U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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Message From the Inspector General

This report, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG) for the 6-month reporting period that ended March 31, 2006.

OIG is dedicated to the mission of detecting fraud, waste, and abuse and promoting economy and efficiency in the programs of the Department of Health and Human Services (HHS). Oversight of the Medicare and Medicaid programs, as well as the over 300 important discretionary programs administered by this Department, involves careful planning and effective resource allocation. To be effective, OIG must consistently evaluate and prioritize activities based on existing responsibilities, new mandates, and unforeseen events.

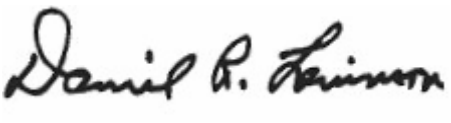
Over the last 6 months, OIG conducted a wide range of planned activities, addressed many significant new oversight responsibilities under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and responded to requests for assistance from the Department and the Inspector General community after the devastating hurricanes in the Gulf region. Balancing all of these activities required coordination between the components within OIG, as well as effective collaboration with the Department, Inspector General community, Federal law enforcement, and State and local entities.

OIG work during this reporting period continued to focus on Medicaid activities, including Medicaid prescription drug fraud, drug pricing under the Federal upper limit program, and State financing mechanisms used to maximize Medicaid payments. In addition, quality of care in nursing homes and community-based settings and durable medical equipment pricing remained OIG priorities.

The MMA mandated and prudent oversight work was also a focal point of OIG activities during the last 6 months. OIG issued a report on Medicare drug reimbursement for cancer patients and a report examining access to drugs under prescription drug plans' formularies for beneficiaries transitioning from Medicaid to Medicare. OIG continued to monitor implementation of the prescription drug benefit and the potential fraud associated with this new program.

As demonstrated by OIG's hurricane response, to be effective, we cannot operate in isolation. We must continue to work closely with our Federal, State, and local partners to leverage limited resources to achieve the maximum results for the American taxpayer. This team approach becomes even more important as OIG begins implementing its new Medicaid fraud responsibilities under the Deficit Reduction Act of 2005.

I want to express my sincere appreciation to Congress, as well as to the senior management of the Department, for their continued support. I am honored to be leading an organization of highly professional and talented employees who are committed to the mission of OIG and the important programs administered by the Department.



Daniel R. Levinson
Inspector General

Highlights

Summary of Accomplishments

For the first half of fiscal year (FY) 2006, the Office of Inspector General (OIG) reported expected recoveries of approximately $1.02 billion: $288 million in audit receivables and $732.4 million in investigative receivables.*

Also for this semiannual period, OIG reported exclusions of 1,540 individuals and entities for fraud or abuse involving Federal health care programs and/or their beneficiaries; 226 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 119 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.

Serono Settlement

Serono, S.A., along with its U.S. subsidiaries, Serono, Inc., Serono Holdings, Inc., and Serono Laboratories, Inc. (collectively known as Serono), agreed to enter a global criminal, civil, and administrative settlement that included the payment of $704 million plus interest and a 5-year Corporate Integrity Agreement (CIA). The global settlement resolved allegations that Serono engaged in the illegal promotion of its AIDS-related drug Serostim and offered and paid illegal remunerations to physicians and pharmacies to induce them to prescribe and/or purchase Serostim. The company also used an unapproved medical device as a marketing tool to diagnose AIDS-wasting syndrome, the condition that Serostim was approved to treat.

SmithKline Beecham Corporation Settlement

Doing business as GlaxoSmithKline, SmithKline Beecham Corporation agreed to pay the Government $149 million plus interest and enter into a 5-year addendum to its existing CIA with OIG. The settlement resolved allegations that the pharmaceutical manufacturer engaged in certain improper pricing and marketing practices for Zofran and Kytril, two antiemetic drugs used primarily in conjunction with oncology and radiation treatment.

Exclusion of South Beach Community Hospital

OIG excluded South Beach Community Hospital (formerly South Shore Hospital and Medical Center) from participation in Medicare, Medicaid, and other Federal health care programs based on the hospital's material breach of a CIA. This action marks the first time that OIG has sought to exclude a provider for failure to abide by the terms of a CIA previously negotiated as part of the resolution of a False Claims Act case against that provider.

*This figure represents HHS investigative receivables only; receivables on behalf of other Federal agencies, States, and others are not included here. Also, savings from implemented recommendations and other actions to put funds to better use are annual only and will be reported in the fall semiannual report.

Medicare Drug Reimbursement

As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, OIG analyzed a new methodology for Medicare Part B reimbursement of certain drugs and biologicals used to treat cancer patients. The report concluded that physician practices in the specialties of hematology, hematology/oncology, and medical oncology could generally purchase the drugs at prices below the new reimbursement rates. OIG based this conclusion on statistical estimates, including an estimate of average prices paid for selected codes that constituted more than 94 percent of the $4.5 billion in total 2004 Medicare-allowed amounts for drugs associated with these three physician specialties. OIG recommended that Congress consider the results of this review in deliberations about drug reimbursement methodology.

Deficiencies in 340B Drug Discount Program Oversight

Because of systemic problems with the accuracy and reliability of the Government's record of 340B ceiling prices, OIG found that the Health Resources and Services Administration (HRSA) cannot appropriately oversee the 340B Drug Pricing Program because it lacks the oversight mechanisms and authority to ensure that 340B entities pay at or below the 340B ceiling price. HRSA and the Centers for Medicare & Medicaid Services (CMS) agreed with most of OIG's recommendations and have already taken steps to improve the calculation of the 340B ceiling price.

Dual Eligibles' Transition: Drug Access Under Prescription Drug Plans' Formularies

This study found that "dual eligibles"—beneficiaries of both Medicare and Medicaid—may need targeted assistance to navigate the transition from Medicaid to the new Medicare Part D drug benefit, given the variation among Part D formularies, as well as the medical and resource challenges faced by this population. Taking advantage of the options available when their drug is not covered requires knowledge and proactive effort by beneficiaries and may require additional assistance from CMS and States to ensure a smooth transition.

Outside Activities of FDA Employees

OIG identified several vulnerabilities that limit the ability of the Food and Drug Administration (FDA) to effectively review the outside activities of its employees. Departmental employees are allowed, with approval, to work privately with non-Federal entities on their personal time, but these activities must not conflict with employees' official duties.

Series of Inspections on Caseworker Visits for Children in Foster Care

Caseworker visitation is an element critical to maintaining the safety and wellbeing of children in foster care. Two related OIG reports found that a significant number of States could not quantify the extent to which children were receiving visits, despite Federal

investment in statewide automated systems. The Administration for Children and Families is taking steps to address these issues with the States.

Medicaid Upper-Payment-Limit Calculations in Four States

The Federal upper payment limit is an estimate of the amount that would be paid for Medicaid services under Medicare payment principles. As part of a series of reviews, OIG found that four States had made large Medicaid overpayments to hospitals and/or nursing facilities because the States had not calculated the upper payment limits in compliance with Federal regulations and State Medicaid plans. OIG recommended that Alabama, Indiana, and New York refund a total of approximately $72.2 million to the Federal Government and that Mississippi work with CMS to resolve approximately $171 million in potential Federal overpayments.

Departmental Financial Statement Audit

For the seventh consecutive year, the Department received a "clean" opinion on its financial statements, meaning that the statements were reliable and fairly presented. However, the auditors noted two material weaknesses. First, the lack of an integrated financial management system and weaknesses in internal controls made it difficult for the Department to prepare timely and accurate financial statements. Second, CMS lacked comprehensive controls over the payment of Medicare managed care benefits. Material weaknesses are systemic problems that affect a number of operating divisions or problems of significant dollar amounts that affect a single division.

OIG's Hurricane-Related Activities

In the months after Hurricanes Katrina and Rita hit the Gulf Coast, OIG launched an aggressive coordinated oversight effort. OIG is working to ensure that: Federal response and recovery funds are spent appropriately; those attempting to defraud the Government are brought to justice; and the individuals responsible for the relief efforts are wise stewards in their work assisting those impacted by the hurricanes and their aftermath. In addition, more than 2,500 HHS staff and volunteers have been sent to the Gulf States in response to the hurricane disasters.

OIG is working with Federal, State, and local partners in this effort, including participating as a member of the President's Council on Integrity and Efficiency Homeland Security Roundtable, which is coordinating the oversight activities of the various Inspectors General. In addition, along with other members of the OIG community, OIG is a member of the Department of Justice Katrina task force in Baton Rouge. This task force is designed to investigate allegations of fraud related to Federal outlays in connection with Hurricane Katrina. Separate from this, OIG is conducting several investigations jointly with the Medicaid Fraud Control Unit in the State of Louisiana in connection with allegations of poor quality of care and patient abuse and neglect that occurred during and in the aftermath of Hurricane Katrina.

OIG has initiated extensive audit, inspection, and investigative activities related to the oversight of HHS hurricane recovery efforts. A list of current projects follows.

HHS Tasks Requested by FEMA

As of March 31, 2006, the total spending authority for hurricane-related tasks that the Federal Emergency Management Agency (FEMA) asked HHS to perform totaled $349.4 million. HHS should provide timely, accurate, complete, and consistent accounting for Gulf Coast-related costs reimbursed by FEMA. An OIG audit will determine whether HHS is appropriately accounting for these costs.

Transporting Medically Needy Evacuees

OIG is evaluating the performance of a contactor in charge of returning all Texas, Louisiana, and Mississippi evacuees who require en-route medical care and therefore cannot travel via commercial air or without medical assistance. It is estimated that 6,000 individuals may need to be transported. This contractor was awarded $21 million for Texas evacuees, and an additional $20 million may be awarded when Louisiana's infrastructure is reestablished to permit transporting evacuees back to their respective medical facilities.

Auditing Vulnerable Hurricane-Related Procurements

OIG is reviewing all hurricane-related contractual procurements over $100,000 and a sample of contracts under $100,000 in two stages. Initially, OIG is assessing the risk of fraud, waste, or abuse in these procurements. Based on these risk assessments, OIG will

select for indepth audit the most vulnerable hurricane-related HHS procurements. These audits will specifically focus on the methods of procurement, costs incurred, and the quantity, quality, and timeliness of deliverables. Ten audits are currently in progress.

Investigations of Quality of Care Allegations

OIG is currently investigating 13 quality of care cases in the Gulf area. The treatment of certain beneficiaries residing in health care facilities during the disaster is being investigated based on allegations of euthanasia, gross negligence, and poor quality of care.

The Use of Purchase Cards in Response to Hurricane Katrina

OIG is presently analyzing the use of purchase cards by HHS personnel deployed in response to Hurricane Katrina. The study focuses on compliance with both established and emergency HHS and agency spending guidelines and procedures. This study builds on OIG's March 2003 report "International Merchant Purchase Authorization Card Program: Review of Calendar Year 2001 Transactions." That study found that 44 percent of transactions sampled did not fully comply with requirements for using the IMPAC cards. These past findings, combined with the urgent nature of the responses to Hurricane Katrina, provide a useful opportunity to examine the use of HHS purchase cards during responses to large-scale public health emergencies.

Implementation of National Response Plan Responsibilities

OIG will audit HHS's implementation of its responsibilities under the National Response Plan, specifically, Emergency Support Function #8: Public Health and Medical Services. At appropriate departmental, operating division, and staff division levels, OIG will assess the handling of FEMA-requested mission assignments using established plans, objectives, and other pertinent benchmarks. The audit results will be critical for improving departmental processes for future public emergencies.

Use of Emergency Preparedness Grants in Selected Gulf Coast States

OIG will audit the use of HHS emergency preparedness grant funding in the Gulf Coast States. OIG will determine whether such funding, which is provided annually by the Centers for Disease Control and Prevention and the Health Resources and Services Administration, has been utilized for approved purposes and whether items funded by these grants were effective in the hurricane response and recovery efforts. Reviews will be performed in Florida, Alabama, Louisiana, Texas, and Mississippi.

Claims for Services Not Rendered in Medicare and Medicaid Programs

OIG auditors will perform a data match of services performed during the months immediately following Hurricane Katrina to providers located in zip codes declared national disaster areas. The results will be analyzed to determine whether any providers that were not in operation were continuing to bill the Medicare and/or Medicaid programs.

Identification of Aberrant Providers in Medicare and Medicaid Programs

Through the use of software applications, OIG auditors will identify providers who submitted claims to Medicare and/or Medicaid for services provided to evacuees that greatly exceeded the number of claims submitted by other providers in the peer group.

These claims will then be selectively reviewed to determine whether they are legitimate and medically necessary.

Establishment of Claims Identifiers in Medicare

In "Consolidated HHS Response to OMB Data Call: Katrina Stewardship," the Centers for Medicare & Medicaid Services (CMS) presented a risk assessment for Hurricane Katrina-related activities. As noted in this document, OIG auditors plan to determine whether (1) CMS established the necessary claims identifiers (called "special claims condition codes and modifiers") and CMS contractors implemented those claims identifiers and (2) the claims identifiers accurately represent the numbers, dollars, and nature of disaster-related claims.

Duplicate Medicaid Payments to Providers in Medicaid

OIG auditors will determine whether providers submitted claims and were paid by multiple State Medicaid agencies for the same service for the same evacuee. OIG auditors will conduct work to determine whether providers received (1) Medicaid payments from both the evacuee's home State and the host State in which the evacuee is residing or (2) Medicaid payments for services paid by FEMA.

Commissioned Corps Deployment in Response to Hurricane Katrina

OIG will evaluate whether the U.S. Public Health Service Commissioned Corps has achieved its goal to be 100 percent deployable in order to effectively mobilize and respond to public health emergencies by the end of 2005, focusing on the recent deployments associated with Hurricanes Katrina and Rita. The timing of the Commissioned Corps's goal coincides with one of the Corps's largest deployments in its 207-year history. In the weeks following Hurricane Katrina, more than 1,400 officers worked with State, local, and private agencies in 7 Gulf States, and after 1 month, over 700 remained in the Gulf States and evacuee areas to provide relief services.

Nursing Home Evacuation Planning and Execution

Nursing home residents and their families rely on facility administrators to plan for and execute appropriate evacuation procedures during times of disaster. However, the recent catastrophes in the Gulf States precipitated by Hurricanes Katrina and Rita have raised concerns about nursing home evacuation plans and coordination efforts between facilities and State/local resources in times of disaster. To address these concerns, the Senate Special Committee on Aging requested OIG to conduct a study of facility evacuation planning and execution. This study responds to the Committee's request and also continues the ongoing work of OIG to monitor the health and safety of nursing home residents.

Specifically, OIG will determine whether these homes complied with Federal requirements to develop and practice emergency preparedness plans and whether the plans included evacuation of residents. This report will also examine to what extent plans were executed for facilities that evacuated or considered evacuation during recent disasters. Additionally, the report will identify lessons learned from these facilities regarding development and

execution of emergency preparedness plans, including factors that promote or hinder successful evacuation.

Hurricane Katrina-Related Medical Review Contract

Because of the tragedy of Hurricanes Katrina and Rita, beneficiaries of HHS programs who resided in the Gulf Coast States may have been evacuated to various places around the United States or otherwise significantly affected. In response to this tragedy, HHS expanded coverage criteria for some programs, including Medicaid, to make Federal benefits available to victims in their time of need. In this series of studies, OIG will focus on identifying the appropriateness of payments made to providers for medical and durable medical equipment services for beneficiaries who had benefits before the hurricanes and those who have qualified as a result of the hurricanes.

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Please note: Numerical information in this report is rounded.

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 individuals 65 years old or older and for certain disabled persons. Medicare Part B (Supplementary Medical Insurance) is an optional program that covers most of the costs of medically necessary physician and other services and is financed by participants and general revenues.

Medicare Part C (Medicare Advantage) enables beneficiaries of Medicare Parts A and B to choose to receive all of their health care services through a coordinated Medicare Advantage (MA) plan, which replaced the previous Medicare+Choice managed care plans. In addition, Medicare Part D is a new, optional program offering prescription drug coverage through private drug plans. Beneficiaries may opt either to enroll in a stand-alone prescription drug plan and receive their Part A and Part B benefits through fee-for-service or to enroll in a Medicare Advantage prescription drug plan and receive all Medicare benefits, including drug coverage, through an MA plan.

The Medicaid program provides funding to States for medical care and other support and services for low-income individuals. State expenditures for medical assistance are matched by the Federal Government using a formula that compares 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 Medicare and Medicaid fraud, waste, and abuse and to monitoring these programs. These activities have helped ensure the cost-effective delivery of Medicare, Medicaid, and SCHIP services; safeguarded quality of care to beneficiaries of these programs; and reduced the potential for fraud, waste, and abuse. In addition, these efforts have led to criminal, civil, and/or administrative actions against perpetrators of fraud and abuse.

OIG also reports on audits of CMS financial statements, which currently account for more than 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.

CMS-Related Reports

Review of Services Provided by Inhalation Drug Suppliers

In conjunction with drug payment cuts mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), CMS raised the dispensing fee paid to Medicare suppliers of inhalation drugs from $5 to an interim amount of $57 for a 30-day drug supply, prompted in large part by a report sponsored by the American Association for Homecare showing that beneficiaries receive numerous important services from those suppliers. This OIG report was designed to identify services provided by suppliers and thereby assist CMS in setting a new dispensing fee for inhalation drugs for 2006.

OIG reviewed services provided to a sample of Medicare beneficiaries in 2003 and found that 60 percent of beneficiaries received at least one contact for a monthly drug refill. However, 31 percent of beneficiaries who should have been contacted for a refill were not contacted, contrary to the *Medicare Program Integrity Manual*. Fewer than one-third of beneficiaries had their medication compliance reviewed by their suppliers. Service levels dropped off after the first month suppliers billed for drugs. Few beneficiaries received more intensive services such as education, care plan revision, or a respiratory assessment, and 16 percent of beneficiaries received no services at all. The most common way beneficiaries received services was by telephone; only 1 in 10 beneficiaries received a home visit. OIG also found that beneficiaries were three times more likely to receive a service beyond a refill contact if their drug supplier also provided their respiratory equipment. (OEI-01-05-00090)

Calculation of Volume-Weighted Average Sales Price for Medicare Part B Prescription Drugs

In 2005, Medicare began paying for most Part B drugs using a new methodology based on average sales prices (ASP). Section 1847A(b)(2)(B) of the Social Security Act (the Act) specifies the unit that manufacturers must use when submitting ASP data. The Act also specifies the way to calculate a volume-weighted ASP for a Medicare payment code based on manufacturer-reported ASP data. However, CMS opted to change the unit of ASP submission, exercising discretion permitted by section 1847A(b)(2)(B) of the Act. It was therefore necessary for CMS to modify the method for calculating volume-weighted ASP described in the law. OIG found that the method CMS currently uses to calculate a volume-weighted ASP is mathematically incorrect. Therefore, CMS's equation may not always yield a volume-weighted ASP that is consistent with the volume-weighted ASP derived from the calculation set forth in section 1847A(b)(3) of the Act. Because CMS calculates volume-weighted ASPs incorrectly, current and future reimbursement amounts may not be accurate. OIG recommended that CMS change its calculation of volume-weighted ASP.

