additional savings of \$3.3 million (\$1.65 million Federal share) a year by seeking rebates for section 340B entities that do not bill the State at discounted prices. (The 340B Drug Discount Program requires pharmaceutical manufacturers to sell their products to 340B entities, such as public hospitals, at or below a specified ceiling price.) In addition, OIG noted that the State did not report to CMS an estimated balance of \$350.6 million in outstanding rebates and understated the Federal share of some drug rebates by approximately \$730,000 per year.

OIG recommended that the State work with CMS to realize the additional savings, improve the program's processes and controls, ensure that the Federal Government receives its share of drug rebates, and use the estimate of outstanding rebates to develop a viable accounts receivable system for the program. The State generally concurred with the recommendations. (A-02-03-01009)

Incarcerated Beneficiaries

Federal Medicaid payments are not available for services provided to incarcerated beneficiaries except when an inmate becomes an inpatient in a medical institution. This review aimed to quantify the Medicaid funds, if any, improperly used to pay for inmates' outpatient health care services and the potential cost savings if Medicaid had not allowed Federal funding of inmates' inpatient services. Based on statistical samples, OIG estimated that improper Federal Medicaid payments for outpatient services totaled \$1.5 million and that Medicaid could have saved about \$1.5 million (Federal share) if the Medicaid payment policy on inmates' inpatient services had been consistent with the policy on outpatient services.

OIG recommended that CMS ensure that States have effective procedures for identifying incarcerated beneficiaries so that Federal funds are not claimed for outpatient services. OIG also recommended that CMS consider a policy change to exclude Federal sharing of payments for inpatient services provided to incarcerated beneficiaries. CMS concurred with OIG's recommendations. (A-04-02-06002)

Deceased Beneficiaries

The Social Security Administration maintains a comprehensive file on all reported deaths of people who have Social Security numbers. This information is available to State and Federal agencies as a way to prevent payments for services claimed to have been rendered after a beneficiary's death. However, based on a statistical sample covering a 3-year period, OIG estimated that Tennessee paid \$5 million (\$3.2 million Federal share) for Medicaid services claimed to have been rendered after beneficiaries' deaths.

OIG recommended that the State review the sampling universe to identify and refund overpayments made on behalf of deceased beneficiaries, develop procedures for identifying deceased enrollees and develop a policy to allow for the recovery of capitation and fee-for-service overpayments. The State partially agreed. (A-04-02-07020)

SCHIP: States' Progress in Reducing the Number of Uninsured Children

Of the 46 States that submitted 2002 State Children's Health Insurance Program (SCHIP) Annual Reports as of June 1, 2003, this inspection found that 44 provided some response to the requirement that all States describe their progress in reducing the number

of uninsured, low-income children in their Annual Reports. However, only 22 of these States directly addressed the CMS regulation to report on change in the number of uninsured children. Of these 22 States, 17 reported a reduction in the number of uninsured children, 3 reported an increase, and 2 reported no change. National data indicate that the rate of uninsured children nationally has declined.

Instead of measuring changes in insurance among children, 19 other States responded to this requirement by reporting on SCHIP enrollment, and 3 States reported on something other than the number of uninsured children or SCHIP enrollment. Two States submitted Annual Reports that did not provide any response to this requirement. This report recommended that CMS resolve the inconsistency between the requirement that States report on changes in the number of uninsured children and the practice of accepting enrollment data as a proxy. In addition, CMS should ensure the integrity, validity, and usefulness of the SCHIP Annual Report and SCHIP enrollment data.

This report fulfills the congressional mandate under SCHIP that OIG assess States' progress in reducing the number of uninsured, low-income children. It also reviews States' self-assessment methods and CMS's oversight of them. (OEI-05-03-00280)

Outreach

OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins, and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry.

Advisory Opinions

In accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996, OIG, in consultation with the Department of Justice, may issue advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Medicare and State health care programs. This authority allows OIG to provide case-specific formal guidance regarding the application of the anti-kickback statute and safe harbor provisions, and other OIG health care fraud and abuse sanctions. From the period April 1, 2004, through September 30, 2004, OIG received 27 advisory opinion requests and issued 10 advisory opinions.

Compliance Guidance

Because the great majority of providers are honest and want to avoid fraud and abuse, OIG is actively working with the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct. OIG has already initiated significant outreach efforts with the private sector to encourage these compliance

endeavors. OIG's compliance program guidances are available on the Internet at <http://oig.hhs.gov> in the "Fraud Prevention & Detection" section.

OIG has developed and released 11 compliance program guidances for: clinical laboratories, hospitals, home health agencies, third-party billing companies, durable medical equipment, prosthetics, orthotics and supply industry, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, individual and small group physician practices, ambulance service providers, and pharmaceutical manufacturers. OIG issued a draft supplemental guidance for the hospital industry and is developing a guidance for recipients of NIH research grants.

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG established a set of comprehensive guidelines for voluntary self-disclosures, titled "Provider Self-Disclosure Protocol," available on the Internet at <http://oig.hhs.gov> in the "Fraud Prevention & Detection" section.

Essentially, the Protocol guides providers and suppliers through the process of structuring a disclosure to OIG of matters that appear to constitute potential violations of Federal laws (as opposed to honest mistakes that may have resulted in overpayments). After making an initial disclosure, the provider or supplier is expected to undertake a thorough internal investigation of the nature and cause of the matters uncovered and make a reliable assessment of their economic impact (e.g., an estimate of the losses to Federal health care programs). OIG evaluates the reported results of each internal investigation to determine the appropriate course of action.

To date, OIG has received 234 submissions. Self-disclosure cases have resulted in 49 recoveries and 35 settlements, totaling over \$86.8 million collectively. Examples include the following:

- ▶ ***North Carolina***—Southeastern Regional Medical Center voluntarily disclosed a billing problem it discovered in the billing practices of a subsidiary, now closed. Through an internal audit, Southeastern discovered that some claims for alcohol and drug rehabilitation services were submitted with an incorrect principal diagnosis code. All cases using the incorrect code were reviewed to determine the overpayment. The case was referred to the fiscal intermediary for resolution and Southeastern paid \$1.5 million in overpayments to resolve this matter.

- ▶ **South Carolina**—To resolve a self-disclosure made to OIG, Piedmont Orthopaedics Associates, P.A., agreed to pay the Government \$411,000 and enter into a 3-year corporate integrity agreement for submitting improper claims between May 2001 and May 2003. Piedmont submitted claims to Medicare and Medicaid for occupational therapy services which were not supported by adequate documentation and/or were for more units of therapy than were actually provided.
- ▶ **Virginia**—Inova Health System paid \$125,000 to resolve a self-disclosure matter relating to the hospital's relationships with three excluded individuals. The hospital initially notified the OIG that it had hired two nursing employees who were excluded individuals. During the hospital's review of the facts surrounding the initial disclosure, the hospital also identified an excluded physician who was under contract to provide part-time house staff services. As part of the settlement, the hospital agreed to certify for 3 years that it is screening all prospective and current employees, contractors, and physicians.
- ▶ **Pennsylvania**—St. Luke's Quakertown Hospital agreed to pay \$52,000 and a \$10,000 civil monetary penalty to resolve issues raised in the hospital's self-disclosure of its employment of an excluded individual. After performing a routine check of OIG's List of Excluded Individuals/Entities in 2003, St. Luke's identified one employee, a registered nurse, who was excluded in 2001, almost a year after she was hired. The settlement agreement requires St. Luke's to submit an annual certification for 3 years, indicating that the hospital is appropriately screening all prospective and current employees, contractors, and physicians against the list.

Federal and State Partnership: Joint Audits of Medicaid

One of OIG's major outreach initiatives has been to work more closely with State auditors in reviewing the Medicaid program. A Partnership Plan was developed to foster these joint reviews and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 25 States.

Reports issued to date have resulted in identifying over \$262.8 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

OIG Administrative Sanctions

During this reporting period, OIG administered 1,910 sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. A brief explanation of these sanction authorities can be found in Appendix F.

Program Exclusions

During this reporting period, OIG excluded 1,749 individuals and entities from participating in the Medicare and Medicaid programs and other federally sponsored health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. Examples include the following:

- ▶ **Ohio**—A gynecologist was excluded for 60 years based on his conviction for rape, sexual battery, and sexual imposition against 15 separate patients over an approximate 16-month period. He was sentenced to 20 years for rape and 25 years for sexual battery.
- ▶ **Texas**—An internist was excluded for 27 years based on his conviction for electronically submitting, or causing to be submitted, false claims for medical services and testing to Medicare, Medicaid, the Federal Employees Health Benefits Program, and private health insurers during a 4-year period. The internist not only submitted false claims for allergy services that were not covered, but also had his staff randomly select 13 to 15 patient files per week to create “phantom” billings for patients he had not seen or treated on the claimed date of service. The court ordered him to pay more than \$4 million in restitution and to serve 60 months in jail. In addition, his Texas license to practice medicine was revoked.
- ▶ **Nevada**—A husband and wife were excluded for 15 years and 20 years, respectively, for executing a Medicare fraud scheme over a 3-year period. They visited nursing homes and community centers in Utah, Nevada, and Arizona to find Medicare beneficiaries to whom they could sell DME. To get the beneficiaries to release their names and Medicare identification numbers, the couple made many misrepresentations, including that Congress had passed the “Fair Foot Bill,” making shoes available to all Medicare beneficiaries at no charge. Though the couple only supplied shoes to the beneficiaries, they used their Medicare information to fraudulently bill for numerous products. The court ordered the

husband to be incarcerated for 21 months and the wife for 46 months. They were also ordered to pay \$1.4 million in joint restitution.

- ▶ **Florida**—A man was sentenced to 10 years in prison, lost his State nursing license, and received a 20-year exclusion after being convicted of a criminal offense related to the neglect or abuse of patients in connection with the delivery of a health care item or service. He committed sexual battery on a child less than 12 years of age.
- ▶ **Michigan**—A nursing home was excluded for 5 years based on its conviction for involuntary manslaughter. A resident at the Medicare facility had been found dead outside after the resident left the facility's Alzheimer's unit unobserved.
- ▶ **Washington**—Under the terms of a settlement agreement with OIG, the former head of the Nephrology Division at a medical school agreed to be excluded from participation in Federal health care programs for a 3-year period. The settlement resolved allegations that the physician submitted or caused to be submitted false or fraudulent claims for nephrology services. OIG alleged that the claims were false because they reflected that the physician was present during dialysis treatments when, in fact, the physician was not present.
- ▶ **Florida**—In a settlement with OIG, the former president and CEO of a small hospital in Colorado agreed to be excluded for 3 years. Previously, he was convicted of theft of public funds involving his use of Department of Veterans Affairs payments that were deposited into an account he held jointly with his stepmother (the intended beneficiary of the funds). The funds were deposited into the account for 14 years following the stepmother's death.

Affirmative Exclusion Action

- ▶ **California**—Last year, the United States entered into a civil settlement with Redding Medical Center (RMC), a 246-bed hospital owned by Tenet Healthcare Corporation, Inc. (Tenet). The settlement resolved RMC's liability under the False Claims Act but did not resolve RMC's liability under OIG's permissive exclusion authority. OIG issued a notice of intent to exclude RMC under section 1128(b)(6)(B) of the Social Security Act. The basis for the Notice was OIG's initial determination that from at least May 1999 through May 2002, RMC furnished or caused to be furnished to patients cardiac services that were medically unnecessary and of a quality which failed to meet professionally recognized standards of health care. Tenet agreed to divest RMC to an unrelated third party and OIG agreed to withhold issuing a formal notice of exclusion for the conduct at issue.

Civil Monetary Penalties

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person or entity that submits claims to a Federal health care program that the person or entity knows or should know are false or fraudulent. During this reporting period, OIG collected over \$874,000 in civil monetary penalties and assessments. For example:

- ▶ **Oklahoma**—Wadley Ambulance Service (WAS) agreed to pay \$28,000 to resolve its liability under the CMPL for employing an individual that WAS knew or should have known was excluded from participation in Federal health care programs. OIG alleged that the owner of WAS employed his half-brother to work as an Emergency Medical Technician for WAS. Notwithstanding the half-brother's exclusion, WAS continued to employ him for almost a year after the date of exclusion. As part of the settlement, WAS agreed to submit an annual certification to OIG for 3 years attesting that it has a policy for screening all current and prospective employees and contractors.

Kickbacks

Individuals or entities that engage in unlawful referral or kickback schemes may be subject to criminal penalties under the Federal criminal anti-kickback statute, civil monetary penalties under OIG's CMPL authority, and/or program exclusion under OIG's permissive exclusion authority. A description of these enforcement authorities can be found in Appendix F. The following is an example of a kickback enforcement action during this reporting period:

- ▶ **New Jersey**—An internist agreed to pay \$500,000 and enter a 5-year integrity agreement to resolve his CMPL liability for allegedly violating the Stark Law and anti-kickback statute. The internist entered into two lease agreements with a home health agency/durable medical equipment supplier to which he referred Federal health care program beneficiaries. The investigation uncovered that neither lease was commercially reasonable and that both were shams to disguise kickbacks paid to the internist in exchange for referrals.

Patient Dumping

Between April 1, 2004, and September 30, 2004, OIG collected civil monetary penalties of more than \$237,000 from 11 hospitals and one physician under the Emergency Medical Treatment and Labor Act, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements involving alleged violations of this statute:

- ▶ **Louisiana**—Christus Schumpert Health System paid \$50,000 to resolve allegations that it failed to screen or treat two pregnant women who presented to the hospital’s emergency department. Both women were told to go to another hospital for help. One delivered her baby in the parking lot of the second hospital.

In another Louisiana case, a doctor paid \$10,000 to resolve allegations that he refused to examine and treat a pregnant 17-year-old who presented to the emergency department complaining of perineal numbness and vaginal bleeding. The doctor mistakenly believed he could not examine or treat the patient without parental consent. The patient died the next day due to an ectopic pregnancy.

- ▶ **Minnesota**—Sioux Valley Regional Health Services, doing business as Sioux Valley Canby, paid \$15,000 to resolve an allegation that it failed to provide an appropriate medical screening and treatment to a baby who presented in the evening with vomiting and a high fever. The baby was taken to a hospital more than 18 miles away where he was admitted and treated for pneumonia and dehydration.
- ▶ **Illinois**—Good Samaritan Regional Health Center paid \$15,000 to resolve an allegation that it failed to provide appropriate examination and treatment to a man who presented by ambulance with the chief complaint of rectal bleeding. He was turned away because the hospital was on diversion status. He proceeded to another hospital where he was found to have a life-threatening upper gastrointestinal bleed. Good Samaritan implemented a comprehensive corrective action plan immediately after this incident.
- ▶ **Iowa**—Ottumwa Regional Health Center paid \$15,000 to resolve an allegation that it failed to provide an appropriate screening, treatment, or transfer of a 76-year-old man who presented with complaints of severe pain and inability to urinate. The man went to another hospital where he was given pain relief and emergency surgery.
- ▶ **New York**—Carthage Area Hospital paid \$10,000 to resolve an allegation that it failed to provide an appropriate medical screening examination, stabilizing treatment, or transfer of a man who rolled over in an all-terrain vehicle. He complained of pain in his chest, neck, back, and shoulder blades, and of difficulty breathing. He was diagnosed with two fractures and allegedly discharged while he was still in a great deal of pain. Within one hour of discharge he was taken by ambulance to another hospital where he was found to have additional fractures of ribs and his back, requiring surgery.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves the filing of false claims for reimbursement. False claims may be pursued under the civil False Claims Act and, in appropriate cases, under Federal and State criminal statutes. A description of these enforcement authorities can be found in Appendix F. The successful resolution of these matters often involves the combined investigative efforts and resources of OIG, the FBI, Medicaid Fraud Control Units (MFCUs), and a variety of other law enforcement agencies.

OIG has the responsibility to assist the Department of Justice in bringing and settling cases under the civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter integrity agreements with OIG to avoid exclusions and be permitted to continue to participate in Medicare, Medicaid, and other Federal health care programs. These agreements are monitored by OIG and require the providers to establish compliance programs. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent activities.

In the 6 months ending September 30, 2004, the Government negotiated more than \$297 million in False Claims Act civil settlements related to Medicare, Medicaid, and other Federal health care programs. Some of these successful settlements, as well as notable criminal enforcement actions, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Prescription Drugs

- ▶ **Massachusetts**—As part of a global settlement for \$430 million plus interest, Pfizer Inc. (Pfizer), Warner-Lambert Company LLC (Warner-Lambert), and the Parke-Davis Division agreed to pay \$190 million in a civil False Claims Act settlement relating to Warner-Lambert's promotion of the drug Neurontin. Pfizer acquired Warner-Lambert and its Parke-Davis Division in June 2000. Between July 1995 and June 2001, Neurontin was approved by FDA only for use in treating epilepsy, but Warner-Lambert allegedly engaged in a wide-ranging program to promote Neurontin for other uses. The Government alleged that Warner-Lambert promoted Neurontin for a variety of conditions for which FDA had not approved the use; offered and paid illegal remuneration to doctors to induce them to promote and prescribe Neurontin for off-label uses; and made and/or disseminated false

statements about Neurontin in presentations and marketing literature provided to doctors. The Government alleged that these activities caused the submission of false and/or fraudulent claims to Medicaid.

To resolve its criminal liability, Warner-Lambert pled guilty to violating the Federal Food, Drug and Cosmetic Act and agreed to pay a \$240 million criminal fine. Pfizer entered a comprehensive 5-year corporate integrity agreement with OIG which superceded an existing corporate integrity agreement.

- ▶ **Pennsylvania**—Rite Aid Corporation agreed to pay \$7 million and enter a 4-year corporate integrity agreement to resolve its civil and administrative liability relating to the submission of claims to Medicaid and other Government health care programs for partially-filled prescriptions for drugs that were not delivered to the beneficiaries and, in some instances, were ultimately returned to stock. In addition to the settlement with the Federal Government, Rite Aid entered settlements with 28 States and the District of Columbia to resolve alleged liability to the States for the Medicaid damages. In a model of law enforcement cooperation, the Federal Government worked jointly with the MFCUs on this case.

Practitioners

- ▶ **Washington**—The Association of University Physicians, doing business as University of Washington Physicians and as Children’s University Medical Group (collectively referred to as the UW FPPs), agreed to pay \$34.4 million and enter a 5-year corporate integrity agreement. During the relevant time period, the UW FPPs employed and/or billed for the services of teaching physicians who supervised residents and interns at the University of Washington. An audit and investigation determined that the UW FPPs allegedly submitted false claims to the Medicare, Medicaid, and TRICARE programs. The claims were allegedly false because the physicians failed to appropriately document their presence during the rendering of professional services by residents and interns, and/or were not present during the rendering of such services. Other claims were for improperly upcoded services.
- ▶ **Alabama**—A psychologist was sentenced to 33 months in prison and ordered to pay \$1.8 million in restitution. From 1998 to 2000, the psychologist allegedly submitted false claims to Medicare for services performed primarily by masters-level psychology graduate students as though he rendered the services himself. He also allegedly billed Medicare for a predetermined number of hours of psychological testing services regardless of the actual amount of time spent with patients.

Another physician in Alabama was sentenced to 57 months imprisonment

and ordered to pay \$926,000 in restitution and a \$557,000 fine for mail fraud. The physician submitted false documentation to a pharmaceutical company she contracted with as an investigator in a clinical study conducted for FDA approval of a new drug. She falsely stated that certain persons participated in and completed the study when they had not, and she submitted Medicare claims for subsequent office visits to study patients when such visits never occurred.

- ▶ ***New York***—A dentist was sentenced to 63 months in prison (16 months of which was suspended) and ordered to pay \$225,000 in restitution for false statements relating to health care matters and mail fraud. The dentist billed insurers for services that were upcoded or never rendered. To increase his earnings, the dentist also performed oral surgeries on patients who did not need the treatments.
- ▶ ***Virginia***—A physician was sentenced to 18 months incarceration and ordered to pay a \$10,000 fine and \$191,000 in restitution for health care fraud in connection with false claims he submitted to Medicare and a private insurer. The physician, who operated a medical office, routinely submitted reimbursement forms reflecting charges for patients who received no medical services or received services less complex than those billed. The investigation into his billing practices began when the private insurer observed that the physician's billing submissions were inconsistent with the billings by other medical providers in the area. Shortly after the private insurer requested to review the physician's medical files, a fire occurred at his medical office. Officials determined the fire began by arson. Although a grand jury returned an indictment charging the physician with arson in connection with the fire, the Government dismissed the charge in exchange for his guilty plea to health care fraud.

