Appendixes:

A: Reporting Requirements

B: Questioned Costs and Funds Put to Better Use

C: Peer Review Results

D: Sanction Authorities

E. Acronyms and Abbreviations

Appendix A: Reporting Requirements

The Inspector General Act of 1978

The reporting requirements of the Inspector General Act of 1978, as amended, are listed in the following table along with the location of the required information. Page numbers in the table indicate pages in this report. The word "None" appears where there are no data to report under a particular requirement.

Section of the Act	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	Part IV. See page IV-16.
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout this report
(a)(3)	Prior significant recommendations on which corrective action has not been completed	See the *Compendium of Unimplemented Recommendations*: www.oig.hhs.gov/publications.html
(a)(4)	Matters referred to prosecutive authorities	Legal and Investigative Section
(a)(5)	Summary of instances in which information was refused	None
(a)(6)	List of audit reports	Submitted to Secretary under separate cover
(a)(7)	Summary of significant reports	Throughout this report

Section of the Act	Requirement	Location
(a)(8)	Statistical Table 1 – Reports With Questioned Costs	Appendix B
(a)(9)	Statistical Table 2 – Funds Recommended To Be Put to Better Use	Appendix B
(a)(10)	Summary of previous audit reports without management decisions	Appendix B
(a)(11)	Description and explanation of revised management decisions	Appendix B
(a)(12)	Management decisions with which the Inspector General is in disagreement	None
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	Reported annually in the spring *Semiannual Report*. See page IV-13.
(a)(14)-(16)	Results of peer reviews of HHS-OIG conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by HHS OIG of other OIGs.	Appendix C

Other Reporting requirements

§ 845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for FY 2008 (P.L. No. 110-181), § 845.	Departmentwide Issues, See page IV-15.

Appendix B: Questioned Costs and Funds To Be Put to Better Use

The following statistical tables summarize the Office of Inspector General's (OIG) monetary recommendations and the Department of Health & Human Services' (HHS) responses to those recommendations. This information is provided in accordance with sections 5(a)(8) and (a)(9) of the Inspector General Act (5 U.S.C. App. §§ 5(a)(8) and (a)(9)) and the Supplemental Appropriations and Rescissions Act of 1980.

Table 1: Audit Reports With Questioned Costs

Questioned costs are those costs questioned by OIG audits because of an alleged violation of a provision of a law, regulation, contract, grant, or other agreement governing the expenditure of funds. Costs are questioned because the expenditure was not supported by adequate documentation or because the expenditure was unnecessary or unreasonable.

OIG includes those questioned costs that HHS program officials, in a management decision, have agreed should not be charged to the Federal Government, commonly referred to as disallowed costs, as part of the expected recoveries in the Accomplishments section at the beginning of the *Semiannual Report*. Superscripts indicate end notes.

Audit Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decision had been made by the beginning of the reporting period[1]	175	$859,558,000	$88,104,000
Reports issued during the reporting period	68	$493,208,000	$3,169,000
Total Section 1	243	$1,352,766,000	$91,273,000
Section 2			
Reports for which a management decision was made during the reporting period[2, 3]			
Disallowed costs	132	$222,380,000	$6,138,000
Costs not disallowed	6	$8,848,000	$10,000
Total Section 2	138	$231,228,000	$6,148,000
Section 3			
Reports for which no management decision had been made by the end of the reporting period			

Audit Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Total Section 1 Minus Total Section 2	105	$1,121,538,000	$85,125,000

Audit Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 4			
Reports for which no management decision was made within 6 months of issuance[4]	64	$742,254,000	$84,116,000

Table 2: Funds Recommended To Be Put to Better Use

Recommendations from audit reports that funds be put to better use are recommendations that funds could be used more efficiently if management took action to implement an OIG recommendation through reductions in outlays, deobligation of funds, and/or avoidance of unnecessary expenditures. Table 2 reports HHS program officials' decisions to take action on these audit recommendations. Implemented recommendations are reported in the fall Semiannual Reports.