OIG proposed that CMS adopt an alternate equation that produces a volume-weighted ASP that is both mathematically correct and consistent with the results of the calculation set forth in section 1847A(b)(3) of the Act. CMS indicated that the report's findings are helpful to its ongoing refinement of the ASP payment methodology. As CMS gains more

experience with the ASP data, and as more information becomes available, CMS may consider altering the ASP methodology. (OEI-03-05-00310)

Adequacy of Medicare Part B Drug Reimbursement to Physician Practices for the Treatment of Cancer Patients

The MMA established a new methodology for Medicare Part B reimbursement of drugs and biologicals. This report found that physician practices in the specialties of hematology, hematology/oncology, and medical oncology could generally purchase drugs for the treatment of cancer patients at prices below the MMA-established reimbursement rates. This finding was based on a statistical estimate of average prices paid by physician practices for 39 payment codes, constituting more than 94 percent of the $4.5 billion in total 2004 Medicare-allowed amounts for drugs associated with these three specialties. This finding was also based on a statistical estimate of the percentage of months for which physician practices were able to purchase drugs at prices below the reimbursement amounts. Overall, OIG estimated that the average prices paid for drugs associated with 35 of the 39 payment codes were less than the reimbursement amounts.

OIG recommended that Congress consider the results of this review in deliberations about the Medicare Part B reimbursement methodology for drugs for the treatment of cancer patients. CMS stated that the report provided useful information about the payment adequacy for Part B drugs used in cancer treatment. (A-06-05-00024)

Allergen Immunotherapy for Medicare Beneficiaries

OIG found that approximately 62 percent of allergen immunotherapy and related services allowed by Medicare in calendar year (CY) 2001 were not medically necessary (and, therefore, not covered by Medicare), were miscoded, and/or were undocumented. These inappropriately paid services potentially cost the program and its beneficiaries approximately $75 million. Furthermore, approximately 70 percent of Medicare beneficiaries who received allergen immunotherapy in CY 2001 received care at some point during their course of treatment that did not meet professionally recognized standards. Finally, in the absence of national guidance, some carriers have adopted policies that diverge from professionally recognized standards of health care.

To address these issues, OIG recommended that CMS instruct its carriers to educate physicians who provide allergen immunotherapy about existing coverage, coding, and documentation requirements. OIG also recommended that CMS develop national coverage criteria for allergen immunotherapy based on professionally recognized standards of health care. CMS agreed with the recommendations. (OEI-09-00-00531)

Use of Modifier 25

"Modifier 25" is used to allow additional payment for evaluation and management (E/M) services performed by a provider on the same day as a Medicare-covered procedure. Such payments are permissible when the E/M services are significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure. OIG found that 35 percent of claims for E/M services allowed by Medicare in FY 2002 did not meet program requirements, resulting in $538 million in improper payments. Modifier 25 was also used unnecessarily on a

large number of other claims and, although such use may not have led to improper payments, the claims failed to meet program requirements.

OIG recommended that CMS work with Medicare carriers to reduce the number of claims submitted using modifier 25 that do not meet program requirements. OIG also recommended that CMS stress to providers that they must maintain appropriate documentation of both the E/M services and procedures and remind them that modifier 25 should be used only on claims for E/M services. CMS concurred with OIG's recommendations. (OEI-07-03-00470)

Use of Modifier 59 To Bypass National Correct Coding Initiative Edits

"Modifier 59" is a coding modifier used to bypass automated edits in Medicare carriers' claims processing systems. Modifier 59 indicates that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service—so-called code pairs—that normally should not be billed as more than one service.

Based on a review of a sample of code pairs billed with modifier 59 in FY 2003, OIG found that 40 percent of code pairs did not meet program requirements, resulting in an estimated $59 million in improper payments. For 15 percent of these code pairs, the services were not distinct from each other. For 25 percent of these code pairs, the services were not adequately documented. Also, separate analysis of 3.4 million code pairs billed with modifier 59 showed that 11 percent of code pairs were paid when modifier 59 was attached to the incorrect code. This billing error represented $27 million in Medicare paid claims. In addition, OIG found that most carriers did not conduct reviews of modifier 59; those that did found providers who were using modifier 59 inappropriately.

OIG recommended that CMS encourage carriers to conduct prepayment and postpayment reviews of the use of modifier 59 and ensure that carriers' claims processing systems pay claims with modifier 59 only when the modifier is billed with the correct code. CMS concurred with these recommendations. (OEI-03-02-00771)

Billings for Home Health Services

Under the Medicare prospective payment system, home health agencies use a data instrument called the Outcome and Assessment Information Set (OASIS) to measure the care that each beneficiary needs over a 60-day service period known as an episode. One item on the OASIS requires home health agencies to identify all facilities that discharged the beneficiary in the 14 days preceding the home health episode. Medicare pays more for an episode preceded only by a discharge from a postacute care facility (a skilled nursing or rehabilitation facility) than for the same episode preceded by discharges from both an acute care hospital and a postacute care facility.

This review found that home health agencies did not comply with Medicare requirements in billing for services that were preceded within 14 days by discharges from both an acute care hospital and a postacute care facility. Specifically, the agencies improperly coded all 400 sampled claims as discharges from a postacute care facility only, rather than discharges from both an acute care hospital and a postacute care facility. The

overpayments occurred because home health agencies had not established the controls necessary to identify on the OASIS all facilities that discharged the beneficiary in the 14 days before the home health episode. In addition, during the audit period, Medicare had not established sufficient controls to prevent or detect overpayments and initiate recovery. As a result, OIG estimated that Medicare overpaid home health agencies approximately $48.1 million during FYs 2002 and 2003.

OIG recommended that CMS (1) instruct its contractors to recover the overpayments; (2) emphasize to home health agencies the need to educate their staffs regarding the identification on the OASIS of all facilities that discharged the beneficiary within 14 days of the home health episode; (3) monitor the effectiveness of newly established prepayment edits and postpayment controls; and (4) develop data analysis techniques to identify home health agencies with significant numbers of claims rejected or adjusted by the new payment controls, and then to subject those agencies to corrective action. CMS concurred with the recommendations. (A-01-04-00527)

Fiscal Year 2005 Hospital Payment Monitoring Program

CMS developed the Hospital Payment Monitoring Program (HPMP) to establish the Medicare fee-for-service paid claims error rate for inpatient hospital services. Several CMS contractors operate the HPMP and conduct admission-necessity screenings, diagnosis-related group (DRG) validations, and quality control reviews under contracts with CMS.

For FY 2005, CMS generally ensured that its HPMP contractors had appropriate controls to ensure that admission-necessity and DRG validation screenings and quality control reviews followed established procedures and operated effectively. However, CMS and its contractors incorrectly sampled long term care hospital claims and did not complete the follow-up process for obtaining medical records. In addition, CMS did not ensure that an HPMP contractor used CMS's software to calculate error amounts and, during the audit period, did not calculate and report certain error amounts.

OIG recommended that CMS direct its HPMP contractors to select a long term care hospital sample in accordance with established criteria, use the CMS software to reprice certain error amounts, and include all error amounts in future error rate calculations. CMS said that it would consider incorporating the CMS software into the HPMP process and agreed to implement the other recommendations. (A-03-05-00007)

Fiscal Year 2005 Comprehensive Error Rate Testing Program

CMS developed the Comprehensive Error Rate Testing (CERT) program to establish the Medicare fee-for-service paid claims error rate for all types of services other than inpatient hospital services. In this evaluation of the FY 2005 CERT program, OIG found that CMS and the CERT contractor generally had in place appropriate controls to ensure that the contractor made medical review decisions in accordance with established procedures and that it adequately maintained, updated, and reported the results of those reviews. The CERT contractor had also implemented previous OIG recommendations to improve the completeness of quality assurance reviews. Finally, OIG found that CMS could do more to ensure consistency and coordination of the error rate programs.

OIG recommended that CMS work to establish CERT and HPMP sample periods that are more consistent with each other and more closely aligned with the FY. OIG also recommended that CMS consider centralizing the management of the error rate programs under a single office for consistency in methodology and uniformity in reporting. CMS concurred with OIG's recommendations. (A-03-05-00006)

Hospital Wage Data Used To Calculate Inpatient Prospective Payment System Wage Indexes

Under the acute care inpatient prospective payment system, the Medicare base rate paid to hospitals includes a labor-related share. CMS adjusts the labor-related share by the wage index applicable to the metropolitan statistical area in which each hospital is located. The wage index values are based on data on hospitals' Medicare cost reports.

OIG determined that a hospital in Connecticut did not fully comply with Medicare requirements for reporting wage data. Specifically, the hospital's FY 2003 Medicare cost report overstated wage data by approximately $2 million and 23,221 hours. If the hospital does not revise the wage data, the FY 2007 Connecticut rural wage index will be inflated, which will result in overpayments to the hospital and the 14 other hospitals that use this wage index.

The hospital concurred with OIG's recommendations to submit a revised FY 2003 cost report and ensure that the wage data reported on future cost reports comply with Medicare requirements. (A-01-05-00506)

Compliance With the Interrupted Stay Provision of the Inpatient Rehabilitation Facility Prospective Payment System

OIG found that inpatient rehabilitation facilities (IRFs) did not always bill claims in compliance with Medicare prospective payment system regulations for interrupted stays. Specifically, during calendar years 2002 and 2003, Medicare made net overpayments of $5.9 million to 589 IRFs for interrupted stays billed as 2 or more claims.

OIG recommended that CMS (1) direct its fiscal intermediaries to recover the $5.9 million in net overpayments identified in the review; (2) use the results of this review to clarify guidance to IRFs regarding the correct billing of interrupted stays; (3) strengthen its system edit to detect all interrupted stays incorrectly billed as two or more claims and prevent associated payments; and (4) instruct its fiscal intermediaries to conduct matches similar to the one that OIG conducted to identify additional payment errors for claims after December 31, 2003.

CMS agreed with OIG's recommendations to recover the overpayments and clarify guidance to the IRFs and stated that it had already implemented the recommended edit. CMS did not agree to instruct its fiscal intermediaries to conduct matches for payment errors that occurred between January 1, 2004, and the date the edit was implemented. (A-01-04-00525)

Graduate Medical Education for Dental Residents

The Medicare program makes payments to teaching hospitals to support graduate medical education (GME) programs for physicians and other practitioners. The payments, which cover both direct and indirect GME, are based in part on the number of full-time equivalent (FTE) residents that the hospitals train. The Balanced Budget Act of 1997 permitted hospitals to count dental residents who train in nonhospital settings in their calculations of indirect, in addition to direct, GME payments. OIG reviewed hospitals in several States to determine whether they included the appropriate number of dental residents in their FTE counts when computing Medicare GME payments.

■ **Connecticut**–A hospital in Connecticut appropriately included dental residents in the FTE counts it used to compute FYs 2000 through 2002 GME payments. The hospital's controls over the accumulation and computation of dental FTEs appeared to be adequate. Therefore, OIG did not make any recommendations to the hospital. (A-04-04-06010)

■ **Iowa**–A hospital in Iowa generally included the appropriate number of dental residents in its FTE counts used to compute FYs 2001 and 2002 GME payments. However, the hospital claimed classroom time for residents working in nonhospital settings. OIG recommended that the hospital work with CMS to resolve about $338,000 associated with classroom time. The hospital disagreed, saying that the classroom time was allowable. (A-04-04-06011)

■ **Kentucky**–A hospital in Kentucky appropriately included dental residents in the FTE counts it used to compute FYs 2000 and 2001 GME payments. However, in FY 2002, the hospital inappropriately included a dental resident who did not meet the requirements for graduates of foreign dental schools. As a result, the hospital overstated its GME claims by about $16,000. In addition, the hospital claimed classroom time for residents working in nonhospital settings. OIG recommended that the hospital make a financial adjustment for the foreign graduate, establish procedures for FTE counts for foreign graduates, and work with CMS to resolve about $140,000 associated with classroom time. The hospital generally agreed. (A-04-04-06005)

■ **Massachusett**s–A hospital in Massachusetts inappropriately included some dental residents in the FTE counts used to compute FYs 2001 and 2002 GME payments. Contrary to Federal regulations, the hospital included the residents without incurring all of their training costs in nonhospital settings. As a result, the hospital overstated its GME claims by $4.9 million. OIG recommended that the hospital refund the $4.9 million, ensure that FTEs for residents in nonhospital settings include only those for which the hospital has incurred all or substantially all of the training costs, and refund any overpayments after FY 2002. The hospital generally disagreed. (A-04-04-06003)

■ **Pennsylvania**–A hospital in Pennsylvania generally included the appropriate number of dental residents in the FTE counts it used to compute FYs 2001 and 2002 GME payments. However, the hospital claimed classroom time for residents working in nonhospital settings. OIG recommended that the hospital work with CMS to resolve about $580,000 associated with classroom time. The hospital agreed to do so. (A-04-04-06002)

Medicare Payments for Ambulance Transports

Medicare covers and pays for emergency and nonemergency ambulance transports when a beneficiary's medical condition, at the time of transport, is such that other means of transportation—such as taxi, private car, wheelchair van, or other type of vehicle—would be contraindicated.

OIG found that 25 percent of ambulance transports in calendar year 2002 did not meet Medicare program requirements, resulting in an estimated $402 million in improper payments. Despite previous OIG reports indicating that transports for dialysis treatment and other nonemergency transports were vulnerable to abuse, the error rates for these kinds of transports continued to be high. Contractor safeguards were found to be insufficient to identify and prevent improper payments for ambulance transports. Contractors used few ambulance-specific prepayment edits consistently and fewer than half of the contractors conducted postpayment reviews of ambulance claims. When reviews were conducted, there was no uniform requirement regarding what documentation should be reviewed. Even though almost two-thirds of the coverage errors involved transport from a dialysis facility, hospital, or other third-party provider, those providers received little education regarding Medicare's coverage requirements for ambulance transports.

In this report, OIG recommended that CMS implement program integrity activities designed to reduce improper payments for ambulance transports at greatest risk for error. The following measures should be included in these activities: (1) instruct all Medicare contractors to implement prepayment edits that target dialysis and nonemergency ambulance transport claims; (2) instruct all Medicare contractors conducting postpayment medical reviews to obtain documentation from ambulance suppliers and third-party providers so as to determine that ambulance transports meet program requirements; and (3) direct all Medicare contractors to educate third-party providers responsible for initiating ambulance transports. CMS generally concurred with the recommendations. (OEI-05-02-00590)

Billings for Ambulance Services

Under the prospective payment system for acute care hospitals, suppliers that render Medicare Part B ambulance services during inpatient stays are required to bill the hospitals, not the carriers, for those services. Medicare carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients.

OIG found that during calendar years 2001 through 2003, carriers inappropriately made Part B payments for 203,377 ambulance services provided to hospital inpatients. Rather than billing the hospitals for services, ambulance suppliers billed the carriers and received separate payments. As a result, Medicare potentially overpaid $21.7 million by paying twice: once to the hospital as part of the prospective payment and again to the ambulance supplier under Part B. Furthermore, the Medicaid program, beneficiaries, or their supplemental insurers could have paid more than $6.2 million in coinsurance and deductibles related to these potential overpayments.

OIG recommended that CMS instruct the carriers to recover the $21.7 million in potential overpayments, establish prepayment controls to detect and prevent such improper payments or postpayment review procedures to identify noncompliant providers, and alert the carriers to the most common types of payment errors and help them to educate ambulance suppliers about such improper billings. CMS agreed with the recommendations. (A-01-04-00513)

A Review of Nursing Facility Resource Utilization Groups

In this report, OIG described the extent to which Resource Utilization Groups (RUGs) on claims submitted by nursing facilities differ from those generated based on evidence in the rest of the medical record. Medicare pays for Part A skilled nursing facility stays using a prospective payment system that classifies residents into RUGs that each are weighted differently resulting in varying Medicare payment rates. Skilled nursing facilities determine a resident's RUG based on an assessment of the resident. This report was based on an independent review of the medical records for 272 skilled nursing facility claims. When reviewers found that a particular resident assessment item was inconsistent with the rest of the medical record, they recoded that item based on the entire medical record and used this recoded item to generate a new RUG.

OIG found that 26 percent of claims submitted by skilled nursing facilities had a RUG that was different from the one reviewers generated based on evidence in the rest of the medical record. These differences represented a net $542 million in potential Medicare overpayments for fiscal year 2002.

OIG recommended that CMS take steps to ensure that skilled nursing facilities complete the minimum data set (MDS) accurately and assign each resident to the correct RUG. These steps could include (1) continuing the type of analysis conducted by the Data Assessment and Verification project and (2) more carefully examining the 11 MDS items that OIG found were most often inconsistent with the rest of the medical record. CMS concurred with the recommendation. (OEI-02-02-00830)

Community Mental Health Center Payments

A community mental health center (CMHC) may provide a partial hospitalization program, an intensive outpatient program of psychiatric services provided to patients instead of inpatient psychiatric care. Partial hospitalization services are included in the Medicare hospital outpatient prospective payment system.

OIG sampled 100 partial hospitalization claims from a CMHC in Louisiana and found that 51 did not meet Medicare reimbursement requirements, primarily because the services were unnecessary or lacked required documentation. Based on the sample results, OIG estimated that the CMHC received at least $3 million in unallowable payments.

OIG recommended that CMS determine the allowability of the estimated unallowable payments. The CMHC disagreed with the findings. (A-06-04-00076)

Medicare Contractor Pension Costs

Since its inception, Medicare has paid a portion of Medicare contractors' annual contributions to their pension plans. CMS requires that contractors' claims for pension costs comply with the Medicare contracts. This review found that a contractor in Indiana claimed more than $4.8 million of unallowable pension costs for FYs 1991 through 2002.

OIG recommended that the contractor make a financial adjustment and claim future pension costs in accordance with the Medicare contracts. The contractor agreed. (A-07-05-00187)

Dual Eligibles' Transition: Drug Access Under Prescription Drug Plans' Formularies

This study determined the extent to which Medicare prescription drug plan (PDP) formularies include drugs that the "dual eligible population"—beneficiaries of both Medicare and Medicaid—commonly use under Medicaid. On January 1, 2006, outpatient prescription drug coverage for dual eligibles was transferred from Medicaid to Medicare. Differences in coverage of commonly used drugs may present challenges during this transition. OIG identified 200 drugs highly utilized by the dual eligible population in 2005. Of these, 178 drugs are eligible for Part D coverage, and 22 fall into categories that are statutorily excluded from Part D, but which States may opt to cover through their Medicaid programs.