Hospitals

- ▶ ***Florida***—The Government entered into a settlement agreement with Tenet Healthcare Corporation and several of its subsidiaries including AMISUB (North Ridge Hospital), Inc., doing business as North Ridge Medical Center, and 106 Tenet hospitals to resolve two sets of allegations. With regard to North Ridge Medical Center, Tenet agreed to pay \$22.5 million plus interest to settle allegations that it falsely billed Medicare for medical services provided pursuant to referrals by 11 physicians with whom Tenet had improper financial relationships under the Stark Law, and that Tenet included various non-reimbursable costs on its cost reports. With regard to the group of 106 hospitals, Tenet agreed to pay \$8.3 million to settle allegations that from January 1992 through December 2000, the group of 106 hospitals falsely billed Medicare and improperly received higher reimbursement for inpatient discharges when the patients were actually transferred to other hospitals.

- ▶ **Wisconsin**—St. Luke’s Medical Center agreed to pay \$2.2 million to resolve its civil and administrative liabilities for submitting false claims involving cardiac investigational devices and procedures performed by a hospital physician. The Government alleged that from March 1994 through February 2000, St. Luke’s submitted false claims to Medicare for aortic aneurysm repairs performed by the physician with an investigational stent-graft device, when the devices and procedures were not covered by Medicare. From March 1994 to January 1997, the devices and procedures were not covered because they lacked FDA approval. From January 1997 through February 2000, the devices and procedures had FDA approval but were not covered because the physician did not follow FDA and Institutional Review Board protocols. In addition to St. Luke’s, Wisconsin Heart and Vascular, S.C., agreed to pay \$163,000 in a separate settlement to resolve similar allegations.

Medicare Contractors

- ▶ **California**—Aetna Life Insurance Company, CareFirst Blue Cross Blue Shield, and Manor Care, Inc., entered into settlement agreements with the Government to settle allegations relating to false skilled nursing facility cost reports submitted to Medicare. To resolve their False Claims Act liability, Aetna and CareFirst each agreed to pay \$3 million, and Manor Care agreed to pay \$8.4 million. At issue in the three settlements was an agreement between Manor Care, a nursing home chain, and its then fiscal intermediary (FI), Aetna, which set a ceiling and floor for nursing ratios that determined Manor Care’s Medicare reimbursement. Under the agreement, which was in place from 1992 through 1998, Aetna agreed not to audit Manor Care’s cost reports. In September 1997, CareFirst became the FI and continued the agreement until 1998.
- ▶ **New York**—HealthNow New York, formerly known as BlueCross BlueShield of Western New York, agreed to pay \$2.6 million as part of a settlement agreement. The government alleged that during the years 1990 through 1994, the Medicare carrier falsely reported certain performance information to CMS and inappropriately charged Medicare for costs relating to its private insurance business. In October 1999, two corporate officers and two other employees were sentenced for their involvement in this matter.*

* This narrative was revised in December 2004 to correct an error.

Laboratories

- ***California***—Health Line Clinical Laboratories, Inc., and two individual defendants agreed to pay \$10 million to the Government and the State of California to resolve their False Claims Act liability. From January 1996 through September 2003, Health Line allegedly added certain esoteric and expensive laboratory tests to commonly ordered laboratory panels, thereby enabling physicians to order the tests unwittingly. From September 1997 through September 2003, Health Line also allegedly substituted the primary test used for syphilis screening with a more expensive test not approved by the FDA and billed that test using a general code to avoid detection by the Medicare carrier. As part of the settlement, Health Line also entered a comprehensive 5-year corporate integrity agreement that requires, among other things, an independent annual review of the laboratory’s billings to both Medicare and Medi-Cal, California’s Medicaid program.

- ***Illinois***—A laboratory owner was sentenced to 5 years incarceration and ordered to pay \$2.5 million in restitution for mail fraud. Through his laboratory which provided services to more than 100 nursing homes, the owner billed Medicare and Medicaid for tests not performed and fraudulently claimed mileage to obtain lab specimens.

Home Health Agencies (HHAs)

- ***Wyoming***—Banner Health Systems Corporation agreed to pay \$6.1 million to resolve its civil and administrative liabilities for allegedly submitting improper claims to Medicare. Between 1995 and 1999, Banner billed Medicare for patients who did not require skilled nursing services and for chronically ill patients for whom no changes in their plans of care occurred to qualify them for home health services. All of the Banner-owned HHAs in Wyoming were included within the settlement agreement. Banner also agreed to maintain its corporate compliance program and submit annual reports to OIG for 3 years.

- ***Michigan***—Three individuals and an HHA were ordered to pay \$866,000 in restitution for conspiracy to commit health care fraud and mail fraud. The president of the HHA and her husband, a director for the HHA, were sentenced to respective terms of 48 months and 30 months in prison and were each ordered to pay a \$100,000 fine. Through the HHA’s cost reports, the two billed Medicare and a private insurer for the construction of their luxury home, including contractors’ salaries and building materials. The general contractor, listed as a ghost employee

on the HHA's cost reports, was also sentenced to 15 months in prison, and the HHA was ordered to pay a \$10,000 fine.

- ▶ **Ohio**—A billing and payroll manager at an HHA was sentenced to 30 months incarceration and ordered to pay \$145,000 in restitution for wire fraud, mail fraud, and health care fraud. The manager made computer data entries representing home health visits that never occurred. These fabricated entries caused paychecks to be improperly generated in the names of nurses and home health aides, and caused programs, including Medicaid, to be inappropriately billed. The manager deposited these checks into her own bank account.

Ambulance Company

- ▶ **California**—American Medical Response West, Inc., an ambulance company, agreed to pay the Government \$3.5 million and enter a 5-year corporate integrity agreement with OIG. The settlement resolved the company's False Claims Act liability for the submission of false claims for ambulance transport services from January 1995 through December 1999. The Government alleged that American Medical Response West routinely billed Medicare for emergency transports that originated with a 911 call and/or were scheduled critical care transports when, in fact, the beneficiaries were in non-emergency conditions.

Nursing Homes

- ▶ **California**—A 76-bed nursing home and its owner were sentenced for grossly inflating the cost of nursing care rendered to the facility's Medicare patients. The owner was sentenced to 78 months in prison and ordered to pay \$1.6 million in restitution for health care fraud, filing three false cost reports from 1996 to 1998, making false statements to Medicare auditors, and obstructing a Federal audit.
- ▶ **Georgia**—Westbury Medical Care Home, Inc., and Brightmoor Health Care, Inc., agreed to pay the Government \$430,000 to resolve the skilled nursing facilities' False Claims Act liability. From January 1998 to July 1998, Westbury and Brightmoor allegedly submitted false claims to Medicare in connection with respiratory services that were not actually performed, or were medically unnecessary, substandard in quality, and/or provided under inadequate supervision. In addition, Westbury and Brightmoor each agreed to enter a 5-year corporate integrity agreement.

- ▶ **Virginia**—Beverly Enterprises, Inc., owner and operator of Beverly Healthcare at Fredericksburg, agreed to pay the Government \$315,000 for allegedly providing inadequate care to Medicare and Medicaid residents from 1998 through 2003. The investigation found that the nursing home provided poor quality of care, resulting in residents falling and suffering bone fractures. Staff members at the home also allegedly placed residents in physical restraints unnecessarily and failed to follow doctors' orders in procedures such as administering oxygen. Part of the settlement amount will be used to hire five new care givers, and another part will be set aside for equipment to enhance the residents' quality of life.

- ▶ **Pennsylvania**—Brinton Manor Nursing Facility agreed to enter a False Claims Act settlement to resolve allegations that it billed for poor quality services. Although Brinton had a history of poor quality of care at the facility, the case focused on one resident whose care with respect to diabetes blood level monitoring resulted in her death. Brinton agreed in the settlement to pay at least \$90,000 and hire a full-time clinical practice nurse specialist for at least 2 years to work with staff to improve care for residents with diabetes. Brinton subsequently hired this specialist. (If Brinton had failed to hire the nurse specialist, it agreed to pay the Government an additional \$20,000.) The nursing home also agreed to pay up to \$40,000 for the cost of a monitor for at least 1 year.

Also in Pennsylvania, Majestic Oaks Nursing Home agreed to pay the Government \$50,000 to resolve its liability for providing poor quality services. Based on a history of poor quality of care at the facility, the case involved deficiencies stemming from a high turnover of personnel and a lack of proper management and protocols. The deficiencies included a high number of resident falls and inadequate services with respect to pressure ulcer care and the prevention and treatment of wounds. As part of the settlement, Majestic Oaks agreed to establish a fund through which \$25,000 will be expended within 1 year for additional services to improve the quality of life of residents; expend up to \$50,000 on consultants chosen by the Government to ensure the facility's compliance with the terms of the settlement for a period of at least 1 year; and continue its corporate compliance program incorporating principles and policies set forth by OIG.

Durable Medical Equipment (DME) Suppliers

- ▶ **Pennsylvania**—Inglis Durable Medical Equipment Company, Inc., agreed to pay the Government \$336,000 and enter a 3-year corporate integrity agreement to resolve the company's liability under the False Claims Act. Inglis allegedly billed Medicare and other programs for highly specialized wheelchairs when different

motorized wheelchairs were actually provided; upcoded accessories and other equipment associated with motorized wheelchairs; billed used wheelchairs as new; and improperly completed certificates of medical necessity.

- ▶ **Texas**—The owner of three DME companies was sentenced to 13 months incarceration and ordered to pay \$104,000 in restitution for billing Medicare for different power wheelchairs than he actually provided.
- ▶ **Florida**—A DME company, its president, and general manager were sentenced for their involvement in a fraud scheme. As part of their sentences, the company and its president were ordered to pay \$63,000 in joint restitution and to forfeit \$30,000. The alleged fraudulent activities included the use of sham “oxygen discontinue” orders to steal patients from competitors, illegal qualification of patients for home oxygen, kickback violations, forgery/alteration of certificates of medical necessity, unbundling of wheelchair accessories, and obstruction of justice.

Medicaid Fraud Control Units

Currently, 48 States and the District of Columbia have Medicaid Fraud Control Units (MFCUs), which investigate and prosecute providers charged with defrauding the Medicaid program or abusing or neglecting patients. Forty-one of these MFCUs are located within the Offices of State Attorneys General and the remaining seven MFCUs are located in other State agencies. Each MFCU operates within a framework of its respective State laws and prosecutorial guidelines.

OIG annually certifies each MFCU as eligible to receive Federal grant funds. Two States—Idaho and North Dakota—have sought and received waivers from the requirement that all States operate MFCUs.

During FY 2004, OIG provided oversight for and administration of approximately \$131 million in funds to the units. Examples of cases worked jointly by OIG with MFCUs include the following:

- ▶ **Texas**—Two individuals were sentenced to 60 months incarceration and ordered to pay \$4.5 million in joint restitution for their roles in a scheme to defraud Medicare and Medicaid. The two were among a group of conspirators who owned, operated, and/or were employed by six physical therapy clinics. Their scheme involved billing for services not rendered; providing physical therapy treatments to beneficiaries in their homes by unlicensed, unsupervised physical therapy technician, paying kickbacks, and laundering Medicare and Medicaid proceeds

obtained through the fraud. This investigation involved OIG, the Texas MFCU, and the FBI.

- ▶ **Ohio**—As the result of a joint investigation by OIG and the Ohio MFCU, a clinic owner was ordered to pay \$3.4 million in restitution and fined \$30,000 for charges related to upcoded claims submitted to Medicare and Medicaid. From September 2001 through May 2003, the clinic submitted upcoded claims for office visits that were performed at a lower level of service. The investigation found that patients were seen for approximately 5 to 10 minutes on average but were billed for 40-minute office visits.
- ▶ **Indiana**—The billing clerk for a DME company was ordered to pay \$460,000 in restitution for health care fraud. The billing clerk participated with the company's operators in a scheme to submit false claims to Medicaid. Her role involved routinely upcoding and billing for more items than were actually provided. The company's operators have pled guilty and are awaiting sentencing. This investigation involved OIG, the Indiana MFCU, the FBI, and the IRS.
- ▶ **Washington**—Through a joint effort by OIG and the Washington MFCU, a woman was sentenced to 1 year in prison (335 days suspended) and ordered to pay \$3,000 in restitution and related court costs for misdemeanor theft. The woman submitted false statements to the State's Department of Social and Health Services for payment under a medical care program for in-home services for her mother who was actually hospitalized during the period the woman claimed to have rendered the services. This federally funded program is known as Community Options Program Entry System.

Public Health Agencies

The activities conducted and supported by HHS public health agencies represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. Agencies within the Department include:

- National Institutes of Health (NIH)
- Food and Drug Administration (FDA)
- Centers for Disease Control and Prevention (CDC)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Agency for Healthcare Research and Quality (AHRQ)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

OIG continues to examine the policies and procedures of these agencies to determine whether appropriate controls are in place to guard against fraud, waste, and abuse. These activities include preaward and recipient capability audits and evaluations. This oversight work has provided valuable recommendations to program managers for strengthening the integrity of agency policies and procedures and improving program performance.

Select Agent Security at Universities

This report consolidates OIG's select agent security reviews at 11 universities during 2002 and 2003. Select agents have the potential to pose a severe threat to public health and safety and to be used as weapons by criminals or terrorists. Serious weaknesses compromised the security of select agents at all universities reviewed. Physical security weaknesses left select agents vulnerable to theft or loss, thus elevating the risk of public exposure. Poor inventory and recordkeeping procedures prevented OIG from concluding that universities had complied with select agent transfer requirements. Only 2 of the 11 universities had procedures to identify persons barred from accessing select agents as required under the USA PATRIOT Act. Finally, at the six universities that used information technology resources for select agent data, OIG noted control weaknesses that could compromise the security and integrity of the data.

The universities generally agreed with OIG's recommendations, and all stated that they had begun implementing corrective actions. (A-04-04-02000)

State and Local Bioterrorism Preparedness and Response Funds

State and major local health departments receive funds from both CDC and HRSA to improve their bioterrorism preparedness. After a 2003 audit found deficiencies in California's accounting for CDC funds, OIG reviewed CDC-funded bioterrorism programs in 13 additional States and 4 major metropolitan areas as well as HRSA-funded programs in the same locations, plus California. The audit objectives were to determine whether the awardees correctly reported program transactions, established procedures to monitor subrecipient expenditures, and had any unobligated fund balances.

- ▶ **CDC Funds**—Three awardees did not report program transactions correctly, 10 needed to improve their monitoring of subrecipient expenditures, and 15 carried a total of nearly \$65 million in unobligated balances as of August 30, 2003. Large unobligated balances suggest that funds were not fully used to meet bioterrorism preparedness goals.

OIG recommended that CDC ensure awardee compliance with accounting procedures, provide guidance to awardees on reviewing and assessing sub-recipients' progress in improving bioterrorism preparedness, and assist awardees in reducing their unobligated balances. CDC agreed with the recommendations. (A-05-04-00027)

- **HRSA Funds**—None of the awardees properly recorded program transactions, 12 needed to improve their monitoring of subrecipient expenditures, and all 18 had unobligated balances totaling approximately \$19.2 million as of August 30, 2003. OIG recommended that HRSA take steps similar to those recommended for CDC, and HRSA agreed to do so. (A-05-04-00028)

Deficiencies in the 340B Drug Discount Program's Database

Section 340B of the Public Health Service Act (the PHS Act) created the 340B Drug Discount Program to lower drug prices for over 10,500 entities, including community health centers, public hospitals, and various Federal grantees. Pharmaceutical manufacturers calculate a 340B ceiling price using a specified formula and must sell their products at or below this price to continue to receive reimbursement from Medicaid.

This report examined deficiencies in the 340B drug discount program's database. OIG found that the poor quality of the Pharmacy Affairs Branch's database interferes with the successful administration of the 340B program. Thirty-eight percent of the sampled entities listed as enrolled in the 340B database reported that they do not participate in the program. The database had incorrect addresses for 43 percent of sampled entities and does not provide essential information on the entities' billing and shipping arrangements. According to interviews with nine major pharmaceutical corporations, the extent of incorrect addresses listed in the database hinders their ability to effectively identify entities eligible for the discount program.

OIG recommended HRSA develop a strategic plan for improved management of the 340B database, including a revalidation of current information in the database, an annual recertification process for entities participating in the discount program, a separate listing of newly added or deleted entities, a standard reporting format for entities' addresses, and an additional field to designate entities with contracted pharmacy arrangement. HRSA commented about actions already performed to improve the 340B database, but stated that budgetary limitations prevent the agency from committing to a timetable for full implementation. OIG encouraged HRSA to optimize its Pharmacy Services Support Center contract as a means to move toward complete action. (OEI-05-02-00071)

NIH Grants Management ❖❖

Grants management is a priority area for both the Department and OIG. During this reporting period, OIG issued two reports relating to NIH grants management issues: late awards and late closeouts.

- ▶ **Late Awards**—This report found that NIH awarded 35 percent of awards late for 3 common funding mechanisms of noncompeting continuation awards in fiscal years 2000 through 2002, totaling \$9.2 billion in late funding. Noncompeting continuation awards account for about 70 percent of NIH’s extramural research funding. Potential factors contributing to late awards were late or incomplete applications from grantees, process delays at NIH, and late congressional budget appropriations. For example, 55 percent of awards that were 30 days or more late at 3 institutes had late applications, 39 percent had incomplete applications, and 12 percent had process delays. Late awards can create problems at NIH and, to some extent, at grantee institutions. NIH has several initiatives planned or underway to help facilitate timely awards.

OIG recommended that NIH develop a centralized system to monitor late awards and address late awards more systematically by focusing on grantee institutions. NIH concurred with the recommendations. (OEI-01-03-00020)

- ▶ **Late Closeouts**—This report found that 88 percent of all grants in the computer system module that NIH uses to monitor grant closeouts were closed out late. The primary cause of late closeouts is grantees submitting closeout documents late. Tracking down these late closeout documents requires significant time and effort for NIH staff. While the closeout module is a promising tool to help NIH monitor closeouts, it has some limitations. OIG recommended that NIH develop an automated reminder system to alert grantees about upcoming due dates for closeout documents, facilitate the electronic submission of all closeout documents, enhance the closeout module’s capabilities, and address late closeouts more systematically by focusing on grantee institutions. NIH is taking several steps toward addressing late closeouts, including developing the closeout module and planning to manage the closeout function from a central office. (OEI-01-03-00021)

❖❖ Indicates performance measure. Details can be found in Appendix H.

Health Education Assistance Loan Defaults

Through the Health Education Assistance Loan (HEAL) program, HRSA guarantees commercial loans to students seeking education in health-related fields of study. The students are allowed to defer repayment of these loans until after they have graduated and begun to earn an income. Although the Department's Program Support Center (PSC) takes all steps it can to ensure repayment, there are loan recipients who ignore their indebtedness.

After PSC has exhausted efforts to secure repayment of a debt, it declares the individual in default. Thereafter, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid, and all Federal health care programs for nonpayment of these loans. Exclusion means that the individual may not receive reimbursement under these programs for professional services rendered. During the 6-month period from April 1, 2004, to September 30, 2004, 45 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 their default may enter into settlement agreements, whereby the exclusion is stayed while they pay specified amounts each month to satisfy the debt. If they default on these settlement agreements, the individuals can then be excluded until the entire debt is repaid and cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debts.

After being excluded for nonpayment of their HEAL debts, a total of 1,851 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 62 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals over \$132.4 million. Of that amount, \$5.4 million is attributable to this reporting period.

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

- Arizona Osteopath—\$366,000
- New Jersey Dentist—\$347,000
- Florida Medical Doctor—\$244,000
- New York Chiropractor—\$165,000

Misuse of Public Health Grant Funds

OIG also investigates cases involving the misuse of HHS grant funds. Resolution of allegations involving the improper use of funds granted by HHS public health agencies occurred in the following examples during this reporting period:

- ▶ **Massachusetts**—Harvard College and Beth Israel Deaconess Medical Center agreed to pay the Government a total of \$2.4 million, in addition to \$850,000 Harvard previously paid, for alleged improprieties in the administration of four grants to Harvard from the National Institute on Aging (NIA). Harvard and Beth Israel voluntarily disclosed the grant mismanagement issues to NIA. The issues involved improperly charging a variety of salary and equipment expenses to the grants, including salaries of physician scientists who did not work on the grant, expenses that were incurred in the course of other research, and expenses of physician scientists who were not eligible to work on the charged grants.
- ▶ **Montana**—A former university professor was sentenced to 10 months confinement and ordered to pay \$39,000 in restitution for embezzling funds from an HHS grant-funded program. While a professor of marketing for the university, he received grant funds to coordinate a community campaign against teen drug, alcohol, and tobacco use. He failed to complete the grant project and used the funds for his own personal expenses and accounts.
- ▶ **South Carolina**—The former executive director of a rural health clinic that received HRSA grant funds was ordered to pay \$30,000 in restitution for embezzlement and theft. While working at the clinic, the director used her corporate credit card to make frequent cash withdrawals and to purchase shoes, automobile repairs, and other items for personal use.

Ryan White CARE Act Grantees ❖❖

At the request of the Senate Committee on Finance, OIG audited Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title I and II grantees and their

❖❖ Indicates performance measure. Details can be found in Appendix H.

subgrantees. The CARE Act, which is administered by HRSA, funds health and social services for HIV/AIDS patients who are uninsured or underinsured.