Audit Reports	Number of Reports	Dollar Value
Section 1		
Reports for which no management decision had been made by the beginning of the reporting period[1]	28	$4,280,541,000
Reports issued during the reporting period	6	$549,817,000
Total Section 1	34	$4,830,358,000
Section 2		
Reports for which a management decision was made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	11	$1,213,303,000
Based on proposed legislative action	0	$0
Value of recommendations not agreed to by management	1	$4,764,000
Total Section 2	12	$1,218,067,000
Section 3		
Reports for which no management decision had been made by the end of the reporting period[2]		
Total Section 1 Minus Total Section 2	22	$3,612,291,000

End Notes to Tables 1 and 2

Table 1 End Notes

[1] The opening balance was adjusted upward by $50 million because of a reevaluation of previously issued audit recommendations.

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

- A-02-08-01002, *Review of High-Dollar Medicare Payments to Hospitals for Inpatient Claims Processed by National Government Services for the Period January 1, 2003, Through December 31, 2005*. The Centers for Medicare & Medicaid Services (CMS) completed its review of high-dollar claims processed during calendar years (CY) 2003-2005 and identified an additional $1,593,363 in overpayments.

- A-03-03-00220, *Review of Family Planning Service Costs Claimed by Delaware's Medicaid Managed Care Program*. Based on a review of additional documentation provided by the State to support family planning claims, CMS determined that the original disallowance of $2,916,288 should be reduced by $2,003,492.

- A-04-95-02111, *Review of Hospice Eligibility at the Hospice of the Florida Suncoast, Inc.* CMS reversed its 1998 decision to recover overpayments totaling $14,800,000 because it had not been able to determine that beneficiaries were not eligible for coverage.

- A-04-06-00026, *Review of Medicaid Services to Incarcerated Juveniles in the State of Georgia For Federal Fiscal Years 2003 and 2004*. CMS, after a review of additional information submitted by the State and in consultation with the OIG, reduced its original disallowance by $1,653,356.

- A-07-07-00243, *Review of the Qualified Pension Plan at CareFirst of Maryland, Inc., a Terminated Medicare Contractor, for the Period January 1, 2002, to December 31, 2005*. CMS negotiated a settlement with a terminated Medicare contractor to reduce CMS's share of the contractor's Medicare pension assets by $1,325,834 to reflect lump sum pension payouts that had been made by the contractor.

Not detailed are net reductions to previously reported disallowed costs totaling $523,114.

[3] Included are management decisions to disallow $39.8 million in questioned costs that were identified by non-Federal auditors in audits of States and local governments, colleges and universities, and nonprofit organizations receiving Federal awards conducted in accordance with Office Management and Budget (OMB) Circular A-133. By law, OIG is responsible for ensuring that work performed by these non-Federal

auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

[4] Because of administrative delays, some of which were beyond management control, resolution of the following 64 audits was not completed within 6 months of issuance of the report. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-06-07-00041	REVIEW OF AMP CALCULATION, MFR A, MAR 2008, $268,000,000.
CIN: A-06-07-00039	REVIEW OF AMP CALCULATION, MFR C, MAR 2008, $101,000,000.
CIN: A-03-07-00560	PA FOSTER CARE MAINTENANCE PAYMENTS, PHILADELPHIA, UNDER $300, MAY 2008, $56,513,439.
CIN: A-09-06-00023	REVIEW OF LOS ANGELES COUNTY APPROVAL PROCESS OF RELATIVE FOSTER FAMILY HOMES, OCT 2009, $45,520,603.
CIN: A-01-09-00507	NATIONWIDE REVIEW OF INPATIENT REHABILITATION FACILITIES PATIENT ASSESSMENT INSTRUMENTS, JUN 2010, $39,247,645.
CIN: A-04-09-00059	REVIEW OF INPATIENT REHABILITATION CARE FACILITIES MEDICARE CLAIMS FOR COMPLIANCE WITH CMS TRANSFER CLASSIFICATION REQUIREMENTS FOR 10/1/03 THROUGH 9/30/07, JUN 2010, $34,051,807.
CIN: A-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, $33,318,976.
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES, CT, MAY 2003, $32,780,146.
CIN: A-06-07-00040	REVIEW OF AMP CALCULATION, MFR B, MAR 2008, $27,700,000.
CIN: A-01-07-00013	REVIEW OF MEDICAID SUPPLEMENTAL PAYMENT TO UMASS MEMORIAL HEALTH CARE, INC., DEC 2009, $14,789,242.
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEP 2002, $14,165,950.
CIN: A-03-06-00564	PA FOSTER CARE MAINTENANCE PAYMENT, PHILADELPHIA, OVER $300/DAY, DEC 2007, $11,693,989.
CIN: A-03-05-00550	AUDIT OF PA FOSTER CARE MAINTENANCE PAYMENTS, CASTILLE SAMPLE, SEP 2007, $11,611,822.
CIN: A-03-08-03000	REVIEW OF PROCUREMENTS MADE BY NIH FOR THE DEPARTMENT OF DEFENSE, MAY 2009, $6,300,000.
CIN: A-04-08-03521	AUDIT OF UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS IN TN FOR THE PERIOD OCTOBER 1, 1998 TO DECEMBER 31, 2007, FEB 2009, $5,768,243.