This study found that PDP formularies include an average of 92 percent of the 178 eligible drugs OIG reviewed. Approximately half of these 178 common drugs are covered by all formularies. For the 22 drugs in OIG's review that are excluded from Part D, dual eligibles' access under Medicaid will not change in 45 of the 47 States OIG interviewed. Two States plan to cut Medicaid coverage of some categories of excluded drugs.

Given the variation OIG found in PDP formularies' inclusion of 178 common drugs, as well as the medical and resource challenges faced by this population, dual eligibles may need targeted assistance to navigate the transition from Medicaid to Medicare coverage. CMS and States have undertaken efforts to educate and assist dual eligibles and to incorporate safeguards into the program to ensure access to needed drugs. However, taking advantage of any of the options requires knowledge and proactive effort by beneficiaries and may require additional assistance from CMS and States to ensure a smooth transition. CMS expressed concern with the report's methodologies and scope, but came to conclusions similar to those found in OIG's report. (OEI-05-06-00090)

How Inflated Published Prices Affect Drugs Considered for the Federal Upper Limit List

The Federal upper limit program was established to ensure that the Federal Government acts as a prudent payer by taking advantage of current market prices for multiple-source drugs (i.e., drugs with generic equivalents). The Federal upper limit for a drug is set at 150 percent of the published price for the least costly, therapeutically equivalent product found in national compendia plus a reasonable dispensing fee. The aim of this report was to determine the extent to which the mandated method for calculating Medicaid Federal

upper limit amounts causes qualified products to be excluded from the Federal upper limit list and the potential financial implications of these exclusions for Medicaid.

OIG found that in the first two quarters of 2004, 58 drug products that met all statutory and regulatory requirements were not added to the Federal upper limit list because of inflated published prices. On average, the lowest published prices for these 58 drugs were almost two-and-a-half times the average manufacturer prices (AMP). Given that Federal regulation requires that these "minimum" published prices be multiplied by 150 percent, the difference between Federal upper limit amounts and AMPs has grown even wider. If Medicaid based Federal upper limit amounts on 150 percent of the average AMP—the wholesale price—rather than 150 percent of the lowest published price, the program might have saved approximately $75 million in the first two quarters of 2004, because these excluded drugs would have been added to the Federal upper limit list. These savings would have been in addition to the $650 million per year identified in a previous report that would have been saved based on similar reductions in the Federal upper limit amounts of drugs already included on the list. The report did not include any recommendations for CMS. (OEI-03-05-00350)

Medicaid Disproportionate Share Hospital Payments

States are required to make Medicaid disproportionate share hospital (DSH) payments to hospitals that serve disproportionate numbers of low-income patients with special needs. Section 1923(g) of the Social Security Act (the Act) limits these payments to a hospital's uncompensated care costs, which are the annual costs incurred to provide services to Medicaid and uninsured patients less payments received for those patients. The MMA implemented annual reporting and audit requirements for the DSH program beginning in FY 2004.

In a report summarizing reviews of 10 States' DSH programs, OIG noted that 9 of the 10 States had not complied with the hospital-specific DSH limits imposed by section 1923(g) of the Act. As a result, DSH payments exceeded the hospital-specific limits by approximately $1.6 billion ($902 million Federal share). Of the $902 million Federal share, $679 million resulted from using historical costs rather than actual costs, and $223 million resulted from including unallowable costs in the DSH calculations.

Also, three States required hospitals to return DSH payments totaling approximately $3.6 billion through intergovernmental transfers. The use of such transfers does not further the intended purpose of the DSH program, which is to cover the uncompensated costs of treating Medicaid and uninsured patients at DSH-eligible hospitals.

OIG recommended that CMS ensure that the monetary recommendations to the States are resolved; strengthen its review and approval of State plans to ensure consistency with Federal requirements; use the results of audits conducted under the MMA as part of this review process; and establish regulations requiring States to adjust future DSH payments to actual incurred costs, incorporate these adjustment procedures into their approved State plans, and include only allowable costs as uncompensated care costs in their DSH calculations. CMS agreed with the recommendations. (A-06-03-00031)

Family Planning Service Costs

The Federal Government reimburses the costs of family planning services provided pursuant to Medicaid State plans at an enhanced 90-percent matching rate. These services are intended to prevent or delay pregnancy or to otherwise control family size. In two reviews, OIG found that States did not always comply with Federal requirements for claiming these costs to Medicaid.

■ **Delaware**–OIG could not validate Delaware's family planning service rates, which were based on claims incurred between July 1991 and June 1994, because Delaware did not provide relevant data. Delaware contended that the Federal Government's right to review these data ended in July 2000. Because Delaware could not justify its calculation, it was not entitled to the approximately $2.9 million enhanced Federal share.

OIG recommended that Delaware (1) provide support for family planning service costs claimed between October 2000 and June 2004 or refund the overpayment and (2) work with CMS to determine the amounts claimed for family planning service costs after the audit period, refund the enhanced portion, and discontinue claiming such costs at the enhanced rate until it provides adequate support for its family planning rates. Delaware partially concurred with both recommendations. (A-03-03-00220)

■ **Pennsylvania**–The State calculated its family planning service costs by multiplying a rate, known as the family planning factor, by its managed care capitation payments. The family planning factor represented the ratio of family planning expenditures to total health care expenditures. However, the State incorrectly included family planning service costs for beneficiaries not eligible to enroll in managed care and services that did not qualify as family planning. As a result, Pennsylvania overstated its claim for family planning service costs by more than $44 million. By claiming these costs at the enhanced family planning rate, Pennsylvania received about $15.1 million in unallowable Federal reimbursement.

OIG recommended that Pennsylvania refund the overpayment, use the audited family planning factors for future claims, and refund any associated overpayments. Pennsylvania did not concur with the refund, but it agreed to consider the prospective use of the audited factors. (A-03-03-00214)

Medicaid Upper-Payment-Limit Calculations for Hospitals and Nursing Facilities in Four States

The Federal upper payment limit (UPL) is based on an estimate of the amount that would be paid for Medicaid services under Medicare payment principles. Some States make supplemental payments based on the difference between the regular Medicaid payment and the UPL. States must consider UPL payments and other payments received on behalf of Medicaid and uninsured patients when calculating hospital-specific DSH payment limits.

In this reporting period, OIG issued four reports on UPL calculations for hospitals and nursing facilities:

■ **Alabama**–OIG found that for State FY 2003, Alabama generally calculated the State and non-State government hospital outpatient UPLs in compliance with Federal regulations and its State plan amendment. However, Alabama did not comply with its State plan amendment when calculating the State and non-State government hospital inpatient UPLs, nor did it comply with the revised Federal regulations when calculating the non-State government nursing facility UPL. As a result, Alabama made UPL overpayments of nearly $35.7 million ($25.7 million Federal share). Because Alabama did not include all hospital UPL payments in its calculation of hospital-specific DSH limits, the State also made potential DSH overpayments of $67.5 million (nearly $47.7 million Federal share). The actual DSH limits and associated overpayments cannot be computed until the UPL findings in this report are resolved.

OIG recommended that Alabama (1) refund $25.7 million for UPL overpayments to State and non-State government facilities; (2) work with CMS to resolve potential DSH overpayments currently valued at approximately $47.7 million; and (3) make procedural improvements. The State did not specifically address all of OIG's recommendations. Alabama believed that it had complied with its State plan amendment in the UPL calculations for inpatient hospital services and that it had properly calculated the cost of uncompensated care. (A-04-03-02027)

■ **Indiana**–The State overstated the amounts available for UPL payments to non-State government hospitals for State FYs 2001 and 2002. Indiana overstated those amounts primarily because it included unpaid Medicaid claims (claims that the State had denied as untimely) in its UPL calculations for many of the hospitals. Indiana made unallowable UPL payments to many non-State government hospitals for the 2-year period totaling more than $5.1 million (about $3.2 million Federal share).

OIG recommended that Indiana refund the $3.2 million and revise its UPL methodology to exclude unpaid Medicaid claims from its calculations. The State said that Federal regulations and the State plan supported the inclusion of Medicaid unpaid claims in the UPL calculations. The State also said that it should not be required to refund the Federal share. (A-05-03-00068)

■ **Mississippi**–The State calculated State FYs 2002 and 2003 UPLs for non-State government nursing facilities in accordance with Federal regulations and the approved State plan amendment. However, the State did not comply when calculating the inpatient and outpatient UPLs for private, State, and non-State government hospitals. As a result, Mississippi potentially overstated hospital inpatient UPL payments by about $183 million and hospital outpatient UPL payments by about $41 million.

OIG recommended that Mississippi (1) work with CMS to resolve the potential UPL overpayments of approximately $224 million ($171 million Federal share) for hospital inpatient and outpatient services; (2) implement procedures to ensure that future UPL calculations comply with Federal regulations; and (3) identify and refund any overpayments made subsequent to the audit period. Mississippi said that because of the

Hurricane Katrina disaster, it had asked CMS to waive any requirement for the repayment of potential UPL overpayments. Also, Mississippi said that it had made procedural improvements to ensure that future UPL calculations comply with Federal regulations and that it was not aware of any overpayments made subsequent to the audit period. (A-04-03-02025)

■ **New York**–OIG found that the State calculated the State FY 2003 category-specific UPLs for non-State government hospitals and nursing homes in accordance with Federal and State requirements and properly included DSH payments in the limits. However, contrary to Federal regulations, New York based its State FY 2003 transition period excess payment on estimated, rather than actual, Medicaid payment data from the base year.

OIG recommended that New York refund to the Federal Government $43.3 million in overpayments to non-State government nursing homes for State FYs 2003, 2004, and 2005. In response, State officials did not specifically address OIG's recommendations or the State's use of estimated, rather than actual, Medicaid data in its calculations. The officials took exception to OIG's calculation of the overpayment amount. (A-02-03-01021)

Medicaid Services Delivered in Schools

The Medicaid program allows Medicaid reimbursement for covered health-related services in a school setting. Local education agencies (LEAs) bill the costs for these services to the States, which in turn bill them to Medicaid. OIG examined in two states reimbursement for Medicaid services provided in schools.

■ **Kansas**–This State used bundled payment rates to reimburse LEAs for health-related services if students eligible for Medicaid attended school at least once during the service month. OIG found that Kansas did not reimburse LEAs consistent with the payment rates' design or pursuant to Federal regulations and the State plan. Kansas designed the monthly payment rates to reimburse LEAs for a full year's costs over 9 school months. However, Kansas used the rates to reimburse LEAs for 12 months. As a result, Kansas overstated its Federal claim by $13.9 million for State FYs 1998 through 2003. Pursuant to a May 21, 1999, Dear State Medicaid letter, States are no longer permitted to claim through a bundled rate methodology.

OIG recommended that Kansas refund the overpayment and ensure that future claims comply with Federal regulations and the State plan. Kansas agreed to do so. (A-07-04-01003)

Another review noted that Kansas claimed some costs that were not in accordance with Federal requirements or the State plan. Of 300 sampled claims in 3 districts, 217 were unallowable, and many had incomplete documentation. As a result, the Federal Government overpaid an estimated $5.1 million for FY 2002. Other claims outside the sampled districts may also have been unallowable.

OIG recommended that Kansas refund the overpayment, calculate and refund overpayments from districts outside the sample, provide correct billing instructions, and

ensure that LEAs maintain required documentation. Kansas partly concurred with the recommendations. (A-07-03-00155)

■ **Texas**–OIG found that of 2,175 claims sampled in Texas, 991 did not comply with Federal and State requirements and contained 1,146 errors. The State claimed reimbursement for services that were unallowable because of programmatic deficiencies (accounting for 804 errors) or that were rendered by unqualified Medicaid providers (accounting for 342 errors). OIG estimated that the State agency inappropriately claimed at least $8.7 million in Federal reimbursement during State FY 2000. OIG stated that these errors occurred because the State agency did not adequately monitor the LEAs' claims and issued improper guidance and because the LEAs did not maintain adequate supporting documentation.

OIG recommended that the State refund the overpayment and make several procedural improvements; work with CMS to determine the financial impact to the Federal Government for overpayments made by the State agency for counseling services and make an appropriate refund; review time periods after the OIG audit and make appropriate financial adjustments for unallowable services; routinely monitor claims from LEAs for compliance with Federal and State requirements; direct LEAs to ensure that service providers meet licensing requirements; and issue guidance requiring LEAs to bill only for allowable Medicaid services rendered by qualified Medicaid providers. The State replied that before resolving any issues, it would need to analyze OIG's documentation. (A-06-02-00047)

In another review, OIG reported on school-based administrative costs claimed by a consortium of Texas LEAs. Some of the costs claimed were not reasonable, allowable, or adequately supported. The costs included expenditures for ineligible personnel, operating costs, and overstated costs. In addition, the consortium incorrectly allocated costs and did not offset costs with revenues received from other sources. As a result, an estimated $2.4 million was unallowable.

OIG recommended that the consortium refund the overpayment and improve its procedures. The consortium partly concurred and requested further information on certain findings. (A-06-02-00051)

Determining if Children Classified as SCHIP Medicaid Expansion Meet Eligibility Criteria

OIG assessed whether children classified under Medicaid expansion in the State Children's Health Insurance Program (SCHIP) met State Medicaid-expansion eligibility criteria. To encourage States to expand child health insurance eligibility, the Federal match rate for States' SCHIP expenditures, including Medicaid expansion, is greater than the rate for traditional Medicaid.

Approximately 7 percent of sampled children did not meet States' eligibility criteria, based on a simple random sample of 357 cases from 29 of the 30 States that had expanded their Medicaid programs as of January 1, 2003. For 10 percent of sampled children, States could not support their Medicaid-expansion eligibility determinations.

Two States had difficulty identifying their Medicaid-expansion populations, raising concerns about whether those States claimed the appropriate Federal match rate for some children.

OIG recommended that CMS (1) work with States to improve caseworker performance in making eligibility determinations; (2) work with States to ensure that automated eligibility systems accurately classify children determined eligible under Medicaid-expansion criteria; (3) ensure that State Medicaid programs conduct redeterminations of Medicaid-expansion eligibility, as required; (4) remind States of the requirement to properly maintain case-file documentation; and (5) ensure that all States can accurately identify children determined eligible based on Medicaid-expansion criteria. CMS concurred with these recommendations. (OEI-07-03-00221)

Medicaid Hospital Outlier Payments

Some States make outlier payments to hospitals when the cost of treating a Medicaid inpatient is extraordinarily high compared with the average cost of treating comparable conditions. OIG reported on three States' methods of computing outlier payments.

■ **North Carolina**–North Carolina's formula allowed inpatient hospitals to receive outlier payments for high charges rather than high costs. As a result, outlier payments increased at a significantly faster rate than Medicaid base payments. If the State had modified its outlier payment policy to achieve budget neutrality, it could have saved approximately $89.4 million during the 6-year audit period.

OIG recommended that North Carolina revise its policy to ensure that future outlier payments achieve budget neutrality and more closely monitor the payments. North Carolina disagreed with the recommendations. (A-07-04-04038)

■ **Ohio**–Ohio's computation method did not result in reasonable inpatient cost outlier payments because the State used outdated fixed ratios rather than recent hospital-specific cost-to-charge ratios to convert allowable billed charges to outlier payments. As a result, outlier payments exceeded estimated costs by approximately $24.7 million during the 3-year audit period.

OIG recommended that Ohio work with the State legislature to revise the State's cost outlier payment method. Ohio agreed. (A-05-04-00064)

■ **Pennsylvania**–The State's computation method did not result in reasonable outlier payments because the State used an outdated cost-to-charge ratio. As a result, the payments increased significantly and at a faster rate than other types of Medicaid payments. If Pennsylvania had applied a more current cost-to-charge ratio, it could have saved approximately $11.4 million at three sampled hospitals during the 5-year audit period.

OIG recommended that Pennsylvania monitor and adjust the cost-to-charge ratio as necessary during the year and use the cost-to-charge ratio from the most recent cost

reporting period to adjust payments retroactively. Pennsylvania said that it would evaluate its outlier policy to provide more precise payments. (A-03-04-00211)

Medicaid Provider Overpayments

An overpayment is a payment to a provider in excess of the allowable amount. Federal regulations require that State Medicaid agencies refund the Federal share of overpayments at the end of the 60-day period following discovery, whether or not the State has recovered the overpayment from the provider, unless the provider has filed for bankruptcy or gone out of business. Two OIG reviews focused on whether States reported Medicaid overpayments in accordance with Federal requirements.

■ **Florida**–The State did not report all adjustments of Medicaid provider overpayments to CMS in accordance with Federal requirements between October 1, 2001, and December 31, 2002. Many adjustments were improper or untimely.

OIG recommended that the State refund $14.5 million and improve its procedures and training on relevant Medicaid regulations. The State generally disagreed with OIG's recommendations. (A-04-03-06003)

■ **New Jersey**–The State did not report all overpayments in accordance with Federal requirements as of March 31, 2004. In addition, the State did not return the Federal share of the overpayment interest collected from providers, which it considered State revenue. The State's practices resulted in reporting delays ranging from 90 days to more than 5 years.

OIG recommended that the State refund $6.6 million and ensure that future overpayments are reported in accordance with Federal requirements. The State did not directly address OIG's recommendations. (A-02-04-01009)

State Fees for Nurse Aide Registration

Federal law prohibits States from imposing on individuals listed in a State's Nurse Aide Registry any charges related to registration. This study found that 24 States imposed fees that nurse aides may be required to pay for initial or continued placement on nurse aide registries. Of these 24 States, 20 States listed nurse aides as a source of payment for initial placement fees, and 14 States listed nurse aides as a source of payment for continued placement fees on their registries. Four additional States imposed fees on nurse aides as a requirement to work in long term care facilities. Also, CMS provided inconsistent guidance and limited oversight to States regarding registry fees.

This report recommended that CMS (1) ensure that States cease imposing on nurse aides fees that violate Federal statute; (2) clarify prohibitions on the charging of fees related to nurse aide registries; and (3) conduct appropriate oversight to stop States from charging inappropriate fees. CMS concurred with all OIG recommendations. (OEI-07-05-00070)

CMS Financial Statement Audit

The CMS FY 2005 financial statements received an unqualified audit opinion, which means that the statements were fairly presented in accordance with generally accepted

accounting principles. However, auditors identified a material weakness in CMS's managed care benefits payment cycle. (A-17-05-02005)

Outreach

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

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, issues advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Federal 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. For the period October 1, 2005, through March 31, 2006, OIG received 33 advisory opinion requests and issued 4 advisory opinions.

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-disclosure, entitled "Provider Self-Disclosure Protocol," available on the Internet at http://oig.hhs.gov in the "Fraud Prevention & Detection" section.