Two metropolitan areas that received Title I funds (Miami-Dade, FL, and San Francisco, CA) provided poor oversight of their subgrantees. As a result, neither metropolitan area had identified the program and financial deficiencies of the subgrantees that OIG audited. For example, a Miami subgrantee did not always have documentation to support services claimed, and a San Francisco subgrantee offered “emergency” housing services beyond reasonable time limits—in some cases up to 8 years. Also, contrary to Federal requirements, neither subgrantee’s accounting system could accurately identify the costs of Title I activities. Miami-Dade agreed with OIG’s findings and recommendations and pledged to take corrective actions. San Francisco generally disagreed, particularly with regard to amounts recommended for refund. (A-04-03-01001; A-09-03-01017)

Three States that received Title II funds (Florida, New York, and Texas) exceeded or substantially met their service delivery performance goals in terms of the number of clients served and drug prescriptions provided while complying with other CARE Act requirements. OIG noted, however, that Texas needed to improve its monitoring of subgrantees. (A-04-03-08014; A-02-03-02008; A-06-03-00010)

Monitoring Ryan White CARE Act Grantees ❖❖

In response to a Senate Finance Committee request, OIG issued three inspection reports on the monitoring of Ryan White CARE Act Title I and Title II grantees by HRSA. The first report found weak oversight due to HRSA’s limited support of systematic monitoring by project officers. The second report found that sampled grantees are not adequately or consistently monitoring their subgrantees, but that they are aware of some subgrantee issues. HRSA allows grantees to establish their own monitoring standards, but does not always require grantees to report these standards. Finally, the third report found that HRSA’s oversight of the AIDS Drug Assistance Program (ADAP) is weak.

Based on these findings, OIG recommended that HRSA should strengthen its oversight of Ryan White CARE Act Title I and Title II grantees and its monitoring of the ADAP portion of the Title II grant. Furthermore, OIG recommended that HRSA should also ensure the adequacy of Title I and Title II grantees’ monitoring of subgrantees. OIG is aware that HRSA has made changes that may enable the agency to address the grantee monitoring issues discussed in OIG reports. HRSA has consolidated its grants management offices, relocated most Title II monitoring responsibilities from regional offices to headquarters, and refocused the Office of Field Operations, now called the Office of Performance Review. (OEI-02-01-00640; OEI-02-01-00641; OEI-02-01-00642)

❖❖ Indicates performance measure. Details can be found in Appendix H.

Credentialing and Privileging at IHS Hospitals

At the request of IHS, OIG reviewed credentialing, privileging, and personnel suitability practices at several hospitals. Industry-wide standards and IHS policy require credentialing and privileging reviews of medical practitioners, and the Indian Child Protection and Family Violence Prevention Act requires background investigations of all IHS employees and contractors.

At an IHS-operated hospital in New Mexico, OIG's review of 84 practitioners revealed that the hospital had not verified the credentials of 32 practitioners before they provided patient care. In addition, the hospital had failed to ensure that 67 practitioners had current privileges, with lapsed periods as long as 3 years, and had not requested background investigations on 41 practitioners. In response to OIG's recommendations to assign sufficient resources to, and otherwise strengthen, the credentialing, privileging, and personnel suitability processes, IHS stated that it had taken all recommended actions. (A-06-04-00023)

Two tribally operated hospitals in Oklahoma had effective controls in place to ensure that credentialing and privileging reviews were completed at practitioners' initial appointments and reappointments. Although these hospitals had not performed the required background investigations, both immediately initiated such investigations during OIG's review to ensure compliance with the law. (A-06-04-00039; A-06-04-00040)

Administrations for Children and Families and on Aging

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families. Some of the major programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant. OIG reviews of these programs focus on ways to increase the efficient use of program dollars; to more effectively implement programs; to better coordinate programs among the Federal, State, and local governments; and to strengthen States' financial management practices.

The Administration on Aging (AoA) awards grants to States for establishing comprehensive community-based systems that assist the elderly in maintaining their independence and in remaining in their homes as long as possible. Socially and economically disadvantaged elderly and low-income minority elderly are targeted for assistance, including supportive and nutrition services, education and training, low-cost transportation, and health promotion. OIG has reported opportunities for program improvements to target the neediest for services, expand available financial resources, upgrade data collection and reporting, and enhance program oversight.

Noncustodial Parents' Contributions to SCHIP Costs ❖❖

Some children who receive child support services (Title IV-D children) are enrolled in the State Children's Health Insurance Program (SCHIP) because neither their noncustodial nor their custodial parents have access to affordable private health insurance. An OIG seven-State initiative was designed to determine, through statistical samples, the number of Title IV-D children whose noncustodial parents could have contributed toward their children's SCHIP costs and the amount that they could have potentially contributed.

The reports found that States could increase SCHIP enrollment and have noncustodial parents pay part of the costs incurred by the States and the Federal Government. OIG recommended that each State take steps to recover SCHIP premiums from noncustodial parents with medical support orders and the ability to pay for their dependent children. The States were generally responsive.

- ▶ ***Indiana***—The noncustodial parents of 10,900 children eligible for, but not enrolled in, SCHIP could have potentially contributed \$6.4 million toward the \$10.7 million in SCHIP costs that would have been incurred had the children been enrolled. More than 400 other children who received SCHIP benefits had noncustodial parents who could have potentially contributed about \$163,000 toward the \$247,000 in SCHIP premiums paid on their children's behalf. (A-05-02-00073)
- ▶ ***Michigan***—The noncustodial parents of 22,700 children eligible for SCHIP benefits could have potentially contributed \$9.8 million toward the \$22.5 million in SCHIP costs that would have been incurred. The noncustodial parents of more than 400 other children who received SCHIP benefits could have potentially contributed \$168,000 toward SCHIP premiums totaling \$289,000. (A-05-02-00076)
- ▶ ***New Jersey***—The noncustodial parents of 37,200 children eligible for SCHIP could have potentially contributed \$17.5 million toward potential SCHIP costs of \$28.2 million that would have been incurred. Also, about 2,200 children who received SCHIP benefits had noncustodial parents who could have potentially contributed more than \$961,000 toward the \$1.3 million in premiums. (A-02-02-02007)

❖❖ Indicates performance measure. Details can be found in Appendix H.

- ▶ **New York**—The noncustodial parents of almost 36,900 children eligible for SCHIP could have potentially contributed about \$22.3 million toward the \$40.7 million in premiums that would have been incurred. Also, the noncustodial parents of an estimated 12,300 children who received SCHIP benefits could have potentially contributed about \$5.1 million toward the \$9.3 million in SCHIP premiums. (A-02-02-02005)
- ▶ **North Carolina**—About 20,600 SCHIP-eligible children had noncustodial parents who could have potentially contributed \$16.4 million toward the \$24.9 million in potential SCHIP premiums. The noncustodial parents of almost 3,700 other children who received SCHIP benefits could have potentially contributed \$1.9 million toward the \$3.6 million in SCHIP premiums. (A-04-02-00014)
- ▶ **Texas**—The noncustodial parents of more than 81,000 children eligible for SCHIP could have potentially contributed \$39.7 million toward the \$65.1 million in premiums that would have been incurred. In addition, almost 14,300 children who received SCHIP benefits had noncustodial parents who could have potentially contributed more than \$5 million toward the \$6.5 million in SCHIP premiums paid on their children’s behalf. (A-06-02-00068)
- ▶ **Virginia**—The noncustodial parents of almost 10,000 children eligible to receive SCHIP benefits could have potentially contributed \$5.2 million toward the \$7.3 million in premiums that would have been incurred. Additionally, more than 400 children who received SCHIP benefits had noncustodial parents who could have potentially contributed \$193,000 toward the \$303,000 in SCHIP premiums paid on behalf of their children. (A-03-02-00203)

Health Care Services for Children in Foster Care ❖❖

Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) guidelines require each State to provide coverage of preventive health care services to Medicaid-eligible individuals under the age of 21, at intervals which meet reasonable standards of medical and dental practice as established by statute. These multi-state reports aimed to assess the extent to which children in foster care were receiving Medicaid health services in accordance with Federal and State requirements.

❖❖ Indicates performance measure. Details can be found in Appendix H.

Oregon

OIG reviewed a random sample of 50 children in foster care in Oregon and found that the children in the sample had Medicaid coverage and access to services. Targeted case management, the most common and most costly Medicaid claim for children in the sample, is designed to enable eligible individuals to gain access to needed medical services. Yet, this study found that targeted case management did not result in recipients receiving additional health care. Twenty of the fifty sampled foster care children did not have preventive care claims during the study period. This lack of preventive care may be due, in part, to the mistaken belief of some Oregon officials that Oregon is not bound by EPSDT requirements. In fact, Oregon is bound by EPSDT requirements and is only relieved from its obligation to pay for services required to treat a condition identified in an EPSDT screening when such services are beyond the scope of the benefits package available to an individual receiving Medicaid. Some caregivers had difficulty obtaining medical records and accessing dental and medical health services for foster children in their care. Sampled children placed in homes outside of the State experienced problems obtaining medical coverage.

CMS and ACF concurred with OIG recommendations that: CMS review the use of targeted case management and clarify the intent of the EPSDT portion of Oregon’s 1115 waiver; ACF and CMS promote preventive health care consistent with EPSDT; and ACF address the health care needs of foster care children placed across State lines. (OEI-02-00-00363)

North Dakota

OIG found that all 50 sampled children in the North Dakota foster care program had Medicaid coverage and claims. Thirty-five received their most recent required EPSDT examinations and 30 of 38 children required to receive dental services had received their most recent EPSDT dental service. Some children waited months after entering foster care to receive a comprehensive medical examination recommended by the State. Nine of 48 foster care providers (foster parents or residential care facility staff) reported never receiving a medical history for the sampled child in their care, and mental health needs were undocumented in the case plans for 12 of the 34 sampled children receiving mental health services, both of which are required under Federal regulations.

OIG recommended that ACF and CMS work with the North Dakota Department of Human Services to address these shortcomings. (OEI-07-00-00643)

Child Support Enforcement

The detection, investigation, and prosecution of noncustodial parents who fail to pay court-ordered child support is a priority for OIG. Working with the Office of Child Support Enforcement (OCSE), the Department of Justice, U.S. Attorneys’ Offices, U.S.

Marshals Service, and other Federal, State, and local partners, OIG develops ways to expedite the collection of child support. Since 1995, OIG has opened 2,712 investigations of child support cases nationwide, which have resulted in 981 convictions and court-ordered criminal restitution and settlements of over \$51 million.

Task Forces

In 1998, OIG and OCSE initiated “Project Save Our Children” (PSOC), a child support initiative made up of multiagency, multijurisdictional investigative task forces. The task forces are designed to identify, investigate, and prosecute egregious criminal nonsupport cases both on the Federal and State levels through coordinating law enforcement, criminal justice, and child support office resources.

Task Force Table

Task Force Regions	Task Force Headquarters	Task Force States
Mid-Atlantic	Baltimore, Maryland	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Midwest	Columbus, Ohio	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Northeast	New York, New York	New Jersey, New York, Puerto Rico
Southeast	Atlanta, Georgia	Alabama, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee
Southwest	Dallas, Texas	Arkansas, Louisiana, Mississippi, New Mexico, Oklahoma, Texas
West Coast	Sacramento, California	Arizona, California, Hawaii, Nevada
New England	Boston, Massachusetts	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Great Plains	Topeka, Kansas	Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota
Rocky Mountains	Denver, Colorado	Colorado, Montana, Utah, Wyoming
Pacific North	Olympia, Washington	Alaska, Idaho, Oregon, Washington

Central to the task forces are the screening units located in each task force region and staffed by Investigative Analysts from OIG and OCSE. The units receive child support cases from the States, conduct pre-investigative analyses of these cases through the use of databases, and then forward the cases to the investigative task force units where they are assigned and investigated. The task force approach streamlines the process by which the cases best suited for criminal prosecution are identified, investigated, and resolved.

At this point, the task force units have received over 8,200 cases from the States. As a result of the work of the task forces, 494 Federal arrests have been executed and 458 individuals sentenced. The total ordered amount of restitution related to Federal investigations is over \$22.8 million. There have been 352 arrests at the State level and 310 convictions or civil adjudications to date, resulting in over \$17.3 million in restitution being ordered.

Investigations

OIG investigations of child support cases, nationwide, resulted in 86 convictions and court-ordered criminal restitution of over \$4.3 million during this semiannual period. Examples of the Federal arrests, convictions, and sentences for failure to pay child support include the following:

- ▶ ***Maryland***—A former United States professional basketball player was sentenced to 12 months and 1 day in prison and 12 months supervised release. During his period of release, he was ordered to remain current on his court-ordered support payments as well as pay \$2,000 a month toward his arrearage of \$128,000. His sentencing was the culmination of a 5-year investigation during which the basketball player lived in Spain. Proof of his sizeable professional earnings in three foreign ball clubs was obtained, establishing his ability to support his son during the same years in which he benefitted from declaring the boy as a dependent on his income taxes.
- ▶ ***Minnesota***—A former attorney once responsible for overseeing the State’s child support enforcement division was sentenced to 10 months time served, 1 year supervised release and ordered to pay \$109,000 in restitution. Since approximately 1996, his whereabouts had been unknown after he fled New York to avoid paying child support. The subsequent investigation found he was living and working under an alias in Nevada and had received in excess of \$30,000 from his father’s estate.
- ▶ ***Louisiana***—A man was sentenced to 2 years probation and ordered to pay a \$2,500 fine. Prior to sentencing, he paid his former wife almost \$65,000 for nearly 11

years of arrearage due at the time. He also paid all future support payments that will accrue from the present to his daughter's age of majority. The man operated a successful business, earning a taxable annual income of \$184,000 in 2002, and a greater income in 2003. Meanwhile, his former wife and minor daughter were living in Government subsidized housing.

- ▶ **Nevada**—A man was sentenced and fined \$5,000. When his plea agreement was entered, he paid his arrearage of \$46,000 in full. This individual was the chief executive officer of a medical supply company in New York.
- ▶ **Virginia**—A man was sentenced to 24 months in prison, 1 year supervised release and ordered to pay \$47,000 in restitution. Although gainfully employed during the charging period, he made no payments in support of his 9-year-old son. At the time of sentencing, this individual, who has an extensive criminal history, was completing a term of incarceration in Florida on an unrelated conviction.
- ▶ **South Dakota**—A man was sentenced to 18 months confinement, 1 year supervised release and ordered to pay \$23,000 in restitution. This individual, who never paid any support, failed to appear in this matter and was a fugitive from May 2003 to January 2004. With assistance from OIG and the PSOC task force in Denver, the U.S. Marshals Service located and arrested him in Missouri where he lived under an assumed name.

Misuse of ACF Grant Funds

In addition to investigating the misuse of public health grant funds (details on page p. 38), OIG also investigates cases involving the misuse of ACF grant funds. Resolution of charges involving the improper use of these funds occurred in the following example during this reporting period:

- ▶ **Georgia**—A former supervisor at a county family and children services agency and two day care owners were sentenced for their involvement in creating false invoices submitted to the agency for day care reimbursement. The former supervisor was sentenced for conspiracy, bribery, false claims, and Social Security fraud to 40 months incarceration and ordered to pay \$150,000 in joint restitution with the day care owners and a \$5,000 special assessment fee. One of the day care owners was sentenced for conspiracy, false claims, and Social Security fraud to 20 months incarceration and held jointly responsible for paying \$129,000 of the restitution figure with the former supervisor, a \$5,000 fine, and a \$4,000 special assessment fee. The other owner was held jointly responsible for paying \$21,000 of the

restitution figure with the former supervisor for conspiracy to defraud the United States. Through an ACF block grant, the agency provided funding for the State of Georgia Childcare and Parent Services (CAPS) program which assists low-income families with the costs of childcare. The co-defendants' scheme caused CAPS funds to be paid to the day care owners for the care of fictitious children. The former supervisor created false documents using fictitious Social Security numbers, initialed final invoices approving payment, and directed staff to process final invoices for fictitious children. The day care owners, in turn, paid the supervisor for her services.

General Oversight

The Office of the Assistant Secretary for Budget, Technology and Finance (ASBTF) is responsible for developing and executing the Department of Health and Human Services's (HHS) budget; ensuring that HHS performance measurement and reporting are in compliance with the Government Performance and Results Act; establishing and monitoring departmental policy for financial management (including debt collection, audit resolution, cost policy, and financial reporting); and developing and monitoring HHS information technology policy (including IT security). The Assistant Secretary is the Department's Chief Financial Officer and oversees the Department's Chief Information Officer. The Department also has the responsibility, by virtue of the magnitude of its funding, to negotiate the payment rates and methods that many outside entities, such as State and local governments, charge for administering HHS and other Federal programs.

The Office of the Assistant Secretary for Administration and Management (ASAM) is responsible for HHS policies regarding human resources, grants, and acquisition management. This office also oversees the Program Support Center, which provides a range of administrative services, such as human resources, financial management, and administrative operations.

OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget Circular A-133, under which HHS is the cognizant agency to audit the majority of Federal funds awarded to major research schools, State and local government cost allocation plans, and separate indirect cost plans of State agencies and local governments. OIG also oversees the work of non-Federal auditors of Federal money at some 6,700 entities, such as community health centers and Head Start grantees, as well as at State and local governments, colleges and universities, and other nonprofit organizations. In addition, OIG is responsible for auditing the Department's financial statements.

OIG also reviews audits, inspections, and studies performed by others, such as the Office of Management and Budget's Program Assessment and Rating Tool and reports of the General Accounting Office. It takes these studies into account when planning its own work and examines management actions designed to correct the deficiencies cited in these prior studies.

The Government Performance and Results Act of 1993 ❖❖

The Government Performance and Results Act of 1993 mandates that Federal agencies establish strategic planning, prepare annual performance plans that set measurable goals for the year's accomplishments, and compare those goals with actual performance. OIG's audits, inspections, and investigations identifies performance results and recommend improvements, focusing on measures related to mission-critical issues and areas at high risk of fraud, waste, and abuse.

An important part of OIG's previous work was the estimate of Medicare fee-for-service payment errors, which CMS used to set performance goals and measure performance. Beginning in FY 2003, CMS assumed responsibility for developing the error rate, and OIG became responsible for assessing the validity and reliability of CMS's estimate. During the FY 2003 error rate process, CMS experienced a significant problem with providers that failed to respond to requests for medical records. OIG later reported that CMS's corrective actions appeared to have increased provider responsiveness during FY 2004 and initiated an indepth review to determine the reasons for the remaining nonresponses.

OIG also evaluates progress in achieving other HHS strategic goals. For example, OIG conducted numerous reviews of the Department's bioterrorism preparedness efforts, including the security of select agents at university laboratories and State and local preparedness and response programs. Future projects in this area will cover the safety and distribution of pharmaceutical stockpiles, State bioterrorism alert systems, and the Biowatch warning system. To assess the Department's efforts to improve health care services for Americans, OIG reviewed the performance of Medicare-approved heart transplant centers and the impact of intergovernmental transfers of Medicaid funds on public nursing facilities. Future work will address levels of care in long-term hospitals and working disabled individuals' eligibility for Medicaid. As part of the Department's push to ensure the healthy development of the Nation's children, OIG reviewed noncustodial parents' contributions to their children's Medicaid and SCHIP costs. Future work will address State investigations of abuse and neglect, Head Start enrollment, and foster care requirements.

❖❖ Indicates performance measure. Details can be found in Appendix H.

Reasonableness of Pension Charges

OIG found that North Carolina claimed Federal reimbursement for \$127.4 million (\$7.8 million Federal share) in unfunded retirement contributions. Under Federal cost principles, States are not entitled to seek reimbursement from the Federal Government for pension costs until such costs are funded. In a related matter, OIG noted that retirement fund assets exceeded actuarial liabilities by \$4.4 billion (\$315 million Federal share) as of December 31, 2001. Although North Carolina had taken steps to address the actuarial surplus, the surplus continued.

OIG recommended that North Carolina refund the \$7.8 million to the Federal Government, but the State did not concur with the recommendation. (A-04-02-00011)

Non-Federal Audits

OMB Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have an annual organization-wide audit of all Federal money they receive. These audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the second half of FY 2004, OIG's National External Audit Review Center reviewed 960 reports that covered \$908.6 billion in audited costs. Federal dollars covered by these audits totaled \$324.9 billion, about \$132.8 billion of which was HHS money.

OIG's oversight of non-Federal audit activity informs Department managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs that require formal resolution by Federal officials. OIG identifies entities for high-risk monitoring, alerts program officials to any trends that could indicate problems in HHS programs, and profiles non-Federal audit findings of a particular program or activity over time to identify systemic problems. OIG also provides training and technical assistance to grantees and the auditing profession.

OIG maintains a quality control review process to assess the quality of the non-Federal reports received and the audit work that supports selected reports. The non-Federal audit reports reviewed and issued during this reporting period are categorized on the next page.