CIN: A-01-08-00511	REVIEW OF SEPARATELY BILLED CLINICAL LABORATORY SERVICES PROVIDED TO ESRD BENEFICIARIES BY FMCNA, MAR 2010, $5,410,712
CIN: A-01-06-00007	REVIEW OF RHODE ISLAND'S MEDICAID ADMINISTRATIVE COST CLAIMS, FY 2004 - FY 2005, MAR 2008, $5,092,735.
CIN: A-02-09-02019	REVIEW OF ADOPTION ASSISTANCE DUPLICATE CLAIMS, SEP 2010, $4,811,735.
CIN: A-04-08-03523	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN FL FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2009, $4,413,264.
CIN: A-04-08-06002	FLORIDA'S 2003 TO 2005 COMPLIANCE WITH THE RYAN WHITE CARE ACT PAYER OF LAST RESORT REQUIREMENT, MAY 2010, $4,400,613.
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFY 1998, SEP 2002, $3,776,054.
CIN: A-10-96-00001	REVIEW OF ESRD PAYMENTS TO GROUP HEALTH COOPERATIVE OF PUGET SOUND, APR 1997, $2,763,498.
CIN: A-07-08-03114	REVIEW OF MISSOURI ACF TRAINING COSTS, AUG 2009, $2,556,099.
CIN: A-07-09-03119	MO CLAIM FOR TITLE IV-E TRAINING COSTS FOR SALARIES AND BENEFITS, JUL 2009, $741,872.
CIN: A-07-09-03121	MO TITLE IV-E TRAINING COSTS FOR RESIDENTIAL TREATMENT CENTERS AND FOSTER CARE PARENTING, SEP 2009, $569,663.
CIN: A-05-09-00047	HEAD START MATCHING COSTS, COMMUNITY ACTION COMMITTEE OF LANCASTER FAIRFIELD COUNTY, JAN 2010, $547,019.
CIN: A-05-06-00038	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, IN, MAR 2007, $461,430.
CIN: A-01-08-00014	AUDIT OF MEDICAID ADMINISTRATIVE COSTS CLAIMED BY THE COMMONWEALTH OF MASSACHUSETTS, OCTOBER 1, 2005 THROUGH SEPTEMBER 30, 2007, FEB 2010, $448,968.
CIN: A-06-06-00072	REVIEW OF COST FOR TEXAS MEDICAL FOUNDATION AUDITEE, MAY 2008, $403,581.
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $319,355.
CIN: A-07-09-03120	MO CLAIM FOR TITLE IVE TRAINING COSTS FOR LONG TERM TRAINING, FEB 2010, $301,187.
CIN: A-07-05-01013	PAYMENTS FOR M+C ORGANIZATION FOR INSTITUTIONAL BENEFICIARIES, OCT 2005, $293,885.
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS, MI, AUG 2006, $257,859.
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCT 2002, $229,656.