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 295 submissions. Self-disclosure cases have resulted in 60 recoveries and 63 settlements, totaling $104.2 million collectively in HHS receivables. For example:

■ **Delaware**–Following a voluntary self-disclosure filed pursuant to OIG's Provider Self-Disclosure Protocol, Delaware Bay Surgical Service, P.A., and a physician agreed to pay the Government $881,000 and enter into a comprehensive 3-year Integrity Agreement. The settlement agreement resolved their liability for allegedly submitting improper claims, i.e., billing Medicare for both the professional and technical components of vascular studies when only the professional component was performed, between 1995 and January 2001.

■ **Virginia**–Following a voluntary self-disclosure filed pursuant to OIG's Provider Self-Disclosure Protocol, Inova Health Care Services, doing business as Inova Fair Oaks Hospital, agreed to pay the Government more than $713,000 and enter into a comprehensive 3-year Certification of Compliance Agreement. The settlement agreement resolved its liability for allegedly subleasing space in one of the hospital's medical office buildings to physician subtenants at rental rates significantly below the fair market value of the spaces the physicians occupied between 1998 and 2004, in potential violation of the Stark law and anti-kickback statute.

Federal and State Partnership: Joint Audits of Medicaid

Another major OIG outreach initiative has been to work more closely with State auditors in reviewing the Medicaid program. To this end, a partnership plan was developed to foster 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 identification of more than $262 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 1,560 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 1,540 individuals and entities from participating in Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. Examples include the following:

■ **Florida**–OIG excluded South Beach Community Hospital (formerly South Shore Hospital and Medical Center) from participation in Medicare, Medicaid, and other Federal health care programs. The exclusion resulted from South Beach's material breach of the terms of a CIA the hospital negotiated with OIG in 2002 as part of the resolution of a False Claims Act case against the hospital. OIG determined that South Beach was in material breach for its repeated failure to submit timely, complete, and accurate required reports, and its failure to implement fully the Independent Review Organization requirements of the CIA. South Beach also neglected to notify OIG, as required under the CIA, of its sale to new owners, who are also subject to the terms of the CIA. OIG determined that South Beach's "repeated and egregious failure in this case to abide by the terms of its CIA [required the] OIG for the first time to seek exclusion for such a violation."

■ **Colorado**–A registered nurse was excluded for a minimum of 60 years based on her conviction for deliberately and intentionally causing the death of a home health patient under her care, and for using the victim's credit card to obtain cash and make purchases. The registered nurse was ordered to serve a life sentence without parole for first-degree homicide. In addition, she was sentenced to 30 years for aggravated robbery against an at-risk adult, 6 years for theft, and 3 years for unauthorized use of a credit card.

■ **Illinois**–A laboratory owner was excluded for a minimum of 30 years based on his conviction for knowingly directing his employees to submit claims for laboratory tests that were not actually conducted, or that otherwise did not qualify for payment from health care benefit programs, including Medicare and Medicaid. The owner was sentenced to 5 years in jail and ordered to pay $2.5 million in restitution for mail fraud.

■ **Maryland**–A psychiatrist was excluded for a minimum of 25 years for his conviction related to a health care fraud scheme. The psychiatrist caused an estimated loss of $1.7 million to the Medicaid program. He was sentenced to 18 months home detention and ordered to pay $305,000 in restitution.

■ **New York**–A clinic owner/operator was excluded for a minimum of 15 years as a result of his conviction for filing false claims to the Medicaid program. The subject was already excluded based on a previous conviction for conspiracy to commit health care fraud involving private health insurers. The owner/operator was sentenced to 1 year in jail and ordered to pay $245,000 in restitution.

Also in New York, a pediatrician was excluded for an indefinite period. The pediatrician surrendered his New York license after he was convicted for possession of child pornography.

Civil Monetary Penalties

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits claims to a Federal health care program that the person knows or should know are false or fraudulent. Among the Civil Monetary Penalties actions resolved during this reporting period were:

■ **New Jersey–**University of Medicine and Dentistry of New Jersey (UMDNJ) agreed to pay $2 million and enter into an Annual Certification Agreement to resolve its liability under the CMPL for two cases in which UMDNJ billed for services provided by excluded individuals. In the first case, OIG alleged that from November 1999 through October 2000, UMDNJ knowingly presented claims to Medicare for payment of medical items or services that were provided by a cardiac surgeon who had been excluded from participation in Federal health care programs in July 1997. The cardiac surgeon did not know that he had been excluded because he left the country in 1997. OIG's evidence against UMDNJ demonstrated that UMDNJ knew or should have known that the surgeon was an excluded individual based on the results of UMDNJ's two inquiries to the National Practitioner Data Bank in September 1999 and April 2000. Both reports specifically stated that the surgeon was excluded. In the second case, OIG alleged that

from 1985 through 2000, UMDNJ presented claims for reimbursement to Medicare and to the New Jersey Medicaid program for prescriptions that were dispensed and supervised by a pharmacist who had also been excluded from participation in Federal health care programs.

■ **Wyoming**–Interim HealthCare of Wyoming, Inc. (Interim HealthCare), Interim HealthCare of Southern Wyoming, Inc., and the home health agencies' owner (collectively, Interim) agreed to pay $250,000 to resolve allegations that Interim violated the CMPL by submitting claims for Medicare services that were not provided as claimed and/or were false or fraudulent. In addition, Interim HealthCare and its owner agreed to enter into 5-year Corporate and Individual Integrity Agreements. Specifically, Interim and its former co-owner/chief financial officer (CFO) allegedly claimed his salary as CFO in cost reports for fiscal years 1994 through 1998, when at the time he was otherwise employed full time. The settlement also resolved allegations that between January 1999 and December 2000, Interim submitted claims for medical services that were false or fraudulent, or not medically necessary. In a separate settlement agreement with OIG, the former CFO agreed to pay $20,000 and to be permanently excluded.

■ **Iowa**–A chiropractor agreed to pay $48,000 to resolve his liability under the CMPL for allegedly submitting claims for chiropractic services that were not provided as claimed and/or were false or fraudulent. OIG alleged that between August 2000 and November 2004, the chiropractor submitted claims for chiropractic services consisting of the manual manipulation of the spine to treat subluxations. However, his documentation allegedly did not support the existence of subluxations that required treatment, nor did it establish that he actually performed services for which he billed. As part of the settlement agreement, he agreed to a 7-year exclusion.

Patient Dumping

Of the total civil monetary penalties OIG collected in the semiannual period ending March 31, 2006, $345,000 represents collections from 12 hospitals and 1 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:

■ **California**–Queen of the Valley Hospital agreed to pay $80,000 to resolve its liability. OIG alleged that the hospital failed to accept transfer of a critical patient who needed the specialized capabilities of the hospital's intensive care unit and also failed to provide a medical screening exam to a pregnant woman who presented to its maternity ward.

■ **Missouri**–Poplar Bluff Regional Medical Center, formerly Three Rivers Healthcare, Inc., agreed to pay $60,000 to resolve its liability. OIG alleged that the hospital failed to provide appropriate medical screening examinations or stabilizing treatment to several patients who presented to the hospital's emergency department requesting evaluation and treatment for several potentially serious medical conditions.

■ **Florida**–Englewood Community Hospital agreed to pay $38,000 to resolve its liability. OIG alleged that the hospital refused to provide an appropriate medical screening

examination and stabilizing treatment to a known patient with a psychiatric history who presented by ambulance seeking help for a medical condition.

■ **Illinois**–Pekin Memorial Hospital agreed to pay $35,000 to resolve its liability. OIG alleged that the hospital failed to provide appropriate screening, stabilizing treatment, and/or appropriate transfer to a pregnant patient, who presented for an evaluation of the progress of her labor, and to a teenager exhibiting symptoms of mental illness who sought help for chemical dependency.

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 Federal Bureau of Investigation, Medicaid Fraud Control Units (MFCUs), and a variety of other law enforcement agencies.

OIG has the responsibility of assisting 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 to be permitted to continue participation in Medicare, Medicaid, and other Federal health care programs. These agreements are monitored by OIG and require the providers to enhance existing compliance programs or establish new ones. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent activities.

In the semiannual period ending March 31, 2006, the Government's enforcement efforts resulted in $544 million in HHS investigative receivables, representing civil and administrative settlements or civil judgments related to Medicare, Medicaid, and other Federal health care programs. Some of these successful actions, 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**–Serono Laboratories, Inc., along with its Swiss parent Serono, S.A., entered into a civil False Claims Act settlement with the Government totaling $567 million. The civil settlement was part of a global criminal, civil, and administrative settlement relating to Serono's promotion of Serostim, a drug used to treat AIDS-wasting syndrome, a condition involving profound involuntary weight loss in AIDS patients. Serono Laboratories, Inc., a subsidiary of Serono Holdings, Inc., pled guilty in December 2005 to two criminal conspiracy charges. One relates to the illegal promotion of Serostim for non-FDA approved indications through the use of an adulterated misbranded medical device and related software. The second charge relates to the payment of

kickbacks to physicians in order to induce them to prescribe Serostim. The kickbacks took the form of an all-expense-paid trip to an HIV conference held in Cannes, France, in 1999. The guilty plea was accepted, and Serono Laboratories, Inc., was ordered to pay a $136.9-million criminal fine. Including interest, the total resolution for this case was more than $716 million. Through the settlement, the Medicaid program will recover all monies paid for Serostim during the time period 1996 through 2004.

As a result of its criminal conviction, Serono Laboratories, Inc., will be excluded from all Federal health care programs for at least 5 years. In addition, Serono Holdings, Inc., the U.S. parent of Serono Laboratories, Inc., agreed to enter into a comprehensive 5-year Corporate Integrity Agreement (CIA) that will cover Serono Laboratories, Inc., and all other U.S. subsidiaries of Serono Holdings, Inc. The CIA contains several unique provisions, including provisions focusing on Serono's sponsorship of continuing medical education and provisions relating to off-label promotion issues.

Also in Massachusetts, SmithKline Beecham Corporation, doing business as GlaxoSmithKline, agreed to pay the Government $149 million plus interest to resolve its liability associated with certain pricing and marketing practices for Zofran and Kytril, two antiemetic drugs used primarily in conjunction with oncology and radiation treatment to prevent nausea. The Government alleged that during different times between 1994 and 2002, GlaxoSmithKline engaged in a scheme to set and maintain fraudulent and inflated prices for the drugs knowing that Federal health care programs established reimbursement rates based on those prices. The inflated prices were substantially higher than the prices paid by the majority of GlaxoSmithKline's customers, and the company is alleged to have used the spread between the inflated prices and actual acquisition costs in marketing and selling the drugs to customers, causing the customers to submit false and fraudulent claims. The Government also alleged that, with regard to Kytril, GlaxoSmithKline engaged in a scheme to encourage customers to pool leftover product from multiple vials of Kytril to create an extra dose of the drug. The extra doses were then allegedly administered to patients and rebilled to Federal health care programs. As part of the settlement, GlaxoSmithKline agreed to enter into a 5-year addendum to its existing CIA with OIG.

Hospitals

■ **Illinois**–Rush University Medical Center agreed to pay $1 million to settle allegations that it filed false claims between September 1997 and September 2003. In July 2003, Rush voluntarily disclosed that it received overpayments related to billings for Medicare and Medicaid patients enrolled in clinical cancer treatment trials conducted by its Division of Hematology and Oncology. To correct billing issues related to clinical trials, Rush has taken extensive actions, including the establishment of a clearinghouse to oversee all clinical trial billings. In exchange for a release from OIG's permissive exclusion authority, Rush entered into a 3-year Certification of Compliance Agreement.

Durable Medical Equipment Supplier

■ **Texas**–A durable medical equipment company owner was ordered to pay $546,000 in restitution. The company billed Medicare for power wheelchairs provided to beneficiaries who either did not receive a power wheelchair or for whom a power wheelchair was not medically necessary.

Ambulance Company

■ **South Dakota**–Sioux Falls Ambulance, Inc., agreed to pay the Government $500,000 and entered into a 5-year Corporate Integrity Agreement to resolve its liability for submitting improper claims to Medicare and TRICARE. The Government alleged that from April 1996 through December 2000 the ambulance provider submitted claims for emergency ambulance services that should have been billed as nonemergency ambulance services.

Practitioners

■ **West Virginia**–An osteopathic physician agreed to pay the Government $311,000 and to be excluded from all Federal health care programs for 10 years. Between May 1998 and June 2004, the osteopath allegedly submitted improper claims to Medicare and Medicaid for office visits for established patients, debridements, and new patient office visits that were not supported in the patients' records.

■ **Maine**–A physician agreed to pay the Government $203,000 to settle allegations that he violated the physician self-referral (Stark) prohibition. Between 1999 and 2004, he allegedly referred Medicare patients to an oxygen supply company he owned at the time. In addition, the settlement requires the physician, who will be working outside the United States, to submit an Annual Certification for 3 years, attesting that he has no involvement in the billing or coding of claims submitted to Federal health care programs, and that he is not receiving reimbursement for treating Federal health care program beneficiaries.

Nursing Homes

■ **Illinois**–The owner of a company that employed nurses and nurse practitioners to treat wounds of nursing home patients was sentenced to 1 year and 1 day in prison, and ordered to pay a total of $187,000 in restitution for health care fraud and bank fraud. The owner billed for nursing home patients' wound care services under a physician's provider number without the physician's knowledge or consent. He billed as if the physician performed the services when nurses and nurse practitioners actually performed them. In addition, he provided false information on a bank loan that he had secured for his company.

Medicaid Fraud Control Units

Currently, 48 States and the District of Columbia have MFCUs, which investigate and prosecute, or refer for prosecution, providers charged with defrauding the Medicaid program or abusing, neglecting, or financially exploiting beneficiaries in Medicaid-

sponsored facilities. In FY 2005, OIG provided oversight for and administration of approximately $149 million in Federal grant funds to the units.

Examples of cases worked jointly by OIG with MFCUs during this semiannual period include:

■ **Maryland**–The founder and owner of a company that provided nutritional counseling to high risk pregnant women and the person in charge of billing pled guilty to Medicaid fraud. Both were given a 5-year suspended sentence and paid a total of $412,000 in restitution and penalties. The two billed Medicaid for prenatal nutritional counseling not provided. This investigation involved OIG and the Maryland MFCU.

■ **Oregon**–A podiatrist agreed to pay the Government $150,000 for allegedly submitting false claims to Medicare and Medicaid from January 1998 to September 2003 for podiatric services that misrepresented the beneficiaries' medical conditions. Specifically, the Government alleged that in order to support his improper billings for nail debridements, the podiatrist falsified his medical records to reflect diagnoses of fungal infections and patient complaints of pain. As part of the settlement, the podiatrist agreed to be excluded from participation in Federal health care programs for 5 years. Prior to the settlement, he was convicted of making false statements related to health care matters for the same conduct and was ordered to pay a fine and special assessment totaling $1,700. This investigation involved OIG, the Oregon MFCU, and the FBI.

■ **Indiana**–The former director of eight drug and alcohol rehabilitation clinics was sentenced to 14 months imprisonment for health care fraud (to run concurrently with the State sentence he received) and ordered to pay $118,000 in restitution. He must also forfeit monies totaling approximately $132,000 and property valued at approximately $165,000. The director billed the Indiana Medicaid program for psychotherapy services he did not provide. This investigation involved OIG and the Indiana MFCU.

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 health of the American people. Public health 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.

Public Health Agency-Related Reports

HHS Agencies' Compliance With the National Practitioner Data Bank Malpractice Reporting Policy

The National Practitioner Data Bank (NPDB) maintains a listing of medical malpractice cases and makes the information available to hospitals, licensure boards, and other designated health care organizations. HHS agencies are required to report medical malpractice cases to the data bank. Failure to report such cases to the NPDB deprives health care organizations, such as hospitals and State licensure boards, of potentially useful information for their credentialing and regulatory activities, respectively.

OIG found that three HHS agencies—the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Indian Health Service (IHS)—underreported as many as 474 medical malpractice cases to the NPDB. Individual agency underreporting was as follows: IHS, 290 cases; HRSA, 179 cases; and NIH, 5 cases. This departmentwide underreporting was caused by a number of factors, including lost medical malpractice files; incomplete information in medical malpractice files; a 1998 decision by the HHS peer review entity, the Quality Review Panel, to not identify practitioners who meet the standard of care; and the failure to replace a key Program Support Center claims official or to reassign his NPDB reporting duties.

OIG recommended that HRSA, IHS, and NIH each take steps to (1) implement a corrective action process that would address the unreported cases, (2) improve internal controls involving case files management, and (3) assign staff to assume responsibility for addressing practitioner questions/complaints and data entry of reports to the NPDB. In response to the report, the Secretary indicated that the Department is working to develop a final action plan, including policy decisions relating to future reporting. The response noted that revised procedures have been implemented to track new reports of malpractice payments to help prevent future backlogs. The reply also stated that recommendations would be made to the Secretary to ensure greater compliance in the future. IHS responded that it is addressing the issues and recommendations identified in the report. (OEI-12-04-00310)

Use of Departmental Alert List by CDC

The Alert List is a tool used by an awarding HHS agency to safeguard Department funds by alerting other agencies to a particular grantee's potential risks, such as the grantee's financial instability or inadequate management systems.

An OIG study found that CDC did not consistently follow Alert List policies. In particular, CDC did not always place grantees on the Alert List, check the Alert List prior to award and document when a grantee was found on the Alert List, consult with the agency that placed the grantee on the Alert List, complete certain monitoring activities when attaching a special award condition to a grant, or provide justification for retaining grantees on the Alert List after 2 years. OIG also found that competing priorities, misunderstandings, and concerns about several aspects of the Alert List may explain why grants officers are not following Alert List policies.

OIG recommended that CDC ensure that grants officers follow Alert List policies, develop methods to ensure accountability to Alert List policies, and improve file maintenance to meet third-party review policies. The CDC took no exception to the report. (OEI-02-03-00010)

National Institute of Environmental Health Sciences Superfund

The National Institute of Environmental Health Sciences receives Superfund money to carry out training and research functions mandated by the Comprehensive Environmental Response, Compensation, and Liability Act. Pursuant to the Act, OIG audited the Institute's Superfund obligations and disbursements for FY 2004. The audit determined that these funds were administered in accordance with applicable laws and regulations. (A-04-05-01019)

Ryan White Title II Funds in Puerto Rico

Pursuant to Title II of the Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act), HRSA makes grants to States and territories to fund comprehensive treatment services and drug therapies for people with HIV/AIDS. The CARE Act Title II program is the payer of last resort for people with no or limited health care coverage.

This review found that Puerto Rico claimed unallowable Title II costs, did not have procedures to ensure that the program was the payer of last resort, and did not always purchase drugs at the lowest prices available. These deficiencies resulted in $2.7 million in unallowable claims and excessive drug payments.