<i>Reports issued:</i>	
<i>Without changes or with minor changes</i>	<i>841</i>
<i>With major changes</i>	<i>89</i>
<i>With significant inadequacies</i>	<i>30</i>
<i>Total</i>	<i>960</i>

The 960 reports included recommendations for HHS program officials to take action on cost recoveries totaling \$3.6 million, as well as 4,367 recommendations for improving management operations. In addition, these audit reports provided information for 103 special memorandums that identified concerns for increased monitoring by departmental management.

Resolving Recommendations

The tables that appear on the following pages are provided in accordance with section 5 of the Inspector General Act and indicate the dollar value of actions taken on OIG recommendations.

Table 1: Reports With Questioned Costs*

<i>Reports</i>	<i>Number of Reports</i>	<i>Dollar Value Questioned</i>	<i>Dollar Value Unsupported</i>
Section 1			
For which no management decision had been made by the beginning of the reporting period ¹	519	2,013,452,000	\$256,302,000
Issued during the reporting period	84	\$366,414,000	\$38,317,000
Total Section 1	603	\$2,379,866,000	\$294,619,000

Section 2			
For which management decision was made during the reporting period ^{2,3,4}			
Disallowed costs		\$539,582,000	\$300,000
Costs not disallowed		\$27,910,000	\$0
Total Section 2	170	\$567,492,000	\$300,000

Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	433	\$1,812,374,000	\$294,319,000

Section 4			
For which no management decision was made within 6 months of issuance ⁵	340	\$1,365,588,000	\$136,559,000

*Details concerning footnotes can be found in Appendix D.

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

<i>Reports</i>	<i>Number of Reports</i>	<i>Dollar Value</i>
<i>Section 1</i>		
For which no management decision had been made by the beginning of reporting period ¹	69	\$8,867,257,000
Issued during the reporting period	10	\$163,503,000
<i>Total Section 1</i>	73	\$9,030,760,000

<i>Section 2</i>		
For which management decision was made during the reporting period		
Value of recommendations that were agreed to by management		
Based on proposed management action	7	\$1,337,920,000
Based on proposed legislative action		
Value of recommendations that were not agreed to by management		\$0
<i>Total Section 2</i>	7	\$1,337,920,000

<i>Section 3</i>		
For which no management decision had been made by the end of the reporting period ²		
<i>Total Section 1 minus Total Section 2</i>	72	\$7,692,840,000

*Details concerning footnotes can be found in Appendix D.

Legislative and Regulatory Review and Development

Regulatory Review Functions

Section 4(a) of the Inspector General Act of 1978 requires that the Inspector General review existing and proposed legislation and regulations and make recommendations in this report concerning the impact on the economy and efficiency of the administration of the Department's programs and on the prevention of fraud and abuse. In reviewing regulations and legislative proposals, OIG uses as the primary basis for its comments the audits, inspections, investigations, and other activities highlighted in this and previous semiannual reports.

Regulatory Development

OIG is responsible for the development and publication of a variety of sanction regulations addressing civil money penalty and program exclusion authorities administered by the Inspector General, as well as advisory opinions and safe harbor regulations related to the anti-kickback statute. During this reporting period, OIG:

- Developed and published, in accordance with section 1860D-31 of the Social Security Act, interim final rulemaking setting forth OIG's new authority for imposing civil money penalties against endorsed sponsors under the Medicare prescription drug discount program that knowingly (1) engage in false or misleading marketing practices; (2) overcharge program enrollees in violation of the terms of an endorsement contract; or (3) misuse transitional assistance funds. In each instance, OIG may impose CMPs of no more than \$10,000 for each of these violations. During this period, OIG also continued to work on the issuance of a final rule in this area to address public comments received in response to the interim final rule. (69 FR 28842; May 19, 2004)
- Developed and published final rulemaking setting forth technical revisions to the Healthcare Integrity and Protection Data Bank data collection reporting requirements by clarifying the types of personal numeric identifiers that may be reported to the data bank in connection with adverse actions. Specifically, the final rule clarified that in lieu of a Social Security Number (SSN), an individual taxpayer identification number may be reported to the data bank when an individual does not have an SSN. The interim final rulemaking was published on June 17, 2004 (69 FR 33866) and final rulemaking was published on September 21, 2004 (69 FR 56364).

- Coordinated regulatory development activities with the Centers for Disease Control and Prevention with regard to the issuance of revised final regulations implementing Public Law 107-88, the Public Health Security and Bioterrorism Act. An interim final rule was published on December 13, 2002 in the *Federal Register* (67 FR 76886) and an amended second interim final rule was published in the *Federal Register* on November 3, 2002 (68 FR 62245). Among other things, the revised final rule makes technical revisions to OIG’s civil money penalties for violations of section 351A of the Public Health Service Act with respect to the control and transfer of listed biological agents and toxins.
- In accordance with section 949 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, continued to develop proposed rulemaking to revise OIG’s waiver of exclusion authority to permit any Federal health care program to request a waiver of an OIG exclusion imposed under sections 1128(a)(1), (a)(3) or (a)(4) of the Social Security Act.
- Continued to develop final rulemaking to clarify the Secretary’s authority to exclude providers and suppliers from the Medicare and Medicaid programs that charge the programs substantially in excess of their usual charges to other customers. The rule is intended to amend OIG’s exclusion regulations at 42 CFR 1001 by setting forth definitions for the terms “substantially in excess” and “usual charges,” and by clarifying the “good cause” exception now contained in the regulations.
- Continued to develop final rulemaking designed to expand the existing safe harbor for certain waivers of beneficiary coinsurance and deductible amounts to benefit the policyholders of Medicare SELECT supplemental insurance. Specifically, the final safe harbor regulation will serve to protect waivers of coinsurance and deductible amounts under Part A or Part B of the Medicare program owed by beneficiaries covered under a Medicare SELECT policy issued in accordance with section 1882(t)(1) of the Social Security Act, if the waiver is in accordance with a price reduction agreement covering such policyholders between the Medicare SELECT issuer and the provider or supplier offering the waiver.

In addition, during this period, OIG continued to develop and publish *Federal Register* notices that serve to reflect OIG policy and procedures with regard to compliance program guidance and other OIG administrative matters. During this period, OIG:

- Published a *Federal Register* notice seeking public comments on draft supplemental compliance program guidance for hospitals designed to provide voluntary guidelines to assist hospitals and hospital systems in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts (69 FR 32012; June 8, 2004).
- Issued a revised OIG Statement of Organization, Functions, and Delegations of Authority to reflect the realignment of functions within OIG and the current work environment and priorities within the organization (69 FR 40386, July 2, 2004).
- Prepared and published a *Federal Register* notice regarding a change in the user fees for self-queries for information in conjunction with the Healthcare Integrity and Protection Data Bank (69 FR 25408; May 6, 2004).

Employee Fraud and Misconduct

Most individuals employed by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their fiduciary responsibilities. OIG conducts or oversees investigations of serious allegations of wrongdoing by Department employees, as in the following examples:

- ***Maryland***—An administrative officer for NIH was ordered to pay \$24,000 in restitution for theft of Government property. The administrative officer used her Government travel card to pay for unauthorized personal travel and cash advances, then submitted fraudulent travel vouchers for reimbursement. In submitting, processing, and approving the vouchers, she used the ID and passwords of her supervisor and administrative assistant without their knowledge or approval.

Also in Maryland, a former FDA employee was sentenced for possession of child pornography to 27 months in prison followed by 3 years supervised release during which he may not possess any devices with Internet access without prior permission from the United States Probation Office. He must also register as a sexual offender and forfeit his computer and several accompanying electronic goods seized during the investigation. The investigation found that the employee viewed, downloaded, and stored hundreds of images of child pornography while at work. A search of his residence also revealed more child exploitation evidence.

- ▶ ***New Mexico***—A former nurse at an IHS hospital was sentenced for unlawful possession of a controlled substance. On numerous occasions, she removed narcotics from the hospital’s emergency room without physician orders.

Investigative Prosecutions

During this semiannual reporting period, OIG investigations resulted in 299 successful criminal actions. Also during this period, 680 cases were presented for criminal prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 325 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over \$673 million was ordered or returned as a result of OIG investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.



Appendices

Appendix A
Savings Achieved Through Policy and Procedural Changes Resulting From Audits, Investigations, and Inspections
April 1, 2004, Through September 30, 2004

The following schedule highlights savings resulting from Office of Inspector General (OIG) efforts to prevent unnecessary obligations for expenditures of Federal funds or to improve agency systems and operations. These achievements depend greatly on the contributions of others, such as partners within the Department. The amounts shown represent funds or resources that will be available for better use as a result of documented measures taken by the Congress or by management in response to OIG audits, investigations, and inspections, including actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward grant reductions from agency programs or operations; and reduction and/or withdrawal of the Federal portion of interest subsidy costs on loans or loan guarantees, insurance, or bonds.

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) fiscal year estimates for the related legislation. OIG calculates the administrative savings based on departmental figures, where available, for the year in which the change is affected or for multiple years, if applicable. A new table has been added at the end of this appendix to reflect OIG's policy of recognizing adjustments from prior periods not previously reported.

Total savings from these sources amount to \$11,893.4 million for this semiannual period.

OIG Recommendation	Implementing Action	Savings (millions)
Centers for Medicare & Medicaid Services		
Medicare Home Health Payments: CMS should restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility determinations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; A-04-96-02121)	Chapter 1 of Subtitle G of the BBA of 1997 (as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998), which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in fiscal year (FY) 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminated periodic interim payments to home health agencies.	\$5,970
Medicare Indirect Medical Education: CMS should base the indirect medical education adjustment factor on the level support by CMS's empirical data. (A-07-88-00111)	Section 4621 of the BBA (as amended by the BBRA of 1999) reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998, 6.5 percent in FY 1999, 6.0 percent in FY 2000, and 5.5 percent in FY 2001 and thereafter.	\$2,210

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<p>Medicaid Enhanced Payments to Local Providers: CMS should reconsider capping the aggregate upper payment limit (UPL) at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned government hospitals. (A-03-00-00216)</p>	<p>On January 18, 2002, CMS issued a final rule that modified the Medicaid UPL provisions to remove the 150 percent UPL for services furnished by non-State-owned or operated hospitals. The rule became effective on May 15, 2002.</p>	<p>\$1,900</p>
<p>Graduate Medical Education Payments: CMS should reevaluate Medicare’s policy of paying graduate medical education (GME) costs for all physician specialities and should consider submitting legislation to reduce Medicare’s investment in GME to arrive at a more accurate and representative sharing of GME costs. (A-06-92-00020)</p>	<p>Sections 4623 and 4626 of the BBA provided for limits in the number of residents counted for purposes of Medicare GME payments and offered payments for voluntary reductions in the number of residents to limit Medicare’s share of GME costs.</p>	<p>\$480</p>
<p>Medicare Secondary Payer: CMS should ensure sufficient resources and contractor training for retroactively examining paid claims to identify other payer sources and initiating recovery action on all related overpayments, establish penalties, etc. (Multiple reports and testimonies, including A-02-98-01036; A-04-92-02057; A-09-89-00162; A-10-86-62005)</p>	<p>Section 301 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) clarifies, retroactively, the Secretary’s authority to make certain reimbursable conditional payments and take recovery actions against all responsible entities, including collection of damages, under Medicare’s secondary payer provisions. This action builds on other program improvements related to OIG’s work that were implemented by the BBA of 1997, OBRA 1993, OBRA 1990, and OBRA 1989.</p>	<p>\$400</p>
<p>Payment Reform for Part B Drugs and Biologicals: CMS should reexamine drug reimbursement methodologies based on AWP with the goal of reducing payments in both Medicare and Medicaid. (Multiple reports and testimony including OEI-03-96-00420; OEI-03-97-00290; OEI-03-00-00310; OEI-03-97-293; A-06-00-00023; A-06-01-00053; A-06-02-00041).</p>	<p>Sections 303-305 of the MMA revised the current payment methodology for Part B covered drugs and biologicals which were not paid on a cost or prospective payment basis. Under the MMA, most drugs were to be paid at 85 percent of the April 1, 2003 average wholesale price (AWP) effective January 1, 2004, unless they fell under certain exceptions. CBO specifically attributed the FY 2004 savings to sections 304 and 305. After 2004, most drug prices are to be based on the average sales price or competitive acquisition instead of AWP.</p>	<p>\$200</p>

<p>Medicare Home Health Payments: The home health agency update factor should be reduced to account for the high error rate found in OIG's review. The annual update was defined as the home health market basket percentage increase. (A-04-99-01194)</p>	<p>Section 701 of the MMA changes the updates of home health rates from fiscal year to calendar year beginning in 2004, with the update for the last 3 quarters of 2004 equal to the market basket increase minus 0.8 percent.</p>	<p>\$200</p>
<p>Clinical Diagnostic Laboratory Tests: CMS should seek legislation to allow across-the-board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices that laboratories charge physicians in a competitive marketplace and periodically evaluate the national fee schedule levels. (A-09-89-00031; A-09-93-00056)</p>	<p>Section 628 of the MMA froze annual updates for FY 2004 through FY 2008. This action builds on prior legislative actions in the BBA of 1997, OBRA 1993, OBRA 1990, and legislation in 1984 that were also responsive to OIG's recommendations to curb excessive clinical laboratory test reimbursements by Medicare.</p>	<p>\$100</p>
<p>Hospice Certification: CMS should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; A-05-96-00023)</p>	<p>Sections 4441-4449 of the BBA contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60-day benefit periods (each requiring recertification).</p>	<p>\$80</p>
<p>Fraud and Abuse Provisions of the Balanced Budget Act: CMS should require durable medical equipment (DME) suppliers and home health agencies to provide Social Security numbers and employee identification numbers (OEI-04-96-00240; OEI-09-96-00110); refuse to enter into a provider agreement with any home health agency whose owners or principals have prior criminal records or are the relatives of owners of a provider that had defrauded Medicare (OEI-09-96-00110); apply "inherent reasonableness" provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services</p> <p><i>continued—</i></p>	<p>Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work. For example, the BBA authorized the Secretary to collect Social Security numbers and employer identification numbers from entities under Medicare, Medicaid, and Title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized CMS to make inherent reasonableness adjustments up to 15 percent to all Part B services except physician services; authorized up to five demonstration projects to be completed by December 31, 2002 (one must be oxygen and oxygen equipment) which can have multiple sites, to allow competitive bidding; and prohibited "reasonable cost" payments for items such as entertainment, gifts and donations, education expenses, and personal use of automobiles.</p>	<p>\$70</p>

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<p>Fraud and Abuse Provisions of the Balanced Budget Act (continued): (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230). Also, CMS should clarify which general and administrative and fringe benefit costs at hospitals and home health agencies are related to patient care; specifically, distinguish between employee benefits and/or prerequisites to entertainment and patient care, and specify that the cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are not allowable. (A-03-92-00017; A-04-93-02067)</p>		
<p>Rural Health Clinics: The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent clinics more equitable. In addition, the certification process should be modified to increase State involvement and placement of the clinics. Recertification should be required within a specific time limit (for example, 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)</p>	<p>Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.</p>	<p>\$70</p>
<p>Hospital Sales: CMS should eliminate the requirement that Medicare adjust for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)</p>	<p>Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.</p>	<p>\$60</p>

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<p>Single Drug Pricer for Medicare-Covered Drugs: CMS should establish a uniform allowed amount for each Common Procedural Coding System (HCPCS) drug code. (OEI-03-00-00310; OEI-03-97-00290)</p>	<p>CMS issued Program Memorandum AB 02-174 (Change Request 2381) establishing a single drug pricer for all drugs for which payment was based on a percentage of the AWP, making reimbursement consistent among all carriers. Payments in 2004 are based on the April 1, 2003 single pricer.</p>	<p>\$50</p>
<p>Payment for Durable Medical Equipment (DME): CMS should take steps to reduce payments for a variety of DME and related supplies. (Multiple reports including OEI-03-01-00680; OEI-03-02-00700; OEI-07-96-00221; OEI-03-96-00230; OEI-03-94-0021; OEI-06-92-00861; OEI-06-92-00866)</p>	<p>Section 302 of the MMA froze payments for certain DME items, including prosthetic devices, prosthetics, and orthotics effective January 1, 2004. CBO scored the FY 2004 savings at “less than \$50 million” and the FY 2005 savings at \$400 million. OIG is conservatively reporting \$40 million in savings from the effect of this change on DME payments in the last 3 quarters of FY 2004.</p>	<p>\$40</p>
<p>Payment for Services Furnished in Ambulatory Surgical Centers (ASC): CMS should set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and establish parity among ASC’s and outpatient departments. (OEI-05-00-00340; OEI-09-88-01003; A-14-98-00400; A-14-89-00221)</p>	<p>Section 626 of the MMA limited the ASC update starting April 1, 2004, then freezes updates for a period beginning the last quarter of FY 2005. CBO scored the savings at “less than \$50 million” for FY 2004 and estimated savings in FY 2005 at \$100 million. Therefore, OIG is conservatively reporting \$40 million in section 626 savings for the last 2 quarters of FY 2004.</p>	<p>\$40</p>
<p>Payments for Ambulance Services: CMS should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)</p>	<p>Section 4531 of the BBA of 1997 made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. Such fee schedule is to be set so that aggregate payments are reduced by 1 percent.</p>	<p>\$10</p>

Various Operating Divisions

<p>Results of Investigations: In addition to restitution, fines, settlements, judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of investigative results to the operating division.</p>	<p>The operating division takes action, based on the results of the OIG investigation, to suspend or terminate payments to the offending individual or entity.</p>	<p>\$7.7</p>
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APPENDIX A

Administration for Children and Families

<p>Availability of Health Insurance for Title IV-D Children: Connecticut should either implement policies and procedures to require noncustodial parents to pay all or part of the Medicaid costs for their dependent children or establish a statewide health insurance plan that provides reasonably priced, comprehensive coverage for children, with costs paid by noncustodial parents. (A-01-97-02506)</p>	<p>The BBA of 1997 established Title XXI of the Social Security Act, known as the State Children’s Health Insurance Program (SCHIP), to enhance Medicaid coverage provided to children and allow States to create insurance options for families who exceed Medicaid resource and income limits. Connecticut received CMS approval in April 1998 to initiate a child health program. Under Connecticut law, applicants include noncustodial parents under court orders to provide health insurance.</p>	<p>\$5.7</p>
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Adjustments from Prior Periods Not Previously Reported

<p>Single Drug Pricer for Medicare-Covered Drugs: CMS should establish a uniform allowed amount for each Common Procedural Coding System (HCPCS) drug code. (OEI-03-00-00310; OEI-03-97-00290)</p>	<p>The savings total for FY 2003 has been adjusted upward to reflect a previously unreported administrative change. CMS issued Program Memorandum AB 02-174 (Change Request 2381) establishing a single drug pricer for all drugs for which payment was based on a percentage of the AWP to make reimbursement consistent among all carriers effective January 1, 2003. The adjustment is for 3 fiscal quarters based on CMS’ estimate of \$50 million in savings annually. The annualized total for FY 2004 is reported in the current period savings section above.</p>	<p>\$37.5</p>
<p>Hospital Outpatient Policy: Sections 4421 - 4523 of the BBA eliminated formula-driven overpayments in FY 1998, extended reductions in payments for costs of hospital outpatient services, and established a prospective payment system for hospital outpatient services beginning FY 1999.</p>	<p>The savings total for FY 2003 has been adjusted downward to reflect Congressional Budget Office estimates for related provisions of the Balanced Budget Refinement Act of 1999 (BBRA), Title II, Subtitle A.</p>	<p>(\$640)</p>
<p>Payments for Skilled Nursing Facilities: Section 4432 of the BBA of 1997 (as amended by the BBRA of 1999 and the BIPA of 2000) required a PPS for Part A SNF care.</p>	<p>The savings total for FY 2003 has been adjusted downward to reflect Congressional Budget Office estimates for increases in rates provided in the BBRA, Title I, Subtitle A.</p>	<p>(\$200)</p>

Appendix B
Unimplemented Office of Inspector General Recommendations
to Put Funds to Better Use

This schedule represents potential annual savings or one-time recoveries which could be realized if OIG recommendations were enacted by the Congress or the Department through legislation, regulation, or management action. In some cases, these recommendations are beyond the direct authority of the departmental operating division. The Congress develops savings over a 5- or 10-year budget cycle which results in far greater dollar impact than the annual estimates shown in the table below. The same can be said for regulations issued and management actions taken by the Department. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may increase or decrease due to interactive effects if enacted together.

More detailed information may be found in OIG's "Red Book," which can be found on the Internet at <http://oig.hhs.gov>.