CIN: A-07-06-01035	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION, IOWA, OCT 2007, $208,974.
CIN: A-03-09-00021	REVIEW OF MEDICARE PART D DRUG PAYMENTS TO VIRGINIA FOR SERVICE DATES JANUARY 1 - MARCH 8 2006, JUL 2010, $168,500.
CIN: A-09-05-00077	REVIEW OF PACIFICARE'S USE OF ADDITIONAL CAPITATION UNDER THE MMA OF 2003, MAR 2006, $135,000.
CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, $124,046.
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, $121,023.
CIN: A-04-07-01045	COSTS CLAIMED FOR ESRD NETWORK 6 OPERATIONS, AUG 2009, $116,728.
CIN: A-09-10-02005	POWER MOBILITY DEVICE CLAIMS BY D&M SALES, LLC FOR CALENDAR YEARS 2006-2008, SEP 2010, $113,941.
CIN: A-05-97-00017	FHP, INC., HMO INSTITUTIONAL STATUS PROJECT, JUN 1998, $109,114.
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $100,692.
CIN: A-05-01-00090	PAYMENTS TO AETNA U.S. HEALTHCARE PA FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, $87,516.
CIN: A-03-08-00011	REVIEW OF DUPLICATE PAYMENTS TO PHARMACIES FOR MEDICARE PART D DRUGS (PDE-DEMO): BARON DRUGS, SEP 2009, $79,489.
CIN: A-02-06-01023	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION, NEW YORK, MAR 2008, $77,358.
CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCT 2002, $77,000.
CIN: A-09-06-00039	MEDICARE INTEGRITY - AUDIT OF QUALITY IMPROVEMENT ORGANIZATION, WASHINGTON STATE, FEB 2008, $73,636.
CIN: A-01-10-00600	REVIEW OF VERMONT'S COMPLIANCE WITH CMS REIMBURSEMENT OF MEDICARE PART D DRUG DEMONSTRATION PROJECT REQUIREMENTS, SEP 2010, $70,027.
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432.
CIN: A-01-08-00601	REVIEW OF COSTS CLAIMED BY RETIREE DRUG SUBSIDY PLAN SPONSOR BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, INC. FOR PLAN YEAR ENDED DECEMBER 31, 2006, APR 2009, $33,300.
CIN: A-04-06-00023	REVIEW OF QUALITY IMPROVEMENT ORGANIZATIONS, TENNESSEE, JUL 2008, $30,654.
CIN: A-08-03-73541	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JAN 2003, $28,573.

CIN: A-07-02-00150	PAYMENTS TO COVENTRY, PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUN 2003, $26,000.
CIN: A-05-01-00078	PAYMENTS TO HEALTH NET, TUCSON, AZ FOR INSTITUTIONAL BENEFICIARIES, APR 2002, $21,233.
CIN: A-08-04-76779	COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, $18,925.
CIN: A-05-01-00100	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842.
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $18,645.
CIN: A-07-03-00151	REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUN 2003, $18,400.
CIN: A-07-04-01011	PAYMENTS FOR UNITED HEALTHCARE FOR INSTITUTIONAL BENEFICIARIES, MAR 2005, $13,128.
CIN: A-05-06-00043	REVIEW OF OHIO KEPRO, FEB 2008, $11,874.
CIN: A-05-01-00070	PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, MISSOURI GROUP HEALTH PLAN, JAN 2002, $11,089.
CIN: A-06-08-00064	LOUISIANA - CDC BIOTERRORISM AND EMERGENCY PREPAREDNESS, SEP 2010, $10,892.
CIN: A-09-09-00111	MEDICARE PAYMENTS FOR DME CLAIMS WITH KX MODIFIERS, SEP 2010, $5,941.
TOTAL CINS:	64
TOTAL AMOUNT:	$742,254,019

Table 2 End Notes

[1] The opening balance was adjusted upward by $127,000.

[2] Because of administrative delays, some of which were beyond management control, resolution of the following 15 audits was not completed within 6 months of issuance of the report. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-06-09-00033	REVIEW OF ADDITIONAL REBATES OF NEW BRAND NAME DRUGS, MAR 2010, $2,500,000,000.
CIN: A-02-07-02000	OPEN AND INACTIVE GRANTS ON THE PAYMENT MANAGEMENT SYSTEM, ACF, FEB 2009, $472,155,156.
CIN: A-09-09-00111	MEDICARE PAYMENTS FOR DME CLAIMS WITH KX MODIFIERS, SEP 2010, $70,000,000.
CIN: A-04-06-03508	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, FLORIDA, JAN 2008, $7,881,447.
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MI, AUG 2006, $4,397,133.
CIN: A-06-00-00073	MANAGED CARE ADDITIONAL BENEFITS, NYLCARE HEALTH PLANS OF THE SOUTHWEST, CY 2000, MAR 2002, $4,000,000.