OIG recommended that Puerto Rico refund the overpayments and make procedural changes to comply with Federal requirements. Puerto Rico neither concurred nor nonconcurred with the recommendations. (A-02-03-02002)

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 some 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 period covered by this report, 34 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of default may enter into settlement agreements, whereby the 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 1,989 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 50 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 $141.9 million. Of that amount, $3.3 million is attributable to this reporting period.

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

- A Pennsylvania physician–$165,000
- A Texas podiatrist–$164,000
- A Minnesota psychologist–$122,000
- A Michigan podiatrist–$96,000

Public Health-Related Investigations

OIG also investigates cases involving the misuse of public health agency funds and threats to public health and safety, such as the improper use of select agents.

The following are examples of cases involving improper use of HHS grant funds resolved during this reporting period:

- **Massachusetts**–The National Coalition of Advocates for Students (NCAS) agreed to pay the Government $100,000 to settle allegations that it improperly used CDC grant funds. In 2001, CDC awarded NCAS a 5-year grant to provide HIV education to migrant youths. NCAS, acting through an employee, allegedly misused the funds by charging inappropriate expenses to the grant, including certain entertainment and travel expenses. NCAS is no longer in business.

- **Utah**–A pediatrician who operated an immunization program utilizing Federal Vaccines for Children program funds agreed to pay the Government $65,000. The pediatrician allegedly administered 3,851 vaccine doses to children who were not eligible to receive the free immunizations. He also allegedly administered expired vaccines to children in at least two cases.

With regard to investigating the improper use of select agents, Section 201 of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Section 351A(a) of the Public Health Service Act, 42 U.S.C. § 262a(a), grants the Secretary authority to establish and maintain a list of each biological agent and toxin that has the potential to pose a severe threat to public health and safety. Section 351A(i) of the Public

Health Service Act, 42 U.S.C. § 262a(i), permits the imposition of civil monetary penalties on individuals or entities for failure to abide by regulations pertaining to the transfer, use, and possession of those agents and toxins (Select Agent regulations) promulgated by the Secretary, set forth in 42 C.F.R. part 73.

The following case resolved in this reporting period involved the improper use of select agents:

■ **Maryland**–An entity agreed to pay $150,000 to settle allegations that it violated the Select Agent regulations by making an unauthorized transfer of a select agent to an unregistered research facility. OIG alleged that in March 2004 the entity shipped the select agent to a research facility that was not registered with CDC to possess the select agent. In addition, OIG alleged that the entity never obtained authorization from CDC to ship the select agent to the research facility.

Administration for Children and Families and Administration 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 these programs to focus on ways to increase the efficient use of program dollars; to implement programs more effectively; 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. Over the years, 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.

Administration for Children and Families-Related Reports

State Standards and Capacity To Track Frequency of Caseworker Visits With Children in Foster Care

A critical element in maintaining the safety and well-being of children in foster care is face-to-face visits with caseworkers. There is no Federal requirement regarding how often children in foster care are visited by caseworkers. However, the Administration for Children and Families (ACF) reviews caseworker visits as part of its Child and Family Service Reviews (CFSRs).

The objectives of this evaluation were to determine (1) whether States have implemented written standards for frequency of caseworker visits with children in foster care, (2) the extent to which States could generate statewide automated reports reflecting the frequency of caseworker visits, and (3) the extent to which statewide reports indicate that children were visited. Forty-three States had written standards calling for caseworkers to visit children in foster care at least monthly. Fifty of fifty-one States (including the District of Columbia) had statewide minimum standards regarding the frequency of caseworker visits covering the majority of children in foster care placed in-State. Twenty States demonstrated their ability to produce statewide reports detailing the extent to which visits occurred during fiscal year (FY) 2003. Seven of the twenty statewide reports indicated on average that fewer than half of children in foster care were visited monthly in FY 2003.

OIG recommended that ACF promote the development of automated systems such as the Statewide Automated Child Welfare Information System and work with States with automated system capacity to record the frequency of caseworker visits to ensure that visitation data are recorded in automated systems. ACF concurred with the report's recommendations. (OEI-04-03-00350)

State Standards and Practices for Content of Caseworker Visits With Children in Foster Care

Caseworker visits are a critical element in maintaining the safety and well-being of children in foster care. There are no Federal requirements regarding specific activities that caseworkers must perform during visits with children in foster care. However, ACF reviews caseworker visits as part of its CFSRs.

The objective of this evaluation was to identify the written standards that States have implemented for the content of caseworker visits with children in foster care and the practices of States without written standards. Forty-one out of fifty-one States (including the District of Columbia) reported having statewide written standards addressing the content of caseworker visits. Thirty-eight of these States had written standards specific to caseworker visits. Three of the forty-one States reported having written documents addressing the content of caseworker visits, but as part of broader program areas such as case planning and family service plans. Ten States did not have written standards, but eight of these States provided information about the content of caseworker visits.

OIG's report provides a national picture of State written standards and practices that could assist ACF as it conducts CFSRs and the States as they consider program enhancements. (OEI-04-03-00351)

Title IV-E Training Costs

Pursuant to Title IV-E of the Social Security Act, the Federal Government shares in the costs of training State caseworkers who service foster and adoptive children meeting Federal eligibility requirements. OIG determined whether two States' claims for Title IV-E administrative and training costs complied with their approved plans for allocating costs between Federal and State programs.

■ **Maryland**–Maryland claimed costs for activities that were not included in its cost allocation plan or that were identified as State-funded activities. As a result, Maryland overstated its Federal claims by $4.3 million during 1999–2001. Maryland later adjusted its claims by about $3.2 million.

OIG recommended that Maryland refund the remaining overpayments and review subsequent claims to identify any further overpayments. Maryland agreed to do so. (A-03-04-00580)

■ **New Hampshire**–Contrary to Federal requirements, New Hampshire did not allocate its training costs between Federal and State programs. As a result, New Hampshire overstated Federal claims by $1.76 million during State FYs 2001 through 2003.

OIG recommended that New Hampshire make a financial adjustment and ensure that it follows allocation requirements in the future. New Hampshire disagreed with the recommendations. (A-01-05-02500)

Undistributable Child Support Collections in Ohio

ACF's Office of Child Support Enforcement (OCSE) requires States to offset Child Support Enforcement program costs by recognizing and reporting program income from undistributable child support collections and interest earned on program funds.

In this report, OIG found that Ohio did not report over $2.8 million ($1.8 million Federal share) in program income for undistributed collections for the quarters that ended December 1998 through September 2004. The State also did not recognize program income of more than $500,000 (over $330,000 Federal share) for unclaimed and undistributable collections that should have been considered abandoned. These deficiencies happened because the State and certain county personnel were unaware of the reporting requirement and because the State did not provide sufficient oversight of county reporting of undistributable collections and county and State recognition of unclaimed collections.

OIG recommended that the State make financial adjustments and strengthen program oversight. The State agreed and said that the proper systems were in place to assist the State and counties in following regulations and OIG's recommendations. (A-05-04-00075)

Administration on Aging-Related Report

Performance Data for the Senior Medicare Patrol Projects: December 2005 Performance Report

The Senior Medicare Patrol Projects receive grants from the Administration on Aging to recruit retired professionals to serve as educators and resources to assist beneficiaries in detecting and reporting fraud, waste, and abuse in the Medicare program. A total of 57 projects operated from January through June 2005. The objectives of this report were to: (1) track performance data, (2) perform comparative data analysis, and (3) verify documentation of overpayments recovered as a result of this project.

The projects educated more than 192,000 beneficiaries in more than 64,000 group training sessions, and documented $83,200 returned to the Medicare program. The projects also reported $44,500 in savings to beneficiaries. All of the projects provided descriptions of out-of-pocket expenses being returned to beneficiaries and savings due to the resolution of billing errors. (OEI-02-04-00362)

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 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 3,085 investigations of child support cases nationwide, resulting in 1,165 convictions and court-ordered restitution and settlements of $60.8 million.

Task Forces

In 1998, OIG and OCSE initiated "Project Save Our Children," a child support initiative made up of multiagency, multijurisdictional investigative task forces for child support enforcement. The task forces are designed to identify, investigate, and prosecute egregious criminal nonsupport cases on both the Federal and State levels by coordinating law enforcement, criminal justice, and child support office resources. The child support Task Forces Table appears on the following page.

Task Force Table

Task Force Regions	Task Force Headquarters	Task Force States
Great Plains	Topeka, Kansas	Iowa, Kansas, Missouri, Nebraska, North Dakota, South Dakota
Mid-Atlantic	Baltimore, Maryland	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia
Midwest	Columbus, Ohio	Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
New England	Boston, Massachusetts	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Northeast	New York, New York	New Jersey, New York, Puerto Rico, Virgin Islands
Pacific North	Olympia, Washington	Alaska, Idaho, Oregon, Washington
Rocky Mountains	Denver, Colorado	Colorado, Montana, Utah, Wyoming
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

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 forward the cases to the investigative task force units, wherein 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.

To date, the task force units have received over 10,006 cases from the States. As a result of the work of the task forces, 605 Federal arrests have been executed and 586 individuals sentenced. The total ordered amount of restitution related to Federal investigations is $26.8 million. There have been 380 arrests at the State level and 364 convictions or civil adjudications to date, resulting in $20.2 million in restitution being ordered as a result of State investigations.

Investigations

Nationwide, OIG investigations of child support cases resulted in 59 convictions and court-ordered restitution and settlements of $3.6 million during this semiannual period. Examples of the Federal arrests, convictions, and sentences for failure to pay child support include the following:

■ **Washington**–A man was sentenced to 5 years probation, 250 hours community service, and was ordered to pay $69,000 in restitution for failure to pay child support. He had three separate child support orders from Indiana. The man, who works as a phlebotomist at a hospital, was also ordered to cease identifying himself as a Federal agent and medical doctor.

■ **Ohio**–A man was sentenced to 5 years probation and ordered to pay $45,000 in restitution for failure to pay child support. The man held various positions in the telecommunications industry and evaded his child support obligation by receiving cash payments for his work and/or by moving from job to job within the industry.

■ **Maine**–A man was sentenced to 3 months in prison, 3 months home confinement, and 1 year probation for failure to pay child support. He was also ordered to pay $43,000 in restitution for three separate child support obligations. Although the man inherited a significant amount of money, he never voluntarily paid any of his obligations.

■ **South Dakota**–A woman was sentenced to 5 years supervised probation and ordered to pay $11,000 in restitution for failure to pay child support. After her arrest in November 2004 and prior to sentencing, she paid $1,000 toward her arrearage. In 1999, she was ordered to pay $260 per month in support of her children.

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 (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 information technology 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 general oversight responsibility for these activities. A related major responsibility derives from Office of Management and Budget (OMB) Circular A-133, under which HHS is the cognizant agency to audit the majority of Federal funds awarded to major research schools and State and local government cost allocation plans. 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. OIG also is responsible for auditing the Department's financial statements.

OIG reviews audits, evaluations, and studies performed by others, such as OMB's Program Assessment and Rating Tool and reports of the Government Accountability 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.

General Oversight-Related Reports

Departmental Financial Statement Audit

The Chief Financial Officers Act (the Act) of 1990, as amended, requires OIG or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards. Auditors provided an unqualified opinion on the FY 2005 HHS consolidated/combined financial statements. This means that for the seventh consecutive year, the statements were reliable and fairly presented. However, the report on internal controls noted two material weaknesses:

■ **Financial Systems and Processes**–Although HHS made some progress in preparing financial statements, the lack of an integrated financial management system(s) and weaknesses in internal controls made it difficult for HHS to prepare timely and accurate financial statements. Substantial manual processes, significant adjustments to reported balances, and numerous accounting entries recorded outside HHS's general ledger system were necessary. In addition, deficiencies were noted in regional office oversight of States' Medicaid and SCHIP programs and data analyses and reconciliations.

■ **Managed Care Payments**–CMS lacked comprehensive controls over the managed care benefits payment cycle, including oversight of managed care organizations. CMS implemented the Medicare Managed Care System despite known deficiencies in the system that led to erroneous payments. In addition, CMS failed to establish a process to ensure that accounting and operational issues were addressed throughout the new payment system implementation process. Although the majority of the payment errors were identified and corrected, policies and procedures did not adequately reduce the risk that material benefit payment errors would occur and not be detected and corrected in a timely manner. These material weaknesses represented departures from certain Federal laws and regulations. (A-17-05-00001)

Departmental Service Organizations

To support the audit of the Department's FY 2005 financial statements, OIG contracted for examinations of several service organizations that provide common administrative, data processing, and accounting services to the operating divisions. In accordance with the Statement on Auditing Standards No. 70, independent certified public accounting firms examined the organizations' controls and tested their operating effectiveness. The results follow:

■ **Division of Payment Management, Program Support Center**–Controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-05-00009)

■ **Division of Financial Operations, Program Support Center**–Controls were suitably designed and operating with sufficient effectiveness, with the exceptions of application software development and change controls, logical access controls, and system software controls. (A-17-05-00011)

■ **Human Resources Service, Program Support Center**–Controls were suitably designed and operating with sufficient effectiveness, with the exceptions of application software development and change controls and certain deficiencies in the transaction processing system. (A-17-05-00012)

■ **Center for Information Technology, National Institutes of Health**–Controls were suitably designed and operating with sufficient effectiveness, with the exceptions of documentation and logging of change requests, authorizations, testing, and approval on mainframe and Windows host platforms. (A-17-05-00010)

North Carolina Internal Service Fund

North Carolina's Office of Information Technology Services (ITS) operates an internal service fund that provides centrally managed computing services to State agencies and some county and city governments. The Federal Government shares in the costs of ITS services when the user agencies claim reimbursement for those costs under Federal programs.

This review found that the State failed to return the $8.2 million Federal share of excess revenues transferred from its internal service fund. The State did not return the funds because ITS did not have procedures to ensure that the Federal Government received its share of all revenues in excess of costs.

OIG recommended that the State refund the $8.2 million and implement procedures to ensure that the Federal Government receives its share of future excess revenues. The State generally disagreed with OIG's computation. (A-04-04-03503)

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 first half of FY 2006, OIG's National External Audit Review Center reviewed 1,191 reports that covered $473.2 trillion in audited costs. Federal dollars covered by these audits totaled $118.5 billion, about $61.5 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 in the box below:

Reports issued:	
Without changes or with minor changes	**1,015**
With major changes	**117**
With significant inadequacies	**59**
Total:	**1,191**

The 1,191 reports included recommendations for HHS program officials to take action on cost recoveries totaling $522,000, as well as 4,333 recommendations for improving management operations. In addition, these audit reports provided information for 95 special memoranda that identified concerns for increased monitoring by departmental management.

Resolving Recommendations

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

Table 1: Reports With Questioned Costs*

Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
For which no management decision had been made by the beginning of the reporting period[1]	334	$2,122,383,000	$259,718,000
Issued during the reporting period	62	$563,007,000	$701,000
Total Section 1	396	$2,685,390,000	$260,419,000
Section 2			
For which a management decision was made during the reporting period[2,3]			
Disallowed costs	124	$288,034,000	$1,472,000
Costs not disallowed	10	$64,163,000	$1,839,000
Total Section 2	134	$352,197,000	$3,311,000
Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	262	$2,333,193,000	$257,108,000
Section 4			
For which no management decision was made within 6 months of issuance[4]	198	$1,764,715,000	$176,471,000

* Details concerning footnotes can be found in Appendix D.

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

Reports	Number of Reports	Dollar Value
Section 1		
For which no management decision had been made by the beginning of the reporting period[1]	37	$533,880,000
Issued during the reporting period	8	$132,739,000
Total Section 1	45	$666,619,000
Section 2		
For which a management decision was made during the reporting period	9	$58,128,000
Value of recommendations agreed to by management		
Based on proposed management action		
Based on proposed legislative action		
Value of recommendations not agreed to by management	1	$5,705,000
Total Section 2	10	**$63,833,000**
Section 3		
For which no management decision had been made by the end of the reporting period[2]		
Total Section 1 minus Total Section 2	35	**$602,786,000**

* 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, evaluations, investigations, and other activities highlighted in this and previous semiannual reports.

During the first half of FY 2006, OIG was involved in the review and clearance of the implementing regulations and other policy guidance resulting from the various Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provisions. OIG reviewed and provided comments on potential fraud and abuse issues arising in connection with implementation of the Medicare Part D Prescription Drug Benefit, establishment of the Medicare Advantage program, and e-prescribing standards for the prescription drug program.

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 regulations promulgating safe harbors related to the anti-kickback statute. During this semiannual reporting period, OIG did the following:

■ In accordance with the MMA, published proposed rulemaking that would establish a new safe harbor under the anti-kickback statute for certain arrangements involving the provision of electronic prescribing technology. Specifically, the safe harbor would protect certain arrangements involving hospitals, group practices, and prescription drug plan sponsors and Medicare Advantage organizations that provide to specified recipients certain nonmonetary remuneration in the form of hardware, software, or information technology and training services necessary for and used solely to receive and transmit electronic prescription drug information. (70 FR 59015; October 11, 2005)

■ In accordance with section 205 of the Health Insurance Portability and Accountability Act, published a Federal Register notice soliciting proposals and recommendations for developing new and modifying existing safe harbor provisions under the anti-kickback statute, as well as new OIG Special Fraud Alerts. (70 FR 73186; December 9, 2005)

■ Continued to develop proposed rulemaking that would reorganize and revise 42 CFR part 1003 by establishing separate subparts to address OIG's authority to propose the imposition of civil money penalties and assessments for false or fraudulent claims, violations by managed care organizations, and other violations.

In addition, OIG published a number of Federal Register notices that offer guidance to alert health care providers and program beneficiaries about potential problems or areas of special interest. During this semiannual period, OIG guidance included:

■ A Federal Register notice setting forth OIG's Special Advisory Bulletin on patient assistance programs for Medicare Part D enrollees.
(70 FR 70623; November 22, 2005)

■ A Federal Register notice seeking public comment on draft compliance program guidance for recipients of extramural research awards from the National Institutes of Health and other agencies of the U.S. Public Health Service. The guidance is intended to set forth OIG's general views on the value and fundamental principles of compliance programs for colleges and universities and other recipients of PHS awards for biomedical and behavioral research and the specific elements that these award recipients should consider when developing and implementing an effective compliance program.
(70 FR 71312; November 28, 2005)

■ A Federal Register notice setting forth an adjustment in the fees charged for each query submitted by authorized entities to access the data bank, in accordance with the implementing regulations for the Healthcare Integrity and Protection Data Bank.
(71 FR 12368: March 10, 2006)

Employee Fraud and Misconduct

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

■ **Maryland**–A former NIH employee was ordered to pay $49,000 in restitution for theft of Government property. The employee recorded unauthorized overtime she did not work into the time and attendance system, resulting in her obtaining fraudulent payments. Also in Maryland, a former NIH employee was ordered to pay $12,000 in restitution for theft of Government property. The employee used her Government-issued credit card in an unauthorized manner, including to pay her monthly apartment rent, college tuition fees for her daughter, and kennel services for her dog.