OIG Recommendation	Status	Savings (millions)
Centers for Medicare & Medicaid Services		
<p>Clinical Laboratory Tests: CMS should develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (A-09-89-00031; A-09-93-00056)</p>	<p>CMS initially agreed with the first recommendation but not the second. The BBA required the Secretary to request that the Institute of Medicine (IOM) study Part B laboratory test payments. As a result of the IOM's recommendations, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandates that CMS conduct a demonstration that applies competitive bidding for clinical laboratory services. The initial report to Congress is due by December 31, 2005.</p>	\$1,130*
<p>Outpatient Surgery Rates: CMS should seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and remove the procedure codes that meet its criteria for removal from the Ambulatory Surgery Center list of covered procedures. (A-14-89-00221; A-14-98-00400; OEI-09-88-01003; OEI-05-00-00340)</p>	<p>CMS agreed to consider seeking authority to set rates that are consistent across sites as it develops its legislative program. CMS also issued a notice of proposed rulemaking, which has not been finalized, that would remove certain procedure codes from the ASC list of covered procedures.</p>	\$1,100

**This savings estimate would result from the copayment; the savings estimate for panels has yet to be determined.*

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<p>Medicare Payments for Mental Health Services: CMS should ensure mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance of mental health services. (OEI-02-99-00140; OEI-03-99-00130; A-04-98-02145; A-01-99-00507; A-01-99-00530)</p>	<p>CMS concurred and has initiated some efforts, particularly regarding community mental health centers. OIG is reviewing this area to determine if substantial errors are still present.</p>	<p>\$676</p>
<p>Payment Policy for Medicare Bad Debts: OIG presented four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group rates. CMS should seek legislative authority to further modify bad debt policies. (A-14-90-00339)</p>	<p>The BBA of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act of 2000 subsequently adjusted upwards the percentage of total hospital bad debt that would be reimbursed. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	<p>\$340</p>
<p>Cost Effectiveness of “Pay and Chase” Methods for Medicaid Pharmacy Third-Party Liability Recoveries: CMS should determine whether States’ cost-avoidance waivers for pharmacy claims are meeting the cost-effectiveness criterion. CMS can ascertain cost-effectiveness by requiring States to track dollars that they pay and chase and the amounts that they recover. CMS should also review States’ policies to determine if they are paying and chasing pharmacy claims without waivers. (OEI-03-00-00030)</p>	<p>CMS agreed that States’ cost-avoidance waivers should be reexamined and has made a concerted effort to track States’ pay- and-chase activities. The CMS central office asked the regional offices to identify any waivers that have been granted, any pending waiver requests, and situations where a State is using pay-and-chase without an approved waiver. CMS is also working with States that cost-avoid pharmacy claims and with the National Association of Chain Drug Stores in developing guidance to assist States in implementing cost avoidance.</p>	<p>\$185</p>
<p>Graduate Medical Education: CMS should revise the regulations to remove from a hospital’s allowable graduate medical education (GME) base-year costs any cost center with little or no Medicare utilization and submit a legislative proposal to compute Medicare’s percentage of participation under the former, more comprehensive system. (A-06-92-00020)</p>	<p>CMS did not concur with the recommendations. Although the BBA of 1997 and the BBRA of 1999 contained provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	<p>\$157.3</p>

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<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (A-06-94-00039)</p>	<p>CMS continues to disagree with the recommendation. OIG continues to monitor the drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program.</p>	<p>\$123</p>
<p>Inappropriate Payments for Nail Debridement: CMS should require Medicare carriers to recoup the overpayments found in OIG’s sample and to carefully scrutinize payments for nail debridement services through medical reviews, require podiatrists to adequately document the medical necessity of all nail debridement services, and require CMS regional offices and carriers to educate podiatrists on Medicare payment policies for nail debridement claims. (OEI-04-99-00460)</p>	<p>CMS concurred; the agency planned to continue to maximize the effectiveness of its medical review strategy, collect the overpayments identified in OIG’s sample, and educate podiatrists on Medicare policy for paying nail debridement claims.</p>	<p>\$96.8</p>
<p>Medical Equipment/Supply Claims Lacking Valid, Active UPINs: CMS should create edits to identify medical equipment and supply claims that do not have a valid and active unique physician identification number (UPIN) listed for the ordering physician. (OEI-03-01-00110)</p>	<p>CMS concurred and implemented an edit to reject claims listing a deceased physician’s UPIN beginning in April 2002. CMS decided not to implement edits for inactive and invalid UPINs. Instead, the agency initiated provider education efforts and issued two program memorandums.</p>	<p>\$91</p>
<p>Medicare Orthotics: CMS should take action to improve Medicare billing for orthotic devices. CMS should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-95-00380; OEI-02-99-00120; OEI-02-99-00121)</p>	<p>CMS generally concurred with OIG’s original recommendations. The agency is working on a proposed rule regarding orthotics and intends to put in place standards for custom orthotics.</p>	<p>\$43</p>
<p>Expansion of the DRG Payment Window: CMS should propose legislation to expand the DRG payment window to at least 7 days immediately before the day of admission. (A-01-02-00503)</p>	<p>CMS did not concur with the recommendation and has not pursued a legislative proposal.</p>	<p>\$37</p>

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<p>End Stage Renal Disease Payment Rates: CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (A-14-90-00215)</p>	<p>CMS agreed, and the BIPA of 2000 required the Secretary to develop a composite rate that includes, to the extent feasible, payment for laboratory tests and drugs that are routinely used in dialysis treatments but are now separately billable. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Secretary to establish a case-mix adjusted composite rate for 2005 and to conduct a demonstration of a bundled case-mix adjusted prospective payment system. The Act also directs CMS to use the results of an OIG study on separately billable end stage renal disease (ESRD) drug payments and costs to set the 2005 composite payment rate.</p>	<p>\$22**</p>
<p>Respiratory Assist Devices With a Back-Up Rate: CMS should reclassify bi-level respiratory assist devices with a back-up rate from the “frequent and substantial servicing” category to the “capped rental” category under the durable medical device benefit. (OEI-07-99-00440)</p>	<p>CMS concurred and published a proposed rule in August 2003 clarifying that bi-level respiratory assist devices with a back-up rate be paid as capped rental items.</p>	<p>\$11.5</p>
<p>Indirect Medical Education: CMS should reduce the indirect medical education (IME) adjustment factor to the level supported by CMS’s empirical data and initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (A-07-88-00111)</p>	<p>CMS agreed with the recommendation. The BBA of 1997, as amended by the BBRA of 1999, reduced the IME adjustment to 5.5 percent in 2002 and thereafter. OIG thinks the factor should be further reduced to eliminate overlap with the disproportionate share adjustment.</p>	<p>TBD***</p>
<p>Medicare Secondary Payer—End Stage Renal Disease Time Limit: CMS should extend the Medicare secondary payer (MSP) provisions to include ESRD beneficiaries without a time limitation. (A-10-86-62016)</p>	<p>CMS was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare based on age or disability. At that point, Medicare would become the primary payer.</p>	<p>TBD</p>

***This estimate represents annual program savings of \$22 million for each dollar reduction in the composite rate, given the population of ESRD beneficiaries at the time of OIG’s review.*

***To be determined.

<p>Inpatient Psychiatric Care Limits: CMS should develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services and apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (A-06-86-62045)</p>	<p>CMS agreed with OIG’s findings but stated that further analysis would be required before any legislative changes could be supported.</p>	<p>TBD</p>
<p>Hospital Capital Costs: CMS should determine the extent that capital reductions are needed to fully account for hospitals’ excess bed capacity and report the percentage to the Congress. (A-09-91-00070; A-14-93-00380)</p>	<p>CMS did not agree with the recommendation. Although the BBA of 1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs.</p>	<p>TBD</p>
<p>Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: CMS should seek legislation that would require participating manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price to calculate the rebates. This legislation would have resulted in about \$1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-96. (A-06-97-00052)</p>	<p>CMS agreed to pursue a change in the rebate program similar to that recommended. The President’s FY 2003 budget proposed a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug. That legislative change was ultimately dropped, and none of the subsequent Presidential budgets included a similar proposal.</p>	<p>TBD</p>
<p>Home Health Agencies: CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-04-93-00262; OEI-04-93-0026; OEI-12-94-00180; OEI-02-94-00170; A-04-95-01103; A-04-95-01104; A-04-94-02087; A-04-94-02078; A-04-96-02121; A-04-97-01169; A-04-97-01166; A-04-97-01170; A-04-99-01195)</p>	<p>Although the BBA of 1997 included provisions to restructure home health benefits, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to the BBA, OIG’s four-State review found that unallowable services continued to be provided because of inadequate physician involvement. While agreeing in principle, CMS said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. CMS also provided additional payments for physician care plan oversight and education for physicians and beneficiaries.</p>	<p>TBD</p>

APPENDIX B

Various Operating Divisions

<p>Recharge Center Costs: The Assistant Secretary for Administration and Management should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (A-09-96-04003)</p>	<p>The Department concurred and has worked with OMB on a revision to A-21. The proposed revision, which was published in the <i>Federal Register</i> in August 2002, would require that adjustments to a recharge center's billing rate take into account overrecoveries and/or underrecoveries from previous periods. Rate adjustments would be required at least every 2 years. The final rule is expected to be issued in FY 2004.</p>	<p>\$1</p>
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Appendix C
**Unimplemented Office of Inspector General Program
and Management Improvement Recommendations**

This schedule outlines Office of Inspector General (OIG) findings and recommendations which, if implemented, would result in substantial benefits. The benefits relate primarily to effectiveness rather than cost-efficiency.

More detailed information can be found in OIG’s “Orange Book,” which can be found on the Internet at <http://oig.hhs.gov>.

OIG Recommendation

Status

Centers for Medicare & Medicaid Services

<p>Accountability Over Billing and Collection of Medicaid Drug Rebates: CMS should ensure that States implement accounting and internal control systems in accordance with Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current, and complete disclosure of drug rebate transactions and provide CMS with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (A-06-92-00029)</p>	<p>CMS concurred with the recommendation and set up a reporting mechanism to capture rebate information. The agency still needs to ensure that States establish adequate accounting and internal control systems to obtain reliable information. Current audit results have shown that this remains a problem in most States.</p>
<p>Fairly Presenting the Medicare Accounts Receivable Balance: CMS should require Medicare contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (A-17-95-00096; A-17-97-00097; A-17-98-00098; A-17-00-00500; A-17-00-02001; A-17-01-02001; A-17-02-02002; A-17-03-03003)</p>	<p>CMS hired consultants to assist in validating accounts receivable reported by Medicare contractors and provided comprehensive instructions to contractors. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.</p>
<p>Guidance to Drug Manufacturers To Better Implement the Medicaid Drug Rebate Program: CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). CMS should also develop a more specific policy for calculating this price which would protect the interests of the Government and which would be equitable to the manufacturers. (A-06-91-00092)</p>	<p>CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. OIG disagrees because the rebate law and agreements defined AMP but did not provide specific written methodology for computing it.</p>

APPENDIX C

<p>Accuracy of Carrier Payment Data: CMS should conduct a review of carriers’ claims processing data to examine the scheduled date of payment entered on claims sent to the Common Working File (CWF). If there is no correlation between the claims payment date variable and the actual date of payment, CMS should define what data should be entered into this field and how it should be calculated, and/or revise the current variable definition to clarify for National Claims History data users that the scheduled date of payment is not an accurate reflection of the actual claim payment date. CMS should also review the carriers’ claims processing data to determine the accuracy of the information contained in the CROWD system. (OEI-03-00-00350)</p>	<p>CMS stated that a review is under way to compare data contained in the National Claims History File with data at the carrier level. CMS has also approved two new edits which will enforce the payment floor standards on claims sent to the CWF.</p>
<p>Duplicate Payments for the Same Service by Multiple Carriers: CMS should revise CWF edits to detect and deny duplicate billings to individual carriers or to more than one carrier, or increase postpayment reviews if such edits are determined not to be cost effective. (OEI-03-00-00090; OEI-03-00-00091)</p>	<p>CMS concurred with OIG’s recommendations and will reexamine existing criteria regarding duplicate editing in the CWF system to determine the cost-effectiveness of including the carrier number in the match criteria. CMS entered a contract to study duplicate billing.</p>
<p>Inappropriate Payments for Blood Glucose Test Strips: CMS should alert suppliers of the importance of properly completed documentation to support their claims for test strips; require suppliers to indicate actual and accurate “start” and “end” dates on claim forms; promote supplier concurrence and cooperation with OIG’s recently issued compliance guidelines; and advise beneficiaries to report any instances of fraudulent or abusive practices involving their home blood glucose monitors, test strips, or related supplies to their DMERCs. (OEI-03-98-00230)</p>	<p>CMS concurred with the recommendations and noted a number of initiatives that have reduced the incidence of improper payments in recent years.</p>
<p>Educating Beneficiaries on Reducing Financial Liability for Durable Medical Equipment: CMS should educate beneficiaries on ways to reduce financial liability for medical equipment and supplies and reevaluate Medicare fee schedules for ostomy supplies. (OEI-07-99-00510)</p>	<p>CMS concurred with OIG’s recommendations and has undertaken a number of efforts to increase beneficiary education and awareness about the consequences of assigned and nonassigned claims.</p>

<p>Resident Assessment Instruments: CMS should more clearly define minimum data set (MDS) elements and work with States to train nursing home staff. OIG recommended that CMS establish an audit trail to validate the 108 MDS elements that affect facility reimbursement by Medicare. (OEI-02-99-00040; OEI-02-99-0041)</p>	<p>CMS generally concurred with OIG’s recommendations for improved data definitions and training, but did not concur with the recommendation to establish an audit trail.</p>
<p>Assessments of Mental Illness: CMS should work with States to improve the assessment of persons with serious mental illness and use survey and certification to monitor compliance. OIG also recommended that CMS define specialized services that are to be provided by the State to nursing home residents with mental illness. (OEI-05-99-00700)</p>	<p>CMS concurred with most of OIG’s recommendations and has made revisions to its training curriculum for nursing home surveyors.</p>
<p>Nursing Home Residents With Serious Mental Illness: CMS should improve the quality and usefulness of its data sources by requiring the use of a unique provider number across systems, requiring reporting of resident data by age and diagnosis, and encouraging States to use these data in demonstrating their progress in placing disabled persons in the most integrated settings. OIG also recommended training to improve data collection and accurate coding. (OEI-05-99-00701)</p>	<p>Except for reporting MDS records by primary, secondary, and tertiary diagnoses, CMS concurred with most of OIG’s recommendations. CMS does not feel that adding space to the MDS to record diagnoses would solve the problem.</p>
<p>Payments for Mental Health Services: CMS should promote provider awareness of documentation and medical necessity requirements, develop a comprehensive list of psychological testing tools that can be correctly billed, target problematic services for prepayment edits or postpayment medical review, and encourage carriers to take advantage of the MDS, especially for its assessment of patient cognitive level. (OEI-03-99-00130; OEI-02-99-00140)</p>	<p>CMS generally concurred with the recommendations, plans to explore a variety of educational efforts, and will refer the reports to the carrier clinical workgroup on psychiatric services. Carriers will conduct data analysis of psychological testing and psychotherapy claims and will conduct medical review, if indicated.</p>

Public Health Agencies

<p>Organ Donation: CMS should revise the Medicare conditions for coverage for Organ Procurement Organizations (OPOs) to make them more accountable for implementing the new donation rule and require OPOs to provide hospital-specific data on referrals and on organ recovery. HRSA should require that OPOs submit hospital-specific data on referrals and on organ recovery and support demonstration projects on how to effectively train and make use of designated requestors. (OEI-01-99-00020)</p>	<p>CMS concurred with the recommendations and indicated it will explore ways in which additional data can be used to assess OPO effectiveness and hospital compliance with the donation rule. CMS has prepared a draft regulation that would address many of OIG’s concerns; the regulation is currently passing through HHS clearance. HRSA also concurred with the recommendations.</p>
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APPENDIX C

<p>Oversight of Tissue Banking: FDA should expedite publication of its regulatory agenda requiring registration of tissue banks, enhanced donor suitability screening and testing the use of good tissue practices. FDA should set a realistic, yet aggressive date by which it would complete an initial inspection of all tissue banks. FDA should determine the appropriate minimum cycle for tissue bank inspections, and work with States and professional associations to determine in what areas oversight activities could be coordinated. (OEI-01-00-00441)</p>	<p>The Deputy Secretary concurred that FDA should expedite its planned rulemaking activities related to tissues, specifically the final rule to require registration of tissue banks. The Department also found “considerable merit” in OIG’s recommendation for an intensified inspection program directed towards entities that procure, process, and store human tissues. In congressional testimony, FDA said that all three of the proposed rules have been published, and one rule (Establishment Registering and Listing) was finalized. FDA has completed contacting the 36 uninspected tissue banks. The results were: 31 inspections were completed, 3 firms were out of business, 1 firm could not be located, and 1 firm was not an FDA obligation since it handles only vascularized organs. As of March 2004, FDA had not issued the final regulation on good manufacturing practices.</p>
<p>Effectiveness of FDA’s Adverse Event Reporting System for Dietary Supplements: FDA should (1) facilitate greater detection of adverse events by requiring dietary supplement manufacturers to report serious events to FDA for some products, (2) obtain more information on adverse event reports by requiring manufacturers to register themselves and their products with FDA, (3) notify manufacturers when FDA receives a serious adverse event report and develop a new computer database to track and analyze adverse event reports, (4) expedite the development and implementation of good manufacturing practices for dietary supplement manufacturers, and (5) disclose more useful information to the public about dietary supplement adverse events. (OEI-01-00-00180)</p>	<p>FDA has begun to address a number of the recommendations from the OIG report. The Center for Food Safety and Applied Nutrition is developing a system for entering adverse event and consumer complaint reports involving foods, cosmetics, and dietary supplements. This system went operational in a limited manner in June 2003. FDA published proposed current Good Manufacturing Practices regulations for dietary supplements in March 2003 and is now preparing the final regulation. Pursuant to the requirement for food facility registration in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, FDA requires facilities that manufacture, process, pack, or hold dietary supplements to be registered with the FDA. FDA strives to inform the public of current developments with respect to dietary supplements through its dietary supplement Web site.</p>

<p>Protection for Research Subjects in Foreign Clinical Trials: FDA should examine ways to obtain more information about the performance of non-U.S. Institutional Review Boards (IRBs) and help those inexperienced IRBs build their capacities; encourage all non-U.S. investigators participating in research to sign attestations upholding human subject protections; and develop a database to track the growth and location of foreign research. OHRP should exert leadership in developing strategies to ensure adequate human subject protections for non-U.S. clinical trials funded by the Federal Government and those that contribute data to new drug applications. (OEI-01-00-00190)</p>	<p>FDA supported OIG’s recommendations, but noted that in most cases it did not have the resources to implement the recommendations. FDA has published a proposed rule to revise its regulations pertaining to foreign clinical studies that are not conducted under an Investigational New Drug Application (IND). The proposed revision would require that studies be conducted in accordance with good clinical practice (GCP), including review and approval by an independent ethics committee (IEC). The proposed rule also specifically recommends that sponsors collect attestations by clinical investigators that the studies were conducted in compliance with GCP. OHRP published proposed rules for a single HHS IRB registration system.</p>
<p>Managed Care Organizations’ Reporting to the National Practitioner Data Bank: The Agency for Healthcare Research and Quality should devote attention to the kind of educational and remedial efforts that could be directed to practitioners who have been experiencing performance problems. HRSA should conduct an outreach program to inform managed care organizations of their reporting responsibilities, and CMS should examine its practitioner monitoring systems. (OEI-01-99-00690)</p>	<p>Under contract to HRSA, PricewaterhouseCoopers recently completed a study on hospital and managed care reporting to the National Practitioner Data Bank (NPDB). The study recommended that HRSA try to facilitate reporting by: seeking legislative authority and funding for conducting compliance reviews of clinical privileges reporting including authority to access peer review records; developing a strategy for communicating to key stakeholders, including trade associations and accrediting organizations (American Medical Association, American Hospital Association, etc.); linking communication strategies to quality of care and patient safety initiatives; and consider focus groups as a vehicle for garnering support for the NPDB. HRSA did not agree with the recommendation to do compliance reviews. However, HRSA has taken steps to implement the other recommendations. HRSA and AHRQ plan to address outreach issues at a conference in the Fall of 2004.</p>

APPENDIX C

Administration for Children and Families

<p>Child Support Orders for Low-Income Noncustodial Parents: ACF's Office of Child Support Enforcement should work with States to emphasize parental responsibility and improve the ability of low-income noncustodial parents to meet their obligations. ACF should facilitate and support State experiments to test the payment effects of using various periods of retroactivity in determining the amount of support owed and facilitate and support State experiences to test negotiating child support debt owed to the States in exchange for improved payment compliance. (OEI-05-99-00391)</p>	<p>ACF is helping nine States test approaches to serving young, never-married fathers who may have obstacles to employment and who do not have a child support order. ACF has granted a contract to determine how computerized income data can be used by local child support offices to independently verify the income of noncustodial parents and be used in the establishment or modification of child support orders where income documentation or verification is lacking or incomplete.</p>
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General Oversight

<p>Cost Principles for Federally Sponsored Research Activities: The Department should modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (A-01-92-01528)</p>	<p>The Department circulated several draft iterations of the hospital cost principles to internal users for comment. Many of the policies in the outdated document have been updated in the draft regulation. The target date for issuing the draft regulation as a notice of proposed rulemaking is December 31, 2004. Once the formal notice and rulemaking process is complete, the updated cost principles will be issued.</p>
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Appendix D
Notes to Tables 1 and 2

Notes to Table 1

¹ The opening balance was adjusted downward \$59.8 million.