CIN: A-06-08-00026	REVIEW OF WORKFORCE STABILIZATION GRANT FOR THE GREATER NEW ORLEANS AREA, MAR 2010, $1,435,000.
CIN: A-09-09-00055	MEDICAID, REVIEW OF CALIFORNIA DRUG EXPENDITURES (MANUAL CLAIMS), JUN 2010, $1,096,464.
CIN: A-05-06-00038	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, IN, MAR 2007, $871,677.
CIN: A-03-10-03302	BID PROPOSAL AUDIT, SEP 2010, $354,689.
CIN: A-03-10-03301	BID PROPOSAL AUDIT, SEP 2010, $115,180.
CIN: A-05-01-00070	PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, MISSOURI GROUP HEALTH PLAN, JAN 2002, $98,689.
CIN: A-05-06-00023	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS, MN, SEP 2006, $28,240.
CIN: A-05-10-00081	BID PROPOSAL AUDIT, SEP 2010, $23,047.
CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, $17,764.
TOTAL CINS:	15
TOTAL AMOUNT:	$3,062,474,486

Appendix C: Peer Review Results

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

Office of Audit Services Peer Review Results

During this semiannual reporting period, no peer reviews were conducted by another OIG organization on the Department of Health & Human Services (HHS) OIG's Office of Audit Services (OAS) and OAS did not conduct a peer review on other OIGs. Listed below is information concerning OAS's peer review activities during prior reporting periods.

Date	Reviewing Office	Office Reviewed	Findings
June 2009	U.S. Postal Service OIG	HHS-OIG, OAS	The system of quality control for the audit organization of HHS OIG in effect for the year ending September 30, 2008, has been suitably designed and complied with to provide HHS OIG with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Federal audit organizations can receive a rating of pass, pass with deficiencies, or fail. HHS OIG received a peer review rating of pass.
December 2009	HHS OIG, OAS	U.S. Department of Defense (DoD) OIG	The system of quality control for the audit organization of DoD OIG in effect for the year ending March 31, 2009, has been suitably designed and

Date	Reviewing Office	Office Reviewed	Findings
			complied with to provide DoD OIG with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Federal audit organizations can receive a rating of pass, pass with deficiencies, or fail. DoD OIG received a peer review rating of pass. HHS OIG recommended that DoD OIG continue to improve its system of quality control, including audit supervision, audit documentation, and report content, by ensuring compliance with audit standards and its policies and procedures. The DoD OIG indicated that it has completed the corrective actions to improve its quality control system that were underway during December 2009.

Office of Investigations Peer Review Results

During this semiannual reporting period, no peer reviews were conducted by another OIG organization on HHS OIG's Office of Investigations (OI). OI conducted a peer review on another OIG. Listed below is information concerning OI's peer review activities during the current and prior reporting periods.

Date	Reviewing Office	Office Reviewed	Findings
March 2009	U.S. Department of Labor OIG	HHS OIG, OI	The system of internal safeguards and management procedures for the investigative

Date	Reviewing Office	Office Reviewed	Findings
			function of HHS OIG in effect for the year ending September 30, 2008, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.
January 2010	HHS OIG, OI	U.S. Department of Justice (DOJ) OIG	The system of internal safeguards and management procedures for the investigative function of DOJ OIG in effect for the year ending September 30, 2009, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.
January 2011	HHS OIG, OI	U.S. Department of Housing and Urban Development (HUD)	The system of internal safeguards and management procedures for the investigative function of HUD OIG in effect through February 2011 was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Appendix D: Summary of Sanction Authorities

The Inspector General Act of 1978, as amended, sets forth specific requirements for semiannual reports to be made to the Secretary for transmittal to Congress. A selection of other authorities appears below.

Program Exclusions

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

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) added another basis for the imposition of a permissive exclusion, that is, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program, including managed care programs under Medicare and Medicaid, as well as Medicare's prescription drug program.