Prosecutions

During this semiannual reporting period, OIG investigations resulted in 226 successful criminal actions. Also during this semiannual period, 595 cases were presented for criminal prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Prosecutors brought criminal charges against 263 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, $732.4 million was ordered to be returned, or was returned, as a result of OIG

investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.

APPENDIXES

Appendix A: Savings Achieved Through Implementation of Recommendations in Audits and Evaluations and Investigative Recoveries October 1, 2005, Through March 31, 2006

The Congressional Budget Office (CBO) estimates annual Federal savings expected to result from the enactment of legislation as part of the process of informing Congress of the potential impact of legislation under consideration. After laws involving HHS programs have been enacted, OIG analyzes them to identify provisions that were recommended in OIG-issued reports. A similar process occurs with respect to administrative changes recommended by OIG and implemented by HHS operating or staff divisions. When this occurs, the savings estimated to accrue are developed by the relevant HHS operating or staff division or by OIG.

Savings of this kind depend greatly on the contributions of others, such as other HHS divisions and the Department of Justice. The amounts claimed represent funds that will be available for better use as a result of documented actions taken, including reductions in budget outlays, deobligations of funds, reductions in costs incurred, preaward grant reductions, and reductions and/or withdrawal of the Federal portion of interest subsidy costs of loans or loan guarantees, insurance, or bonds.

Total estimated savings from implemented recommendations and other actions to put funds to better use were $32.6 billion for the fiscal year ended September 30, 2005.

Effective with this semiannual report, OIG will report savings in the Fall issue only. In doing this, OIG's presentations of savings will be consistent with the annualized estimates reported by CBO.

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

This schedule represents potential annual savings or one-time recoveries that could be realized if OIG recommendations were enacted by Congress or the Department through legislation, regulation, or management action. In some cases, these recommendations are beyond the direct authority of the respective departmental operating division. Congress develops savings over a 5- or 10-year budget cycle that result 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 that are subject to change. The magnitude of the savings may increase or decrease because of interactive effects if changes are enacted together.

More detailed information may be found in OIG's *Red Book*. (See http://oig.hhs.gov.)

OIG Recommendation	Status	Savings (millions)
Centers for Medicare & Medicaid Services		
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)	CMS has taken corrective actions to reduce payments for laboratory services. A proposal to reduce payment updates from FY 2003 through 2005 was included in the President's FY 2001 budget, as well as was a proposal to reinstate laboratory cost sharing. Neither of these proposals was enacted. The Balanced Budget Act (BBA) required the Secretary to request that the Institute of Medicine (IOM) study Part B laboratory test payments. As a result of IOM's recommendations, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandates that CMS conduct a demonstration that applies competitive bidding for clinical laboratory services. The MMA also set the laboratory fee schedule updates at 0 percent for 2004 through 2008.	$1,130*
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 (ASC) list of covered procedures. (A-14-89-00221, A-14-98-00400, OEI-09-88-01003, OEI-05-00-00340)	CMS agreed to consider seeking authority to set rates that are consistent across sites as it develops its legislative program. CMS published the Medicare Program; Updated ASC List of Covered Procedures on May 4, 2005. The MMA requires CMS to implement a revised payment system for ASCs between January 2006 and January 2008.	$1,100

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

Appendix B

OIG Recommendation	Status	Savings (millions)
Medicaid Reimbursement for Brand-Name Drugs: CMS should encourage States to bring pharmacy reimbursement in line with pharmacies' actual acquisition costs of brand-name drugs. OIG recommended a four-tier approach to reimbursement: single-source innovator drugs, all drugs without Federal upper limits (FUL), multiple-source drugs without FULs, and multiple-source drugs with FULs. (A-06-00-00023, A-06-02-00041)	CMS concurred with OIG's recommendation and is working with States to review their estimates of acquisition costs in light of OIG's findings. OIG will continue to monitor the pricing of Medicaid reimbursement for brand-name drugs.	$1,080
Medicare Payments for Mental Health Services: CMS should ensure that 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)	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.	$676
Medicaid Reimbursement for Generic Drugs: CMS should encourage States to bring pharmacy reimbursement more in line with pharmacies' actual acquisition costs of generic drugs. OIG recommended a four-tier approach to reimbursement: single-source innovator drugs, all drugs without FULs, multiple-source drugs without FULs, and multiple-source drugs with FULs. (A-06-01-00053, A-06-02-00041)	CMS concurred with OIG's recommendation. The agency is working with States to strongly encourage them to review their estimates of acquisition costs and will follow up to ensure that they take OIG's findings into account. The Deficit Reduction Act (DRA) changed the Medicaid reimbursement rate for generic drugs, whereby the Federal Government will set a FUL on Medicaid drug payment that is equal to 250 percent of the average manufacturer's price (AMP) for a generic version of the drug. The DRA redefined AMP as the average price at which manufacturers sell their drugs to wholesalers. The President's FY 2007 Budget would build on the DRA with changes to the FULs for multiple source drugs and would limit reimbursement for multiple source drugs to 150 percent of AMP. OIG will continue to monitor the pricing of Medicaid reimbursements for generic drugs.	$470
Payment Policy for Medicare Bad Debts: OIG presented options for CMS to consider: 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)	The BBA provided for some reduction of bad debt payments to providers. The Benefits Improvement Protection Act of 2000 (BIPA) subsequently adjusted upwards the percentage of total hospital bad debt that would be reimbursed. Medicare now pays 70 percent of allowable bad debts. Additional legislative changes are required to implement the modifications OIG recommended.*	$340

* The President's FY 2007 budget proposal phases out bad debt payments over 4 years.

OIG Recommendation	Status	Savings (millions)
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, OEI-03-00-00031)	CMS agreed with the recommendation and has worked to improve its oversight of the cost avoidance waiver process. The recommendation was discussed with CMS's regional offices in February 2005 to assess whether States are appropriately paying and chasing claims. In addition, CMS provided training for staff to ensure that appropriate cost avoidance waiver criteria are being applied in granting any such waivers. In addition, CMS is currently planning to survey and update State progress in cost avoiding several major claim types. The President's FY 2007 Budget proposes to discontinue all waivers that permit pay and chase of pharmacy claims.	$185
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)	CMS did not concur with the recommendations. Although the BBA and the Balanced Budget Refinement Act of 1999 (BBRA) 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.	$157.3
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)	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. OIG has issued rebate reports to each State Medicaid agency as it relates to the State's internal control.	$123
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)	CMS concurred; the agency plans 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. The agency planned to continue to maximize the effectiveness of its medical review strategy and collect the overpayments identified in our sample. CMS prepared a provider education article to educate podiatrists on Medicare policy for paying nail debridement claims.	$96.8
Medical Equipment/Supply Claims Lacking Valid, Active Unique Physician Identification Numbers: 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)	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.	$91

OIG Recommendation	Status	Savings (millions)
Expansion of the Diagnosis Related Group Payment Window: CMS should propose legislation to expand the diagnosis related group payment window to at least 7 days immediately before the day of admission. (A-01-92-00521, A-01-02-00503)	CMS concurred with OIG's recommendation; however, CMS noted that some additional factors would have to be considered before a legislative change could be advanced.	$37
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)	CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the BBA required the Secretary of the Department of Health and Human Services to audit the cost reports of each dialysis provider at least once every 3 years. The BBRA increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999. The BIPA of 2000 increased the payment rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the maximum extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable by dialysis facilities. The MMA, title VI, section 623, increased the composite rate by 1.6 percent for 2005, restored the composite rate exception for pediatric facilities, and required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services.	$22
Indirect Medical Education: CMS should continue to pursue legislation to 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)	CMS agreed with the recommendation. The BBA, as amended by the BBRA, reduced the IME adjustment to 5.5 percent in 2002 and thereafter. OIG believes that the factor should be further reduced to eliminate overlap with the disproportionate share adjustment.	To Be Determined (TBD)
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)	CMS initially agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.	TBD

OIG Recommendation	Status	Savings (millions)
Hospital Capital Costs: CMS should determine the extent to which capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to Congress. (A-09-91-00070, A-14-93-00380)	CMS did not agree with the recommendation. Although the BBA reduced capital payments, it lacked certain measures concerning excess bed capacity and other elements in the base-year historical costs. The President's FY 2001 budget proposed reducing capital payments and savings $630 million from FY 2001 through FY 2005.	TBD
Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: CMS should seek legislation to require participating manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other alternatives to the current program of using average manufacturer price to calculate the rebates. This legislation would have resulted in $1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-1996. (A-06-97-00052)	CMS agreed to pursue a change in the Medicaid drug rebate program similar to that recommended. No changes have yet been made. However, committees in both the Senate and House have proposed language establishing a better connection. The President's FY 2007 Budget proposed to eliminate best price and revise the rebate percentage, in a budget neutral manner, to help offset the cost.	TBD
Home Health Agencies: CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-12-94-00180, OEI-02-94-00170, OEI-04-93-00260, OEI-04-93-00262, A-04-94-02078, A-04-94-02087, A-04-95-01103, A-04-95-01106, A-04-95-01104, A-04-95-01105, A-04-95-01107, A-03-95-00011, A-04-96-02121, A-02-97-01026, A-04-97-01166, A-04-97-01169, A-04-97-01170, A-02-97-01034, A-04-98-01184, A-04-99-01194, A-04-99-01195)	Although the BBA 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. CMS agreed in principle and recognized the need for physician involvement in home health care planning. CMS also provided additional payments for physician care plan oversight and education for physicians and beneficiaries.	TBD
Payments Returned by Public Providers: CMS should propose legislation to require that Medicaid payments that public providers return to States be declared a refund to be used to offset or credit the Federal financial participation that the original payment generated. (A-03-00-00216)	In April 2004, CMS testified before the House Energy and Commerce Committee and indicated that it supported declaring returned funds as credits or refunds to offset the original State payment. The Federal share would then be calculated based on the net Medicaid payment that the provider retained. The President's FY 2007 Budget proposes an administrative change that builds on past CMS efforts to curb questionable financing practices by (1) recovering Federal funds diverted from Government providers and retained by the State and (2) capping payments to Government providers to no more than the cost of furnishing services to Medicaid beneficiaries.	TBD

OIG Recommendation	Status	Savings (millions)
Definitive Guidance on Calculating Upper Payment Limits and Use of Facility-Specific Limits Based on Actual Costs: CMS should provide States with definitive guidance on calculating UPLs so that a uniform standard is applied to all States. This guidance could be provided through a letter to the Medicaid Directors. States should use facility-specific UPLs that are based on actual cost report data. (A-03-00-00216)	CMS partially concurred with OIG's recommendations. CMS agreed that it should provide more guidance on calculating the UPL. The President's FY 2007 budget contains a proposal to limit payments to Government providers to no more than the cost of providing services.	TBD
Excessive Medicaid Disproportionate Share Hospital Payments: CMS should ensure that the monetary recommendations made to individual States regarding Disproportionate Share Hospital (DSH) payments that exceeded the hospital-specific limits have been resolved. CMS should also establish regulations requiring States to (1) implement procedures to ensure that future DSH payments are adjusted to actual incurred costs, (2) incorporate the procedures into their approved State plans, and (3) include only allowable costs as uncompensated care costs in their DSH calculations. CMS should also strengthen its review and approval of State plans to ensure consistency with Federal requirements and use the results of MMA-required audits as part of its review process. (Various audit reports)	CMS has begun taking action in individual States to recover overpayments. On March 26, 2004, CMS published a notice in the Federal Register on the Medicaid DSH program.	TBD
Compliance With Requirements for Medicaid School-Based Health Services: CMS should recover the overpayments identified during OIG's individual State audits of school-based health claims. In addition, States should disseminate CMS guidance and other information to local education agencies in a timely manner, monitor local education agencies to ensure compliance with Federal and State requirements, and assist local education agencies in developing written policies and procedures that require service providers to document all health services and to retain those records for review. (Various audit reports)	CMS has begun taking action in individual States to recover overpayments. CMS has recently undertaken a significant effort to bring State plans into compliance with Federal law, regulations, and policy in the coverage areas that pertain to Medicaid services delivered in school settings. The President's FY 2007 Budget proposes to prohibit Federal Medicaid reimbursement for school-based administrative or transportation costs.	TBD
Eliminate or Reduce Transition Periods for Compliance With Revised Medicaid Upper Payment Limits: CMS should seek authority to eliminate or reduce the 8-year transition period included in the revised UPL regulation. (A-03-00-00216)	CMS did not concur with OIG's recommendation. According to CMS, the transition periods were established pursuant to either notice-and-comment rulemaking or legislation, and offering new proposals at this time would undermine the consensus reached through those processes. CMS anticipates no further action on OIG's recommendation. Five States remain with transition periods through September 1, 2008.	TBD

Appendix C: Unimplemented Office of Inspector General Program and Management Improvement Recommendations

This schedule represents OIG findings and recommendations that, 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*. (See http://oig.hhs.gov.)

OIG Recommendation	Status
Centers for Medicare & Medicaid Services	
Accountability Over Billing and Collection of Medicaid Drug Rebates: The Centers for Medicare & Medicaid Services (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, A-06-03-00048)	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.
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)	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.
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). In addition, CMS should develop a more specific policy for calculating this price that would both protect the interests of the Government and be equitable to the manufacturers. (A-06-91-00092)	CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing the AMP. OIG disagrees because the rebate law and agreements defined the AMP but did not provide specific written methodology for computing it.

Appendix C

OIG Recommendation	Status
Accuracy of Carrier Payment Date: 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 the data 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 Contractor Reporting of Operational and Workload Data system. (OEI-03-00-00350)	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.
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 impact facility reimbursement by Medicare. (OEI-02-99-00040, OEI-02-99-00041)	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. In 1998, CMS devoted significant resources to the development of an accuracy improvement program by letting a contract to develop MDS accuracy review protocols. Once the protocols were developed, CMS funded a program safeguard contractor in September 2001, known as the data assessment and verification system (DAVE), to audit and verify MDS data. In January 2004, CMS developed and implemented the DAVE project onsite and offsite audit process of the MDS in long term care facilities to assess the accuracy and reliability of assessment data submitted.
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)	CMS concurred with most of OIG's recommendations and has made revisions to its training curriculum for nursing home surveyors. In addition, CMS offered several national satellite broadcasts in 2001 and 2004 to increase surveyor knowledge and ability to recognize mental illness, to educate surveyors on Pre-Admission Screening and Resident Review (PASRR) implementation and oversight, and to improve surveyors' abilities to determine facility compliance with assessment and care requirements. CMS has also held several training conferences for Resident Assessment Instrument coordinators to improve the identification of mental illness symptoms in patients in nursing facilities. CMS is also exploring the role State surveyors may have in identifying compliance with PASRR Level II assessment requirements.

OIG Recommendation	Status
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)	CMS concurred with most of OIG's recommendations, except for reporting the MDS records by primary, secondary, and tertiary diagnoses. In February 2005, CMS issued a letter to State Medicaid directors indicating that it will begin to release MDS data to States with Americans with Disabilities Act compliance activities. CMS will also require States to evaluate the PASRR outcomes, further obligating States to develop accurate data systems useful for identifying serious mental illness in nursing facility residents. In addition, CMS is planning to implement the use of a unique provider number on or before May 2007.
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)	CMS generally concurred with OIG's recommendations. It 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 reviews, if indicated. CMS provided training for providers concerning Medicare payments for Part B mental health services via Medlearn in April 2003.
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. The Health Resources and Services Administration (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)	CMS concurred with the recommendations and indicated that it will explore ways in which additional data can be used to assess OPO effectiveness and hospital compliance with the donation rule. CMS published a Notice of Proposed Rulemaking on February 4, 2005, establishing new conditions of coverage regarding OPOs. That proposed regulation requires OPOs to report hospital-specific organ donation, including organ donor potential and the number of actual donors, at least annually to the public. HRSA, through its contract for operation of the Organ Procurement and Transplantation Network, requires OPOs to submit hospital-specific data on organ recovery.
Outpatient Surgery Rates: CMS should (1) seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and (2) remove the procedure codes that meet its criteria for removal from the Ambulatory Surgery Center list of covered procedures. (OEI-05-00-00340)	Section 626 of Public Law 108-173 mandates that the Government Accountability Office conduct a study that compares the relative costs of procedures furnished in ambulatory surgical centers with the relative costs of procedures furnished in hospital outpatient departments. The report will include recommendations that advise CMS regarding payments to ambulatory surgical centers and CMS will implement a new payment system for ambulatory surgical centers beginning on or after January 1, 2006, and not later than January 1, 2008. CMS issued a proposed rule on November 26, 2004, to update the list continued—

OIG Recommendation	Status
Outpatient Surgery Rates (continued):	of Medicare-approved ambulatory surgical centers procedures in 2005. CMS proposed to remove from the ambulatory surgical centers list a number of the codes recommended for deletion by OIG. Nearly 500 comments were submitted timely and CMS is reviewing those comments and preparing a final rule for implementation.
Medicare-Approved Heart Transplant Centers: CMS should develop standards for continuing approved centers as well as guidelines for what levels of performance trigger specific responses from CMS. In the short term, OIG also recommends that CMS improve its oversight of centers by entering into an arrangement with HRSA for the regular exchange of volume and survival rate data. (OEI-01-02-00520)	On February 4, 2005, CMS published proposed rule (70 FR 6140), "Hospital Conditions of Participation: Requirements for Approval and Reapproval of Transplant Centers to Perform Organ Transplant." The notice of proposed rulemaking established the requirements for approval and reapproval of transplant centers to perform organ transplants. The approval requirements include data submission, outcome measures, and process requirements. CMS expects to publish the final rule within 18 months. HRSA has partnered with CMS in developing outcome measures for the proposed rule and will continue to act as a liaison between CMS and the Scientific Registry of Transplant Recipients to provide assistance to review data on transplant center(s) performance.
Quality Improvement Processes in Dialysis Facilities: CMS should revise the Conditions of Coverage, examine ways to foster the commitment of attending physicians to performance measures, develop more effective intervention strategies for facilities, and work with the corporations to share experiences and minimize reporting burdens on dialysis facilities. (OEI-01-99-00052)	CMS concurred with most of OIG's recommendations. The Conditions of Coverage proposed rule was published in February 2005. The proposed conditions would require a facility-level data driven Quality Assessment and Performance Improvement program (QAPI), an increased participation of attending physicians in patient care and in supporting the facility QAPI program, increased medical director role, and electronic clinical measure reporting.
End-Stage Renal Disease Data Management: CMS should develop a strategic plan for addressing End-Stage Renal Disease (ESRD) data management, including creating short- and long-term remedies for current data problems, reassessing the data needs of users, improving the efficiency of data distribution, improving ongoing communication with users and data contributors, and coordinating better with the Social Security Administration. (OEI-07-01-00250)	CMS concurred with OIG's recommendations. As of February 15, 2005, CMS, the ESRD networks, its contractors, and the renal community worked together to consolidate its three ESRD systems, known as the Consolidated Renal Operations in a Web-enabled Network (CROWN). The three systems include the Renal Management Information System (REMIS), the Standard Information Management System (SIMS), and the Vital Information System to Improve Outcomes in Nephrology. SIMS went into production on January 1, 2000, and REMIS went into production on July 13, 2003. The REMIS application directly addresses concerns raised by OIG. The CROWN is the automated system that combines all of CMS's electronic data on ESRD benefits and utilization; it provides for the collection, validation, and storage of information about the national ESRD program, its beneficiaries, and the services provided to them.