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

CIN: 02-02-05001	REVIEW OF RYAN WHITE TITLE I FUNDS RECEIVED BY RYDER MEMORIAL HOSPITAL: The auditee identified additional overpayments of \$274,070.
CIN: 04-02-02017	MEDICARE COST FOR ORGAN ACQUISITIONS AT TAMPA GENERAL HOSPITAL: The provider agreed to re-file the FY 1999 cost report with an adjustment of \$220,425.
CIN: 06-03-75044	CEN-TEX FAMILY SERVICES INC.: The grantee has submitted additional information to support the questioned cost of \$140,115.
CIN: 10-02-71415	NOOKSACK INDIAN TRIBE: Settlement was reached on a Department Appeals Board Decision which resulted in an adjustment of \$292,886.

Note: revisions to previously disallowed management decisions totaled \$1.7 million.

³Included are management decisions to disallow \$51 million that was identified in non-Federal audit reports.

⁴During this reporting period, DCAA issued reports that included \$3,376 in questioned costs.

⁵A.

Due to administrative delays, many of which are beyond management control, resolution of the following 340 audits was not completed within 6 months of issuance.

CIN: A-04-00-02171	REV. AL MEDICAID INTERGOVERNMENTAL TRANSFERS-HOSP. ENHANC, MAY 2001, \$236,983,528
CIN: A-02-02-01030	REVIEW OF SPEECH SCHOOL HEALTH CLAIMS - REST OF STATE, FEBRUARY 2004, \$172,553,831
CIN: A-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, \$128,269,448
CIN: A-04-99-05561	AUDIT ADMIN COST PROPOSALS FY95-98, BCBSFL, JAX, JULY 2002, \$101,671,328
CIN: A-09-02-00071	AUDIT OF CA DSH PROGRAM FOR FY 1998 - LA COUNTY, MAY 2003, \$98,190,042
CIN: A-04-00-01220	IMPLE. MEDICARE'S POSTACUTE CARE TRANSFER POLICY, OCTOBER 2001, \$52,311,082
CIN: A-05-02-00083	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT MUTUAL OF OMAHA, MARCH 2003, \$41,500,000
CIN: A-07-01-02093	MISSOURI DSH - UNALLOWABLE COSTS, AUGUST 2002, \$36,200,000
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES - CT, MAY 2003, \$32,780,146
CIN: A-04-02-02022	REVIEW OF CIGNA'S MEDICARE FACPS FOR 1996-2001, DECEMBER 2003, \$31,061,144
CIN: A-05-02-00086	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT ADMINASTAR FEDERAL, MARCH 2003, \$25,300,000
CIN: A-05-02-00087	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT UNITED GOVERNMENT SERVICES, MARCH 2003, \$23,300,000

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CIN: A-10-01-00001 REVIEW OF WA COMPLIANCE W/MEDICAID HOSP DSH PYMT, OCTOBER 2002, \$23,291,531

CIN: A-07-01-00125 TRANSAMERICA (TOLIC) - PENSION SEGMENT CLOSING AUDIT, MAY 2002, \$20,227,001

CIN: A-03-01-00224 MEDICAID SCHOOL-BASED SERVICES/MARYLAND, MARCH 2003, \$19,954,944

CIN: A-09-01-00098 AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEPTEMBER 2002, \$19,446,435

CIN: A-06-00-00051 AUDIT OF MEDICARE REHAB AGENCY COSTS IN TX, RHS, I, JUNE 2001, \$18,394,465

CIN: A-05-01-00052 DME REVIEW IN INDIANA, OCTOBER 2001, \$16,377,560

CIN: A-06-01-00035 COLLECTION OF AFDC OVERPAYMENTS, JANUARY 2002, \$13,800,000

CIN: A-01-01-02502 REVIEW OF UNCOLLECTED AFDC OVERPAYMENTS, AUGUST 2001, \$12,400,000

CIN: A-02-02-01028 REVIEW OF RETRO ACUTE CARE HOSPITAL DSH CLAIMS FOR INMATE COSTS, JANUARY 2004, \$11,114,820

CIN: A-05-02-00031 AFDC OVERPAYMENTS - WISCONSIN, AUGUST 2002, \$10,711,338

CIN: A-01-01-00513 MEDICARE PT B PMT FOR DME I/P PRTL MNTH STAYS SNF, OCTOBER 2001, \$10,500,000

CIN: A-05-03-00022 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMISTRATIVE RESPONSIBILITY OF EMPIRE BLUE CROSS, MAY 2003, \$9,700,000

CIN: A-06-02-00034 REV OF COST REPORTS & MEDICARE FEE-FOR-SERVICE PYMTS @ SCOTT & WHITE, MAY 2003, \$8,229,574

CIN: A-05-03-00026 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF CARE FIRSE (MARYLAND), MARCH 2003, \$8,100,000

CIN: A-09-01-00085 AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEPTEMBER 2002, \$7,999,212

CIN: A-02-02-01024 IMD UNDER 21 AUDIT IN NEW YORK, FEBRUARY 2004, \$7,642,194

CIN: A-09-97-44262 STATE OF CALIFORNIA, APRIL 1997, \$7,300,000

CIN: A-07-02-03033 CAREFIRST SEGMENTATION AUDIT, MAY 2003, \$6,788,644

CIN: A-03-91-00552 INDEPENDENT LIVING PROGRAM -- NATIONAL, MARCH 1993, \$6,529,545

CIN: A-03-01-00222 MEDICAL COLLEGE OF VIRGINIA/DSH/MEDICAID, APRIL 2003, \$6,324,796

CIN: A-05-03-00035 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF VERITUS MEDICARE SERVICES, JULY 2003, \$6,300,000

CIN: A-05-02-00049 MEDICAL SERVICE COSTS UNDER ILLINOIS SCHOOL-BASED MEDICAID, DECEMBER 2003, \$6,067,669

CIN: A-07-03-04021 HOME HEALTH PPS SYSTEM CONTROLS 14 DAY PAYMENT, MARCH 2004, \$5,675,661

CIN: A-03-99-00052 ALLEGHENY/CHESAPEAKE ORF, SEPTEMBER 2001, \$5,540,344

CIN: A-04-00-02161 MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOVEMBER 2001, \$5,344,160

CIN: A-09-03-00042 REVIEW OF HHA PRECEDING HOSPITAL STAY UNDER PPS - UGS, FEBRUARY 2004, \$5,306,825

CIN: A-01-97-00516 ADMIN. COSTS-PART A&B, RAILROAD RETIRE BOARD, JUNE 1999, \$4,939,184

CIN: A-03-01-00226 UVA MEDICAL CENTER/DSH/MEDICAID/VIRGINIA, MAY 2003, \$4,760,385

CIN: A-05-01-00023 ADMINISTRATIVE COSTS REVIEW - ADMINASTAR FEDERAL, JANUARY 2002, \$4,694,863

CIN: A-02-00-01047 DEMO BSWNY - FINANCIAL, MARCH 2002, \$4,505,051

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CIN: A-07-98-01263 DENVER CMHC, MAY 2000, \$4,447,607
CIN: A-07-02-00144 IV-E FOSTER CARE ADMINISTRATIVE COSTS CLAIMED, AUGUST 2003, \$4,335,542
CIN: A-01-02-00015 REVIEW OF MA MEDICAID USE OF REVISED FEE SCHEDULES FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES, JANUARY 2004, \$4,100,000
CIN: A-07-00-00108 RURAL HEALTH CENTER REVIEW, OCTOBER 2001, \$4,087,929
CIN: A-07-04-03053 REVIEW OF CAHABA'S UNFUNDED PENSION COSTS, FEBRUARY 2004, \$4,006,541
CIN: A-03-01-00225 VIRGINIA IMD UNDER 21, MARCH 2004, \$3,948,532
CIN: A-05-01-00068 PARTNERSHIP PLAN - ILLINOIS PHYSICIAN BILLING-FAMILY DYNAMICS, JULY 2002, \$3,790,846
CIN: A-02-02-01014 UNLICENSED PROVIDERS IN PUERTO RICO, SEPTEMBER 2003, \$3,607,820
CIN: A-04-01-05002 AUDIT MEDICAID PAYMENTS FOR CLINICAL LABORATORIES, JANUARY 2002, \$3,522,639
CIN: A-02-95-01019 STAFFBUILDERS HOME OFFICE MEDICARE COST REV. ORT, AUGUST 1998, \$3,434,274
CIN: A-07-99-01298 DATE OF DEATH - 2, MAY 2001, \$3,200,000
CIN: A-05-98-00042 ADMINISTAR INS. CO.--ADMIN. COSTS AUDIT, SEPTEMBER 1999, \$3,111,728
CIN: A-06-99-00057 AUDIT OF MEDICARE REHAB AGENCY SRVCS IN TX, RHS,IN, JANUARY 2001, \$3,097,201
CIN: A-09-02-00061 REVIEW OF MEDICAL CLAIMS FOR PRIVATE IMD PATIENTS, DECEMBER 2002, \$3,083,389
CIN: A-07-02-03007 COSTS CLAIMED FOR POST RETIREMENT BENEFITS BY TOLIC, MAY 2002, \$3,060,873
CIN: A-09-98-50183 STATE OF CALIFORNIA, MARCH 1998, \$3,000,000
CIN: A-01-02-00508 REVIEW OF MEDICARE CONTRACT TERMINATION COSTS - UNITED HEALTHCARE, NOVEMBER 2003, \$2,894,010
CIN: A-01-96-00508 MEDICARE ADMIN COSTS PARTS A&B AND RRB - TRAVELERS, MARCH 1996, \$2,803,260
CIN: A-07-03-03039 CAREFIRST OF MARYLAND UNFUNDED PENSION COSTS, MAY 2003, \$2,611,100
CIN: A-05-97-00005 ADMINISTRATIVE COSTS CLAIMED UNDER MEDICARE A & B, FEBRUARY 1998, \$2,569,067
CIN: A-05-92-00026 ASSOCIATED INSURANCE CO. - MEDICARE ADMIN, FEBRUARY 1992, \$2,530,409
CIN: A-09-02-72300 STATE OF CALIFORNIA, JULY 2002, \$2,400,000
CIN: A-05-03-00062 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF NORIDIAN MUTUAL INSURANCE COMPANY, JUNE 2003, \$2,400,000
CIN: A-02-91-01006 BLUE SHIELD OF WESTERN NY MEDICARE ADM CTS PORTER, SEPTEMBER 1991, \$2,379,239
CIN: A-03-99-00038 EDGEWATER PSYC HOSPITAL, MARCH 2001, \$2,348,604
CIN: A-06-01-00083 AUDIT OF MEDICAID SCHOOL-BASED SERVICES IN OKLAHOMA, APRIL 2003, \$2,332,774
CIN: A-07-97-01247 DUPLICATE PAYMENTS - HMO/FFS, OCTOBER 1999, \$2,300,000
CIN: A-10-02-00008 REVIEW OF WASHINGTON STATE'S MEDICAL ASSISTANCE COSTS CLAIMED FOR SCHOOL-BASED HEALTH SERVICES, JULY 2003, \$2,279,752
CIN: A-04-02-07007 MEDICAID FEE FOR SERVICE PAYMENTS FOR DUALY ELIGIBLE MEDICARE MANAGED CARE ENROLLEES, FEBRUARY 2003, \$2,231,100

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CIN: A-04-97-01170 REVIEW HOME HLTH SRVCS BY MEDCARE HOME HLTH SRVCS, APRIL 1999, \$2,200,000

CIN: A-09-01-00056 PACIFICARE-CALIFORNIA JAN 1998 INSTITUTIONAL PMTS, SEPTEMBER 2001, \$2,158,577

CIN: A-05-03-00063 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF MEDICARE NORTHWEST (BLUE CROSS BLUE SHIELD OF OREGON), OCTOBER 2003, \$2,100,000

CIN: A-07-01-03001 BCBS OF MN PENSION SEGMENT CLOSING, JANUARY 2003, \$2,003,341

CIN: A-05-00-00034 PROVENA ST. JOSEPH HOSPITAL-O/P PSYCH SERVICES, NOVEMBER 2000, \$1,978,583

CIN: A-05-02-00048 REVIEW OF MEDICAID DME CLAIMS - TEXAS, SEPTEMBER 2002, \$1,969,704

CIN: A-01-03-00500 HOME HEALTH PPS SYSTEM CONTROLS 14 DAY PAYMENT-WHEN PRECEDED BY A HOSPITAL DISCHARGE, JULY 2003, \$1,861,857

CIN: A-05-97-00014 GROUP HEALTH PLAN INC.(HEALTHPARTNERS) INST. BENES, JUNE 1998, \$1,808,308

CIN: A-05-03-00071 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ANTHEM HEALTH PLANS OF MAINE, INC., OCTOBER 2003, \$1,800,000

CIN: A-01-02-00516 REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES UNITED GOVERNMENT SERVICES, MARCH 2003, \$1,768,783

CIN: A-09-00-00127 BLUE CROSS OF CALIF - MEDICARE ADMIN COSTS, DECEMBER 2002, \$1,677,822

CIN: A-04-99-01196 OIG-HCFA JOINT REVIEW OF JMV MEDICAL CORP., DECEMBER 2000, \$1,600,417

CIN: A-03-00-00215 ANNABURG MANOR NURSING HOME COST REPORT, MARCH 2002, \$1,582,079

CIN: A-03-96-00012 BCBSM PT-B NON-RENEWAL COSTS, AUGUST 1998, \$1,557,459

CIN: A-01-01-00547 REVIEW OF GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION AT THE HARTFORD HOSPITAL, OCTOBER 2003, \$1,530,441

CIN: A-04-01-05011 REVIEW OF FLORIDA MEDICAID PAYMENTS FOR SERVICES PROVIDED TO INMATES, OCTOBER 2002, \$1,450,077

CIN: A-07-02-03022 WELLMARK PENSION SEGMENT CLOSING, MARCH 2003, \$1,353,036

CIN: A-07-02-03021 ANTHEM BCBS OF CT - PENSION SEGMENT CLOSING, FEBRUARY 2004, \$1,351,284

CIN: A-04-03-02024 REVIEW OF BCBSFL RESPONSE TO SET-ASIDE COSTS IN PRIOR FACP AUDIT, APRIL 2003, \$1,277,247

CIN: A-05-01-00064 REVIEW OF OUTPATIENT REHABILITATION CLAIMS REIMBURSED BY MEDICARE DURING CALENDAR YEAR 1999, FEBRUARY 2002, \$1,235,892

CIN: A-03-01-00251 AFDC OVERPAYMENTS - VIRGINIA, MARCH 2003, \$1,221,494

CIN: A-04-02-72903 STATE OF TENNESSEE, SEPTEMBER 2002, \$1,213,353

CIN: A-01-02-00014 REVIEW OF MEDICAID SCHOOL-BASED HEALTH SERVICES-RHODE ISLAND, FEBRUARY 2004, \$1,201,193

CIN: A-05-00-00004 NEW CENTER COMMUNITY MENTAL HEALTH CENTER, JUNE 2000, \$1,181,000

CIN: A-05-00-00049 PARTNERSHIP PLAN - IL HOSPITAL TRANSFERS, JUNE 2001, \$1,150,113

CIN: A-02-97-01026 EDDY VNA (#337152) HHA ELIGIBILITY REVIEW, SEPTEMBER 1999, \$1,131,593

CIN: A-05-03-00086 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ARKANSAS BLUE CROSS AND BLUE SHIELD, OCTOBER 2003, \$1,100,000

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CIN: A-05-98-00050 FOLLOW-UP MEDICAID CLINICAL LABORATORIES, JULY 1999, \$1,097,036

CIN: A-09-98-00052 CALIFORNIA MEDICAL REVIEW INC. (CA. PRO), JANUARY 1999, \$1,067,991

CIN: A-05-01-00037 BC/BS OF MN. ADMIN COSTS--LEON SNEAD & CO., JUNE 2001, \$1,037,090

CIN: A-01-98-00500 PAYMENT EDITS FOR PSYCHIATRIC AT MA PART B CARRIER, SEPTEMBER 1998, \$1,000,000

CIN: A-02-04-77762 MONTCLAIR CHILD DEVELOPMENT CENTER INC., MARCH 2004, \$992,617

CIN: A-09-94-01010 CLOSEOUT AUDIT--CONT NO. N01-ES-75196 (STRATAGENE), MARCH 1994, \$983,208

CIN: A-06-02-00027 TEXAS MEDICARE BAD DEBT COLLECTIONS, OCTOBER 2002, \$919,331

CIN: A-05-92-00060 CONTRACTOR AUDIT - BCBS - ADMIN, FEBRUARY 1993, \$879,609

CIN: A-05-04-77356 TRI-VALLEY OPPORTUNITY COUNCIL INC., FEBRUARY 2004, \$866,666

CIN: A-07-98-02533 TRAVELERS FACP, DECEMBER 1998, \$854,214

CIN: A-04-01-05004 REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MARCH 2002, \$836,711

CIN: A-02-98-01040 NIAGARA CTY DEPT. OF HLTH-#337001-HHS ELIG REVIEW, DECEMBER 1999, \$807,679

CIN: A-06-03-00013 MEDICARE ADMINISTRATIVE COST PROPOSAL-ARKANSAS BCBS, OCTOBER 2003, \$759,748

CIN: A-07-99-00981 ASSIST REVIEW OF MEDICARE A/R HCFA RO DENVER, JANUARY 2000, \$754,926

CIN: A-01-04-76290 STATE OF MAINE, JANUARY 2004, \$735,765

CIN: A-05-02-00041 INDIANA MEDICAID HOSPITAL PATIENT TRANSFERS, JANUARY 2003, \$730,061

CIN: A-09-00-00103 PACIFICARE HMO - MEDICARE DUAL ELIGIBLES, MAY 2001, \$720,858

CIN: A-07-02-03035 COSTS CLAIMED FOR PRB'S BY WELLMARK, FEBRUARY 2003, \$717,106

CIN: A-09-97-00078 PHYSICIAN BILLINGS DR. SPENCER, JANUARY 1999, \$683,264

CIN: A-06-01-00090 PREAWARD-APASS MAINTAINER DATA PROCESSING SERVICES-ABCBS, SEPTEMBER 2001, \$678,651

CIN: A-05-00-64226 NA-ILLINOIS DEPT. OF PUBLIC AID, MAY 2000, \$654,017

CIN: A-01-99-00535 AUDIT OF M/C PART A ADMIN COSTS-ANTHEM BC/BS CT, AUGUST 2000, \$621,256

CIN: A-04-00-00138 MEDICAID ESCHEATED WARRANTS - FLORIDA, JANUARY 2002, \$613,891

CIN: A-02-02-01025 NEW YORK NURSING HOME DUPLICATE PAYMENTS, SEPTEMBER 2003, \$606,403

CIN: A-06-98-00066 ORT REVIEW OF ULTIMATE HOME HEALTH CARE INC., OCTOBER 1999, \$602,982

CIN: A-04-94-01078 MONITORING ADMIN COST - AUDIT MEDICARE P.B BCBSCT, JULY 1994, \$594,092

CIN: A-04-93-01069 MONITORG ADMIN COST AUDIT MCARE PART A BCBSCT, JULY 1994, \$590,844

CIN: A-04-01-01007 GABCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, \$575,471

CIN: A-09-01-00055 REVIEW OF IMD CLAIMS - STATE OF CALIFORNIA, MARCH 2002, \$551,394

CIN: A-07-02-03015 BCBS OF MN PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEBRUARY 2003, \$550,083

CIN: A-05-02-72811 COMMUNITY ACTION OF GREATER INDIANAPOLIS INC. , AUGUST 2002, \$547,899

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CIN: A-07-02-03029 WELLMARK - PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEBRUARY 2003, \$547,053

CIN: A-05-99-00062 AMERICARE PHYSICAL THERAPY SERVICES, DECEMBER 2000, \$503,619

CIN: A-09-99-56858 HAWAII DEPT. OF HUMAN SERVICES, FEBRUARY 1999, \$502,000

CIN: A-03-92-16229 STATE OF PENNSYLVANIA, MARCH 1992, \$496,876

CIN: A-02-02-01004 MEDICAID PPS TRANSFERS, MAY 2003, \$493,158

CIN: A-05-01-67384 MICHIGAN DEPT. OF COMMUNITY HEALTH , FEBRUARY 2001, \$481,693

CIN: A-07-01-00120 REVIEW OF UNFUNDED PENSION COCST AT BCBS OF OK, JULY 2001, \$413,800

CIN: A-05-03-00053 ESRD PRICING ERRORS AT INDEPENDENT FACILITIES, NOVEMBER 2003, \$407,300

CIN: A-02-01-67912 STATE OF NEW YORK, MARCH 2001, \$389,536

CIN: A-05-00-00030 CONTRACTED AUDIT-NATIONWIDE INS.-MEDICARE ADMIN., OCTOBER 2000, \$385,081

CIN: A-04-02-02014 MEDICAID CLAIMS FOR IMD RESIDENTS UNDER AGE 21, FEBRUARY 2003, \$362,931

CIN: A-01-02-73084 STATE OF MAINE , SEPTEMBER 2002, \$362,326

CIN: A-06-01-00087 AUDIT OF OBSERVATION SERVICE BILLING BY PRESBYTERIAN HOSP OF DALLAS, JUNE 2002, \$361,832

CIN: A-07-03-02653 REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION BC/BS ARKANSAS, JANUARY 2003, \$344,883

CIN: A-10-01-00005 AUDIT OF ADMIN COSTS AT MEDICARE NORTHWEST, SEPTEMBER 2001, \$332,274

CIN: A-07-01-02630 REVIEW OF MUTUAL'S SETTLEMENT OF HHA COST REPORTS, JANUARY 2002, \$319,949

CIN: A-05-01-00096 PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$319,355

CIN: A-09-03-00032 BLUE CROSS OF CALIFORNIA, MEDICARE, TERMINATION COSTS, OCTOBER 2003, \$319,187

CIN: A-05-02-00023 SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MARCH 2003, \$315,474

CIN: A-03-03-72652 NATIONAL ASSOCIATION FOR EQUAL OPPORTUNITY IN HIGH, OCTOBER 2002, \$313,256

CIN: A-06-01-00028 AUDIT OF OBSERVATION SERVICE BILLINGS BY PPS HOSPITALS, FEBRUARY 2002, \$298,549

CIN: A-09-03-00050 OREGON MEDICAID REIMBURSEMENT RATE FOR NURSING FACILITY ADMINISTRATIVE COSTS, OCTOBER 2003, \$290,769

CIN: A-05-96-00069 CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEBRUARY 1998, \$280,515

CIN: A-09-94-30178 STATE OF ARIZONA, JUNE 1994, \$267,021

CIN: A-05-02-00047 UNITED GOVERNMENT SERVICES, MEDICARE PART A ADMIN. COSTS FY 1999-2001, JUNE 2003, \$260,831

CIN: A-07-03-02662 REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DECEMBER 2002, \$258,112

CIN: A-02-03-04001 AUDIT OF RUTGERS CONTRACT NO. SPO 103-96-D-0016/0001, AUGUST 2003, \$249,381

CIN: A-05-01-00094 PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCTOBER 2002, \$229,656

CIN: A-04-00-01222 CAPITAL HLTH PLAN, COST-BASED MANAGED CARE PLAN, SEPTEMBER 2001, \$221,952

CIN: A-01-00-00549 BETH ISRAEL AUDIT OF OUTPATIENT PHARMACY SVC, MARCH 2001, \$221,905

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CIN: A-05-99-00067 WPS PART B ADMINISTRATIVE COSTS, NOVEMBER 2000, \$221,644
CIN: A-02-03-04006 GRANT REVIEW DAAG 55-97-1-0281, MARCH 2004, \$221,365
CIN: A-02-01-65217 PUERTO RICO DEPT. OF THE FAMILY , DECEMBER 2000, \$213,264
CIN: A-05-01-00103 PAYMENTS FOR SERVICES TO DECEASED BENEFICIARIES - MICHIGAN, OCTOBER 2003, \$211,894
CIN: A-02-01-01019 DEMO BSWNY - CASH MANAGEMENT, OCTOBER 2002, \$208,271
CIN: A-06-96-00064 ORT SNF RESEARCH AT METHODIST HOSPITAL, JANUARY 1997, \$200,000
CIN: A-07-01-02631 REVIEW OF HOSPITAL OBSERVATION BEDS, MAY 2002, \$197,773
CIN: A-07-03-02656 REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION KANSAS, DECEMBER 2002, \$190,106
CIN: A-03-01-00555 PDPI INC. -- HEAD START, JUNE 2001, \$185,577
CIN: A-07-02-03016 TRANSAMERICA SUPPLEMENTAL PENSION PLAN COSTS, MARCH 2002, \$180,244
CIN: A-05-02-73374 STATE OF OHIO , SEPTEMBER 2002, \$179,797
CIN: A-10-01-00006 REVIEW OF OREGON MEDICAID SCHOOL BASED HEALTH SERVICES - REIMBURSEMENT OF DIRECT SERVICES, AUGUST 2002, \$166,671
CIN: A-07-01-02094 SURVEY OF OUTPATIENT OBSERVATION SERVICES, OCTOBER 2002, \$165,125
CIN: A-03-98-00034 FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MARCH 1999, \$156,987
CIN: A-01-02-01504 REVIEW OF CDC'S HIV PROGRAMS AT FENWAY COMMUNITY HEALTH CENTER, JUNE 2003, \$151,912
CIN: A-07-03-02664 REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION TRAILBLAZERS, DECEMBER 2002, \$140,202
CIN: A-08-03-74616 OGLALA SIOUX TRIBAL DEPT. OF PUBLIC SAFETY, MARCH 2003, \$136,764
CIN: A-02-98-01002 IPRO CLOSEOUT AUDIT - CPA CONTRACT MONITORING, DECEMBER 1998, \$135,492
CIN: A-05-00-00060 MEDICA FOLLOW-UP, REIMB. RATES FOR INSTI. BENES, JUNE 2001, \$133,795
CIN: A-06-00-00014 REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCAR, JUNE 2000, \$132,238
CIN: A-07-03-02661 REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION NHIC, JANUARY 2003, \$129,748
CIN: A-02-01-04000 INTERIM AUDIT OF RUTGER'S CONTRACT NO.SP0103-96-D-, JANUARY 2002, \$125,415
CIN: A-05-01-00069 MERITER - MC/MA CREDIT BALANCES, JULY 2002, \$122,713
CIN: A-05-01-00091 PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEPTEMBER 2002, \$121,023
CIN: A-09-99-52846 INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEBRUARY 1999, \$119,099
CIN: A-02-02-71384 STATE OF NEW YORK , MARCH 2002, \$118,773
CIN: A-02-96-02001 INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, \$114,631
CIN: A-09-02-71247 WATTSHEALTH FOUNDATION INC. , APRIL 2002, \$113,000
CIN: A-03-01-00001 EASTERN SHORE AMBULANCE CO., AUGUST 2001, \$110,417
CIN: A-01-02-00527 REVIEW OF ANTHEM BLUE CROSS/BLUE SHIELD MEDICARE CONTRACT TERMINATION AND SEVERANCE COSTS, SEPTEMBER 2003, \$104,468
CIN: A-01-02-01502 NORTHEASTERN UNIVERSITY DHHS CONTRACT COSTS, JUNE 2003, \$102,378
CIN: A-05-01-00079 PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, \$100,692

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CIN: A-04-03-06007 NURSING HOME QUALITY OF CARE SANCTIONS - FLORIDA, FEBRUARY 2004, \$99,957

CIN: A-05-00-65775 STATE OF WISCONSIN, SEPTEMBER 2000, \$98,586

CIN: A-05-02-00067 REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS & COST REPORTS @ WELBORN, JUNE 2003, \$97,623

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

CIN: A-10-97-00003 BCWAAK-ADM COSTS REMOTE NETWORK ACTIVITIES FY93&94, FEBRUARY 1998, \$94,643

CIN: A-06-03-00021 CMS FY 02 MEDICARE ERROR RATE - TRAILBLAZER REPORT QTR 1 (NOV-DEC), JULY 2003, \$93,863

CIN: A-07-95-01164 MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER 1995, \$89,929

CIN: A-05-02-00074 IL PARTNERSHIP PLAN - TRANSPORTATION DURING AN INPATIENT STAY, APRIL 2003, \$89,147

CIN: A-05-01-00090 PAYMENTS TO AETNA OFFOR INSTITUTIONAL BENEFICIARIES, JULY 2002, \$87,516

CIN: A-07-00-00118 REVIEW OF KANSAS RURAL HEALTH CENTER, MAY 2001, \$87,493

CIN: A-08-99-56914 RURAL AMERICA INITIATIVES, JULY 1999, \$87,468

CIN: A-04-01-01006 MBCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, \$87,042

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

CIN: A-05-01-00071 PAYMENTS TO HUMANA-K.C. FOR INSTITUTIONAL BENEFICIARIES, DECEMBER 2001, \$84,808

CIN: A-02-03-74061 PUERTO RICO DEPT. OF THE FAMILY, AUGUST 2003, \$80,001

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

CIN: A-01-99-00530 NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DECEMBER 2000, \$75,413

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

CIN: A-08-03-74429 PORCUPINE CLINIC, JULY 2003, \$65,027

CIN: A-04-03-73667 MANATEE OPPORTUNITY COUNCIL INC. , OCTOBER 2002, \$63,321

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

CIN: A-05-99-00045 KAISER HEALTH PLAN OF OHIO - INSTITUTIONAL STATUS, MAY 2000, \$61,177

CIN: A-05-02-72716 SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND , SEPTEMBER 2002, \$60,378

CIN: A-05-96-00072 MI DEPT. OF COMMUNITY HEALTH/MEDICAID LAB SERVICES, AUGUST 1997, \$59,956

CIN: A-06-01-68876 STATE OF LOUISIANA , JUNE 2001, \$59,914

CIN: A-01-96-00505 CFO AUDIT OF HCFA'S FINANCIAL STATEMENTS, JULY 1997, \$59,327

CIN: A-09-97-00059 HEALTH SERVICES ADVISORY GROUP, INC PRO-AZ, MAY 1997, \$57,925

CIN: A-06-00-00053 OIG HCFA NEBULIZER PROJECT - NATIONAL ERROR RATE, OCTOBER 2001, \$52,550

CIN: A-08-00-60687 SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, NOVEMBER 1999, \$52,536

CIN: A-04-02-68936 STATE OF TENNESSEE , JUNE 2002, \$50,717

CIN: A-05-00-00059 TITLE XIX - MEDICAID ESCHEATED WARRANTS, MARCH 2001, \$50,162

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

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

CIN: A-09-95-00095 HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DECEMBER 1995, \$49,585

CIN: A-03-93-03306 SURVEY RESEARCH ASSOC. CACS NO1-ES-45067, DECEMBER 1993, \$48,779

CIN: A-06-03-75523 UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JUNE 2003, \$48,400

CIN: A-02-04-76883 UNIV. OF PUERTO RICO-SYSTEM, OCTOBER 2003, \$47,532

CIN: A-03-02-00373 REVIEW OF US HELPING US, DECEMBER 2003, \$45,558

CIN: A-07-00-00106 PENSION SEGMENTATION AUDIT AT BCBS OF OKLAHOMA, JULY 2001, \$45,508

CIN: A-10-03-00004 REVIEW OF OUTLIER PAYMENT MADE TO VIRGINIA MASON MEDICAL CENTER, OCTOBER 2003, \$44,631

CIN: A-09-99-52845 INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEBRUARY 1999, \$43,315

CIN: A-09-99-57306 PICAYUNE RANCHERIA OF THE CHUKCHANSI INDIAN TRIBE, SEPTEMBER 1999, \$43,159

CIN: A-07-01-00121 REVIEW OF PEN. COSTS FOR MED. REIMB. FOR BCBS OF OK, JULY 2001, \$42,463

CIN: A-03-99-00017 PSU-HERSHEY/PHY CREDIT BALANCES/MEDICARE, DECEMBER 1999, \$41,712

CIN: A-01-03-01500 REVIEW OF CDC HIV PROGRAMS AT GREATER BRIDGEPORT ADOLESCENT PREGNANCY PROGRAM, JULY 2003, \$41,088

CIN: A-10-02-72331 IDAHO MIGRANT COUNCIL INC. , JULY 2002, \$40,541

CIN: A-05-00-00017 INDIANA MEDICAID TRANSPORTATION SERVICES, MARCH 2001, \$39,735

CIN: A-10-03-00003 REVIEW OF DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTS AT REGENCE BLUESHIELD OF IDAHO, OCTOBER 2003, \$39,660

CIN: A-10-04-76879 STATE OF ALASKA, DECEMBER 2003, \$37,372

CIN: A-08-00-65136 STATE OF SOUTH DAKOTA, JUNE 2000, \$36,380

CIN: A-06-03-00020 CMS FY 02 MEDICARE ERROR RATE - TRAILBLAZER REPORT QTR 3 (APR-JUN), JULY 2003, \$35,474

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

CIN: A-06-03-74833 AMIGOS VOLUNTEERS IN EDUCATION & SERVICES INC. (AV, APRIL 2003, \$31,180

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

CIN: A-04-01-01005 REVIEW DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTS AT CAPITAL HEALTH PLAN, NOVEMBER 2001, \$30,293

CIN: A-06-02-00018 GRADUATE MEDICAL EDUCATION COST AT METHODIST HOSP IN HOUSTON, JUNE 2002, \$30,230

CIN: A-03-00-00209 STATE SURVEY AND CERTIFICATION COSTS - VA, AUGUST 2001, \$29,298

CIN: A-01-02-71527 STATE OF MASSACHUSETTS , APRIL 2002, \$29,260

CIN: A-04-02-72213 STATE OF FLORIDA , JUNE 2002, \$28,612

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

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

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

CIN: A-04-03-01004 OUTPATIENT CARDIAC REHAB SERVICES - HEALTHSOUTH SEA PINES REHAB HOSPITAL, DECEMBER 2003, \$26,279

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

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CIN: A-06-02-70732 UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION , JANUARY 2002, \$23,483

CIN: A-04-00-01206 BCBSNC - MEDICARE PART A ADMIN COST AUDIT-CARMICHAEL, SEPTEMBER 2000, \$21,302

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

CIN: A-02-03-04004 CONTRACT CLOSING - NAS 9-19441, JULY 2003, \$20,595

CIN: A-05-02-72480 HANSEL NEIGHBORHOOD SERVICE CENTER INC., SEPTEMBER 2002, \$20,266

CIN: A-05-02-00079 MEDICAID FFS PAYMENTS FOR MEDICAID MANAGED CARE ENROLLEES, SEPTEMBER 2003, \$20,165

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

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

CIN: A-08-04-76779 COLORADO FOUNDATION FOR MEDICAL CARE, DECEMBER 2003, \$18,925

CIN: A-05-01-00100 PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, \$18,842

CIN: A-04-97-01163 VIMI MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, \$18,758

CIN: A-05-01-00095 PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, \$18,645

CIN: A-07-03-00151 REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUNE 2003, \$18,400

CIN: A-03-97-00007 NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MARCH 1997, \$17,045

CIN: A-07-00-00117 REV. OF PENSION COSTS FOR MED. REIMB. BC/BS OF ND, JANUARY 2001, \$16,863

CIN: A-05-03-75408 MICHIGAN DEPT. OF COMMUNITY HEALTH, APRIL 2003, \$16,645

CIN: A-01-99-55594 STATE OF VERMONT, NOVEMBER 1998, \$16,623

CIN: A-01-97-44143 BRANDEIS UNIV., JANUARY 1997, \$16,602

CIN: A-06-01-68297 NATIVE AMERICAN CENTER OF RECOVERY INC. , MAY 2001, \$16,314

CIN: A-03-03-00006 CARDIAC REHABILITATION - WASHINGTON ADVENTIST HOSPITAL, AUGUST 2003, \$15,946

CIN: A-03-04-77692 AMERICAN ASSOCIATION OF POISON CONTROL CENTERS INC, FEBRUARY 2004, \$15,060

CIN: A-06-04-77400 UNIV. OF ARKANSAS FOR MEDICAL SCIENCES, JANUARY 2004, \$14,989

CIN: A-05-01-00044 MINNESOTA MEDICAID PERSONAL CARE SERVICES REVIEW, APRIL 2002, \$14,844

CIN: A-03-97-00008 NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MARCH 1997, \$14,596

CIN: A-09-00-00104 PACIFICARE OF CALIFORNIA - INSTITUTIONAL STATUS, MARCH 2001, \$14,278

CIN: A-05-03-73921 NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NOVEMBER 2002, \$13,317

CIN: A-03-03-72847 DISTRICT OF COLUMBIA DEPT. OF HEALTH , OCTOBER 2002, \$12,850

CIN: A-06-03-74511 SOUTHERN UNIV. SYSTEM, FEBRUARY 2003, \$12,693

CIN: A-08-03-74361 PORCUPINE CLINIC, JULY 2003, \$12,611

CIN: A-07-02-04002 FY 2002 CFO/CMS/MEDICARE ERROR RATE MUTUAL OF OMAHA, OCTOBER 2002, \$12,070

CIN: A-05-03-00012 FROEDTERT MEDICAID CREDIT BALANCES, FEBRUARY 2003, \$12,066

CIN: A-03-04-76133 MINORITY ACCESS INC., OCTOBER 2003, \$11,141

CIN: A-05-01-00070 PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JANUARY 2002, \$11,089

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CIN: A-03-01-00513 IRSA - KOSOVO ASSISTANCE GRANT 90-ZK-0002/01, DECEMBER 2001, \$10,913

CIN: A-03-02-71608 SUPPORTIVE CHILD ADULT NETWORK INC. , APRIL 2002, \$10,561

CIN: A-03-04-75382 NATIONAL HISPANIC MEDICAL ASSOCIATION, JANUARY 2004, \$10,505

CIN: A-09-02-71757 PYRAMID LAKE PAIUTE TRIBE , MAY 2002, \$9,857

CIN: A-10-97-00002 GROUP HEALTH INSTITUTIONALIZED, NOVEMBER 1997, \$9,769

CIN: A-06-02-00032 CMS FY 01 MEDICARE ERROR RATE - ARK BC/BS REPORT, NOVEMBER 2002, \$9,655

CIN: A-02-01-02003 FORDHAM UNIVERSITY - DISCRETIONARY GRANT REVIEW, MAY 2002, \$9,451

CIN: A-03-03-00004 MEDICARE AUDIT CARDIAC REHABILITATION CENTERS - SHADY GROVE, OCTOBER 2003, \$9,127

CIN: A-02-01-66887 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001, \$9,000

CIN: A-05-01-67360 MICHIGAN FAMILY INDEPENDENCE AGENCY , FEBRUARY 2001, \$8,708

CIN: A-02-02-70019 SENECA NATION OF INDIANS , DECEMBER 2001, \$8,706

CIN: A-03-03-74002 MINORITY ACCESS INC., NOVEMBER 2002, \$8,113

CIN: A-07-97-01231 PROWEST-DOSHI WASHINGTON, JUNE 1997, \$8,027

CIN: A-03-02-72715 DISTRICT OF COLUMBIA DEPT. OF HEALTH , JULY 2002, \$7,851

CIN: A-05-01-68270 LAKE COUNTY COMMUNITY ACTION PROJECT , MAY 2001, \$7,614

CIN: A-03-03-00007 CARDIAC REHABILITATION - HOLY CROSS HOSPITAL, NOVEMBER 2003, \$7,470

CIN: A-03-98-00045 TEMPLE UNIV/PHYSICIAN CREDIT BALANCES/MEDICARE, JULY 1999, \$7,280

CIN: A-10-03-74448 K-12 WASHINGTON EDUCATION SYSTEM, JULY 2003, \$7,180

CIN: A-01-97-49174 BRANDEIS UNIV., AUGUST 1997, \$7,068

CIN: A-04-04-77116 MOORE COMMUNITY HOUSE INC., JANUARY 2004, \$6,521

CIN: A-07-95-01167 PENSION COSTS CLAIMED NEBRASKA BC/BS, JANUARY 1996, \$6,075

CIN: A-06-97-48062 SER-JOBS FOR PROGRESS NATIONAL INC., MAY 1997, \$5,924

CIN: A-15-02-20006 REVIEW OF CDC COOPERATIVE AGREEMENT AND HRSA RYAN WHITE ACTIVITIES AT HEALTH EDUCATION RESOURCE ORGANIZATION (HERO), INC. (BALTIMORE EMA/BALTIMORE CITY HEALTH DEPT), MARCH 2003, \$5,010

CIN: A-01-00-60299 INDIAN TOWNSHIP TRIBAL GOVERNMENT PASSAMAQUODDY TR, JANUARY 2000, \$4,597

CIN: A-04-03-01006 OUTPATIENT CARDIAC REHAB SERVICES AT MORTON PLANT HOSPITAL, JANUARY 2004, \$4,426

CIN: A-07-03-00158 REVIEW OF CARDIAC REHABILITATION SERVICES - SPENCE, IOWA, JANUARY 2004, \$4,026

CIN: A-07-02-04001 FY-2002 CFO/CMS MEDICARE ERROR RATE NORIDIAN (ND B/C), OCTOBER 2002, \$3,999

CIN: A-03-03-00011 CARDIAC REHABILITATION - ANNE ARUNDLE HOSPITAL, JANUARY 2004, \$3,997

CIN: A-02-02-01035 EVALUATION OF BID PROPOSAL - MEDICARE HELP LINE, AUGUST 2002, \$3,760

CIN: A-05-03-00084 MEDICARE OUTPATIENT CARDIAC REHAB - NORTHERN MICHIGAN HOSPITAL, OCTOBER 2003, \$3,738

CIN: A-02-03-01013 HORTON MEDICAL CENTER MEDICARE CARDIAC REHAB SERVICES, JANUARY 2004, \$3,485

CIN: A-09-01-00067 EAST BAY NEPHROLOGY MEDICAL GROUP, AUGUST 2001, \$3,418

CIN: A-03-01-03303 JOHNS HOPKINS UNIVERSITY/KPMG/NIDA/N01DA-3-7301, FEBRUARY 2001, \$3,347

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CIN: A-05-02-69215	ONEIDA TRIBE OF INDIANS OF WISCONSIN, OCTOBER 2001, \$3,109
CIN: A-02-01-66889	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES , FEBRUARY 2001, \$3,103
CIN: A-03-95-03318	TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996, \$3,016
CIN: A-02-01-66888	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES , FEBRUARY 2001, \$2,883
CIN: A-07-98-02502	CT. BC/BS PENSION COSTS CLAIMED, MARCH 1998, \$2,725
CIN: A-03-98-51505	ALLIEDSIGNAL TECHNICAL SERVICES CORP., APRIL 1998, \$2,722
CIN: A-01-97-45487	ABT ASSOCIATES INC., JANUARY 1997, \$2,596
CIN: A-02-03-04002	GRANT REVIEW DAAH 04-93-G-0234, SEPTEMBER 2003, \$2,576
CIN: A-02-02-01037	MSP PROCESSES AT MAIMONIDES MEDICAL CENTER, FEBRUARY 2004, \$2,315
CIN: A-04-03-01002	OUTPATIENT HOSPITAL CARDIAC REHAB - MEMORIAL HOSPITAL JACKSONVILLE, FLORIDA, NOVEMBER 2003, \$2,123
CIN: A-04-03-01005	OUTPATIENT CARDIAC REHAB SERVICES CENTRAL FLORIDA REGIONAL HOSPITAL, NOVEMBER 2003, \$2,003
CIN: A-05-97-00013	PACIFICARE OF CA-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, \$2,000
CIN: A-02-03-01026	MEADOWLANDS HOSPITAL MEDICAL CENTER CARDIAC REHAB SERVICES, JANUARY 2004, \$1,703
CIN: A-07-97-01232	PROWEST - DOSHI ALASKA, JUNE 1997, \$1,473
CIN: A-09-03-00043	AUDIT OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT REDDING MEDICAL CENTER, OCTOBER 2003, \$1,239
CIN: A-05-03-00070	MEDICARE OUTPATIENT CARDIAC REHAB - ST. CHARLES MERCY HOSPITAL, OCTOBER 2003, \$1,158
CIN: A-03-03-00393	AUDIT OF CDC HIV/AIDS GRANT TO SEXUAL MINORITY YOUTH ASSISTANCE LEAGUE, OCTOBER 2003, \$1,155
CIN: A-01-03-00514	REVIEW OF CARDIAC REHABILITATION SERVICES- BERKSHIRE MEDICAL CENTER, DECEMBER 2003, \$1,138
CIN: A-07-00-02082	REVIEW OF A COST HMO - IOWA, FEBRUARY 2002, \$1,006

⁵B.

The following audits are open pending the resolution of the contractors termination audit, related termination agreements and pending lawsuits:

CIN: A-05-95-00042	BCBSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DECEMBER 1995, \$1,333,598
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Notes to Table 2

¹The opening balance was adjusted downward by \$62 million.

²Management decision has not been made within 6 months on 72 reports.

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

CIN: A-03-00-00203	PA/INTERGOVERNMENTAL TRANSFERS/MEDICAID, FEBRUARY 2001, \$3,700,000,000
CIN: A-05-00-00056	MEDICAID INTERGOVERNMENTAL TRANSFERS - IDPA, MARCH 2001, \$1,870,000,000
CIN: A-06-00-00023	MEDICAID PHARMACY/PHYSICIAN ACTUAL ACQUISITION COST, AUGUST 2001, \$1,080,000,000
CIN: A-10-00-00011	MEDICAID INTERGOVERNMENTAL TRANSFERS - WASHINGTON STATE, MARCH 2001, \$475,000,000

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CIN: A-06-01-00069 EVALUATION OF LEGISLATION TO INCREASE MEDICAID HOSP-SPEC DSH PYMT LIMITS, DECEMBER 2001, \$380,000,000

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

CIN: A-01-99-00507 NAT-WIDE REF OPNT PSYCH SVC AT ACUTE CARE HOSPITLS, MARCH 2000, \$224,466,692

CIN: A-04-00-02165 REVIEW OF AL MEDICAID INTERGOVERNMENTAL TRANSFERS, MARCH 2001, \$147,500,000

CIN: A-06-00-00053 OIG HCFA NEBULIZER PROJECT - NATIONAL ERROR RATE, OCTOBER 2001, \$133,960,552

CIN: A-04-00-02169 REV. AL MEDICAID INTERGOVERNMENTAL TRANSFERS-HOSPITAL ENHANCE, MAY 2001, \$63,000,000

CIN: A-01-99-00530 NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DECEMBER 2000, \$56,936,287

CIN: A-07-98-02534 EMPIRE BC/BS PENSION PLAN TERMINATION, MARCH 2000, \$38,626,351

CIN: A-01-02-00503 FURTHER EXPANSION OF THE DRG PAYMENT WINDOW, AUGUST 2003, \$37,000,000

CIN: A-02-03-73313 CITY OF NEW YORK ADMINISTRATION FOR CHILDRENS SERV, JANUARY 2003, \$22,203,439

CIN: A-02-01-67912 STATE OF NEW YORK, MARCH 2001, \$19,000,000

CIN: A-06-99-00060 REVIEW OF AN HMO UNDERPAYMENT CLAIM OF 21 MILLION, JUNE 2001, \$12,191,579

CIN: A-01-00-00502 REV OF EXORBITANT MEDICARE PMTS FOR O/P SVCS, MAY 2001, \$12,100,000 **CIN: A-03-91-00552**

CIN: A-03-91-00552 INDEPENDENT LIVING PROGRAM - NATIONAL, MARCH 1993, \$10,161,742

CIN: A-07-96-01177 MEDICARE POST RETIREMENT CLAIM BC MICH, NOVEMBER 1996, \$8,978,998

CIN: A-06-99-00045 MEDICARE LEFT AGAINST MEDICAL ADVICE DISCHARGES, MARCH 2002, \$6,800,000

CIN: A-03-00-00007 REVIEW OF 1-DAY DISCHARGES-PA., APRIL 2001, \$6,300,000

CIN: A-01-99-00506 FOLLW-UP REVIEW OF SEPRTLY BILLABLE ESRD LAB TESTS, JANUARY 2001, \$6,100,000

CIN: A-01-97-02506 REVIEW OF THE AVAIL OF MEDICAL COVERAGE/CSE SUPORT, JUNE 1998, \$5,704,585

CIN: A-05-01-00052 DME REVIEW IN INDIANA, OCTOBER 2001, \$4,400,000

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

CIN: A-02-02-01026 NEW JERSEY PARTNERSHIP - NURSING HOME DAY CARE SERVICES, MARCH 2003, \$3,500,000

CIN: A-04-98-01188 REVIEW ADMIN. COSTS @ MEDICARE MANAGED RISK PLAN, AUGUST 1999, \$2,559,357

CIN: A-05-00-00083 REVIEW OF MEDICAID DME CLAIMS - MICHIGAN, OCTOBER 2001, \$2,500,000

CIN: A-05-02-00066 REVIEW OF RFP CMS-02-001/ELH1, MAY 2002, \$1,885,793

CIN: A-09-95-00095 HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DECEMBER 1995, \$1,389,723

CIN: A-05-01-00031 WI MEDICAID - DME, OCTOBER 2001, \$1,250,000

CIN: A-07-99-01298 DATE OF DEATH - 2, MAY 2001, \$700,000

CIN: A-05-02-00082 BID PROPOSAL FOR 1-800 MEDICARE HOTLINE ADMINISTRATION, AUGUST 2002, \$609,950

CIN: A-05-02-00080 SINAI - MC/MA CREDIT BALANCES, JANUARY 2003, \$515,942

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CIN: A-05-03-00021 CIMRO PRO PRE-AWARD AUDIT FOR NEBRASKA, NOVEMBER 2002, \$504,650

CIN: A-03-99-00052 ALLEGHENY/CHESAPEAKE ORF, SEPTEMBER 2001, \$467,646

CIN: A-05-00-00057 REVIEW OF MEDICAID MUTUALLY EXCLUSIVE CODES - OH, NOVEMBER 2001, \$450,000

CIN: A-05-01-00074 REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUNE 2001, \$282,049

CIN: A-03-99-00038 EDGEWATER PSYC HOSPITAL, MARCH 2001, \$208,731

CIN: A-07-97-01230 OFMQ - DOSHI OKLAHOMA, JUNE 1997, \$203,510

CIN: A-07-97-01231 PROWEST-DOSHI WASHINGTON, JUNE 1997, \$163,552

CIN: A-01-02-73084 STATE OF MAINE , SEPTEMBER 2002, \$149,082

CIN: A-05-02-00023 SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MARCH 2003, \$144,909

CIN: A-05-03-00059 ESRD #9 PRE-AWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, \$139,816

CIN: A-04-03-08013 ESRD NETWORK COST PROPOSAL, MAY 2003, \$116,085

CIN: A-05-03-00060 ESRD #10 PRE-AWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, \$114,289

CIN: A-05-01-00070 PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JANUARY 2002, \$98,698

CIN: A-02-96-02001 INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, \$90,528

CIN: A-05-02-00089 REVIEW OF RFP CMS-500-97-0408/0008, NOVEMBER 2002, \$84,457

CIN: A-05-02-00084 MEDICARE OUTPATIENT CARDIAC REHAB - ST. LUKE'S MEDICAL CENTER, JULY 2003, \$47,247

CIN: A-07-97-01232 PROWEST - DOSHI ALASKA, JUNE 1997, \$21,218

CIN: A-05-96-00069 CPA AUDIT OF HOOPER HOLMES HHA G&A - OI CASE OPEN, FEBRUARY 1998, \$17,555

CIN: A-07-95-01164 MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER 1995, \$16,632

CIN: A-01-97-00526 PSYCHIATRIC OUTPATIENT SERVICES, MARCH 1998, \$7,245

CIN: A-06-03-00033 REVIEW OF GOOD SHEPHERD MEDICAL CENTER CARDIAC REHABILITATION SERVICE, JULY 2003, \$3,737

CIN: A-01-98-00506 PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY HOSPITA, MARCH 1998, \$1,120

Appendix E
Reporting Requirements of the Inspector General Act of 1978, as Amended

The reporting requirements of the Inspector General Act of 1978, as amended, are listed below with reference to the page in the semiannual report on which each is addressed. Where there are no data to report under a particular requirement, the word “none” appears in the column. A complete listing of audit and inspection reports is being furnished to the Congress under separate cover. Copies are available upon request.

<i>Section of the Act</i>	<i>Requirement</i>	<i>Page</i>
Section 4(a)(2)	Review of legislation and regulations	55
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	throughout
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	Appendices B & C
(a)(4)	Matters referred to prosecutive authorities	58
(a)(5)	Summary of instances where information was refused	none
(a)(6)	List of audit reports	under separate cover
(a)(7)	Summary of significant reports	throughout
(a)(8)	Statistical Table 1—Reports With Questioned Costs	53
(a)(9)	Statistical Table 2—Funds Recommended To Be Put to Better Use	54
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	none

Appendix F

Summary of Sanction Authorities

The Inspector General Act of 1978 (Public Law 95-452), as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to the Congress. A selection of other authorities appears below:

Program Exclusions

Section 1128 of the Social Security Act (42 U.S.C. § 1320a-7) provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs. Exclusions are required for individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felonies for other health care fraud; and (4) felonies for illegal manufacture, distribution, prescription or dispensing of controlled substances. OIG has the discretion to exclude individuals and entities on several other grounds, including: misdemeanors for other health care fraud (other than Medicare or Medicaid) or for illegal manufacture, distribution, prescription or dispensing of controlled substances; suspension or revocation of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; and engaging in unlawful kickback arrangements.

Providers subject to exclusion are granted due process rights (such as including a hearing before an HHS administrative law judge and appeals to the HHS Departmental Appeals Board and Federal district and appellate courts) regarding whether the basis for the exclusion exists and the length of the exclusion is reasonable.

Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. § 1395dd) provides that when an individual presents to the emergency room of a Medicare-participating hospital, the hospital must provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide either treatment to stabilize the condition or an appropriate transfer to another medical facility.

If a transfer is ordered, the transferring hospital must provide stabilizing treatment to minimize the risks of transfer and must ensure that the receiving hospital agrees to the transfer and has available space and qualified personnel to treat the individual. In addition, the transferring hospital must effect the transfer through qualified personnel and transportation equipment. Further, a participating hospital with specialized capabilities or facilities may not refuse to accept an appropriate transfer of an individual who needs services if the hospital has the capacity to treat the individual.

OIG is authorized to collect civil monetary penalties of up to \$25,000 against small hospitals (less 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.

APPENDIX F

Civil Monetary Penalties Law

Under the Civil Monetary Penalties Law (CMPL), section 1128A of the Social Security Act, 42 U.S.C. § 1320a-7a, a person is subject to penalties, assessments, and exclusion from participation in Federal health care programs for engaging in certain activities. For example, a person who submits to a Federal health care program a claim for items and services that the person knows or should know is false or fraudulent is subject to a penalty of up to \$10,000 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion.

For the purposes of the CMPL, “should know” is defined to mean that the person acted in reckless disregard or deliberate ignorance of the truth or falsity of the claim. The CMPL also authorizes actions for a variety of other violations, including submission of claims for items or services furnished by an excluded person, requests for payment in violation of an assignment agreement, and payment or receipt of remuneration in violation of the anti-kickback statute (42 U.S.C. § 1320a-7b(b)).

Anti-Kickback Statute

The anti-kickback statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers or pays remuneration, in cash or in kind, to induce or in return for (1) referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Federal health care programs; or (2) purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing or ordering of any good, facility, service, or item payable under the Federal health care programs (Section 1128B(b) of the Social Security Act, 42 U.S.C. § 1320a-7b).

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

False Claims Act

Under the Federal civil False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, a person or entity is liable for up to treble damages and up to \$11,000 for each false claim it knowingly submits or causes to be submitted to a Federal program. Similarly, a person or entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid.

The FCA defines “knowing” to include not only the traditional definition, but also instances when the person acted in deliberate ignorance of the truth or falsity of the information or in reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a *qui tam* or whistleblower provision that allows private individuals to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries.

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

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

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

In response to the 2003 annual solicitation, OIG received the following proposals related to safe harbors:

<i>Proposal</i>	<i>OIG Response</i>
New safe harbor for post-marketing research for medical products.	OIG is not adopting this suggestion. Industry-sponsored post-marketing studies are subject to abuse and should be evaluated on a case-by-case basis, such as under OIG's advisory opinion procedures.
New safe harbor for chronic disease management programs sponsored by providers or suppliers of medical items and/or services.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under OIG's advisory opinion procedures.
New safe harbor to protect arrangements: (1) between Indian health providers; (2) between Indian health providers and their patients; and (3) between Indian health providers and third parties that enhance the services provided.	OIG is not adopting this suggestion. The suggestion lacks specificity. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under OIG's advisory opinion procedures.
New safe harbor for manufacturer donations to charitable organizations that provide items or services to financially needy patients, including copayment assistance.	OIG is considering this suggestion.
New safe harbor to exclude from the definition of remuneration under the anti-kickback statute any payments or exchanges that are made between parties who have obtained a favorable advisory opinion in accordance with an arrangement that is the subject of such favorable advisory opinion.	OIG is not adopting this suggestion. OIG believes the suggestion is not consistent with the advisory opinion statute.

APPENDIX G

Modification of the discount safe harbor to clarify its application to the additional entities with which pharmaceutical manufacturers may contract under MMA (e.g., discount drug card sponsors, pharmacy benefits managers, retail pharmacies, and Part D drug plan sponsors).	This suggestion requires further study.
Modification of the discount safe harbor to allow explicitly for hospital purchasers to bundle capital and non-capital items together at a single purchase price.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.
Rescission of the safe harbor for group purchasing organizations (GPOs).	OIG is not adopting this suggestion. The GPO safe harbor is statutory.
New safe harbor for patronage dividends paid by GPOs that operate as Subchapter T cooperative organizations.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under OIG's advisory opinion procedures.

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

New safe harbor for certain practices related to "economic credentialing" of physicians by hospitals.	OIG received a substantial number of public comments from a cross-section of interested parties in response to OIG's specific solicitation of comments on this topic. The public comments variously suggest issuance of different types of guidance; some comments suggest that OIG take no action. OIG is reviewing the comments and studying the issue.
Modification of the Medicare SELECT safe harbor to cover (1) coinsurance waivers for inpatient services negotiated between a hospital and an ERISA employee welfare benefit plan that covers retirees and (2) Part B waivers for employer group plans.	These suggestions require further study. In September 2002, OIG issued a notice of proposed rulemaking to make certain modifications to the safe harbor. The public comments to that rulemaking are under review.
New safe harbor for inducements offered to beneficiaries that fit in an exception to the beneficiary inducements statute at section 42 U.S.C. §1320a-7a(a)(5).	OIG is considering this suggestion.
Modification of the existing shared risk exception to cover (1) second tier contractors of Federally qualified health centers (FQHCs) and (2) the TriCare program.	OIG is considering this suggestion.
New safe harbor for certain fee-for-service arrangements between FQHCs and other providers, practitioners and suppliers.	OIG is developing a proposed rule on this suggestion in accordance with the provisions in MMA.

Modification of the discount safe harbor to include a discount obtained by a commercial health plan that does not file claims with the Federal health care programs, where the discount otherwise meets the safe harbor conditions.	OIG is considering this suggestion.
Modification of the discount safe harbor to clarify its application to discounts applied to a manufacturer's full product line.	This suggestion requires further study.
Modification of the discount safe harbor's reporting requirements.	This suggestion requires further study.
Modification of the existing safe harbors to conform them to the final regulations under the physician self-referral statute published by the Centers for Medicare & Medicaid Services (CMS), and new safe harbors analogous to the new self-referral exceptions created by the CMS regulations.	OIG is considering making some conforming changes with respect to the group practice safe harbor. With respect to other safe harbors, the statutes generally serve somewhat different purposes and conforming the safe harbors to the self-referral exceptions may not be appropriate.
Modification of the ambulatory surgical center (ASC) safe harbor to address protection of start-up multi-specialty ASCs that otherwise comply with the current safe harbor conditions.	OIG is considering this suggestion.
Modification of the safe harbor for ASCs jointly owned by hospitals and physicians to add conditions under which a hospital would not be in a position to make or influence referrals.	OIG is considering this suggestion.
Modification of the ASC safe harbor to indicate whether an ASC can require investors to comply with safe harbor conditions.	OIG is considering this suggestion.
Modification of the ASC safe harbor to clarify (1) the use of "pass-through" entities to hold ownership interests and (2) the treatment of physician investors who invest at different times.	OIG is considering these suggestions.
New safe harbor for rural health networks operating pursuant to the Medicare Rural Hospital Flexibility Program.	This suggestion requires further study.
New safe harbor for arrangements that comply with section 513 of the IRS Code pertaining to the provision of certain supporting goods and services by tax-exempt hospitals to other tax-exempt hospitals.	This suggestion requires further study.

Appendix H

Performance Measures

Performance measures are used to evaluate the achievement of a program goal, such as the efficiency of an immunization program measured by the number of inoculations provided per dollar of cost. OIG has identified some items throughout this report as **performance measures** by following the item with the symbol ❖❖. In OIG's opinion, the audits, inspections, and investigations identified with the performance measure symbol offer management information about whether some aspect or all of the programs or activities reviewed are achieving their missions and goals. These proposals are provided to management for their consideration as they develop their performance measures.

The reports listed in each of the following sections warrant the performance measure symbol:

Centers for Medicare & Medicaid Services:

Comprehensive Error Rate Testing Improvements

Public Health Agencies:

NIH Grants Management
Ryan White CARE Act Grantees
Monitoring Ryan White CARE Act Grantees

Administrations for Children and Families and on Aging:

Noncustodial Parents' Contributions to SCHIP Costs
Health Care Services for Children in Foster Care

General Oversight:

The Government Performance and Results Act of 1993