Providers subject to exclusion are granted due process rights. These include a hearing before an administrative law judge and appeals to the Department of Health & Human Services (HHS) Departmental Appeals Board and Federal district and appellate courts regarding the basis for the exclusion and the length of the exclusion.

Patient Dumping

The Social Security Act, § 1867 (42 U.S.C. § 1395dd), provides that when an individual 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 (fewer than 100 beds) and up to $50,000 against larger hospitals (100 beds or more) for each instance in which the hospital negligently violated any of the section 1867 requirements. In addition, OIG may collect a penalty of up to $50,000 from a responsible physician for each negligent violation of any of the section 1867 requirements and, in some circumstances, may exclude a responsible physician.

Civil Monetary Penalties Law

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

For the purposes of the civil monetary penalties law, "should know" is defined to mean that the person acted in reckless disregard or deliberate ignorance of the truth or falsity of the claim. The law and its implementing regulations also authorize actions for a variety of other violations, including submission of claims for items or services furnished by an excluded person; requests for payment in violation of an assignment agreement; violations of rules regarding the possession, use, and transfer of biological agents and toxins; and payment or receipt of remuneration in violation of the anti-kickback statute (42 U.S.C. § 1320a-7b(b)).

The Affordable Care Act added more grounds for imposing civil monetary penalties. These include, among other conduct, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program (including Medicare and Medicaid managed care programs and Medicare Part D) for which the Affordable Care Act authorizes a penalty of up to $50,000 for each false statement, as well as activities relating to fraudulent marketing by managed care organizations, their employees, or their agents.

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

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

Individuals and entities that engage in unlawful referral or kickback schemes may be subject to criminal penalties under the general criminal anti-kickback statute; a civil monetary penalty under OIG's authority pursuant to the Social Security Act, § 1127(a)(7) (42 U.S.C. § 1320a-7a); and/or program exclusion under OIG's permissive exclusion authority under the Social Security Act, § 1128(b)(7) (42 U.S.C. § 1320a-7(b)(7)).

False Claims Amendments Act of 1986 – Under the Federal False Claims Amendments Act of 1986 (FCA) (31 U.S.C. §§ 3729–3733), a person or an entity is liable for up to treble damages and a penalty between $5,500 and $11,000 for each false claim it knowingly submits or causes to be submitted to a Federal program. Similarly, a person or an entity is liable under the FCA if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid.

The FCA defines "knowing" to include not only the traditional definition but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Under the FCA, no specific intent to defraud is required. Further, the FCA contains a qui tam, or whistleblower, provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any fraud recoveries. The FCA was again amended in 2009 in response to recent Federal court decisions that narrowed the law's applicability. Among other things, these amendments clarify the reach of the FCA to false claims submitted to contractors or grantees of the Federal Government.

Appendix E: Acronyms and Abbreviations

Following are selected acronyms and abbreviations used in this publication.

Terms, Titles, and Organizations

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

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

Public Laws

Affordable Care Act	Patient Protection and Affordable Care Act of 2010, P.L. No. 11-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-52
ACA	See Affordable Care Act above.
CARE Act	Ryan White Comprehensive AIDS Resources Emergency Act of 1990, P.L. No. 101-381
CFO Act	Chief Financial Officer Act of 1990, P.L. No. 101-576
EMTALA	Emergency Medical Treatment and Labor Act of 1986, P.L. No. 99-272
FCA	False Claims Act Amendments of 1986, P.L. No. 99-562 (Updated in P.L. No. 111-203)

FDCA	Federal Food, Drug, and Cosmetic Act of 1938, P.L. No. 75-717
FFMIA	Federal Financial Management Improvement Act of 1996, P.L. No. 110-181
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
IG Act	Inspector General Act of 1978, as amended by P.L. No. 111-25, 5 U.S.C. App.
MIPPA	Medicare Improvements for Patients and Providers Act, P.L. No. 110-275
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173
PHS Act	Public Health Service Act of 1944
Recovery Act	American Recovery and Reinvestment Act of 2009, P.L. No. 111-5
Not Abbreviated	Social Security Act of 1935, P.L. No. 74-271