OIG Recommendation	Status
Accuracy of Nursing Home Compare: CMS should require State agencies to verify that the most recent inspection results are in CMS databases and establish a single point of contact for reporting discrepancies on the Web site. (OEI-01-03-00130)	CMS agreed with the first recommendation. CMS will consider adding regional office contact information to the Nursing Home Compare to facilitate corrections to the Web site. CMS is currently working with the Web site designers and the regional offices to develop the most efficient means of providing CMS oversight over State survey agency data entry.
Variation in State Medicaid Drug Prices: CMS should share more accurate drug pricing information 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. (OEI-05-02-00681)	CMS plans to follow up with States that paid higher relative drug prices, particularly States with prices above the UPL.
CMS Oversight of Cost-Avoidance Waivers: CMS should approve only waivers that meet the criteria for cost-effectiveness as set forth by Federal regulations, strengthen oversight activities through improved document retention, and collect information from States regarding recovery rates from pay-and-chase activities. Cost avoidance involves returning claims to providers so that the providers can bill the liable third parties. (OEI-03-00-00031)	CMS concurred with OIG's recommendation that it approve only cost-effective waivers. CMS continues to address the oversight of and/or need for cost-avoidance waivers. CMS central and regional offices continue to work closely with States to identify circumstances for which cost-avoidance waivers are not necessary (i.e., Medicaid services not covered by third parties or benefits not directly available to the provider). CMS has also worked with States to diminish the need for waivers by frequently encouraging States to eliminate paying and chasing of claims and relying instead on cost-avoidance. CMS has made substantial progress on Medicaid pharmacy claims. In August 2001, OIG reported that only 17 States were cost-avoiding (in part or whole) pharmacy claims. A recent CMS survey indicated that 40 States currently meet that description and an additional 4 States are planning systems conversions. CMS plans to follow up with remaining States to consider what further assistance should be offered. Where waivers continue to be necessary, CMS will continue to emphasize cost-effectiveness and proper document retention.
Uninsured Children Through State Children's Health Insurance Programs: CMS should 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, and ensure the integrity, validity, and usefulness of the State Children's Health Insurance Program (SCHIP) Annual Report and SCHIP enrollment data. (OEI-05-03-00280)	CMS concurred with several of OIG's specific recommendations and has already implemented steps to improve the integrity of the State Annual Report submissions. In addition, CMS has taken steps to enhance technical assistance (TA) to States to improve their measurement capabilities and has held a TA session at the National Academy for State Health Policy's annual conference in August 2004. CMS is currently reviewing all State reports on progress towards covering the uninsured and providing State-specific TA to the States not measuring progress.

OIG Recommendation	Status
Public Health Agencies	
Oversight of Tissue Banking: The Food and Drug Administration (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. It 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)	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 toward 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 Registration and Listing) was finalized. FDA contacted all 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 because it handled only vascularized organs. In 2004, FDA finalized donor eligibility and good tissue practices regulations, which became effective on May 25, 2005. This completes the rulemaking activities related to human tissues.
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, (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)	In response, the Center for Food Safety and Applied Nutrition (CFSAN) developed a single system for entering adverse events and product quality complaints reports involving foods, cosmetics, and dietary supplements: the CFSAN Adverse Event Reporting System (CAERS). CAERS became partially operational in June 2003. The new system incorporates all existing adverse event reporting systems into one state-of-the-art reporting and monitoring system. FDA routinely notifies manufacturers regarding adverse events associated with the use of their products. A proposed final rule for good manufacturing practices for dietary supplements was submitted to the Office of Management and Budget (OMB) on October 25, 2005. In response to the food facility registration in the Public Health Security and Bioterrorism Preparedness Act of 2002, FDA requires facilities that manufacture, process, pack, or hold dietary supplements to be registered with the FDA. FDA informs the public of developments through its dietary supplements Web site.
Protection for Research Subjects in Foreign Clinical Trials: FDA should examine ways to obtain more information about the performance of non-U.S.	OHRP concurred with OIG's recommendations and a variety of national, regional, and international organizations with a goal of establishing effective continued—

OIG Recommendation	Status
Protection for Research Subjects in Foreign Clinical Trials (continued): Institutional Review Boards (IRBs) and help 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. The Office for Human Research Protections (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)	education and review processes around the world. In 2004, OHRP sponsored capacity-building workshops for IRB members, gave presentations at international conferences, and began translating key guidance documents into foreign languages. FDA published a proposed rule in 2004, "Human Subject Protection: Foreign Clinical Studies Not Conducted Under an Investigational New Drug Application" (21 CFR 312.120), to promote good clinical practice regardless of the location of the clinical trial. FDA also contributed to the HHS/OHRP/National Institutes of Health Working Group for Equivalent Protections in developing a HHS report and Federal Register Notice announcing proposed criteria for clinical trials conducted outside of the United States. In addition, FDA has assisted other countries with capacity-building activities, including Singapore and Australia, for international good clinical practices (GCP) inspectorates. An ongoing FDA initiative to develop better communication with the European Medicines Agency will improve coordination between the respective European and FDA programs involving clinical trials. FDA has also provided staff as faculty to professional associations for outreach training programs, as well as creating a GCP Web site for current information about FDA clinical trial requirements.
Administration for Children and Families	
Children's Use of Health Care Services While in Foster Care: OIG conducted a series of inspections examining the access of foster care children in several States to Medicaid health care services. OIG found that access varied in each state and generally recommended that CMS and the Administration for Children and Families (ACF) work with the States to increase access to health care services for eligible foster care children and educate foster parents on available services. (OEI-02-00-00360, OEI-02-00-00363, OEI-07-00-00640, OEI-07-00-00642, OEI-07-00-00643)	CMS and ACF generally concurred with the recommendations and in many cases are actively working with the State and local entities to improve access, clarify obligations, and educate all the parties involved regarding Medicaid health care services.

OIG Recommendation	Status
General Oversight	
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)	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 a draft regulation. As of March 2006, the draft regulation had not been issued.

Appendix D: Notes to Tables 1 and 2

Notes to Tables 1

[1]The opening balance was adjusted upward $ 82.4 million

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

Central Identification Number (CIN): A-02-91-01006 BLUE SHIELD OF WESTERN NY–Final settlement of an audit resulted in a decrease in the original concurrence amount of $1.5 million.

CIN: A-06-92-00043 MEDICARE GME COSTS TEXAS–The fiscal intermediary determined that original amount as recommended should be reduced by $1.7 million.

CIN: A-07-02-03023 TITLE XIX CLAIMED FOR FAMILY SERVICES–CMS reviewed findings covering claims that Iowa disputed, and determined that $1.0 million in previously disallowed claims was allowable.

Not detailed are revisions to previously disallowed management decisions totaling $2.5 million.

[3]Included are management decisions to disallow $68.6 million that was identified in nonfederal audit reports.

[4]Due to administrative delays, many of which are beyond management control, resolution of the following 98 audits was not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

CIN: A-02-02-01029	REVIEW OF SPEECH SCHOOL HEALTH CLAIMS - NYCDE, JUN 2005, $435,903,456
CIN: A-02-02-01030	REVIEW OF SPEECH SCHOOL HEALTH CLAIMS - REST OF STATE, FEB 2004, $172,553,831
CIN: A-05-01-00099	U OF I HOSPITAL-DSH PAYMENT LIMITS, OCT 2004, $140,281,912
CIN: A-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, $128,269,448
CIN: A-02-03-01023	REVIEW OF TRANSPORTATION SCHOOL HEALTH CLAIMS - NYC DEPT. OF EDUCATION, SEP 2005, $108,241,199
CIN: A-04-99-05561	AUDIT ADMIN COST PROPOSALS FY95-98, BCBSFL, JAX, JUL 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-04-04-03000	COMPLIANCE WITH MEDICARE'S POSTACUTE CARE TRANSFER POLICY - FY 01 & 02, APR 2005, $72,369,964
CIN: A-02-03-01008	REVIEW OF TRANSPORTATION SCHOOL HEALTH CLAIMS - REST OF STATE, AUG 2004, $53,037,302
CIN: A-05-01-00058	OHIO MEDICAID HOSPITAL-SPECIFIC DSH PAYMENT LIMITS, JUN 2004, $47,000,000
CIN: A-04-01-02006	MEDICAID DISPROPORTIONATE SHARE PAYMENTS IN ALABAMA, JUN 2004, $45,763,327
CIN: A-07-01-02093	MISSOURI DSH - UNALLOWABLE COSTS, AUG 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-03-01-00224	MEDICAID SCHOOL-BASED SERVICES/MARYLAND, MAR 2003, $19,954,944
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEP 2002, $19,446,435
CIN: A-01-02-00509	REVIEW OF MEDICARE ADMINISTRATIVE COSTS - PART A & B - UNITED HEALTHCARE INSURANCE COMPANY, MAR 2005, $12,991,420
CIN: A-06-03-00046	REVIEW OF OKLAHOMA'S MEDICAID ADMINISTRATIVE COSTS, APR 2005, $10,875,782
CIN: A-02-03-01019	UPPER PAYMENT LIMIT CALCULATIONS - NEW JERSEY, MAR 2005, $10,698,309
CIN: A-06-03-00027	REVIEW OF HUMANA'S BIPA MODIFICATIONS, JUL 2005, $10,500,000
CIN: A-06-02-00034	REV OF COST REPORTS & MEDICARE FEE-FOR-SERVICE PYMTS @ SCOTT & WHITE, MAY 2003, $8,229,574
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEP 2002, $7,999,212
CIN: A-09-97-44262	STATE OF CALIFORNIA, APR 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, MAR 1993, $6,529,545
CIN: A-05-02-00049	MEDICAL SERVICE COSTS UNDER ILLINOIS SCHOOL-BASED MEDICAID, DEC 2003, $6,067,669
CIN: A-03-03-00562	DELAWARE TITLE IV-E TRAINING AND ADMIN COSTS, JUL 2005, $5,912,733
CIN: A-04-00-02161	MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOV 2001, $5,344,160
CIN: A-01-02-00016	MEDICAID SCHOOL-BASED HEALTH SERVICE ADMINISTRATIVE CLAIMING REVIEW-MASSACHUSETTS, SEP 2004, $5,312,447
CIN: A-09-03-00042	REVIEW OF HHA PRECEEDING HOSPITAL STAY UNDER PPS - UGS, FEB 2004, $5,306,825
CIN: A-09-04-00049	WEDGE: REVIEW OF FEDERAL MATCHING FUNDS CLAIMED BY CALIFORNIA FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL, AUG 2005, $5,295,373
CIN: A-06-02-00060	REVIEW PACIFICARE OK BIPA MODIFICATIONS TO CY 2001 ACRP, JUN 2004, $5,204,042
CIN: A-05-03-00096	REVIEW OF ADMINISTRATIVE COSTS FOR ADMINASTAR FEDERAL, AUG 2004, $5,000,598
CIN: A-09-03-00051	REVIEW OF BLUE SHIELD CALIFORNIA BIPA MODIFICATIONS TO CY 2001 ACRP, OCT 2004, $4,555,992
CIN: A-05-01-00102	MT. SINAI HOSPITAL-DSH PAYMENT LIMITS, OCT 2004, $4,516,112
CIN: A-02-00-01047	DEMO BSWNY - FINANCIAL, MAR 2002, $4,505,051
CIN: A-07-02-00144	IV-E FOSTER CARE ADMINISTRATIVE COSTS CLAIMED, AUG 2003, $4,335,542
CIN: A-01-04-02503	REVIEW OF MAINE'S ADOPTION ASSISTANCE SUBSIDY PAYMENTS, APR 2005, $4,200,000
CIN: A-01-02-00015	REVIEW OF MA MEDICAID USE OF REVISED FEE SCHEDULES FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES, JAN 2004, $4,100,000
CIN: A-07-04-03053	REVIEW OF CAHABA'S UNFUNDED PENSION COSTS, FEB 2004, $4,006,541
CIN: A-03-01-00225	VIRGINIA IMD UNDER 21, MAR 2004, $3,948,532

CIN: A-09-03-00053	AUDIT OF ORGAN ACQUISITION COSTS AT CPMC, JAN 2005, $3,731,752
CIN: A-09-04-00023	AUDIT OF OREGON'S MEDICAID UPPER PAYMENT LIMITS FOR NON-STATE GOVERNMENT INPATIENT HOSPITALS FOR STATE FISCAL YEAR 2003, FEB 2005, $3,412,987
CIN: A-01-02-00525	MAINE ANTHEM BCBS - MEDICARE ADMINISTRATIVE COSTS, APR 2004, $3,389,716
CIN: A-04-01-00005	MEDICAID FFS PAYMENTS TO LEA'S IN NORTH CAROLINA, MAY 2004, $3,066,806
CIN: A-01-04-00004	REVIEW OF MAINE'S MEDICAID RETROACTIVE CLAIMS FOR SCHOOL-BASED HEALTH SERVICES - JANUARY 2001 THROUGH JUNE 2003, JAN 2005, $3,044,211
CIN: A-09-98-50183	STATE OF CALIFORNIA, MAR 1998, $3,000,000
CIN: A-03-04-00207	MEDICAID OVERPAYMENTS - WEST VIRGINIA, JUN 2005, $2,940,469
CIN: A-01-02-00508	REVIEW OF MEDICARE CONTRACT TERMINATION COSTS - UNITED HEALTHCARE, NOV 2003, $2,894,010
CIN: A-05-02-00085	MEDICAID FFS PAYMENTS FOR OHIO BENEFICARIES ENROLLED IN MEDICARE MCOS, JUN 2004, $2,700,000
CIN: A-01-04-78839	STATE OF NEW HAMPSHIRE, JUN 2004, $2,631,648
CIN: A-07-03-03039	CAREFIRST OF MARYLAND UNFUNDED PENSION COSTS, MAY 2003, $2,611,100
CIN: A-01-04-00523	REVIEW OF ADMINISTRATIVE COSTS - PART A & B AT RHODE ISLAND BLUE CROSS AND BLUE SHIELD, SEP 2005, $2,582,664
CIN: A-09-02-72300	STATE OF CALIFORNIA, JUL 2002, $2,400,000
CIN: A-07-04-03050	PENSION SEGMENTATION REVIEW AT HIGHMARK, INC. OF PA, JAN 2005, $2,394,501
CIN: A-10-02-00008	REVIEW OF WASHINGTON STATE'S MEDICAL ASSISTANCE COSTS CLAIMED FOR SCHOOL-BASED HEALTH SERVICES, JUL 2003, $2,279,752
CIN: A-03-03-00222	MEDICAID ACCOUNTS RECEIVABLE OVERPAYMENTS IN WASHINGTON, DC, AUG 2005, $2,195,049
CIN: A-07-04-00173	REVIEW OF UNFUNDED PENSION COSTS FOR PENNSYLVANIA BLUE SHIELD, NOV 2004, $2,154,481
CIN: A-05-03-00063	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF MEDICARE NORTHWEST (BLUE CROSS BLUE SHIELD OF OREGON), OCT 2003, $2,100,000
CIN: A-05-02-00048	REVIEW OF MEDICAID DME CLAIMS - TEXAS, SEP 2002, $1,969,704
CIN: A-01-02-00516	REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES UNITED GOVERNMENT SERVICES, MAR 2003, $1,768,783
CIN: A-03-01-00228	PENNSYLVANIA IMD UNDER 21, JUL 2005, $1,694,148
CIN: A-09-00-00127	BLUE CROSS OF CALIF - MEDICARE ADMIN COSTS, DEC 2002, $1,677,822
CIN: A-02-04-01010	REVIEW OF PHYSICIAN PLACE OF SERVICE CODING FOR AMBULATORY SURGICAL AND RELATED PROCEDURES, JAN 2005, $1,467,318
CIN: A-04-01-05011	REVIEW OF FLORIDA MEDICAID PAYMENTS FOR SERVICES PROVIDED TO INMATES, OCT 2002, $1,450,077

CIN: A-03-04-00209	VIRGINIA MEDICAID MANAGED CARE FAMILY PLANNING FACTOR VALIDATION AUDIT, JUN 2005, $1,388,506
CIN: A-07-02-03021	ANTHEM BCBS OF CT - PENSION SEGMENT CLOSING, FEB 2004, $1,351,284
CIN: A-04-03-02024	REVIEW OF BCBSFL RESPONSE TO SET-ASIDE COSTS IN PRIOR FACP AUDIT, APR 2003, $1,277,247
CIN: A-07-04-00169	PENSION SEGMENTATION REVIEW AT PBS, NOV 2004, $1,214,985
CIN: A-04-02-72903	STATE OF TENNESSEE, SEP 2002, $1,213,353
CIN: A-04-03-01000	REVIEW OF HOME HEALTH SERVICES CLAIMED BY LIFELINE HEALTH GROUP, INC, JUN 2004, $1,173,330
CIN: A-05-04-00039	IL-UNDISTRIBUTED CHILD SUPPORT COLLECTIONS, AUG 2005, $1,095,077
CIN: A-09-02-01004	USC GRANTS MANAGEMENT REVIEW, JUL 2004, $1,082,554
CIN: A-09-94-01010	CLOSEOUT AUDIT - CONT NO. N01-ES-75196 (STRATAGENE), MAR 1994, $983,208
CIN: A-07-04-02016	HEAD START KCMC CHILD DEVELOPMENT CORP. - KANSAS CITY, MO (DIRECTOR'S PAY), APR 2005, $953,245
CIN: A-05-04-77356	TRI-VALLEY OPPORTUNITY COUNCIL INC., FEB 2004, $866,666
CIN: A-04-01-05004	REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MAR 2002, $836,711
CIN: A-06-03-00013	MEDICARE ADMINISTRATIVE COST PROPOSAL-ARKANSAS BCBS, OCT 2003, $759,748
CIN: A-05-02-00041	INDIANA MEDICAID HOSPITAL PATIENT TRANSFERS, JAN 2003, $730,061
CIN: A-09-03-00046	AUDIT OF ORGAN ACQUISITION COSTS AT ST VINCENT, JUL 2004, $683,315
CIN: A-09-04-00027	MEDICAID FAMILY PLANNING SERVICES - ARIZONA, JUL 2005, $658,093
CIN: A-06-03-00032	AUDIT OF ADMIN COSTS PART A & PART B OF MEDICARE PROGRAM-TRAILBLAZERS, APR 2004, $622,078
CIN: A-04-00-00138	MEDICAID ESCHEATED WARRANTS - FLORIDA, JAN 2002, $613,891
CIN: A-07-04-00170	REVIEW OF PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT FOR VERITUS, AUG 2004, $594,806
CIN: A-02-03-01024	MEDICAID DRUG REBATE COLLECTIONS - NEW JERSEY, OCT 2004, $567,186
CIN: A-05-04-00054	STATE AGENCY USE OF CONTRACTED SERVICES - OHIO, MAY 2005, $560,249
CIN: A-07-02-03015	BCBS OF MN PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEB 2003, $550,083
CIN: A-05-02-72811	COMMUNITY ACTION OF GREATER INDIANAPOLIS INC., AUG 2002, $547,899
CIN: A-01-04-00008	AUDIT OF MEDICAID PAYMENTS FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL REIMBURSED AT ENHANCED RATES OCTOBER 1, 2002 THROUGH SEPTEMBER 30, 2003 OFFICE OF VERMONT HEALTH ACCESS, MAR 2005, $534,438
CIN: A-03-92-16229	STATE OF PENNSYLVANIA, MAR 1992, $496,876
CIN: A-02-02-01004	MEDICAID PPS TRANSFERS, MAY 2003, $493,158
CIN: A-03-04-00205	MEDICAID PROVIDER OVERPAYMENTS - DELAWARE, OCT 2004, $437,592

CIN: A-01-04-00506	REVIEW OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS CLAIMED BY SAINT MARY'S HOSPITAL FOR FISCAL YEAR ENDING DECEMBER 31, 2002, MAY 2004, $433,502
CIN: A-05-03-00053	ESRD PRICING ERRORS AT INDEPENDENT FACILITIES, NOV 2003, $407,300
CIN: A-10-04-00003	MEDICAID OVERPAYMENTS IN WASHINGTON, SEP 2005, $396,941
CIN: A-02-01-67912	STATE OF NEW YORK, MAR 2001, $389,536
CIN: A-01-02-73084	STATE OF MAINE, SEP 2002, $362,326
CIN: A-09-04-00058	REVIEW OF ALASKA'S CLAIM FOR FEDERAL MATCHING FUNDS FOR REIMBURSABLE SERVICE EXPENDITURES CLAIMED AS OTHER FINANCIAL PARTICIPATION, OCT 2004, $346,217
CIN: A-02-04-01003	ORGAN ACQUISITION COST SURVEY - REGION II, DEC 2004, $343,272
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, OCT 2003, $319,187
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MAR 2003, $315,474
CIN: A-03-04-00204	SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPMP) - WEST VIRGINIA, DEC 2004, $299,360
CIN: A-01-04-00522	THE MID COAST HOSPITAL IN MANIE DSH PAYMENT, SEP 2004, $289,936
CIN: A-01-04-01505	UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL REVIEW OF NIH GRANT NO. 5 R01 GM30626-22, AUG 2005, $281,993
CIN: A-01-04-00003	APPLICATION CONTROLS AT NEW HAMPSHIRE MEDICAID STATE AGENCY, FEB 2005, $274,370
CIN: A-09-94-30178	STATE OF ARIZONA, JUN 1994, $267,021
CIN: A-07-04-00175	REVIEW OF UNFUNDED PENSION COSTS AT VERITUS, INC., OCT 2004, $266,052
CIN: A-05-02-00047	UNITED GOVERNMENT SERVICES, MEDICARE PART A ADMIN. COSTS FY 1999-2001, JUN 2003, $260,831
CIN: A-07-03-02662	REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DEC 2002, $258,112
CIN: A-01-05-00508	REVIEW OF FISCAL YEAR-END BILLING AT MAINE GENERAL MEDICAL CENTER, AUG 2005, $254,915
CIN: A-03-04-00353	ACCOUNTABILITY OVER CDC BT FUNDS, JUN 2005, $238,537
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCT 2002, $229,656
CIN: A-02-01-01019	DEMO BSWNY - CASH MANAGEMENT, OCT 2002, $208,271
CIN: A-05-04-00058	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC., JUL 2004, $206,495
CIN: A-01-05-00509	REVIEW OF MEDICARE CONTRACT TERMINATION/SEVERANCE COSTS CLAIMED BY BLUE CROSS & BLUE SHIELD OF RHODE ISLAND (RIBCBS), SEP 2005, $205,384
CIN: A-01-04-01501	NORTHEASTERN UNIVERSITY DHHS GRANT COSTS GRANT #S 9274, 4000 AND 4111, JAN 2005, $194,890
CIN: A-05-05-81921	ILLINOIS COMMUNITY ACTION ASSOCIATION, MAY 2005, $187,395

CIN: A-07-01-02094	SURVEY OF OUTPATIENT OBSERVATION SERVICES, OCT 2002, $165,125
CIN: A-09-02-00083	REVIEW MEDICAID PAYMENTS FOR RESIDENT UNDER 21/22 IN PRIVATE IMDS, NOV 2004, $155,133
CIN: A-07-05-03072	MEDICAID PROVIDER OVERPAYMENTS IN SOUTH DAKOTA, JUN 2005, $154,741
CIN: A-07-04-03051	MEDICAID PROVIDER OVERPAYMENTS IN UTAH, AUG 2004, $132,749
CIN: A-05-03-00067	ADMINISTRATIVE COSTS - WI MEDICAID WAIVERS, JUN 2004, $129,663
CIN: A-01-03-00010	MEDICAID SCHOOL-BASED HEALTH SERVICES ADMINISTRATIVE CLAIMING REVIEW - RHODE ISLAND, JUN 2004, $123,010
CIN: A-05-01-00069	MERITER - MC/MA CREDIT BALANCES, JUL 2002, $122,713
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, $121,023
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JAN 1998, $114,631
CIN: A-05-05-00044	DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLAN- ARNETT HEALTH PLANS, INC. FOR FISCAL YEARS 2000, THROUGH 2003, SEP 2005, $111,862
CIN: A-01-02-00527	REVIEW OF ANTHEM BLUE CROSS/BLUE SHIELD MEDICARE CONTRACT TERMINATION AND SEVERANCE COSTS, SEP 2003, $104,468
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $100,692
CIN: A-04-03-06007	NURSING HOME QUALITY OF CARE SANCTIONS - FLORIDA, FEB 2004, $99,957
CIN: A-04-04-01002	USE OF CDC BIOTERRORISM GRANT FUNDS, JUL 2005, $98,929
CIN: A-05-02-00067	REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS & COST REPORTS @ WELBORN, JUN 2003, $97,623
CIN: A-10-05-80407	FIRST A.M.E. CHILD & FAMILY CENTER, MAR 2005, $96,803
CIN: A-09-97-00066	WALTER MCDONALD - INDIRECT COST RATE AUDIT, MAR 1998, $95,733
CIN: A-05-05-00042	DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLAN- DEAN HEALTH PLANS, INC. FOR FISCAL YEARS 2000, THROUGH 2003, AUG 2005, $91,710
CIN: A-05-02-00074	IL PARTNERSHIP PLAN - TRANSPORTATION DURING AN INPATIENT STAY, APR 2003, $89,147
CIN: A-05-01-00090	PAYMENTS TO AETNA OF FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, $87,516
CIN: A-01-04-77722	STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS, JAN 2004, $86,792
CIN: A-05-05-00043	DUPLICATE MEDICARE PAYMENTS TO COST-BASED HEALTH MAINTENANCE ORGANIZATION PLAN - JOHN DEERE HEALTH PLANS, INC. FOR FISCAL YEARS 2000 THROUGH 2003, SEP 2005, $78,799
CIN: A-05-04-00061	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF BLUE CROSS BLUE SHIELD OF NEBRASKA, DEC 2004, $78,352

CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCT 2002, $77,000
CIN: A-05-03-00085	NURSING HOME QUALITY OF CARE SANCTIONS - ILLINOIS, MAY 2004, $69,892
CIN: A-03-05-79945	BOARD OF EDUCATION OF PRINCE GEORGE'S COUNTY MARYL, DEC 2004, $67,937
CIN: A-01-03-75448	STATE OF NEW HAMPSHIRE, APR 2003, $65,917
CIN: A-07-05-82237	NORTHEAST IOWA COMMUNITY ACTION CORP., JUL 2005, $65,855
CIN: A-08-03-74429	PORCUPINE CLINIC, JUL 2003, $65,027
CIN: A-04-05-02000	AUDIT OF HHA THERAPY BILLINGS, SEP 2005, $63,425
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
CIN: A-09-04-00029	REVIEW OF AIR AMBULANCE SERVICES FOR CALENDAR YEAR 2002, JUL 2005, $62,408
CIN: A-04-02-68936	STATE OF TENNESSEE, JUN 2002, $50,717
CIN: A-05-02-00054	UNITED GOVERNMENT SERVICES, Y2K COSTS FY 1998 & 1999, APR 2003, $49,923
CIN: A-02-99-58263	PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD, JUL 1999, $49,684
CIN: A-08-05-79580	PORCUPINE CLINIC, OCT 2004, $45,688
CIN: A-03-02-00373	REVIEW OF US HELPING US, DEC 2003, $45,558
CIN: A-01-03-01500	REVIEW OF CDC HIV PROGRAMS AT GREATER BRIDGEPORT ADOLESCENT PREGNANCY PROGRAM, JUL 2003, $41,088
CIN: A-05-03-00105	AUDIT OF MEDICAID NURSING FACILITY ADMINISTRATIVE COSTS, OCT 2004, $39,104
CIN: A-01-04-01506	DARTMOUTH COLLEGE REVIEW OF NIH GRANT COSTS 5 P01 GM1630-06, SEP 2005, $37,780
CIN: A-07-04-04035	REVIEW OF MEDICARE OUTLIER PAYMENTS TO FOUNDATION CMHC, APR 2005, $36,000
CIN: A-02-00-65502	ABYSSINIAN DEVELOPMENT CORP., AUG 2000, $34,737
CIN: A-06-03-74833	AMIGOS VOLUNTEERS IN EDUCATION & SERVICES INC. (AV, APR 2003, $31,180
CIN: A-05-02-69155	STATE OF WISCONSIN, DEC 2001, $30,900
CIN: A-08-03-73541	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JAN 2003, $28,573
CIN: A-03-98-03301	AAUAP - INCURRED COST REVIEW - HHS 105-95-7011, APR 1998, $28,289
CIN: A-05-03-00097	MEDICARE OUTPATIENT CARDIAC REHAB - NORTHFIELD HOSPITAL, NOV 2003, $27,013
CIN: A-04-03-01004	OUTPATIENT CARDIAC REHAB SERVICES - HEALTHSOUTH SEA PINES REHAB HOSPITAL, DEC 2003, $26,279
CIN: A-07-02-00150	PAYMENTS TO COVENTRY-PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUN 2003, $26,000
CIN: A-09-05-80636	SOUTH COUNTY ECONOMIC DEVELOPMENT COUNCIL, FEB 2005, $25,000
CIN: A-01-04-78952	STATE OF CONNECTICUT, AUG 2004, $24,457
CIN: A-05-01-00078	PAYMENTS TO HEALTH NET-TUCSON, AZ.- FOR INSTITUTIONAL BENEFICIARIES, APR 2002, $21,233

CIN: A-05-02-72480	HANSEL NEIGHBORHOOD SERVICE CENTER INC., SEP 2002, $20,266
CIN: A-05-02-70624	STATE OF OHIO, JAN 2002, $19,970
CIN: A-04-01-67441	CATAWBA INDIAN NATION, APR 2001, $19,204
CIN: A-08-04-76779	COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, $18,925
CIN: A-05-01-00100	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $18,645
CIN: A-07-03-00151	REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUN 2003, $18,400
CIN: A-10-04-76879	STATE OF ALASKA, DEC 2003, $18,226
CIN: A-01-02-01504	REVIEW OF CDC'S HIV PROGRAMS AT FENWAY COMMUNITY HEALTH CENTER, JUN 2003, $18,028
CIN: A-05-03-00037	NURSING HOME QUALITY OF CARE SANCTIONS - OHIO, MAY 2004, $17,796
CIN: A-07-04-01011	PAYMENTS FOR UNITED HEALTHCARE FOR INSTITUTIONAL BENEFICIARIES, MAR 2005, $13,128
CIN: A-08-03-74361	PORCUPINE CLINIC, JUL 2003, $12,611
CIN: A-05-03-00012	FROEDTERT MEDICAID CREDIT BALANCES, FEB 2003, $12,066
CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JAN 2002, $11,089
CIN: A-08-05-81400	RURAL AMERICA INITIATIVES, JUN 2005, $8,000
CIN: A-05-01-68270	LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, $7,614
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), MAR 2003, $5,010
CIN: A-05-04-00030	PAYMENTS FOR SERVICES TO DECEASED MEDICAID BENEFICIARIES - MASSACHUSETTS, FEB 2005, $4,696
CIN: A-04-03-01006	OUTPATIENT CARDIAC REHAB SERVICES AT MORTON PLANT HOSPITAL, JAN 2004, $4,426
CIN: A-02-02-01035	EVALUATION OF BID PROPOSAL - MEDICARE HELP LINE, AUG 2002, $3,760
CIN: A-05-03-00084	MEDICARE OUTPATIENT CARDIAC REHAB - NORTHERN MICHIGAN HOSPITAL, OCT 2003, $3,738
CIN: A-03-95-03318	TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996, $3,016
CIN: A-04-03-01002	OUTPATIENT HOSPITAL CARDIAC REHAB - MEMORIAL HOSPITAL JACKSONVILLE, NOV 2003, $2,123
CIN: A-04-03-01005	OUTPATIENT CARDIAC REHAB SERVICES CENTRAL FL REGIONAL HOSPITAL, NOV 2003, $2,003
CIN: A-02-03-01026	MEADOWLANDS HOSPITAL MEDICAL CENTER CARDIAC REHAB SERVICES, JAN 2004, $1,703
CIN: A-06-02-00032	CMS FY 01 MEDICARE ERROR RATE - ARK BC/BS REPORT, NOV 2002, $1,311
CIN: A-05-03-00070	MEDICARE OUTPATIENT CARDIAC REHAB - ST. CHARLES MERCY HOSP, OCT 2003, $1,158

CIN: A-03-03-00393 AUDIT OF CDC HIV/AIDS GRANT TO SEXUAL MINORITY YOUTH ASSISTANCE LEAGUE, OCT 2003, $1,155

Total CINs: 198
TOTAL AMOUNT: $1,764,717,748

B. The following audit is open pending the resolution of the contractors termination audit related termination agreements and pending lawsuits:

CIN: 04-01-67441 CATAWBA INDIAN NATION. UNABLE TO DETERMINE WHEN THE REPORT WILL BE CLOSED. THE REPORT HAS 1 MONETARY FINDING FOR $19,204.

Notes to Table 2

[1]The opening balance was adjusted downward by $416 million.

[2]Management decision has not been made within 6 months on 29 reports. Discussions with management are on going and it is expected that the following audits will be resolved by the next semiannual reporting period.

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

CIN: A-07-04-04031 MEDICAID HOSPITAL OUTLIER PAYMENTS IN ILLINOIS, MAY 2005, $56,449,668

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

CIN: A-05-02-00078 ROLLUP OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, FEB 2004, $12,764,202

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

CIN: A-05-03-00019 PAYMENTS FOR SERVICES TO DECEASED RECIPIENTS - NEW YORK, OCT 2004, $6,707,623

CIN: A-05-04-00073 ROLL-UP ON ADDITIONAL GPOS, MAY 2005, $6,600,000

CIN: A-05-02-00077 MICHIGAN MEDICAID/SCHIP REVIEW, NOV 2003, $5,908,350

CIN: A-03-02-00203 VIRGINIA - SCHIP/TITLE IV - D SURVEY, JUL 2004, $5,402,491

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

CIN: A-01-04-02503 REVIEW OF MAINE'S ADOPTION ASSISTANCE SUBSIDY PAYMENTS, APR 2005, $1,900,000

CIN: A-05-02-00075 INDIANA MEDICAID/SCHIP REVIEW, NOV 2003, $1,885,708

CIN: A-05-04-00025 REVIEW OF MEDICARE PHYSICIAN PLACE OF SERVICE CODING FOR AMBULATORY SURGICAL AND RELATED PROCEDURES, OCT 2004, $742,510

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

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

CIN: A-05-04-00030 PAYMENTS FOR SERVICES TO DECEASED MEDICAID BENEFICIARIES - MASSACHUSETTS, FEB 2005, $503,715

CIN: A-05-04-00054 STATE AGENCY USE OF CONTRACTED SERVICES - OHIO, MAY 2005, $277,243

CIN: A-07-04-01008	FAMILY PLANNING - FEE-FOR-SERVICE - COLORADO, JAN 2005, $269,024
CIN: A-05-00-00006	MEDICAID MUTUALLY EXCLUSIVE CODES - MI, JUN 2000, $240,000
CIN: A-05-04-00023	HEAD START COMPENSATION REVIEW - CEOGC, JAN 2005, $178,000
CIN: A-01-02-73084	STATE OF MAINE, SEP 2002, $149,082
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MAR 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 PREAWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, $114,289
CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JAN 2002, $98,698
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JAN 1998, $90,528
CIN: A-05-02-00084	MEDICARE OUTPATIENT CARDIAC REHAB - ST.LUKE'S MEDICAL CENTER, JUL 2003, $47,247
CIN: A-05-04-00051	ALLOWABILITY OF CDC BIOTERRORISM COSTS - OHIO DEPARTMENT OF HEALTH, FEB 2005, $4,154

TOTAL CINS : 29
TOTAL AMOUNT: $472,209,684

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 Congress under separate cover. Copies are available upon request.

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	p. 45
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	Appendixes B and C
(a)(4)	Matters referred to prosecutive authorities	p. 46
(a)(5)	Summary of instances in which 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	p. 43
(a)(9)	Statistical Table 2—Funds Recommended To Be Put to Better Use	p. 44
(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 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; or engaging in unlawful kickback arrangements.

Providers subject to exclusion are granted due process rights (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.

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; violations of rules regarding the possession, use, and transfer of biological agents and toxins; and payment or receipt of remuneration in violation of the anti-kickback statute (42 U.S.C. § 1320a-7b(b)).

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

The Anti-Kickback Statute–The anti-kickback statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers, or pays remuneration, in cash or in kind, to induce or in return for (1) referring an individual to a person or 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 a penalty between $5,500 and $11,000 for each false claim it knowingly submits or causes to be submitted to a Federal program. Similarly, a person or entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid.

The FCA defines "knowing" to include not only the traditional definition, but also instances in which the person acted in deliberate ignorance 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 a private individual to file suit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries.