

**OFFICE OF
INSPECTOR GENERAL**

U.S. Department of Health and Human Services

**SEMIANNUAL REPORT
TO CONGRESS**

April 1 – September 30, 2014

A Message From the Inspector General

This *Semiannual Report to Congress*, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG), Department of Health and Human Services (HHS or the Department), for the 6-month period that ended September 30, 2014.



Daniel R. Levinson
Inspector General

Combating fraud, waste, and abuse across more than 100 Department programs is our mission. In this reporting period, we have recommended legislative fixes that could save Medicare billions of dollars and published notable Medicare and Medicaid work that resulted in significant monetary returns and improvements in adherence to Federal requirements. OIG has continued to work diligently with its partners to fight fraud. Our partnership with other Federal, State, and local law enforcement entities as part of the Health Care Fraud Prevention and Action Team (HEAT) continues to produce strong results, with over \$440 million in investigative receivables for this reporting period alone. Our fraud-fighting efforts in non-Centers for Medicare & Medicaid Services programs continue, and this report includes results about investigative efforts to combat grant fraud in Indian Health Service programs.

One important area of focus for OIG is promoting the economy, efficiency, and effectiveness of the Patient Protection and Affordable Care Act (ACA) programs. Several reports generated during this reporting period included recommendations to strengthen the integrity of the new health insurance marketplaces. Two reports provided a first look at enrollee eligibility verifications, a critical component of marketplace operations. Our examination of the effectiveness of enrollment procedures and safeguards revealed deficiencies in internal controls that may have limited certain marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining qualified health plan eligibility. Another report examined the process for resolving inconsistencies between applicants' self-attested application information and other data and revealed that, at the time of our work, marketplaces were unable to resolve most inconsistencies. A third recent report found that selected marketplaces generally protected personally identifiable information, but could improve some information security controls. Collectively, these reports demonstrate OIG's commitment toward providing timely information to the Department as it works to implement and improve marketplace operations.

OIG's ongoing and planned reviews will assess the Department's implementation and operation of ACA programs and progress toward achieving goals. Additional marketplace work is examining, among other things, expenditures, Department management and administration of marketplace programs, and information technology security. Additional priority areas for ACA oversight include Medicare and Medicaid reforms and new public health grant programs.

I would once again like to express my appreciation to Congress and to the Department for their sustained commitment toward improving the efficiency and effectiveness of HHS programs.

Daniel R. Levinson
Inspector General

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Highlights

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Semiannual Report to Congress* (Semiannual Report) describes significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. This edition addresses work completed during the second half of fiscal year (FY) 2014 (April–September) and summarizes key accomplishments during the period.

Fiscal Year 2014 accomplishments

During FY 2014, OIG reported expected recoveries of over \$4.9 billion consisting of nearly \$834.7 million in audit receivables and about \$4.1 billion in investigative receivables, which include about \$1.1 billion in non-HHS investigative receivables resulting from our work in areas such as the States' shares of Medicaid restitution.

OIG reported 971 criminal actions against individuals or entities that engaged in crimes against HHS programs and 533 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters. We also reported exclusions of 4,017 individuals and entities from participation in Federal health care programs.

Medicare Fraud Strike Force accomplishments

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

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. The teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force began in March 2007 and is operating in nine major cities. During this FY, Strike Force efforts resulted in the filing of charges against 228 individuals or entities, 232 criminal actions, and \$441 million in investigative receivables. The effectiveness of the Strike Force model is enhanced by interagency collaboration.

Strike Force nationwide takedown

During this reporting period, a nationwide Strike Force takedown resulted in charges against 90 individuals who were involved in different health care fraud schemes. These individuals, including doctors, nurses, and other medical professionals, allegedly participated in schemes involving approximately \$260 million in false claims billed to Medicare. The defendants charged are accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statute, and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services, including home health care, mental health

services, psychotherapy, physical and occupational therapy, durable medical equipment, and pharmacy fraud.

According to court documents, the defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and/or were never provided. In many cases, court documents allege that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, which enabled the providers to then submit fraudulent claims to Medicare for services that were medically unnecessary or never performed. The Strike Force takedown occurred in Detroit, Michigan; Miami and Tampa, Florida; Houston, Texas; Brooklyn, New York; and Los Angeles, California.

Medicare wasteful payments, policies, and practices

Medicare Part A covers certain inpatient services, such as those provided in hospitals and skilled nursing facilities and some home health services. Part B covers certain other medical services, equipment, supplies, and drugs that Part A does not cover. Health care providers and suppliers bill Medicare. The claims are processed by Medicare contractors. Part D is Medicare's optional prescription drug program through which private insurance companies and other plan sponsors offer prescription drug coverage to Medicare beneficiaries. "Waste" is a broad term that applies to situations in which Medicare pays more than it should. Policies or practices sometimes result in waste when unintended loopholes or other inherent problems invite exploitation or hinder consistent payment determinations. Medicare's supporting systems and practices sometimes result in waste by hindering timely and appropriate payment adjustments.

Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs ([OEI-02-11-00170](#))

Almost 1,600 Medicare Part D beneficiaries had questionable utilization patterns for human immunodeficiency virus (HIV) drugs in 2012, at a cost of \$32 million. These beneficiaries had no indication of HIV in their medical histories, received an excessive dose or supply of HIV drugs, received HIV drugs from a high number of pharmacies or prescribers, or received contraindicated drugs (i.e., HIV drugs that should not be used in combination with one another). These patterns may indicate that a beneficiary is receiving inappropriate drugs and diverting them for illegal sale, that a pharmacy is billing for drugs that a beneficiary never received, or that a beneficiary's identification number was stolen.

Manufacturer Safeguards May Not Prevent Copayment Coupon Use for Part D Drugs ([OEI-05-12-00540](#))

We identified the safeguards that pharmaceutical manufacturers have in place to prevent copayment coupons from being used to purchase drugs paid for by Medicare Part D and determined that their safeguards may not stop all coupons from being used for Part D covered drugs. These findings raise concerns that copayment coupons may encourage Part D beneficiaries to purchase higher cost brand drugs instead of lower cost, equally effective alternative drugs. This could increase costs for Part D plans, the Part D program, and Part D beneficiaries. Additionally, manufacturers may be liable under the anti-kickback statute if they offer coupons to induce the purchase of drugs paid for by Part D or any other Federal health care program.

OIG's Special Advisory Bulletin affirmed that pharmaceutical manufacturers are at risk of sanctions if they fail to take appropriate steps to ensure that their copayment coupons do not induce the purchase of items or services covered by Federal health care programs, including, but not limited to, drugs covered by Part D. For this reason, manufacturers may engage industry stakeholders and Centers for Medicare & Medicaid Services (CMS) in an effort to identify a solution to ensure that coupons are not used for drugs covered by Part D. CMS should cooperate with industry stakeholder efforts to improve the reliability of pharmacy claims edits and make coupons transparent.

Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to ASC Payment Rates ([A-05-12-00020](#))

Medicare and its beneficiaries could save \$12 billion during calendar years (CYs) 2012 through 2017 if CMS reduces hospital outpatient department payment rates for ambulatory surgical center (ASC)-approved procedures to the same level as ASC payment rates. When outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department, the payment rates are generally lower.

Medicare Part B Prescription Drug Dispensing and Supplying Fee Payment Rates Are Considerably Higher Than the Rates Paid by Other Government Programs ([A-06-12-00038](#))

Medicare Part B would have saved more than \$100 million in 2011 if its rates for dispensing and supplying fees for certain drugs were aligned with the rates that Part D or State Medicaid programs paid.

Medicare and Medicaid improper claims and payments

Medicare and Medicaid make improper payments (a form of wasteful spending) when the programs do not effectively prevent, deter, identify, or address inappropriate and abusive billing by providers and suppliers. Some, but not all, abusive billing is fraudulent. Health care providers and suppliers bill Medicare directly for reimbursement. For the Medicaid program, health care providers and suppliers are paid by the States; the States then report the amounts to CMS to receive the Federal share.

Limited Compliance With Medicare's Home Health Face-to-Face Documentation Requirements ([OEI-01-12-00390](#))

For 32 percent of home health claims that required face-to-face encounters, the documentation did not meet Medicare requirements and physicians inconsistently completed the narrative portion of the face-to-face documentation. This resulted in \$2 billion in payments that should not have been made.

Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010 ([OEI-04-10-00181](#))

Medicare inappropriately paid \$6.7 billion for claims for evaluation and management (E/M) services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. E/M services are 50 percent more likely to be paid for in error than other Part B services, and most improper payments result from errors in coding and from insufficient documentation.

Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health-Care-Related Tax ([A-03-13-00201](#))

Pennsylvania's Gross Receipts Tax on Medicaid managed care organizations appears to be a health-care-related tax that is impermissible for Medicaid funding. Through this tax, Pennsylvania collected \$1.76 billion from its Medicaid managed care organizations over 3 years and used that money to pay some of its share of capitation payments.

Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy ([A-09-13-02036](#))

Medicare inappropriately paid hospital inpatient claims subject to its postacute care transfer policy, resulting in overpayments totaling approximately \$19.5 million over 4 years. Medicare overpaid the hospitals because the Common Working File edits related to postacute care transfers were not working properly.

HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Was Not Fully Compliant ([A-17-14-52000](#))

HHS met many requirements of the Improper Payments Information Act of 2002 (IPIA) as amended by the Improper Payments Elimination and Recovery Act of 2010 but did not fully comply with it for FY 2013. We did not identify any new issues in this, OIG's third, report on HHS's compliance with the IPIA, but continue to recommend that the Department improve its compliance with the IPIA.

Affordable Care Act implementation

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, made changes to HHS programs and enacted a range of new programs that affect the Department. Our work has encompassed and will continue to encompass Health Insurance Exchanges (Marketplaces), Medicaid expansion, use of State establishment grants, and the use of startup and solvency loans for Consumer Operated and Oriented Plan Loans.

Certain Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces To Meet Applicable Federal Requirements Were Less Than Effective ([A-09-14-01000](#))

Not all internal controls implemented by the Federal, California, and Connecticut Marketplaces were effective in ensuring that individuals were enrolled in qualified health plans (QHPs) according to Federal requirements. The deficiencies in internal controls that we identified may have limited the Marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment in QHPs.

Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data ([OEI-01-14-00180](#))

From October through December 2013, Marketplaces were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income, although each applicant can have multiple inconsistencies. Specifically, the Federal Marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational.

Oversight of HHS grants

HHS is the largest grant-making organization in the Federal Government, and its funding of health and human services programs touches the lives of almost all Americans. The size and scope of Departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public. Yet OIG has noted weaknesses in the oversight of grantees year after year.

Grant fraud in Indian country

In a collaborative effort by OIG's Office of Investigations, Office of Audit Services, Office of Evaluation and Inspections, and Office of Counsel to the Inspector General, OIG has conducted a grant project called the Indian Country Grant Fraud Initiative. The project involves the review of various HHS grant programs—primarily the Low Income Home Energy Assistance program (LIHEAP), Temporary Assistance for Needy Families program, and Head Start program—overseen by HHS operating divisions (OpDivs), such as the Administration for Children and Families, the Indian Health Service, and the Health Resources and Services Administration. The project has exposed a number of fraudulent schemes, including theft and embezzlement; bribery of tribal officials and grantees; provision of false information on applications by recipients; unauthorized or inflated salaries (paid to staff, family, and friends); wages paid without work being conducted or completed; and use of grant funds for personal travel.

The Indian Country Grant Fraud Initiative has resulted in 31 Federal criminal indictments, 20 convictions, and court-ordered restitutions ranging from \$10,000 to \$1.7 million. Several Federal law enforcement agencies are also assisting in the initiative, including OIGs from the Environmental Protection Agency and the Departments of the Interior, Housing and Urban Development, and Agriculture; the Internal Revenue Service Criminal Investigation Division; and the Federal Bureau of Investigation.

Laws Prohibit the Use of HHS Grant Funds for Lobbying, but Limited Methods Exist To Identify Noncompliance ([OEI-07-12-00620](#))

All awarding agencies reported using Federal and departmental sources of guidance regarding the prohibitions on the use of grant funds for lobbying. However, limited methods exist to identify noncompliance with lobbying prohibitions.

Vulnerabilities in the HHS Small Business Innovation Research Program ([OEI-04-11-00530](#))

Although it was not required to do so, HHS did not consistently collect information on, or assess the commercial success of, Small Business Innovation Research Program awards and therefore cannot determine whether the program is meeting one of its primary goals. We found that 31 percent of awardees had questionable or unverified eligibility for at least one requirement, and none of the awarding OpDivs completed a required check for duplicative awards across other Federal agencies.

OIG participation in congressional hearings

- 04/14/2014** **Gloria Jarmon**, Deputy Inspector General for Audit Services, testified before the House Committee on Ways and Means, Subcommittee on Health: “Ideas to improve Medicare oversight to reduce waste, fraud, and abuse.” [Testimony](#).



Gloria Jarmon, Deputy Inspector General for Audit Services

- 05/20/2014** **Jodi D. Nudelman**, Regional Inspector General for Office of Evaluation and Inspections, testified before the House Committee on Ways and Means, Subcommittee on Health: “Current hospital issues in the Medicare program.” [Testimony](#).



Jodi D. Nudelman, Regional Inspector General, Office of Evaluation and Inspections

- 05/20/2014** **Brian P. Ritchie**, Acting Deputy Inspector General for Evaluation and Inspections, testified before the House Committee on Oversight and Government Reform, Subcommittee on Energy Policy, Health Care and Entitlements: “Medicare mismanagement: Oversight of Federal Government efforts to recapture misspent funds.” [Testimony](#).



Brian P. Ritchie, Acting Deputy Inspector General for Evaluation and Inspections

- 06/25/2014** **Gary Cantrell**, Deputy Inspector General for Investigations, testified before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations: “Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse.” [Testimony](#).



Gary Cantrell, Deputy Inspector General for Investigations

- 07/16/2014** **Kay Daly**, Assistant Inspector General, Office of Audit Services, and Joyce Greenleaf, Regional Inspector General, Office of Evaluation and Inspections, testified before the House Committee on Energy and Commerce, Subcommittee on Health: “Failure To Verify: Concerns Regarding PPACA’s [Patient Protection and Affordable Care Act] Eligibility System.” [Testimony](#).



Kay Daly, Assistant Inspector General, Office of Audit Services, and Joyce Greenleaf, Regional Inspector General, Office of Evaluation and Inspections

07/29/2014 **John Hagg**, Director of Medicaid Audits, Office of Audit Services, testified before the House Committee on Oversight and Government Reform, Subcommittee on Energy Policy, Health Care and Entitlements: “Examining the Federal Government’s Failure to Curb Wasteful State Medicaid Financing Schemes.” [Testimony](#).



*John Hagg, Director of Medicaid Audits,
Office of Audit Services*

07/31/2014 **Statement for the Hearing Record.** OIG submitted a statement for the record to the Senate Special Committee on Aging: “Admitted or Not? The Impact of Medicare Observation Status on Seniors.” [Statement](#).



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Selected acronyms

ACA	Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (as amended by the Health Care Education and Reconciliation Act of 2010)
ACAP	Alameda County Associated Community Action Program
ACF	Administration for Children and Families
AFI	Assets for Independence (Program)
ASC	ambulatory surgical center
ASFR	Office of the Assistant Secretary for Financial Resources
ASP	average sales price
ASPR	Office of the Assistant Secretary for Preparedness and Response
ATCB	Authorized Testing and Certification Body
ATSDR	Agency for Toxic Substances and Disease Registry
CCDF	Child Care and Development Funds
CBO	Congressional Budget Office
CDC	Centers for Disease Control and Prevention
CHIPRA	Children's Health Insurance Program Reauthorization Act
CIN	clinically integrated network
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CME	continuing medical education
CMN	certificate of medical necessity
CMP	civil monetary penalty
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CSBG	Community Services Block Grant
CWF	Common Working File
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005, P.L. No. 109-171
EHR	electronic health record
E/M	evaluation and management
EMTALA	Emergency Medical Treatment and Labor Act, §9121 of the Consolidated Omnibus Reconciliation Act of 1985, P. L. No. 99-272
Energy/LIHEAP	Energy/Low Income Home Energy Assistance Program
ERRP	Early Retiree Reinsurance Program
FBI	Federal Bureau of Investigation
FCA	False Claims Act (31 U.S.C. §§ 3729–3733)
FFP	Federal financial participation
FMAP	Federal medical assistance percentages
FPS	Fraud Prevention System
FY	fiscal year
GAO	Government Accountability Office
HEAT	Health Care Fraud Prevention and Enforcement Action Team

HEAL	Health Education Assistance Loan
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
HHA	home health agency
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IPIA	Improper Payments Information Act of 2002, P.L. No. 107-300
IPERA	Improper Payments Elimination and Recovery Act of 2010, P.L. No. 111-204
IRS	Internal Revenue Service
LTCH	long-term-care hospital
Marketplaces	health insurance exchanges
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
NDC	National Drug Code
NIH	National Institutes of Health
NIST	National Institute of Standards and Technology
NLR	National Level Repository
OCS	Office of Community Services
OHRP	Office of Human Research Protections
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
OpDiv	Operating Division (of HHS)
OPPS	Outpatient Prospective Payment System
PARIS	Public Assistance Reporting Information System
PEPFAR	President's Emergency Plan for AIDS Relief
PHI	protected health information
PII	personally identifiable information
PMS	Payment Management System
PSC	Program Support Center (HHS)
QHP	qualified health plan
RHC	rural health clinic
SBHS	school-based health services
SBIR	Small Business Innovation Research (Program)
SBIR/STTR	Small Business Innovation Research /Small Business Technology Transfer (Program)
SCHIP	State Children's Health Insurance Program
SUPPORT	Surfactant, Positive Pressure, and Oxygenation Randomized Trial
TIGTA	Treasury Inspector General for Tax Administration
VAT	value-added tax

Centers for Medicare & Medicaid Services

CMS records and information systems security and functionality

Fraud Prevention System

- *The Fraud Prevention System Identified Millions in Medicare Savings, but the Department Could Strengthen Savings Data by Improving Its Procedures. A-01-13-00510. 2014 June.*

In the second implementation year of the Fraud Prevention System (FPS), we certified \$54.2 million of actual and projected savings in the Medicare fee-for-service program, \$210.7 million in unadjusted savings, and a return on investment of \$1.34 for every dollar spent on the FPS. The Department is evaluating whether to expand the use of the FPS in Medicaid, but its procedures were not always sufficient to ensure that its contractors provided and maintained reliable data to always support FPS savings. The Department agreed with our recommendations, which were:

- provide contractors with written instructions on how to determine when savings from an administrative action should be attributed to the FPS and
- require contractors to maintain documentation to support how an FPS lead contributes to an administrative action.

Medicare payments, policies, and quality

Medicare improper claims and payments

Entitlement-terminated beneficiaries

- *Medicare Improperly Paid Providers Millions of Dollars for Entitlement-Terminated Beneficiaries Who Received Services During 2010 Through 2012. A-07-13-01127. 2014 April.*

Medicare made improper payments totaling almost \$18.4 million for beneficiaries who received medical services during calendar years (CYs) 2010 through 2012 whose entitlement to Medicare had been terminated because CMS's data systems did not indicate until after a claim had been processed that a beneficiary's entitlement to Medicare had been terminated and CMS's controls were not adequate to detect and recoup the improper payment. CMS did not have policies and procedures to review information for these beneficiaries on a postpayment basis that would have detected the improper payments.

Although CMS did not agree, we continue to recommend that CMS:

- ensure that Medicare contractors recoup the almost \$18.4 million in improper payments,
- implement policies and procedures to detect and recoup improper payments when entitlement termination information is received on previously paid Medicare claims, and
- identify these types of improper payments after our audit period but before implementation of policies and procedures and ensure that Medicare contractors recoup the improper payments.

Unlawfully present beneficiaries

- *Medicare Improperly Paid Medicare Advantage Organizations Millions of Dollars for Unlawfully Present Beneficiaries for 2010 Through 2012. A-07-13-01125. 2014 April.*

Medicare made improper payments to MA organizations totaling more than \$26 million for unlawfully present beneficiaries for CYs 2010 through 2012. The Medicare Advantage (MA) organizations could not prevent enrollment or disenroll beneficiaries already enrolled because CMS did not provide them with the requisite unlawful-presence data. CMS agreed or partially agreed with our recommendations, which were:

- implement policies and procedures to notify MA organizations of unlawful-presence information and thereby prevent enrollment in MA organizations, disenroll beneficiaries already enrolled, and recoup any improper payments;
- identify and recoup improper payments made to MA organizations for unlawfully present beneficiaries after our audit period and until policies and procedures have been implemented; and
- recoup \$26 million in improper payments in accordance with legal requirements.

Beneficiaries confined in mental health facilities

- *The Centers for Medicare & Medicaid Services Paid Medicare Advantage Organizations for Services Provided to Beneficiaries Confined in Mental Health Facilities for Court-Ordered Purposes.* [A-07-13-06043](#). 2014 June.

CMS made payments to Medicare Advantage organizations totaling more than \$1 million on behalf of beneficiaries who were confined in mental health facilities by court order under a penal code during 2011 and 2012. CMS policy permits Medicare payments to be made on behalf of confined beneficiaries enrolled in Medicare Advantage but not on behalf of those enrolled in Part A or Part B.

Although CMS did not agree, we continue to recommend that to be consistent with the relevant provisions of Medicare Part A and Part B, CMS:

- revise the *Medicare Managed Care Manual* to prohibit Medicare Advantage payments made on behalf of beneficiaries who have been confined in mental health facilities by court order under a penal code, which could have resulted in savings totaling more than \$1 million for the 2-year period we reviewed.

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- *The Centers for Medicare & Medicaid Services Provided Medicare Part D Coverage to Beneficiaries Confined in Mental Health Facilities for Court-Ordered Purposes.* [A-07-13-06041](#). 2014 July.

CMS accepted prescription drug event records from Medicare Part D sponsors totaling over \$12.6 million on behalf of beneficiaries who were confined in mental health facilities by court order under a penal code during 2006 through 2011. This occurred because CMS policy permits Medicare payments to be made on behalf of confined beneficiaries enrolled in Part D but not on behalf of those enrolled in Parts A or B. CMS agreed with OIG's recommendation that to be consistent with the relevant provisions of Medicare Parts A and B, CMS:

- revise the *Medicare Prescription Drug Benefit Manual* to prohibit Part D payments made on behalf of confined beneficiaries, which could have resulted in savings associated with \$12.6 million in gross drug costs that CMS accepted for the 6-year period we reviewed.

Certification of rural health clinics

- *CMS Has Yet To Enforce a Statutory Provision Related to Rural Health Clinics.* [OEI-05-13-00290](#). 2014 September.

Approximately 12 percent of rural health clinics (RHCs) no longer met the location requirements in 2013. Pursuant to the Balanced Budget Act of 1997, these RHCs should continue to qualify as RHCs—and receive enhanced reimbursement—only if they are determined to be essential providers.

Although CMS did not indicate whether it agreed or disagreed, we continue to recommend that CMS:

- issue regulations to ensure that RHCs determined to be essential providers remain certified as RHCs.

Hospitals—Postacute care transfer policy

- *Medicare Inappropriately Paid Hospitals' Inpatient Claims Subject to the Postacute Care Transfer Policy.* [A-09-13-02036](#). 2014 May.

Medicare inappropriately paid hospital inpatient claims subject to its postacute care transfer policy, resulting in overpayments totaling approximately \$19.5 million over 4 years. Medicare overpaid the hospitals because the Common Working File (CWF) edits related to postacute care transfers were not working properly. CMS agreed or partially agreed with our recommendations, which were:

- correct the CWF edits and ensure that they are working properly;
- educate hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered;
- direct the Medicare contractors to recover the approximately \$19.5 million in identified overpayments in accordance with CMS's policies and procedures; and
- direct the Medicare contractors to identify any transfer claims on which the patient discharge status was coded incorrectly and recover any overpayments after our audit period.

Hospitals—Outlier payments

- *TrailBlazer Health Enterprises Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required.* [A-07-10-02776](#). 2014 June.

TrailBlazer Health Enterprises did not always refer cost reports whose outlier payments qualified for reconciliation to CMS or always reconcile the outlier payments associated with cost reports whose outlier payments qualified for reconciliation. At least \$2.8 million should be recouped from health care providers and returned to Medicare.

Novitas, which assumed TrailBlazer's responsibilities, described corrective actions that it had taken or planned to take in response to the following recommendations:

- review cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, request CMS approval to recoup at least \$2.8 million and associated interest from health care providers, and refund that amount to the Federal Government;
- review cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to reconcile the \$32.4 million in associated outlier payments;
- work with CMS to resolve the \$6.8 million in outlier payments associated with claims that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that it reconciles all outlier payments in accordance with Federal guidelines; and

- review all cost reports submitted since the end of our audit period and ensure that they are referred and reconciled in accordance with Federal guidelines.

Although Novitas disagreed, we continue to recommend that Novitas:

- review cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS to resolve \$6.6 million in funds and associated interest from health care providers that may be due to the Federal Government.

Improper payments—Evaluation and management services

- *Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010. OEI-04-10-00181. 2014 May.*

We found that Medicare inappropriately paid \$6.7 billion for claims for evaluation and management (E/M) services in 2010 that were incorrectly coded and/or lacking documentation, representing 21 percent of Medicare payments for E/M services that year. E/M services are 50 percent more likely to be paid for in error than other Part B services, and most improper payments result from errors in coding and from insufficient documentation. CMS agreed or partially agreed with the following recommendations:

- educate physicians on coding and documentation requirements for E/M services and
- follow up on claims for E/M services that were paid for in error.

Although CMS did not agree, we continue to recommend that CMS:

- continue to encourage contractors to review E/M services billed for by high-coding physicians.

Questionable billing—HIV drugs

- *Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs. OEI-02-11-00170. 2014 August.*

Almost 1,600 Medicare Part D beneficiaries had questionable utilization patterns for human immunodeficiency virus (HIV) drugs in 2012, at a cost of \$32 million. These beneficiaries had no indication of HIV in their Medicare histories, received an excessive dose or supply of HIV drugs, received HIV drugs from a high number of pharmacies or prescribers, or received contraindicated drugs (i.e., HIV drugs that should not be used in combination with one another). CMS agreed with the following recommendations:

- expand sponsors' drug utilization review programs,
- expand sponsors' use of beneficiary-specific controls,
- restrict certain beneficiaries to a limited number of pharmacies or prescribers,
- increase monitoring of beneficiaries' utilization patterns, and
- follow up on questionable utilization patterns.

Although CMS did not agree, we continue to recommend that CMS:

- expand the Overutilization Monitoring System to include additional drugs susceptible to fraud, waste, and abuse and
- follow up on questionable utilization patterns.

Questionable billing—Electrodiagnostic tests

- *Questionable Billing for Medicare Electrodiagnostic Tests. OEI-04-12-00420. 2014 April.*

In 2011, 4,901 physicians had questionable billing for Medicare electrodiagnostic tests totaling \$139 million; approximately 20 percent of these physicians received comparative billing reports in 2011 on the basis of their 2010 billing for electrodiagnostic tests. The highest total questionable billing for Medicare electrodiagnostic tests in 2011 was from physicians in the New York, Los Angeles, and Houston areas. CMS agreed or partially agreed with our recommendations, which were:

- take appropriate action regarding physicians whom we identified as having inappropriate or questionable billing,
- increase monitoring of billing for electrodiagnostic tests, and
- provide additional guidance and education to physicians regarding electrodiagnostic tests.

Questionable billing—Clinical laboratory services

- *Questionable Billing for Medicare Part B Clinical Laboratory Services. OEI-03-11-00730. 2014 August.*

In 2010, over 1,000 labs exceeded the thresholds (i.e., had unusually high billing) for 5 or more measures of questionable billing for Medicare lab services. Medicare allowed \$1.5 billion across all labs for claims associated with questionable billing. CMS agreed with all of our recommendations, which were:

- review the labs identified as having questionable billing and take appropriate action,
- review existing program integrity strategies to determine whether these strategies are effectively identifying program vulnerabilities associated with lab services, and
- ensure that existing edits prevent claims with invalid and ineligible ordering-physician numbers from being paid.

Medicare wasteful payments, policies, and practices

Ambulatory surgical center-approved procedures

- *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates. A-05-12-00020. April 2014.*

Medicare saved almost \$7 billion during calendar years (CYs) 2007 through 2011 and could potentially save \$12 billion from CYs 2012 through 2017 because ambulatory surgical center (ASC) rates are

frequently lower than outpatient department rates for surgical procedures. In addition, Medicare could generate savings of as much as \$15 billion for CYs 2012 through 2017 if CMS reduces outpatient department payment rates for ASC-approved procedures to ASC payment levels for procedures performed on beneficiaries with low-risk and no-risk clinical needs. When outpatient surgical procedures that do not pose significant risk to patients are performed in an ASC instead of an outpatient department, the payment rates are generally lower.

Although CMS did not agree, we continue to recommend that CMS:

- seek legislation that would exempt the reduced expenditures as a result of lower outpatient prospective payment system (OPPS) payment rates from budget neutrality adjustments for ASC-approved procedures and
- if Congress passes the budget-neutrality exemption for the reduced expenditures, CMS should:
 - reduce OPPS payment rates for ASC-approved procedures on beneficiaries with no-risk or low-risk clinical needs in outpatient departments and then
 - develop and implement a payment strategy in which outpatient departments would continue to receive the standard OPPS payment rate for ASC-approved procedures that must be provided in an outpatient department because of a beneficiary's individual clinical needs.

Long-term care hospitals—Interrupted-stay policy

- *Vulnerabilities in Medicare's Interrupted-Stay Policy for Long-Term Care Hospitals.* [OEI-04-12-00490](#). 2014 June.

We identified several vulnerabilities in the Long-Term Care Hospitals (LTCH) interrupted-stay policy, including inappropriate payments, financial incentives to delay readmissions, and potential overpayments to co-located LTCHs. These findings raise concerns about whether financial incentives, rather than beneficiaries' medical conditions, may have influenced some LTCHs' readmission decisions. CMS agreed with the following recommendations, contingent on receiving more information from OIG:

- review existing safeguards to determine whether additional action is needed to prevent future inappropriate payments for interrupted stays and
- take appropriate action on inappropriate payments and overpayments we identified.

Although CMS did not agree, we continue to recommend that CMS:

- conduct additional analysis to determine the extent to which financial incentives influence LTCHs' readmission decisions,
- develop a system to enforce the 5-percent readmission threshold, and
- take appropriate action regarding LTCHs exhibiting certain readmission patterns.

Compounded drugs—Payment and oversight

- *Compounded Drugs Under Medicare Part B: Payment and Oversight.* [OEI-03-13-00270](#). 2014 April.

Our April 2014 report found that neither CMS nor Medicare Administrative Contractors (MACs) tracked the number of claims for compounded drugs under Part B or the corresponding amounts paid, and the

Part B claims did not contain information that can be used to systematically identify claims for compounded drugs. The inability to track claims for compounded drugs and identify the compounding pharmacies that produce these drugs prevents CMS and MACs from taking steps to stop payments for compounded drugs that are produced in violation of the Federal Food, Drug, and Cosmetic Act. CMS agreed or conditionally agreed with the following recommendations:

- establish a method to identify Part B claims for compounded drugs and
- explore the possibility of conducting descriptive analyses of Part B claims for compounded drugs.

Although CMS did not agree, we continue to recommend that CMS:

- explore the possibility of requiring providers to identify on the Part B claim the pharmacy that produced the compounded drug.

Part B drugs—Price data

- *Limitations in Manufacturer Reporting of Average Sales Price Data for Part B Drugs. OEI-12-13-00040. 2014 July.*

At least one-third of the more than 200 manufacturers of Part B drugs did not submit average sales prices (ASPs) for some of their products in the third quarter of 2012, despite being required to do so; an additional 45 manufacturers were not required to report ASPs that quarter. Furthermore, for a small number of drugs, inaccuracies in CMS's ASP files may have affected Medicare payments. CMS agreed with the following recommendations:

- continue to assist OIG in identifying and penalizing manufacturers that do not meet ASP reporting requirements;
- ensure the accuracy of product information for national drug codes listed in the background and crosswalk files; and
- finalize the implementation of automated ASP-related procedures by using processes related to average manufacturer price as a model, and subsequently require all manufacturers to submit ASPs through the automated system.

Although CMS did not agree, we continue to recommend that CMS:

- seek a legislative change to directly require all manufacturers of Part B drugs to submit ASPs.

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- *Medicare Part B Prescription Drug Dispensing and Supplying Fee Payment Rates Are Considerably Higher Than the Rates Paid by Other Government Programs. A-06-12-00038. September 2014.*

Medicare Part B could save millions of dollars annually if its rates for dispensing and supplying fees for certain drugs were aligned with rates that Medicare Part D and State Medicaid programs pay. We estimated that if Part B rates had been the same as the average Part D rates, Part B would have saved \$110.9 million in 2011. We also estimated that if Part B rates had been the same as the average State Medicaid program rates, Part B would have saved \$106 million.

Although CMS did not agree, we continue to recommend that CMS:

- amend current regulations to decrease the Part B payment rates for dispensing and supplying fees to rates similar to those of other payers, such as Part D and Medicaid.

Part D drugs—Copayment coupon use

- *Manufacturer Safeguards May Not Prevent Copayment Coupon Use for Part D Drugs.*
[OEI-05-12-00540](#). 2014 September.

We identified the safeguards that pharmaceutical manufacturers have in place to prevent copayment coupons from being used to purchase drugs paid for by Medicare Part D and determined that their safeguards may not stop all coupons from being used for Part D-covered drugs. These findings raise concerns that copayment coupons may encourage Part D beneficiaries to purchase higher cost brand drugs instead of lower cost, equally effective alternative drugs. This could increase costs for Part D plans, the Part D program, and Part D beneficiaries. Additionally, manufacturers may be liable under the anti-kickback statute if they offer coupons to induce the purchase of drugs paid for by Part D or any other Federal health care program. CMS concurred with our recommendation, which was:

- cooperate with industry stakeholder efforts to identify a solution to prevent coupons from being used to purchase drugs paid for by Part D.

Diabetes test strips

- *Medicare Market Share of Mail Order Diabetes Test Strips From July–September 2013.*
[OEI-04-13-00680](#). 2014 June.

Twenty-two suppliers submitted claims for at least 43 types of mail order diabetes test strips for the 3-month period of July to September 2013. Two types of diabetes test strips accounted for approximately 45 percent of the Medicare mail order market share, and three types accounted for 59 percent. CMS may consider these data when determining whether subsequent rounds of suppliers' mail order diabetes test strip bids comply with the Medicare Improvements for Patients and Providers Act requirement for suppliers to demonstrate that their bid covers at least 50 percent, by volume, of all types of mail order diabetes test strips. This report did not contain recommendations.

- *Medicare Market Shares of Mail Order Diabetes Test Strips Immediately Prior to the National Mail Order Program.* [OEI-04-13-00681](#). 2014 June.

One hundred fifty-two suppliers submitted claims for at least sixty-two types of mail order diabetes test strips for the 3-month period of April to June 2013. Two types of diabetes test strips accounted for approximately 34 percent of the Medicare mail order market share, and four types accounted for 51 percent. CMS may choose to use these data to evaluate the effect of the Competitive Bidding Program on brand choice. This report did not contain recommendations.

Dual eligibles

- *Iowa Has Shifted Medicare Cost-Sharing for Dual Eligibles to the Federal Government.*
[OEI-07-13-00480](#). 2014 April.

We found that Iowa had made State Supplementary Payments of \$1 per beneficiary per month to a group of about 41,000 dual eligibles, at a cost of approximately \$500,000 to the State, resulting in \$39 million in Federal Financial Participation (FFP) payments to the State. Iowa's \$1 payments are not intended as income assistance; instead, they were created for the express purpose of obtaining FFP for Medicare Part B premiums.

Although CMS did not indicate whether it agreed or disagreed, we continue to recommend that CMS:

- seek a legislative change to prevent States from using State Supplementary Payments to shift Medicare Part B premium costs for full-benefit dual eligibles to the Federal Government and require States to submit more detailed eligibility information.

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- *Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2014.* [OEI-05-14-00170](#).
2014 June.

In our June 2014 mandated report, we found Part D plan formularies included an average of 96 percent of the 195 drugs commonly used by dual eligibles, and formularies applied utilization management tools to 28 percent of the unique drugs we reviewed. These results are largely unchanged from the findings from our 2013 mandated annual report. Pursuant to the Patient Protection and Affordable Care Act (ACA), OIG must annually issue a report regarding the extent to which formularies used by Part D plans include drugs commonly used by full-benefit dual-eligible individuals. This report did not contain recommendations.

Medicare quality of care

Home health

- *Limited Compliance With Medicare's Home Health Face-to-Face Documentation Requirements.*
[OEI-01-12-00390](#). 2014 April.

We found that for 32 percent of home health claims that required face-to-face encounters, the documentation did not meet Medicare requirements and physicians inconsistently completed the narrative portion of the face-to-face documentation. This resulted in \$2 billion in payments that should not have been made. CMS agreed with our recommendations, which were:

- consider requiring a standardized form to ensure that physicians include all elements required for the face-to-face documentation,
- develop a specific strategy to communicate directly with physicians about the face-to-face requirement, and
- develop other oversight mechanisms for the face-to-face requirement.

■ *State Background Check Requirements for HHAs. OEI-07-14-00131. 2014 May.*

We found that 41 States require home health agencies (HHAs) to conduct background checks on prospective employees; of the 10 States that have no background check requirement, 4 States reported that they have plans to implement background check requirements in the future. Thirty-five States specify convictions that disqualify individuals from employment, and 16 States allow an individual who has been disqualified from employment to submit an application to have his/her conviction(s) waived. This information may be useful to CMS as it administers the Nationwide Background Check Program and to States that are considering establishing or enhancing background-check requirements for HHA employees. This report did not contain recommendations.

Medicaid payments, policies, and quality

Improper State claims for Federal reimbursement

Inpatient supplemental payments

- *Colorado Claimed Unallowable Medicaid Inpatient Supplemental Payments. A-07-13-04206. 2014 April.*

Colorado claimed almost \$2.7 million in unallowable Medicaid inpatient supplemental payments during fiscal year (FY) 2012. This occurred because Colorado did not ensure that the payment amounts authorized in its State plan for the Medicaid inpatient supplemental payments program were the actual amounts used to make payments. Colorado agreed with all of our recommendations, which were:

- refund almost \$2.7 million to the Federal Government,
- determine the amount that the State agency incorrectly paid after our audit period and refund that amount to the Federal Government, and
- ensure that the payment amounts specified in its CMS-approved State plan are the amounts used to make payments.

Withdrawal of excessive Medicaid funds

- *Alabama Withdrew Excessive Federal Medicaid Funds for Fiscal Years 2010 Through 2012. A-06-13-00026. 2014 September.*

For FYs 2010 through 2012, Alabama obtained \$18.9 million more in Federal funds than it expended. These inappropriate Medicaid withdrawals occurred because Alabama miscalculated and overstated the Federal share of expenditures, paid for overdrawn balances in previous years' Payment Management System (PMS) accounts, and withdrew funds for expenditures of another federally funded program. Alabama described actions that it has taken to address these recommendations:

- work with CMS to determine whether the \$4 million withdrawn for FY 2013 Medicaid expenditures should be refunded to the Federal Government and ensure that funds are withdrawn from the appropriate PMS account;
- establish procedures to compare withdrawn Federal funds with actual net Medicaid expenditures;
- review CMS's calculations of final grant awards for accuracy;
- investigate reasons for account balances, particularly if CMS has not finalized the funds and the funds are to be used to pay for overdrawn balances in other PMS accounts; and
- separate Medicaid expenditures from other federally funded program expenditures when calculating Medicaid withdrawals.

Although Alabama did not agree, OIG continues to recommend that Alabama:

- refund \$14.8 million to the Federal Government.

■ *Some of New York's Claims for Medicaid Supported Employment Services Were Unallowable. A-02-13-01004. 2014 September.*

New York claimed at least \$23 million in Federal Medicaid reimbursement for supported employment services that were unallowable because of multiple errors by providers in billing, providing, documenting, and claiming services and in beneficiary eligibility. New York partially agreed with our recommendations, which were:

- refund \$23 million to the Federal Government and
- ensure that it complies with certain Federal and State requirements by requiring providers to:
 - claim reimbursement only for documented supported employment services,
 - provide supported employment services only to beneficiaries for whom there is a completed and approved care and supported employment plan,
 - claim reimbursement at the appropriate level-of-support billing rate,
 - ensure and document that all beneficiaries approved for supported employment services have been assessed and evaluated to need the required level of care, and
 - ensure that all beneficiaries receiving similar services from the Education Department are not claimed under its waiver programs.

■ *Washington Received Millions in Unallowable Bonus Payments. A-04-14-08028. September 2014.*

Washington received \$19.5 million in unallowable performance bonus payments under the Children's Health Insurance Program Reauthorization Act for FYs 2009 through 2012. Washington overstated its FYs 2009 through 2012 current enrollment in its bonus requests to CMS because it included individuals who did not qualify because of their basis-of-eligibility code.

Although Washington disagreed, OIG continues to recommend that Washington:

- refund \$19.5 million to the Federal Government and
- ensure that future requests for Children's Health Insurance Program Reauthorization Act bonus payments include only qualifying children to comply with Federal requirements.

Incorrect Medicaid claims adjustments

■ *Massachusetts Did Not Always Make Correct Medicaid Claim Adjustments. A-01-13-00003. 2014 September.*

Massachusetts used incorrect Federal medical assistance percentages (FMAPs) because it processed adjusted claims as new expenditures for both public and private providers, resulting in an overpayment of \$106 million from October 2008 through December 2010. Massachusetts partially agreed with our recommendations, which were:

- refund \$106 million to the Federal Government and
- ensure that it processes future adjustments in accordance with Federal requirements.

Incorrect Medicaid incentive payments

- *Louisiana Made Incorrect Medicaid Electronic Health Record Incentive Payments. A-06-12-00041. 2014 August.*

Louisiana made incorrect Medicaid electronic health record incentive payments of \$4.4 million. Incorrect payments included both overpayments and underpayments, for a net overpayment of \$1.8 million. These errors occurred because of errors in the instructions for calculating incentive payments, errors in the calculations, clerical errors, the lack of system edits to prevent overpayments, and Louisiana's failure to reconcile its CMS-64 cost report with the CMS National Level Repository (NLR). Louisiana agreed with our recommendations, which were:

- refund to the Federal Government \$1.8 million in net overpayments made to the 20 hospitals, adjust the 20 hospitals' remaining incentive payments to account for the incorrect calculations, review the calculations for the hospitals not included in the 25 we reviewed to determine whether payment adjustments are needed, and refund any overpayments identified;
- modify the hospital calculation worksheet to state that inpatient nonacute-care services should be excluded from the discharge lines of the incentive payment calculation, correct the formula to calculate the discharge-related amounts, ensure that the correct cost report periods are used, and review supporting documentation for the numbers provided in the cost reports;
- modify the patient-volume worksheet to clarify that inpatient discharges—not bed-days—should be used in the patient-volume calculation and review the patient-volume calculation for the other hospitals not included in the 25 we reviewed to determine whether they met the patient-volume requirement and refund any overpayments identified if the patient-volume requirement is not met;
- refund to the Federal Government \$3,250 in overpayments made to 13 professionals, implement system edits to prevent payments that exceed threshold amounts, and ensure that personnel are knowledgeable about the electronic health record (EHR) program requirements; and
- work with CMS to ensure that the 13 professional incentive payments not posted to the NLR are posted and establish a policy to reconcile the CMS-64 report to the NLR each quarter.

Overpayment collections

- *Maryland Underreported the Federal Share of Medicaid Overpayment Collections. A-03-11-00208. 2014 April.*

From 2009 through 2010, Maryland underreported the Federal share of Medicaid overpayment collections by \$42.3 million because it applied the incorrect FMAP to its calculations of overpayments. Maryland did not develop and implement effective internal controls to ensure accurate reporting of its collections and reimbursements related to Medicaid overpayments. Maryland agreed with the following recommendations:

- apply the correct FMAP when reporting Medicaid overpayment collections and adjustments and

- develop and implement internal controls that will enable Maryland to correctly report Medicaid overpayment collections and refund the proper Federal share.

Although Maryland did not agree, OIG continues to recommend that Maryland:

- refund to the Federal Government almost \$30.3 million in underreported Federal share for collections and adjustments reported for our audit period and
- refund to the Federal Government \$12 million in underreported Federal share for adjustments reported outside our audit period.

■ *Georgia Did Not Always Accurately Report and Refund the Federal Share of Medicaid Collections for Calendar Years 2008 Through 2011. A-04-12-00085. 2014 April.*

For CYs 2008 through 2011, Georgia underreported approximately \$10.9 million (Federal share) of Medicaid collections to be refunded to the Federal Government. Generally, Georgia did not refund the correct Federal share because it did not maintain adequate documentation supporting the FMAPs used to calculate the Federal share of collections. Georgia agreed with the following recommendation:

- develop and implement internal controls to ensure that it adequately supports specific-period FMAPs used to calculate the Federal share of collections refunded.

Although Georgia did not agree, OIG continues to recommend that Georgia:

- refund approximately \$10.9 million to the Federal Government.

■ *Kansas Improperly Received Medicaid Reimbursement for School-Based Health Services. A-07-13-04207. 2014 August.*

For the Medicaid school-based health services (SBHS) program, Kansas received \$10.7 million in Federal reimbursement for services provided from July 1, 2009, through June 30, 2010, that was not reasonable, allowable, and adequately supported in accordance with Federal and State requirements. These errors occurred because Kansas did not have adequate policies and procedures to monitor the SBHS program and to ensure that it claimed all costs in accordance with applicable Federal and State requirements.

Although Kansas did not indicate whether it agreed, OIG continues to recommend that Kansas:

- refund \$10.7 million to the Federal Government for unallowable SBHS costs and
- strengthen policies and procedures to monitor the SBHS program and ensure that (1) SBHS costs are accurate and supported and (2) it claims all SBHS costs in accordance with applicable Federal and State requirements.

Federal medical assistance percentage funds

- *New Jersey Did Not Comply With Recovery Act Requirements for Receiving Increased Federal Medicaid Assistance. A-02-11-01039. 2014 July.*

To comply with the political subdivision requirement in the American Recovery and Reinvestment Act of 2009 (Recovery Act), New Jersey should redistribute approximately \$45.2 million in increased Federal Medicaid assistance to its counties and local school districts. New Jersey's political subdivisions contributed a greater percentage of the non-Federal share of Medicaid expenditures during the recession-adjustment period than during the base period because New Jersey did not adjust its requirements for these contributions to ensure compliance with the political subdivision requirement before New Jersey accessed increased FMAP funds. New Jersey partially agreed with the Office of Inspector General's (OIG) recommendations to redistribute approximately \$45.2 million in increased FMAP funding to its political subdivisions to comply with the political subdivision requirement.

Health-care-related tax

- *Pennsylvania's Gross Receipts Tax on Medicaid Managed Care Organizations Appears To Be an Impermissible Health-Care-Related Tax. A-03-13-00201. 2014 May.*

Pennsylvania's Gross Receipts Tax on Medicaid managed care organizations appears to be a health-care-related tax that is impermissible for Medicaid funding. Through this tax, Pennsylvania collected \$1.76 billion from its Medicaid managed care organizations over 3 years (State FYs 2009–2012) and used that money to pay some of its share of capitation payments. CMS generally agreed with the following recommendation:

- clarify CMS's policy concerning permissible health-care-related taxes with all States.

Although CMS did not agree, OIG continues to recommend that CMS:

- determine whether the tax on Medicaid managed care organizations is an impermissible health-care-related tax and, if so,
 - offset almost \$1.76 billion in Gross Receipts Tax revenue from State Medicaid expenditures from State FY 2009–2010 through State FY 2011–2012 and
 - offset Gross Receipts Tax revenue from Medicaid expenditures when determining the Federal share of Pennsylvania's Medicaid program expenditures after State FY 2011–2012.

Residential habilitation services

- *New York Claimed Unallowable Room-and-Board Costs Under Its Developmental Disabilities Waiver Program. A-02-12-01031. 2014 May.*

New York claimed approximately \$60.8 million in Federal Medicaid reimbursement over a 3-year period for unallowable room-and-board costs for residential habilitation services provided at State-operated residences under New York's developmental disabilities waiver program. New York did not develop and

implement effective internal controls to ensure accurate reporting of its collections and reimbursements related to Medicaid overpayments.

Although New York disagreed, or did not indicate whether it agreed, OIG continues to recommend that New York:

- refund approximately \$60.8 million to the Federal Government and
- ensure that New York excludes all unallowable room-and-board costs from indirect costs used in payment rate calculations for residential habilitation services.

Physician-administered drugs

- *Oregon Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician-Administered Drugs. A-09-12-02080. 2014 April.*
- *Idaho Did Not Bill Manufacturers for Rebates for Some Medicaid Physician-Administered Drugs. A-09-12-02079. 2014 April.*
- *Nebraska Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs. A-07-13-06040. 2014 August.*
- *The District of Columbia Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs. A-03-12-00205. 2014 August.*

We reviewed States' compliance with Federal Medicaid requirements for billing manufacturers for rebates for physician-administered drugs. Oregon claimed \$2.3 million in Federal reimbursement that was unallowable and \$1.1 million that may have been unallowable in 2010; Idaho did not bill manufacturers for rebates associated with \$2.6 million in paid claims for physician-administered drugs in 2010; Nebraska claimed \$2.5 million over 3 years in Federal reimbursement that was unallowable and \$869,000 that may have been unallowable; and the District of Columbia claimed \$2.4 million over nearly 3 years in Federal reimbursement that was unallowable and \$983,000 that may have been unallowable. Because all four States did not capture National Drug Codes (NDCs) or did not bill the manufacturers for rebates, they improperly claimed Federal reimbursement. All four States agreed or partially agreed to:

- refund to the Federal Government \$2.3 million (Oregon), \$2.4 million (Nebraska), and \$2.4 million (the District) for claims for physician-administered drugs that were ineligible for Federal reimbursement and
- work with CMS to determine and refund the unallowable Federal reimbursement for physician-administered drugs claimed without NDCs and not billed for rebates.

Oregon, Idaho, and the District of Columbia agreed or partially agreed to:

- improve rebate processes to ensure that all physician-administered drugs eligible for rebates are processed for rebates.

Oregon and the District of Columbia agreed or partially agreed to:

- work with CMS to determine the unallowable portion of the other physician-administered drug claims that were ineligible for Federal reimbursement and refund that amount.

Idaho agreed to:

- work with CMS to determine the amount that should be billed to manufacturers for rebates associated with the \$2.6 million (\$1.8 million Federal share) in claim lines for physician-administered drugs and
- bill manufacturers for rebates associated with the claims lines for physician-administered drugs that were incorrectly excluded from the rebate process after CY 2010.

Although Nebraska disagreed, OIG continues to recommend that Nebraska:

- work with CMS to determine the unallowable portion of the \$869,000 for other claims for outpatient physician-administered drugs that were ineligible for Federal reimbursement and refund that amount.

Inpatient hospital services

- *Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Piedmont Geriatric Hospital. A-05-12-00056. 2014 July.*
- *Virginia Improperly Claimed Federal Reimbursement for Most Reviewed Medicaid Payments to Catawba Hospital. A-05-12-00055. 2014 July.*

Most of Virginia's claims for Federal reimbursement for payments to Piedmont Geriatric Hospital and Catawba Hospital for inpatient hospital services it provided to patients aged 65 or older were not in accordance with Federal requirements because the two hospitals did not demonstrate compliance with the special Medicare Conditions of Participation (CoP). Virginia claimed \$36.9 million (Piedmont) and \$17.4 million (Catawba) in unallowable Federal reimbursement because it believed that the hospitals had met the requirements for the inpatient hospital services it provided to these patients.

Although Virginia did not agree, or did not indicate whether it agreed, OIG continues to recommend that Virginia:

- refund \$36.9 million and \$17.4 million to the Federal Government for its share of payments to Piedmont and Catawba, respectively, for inpatient hospital services provided on dates outside the regulatory gap period;
- work with CMS to determine whether Virginia should refund an additional \$2.5 million and \$1.2 million to the Federal Government for its share of payments to Piedmont and Catawba, respectively, for inpatient hospital services provided on dates during the regulatory gap period; and
- ensure that it claims Federal reimbursement for Medicaid payments for inpatient hospital services provided in institutions for mental diseases only if those institutions can demonstrate compliance with the special Medicare CoP.

Family planning services

- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Central Los Angeles County. A-09-13-02012. 2014 July.*

- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in East Los Angeles County. A-09-13-02019. 2014 July.*
- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Southeast Los Angeles County. A-09-13-02047. 2014 August.*
- *California Improperly Claimed Enhanced Federal Reimbursement for Medicaid Family Planning Services Provided in Orange County. A-09-13-02044. 2014 July.*

California claimed at least \$9.1 million for FY 2011 in unallowable enhanced Federal reimbursement for Medicaid family planning services provided in central, east, and southeast Los Angeles County. California claimed at least \$2.2 million for FY 2012 in unallowable enhanced Federal reimbursement for Medicaid family planning services provided in Orange County. The overpayments occurred because California's Medicaid Management Information System (MMIS) lacked edits to prevent family-planning-related services from being claimed at the 90-percent rate. Also, California did not have billing procedures to ensure that it claimed reimbursement at the 90-percent rate only for services clearly provided for family planning purposes.

California agreed or partially agreed with the OIG recommendations to refund the unallowed \$11.3 million in total Federal reimbursement to the Federal Government and provided information on actions that it had taken or planned to take to address OIG's recommendations to:

- establish billing procedures to ensure that only services clearly provided for family planning purposes are claimed for reimbursement at the 90-percent rate and
- establish MMIS edits to ensure that claims from the Family Planning, Access, Care, and Treatment program meet Federal and State requirements for reimbursement at the 90-percent rate and at the regular FMAP for family-planning-related services.

Continuing day treatment services

- *New York Claimed Nonhospital-Based Continuing Day Treatment Services That Were Not in Compliance With Federal and State Requirements. A-02-12-01011. 2014 July.*

We estimated that New York improperly claimed at least \$18.1 million in Medicaid reimbursement for nonhospital continuing day treatment (CDT) services. Certain providers did not comply with Federal and State regulations, and New York did not adequately monitor the CDT program for compliance with certain Federal and State requirements.

Although New York did not agree, or did not indicate whether it agreed, OIG continues to recommend that New York:

- refund \$18.1 million to the Federal Government,
- issue guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement for nonhospital CDT services, and
- improve New York's monitoring of the CDT program to ensure compliance with Federal and State requirements.

Medicaid wasteful policies and practices

Recovery of overpayments—Acute-care hospitals

- *Acute-Care Hospitals in Texas Did Not Always Reconcile Invoice Records With Credit Balances and Refund to the State Agency the Associated Medicaid Overpayments. A-06-11-00060. 2014 May.*

On the basis of our review of eight acute-care hospitals, we estimated that Texas could recover an additional \$15.3 million (\$10.5 million Federal share) from hospitals and obtain future savings if it enhanced its efforts to recover Medicaid overpayments in hospitals' accounts. The eight hospitals did not identify and refund Medicaid overpayments because Texas did not require them to exercise reasonable diligence in determining whether overpayments had been made. Texas agreed with our recommendations, which were:

- refund the \$18,000 Federal share to the Federal Government for overpayments paid to the selected hospitals and
- enhance its efforts to recover additional overpayments, estimated at \$15.3 million (\$10.5 million Federal share), from hospitals and realize future savings by requiring and ensuring that hospitals exercise reasonable diligence in reconciling patient account credit balances and refunding the associated Medicaid overpayments within a specified time period.

Questionable billing—Dental and orthodontic services

- *Questionable Billing For Medicaid Pediatric Dental Services in Louisiana. OEI-02-14-00120. 2014 August.*

We identified 26 general dentists and 1 oral surgeon in Louisiana with questionable billing; these providers were extreme outliers when compared to their peers. Medicaid paid these providers \$12.4 million for pediatric dental services in 2012. The Louisiana Department of Health and Hospitals agreed with our recommendations, which were:

- enhance its monitoring of dental providers to identify patterns of questionable billing and
- take appropriate action on the dental providers identified as having questionable billing.

-
- *Texas Did Not Ensure That the Prior-Authorization Process Was Used To Determine the Medical Necessity of Orthodontic Services. A-06-12-00039. 2014 July.*

Texas did not ensure that the prior-authorization process was used to determine the medical necessity of orthodontic services under State Medicaid guidelines. These deficiencies occurred because Texas did not ensure (1) that the State contractor properly reviewed each prior-authorization request for medical necessity and (2) that the State contractor's dental director followed Medicaid policies and procedures when determining the medical necessity of orthodontic services. Texas partially agreed with OIG's recommendations to provide proper oversight of the orthodontic prior-authorization process to ensure that:

- it is used to determine medical necessity and
- personnel making the prior-authorization decisions follow the appropriate State Medicaid policies and procedures.

Public Assistance Reporting Information System

- *Public Assistance Reporting Information System: State Participation in the Medicaid Interstate Match Is Limited.* [OEI-09-11-00780](#). 2014 July.

States' participation in the Public Assistance Reporting Information System (PARIS) Medicaid Interstate Match program is limited, and States reported that they needed more guidance from CMS. The PARIS Medicaid Interstate Match is an important tool that has the potential to reduce improper Medicaid payments by identifying beneficiaries who are enrolled in multiple State Medicaid programs. CMS agreed with our recommendation, which was:

- issue guidance to States on the requirement for participating in the Medicaid Interstate Match.

Offshore outsourcing of administrative functions

- *Offshore Outsourcing of Administrative Functions by State Medicaid Agencies.* [OEI-09-12-00530](#). 2014 April.

Only 15 of 56 Medicaid agencies have some form of State-specific requirement that addresses the outsourcing of administrative functions offshore; 11 Medicaid agencies allow such outsourcing, and each maintains Business Associate Agreements with contractors to safeguard protected health information (PHI). Seven of the eleven Medicaid agencies reported outsourcing offshore through subcontractors, but none reported sending PHI offshore. This report did not contain recommendations.

Drug rebate dispute resolution

- *Medicaid Drug Rebate Dispute Resolution Could Be Improved.* [OEI-05-11-00580](#). 2014 August.

Twenty-nine of thirty-one States that could provide data estimated that only a small percentage of rebate dollars were disputed. However, surveys of selected States revealed that the lack of high-quality data made it difficult for States to prevent and resolve disputes. CMS agreed or partially agreed with all of our recommendations, which were:

- work with States to improve the quality of claims data submitted by providers and pharmacies,
- help States obtain better data on ineligible drugs,
- facilitate States' submission of standardized claims data, and
- establish a stronger role in dispute resolution.

Children's Health Insurance Program—Bonus payments

- *Louisiana Received More Than \$7.1 Million in Unallowable Bonus Payments. A-04-14-08029. 2014 July.*

Louisiana received more than \$7.1 million in unallowable performance bonus payments under the Children's Health Insurance Program Reauthorization Act (CHIPRA) for FYs 2009 through 2011. If Louisiana had calculated its current enrollment correctly, the current enrollment would not have exceeded baseline enrollment by an amount sufficient for Louisiana to qualify for bonus payments. Louisiana agreed with our recommendations, which were:

- refund \$7.1 million to the Federal Government and
- ensure that future requests for CHIPRA bonus payments include only qualifying children to comply with Federal requirements.

Medicaid quality of care and patient safety

Nursing facilities—Reporting allegations of abuse or neglect

- *Nursing Facilities' Compliance With Federal Requirements for Reporting Allegations of Abuse or Neglect. OEI-07-13-00010. 2014 August.*

We found that 85 percent of nursing facilities reported at least one allegation of abuse or neglect to OIG in 2012, and 76 percent of nursing facilities maintained policies that address Federal regulations for reporting both allegations of abuse or neglect and investigation results. It is both required and expected that nursing facilities will report any and all allegations of abuse or neglect to ensure resident safety. CMS agreed with all of our recommendations, which were to ensure that nursing facilities:

- maintain policies related to reporting allegations of abuse or neglect;
- notify covered individuals of their obligation to report reasonable suspicions of crimes; and
- report allegations of abuse or neglect and investigation results in a timely manner and to the appropriate individuals, as required.

Unqualified nursing home workers

- *CMS's Reliance on California's Licensing Surveys of Nursing Homes Could Not Ensure the Quality of Care Provided to Medicare and Medicaid Beneficiaries. A-09-12-02037. June 2014.*

CMS's reliance on California's licensing surveys of nursing homes could not ensure the quality of care provided to Medicare and Medicaid beneficiaries. CMS agreed with all of our recommendations, which were that CMS work with the State agency to ensure that:

- nursing homes (1) implement and follow adequate policies and procedures for employee health examinations and (2) request approval for optional service units,
- the State agency conducts all required licensing surveys and reviews employee health examination records during those surveys, and

- the State agency improves licensing survey procedures for (1) reviewing employee health examination records and the three required components and (2) determining whether optional service units operated by the nursing homes are approved and optional services are listed on the licenses.

Unqualified hospice workers

- *CMS's Reliance on Illinois Licensure Requirements Could Not Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries. A-05-12-00028. 2014 June.*

We estimated that \$13.4 million (\$8.2 million Federal share) in Medicaid payments for Illinois hospice care services were provided by unqualified hospice workers. CMS's reliance on Illinois licensure requirements could not ensure quality of care and could not ensure that adequate protection was provided to Medicaid hospice beneficiaries. CMS agreed with the following recommendations, and Illinois had no comment:

- work with Illinois to ensure that hospices meet the State licensure requirements for hospice workers and
- consider working with Illinois to modify its hospice payment conditions by implementing provisions similar to Illinois licensure requirements for hospice workers.

-
- *CMS's Reliance on Ohio Licensure Requirements Did Not Always Ensure the Quality of Care Provided to Medicaid Hospice Beneficiaries. A-05-12-00086. September 2014.*

CMS's reliance on Ohio licensure requirements did not always ensure the quality of care provided to Medicaid hospice beneficiaries. We estimated that 15,550 of the 103,668 claims covered by our review were associated with unqualified hospice workers. CMS and Ohio generally agreed with the following recommendations:

- work with the Ohio Department of Job and Family Services and the Ohio Department of Health to ensure that hospices meet Ohio licensure requirements for hospice workers and
- consider working with the Ohio Department of Job and Family Services to modify its hospice payment conditions by implementing provisions similar to the Ohio licensure requirements for hospice workers.

Legal and investigative activities related to Medicare and Medicaid

For April 1 to September 30, 2014, we reported 506 criminal and 267 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported \$1.26 billion in investigative receivables due to the U.S. Department of Health and Human Services (HHS) and \$300.7 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs.

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, when appropriate, under the False Claims Act. Depending on the types of fraud or other violations involved, OIG investigations may culminate in criminal or civil court judgments and decisions, administrative sanctions and decisions, and/or negotiated settlement agreements. Investigative outcomes take many forms, including incarceration, restitution, fines, penalties, forfeitures, assessments, and exclusion of individuals or entities from participation in all Federal health care programs. Frequently used exclusion and penalty authorities are described in Appendix D of this *Semiannual Report* and on our Web site at:

<http://oig.hhs.gov/fraud/enforcement/cmp/>.

Chart 1: Actions—All programs

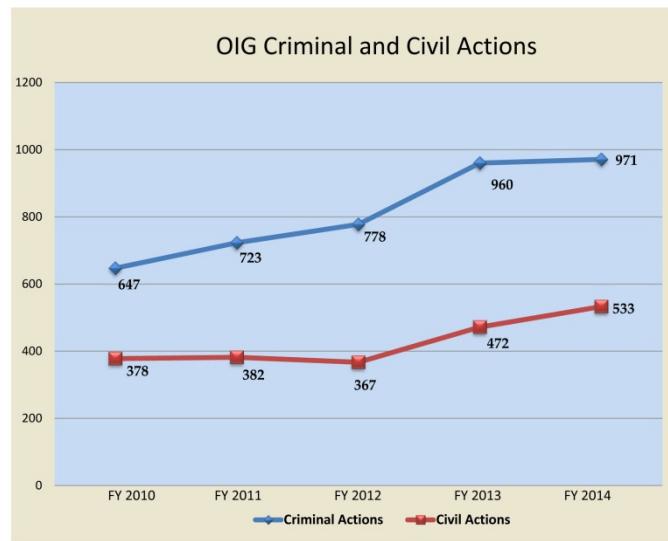
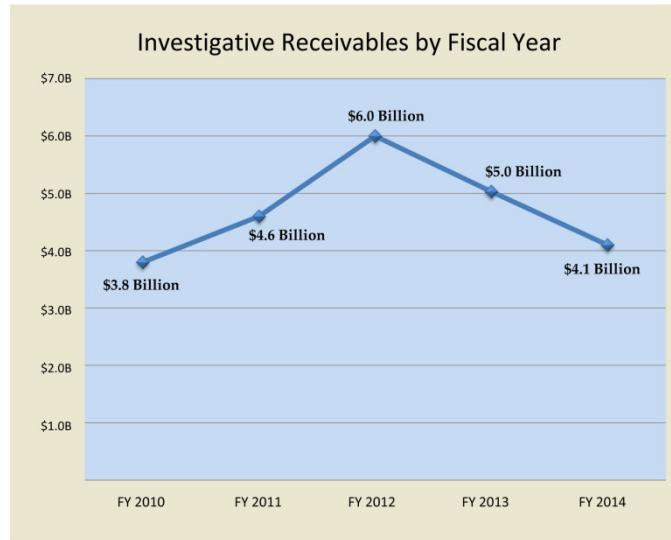


Chart 2: Receivables—All programs



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

Health care fraud prevention and enforcement

Medicare Fraud Strike Force teams

Medicare Fraud Strike Force teams began in 2007 in an effort to combine the resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. These Strike Force teams are partnerships between OIG and HHS, Department of Justice (DOJ), U.S. Attorneys' Offices, the Federal Bureau of Investigation (FBI), and State and local law enforcement with a common goal: to successfully analyze health care fraud data and investigative intelligence to quickly identify fraud and bring prosecutions. Strike Force teams currently operate in nine areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas.

Chart 3: Indictments—Strike Force

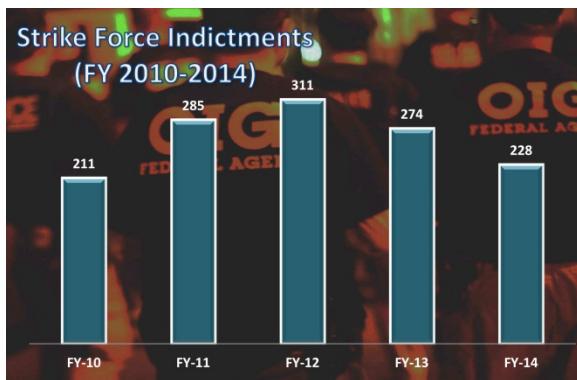


Chart 4: Criminal Actions—Strike Force

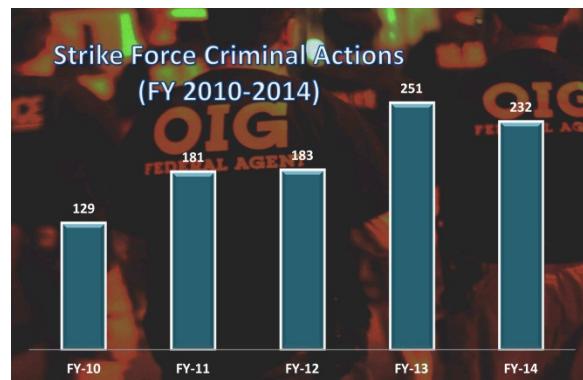
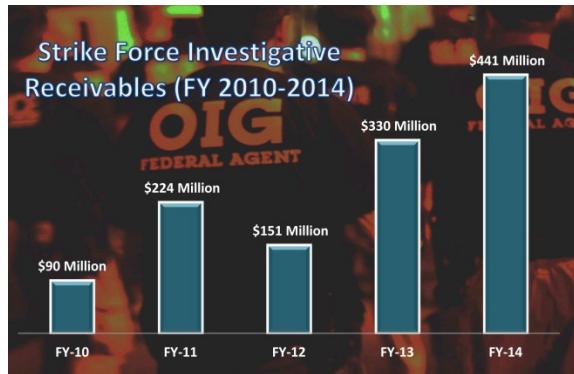


Chart 5: Receivables—Strike Force



From April 1, 2014, to September 30, 2014, Strike Force efforts resulted in the filing of charges against 134 individuals or entities, 125 criminal actions, and \$147 million in investigative receivables.

Strike Force examples

Florida – Michele Petrie was the director of the outpatient facility at Hollywood Pavilion, LLC, which purportedly provided mental health services to Medicare beneficiaries. According to court documents, Petrie and her co-conspirators arranged for illegal bribes and kickbacks to be paid to “patient brokers” in return for referring Medicare beneficiaries to Hollywood Pavilion. Petrie and her co-conspirators then caused the submission of fraudulent claims through Hollywood Pavilion and billed the Medicare program millions of dollars for services that were medically unnecessary and for services provided to patients who were not eligible for treatment. In an attempt to conceal the fraud, Petrie and her co-conspirators caused false, inaccurate, and misleading information to be included in patient files and related documents for Medicare beneficiaries who were purportedly receiving mental health treatment at Hollywood Pavilion. Petrie was convicted on charges of conspiracy to commit health care and wire fraud, wire fraud, and conspiracy to pay and receive kickbacks in connection with a Federal health care benefit program. She was sentenced to 6 years in prison and was ordered to pay \$39 million in joint and several restitution.

New York – Elaine Kim was the office manager at URI Medical Service, PC, while Gilbert Kim was the office manager at Sarang Medical, PC. URI and Sarang purportedly provided physical therapy, electric stimulation treatment, and other medical services to Medicare beneficiaries. According to the indictment, from approximately March 2007 through May 2012, Elaine and Gilbert Kim and their co-conspirators artificially increased demand for medical services by providing Medicare beneficiaries with free goods and services, such as massages, facials, lunches, gift cards, and recreational classes. They then submitted false claims to Medicare for medical services, such as office visits, physical therapy, lesion destruction, and electrical stimulation treatment, which were medically unnecessary, were not provided, and otherwise did not qualify for reimbursement. Once the beneficiaries arrived at the clinics, they were required to give their Medicare numbers to staff and to see a doctor, regardless of medical need, in order to receive the free nonmedical inducements. Gilbert and Elaine Kim acted as patient recruiters and were paid for referring beneficiaries to the clinics. During this reporting period, Elaine and

Gilbert Kim both pleaded guilty to conspiracy to commit health care fraud. Elaine Kim was sentenced to 12 months in jail, and both defendants were ordered to pay \$5.9 million in joint and several restitution. In addition, Elaine and Gilbert Kim were excluded from participating in any Federal health care programs for 18 and 10 years, respectively.

Michigan – Louisa Thompson owned and operated TGW Medical, Inc., and Caldwell Thompson Manor, Inc., two businesses that purportedly provided psychotherapy services. Checarol Robinson owned and operated P&C Adult Day Center, LLC, which also purportedly provided psychotherapy services. According to the indictment, Thompson, a licensed social worker, and other co-conspirators signed patient charts and progress notes for individual and group psychotherapy sessions purportedly performed at TGW, Caldwell Thompson, and P&C that were not medically necessary and were not performed. Thompson used her own provider number as well as the provider number of another social worker at TGW to cause the three clinics to bill Medicare approximately \$20 million for psychotherapy visits. Thompson pleaded guilty to conspiracy to commit health care fraud and was sentenced to 3 years and 4 months of incarceration and was ordered to pay \$5 million in joint and several restitution. In addition, Thompson was excluded from participating in any Federal health care programs for 20 years. Robinson previously pleaded guilty to conspiracy to commit health care fraud and health care fraud and was sentenced to 3 years and 4 months of incarceration and was ordered to pay \$599,438 in joint and several restitution.

Other criminal and civil enforcement activities

Special Assistant U.S. Attorney Program

During this reporting period, DOJ and OIG continued their participation in a program in which OIG attorneys, some of whom are Special Agents, serve as Special Assistant U.S. Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, including assignments to the Medicare Fraud Strike Force. Other attorneys prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the Departments in their efforts to fight fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to the fraudulent billing of medical equipment and supplies, infusion therapy, and physical therapy, as well as other types of Medicare and Medicaid fraud. A related case example follows.

North Dakota – Hovakim John Mkhitarian was an organizer, leader, and manager of a multi-million-dollar health care fraud conspiracy. According to court documents, Mkhitarian recruited co-conspirators to open false-front Medicare provider businesses in several states across the country. He then used stolen physician and beneficiary identities to submit false claims to Medicare. As part of the scheme, Mkhitarian and his co-conspirators hired “handlers” who were in charge of recruiting and driving foreign students around the country to incorporate false-front providers, rent commercial mailboxes, and open bank accounts on behalf of the scheme. The scheme targeted Russian-speaking students traveling under the Summer Work and Travel Program. Mkhitarian and his co-conspirators funneled Medicare payments through check-cashing businesses and gold dealers in order to conceal the source and ownership of unlawful proceeds of the fraud. Medicare paid the false-front providers approximately \$6.4 million in claims reimbursement. Mkhitarian pleaded guilty to conspiracy to commit health care fraud and faces a maximum sentence of 10 years, restitution of \$3.1 million, and criminal forfeiture of all proceeds of the scheme. Mkhitarian’s cousin, Hovakim David Mkhitarian, pleaded guilty to conspiracy to commit health

care fraud and was sentenced to 7 months in prison. Levon Gevorgyan, who was hired as a student handler, pleaded guilty to conspiracy to commit health care fraud and is awaiting sentencing.

Most wanted fugitives listed on OIG's Web site

The OIG Most Wanted Fugitives Web site continues to garner national and international attention and has greatly assisted in helping to capture fugitives charged with defrauding Federal health care programs and stealing millions of taxpayer dollars. The Most Wanted Fugitives Web site is continuously updated and features a profile and statistics for each fugitive, as well as an online tip form and a hotline number for individuals to report fugitive-related information to OIG, in English or Spanish, 24 hours a day, 365 days a year. The Most Wanted Fugitives list can be accessed at <http://oig.hhs.gov/fraud/fugitives>. During this reporting period, three fugitives were captured.

Most Wanted Fugitive Vivian Yusuf was arrested in June 2014 at Houston International Airport after arriving on a flight from Nigeria. In March 2011, Yusuf was indicted on charges of conspiracy to commit health care fraud, health care fraud, and aggravated identity theft. Investigators believe that Yusuf and her co-conspirators billed Medicare more than \$3.4 million for durable medical equipment (DME) that was neither medically necessary nor prescribed by a physician. Yusuf owned and operated Ivy Health Care Supply, a DME company based in Stafford, Texas. According to court records, Yusuf and her co-conspirators allegedly improperly acquired Medicare patient information and forged physicians' signatures on prescriptions and certificates of medical necessity (CMNs). They also altered prescriptions and CMNs after they had been signed by physicians. The defendants then billed Medicare for power wheelchairs, orthotic equipment, and other medical supplies that were not prescribed or otherwise authorized by a physician, were not medically necessary, and were not requested by the beneficiaries. Investigators believe that Yusuf and her co-conspirators falsely billed Medicare for nearly 800 Medicare patients, located primarily in Texas and Louisiana.

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

Recently completed actions and settlements

Home health

Louisiana – Amedisys, Inc., and Amedisys Holding, LLC (collectively, Amedisys), agreed to pay \$150 million to settle allegations under the False Claims Act. Amedisys is a for-profit national company that provides home health care services, including nursing care and physical, speech, and occupational therapy, primarily to Medicare beneficiaries. Amedisys allegedly billed Medicare for home health care services provided to patients who were not homebound and to those who lacked a need for skilled nursing and/or skilled therapy services. Amedisys also allegedly billed Medicare for services provided to patients without regard to medical necessity and overbilled Medicare by upcoding patients' diagnoses. In addition to the settlement, Amedisys agreed to enter into a comprehensive 5-year corporate integrity agreement (CIA) with OIG.

Texas – Nick Patzakis was a doctor of osteopathic medicine and medical director for the home health agencies Jackson Home Healthcare, Inc. (JHH), and Prestige Health Services, Inc. (PHS). Valdie Jackson was the director of JHH, while Valnita Turner was a registered nurse, PHS's director of nursing, and director of the home health agencies Houston Compassionate Care, Inc. (HCC) and Texas Comprehensive Healthcare Resources, Inc. (TCHR). Jarvis Thomas worked at a local hospital. According to the indictment, Thomas accessed hospital files without authorization and obtained personal health information of hospital patients, which he then provided to Jackson in return for payment. Jackson shared the information with others, including Turner and employees of TCHR. Employees of TCHR then used the stolen information to contact beneficiaries and solicit them for home health care services, including falsely stating that the beneficiaries' physicians referred them for a home health evaluation when, in fact, the physicians never made a referral, did not establish a plan of care, and were unaware that the beneficiaries were being contacted by a home health agency. JHH, PHS, and HCC then billed Medicare more than \$12 million for home health services allegedly provided to beneficiaries who had been solicited. However, the services did not qualify for payment because the patients: (1) were not under the care of a physician who had established the plan of care, (2) were not confined to the home, and (3) were not in need of skilled nursing care. The four defendants were sentenced to a combined 13 years and 7 months in prison and were ordered to pay more than \$5.5 million in joint and several restitution.

Pharmacies

Illinois – Sears Holdings Corporation and Kmart Corporation (collectively, Kmart) agreed to pay \$3.3 million to settle allegations that Kmart offered and paid remuneration in the form of gift cards and coupons to beneficiaries of Federal health care programs to induce the beneficiaries to transfer or fill their prescriptions at Kmart pharmacies. The Government alleged that, as a result of this conduct, Kmart violated the False Claims Act by submitting improper claims for payment to Medicare, TRICARE, the Veterans Affairs program, and Medicaid. Sears wholly owns Kmart, which operates retail stores containing pharmacies throughout the United States.

Personal care services

Illinois – During this reporting period, 11 individuals were arrested and 15 individuals were federally charged for allegedly submitting false timesheets for work not performed as personal assistants through the Illinois Home Services Program, a State Medicaid waiver program. The individuals charged allegedly submitted or assisted in submitting fraudulent timesheets for hours in which the personal assistant was working another job or was otherwise out of the area or for a time when the disabled customer was hospitalized or otherwise not using the services. Those charged included Jason Greene, who allegedly submitted false timesheets for at least 300 hours of work performed during times he was incarcerated, and Michelle Calhoun, who allegedly submitted false timesheets for services that were never performed.

Vermont – Four defendants who were involved in different personal care services schemes to defraud the Vermont Medicaid program were sentenced during this reporting period. According to court documents, Kammy McDonald claimed she provided more than 350 hours of personal care services to an adult with physical disabilities in the disabled adult's home. However, at the time these services were purportedly rendered, McDonald allegedly was working at a convenience store. Brooke Scott was employed as the caregiver for a minor child with special needs. He allegedly submitted timesheets for more than 500 hours of care when, in fact, the child was actually in day care. Denise Wildasin was the employer of record and allegedly approved Scott's timesheets, knowing they were false. Tasha Gaudette

was employed as the caregiver for a minor child with special needs. In that capacity, Gaudette allegedly submitted timesheets for more than 400 hours of care purportedly provided after the child moved to a new residence and she no longer provided care. The four defendants were sentenced to a combined 9 years and 6 months of incarceration (each defendant received a suspended sentence) and were ordered to pay a combined \$34,031 in restitution, penalties, and fines.

Hospitals

Florida – Halifax Hospital Medical Center and its wholly owned staffing agency, Halifax Staffing, Inc. (collectively, Halifax), agreed to pay \$85 million to resolve allegations that Halifax entered into certain prohibited contracts with oncologists and neurosurgeons in violation of the Stark Law and caused the submission of false claims. The Government alleged that between 2004 and 2010, Halifax entered into employment contracts with neurosurgeons that greatly exceeded fair market value and varied with the volume and value of the referrals or other business generated. Between 2004 and 2010, the neurosurgeons generated more than \$35 million in Medicare business for the hospital. Halifax allegedly paid the neurosurgeons through a number of means that were not properly documented in contracts, including: (1) \$100,000 annually for unspecified amounts of call coverage, (2) a car allowance in excess of \$1,000 a month, (3) payments well in excess of the Medicare fee schedule for certain categories of patients, and (4) bonuses based upon work that was performed by nurses or physician assistants. The Government also alleged that Halifax entered into employment contracts with oncologists that included “operating margin” bonuses that were based on the volume or value of the referrals or other business generated by the physicians. The Government alleged that because of the prohibited relationship between Halifax and these physicians, the claims that Halifax submitted for their referrals were false. As part of the settlement, Halifax entered into an enhanced CIA with OIG that includes requiring Halifax to retain an independent compliance expert to provide annual reviews of the effectiveness of its compliance program and to hire a Legal Independent Review Organization to review Halifax’s contracts with physicians and other health care providers.

Kentucky – Ashland Hospital Corporation d/b/a King’s Daughters Medical Center (KDMC) agreed to pay \$40.9 million to resolve allegations that it violated the Stark Law and the False Claims Act. Specifically, the Government alleged that KDMC paid several cardiologists compensation that was commercially unreasonable and exceeded fair market value and that KDMC submitted claims to Medicare and Medicaid for medically unnecessary coronary stents and cardiac catheterizations. In addition to agreeing to payment of the settlement amount, KDMC agreed to enter into a comprehensive 5-year CIA with OIG that includes enhanced provisions to address patient care issues and KDMC’s relationships with referral sources.

Identity theft

North Carolina – Victoria Brewton operated a series of after-school and summer childcare programs and recruited Medicaid beneficiaries to enroll in the programs with the promise to their families that the programs were free for Medicaid recipients. According to court documents and court proceedings, Brewton, who was not licensed or qualified to provide mental and behavioral health services and was not a Medicaid-approved provider, then stole the Medicaid numbers of some of the children and families who enrolled in the programs and falsely billed Medicaid for mental and behavioral health services that were never provided. Brewton used the provider numbers of other licensed therapists, some of whom did not know their information had been compromised, to falsely bill Medicaid for millions of dollars.

Rodnisha Cannon worked as a patient recruiter for Brewton before opening her own after-school and summer childcare programs. Cannon ran a similar scheme, whereby she used the Medicaid provider numbers of other companies and individual therapists to submit false claims to Medicaid totaling millions of dollars for mental and behavioral health services that were never provided. For example, Cannon hired a licensed clinical social worker, but the social worker worked for Cannon for only a single day. Cannon stole the social worker's provider information and used it to submit more than \$800,000 in false claims to Medicaid for services never provided, including claims with dates of service before the social worker was hired by Cannon. Brewton and Cannon were sentenced to a combined 17 years and 9 months in prison and were ordered to pay a combined \$10.1 million in restitution, joint and several. Cannon was also excluded from participating in any Federal health care programs for 28 years.

Physicians

West Virginia – Allen Saoud was a doctor of osteopathic medicine who owned the dermatological practices AGS, Inc., and Central West Virginia Dermatology Associates, Inc. Between May 1998 and June 2004, Saoud allegedly submitted false claims to Medicare and Medicaid. He reached a settlement with the United States in August 2005 that included his voluntary exclusion from all Federal health care programs for 10 years. According to the investigation, after his voluntary exclusion, Saoud arranged an elaborate scheme to hide his involvement with his dermatology clinics and continue billing and receiving payment from Medicare and Medicaid, which included sham sales of the clinics. Saoud later lied in Federal bankruptcy court, lied to a Federal investigator, stole the identity of another physician, and obstructed an Internal Revenue Service (IRS) investigation. Saoud was convicted by a jury on charges of health care fraud, bankruptcy fraud, identity theft, and the filing of false tax returns. He was sentenced to 8 years and 3 months of incarceration and was ordered to pay \$265,330 in restitution and a \$2.6 million fine.

Texas – Valley Heart Consultants, PA (VHC); Carlos David Mego, MD; and Subbarao Yarra, MD, agreed to pay \$3.9 million to resolve allegations that they violated the False Claims Act. VHC is a cardiology practice owned by Mego and Yarra that is based in McAllen, Texas. The Government alleged that VHC, Mego, and Yarra billed Medicare Part B for: (1) nuclear stress tests administered in part by unlicensed personnel; (2) unnecessary echocardiograms, carotid Doppler tests, and coronary angiographies; (3) nuclear stress tests that were administered and interpreted so far below the standard of care as to be worthless; and (4) physical examinations that were performed in such a superficial manner as to be worthless. In addition to payment of the settlement amount, VHC, Mego, and Yarra agreed to enter into a 3-year CIA with OIG that includes both quality-of-care and claims reviews.

Mental health services

Michigan – Glenn English acted as the owner and Chief Executive Officer of New Century Adult Day Program Services, LLC. Gregory Lawrence was a Medicare provider and director at New Century, while Richard Hogan, Donald Berry, Felicia Marsh, and Jamie Moreau worked at New Century. According to evidence presented at trial, English and his co-conspirators lured mentally disabled residents of local adult foster care homes, as well as people seeking narcotic drugs, to New Century with the promise that they could see a doctor who would prescribe them the narcotics they wanted if they signed up for New Century's psychotherapy program. New Century used the signatures and Medicare information of these individuals to claim that it was providing them psychotherapy when, in fact, it was not. Additionally, the evidence at trial showed that English directed New Century employees to fabricate patient records to make it appear that psychotherapy was provided and to pre-sign sign-in sheets for months at a time in

order to bill Medicare for services not rendered. Between March 2010 and April 2012, New Century billed Medicare approximately \$3.2 million for psychotherapy services. English, Hogan, and Marsh were sentenced to a combined 14 years of incarceration and were ordered to pay more than \$2.1 million in restitution, joint and several. Lawrence and Moreau previously pleaded guilty to conspiracy to commit health care fraud and are awaiting sentencing. Berry passed away before his trial concluded. English, Hogan, and Marsh were all excluded from participating in any Federal health care programs for 25, 18, and 5 years, respectively.

New York – Mikhail Presman was a licensed psychiatrist formerly employed by the Department of Veterans Affairs. According to court documents, Presman billed Medicare approximately \$4 million for home treatment of beneficiaries. However, many of those visits never occurred. On a number of occasions, Presman submitted claims to Medicare for home medical visits at locations within New York City, even though he was physically located in China at the time of these purported home visits. Additionally, he submitted claims to Medicare for 55 home medical visits to beneficiaries who were actually hospitalized on the date of the purported visits. Presman pleaded guilty to health care fraud, was sentenced to a year-and-a-half in jail, and was ordered to pay \$1.2 million in restitution. In addition, he was excluded from participating in any Federal health care programs for 15 years.

Hospice care

Pennsylvania – Matthew Kolodesh controlled and operated Home Care Hospice, Inc. (HCH), a for-profit hospice provider that purportedly provided hospice services for patients at nursing homes, hospitals, and private residences. According to the indictment, Kolodesh and his co-conspirators billed Medicare more than \$14 million for alleged services provided by HCH, even though (1) some patients were ineligible for hospice care and (2) some services were billed at a higher reimbursement level, but still not provided to the patients. In order to increase HCH’s patient census, Kolodesh authorized payments to certain physicians and other health care professionals as an incentive to refer patients to HCH and to certify that they were appropriate for hospice care, even though they were not eligible. He also paid physicians and other health care professionals to serve as HCH medical directors, hospice physicians, and advisors when, in reality, the contracts for these positions were to mask payments for patient referrals. Kolodesh directed employees to maintain ineligible patients who were not terminally ill on hospice care, in some instances for more than 1 year, and he authorized the fabrication of supporting documentation for patient files to substantiate approximately \$12.8 million in fraudulent claims billed to Medicare. Kolodesh was found guilty by a jury on charges of conspiracy to commit health care fraud, health care fraud, money laundering, and mail fraud. He was sentenced to 14 years and 8 months in prison and was ordered to pay \$16.2 million in restitution, joint and several. To date, 10 other defendants have been sentenced to a combined 8 years in prison in connection with this scheme.

Durable medical equipment

California – Susanna Artsruni was the owner and managing employee of Midvalley Medical Supply, based in Van Nuys, California. Artsruni also worked as an office manager under a different name at the Vermont Clinic in Los Angeles. According to the indictment, Artsruni; co-conspirator Erasmus Kotev, who worked at the Vermont Clinic as a physician’s assistant; and others recruited and transported Medicare beneficiaries to the Vermont Clinic, often with the promise of free, medically unnecessary DME. Some of these beneficiaries lived hundreds of miles away. The beneficiaries were often prescribed DME, such as motorized wheelchairs and orthotics, and underwent medically unnecessary tests, including nerve conduction tests and ultrasounds. Artsruni used the patient information obtained from beneficiaries at

the Vermont Clinic to bill for medically unnecessary DME prescriptions through her DME company, Midvalley. Artsruni pleaded guilty to health care fraud and money laundering, was sentenced to 6 years and 4 months of incarceration, and was ordered to pay \$9.6 million in joint and several restitution. In addition, Artsruni was excluded from participating in any Federal health care programs for 30 years. Kotev pleaded guilty to charges of health care fraud and conspiracy to commit health care fraud and is awaiting sentencing.

New York – Rubin Kaykov owned and operated the purported DME company, Triangle R Inc., based in Queens, New York. Roman Bortnik worked for Triangle R but also had his own purported DME wholesale company, Tracey Drive Medical Supply Co. However, according to the indictment, the listed street address for Tracey Drive Medical was actually a location in which a hair salon operated. According to the indictment, Kaykov and Bortnik billed Medicare and Medicaid millions of dollars for DME, including motorized wheelchairs, that was never provided to patients and/or was more expensive than the DME that was actually provided to patients. Kaykov, Bortnik, and their co-conspirators prepared fraudulent documentation that appeared to legitimize their billings, including hundreds of forged and phony medical prescriptions for DME, at times even forging the signatures of patients and fraudulently altering documentation related to those patients. Both Kaykov and Bortnik pleaded guilty to charges of health care fraud and were sentenced to 2 years and 2 years and 6 months of incarceration, respectively. Both defendants were also ordered to pay \$1 million in joint and several restitution.

Transportation

California – Alex Kapri was the president and chief executive officer of Alpha Ambulance, Inc., a purported ambulance transportation company located in Los Angeles, California. Aleksey Muratov acted as the vice-president and chief financial officer of Alpha. According to the indictment, Kapri, Muratov, and other co-conspirators provided ambulance transportation services to Medicare beneficiaries, knowing that their medical conditions did not necessitate the transportation services. The co-conspirators instructed Alpha employees to document a reason justifying ambulance transportation services on run sheets even if a justification did not exist. Employees were also told not to write certain words, such as “chair,” “walk,” or “sit,” on the run sheets because Medicare would not pay for ambulance services if those words were present. Between June 2008 and July 2012, Alpha submitted approximately \$49 million in claims to Medicare for purported ambulance transportation and related services. Kapri and Muratov both pleaded guilty to conspiracy to commit health care fraud. They were sentenced to a combined 15 years and 3 months in jail and were ordered to pay \$1.6 million in joint and several restitution.

Pennsylvania – Anna Mudrova owned and operated Penn Choice Ambulance, Inc., a purported ambulance transportation company based in Philadelphia, Pennsylvania. According to court records, Mudrova and her co-conspirators transported by ambulance Medicare beneficiaries who could walk or be safely transported by other means, falsely representing to Medicare that these patients required transportation by ambulance. The defendants also targeted and recruited patients who attended dialysis treatment, which is typically required 3 times per week, thereby allowing Penn Choice to bill extensively for these patients. Ambulatory patients were directed to get onto a stretcher when they were able to walk or be moved via wheelchair. Penn Choice often transported two patients in an ambulance at the same time; one sat on a stretcher and the other on a jump seat. In addition, at least one patient rode in the front passenger seat. To induce Medicare beneficiaries to be transported by Penn Choice even though such ambulance transport was not medically necessary, the defendants paid beneficiaries kickbacks of between \$100 and \$500 a month. Penn Choice billed Medicare approximately

\$3.6 million for these false claims, which resulted in a more than \$1.5 million loss to Medicare. Mudrova pleaded guilty to conspiracy to commit health care fraud, was sentenced to 8 years in prison, and was ordered to pay \$1.8 million in joint and several restitution. Three other defendants were sentenced to a combined 9 years in prison in connection with this scheme.

Chiropractor

California — Houshang Pavehzadeh was the owner of Sylmar Physician Medical Group, Inc., a chiropractic clinic located in a strip mall in San Fernando Valley, California. According to court documents, Pavehzadeh billed Medicare for chiropractic manipulations purportedly provided to beneficiaries when, in fact, the treatments were either merely massages and were not reimbursable by Medicare or were never actually provided. In an effort to conceal his fraud from OIG investigators, Pavehzadeh falsely reported to the Los Angeles Police Department that he had been carjacked and that the requested patient files had been stolen. Pavehzadeh billed Medicare more than \$1.7 million for purported chiropractic treatments between 2005 and 2012, for which he was paid more than \$1 million. Pavehzadeh pleaded guilty to health care fraud, was sentenced to 5 years and 3 months in jail, was ordered to pay \$1 million in restitution, and had more than \$300,000 in assets seized.

State Medicaid Fraud Control Units

OIG oversight of State MFCUs

Medicaid Fraud Control Units (MFCUs or Units) are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. OIG has oversight responsibility for MFCUs and administers grants that provide Federal funding for Unit operations. The Federal Government reimburses 75 percent of the costs of operating a Unit; the States contribute the remaining 25 percent. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities or board and care facilities. MFCU accomplishment data and onsite reviews for FY 2014 will be reported in OIG's spring 2015 *Semiannual Report*.

OIG onsite reviews of MFCUs

OIG has developed 12 performance standards for use in assessing the operations of MFCUs. A copy of the [MFCU performance standards](#), most recently revised in June 2012, may be found on the OIG Web site. Periodically—approximately every 5 years—OIG conducts an in-depth onsite review of each Unit to evaluate its operations as related to the 12 performance standards and to assess compliance with laws, regulations, and OIG policy guidance. OIG issued reports of onsite reviews of the following MFCUs from April through September 2014. The full reports are available on our Web site.

- *Connecticut State Medicaid Fraud Control Unit: 2013 Onsite Review* [OEI-07-13-00540](#) 2014 SEP.
- *Mississippi State Medicaid Fraud Control Unit: 2014 Onsite Review* [OEI-09-13-00700](#) 2014 AUG.
- *Indiana State Medicaid Fraud Control Unit: 2013 Onsite Review* [OEI-07-13-00250](#) 2014 JUL.
- *Nebraska State Medicaid Fraud Control Unit: 2014 Onsite Review* [OEI-07-14-00060](#) 2014 JUN.
- *Utah State Medicaid Fraud Control Unit: 2013 Onsite Review* [OEI-09-13-00490](#) 2014 APR.

■ *Texas State Medicaid Fraud Control Unit: 2013 Onsite Review OEI-06-13-00300 2014 APR.*

Joint investigations with MFCUs

Examples of joint efforts with MFCUs include the following:

South Carolina – Truman Lewis owned and operated Helping Hands Youth and Family Services, a business that purportedly provided rehabilitative behavioral health services to Medicaid beneficiaries. Truman’s brother Norman and his wife Melanie also worked in various management roles at Helping Hands. According to court records, Helping Hands management directed employees to fabricate and sign progress notes for mentoring services allegedly performed by other Helping Hands employees or former employees when, in fact, these services were not provided. Employees were also told by management that Medicaid was being billed 40 hours per week for each full-time employee for services rendered; management instructed employees to draft notes to support 40 hours of reimbursable services. Employees who did not draft the notes to those specifications were threatened that they would not be paid. Between January 2009 and October 2010, Medicaid paid more than \$8.9 million to Helping Hands for services purportedly rendered. Truman, Norman, and Melanie Lewis used these funds to purchase certificates of deposit, luxury vehicles, mobile homes, real estate, and other personal items.

Truman and Norman Lewis were sentenced to a combined 17 years and 6 months in jail and were ordered to pay \$3.3 million in restitution, joint and several. Melanie Lewis pleaded guilty and was ordered to pay \$210,020 in restitution. Truman, Norman, and Melanie Lewis were also excluded from participating in any Federal health care programs for 30, 25, and 5 years, respectively. This case was worked jointly with the IRS and the South Carolina MFCU.

Georgia – Schella Hope, a licensed dietitian, owned and operated Hope Nutritional Services, LLC (HNS). HNS purportedly provided nutrition services and counseling almost exclusively for children, most of whom were enrolled in the Government-funded Head Start program. Co-conspirator Arlene Murrell was a licensed dietitian who owned and operated Quality Nutrition Services (QNS), which also purportedly provided nutrition services and counseling to children in Head Start. According to evidence presented at trial and at sentencing, from 2005 through 2011, Hope misappropriated the identities of thousands of children who were enrolled in Head Start programs located throughout the State of Georgia. Once Hope obtained the identities of these children, she fabricated patient files, falsified prescriptions from doctors, and submitted \$4 million worth of bogus claims to Medicaid for nutritional services that were not provided. As the co-conspirator, Murrell allowed Hope to submit false and fraudulent claims under her provider number at QNS and transferred payment to Hope when Medicaid reimbursed her company. The evidence further showed that Hope used the money she stole from Medicaid to pay for luxury automobiles, designer clothing, and luxury vacations, among other things.

Hope was found guilty by a jury on charges of conspiracy, health care fraud, aggravated identity theft, and money laundering. She was sentenced to 16 years in prison and was ordered to pay \$4.3 million in restitution, joint and several. Murrell pleaded guilty to one count of conspiracy and was ordered to pay \$159,273 in joint and several restitution. In addition, Hope and Murrell were excluded from participating in any Federal health care programs for 45 and 5 years, respectively. This case was worked jointly with the FBI, the Georgia MCFU, and the Georgia Department of Community Health.

Advisory opinions and other industry guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with DOJ, are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996, § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. From April 1, 2014, to September 30, 2014, OIG received 26 requests for advisory opinions and issued 6 opinions.

Sanction authorities and other administrative actions

Various Federal laws provide authorities to impose administrative sanctions for fraud and abuse, as well as other activities that pose a risk to Federal health care programs and their beneficiaries. Sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties (CMPs) for submitting false and fraudulent claims to a Federal health care program or for violating the anti-kickback statute; the Stark Law; or the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient dumping statute.

During this semiannual reporting period, OIG imposed 2,360 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. Exclusion and penalty authorities are described in Appendix D and on our Web site at <http://oig.hhs.gov/fraud/enforcement/cmp>.

Program exclusions

During this semiannual reporting period, OIG excluded 2,297 individuals and entities from Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. OIG is also responsible for reinstating providers who apply and have met the requirements of their exclusions. For a list of excluded individuals and entities, see: <http://exclusions.oig.hhs.gov>. Case examples follow.

Texas – Physician Christopher Duntsch, a specialist in neurological surgery, was excluded on the basis of the revocation of his medical license to practice in the State of Texas, for so long as his license remains revoked. The Texas Medical Board revoked Duntsch's license after finding that his treatment of several patients represented a pattern of failing to follow appropriate preoperative planning standards and failing to recognize and respond to complications during surgery and postoperatively. One patient suffered complications from surgery performed by Duntsch that resulted in excessive blood loss and quadriplegia. Another patient suffered a complication of retroperitoneal hemorrhage that was not addressed by Duntsch. A third patient suffered excessive blood loss during surgery and had bone removed unnecessarily, which resulted in injury to the vertebral artery. Those issues led to a series of events that included a stroke, which ultimately resulted in the patient's death. Duntsch also failed to manage severe post-operative complications suffered by a fourth patient, including an esophageal injury and a retained sponge, which was evident during an early post-operative x-ray.

Oregon – Frederick Field, an anesthesiologist, was excluded for a minimum period of 50 years on the basis of his conviction of 11 counts of first-degree sexual abuse and one count of first-degree rape. From about September 2007 to about July 2011, Field engaged in sexual contact and sexual intercourse with patients who were incapacitated and under the influence of anesthetics at the time. Field was sentenced to 23 years and 4 months of incarceration, and his medical licenses were permanently surrendered and revoked in the States of Oregon and California, respectively.

Iowa – David Gierlus, a doctor of osteopathic medicine, was excluded for a minimum period of 18 years on the basis of his conviction for distribution of hydrocodone. Gierlus intentionally distributed hydrocodone to a patient for other than a legitimate medical purpose and outside the course of professional medical practice. Without performing a thorough physical examination and without determining the cause of the patient’s pain, Gierlus prescribed a stronger dose of hydrocodone than he had previously prescribed for the patient. Gierlus was sentenced to 8 years of incarceration. In addition, he surrendered his license to practice in the State of Iowa.

Michigan – Chiradeep Gupta, who held ownership interests in various home health agencies and entities that provided contract physical therapy services to those agencies, was excluded for a minimum period of 40 years on the basis of his conviction for health care fraud conspiracy. From about August 2007 to about September 2009, Gupta conspired with others to submit false and fraudulent claims to Medicare. Gupta and others fabricated medical and billing documents, which reflected or supported that physical therapy had been provided when, in fact, the therapy was not medically necessary or was not provided. Gupta was sentenced to 10 years in prison and was ordered to pay approximately \$10.1 million in restitution, joint and several.

New York – Physician Gustave Drivas was excluded for a minimum period of 50 years on the basis of his conviction for conspiracy to commit health care fraud and health care fraud. From about March 2005 to about July 2010, Drivas participated in a scheme in which cash kickbacks were paid to Medicare beneficiaries to induce them to receive medically unnecessary physician services, physical therapy, and diagnostic testing. Drivas was sentenced to 12 years and 7 months of incarceration and was ordered to pay approximately \$50 million in restitution, joint and several. In addition, Drivas’s licenses to practice medicine in New York and New Jersey were both revoked, and the New York State Office of the Medicaid Inspector General excluded Drivas from participation in Medicaid.

Suspensions and debarments

Suspensions and debarments are administrative tools used by HHS and other Federal agencies to protect the Government from individuals and entities that have engaged in contract fraud, that have misused grant funds, or that are otherwise not presently responsible. Because these are Governmentwide sanctions, an individual or entity that has been suspended or debarred by HHS or any other agency is ineligible from participating in any future funding opportunities across the Federal Government for a specified period of time.

OIG refers individuals and entities that have potentially engaged in grant or contract fraud or misconduct to the HHS Suspension and Debarment Official, who is responsible for determining whether to impose a suspension or debarment. OIG continues to develop a robust Suspension and Debarment program and uses this tool to protect Government programs against fraud, waste, poor performance, and noncompliance with contract provisions or applicable law. In FY 2014, OIG made 20 referrals to the Suspension and Debarment Official for consideration.

Below are two examples of suspensions and/or debarments:

New York – Pedro Espada, an ex-New York State senator, was found guilty on four counts of stealing Federal Health Resources and Services Administration funds from a health care clinic. In a separate trial, the ex-senator and his son pleaded guilty to tax fraud and other outstanding charges. Espada was sentenced to 5 years in prison and was ordered to pay more than \$480,000 in restitution. His son was sentenced to 6 months in prison. HHS currently has the two individuals and three associated entities under a suspension.

Pennsylvania – Eight co-conspirators who participated in a scheme to defraud the Low Income Home Energy Assistance Program (LIHEAP) were debarred from participation in Government programs for a period of 3 years. The debarment was based on criminal convictions on charges of contributing to a scheme to defraud LIHEAP by falsifying information in order to obtain payments from the program that they were not entitled to receive.

Corporate integrity agreements

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

Tennessee – CSHM, LLC, formerly known as FORBA Holdings and Church Street Health Management (CSHM), agreed to be excluded for 5 years on the basis of its alleged material breaches of its CIA. CSHM manages and operates the national chain of Small Smiles Dental Centers, which provides services primarily to children on Medicaid. CSHM's corporate predecessor entered into the CIA in 2010 as part of the resolution of a False Claims Act case involving allegations that the company provided dental services to children on Medicaid that were medically unnecessary or failed to meet professionally recognized standards of care.

This exclusion marked the culmination of a series of alleged failures by CSHM and its corporate predecessors to comply with its CIA. Since the 2010 settlement, OIG had repeatedly cited CSHM and taken actions to address alleged violations of the CIA, including imposing stipulated penalties and forcing the divestiture of one of CSHM's clinics. Despite these actions, CSHM remained in material breach of its CIA, and OIG issued Notices of Intent to Exclude to the company in December 2013 and January 2014. Specifically, OIG found that CSHM had, among other things, failed to report serious quality-of-care reportable events; take corrective action; or make appropriate notifications of those events to the State dental boards, as required by the CIA. Although CSHM represented to OIG that it would cure the material breaches, OIG determined through meetings with CSHM and its Board of Directors and review of its written submissions that CSHM had failed to cure the material breaches and proceeded with the exclusion.

Florida – OIG imposed stipulated penalties totaling \$15,000 against Exactech, Inc., on the basis of the device manufacturer's failure to comply with certain requirements of its CIA. Specifically, Exactech failed to (1) timely screen new "Covered Persons" to ensure that they were not excluded or otherwise

ineligible to participate in the Federal health care programs, (2) distribute revised policies and procedures to Covered Persons whose job functions related to those policies and procedures, and (3) provide copies of Exactech's Code of Conduct and anti-kickback statute policies and procedures to parties entering into new or renewed agreements with Exactech.

Florida – OIG imposed stipulated penalties totaling \$5,000 against American Sleep Medicine, Inc. (ASM), on the basis of its failure to satisfy certain reporting requirements under its CIA. Specifically, ASM failed to timely notify OIG of two incidents involving probable violations of the Anti-Kickback Statute that had been reported to ASM's internal compliance hotline.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties on and assessments against a person who, among other things, submits, or causes to be submitted, claims to a Federal health care program that the person knows or should know are false or fraudulent. During this semiannual reporting period, OIG concluded cases involving more than \$14.4 million in CMPs and assessments. The following are case examples.

New Jersey – Joseph A. Raia, M.D., agreed to pay \$1.5 million for allegedly violating the CMPL. OIG alleged that Raia submitted or caused the submission of thousands of false and fraudulent claims to Medicare for physical therapy and rehabilitation services that he had purportedly rendered. Raia was the owner and chief operating officer of Grafton Medical Center, P.C., and Joseph A. Raia, M.D., P.C., as well as an employee of a physician group practice with multiple locations in Brooklyn, New York. OIG's investigation revealed that Raia failed to perform or directly supervise physical therapy and related services billed under his Medicare provider number while he was either out of the country or out of the State in which the services were being performed. Raia also improperly used chiropractors to provide physical therapy services "incident to" his professional services at his New Jersey practice location. In addition to agreeing to payment of the settlement amount, Raia agreed to be excluded from participation in Medicare, Medicaid, and all other Federal health care programs for 15 years. This represents the largest CMP settlement that OIG has ever obtained against an individual physician.

Texas – Medicus Laboratories, LLC agreed to pay \$5 million for allegedly violating the CMPL. OIG contended that Medicus submitted claims to Medicare that it knew or should have known were false by (1) using Modifier 59 to bill for multiple units of a particular drug test when applicable rules only permitted for a single unit to be billed per patient encounter; and (2) billing for certain urinalysis codes when the testing was for screening purposes only and was not medically reasonable and necessary. In addition to payment of the settlement amount, Medicus agreed to enter into a 5-year CIA with OIG. This settlement was the result of a cooperative effort between OIG's Office of Audit Services and its Office of Counsel to the Inspector General as part of a cross-component initiative focusing on the urine drug testing industry.

Mississippi – Harper's Hospice Care, Inc., agreed to pay \$150,000 for allegedly violating the CMPL provisions applicable to kickbacks. OIG alleged that, over a period of approximately 5 years, Harper's Hospice paid prohibited remuneration to a local physician in the form of medical directorship fees. Harper's Hospice allegedly provided the remuneration to the physician in exchange for the physician's referral of patients to Harper's Hospice for hospice services and pre-signing blank prescription forms for patients treated by Harper's Hospice.

Texas – CVS Pharmacy, Inc., agreed to pay \$1,216,147 for allegedly violating the CMPL. OIG contended that CVS Pharmacy knowingly presented or caused to be presented false or fraudulent claims by billing both Medicare Part B and Medicare Part D plan sponsors for immunosuppressant drugs provided to the same beneficiary on the same date of service.

Arizona – An Arizona research university agreed to pay \$165,000 to resolve its CMPL liability for violating the “select agent” regulations. OIG alleged that the university failed to (1) maintain current and accurate inventory records regarding certain select agents held in long-term storage and (2) implement biosafety and containment procedures commensurate with the risks associated with the select agents and toxins in its possession. Further, OIG contended that the responsible official did not ensure compliance with the governing regulations.

Patient dumping

Some of the CMPL cases that OIG resolved between April 1, 2014, and September 30, 2014, were pursued under EMTALA, a statute designed to prevent hospitals from denying emergency care to patients and to ensure patient access to appropriate emergency medical services. Examples follow.

Indiana – St. Vincent Jennings Hospital agreed to pay the maximum penalty of \$25,000 to resolve its liability under EMTALA. OIG alleged that St. Vincent failed to provide an appropriate medical screening examination to a patient who arrived via ambulance at St. Vincent’s emergency department. The patient was in critical condition with extremely low blood pressure and likely required amputation for a wound on his foot that had necrotizing fasciitis and had become gangrenous. The emergency department physician met the ambulance outside and, rather than examining the patient or providing any medical treatment to stabilize the patient’s condition, instructed the ambulance to transport the patient to another hospital, where the patient ultimately died.

Iowa – Gregory A. Bohn, M.D., agreed to pay \$35,000 to resolve his liability under EMTALA. OIG alleged that Bohn, an on-call surgeon at Trinity Bettendorf, failed to timely respond after an emergency department physician paged him to perform surgery on a patient found to have an emergency medical condition. The patient arrived at Trinity via ambulance complaining of lower abdominal pain and having experienced a blackout episode while vomiting. Bohn did not come to Trinity’s emergency department until approximately 1 hour and 40 minutes after being paged and, upon arrival, refused to treat or examine the patient. As a result of Bohn’s actions, Trinity was forced to transfer the patient to another hospital for surgery.

California – Olive View – UCLA Medical Center agreed to pay \$40,750 to resolve its liability under EMTALA. OIG alleged that Olive View failed to provide an appropriate medical screening examination to a patient who arrived at the hospital’s emergency department with signs of appendicitis and abdominal pain that the patient rated at a 10 on a 10-point scale. Despite the patient’s severe pain and symptoms, he was forced to wait several hours to receive an examination. After waiting 6-and-a-half hours, the patient left to seek care at another hospital, where he was diagnosed with acute appendicitis with a large peritoneal abscess and had to undergo an immediate laparoscopic appendectomy.

Florida – Mercy Hospital, a campus of Plantation General Hospital, agreed to pay \$45,000 to resolve its EMTALA liability. OIG alleged that Mercy failed to provide an appropriate medical screening examination for a 3-week-old baby who arrived at Mercy’s emergency department with her mother and father. Earlier that morning, the baby’s parents had discovered that she was not eating well, felt cold, looked

blue in the lips, and had an oral temperature of 91 degrees. Mercy's emergency department staff failed to respond to the low temperature, ordered no further testing, insisted that the baby was stable, and told the parents to visit another hospital closer to their home if they had further problems. On the way home from Mercy, the baby became unconscious in the car. The baby required critical care treatment at a second hospital for a necrotic bowel, which had led to cardiac arrest, kidney injury, and potential hypoxic injury to the baby's brain.

Provider self-disclosure protocol

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

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws. After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact. OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG Web site at <http://oig.hhs.gov/compliance/self-disclosure-info>.

During this reporting period, self-disclosure cases resulted in \$23 million in HHS receivables. The following are examples of provider self-disclosure settlements.

California – Ukiah Valley Medical Center self-disclosed to OIG that it potentially violated the anti-kickback statute through its development and operation of an ASC. The ASC was a joint venture between Ukiah Valley and a group of physicians. Ukiah Valley disclosed that it provided improper remuneration to the joint venture's physician-investors during the start-up and operation phases. Ukiah Valley agreed to pay \$1,692,588 to resolve allegations that this arrangement violated the CMPL provisions applicable to kickbacks.

West Virginia – Amedisys, Inc., self-disclosed to OIG that two of its wholly owned subsidiaries, Amedisys West Virginia, LLC, and Tender Loving Care Health Care Services of West Virginia, LLC, submitted false or fraudulent claims for hospice services to Medicare and Medicaid. Amedisys disclosed that both facilities billed for hospice care where the underlying certification documents did not meet Federal health care program requirements. Specifically, contracted medical directors at both facilities pre-signed blank medical forms, including certificates of terminal illness and face-to-face visit forms, which were later completed by Amedisys staff members. Amedisys agreed to pay \$1,974,812 for allegedly violating the CMPL.

Massachusetts – Harvard Vanguard Medical Associates, Inc., self-disclosed to OIG that it improperly billed Medicare Part B, Medicare's Atrius Health Pioneer Accountable Care Organization, and the Massachusetts Medicaid program for psychotherapy services performed by one of its physicians. Over a period of approximately 5-and-one-half years, Harvard Vanguard submitted claims for psychotherapy

services provided by the physician that did not meet applicable coverage requirements. Harvard Vanguard agreed to pay \$168,687 for allegedly violating the CMPL.

New York – Americare Certified Special Services, Inc., self-disclosed to OIG that it submitted false claims to Medicare for (1) home health services that were not rendered and (2) services that were furnished by home health aides who did not receive the requisite training or who lacked a home health aide certification. These home health aides posed as individuals who were properly trained and certified, and Americare failed to identify any problems with their qualifications. Americare agreed to pay \$44,593 for allegedly violating the CMPL.

Public health agencies and enforcement activities

Office of the Assistant Secretary for Administration

Office of Security and Strategic Information security controls

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- *Security Controls Over the Implementation of Personal Identity Verification Cards at HHS Were Inadequate Due To Lack of Some Essential Information Security Requirements. [A-18-12-30410](#). 2014 July.*

At HHS, security controls over the implementation of Homeland Security Presidential Directive 12, which requires a standard for and use of secure and reliable forms of identification for Federal employees and contractors, were inadequate because essential information security requirements were not implemented. We recommended that the HHS Office of Security and Strategic Information (OSSI) implement necessary corrective actions to resolve the findings we identified in the areas of enrollment and issuance, deactivation of identification cards, security over system access, security management, physical security, and Web site vulnerabilities. OSSI agreed with 14 recommendations and did not agree with 4. The recommendations are summarized because of the sensitive nature of the information. We provided more detailed recommendations to OSSI.

Office of the Assistant Secretary for Financial Resources

Small Business Innovation Research Program

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- *Vulnerabilities in the HHS Small Business Innovation Research Program. [OEI-04-11-00530](#). 2014 April.*

Although it was not required to do so, HHS did not consistently collect information on, or assess the commercial success of, Small Business Innovation Research (SBIR) Program awards and therefore cannot determine whether the program is meeting one of its primary goals. We found that 31 percent of awardees had questionable or unverified eligibility for at least one requirement, and none of the awarding Operating Divisions (OpDivs) completed a required check for duplicative awards across other Federal agencies. We recommended that:

- HHS create a central office to oversee the SBIR program,
- OpDivs track and assess the commercial success of SBIR projects,
- OpDivs ensure compliance with eligibility requirements, and
- OpDivs improve procedures to check for duplicative awards.

The Office of the Assistant Secretary for Financial Resources (ASFR) did not indicate whether it agreed with each of our recommendations. However, ASFR agreed that additional coordination and oversight

across participating OpDivs is warranted and agreed that HHS must ensure that applicants meet SBIR eligibility requirements.

Lobbying prohibitions on grant funds

- *Laws Prohibit the Use of HHS Grant Funds for Lobbying, but Limited Methods Exist To Identify Noncompliance. [OEI-07-12-00620](#). 2014 July.*

Our report found that all awarding agencies reported using Federal and departmental sources of guidance regarding the prohibitions on the use of grant funds for lobbying. However, limited methods exist to identify noncompliance with lobbying prohibitions. ASFR agreed with our recommendations, which were:

- facilitate Departmentwide information sharing among awarding agencies about methods to identify the use of grant funds for prohibited lobbying activities and
- centralize on its Web site the guidance pertaining to the prohibitions on the use of grant funds for lobbying.

Internal controls for Hurricane Sandy disaster relief funds

- *The Department of Health and Human Services Designed Its Internal Controls Over Hurricane Sandy Disaster Relief Funds To Include Elements Specified by the Office of Management and Budget. [A-02-13-02010](#). 2014 July.*

HHS designed its internal controls for overseeing Hurricane Sandy disaster relief funds to include the following elements specified by the Office of Management and Budget (OMB): additional levels of review, monitoring and oversight of grant recipients, OIG collaboration, and review and resolution of audit findings. HHS also implemented internal controls to address the management of unexpended grant funds. HHS's internal controls for measuring and reporting improper payments were under development during our audit period, so we were unable to assess whether these controls addressed OMB requirements. This report contained no recommendations.

Office of the Assistant Secretary for Health

Office for Human Research Protections oversight

- *The Office for Human Research Protections' Evaluation of the Surfactant, Positive Pressure, and Oxygenation Randomized Trial. [OEI-01-14-00560](#). 2014 September.*

We found that Office of Human Research Protections (OHRP) followed its procedures and exercised its discretion throughout its evaluation of the Surfactant, Positive Pressure, and Oxygenation Randomized Trial (SUPPORT). OHRP's activities to ensure institutions' compliance are not codified in Federal statute or regulations; rather, they appear in compliance procedures issued by the agency. These procedures give OHRP considerable discretion in how it conducts such evaluations. Our report does not contain any recommendations.

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- *OIG Review of Allegations of Interference in OHRP Compliance Determination for SUPPORT. OIG-12-14-04. 2014 September.*

Our review found that OHRP's initial compliance determination triggered extensive scientific debate within HHS and that the National Institutes of Health (NIH) and other officials encouraged OHRP to reverse or revise its determination. We found no directive or order to OHRP from NIH or any other official to take a particular policy or scientific position. Our research disclosed no law, regulation, or written policy that prohibits or restricts the kind of consultation that occurred here or would make such consultations improper. Our report does not contain any recommendations.

Office of the Assistant Secretary for Preparedness and Response

Hospital emergency preparedness and response

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- *Hospital Emergency Preparedness and Response During Superstorm Sandy. OEI-06-13-00260. 2014 September.*

Most hospitals in declared disaster areas sheltered in place during Superstorm Sandy, and 7 percent evacuated, but 89 percent of hospitals in these areas reported experiencing substantial challenges in responding to the storm. Prior to the storm, most hospitals received emergency-related deficiency citations from hospital surveyors, some of which related to the challenges reported by hospitals during Superstorm Sandy. The Office of the Assistant Secretary for Preparedness and Response (ASPR) and CMS agreed with our recommendations, which were to:

- continue to promote Federal, State, and community collaboration in major disasters; and
- examine existing policies and provide guidance regarding flexibility for reimbursement under disaster conditions.

Office of the National Coordinator for Health Information Technology

Electronic health records—testing and certification

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- *The Office of the National Coordinator for Health Information Technology's Oversight of the Testing and Certification of Electronic Health Records. A-06-11-00063. 2014 August.*

The Office of the National Coordinator for Health Information Technology's (ONC) oversight of authorized testing and certification bodies (ATCBs) did not fully ensure that electronic patient information in the currently available EHR applications was secure and protected. If insecure systems have been certified by an ATCB, providers and patients may have a false sense of security and assurance.

Although ONC disagreed, OIG continues to recommend that ONC:

- require the ATCBs to develop procedures to periodically evaluate whether certified EHRs continue to meet Federal standards,
- require the ATCBs to develop a training program to ensure that their personnel are competent to test and certify EHRs and to secure proprietary or sensitive EHR information, and

- work with the National Institute of Standards and Technology (NIST) to strengthen EHR test procedure requirements so that the ATCBs can ensure that EHR vendors incorporate common security and privacy features into the development of EHRs.

Centers for Disease Control and Prevention

President's Emergency Plan for AIDS Relief

- *The University of Zambia School of Medicine Did Not Always Manage President's Emergency Plan for AIDS Relief Funds or Meet Program Goals in Accordance With Award Requirements. A-04-13-04010. 2014 April.*
- *The Republic of Zambia, Ministry of Health, Did Not Always Manage the President's Emergency Plan for AIDS Relief Funds or Meet Program Goals in Accordance With Award Requirements. A-04-13-04004. 2014 June.*
- *The Federal Democratic Republic of Ethiopia, Ministry of Health, Did Not Always Manage President's Emergency Plan for AIDS Relief Funds or Meet Program Goals in Accordance With Award Requirements. A-04-13-04015. 2014 September.*

Of the \$209,000 in judgmentally selected President's Emergency Plan for AIDS Relief (PEPFAR) expenditures that we reviewed from the University of Zambia School of Medicine, approximately \$77,000 was not allowable. Of the \$516,000 PEPFAR expenditures we reviewed from the Republic of Zambia, Ministry of Health, about \$291,000 was not allowable. Of the \$717,800 in judgmentally selected expenditures that we reviewed from the Federal Democratic Republic of Ethiopia, Ministry of Health, \$295,000 was not allowable. These errors occurred because the University and both Ministries of Health did not have adequate policies and procedures. The University and the Zambian Ministry of Health agreed or partially agreed with the following recommendation: refund to the Centers for Disease Control and Prevention (CDC) approximately \$77,000 (University) and approximately \$291,000 (Zambian Ministry of Health) in unallowable expenditures. All three agreed or partially agreed with the following recommendations:

- file amended financial status reports,
- work with CDC to resolve whether the value-added tax (VAT) was an allowable expenditure under the cooperative agreement,
- develop and implement adequate policies and procedures, and
- submit its annual financial audit report in a timely manner to the applicable U.S. agency.

The Zambian Ministry of Health also agreed with the following recommendations:

- apply for a VAT exemption with the Republic of Zambia Government and
- implement a financial management system that complies with Federal regulations.

Although the Ethiopian Ministry of Health disagreed, OIG continues to recommend that it:

- refund to CDC \$295,000 in unallowable expenditures.

National Institutes of Health

National Institute of Environmental Health Sciences—Superfund appropriations

- *The National Institute of Environmental Health Sciences Generally Administered Its Superfund Appropriations During Fiscal Year 2013 in Accordance With Federal Requirements. A-04-14-04024. 2014 September.*

The National Institute of Environmental Health Sciences administered its Superfund appropriations during FY 2013 in accordance with Federal requirements. Accordingly, this report contains no recommendations.

Public-health-related legal actions and investigations

Health Education Assistance Loan Program

OIG excludes individuals who have defaulted on Health Education Assistance Loan (HEAL) loans from participation in Federal health care programs. Under the HEAL program, which stopped making loans in 1998, the Health Resources and Services Administration (HRSA) guaranteed commercial loans to students seeking education in health-related fields.¹ The students are allowed to defer repayment of the loans until after they graduate and begin to earn income. Although HHS's Program Support Center (PSC) takes steps to ensure repayment, some loan recipients do not resolve their indebtedness. After PSC has exhausted efforts to secure repayment of a debt, it declares an individual in default. Thereafter, the Social Security Act permits exclusion of such individuals from Medicare, Medicaid, and all other Federal health care programs for nonpayment of the loans.

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

HEAL exclusions

During this semiannual reporting period, 41 individuals and related entities were excluded as a result of PSC referral of their cases to OIG. Individuals who have been excluded as a result of default may enter into settlement agreements, whereby the exclusions are stayed while they pay specified amounts each month to satisfy their debts. If they default on these settlement agreements, they may be excluded until the entire debt is repaid and they may not appeal the exclusions.

After being excluded for nonpayment of their HEAL debts, 2,554 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 20 individuals who entered

¹ The HEAL Program, noted in previous Semiannual Reports to Congress, was permanently transferred from HHS to the U.S. Department of Education as required by the Consolidated Appropriations Act, 2014 (Pub. L. 113-76). The program transfer was completed on July 1, 2014.

into such settlement agreements or completely repaid their debts from April 1 through September 30, 2014. More than \$200 million is being repaid through settlement agreements or through complete repayment. Of that amount, \$1.5 million is attributable to this semiannual reporting period.

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

Florida – Dentist - \$246,522

California – Osteopath - \$58,355

Georgia – Podiatrist - \$57,425

Wisconsin – Chiropractor - \$56,537

New York – Dentist - \$25,911

Human services agencies and enforcement activities

Administration for Children and Families

Child day care centers—Licensing requirements

- *Some Connecticut Child Day Care Centers Did Not Always Comply With State Health and Safety Licensing Requirements. A-01-13-02506. 2014 April.*
- *Some Michigan Child Care Centers Did Not Always Comply With State Health and Safety Licensing Requirements. A-05-13-00053. 2014 August.*
- *Some Maine Child Day Care Centers Did Not Always Comply With State Health and Safety Licensing Requirements. A-01-13-02503. 2014 August.*
- *Some Louisiana Child Day Care Centers Did Not Always Comply With State Health and Safety Licensing Requirements. A-06-13-00036. 2014 August.*

The child care center providers in these four States did not always comply with applicable State licensing requirements to ensure the health and safety of children (2 out of 3 providers reviewed in Connecticut, 3 out of 3 in Michigan, 16 of 20 in Maine, and 4 of 4 in Louisiana).

We found several types of errors, and the States generally agreed with the following recommendations:

- ensure through more frequent and thorough onsite monitoring that providers comply with health and safety requirements and
- ensure that all providers' employees who provide direct services to children have had criminal records and child abuse and neglect registry checks.

Michigan, Maine, and Louisiana generally agreed with the following recommendations:

- consider State regulatory changes to ensure that unannounced inspections are required to be conducted at least annually,
- ensure adequate oversight by reducing licensing inspectors' caseloads, and
- require providers to complete specific training requirements related to health and safety regulations.

Child care home providers—Licensing requirements

- *Some Michigan Child Care Home Providers Did Not Always Comply With State Health and Safety Licensing Requirements. A-05-13-00031. 2014 July.*
- *Some Maine Family Child Day Care Home Providers Did Not Always Comply With State Health and Safety Licensing Requirements. A-01-13-02507. 2014 August.*

■ *Some Louisiana Family Child Day Care Home Providers Did Not Always Comply With State Health and Safety Requirements. A-06-13-00037. 2014 August.*

The licensed family and group child care homes (home providers) that we reviewed in three States did not always comply with applicable State licensing requirements to ensure the health and safety of children (20 home providers of 20 reviewed in Michigan, 16 of 18 in Maine, and 20 of 20 in Louisiana).

We found several types of errors, and the States generally agreed with all of our recommendations, which were:

- ensure through more frequent onsite monitoring that home providers comply with health and safety regulations,
- ensure adequate oversight by reducing licensing inspectors' caseloads,
- ensure that home providers obtain required criminal record checks and protective services checks for all child care employees who provide direct services to children, and
- develop a mandatory training program to improve home provider compliance with health and safety regulations.

Child Care and Development Fund—Control deficiencies

■ *Arizona Improperly Claimed Some Child Care and Development Targeted Funds. A-09-12-01004. 2014 April.*

Arizona claimed \$2.2 million of unallowable Child Care and Development Fund (CCDF) targeted funds for FY 2009. Better monitoring would have revealed that the targeted funds were not being obligated and liquidated according to the timeframes specified in Federal requirements. Arizona concurred with the following recommendation:

- address monitoring of the obligation and liquidation of CCDF targeted funds.

Although Arizona did not agree, OIG continues to recommend that Arizona:

- refund to the Federal Government \$2.2 million for CCDF targeted funds that were not properly obligated and liquidated.

■ *Texas Improperly Claimed Some Child Care and Development Funds. A-06-13-00038. 2014 August.*

Texas did not comply with Federal requirements for the use of almost \$15 million in CCDF targeted funds for FY 2010. The State agency did not have policies and procedures in place to ensure that only expenditures that improve the quality of child care are reported and to adequately oversee the obligation and liquidation of targeted funds. Texas agreed with the following recommendations:

- refund to the Federal Government \$32,600 for targeted funds that were incurred before the start of the funding period and
- refund to the Federal Government \$25,000 for targeted funds that were not liquidated in the required timeframe.

Although Texas disagreed, OIG continues to recommend that Texas:

- refund to the Federal Government \$14.9 million for expenditures that were not for targeted fund activities or work with the Administration for Children and Families (ACF) to determine whether any of the \$14.9 million was allowable and
- develop policies and procedures to (1) ensure that it claims only the enhanced portion of payments made to providers that have exceeded licensing standards and (2) strengthen monitoring of CCDF targeted funds to ensure that expenditures are properly obligated and liquidated.

Child Care Subsidy program claims—Control deficiencies

- *Not All of Kansas's Controls for Its Child Care Subsidy Program Claims Were Effective.*
[A-07-12-03182](#). 2014 July.

We estimated that approximately \$40.9 million (\$26.1 million Federal share) of Kansas's Child Care Subsidy program claims could have had one or more of the control deficiencies that we identified. These deficiencies left the Child Care Subsidy program vulnerable to fraud, waste, and abuse. Kansas agreed with our recommendations, which were:

- ensure that providers maintain accurate attendance records,
- require that citizenship and qualified alien status of all applicants be verified and documentation of that verification be maintained, and
- require that the ages of all clients be verified and documentation of that verification be maintained.

Head Start—Enrollment

- *The U.S. Virgin Islands Department of Human Services May Not Have Provided Head Start Services to the Neediest Children.* [A-02-12-02002](#). 2014 June.

The U.S. Virgin Islands may not have ensured that the neediest children received priority when filling Head Start enrollment slots because it (1) entered inaccurate information in its Child Output Planning Assessment, (2) did not retain documents used to determine whether enrollees were eligible, and (3) did not meet the required enrollment level for children with disabilities. We estimated that nearly 1 child in every 10 enrolled in the Head Start program as of August 31, 2010, received more priority selection points than they should have, potentially placing them in the Head Start program ahead of needier children on the program's waiting list. The Virgin Islands generally agreed with our recommendations, which were:

- ensure that financial eligibility determinations are based on accurate information,
- retain a record of the documents reviewed and relied upon to determine whether a child is eligible, and
- ensure that the enrollment and/or waiver requirements are met for children with disabilities.

Community Services Block Grants—Monitoring and reporting

- *The Office of Community Services Did Not Fully Comply With Federal Monitoring and Reporting Requirements for the Community Services Block Grant Program.* [A-01-13-02505](#). 2014 June.

The Office of Community Services (OCS) did not fully comply with Federal monitoring and reporting requirements for the Community Services Block Grant (CSBG) program for FYs 2010 through 2012. OCS did not adequately establish individual accountability or processing times for each step to develop, review, and issue reports to States and Congress efficiently and effectively in a timely and relevant manner. ACF detailed corrective action it has taken to address our recommendations, which were:

- issue all delayed evaluation reports and annual CSBG reports expeditiously,
- strengthen and implement (1) policies and procedures over report preparation and issuance and (2) controls over monitoring and reporting requirements,
- incorporate data submission deadlines in cooperative agreements with vendors, and
- ensure management stability and communication to oversee the effective implementation of the recommendations from the Government Accountability Office's (GAO) 2006 report and this review.

Administration for Community Living

Senior Medicare Patrol

■ *Performance Data for the Senior Medicare Patrol Projects: June 2014 Performance Report.*
OEI-02-14-00140. 2014 June.

In the 54 Senior Medicare Patrol (SMP) projects during 2013, active volunteers increased by 5 percent, one-on-one counseling sessions increased 31 percent, and expected Medicare and Medicaid recoveries increased by 50 percent. However, total savings to beneficiaries and others decreased and cost avoidance on behalf of Medicare, Medicaid, beneficiaries, and others increased. The projects may not be receiving full credit for savings attributable to their work. This report did not contain recommendations.

Child support enforcement activities

OIG investigations

OIG investigates noncustodial parents who fail to pay court-ordered child support. OIG works with the Office of Child Support Enforcement; DOJ; U.S. Attorneys' Offices; the U.S. Marshals Service; and Federal, State, and local partners to address egregious child support enforcement cases with appropriate law enforcement and prosecutorial action. OIG investigations of child support enforcement cases nationwide resulted in 36 criminal actions and court-ordered restitution and settlements of \$3.58 million during this semiannual reporting period. The following are examples of child support enforcement cases:

New York – Child support enforcement Most Wanted Fugitive Raihan Chowdhury was sentenced to 5 years of probation and was ordered to pay \$1.5 million in restitution after pleading guilty to a charge of failure to pay child support. According to court documents, Raihan allegedly abandoned his wife and three children and fled the country. He allegedly sold the family home in secret and left the family homeless when they returned back from a vacation. In October 2012, after reentering the country, Raihan was arrested and taken into custody on his outstanding Federal arrest warrant.

Missouri – Child support enforcement Most Wanted Fugitive Randy Lee Essary was sentenced to 1 year and 9 months in prison and was ordered to pay \$170,891 in restitution after pleading guilty to willful failure to pay child support. According to court documents, Essary left the country in 2007 and was working as a Senior Vice President of a hotel company in the Philippines. He stopped making child support payments for his son in 2005, and was arrested when he reentered the United States in 2012.

Washington – Todd Mazur was sentenced to 5 years of probation and was ordered to pay \$137,615 in restitution after pleading guilty to failure to pay child support obligations. Mazur was ordered to pay child support to the custodial parent of his three children. He had not made child support payments since 2001.

Engaging the public in capturing deadbeat parents

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

Other HHS-related reviews

Financial reporting and improper payment reduction

University of South Florida—Unallowable costs

- *The University of South Florida Did Not Always Claim Costs in Accordance With Federal Regulations.* [A-04-12-01016](#). 2014 April.

The University of South Florida did not always claim costs charged directly to HHS awards in accordance with Federal regulations and NIH guidelines. We estimated that, of \$24.8 million in transactions, the University charged at least \$6.4 million in unallowable transactions and related facilities and administrative costs to HHS awards during FYs 2010 and 2011. These unallowable transactions occurred because the University did not provide adequate oversight to ensure consistent compliance with Federal regulations.

Although the University did not agree, OIG continues to recommend that the University:

- refund \$6.4 million to the Federal Government and
- enhance oversight of charges to Federal awards to ensure consistent compliance with Federal regulations.

Compliance with the Improper Payments Information Act

- *HHS Met Many Requirements of the Improper Payments Information Act of 2002 but Did Not Fully Comply for FY 2013.* [A-17-14-52000](#). 2014 April.

HHS met many requirements of the Improper Payments Information Act of 2002 (IPIA) as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) but did not fully comply with it for FY 2013. We did not identify any new issues in this, OIG's third, report on HHS's compliance with the IPIA, but continue to recommend that the Department improve its compliance with the IPIA. HHS agreed with OIG's reemphasizing of the prior recommendations to:

- report an improper payment estimate for Temporary Assistance for Needy Families and
- reduce error rates below 10 percent.

Although HHS disagreed, OIG continues to reemphasize the prior recommendation that HHS publish improper payment target rates for the Children's Health Insurance Program.

Grants and contracts

Grant fraud

HHS is the largest grantmaking organization and the third largest contracting agency in the Federal Government. In FY 2013, HHS awarded over \$345 billion in grants and over \$19 billion in contracts across all program areas. Approximately \$90 billion in grant awards were for programs other than

Medicare or Medicaid. OIG's direct annual discretionary appropriation funding is used to conduct program integrity and enforcement activities with regard to the over 100 public health and human services programs carried out by over 70,000 employees around the world. The size and scope of departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public. Recent appropriations increased OIG's discretionary funding for public health and human services oversight.

Misuse of Grant Funds Examples:

Montana – The Blackfeet Tribe's Po'Ka Project was a multi-million-dollar grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and was developed to help troubled Native American youth. The grant was designed for the tribe to provide in-kind matching contributions to continue to secure Federal payments, with the idea that the Po'Ka Project would ultimately become self-sufficient and continue to survive on its own once Federal funding ended. However, the in-kind commitment could not be honestly met, and various tribal officials began inflating the figures related to in-kind contributions, assigning values to nonexistent and illegitimate "contributions," and manufacturing fraudulent invoices and records to support fictional or inflated contributions. Several witnesses, whose names were used as in-kind contributors, denied preparing or signing the invoices and denied contributing time or goods to the Po'Ka Project, at least in the amounts claimed. An OIG audit determined that \$4.6 million in claims for grant payments paid to the tribe on the basis of Po'Ka's in-kind contribution were unsupported, inflated, or completely falsified.

In addition, the former director and assistant director of the Po'Ka Program embezzled from the program in several ways, from travel fraud to misuse of Po'Ka credit cards, to exorbitant claims of overtime. They also reached an agreement with the grant's national evaluator, an outside observer whose job was to monitor the project's progress, to approve significant payments to the evaluator, who would in turn kick back a sizable portion of what was provided to him. During this reporting period, Francis Onstad, the Po'Ka Program's former director; Delyle Augare, the Po'Ka Program's former assistant director; and Kathryn Sherman, a former Po'Ka staffer who handled the in-kind invoicing for the program, were sentenced to a combined 7 years and 10 months in jail in connection with their participation in this scheme and were ordered to pay a combined \$1.1 million in restitution.

California – Nanette Dillard and her husband Paul Daniels worked for the Alameda County Associated Community Action Program (ACAP). As the Executive Director of ACAP, Dillard submitted false information to HHS in order to receive grant money from ACF. Specifically, Dillard falsely certified that ACAP possessed the required non-Federal matching funds in order to receive more than \$426,000 in grant money from the Assets for Independence (AFI) program. Dillard was convicted at trial on charges of grand theft by false pretenses, a public officer crime, and preparing false documentary evidence. Daniels, the ACAP grants manager who was also involved in the scheme, was convicted at trial on charges of grand theft by false pretenses and a public officer crime. Both Dillard and Daniels were sentenced to 5 years of probation and were ordered to pay \$308,587 in restitution, joint and several.

South Dakota – Samone Milk was the executive secretary for the Oglala Sioux Tribe's Energy/Low Income Home Energy Assistance Program (LIHEAP). According to court records, from May through December 2009, Milk schemed with her co-conspirators to steal funds belonging to the Oglala Sioux Tribe. Milk and others drafted fake invoices and quotes for contract work purportedly to be completed by co-conspirators. Milk facilitated the processing of these documents through the Energy/LIHEAP Program. In turn, checks were issued by the tribe's Treasurer's Office to pay for the fraudulent invoices. Milk and

her co-conspirators received the checks, cashed them, and divided the funds among themselves for their own purposes. Milk pleaded guilty to conspiracy to commit theft concerning programs receiving Federal funds; was sentenced to 1 year and 2 months in jail; and was ordered to pay \$109,135 in restitution, joint and several.

Hurricane Sandy grant and contract vulnerabilities

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

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

Small Business Innovative Research Program

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

Recovery Act retaliation complaint investigations

The Recovery Act, § 1553, prohibits non-Federal employers that have received Recovery Act funding from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds. OIGs are required to include in their *Semiannual Report(s) to Congress* the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. During this reporting period, OIG closed one investigation because of the lack of evidence surrounding the allegations.

Contract audits

Pursuant to the National Defense Authorization Act for Fiscal Year 2008, § 845, Inspectors General appointed under the Inspector General Act of 1978 are required to submit, as part of their *Semiannual*

Report(s) to Congress pursuant to section 5 of such Act, information on final, completed contract audit reports issued during the period to the contracting activity containing significant audit findings. OIG did not issue final reports meeting section 845 criteria during this semiannual period.

OIG reviews of non-Federal audits

OIG reviews audits conducted by non-Federal auditors of entities receiving Federal awards. In this semiannual period, OIG's National External Audit Review Center reviewed 1,302 reports covering \$2.4 trillion in audited costs. Federal dollars covered by these audits totaled \$794.3 billion, of which about \$369.6 billion were HHS funds.

OMB Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities must conduct annual organization-wide "single audits" of all Federal money they receive. These audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entities' management of Federal funds.

OIG's oversight of non-Federal audit activity informs Federal managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs for resolution or followup. We identify entities for high-risk monitoring, alert program officials to any trends that could indicate problems in HHS programs, and profile non-Federal audit findings of a particular program or activity over time to identify systemic problems. We also provide training and technical assistance to grantees and members of the auditing profession. OIG maintains a process to assess the quality of the non-Federal reports received and the audit work that supports the selected reports. OIG's reports on non-Federal audits reviewed during this reporting period are categorized in the following table.

Non-Federal Audits, April 1, 2014, through September 30, 2014

Number of Non-Federal Audits:	
■ <i>Not requiring changes or having minor changes</i>	1,249
■ <i>Requiring major changes</i>	49
■ <i>Having significant technical inadequacies</i>	4
Total	1,302

The 1,302 reports included 3,289 recommendations for improving management operations. In addition, these audit reports provided information for 37 OIG special memorandums that identified concerns for increased monitoring by management.

Other reporting requirements and reviews

Legislative and regulatory reviews

Pursuant to the Inspector General Act, § 4(a)(2), OIG is required to review existing and proposed legislation and regulations relating to HHS's programs and operations and make recommendations concerning their impact on economy and efficiency or the prevention and detection of fraud and abuse. Most audits and other reviews that we conduct are designed to test compliance with, and/or assess the administration and oversight of, existing laws and regulations. Our reports of such reviews describe findings, which include questioned costs, inefficiencies, vulnerabilities to fraud, inconsistencies, errors in application, or weaknesses in oversight or supporting systems. Our corresponding recommendations tell HHS and its operating or staff divisions what administrative, regulatory, or legislative actions we believe are needed to effectively respond to the findings. Our regularly published core publications reflect the relationship between our work and laws and regulations.

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

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

Affordable Care Act implementation

OIG continues to perform reviews on the ACA. The ACA made changes to HHS programs and enacted a range of new programs that affect the Department, such as the Early Retiree Reinsurance Program (ERRP). The rollout of the Health Insurance Exchanges (Marketplaces) is a substantial management challenge to HHS.

OIG's current focus is on areas such as eligibility systems, payment accuracy, contractor oversight, data security, and consumer protection. Our substantial body of work underway was developed in coordination with GAO and other Federal and State oversight agencies. It is focused on identifying risks and vulnerabilities to the Marketplaces to ensure efficient and effective operation and to minimize waste and abuse of funds. Our work has encompassed and will continue to encompass other aspects of ACA implementation, such as Medicaid expansion, use of State establishment grants, and the use of startup and solvency loans for Consumer Operated and Oriented Plan Loans.

Following are examples of recent Affordable Care Act reviews.

Marketplaces

- *Not All Internal Controls Implemented by the Federal, California, and Connecticut Marketplaces Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements.* [A-09-14-01000](#). 2014 June.

The deficiencies in internal controls that we identified may have limited the Marketplaces' ability to prevent the use of inaccurate or fraudulent information when determining eligibility of applicants for enrollment in QHPs. CMS agreed with our recommendations, which were that:

- CMS, Covered California, and Access Health CT take action to improve internal controls related to (1) verifying identity of applicants and entering application information, (2) determining applicants' eligibility for enrollment in QHPs and eligibility for insurance affordability programs, and (3) maintaining and updating eligibility and enrollment data; and
- CMS work with Covered California and Access Health CT to implement our recommendations.

-
- *Marketplaces Faced Early Challenges Resolving Inconsistencies With Applicant Data.* [OEI-01-14-00180](#). 2014 June.

From October through December 2013, Marketplaces were unable to resolve most inconsistencies, which they reported most commonly as citizenship and income, although each applicant can have multiple inconsistencies. Specifically, the Federal Marketplace was unable to resolve 2.6 million of 2.9 million inconsistencies because the CMS eligibility system was not fully operational. CMS agreed with both of our recommendations, which were:

- develop and make public a plan on how and by what date the Federal Marketplace will resolve inconsistencies and
- conduct additional oversight of State Marketplaces to ensure that they are resolving inconsistencies according to Federal requirements.

-
- *An Overview of 60 Contracts That Contributed to the Development and Operation of the Federal Marketplace.* [OEI-03-14-00231](#). 2014 August.

Across the 60 contracts related to the development and operation of the Federal Marketplace, nearly \$800 million had been obligated for the development of the Federal Marketplace as of February 2014. The purposes of the contracts ranged from health benefit data collection and consumer research to cloud computing and Web site development, and the original estimated values of these contracts totaled \$1.7 billion. This report is the first in a series that will address the planning, acquisition, management, and performance oversight of Federal Marketplace contracts, as well as various aspects of Federal Marketplace operations. This report did not contain recommendations.

-
- *Health Insurance Marketplaces Generally Protected Personally Identifiable Information but Could Improve Certain Information Security Controls.* [A-18-14-30011](#). 2014 September.

This is an overview of the results of three reviews of the security of certain information technology at the Federal, Kentucky, and New Mexico Health Insurance Marketplaces. Although CMS had

implemented controls to secure Healthcare.gov and consumer personally identifiable information (PII) in the Federal Marketplace, we identified areas for improvement in its information security controls. Kentucky had sufficiently protected PII on its Marketplace Web sites and databases in accordance with Federal requirements, but opportunities to improve database access and information security controls remain. Although New Mexico management had implemented security controls, policies, and procedures to prevent vulnerabilities in its Web site, database, and supporting information systems, its information technology policies and procedures did not always conform to Federal requirements to secure sensitive information stored and processed by the New Mexico Marketplace. The three Marketplaces agreed with our recommendations that the Marketplaces' management address the findings identified in the individual reports.

Annual fee on prescription drug companies

- *Annual Fee on Branded Prescription Drug Companies Under the Affordable Care Act.
OEI-03-12-00560. 2014 April.*

Between September 2011 and December 2013, the Federal Supplementary Medical Insurance (Medicare Part B) Trust Fund received all but \$938,000 of the total \$8.1 billion amount the ACA provides from branded prescription drug companies for the first 3 fee years. To the extent that the fees were not in the Trust Fund, the Trust Fund may have missed an opportunity to earn interest income on these fees. Our results indicate that it may be beneficial for CMS to periodically monitor the status of the fees from branded prescription drug companies and to contact the Department of the Treasury if CMS finds that the full amount to be collected under the ACA each year has not been received. This report did not contain recommendations.

Appendices

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Appendix A: Savings decisions supported by OIG recommendations

The table below lists policy decisions reflected in legislation, regulations, or other directives from prior periods that are supported by OIG recommendations and for which cost savings were estimated, usually by third parties, such as the Congressional Budget Office (CBO) or HHS actuaries. Of the savings estimated for the decisions below, nearly \$15.7 billion was attributed to FY 2014. This figure reflects the most recent available savings estimates issued by the third party appraiser; actual savings may be higher or lower.

After laws involving HHS programs are enacted, OIG analyzes them to identify the provisions that comport with our prior recommendations, i.e., our recommendations support the decisions that were made. A similar process occurs with respect to administrative decisions in regulations or other directives or agreements (e.g., modifications to Medicaid State Plans). Most of the decisions reported in this appendix reflect ways in which funds could be put to better use, such as reductions in Federal spending and/or avoidance of unnecessary or inappropriate expenditures.

To quantify the value of administrative decisions, we use estimates developed by, or in consultation with, HHS operating or staff divisions. To quantify the value of legislative decisions, we generally use estimates developed by CBO. CBO projects the annual increases and/or reductions in Federal spending that it expects would result from enacting the legislation. The decisions below mirror not only OIG's recommendations, but also the contributions of others, such as HHS staff and operating divisions, congressional committees, and the GAO.

Centers for Medicare & Medicaid Services (CMS) programs

OIG Recommendations	Policy Decisions	Estimated Savings (millions)
Medicare Part C Prepayments. Modify monthly capitated payments to a level fully supported by empirical data. The recommendation reflected findings in OIG report number A-14-00-00212.	Section 3201 of the Patient Protection and Affordable Care Act (ACA) reduced the Medicare Advantage (MA) benchmark percentages that are applied to Medicare fee-for-service, resulting in cost savings for Part C as compared to prior law. CBO estimated Part C savings through FY 2019, including \$13.1 billion for FY 2014. CBO produced its estimate in 2010, prior to two significant implementation decisions by HHS that affect the actual savings; however, neither CBO nor HHS has calculated a	\$13,100

OIG Recommendations	Policy Decisions	Estimated Savings (millions)
<p>Excessive Medicaid Payments to New York Developmental Centers. Ensure that New York's Medicaid daily rate for State-operated developmental centers meets the Federal requirement that payment for services be consistent with efficiency and economy. The recommendation reflected findings in OIG report number A-02-11-01029.</p> <p>Part B Drugs Average Sales Price. Adopt an alternate calculation of volume-weighted average sales price (ASP) that is consistent with the results set forth in section 1847A(b)(3) of the Social Security Act. The recommendation reflected findings in OIG report number OEI-03-05-00310.</p>	<p>revised estimate.²</p> <p>New York's Medicaid State Plan Amendment 12-03, effective April 1, 2013, limits payment to costs with projected savings of nearly \$1.2 billion in FYs 2013 and 2014 (\$399 million for FY 2013 and \$799 for FY 2014). The State expects to issue another amendment for FYs 2015–2017 with additional savings for those years, projected at \$799 million per year.</p>	\$799
<p>Reductions in Medicare Bad Debt Reimbursement. Seek legislative authority to eliminate (or reduce) Medicare payments to hospitals for bad debt associated with beneficiaries' failure to pay their deductibles and coinsurance. The recommendations reflected findings in OIG report number A-14-90-00339 and subsequent reviews.</p>	<p>Section 112 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 establishes a revised method for calculating volume-weighted ASPs for Medicare Part B drugs that comports with OIG's recommendation. CBO estimated savings of \$300 million for FY 2014.</p>	\$300
	<p>Section 3201 of the Middle Class Tax Extension and Job Creation Act of 2012 applied percentage reductions in bad debt reimbursement to all providers eligible to receive bad debt reimbursement. CMS estimated savings to Medicare of \$10.92 billion over 10 years with \$600 million attributed to FY 2014. (77 Fed. Reg. 67523, November 9, 2012.)</p>	\$600

² One implementation decision related to a nationwide quality bonus payment demonstration, which GAO found would reduce MA savings. (See GAO-12-409R.) The other was a change in policy about how HHS calculates the fee-for-service rate against which MA payments are benchmarked that would increase the savings associated with the reduced benchmark. (See CMS's Medicare Advantage Rate Announcement from April 1, 2013.)

OIG Recommendations	Policy Decisions	Estimated Savings (millions)
<p>Medicaid Third Party Liability. Determine whether legislation is needed to explicitly include pharmacy benefit management companies in the Medicaid definition of "third party," require third parties to match their eligibility files with Medicaid's eligibility files, and allow Medicaid up to 3 years to recover payments from liable third parties. The recommendations reflected findings in OIG report number OEI-03-00-00030.</p>	<p>Section 6035 of the Deficit Reduction Act (DRA) made several changes to strengthen Medicaid's third-party liability provisions, including clarification regarding pharmacy benefit managers. The section also requires States to ensure that health insurers provide requested coverage data; accept the State's right of recovery; and agree, conditionally, not to deny a claim solely on the basis of date of submission of the claim when the claim is submitted by the State within a 3-year period beginning on the date of service. CBO estimated savings of \$240 million for FY 2014.</p>	\$240
<p>Additional Rebates for Brand-Name Drugs With Multiple Versions. OIG recommended that CMS continue to seek legislative authority to modify the rebate formula calculation to ensure that manufacturers cannot circumvent additional rebates by bringing new versions of existing brand-name drugs to market. The recommendation reflected findings in OIG report number A-06-09-00033.</p>	<p>Section 2501(d) of the ACA, as amended by section 1206(a) of the Health Care and Education Reconciliation Act of 2010, addresses this issue. CBO estimated savings of \$200 million for FY 2014.</p>	\$200
<p>Capped Rental Durable Medical Equipment. Eliminate the semiannual maintenance payment allowed for capped rental equipment, pay only for repairs that are needed, eliminate the 15-month rental option, and convert rentals to purchases after the 13th month. The recommendations reflected findings in report number OEI-03-00-00410.</p>	<p>Section 5101 of the DRA revised the payment rules for capped rental equipment to require that ownership of the item transfer to the beneficiary after the 13th month and that Medicare pay for maintenance services on a cost-reimbursement basis. CBO estimated savings of \$300 million for FY 2014.</p>	\$300

OIG Recommendations	Policy Decisions	Estimated Savings (millions)
<p>Medicare Secondary Payer. Implement stronger followup procedures for employers who fail to respond to data requests, exercise civil monetary penalty authority, and seek necessary legislative authority for mandatory data reporting. The recommendations reflected findings in the following OIG reports:</p> <p>A-02-98-01036 A-02-02-01037 A-02-02-01038 A-04-01-07002 A-09-89-00100</p>	<p>Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 amended the Medicare secondary payer provisions of the Social Security Act, § 1862(b), to provide for mandatory reporting for various categories. CBO estimated savings of \$100 million for FY 2014.</p>	\$100
<p>Rebates for Physician-Administered Drugs. Encourage States to take action to collect rebates on physician-administered drugs, especially single-source drugs. States should either use National Drug Codes (NDC) instead of procedure codes or link procedure codes to NDCs for single-source drugs. The recommendations reflected findings in OIG report number OEI-03-02-00660.</p>	<p>Section 6002 of the DRA requires States to provide for the collection and submission of utilization data needed to secure rebates for physician-administered drugs and provides that the utilization data for single source and specified multiple-source physician-administered drugs be submitted using NDC numbers (unless the Secretary specifies an alternative coding system). CBO estimated savings of \$15 million for FY 2014.</p>	\$15

Administration for Children and Families programs

OIG Recommendations	Policy Decisions	Estimated Savings (millions)
<p>Triennial Reviews of Child Support Orders and Medical Support by Parents. Ensure that more periodic reviews are initiated and take action to</p>	<p>Section 7302 of the DRA required States to adjust child support orders of families enrolled in the Temporary Assistance for Needy Families program every 3 years.</p>	\$29

increase medical support by parents. The recommendations reflected findings in OIG report number OEI-05-98-00100.

Section 7307 requires States to assess the ability of either or both parents to provide medical support for their children. CBO estimated savings (combined) of \$29 million for FY 2014.

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

The following tables summarize the OIG's monetary recommendations and the Department's responses to them. This information is provided in accordance with the Inspector General Act, §§ 5(a)(8) and (a)(9), (5 U.S.C. App. §§ 5(a)(8) and (a)(9)), and the Supplemental Appropriations and Rescissions Act of 1980.

Audit reports with questioned costs

Questioned costs are those questioned by OIG audits because of an alleged violation of a provision of a law, regulation, contract, grant, or other agreement governing the expenditure of funds. Costs are questioned because the expenditure was not supported by adequate documentation or because the expenditure was unnecessary or unreasonable. OIG includes those questioned costs that HHS program officials, in a management decisions, have agreed should not be charged to the Federal Government, commonly referred to as disallowed costs, as part of the expected recoveries in the Accomplishment section at the beginning of the *Semiannual Report*. Superscripts indicate end notes.

Table 1 follows.

Table 1 – Audit reports with questioned costs

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period ¹	208	\$841,951,000	\$25,138,000
Reports issued during the reporting period	86	\$553,549,000	\$0
Total Section 1	294	\$1,395,500,000	\$25,138,000
Section 2			
Reports for which management decisions were made during the reporting period ^{2,3}			
Disallowed costs	168	\$539,713,000*	\$0
Costs not disallowed	4	\$18,190,000	\$0
Total Section 2	172	\$557,903,000	\$0
Section 3			
Reports for which no management decisions had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	122	\$837,597,000	\$25,138,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance ⁴	61	\$365,266,000	\$25,138,000

*Audit receivables (expected recoveries).

Audit reports with funds recommended to be put to better use

The phrase “recommendations that funds be put to better use” means that funds could be used more efficiently if management took action to implement an OIG recommendation through reductions in outlays, deobligation of funds, and/or avoidance of unnecessary expenditures. Table 2 reports HHS program officials’ decisions to take action on these audit recommendations.

Table 2 – Audit reports with funds to be put to better use

	Reports	Dollar Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period ¹	14	\$1,698,579,000
Reports issued during the reporting period	5	\$15,076,723,000
Total Section 1	19	\$16,775,302,000
Section 2		
Reports for which management decisions were made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	6	\$675,449,000
Based on proposed legislative action	0	\$0
Value of recommendations not agreed to by management	1	\$250,145,000
Total Section 2	7	\$925,594,000
Section 3		
Reports for which no management decisions had been made by the end of the reporting period ² (Sec. 1 minus Sec. 2)	12	\$15,849,708,000

End Notes

Table 1 End Notes

¹ The opening balance was adjusted downward by \$125.1 million because of a reevaluation of previously issued recommendations.

² Revisions to previously reported management decisions:

- A-02-07-01054 *Review of Medicaid Personal Care Services Claims Made by Providers in New York City.* As a result of the Department of Justice's settlement with New York City involving personal care service, the OIG recomputed the total disallowance for 12 unallowable claims. Disallowed cost was reduced by \$155,554,525.
- A-09-11-02024 *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries.* The State provided documentation to support the amount claimed on the CMS-64 report. The \$73,678,263 questioned costs were determined to be allowable.
- A-02-09-01023 *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State.* CMS and OIG subsequent review of additional documentation provided by the State determined that \$15,959,797 of questioned costs were allowable.
- A-05-09-91337 *State of Indiana.* Upon settlement of the cost report, the State determined that the provider received overpayment totaling \$7,239,238. An adjustment was made by CMS reducing disallowed cost by \$9,137,265.
- A-07-11-03171 *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims.* Subsequent review of documentation provided by State reduced medical eligibility error rate. Disallowed costs were reduced by \$3,633,229.
- Not detailed are net reductions to previously disallowed management decisions totaling \$21,118,823.

³ Included are management decisions to disallow \$34.2 million in questioned costs that were identified by non-Federal auditors in audits of State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards conducted in accordance with Office of Management and Budget Circular A-133. OIG is currently 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 61 audits was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations before the end of the next semiannual reporting period:

CIN: A-01-13-00505	REVIEW OF DUPUY ORTHOPAEDICS' PROPOSED GLOBAL PAYMENT TO MEDICARE FOR REVISION SUGERIES RELATED TO THE DUPUY ASR HIP RECALL, JUL 2013, \$98,200,000
CIN: A-07-12-01116	REVIEW OF MEDICARE PAYMENTS FOR UNLAWFULLY PRESENT BENEFICIARIES, JAN 2013, \$91,620,548
CIN: A-07-12-01113	MEDICARE IMPROPERLY PAID PROVIDERS MILLIONS OF DOLLARS FOR INCARCERATED BENFICIARIES WHO RECEIVED SERVICES DURING 2009- THROUGH 2011, JAN 2013, \$33,587,634
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES - CT, MAY 2003, \$32,780,146
CIN: A-07-12-06038	REVIEW OF MEDICARE PART D PAYMENTS FOR UNLAWFULLY PRESENT BENEFICIARIES, OCT 2013, \$28,990,718
CIN: A-01-12-02507	REVIEW OF CONNECTICUT'S TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS, NOV 2013, \$17,499,083
CIN: A-01-11-00534	NATIONWIDE REVIEW OF INPATIENT REHABILITATION FACILITIES PATIENT ASSESSMENT INSTRUMENTS FOR CALENDAR YEARS 2009 AND 2010, SEP 2012, \$7,700,700
CIN: A-03-12-00004	REVIEW OF HORIZON'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$4,344,417
CIN: A-01-11-02500	REVIEW OF MASSACHUSETTS' TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, AUG 2011, \$4,242,540
CIN: A-05-13-00014	OHIO EXCEEDED THE 5-PERCENT LIMIT FOR CLAIMING CHILD CARE DEVELOPMENT FUND ADMINISTRATIVE EXPENDITURES, NOV 2013, \$3,164,630
CIN: A-07-12-03175	REVIEW OF CCDF TARGETED FUNDS IN NEBRASKA, APR 2013, \$2,965,913
CIN: A-03-13-00025	REVIEW OF UAB HEALTH SYSTEM'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$2,812,109
CIN: A-03-13-00026	REVIEW OF USABLE MUTUAL'S (ARKANSAS BLUE CROSS BLUE SHIELD) 2009, 2010, AND 2011 BONA FIDA SERVICE FEES, JAN 2014, \$2,763,821
CIN: A-03-11-00002	REVIEW OF NEW ENGLAND JOINT ENTERPRISE 2009 DIR REPORTS, APR 2012, \$2,710,732
CIN: A-03-12-00006	REVIEW OF TAHMO'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$2,355,532
CIN: A-03-13-00020	REVIEW OF CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$2,070,605
CIN: A-03-12-00007	REVIEW OF ARCADIAN'S 2009 AND 2010 BONA FIDE SERVICE FEES, FEB 2013, \$2,048,967
CIN: A-03-12-00005	REVIEW OF WINDSOR'S 2009 AND 2010 BONA FIDE SERVICE FEES, JAN 2013, \$1,948,737
CIN: A-03-13-00018	REVIEW OF AMERIGROUP CORPORATION'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,943,251

CIN: A-03-13-00019	REVIEW OF BLUECROSS BLUESHIELD OF SOUTH CAROLINA'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, DEC 2013, \$1,799,096
CIN: A-05-12-00021	REVIEW OF CDC'S OVERSIGHT OF PEPFAR FUNDS PROVIDED TO AURUM IN SOUTH AFRICA FOR 2009-10, AUG 2013, \$1,690,605
CIN: A-02-11-02007	LONG ISLAND CHILD AND FAMILY DEVELOPMENT SERVICES, INC.'S FINANCIAL MANAGEMENT SYSTEM DID NOT ACCURATELY DISCLOSE HEAD START PROGRAM RESULTS, MAY 2012, \$1,489,093
CIN: A-07-11-06013	INDIRECT COSTS CLAIMED AS DIRECT COSTS - UNIVERSITY OF COLORADO DENVER, JUN 2013, \$1,419,524
CIN: A-03-12-00008	REVIEW OF XL HEALTH DIR, JAN 2013, \$1,410,342
CIN: A-01-12-02500	REVIEW OF CONNECTICUT'S TITLE IV-E ADMINISTRATIVE/TRAINING COSTS AND MAINTENANCE PAYMENTS, DEC 2012, \$1,316,684
CIN: A-01-12-01501	REVIEW OF SAMHSA COSTS CLAIMED AT LATIN AMERICAN HEALTH INSTITUTE, BOSTON, MA, APR 2013, \$1,261,328
CIN: A-03-13-00021	REVIEW OF FALLON COMMUNITY HEALTH PLAN'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,079,578
CIN: A-05-12-00089	THE COUNCIL ON RURAL SERVICE PROGRAMS, INC., CLAIMED UNALLOWABLE HEAD START COSTS, NOV 2013, \$1,074,352
CIN: A-03-13-00022	REVIEW OF MD CARE, INC.'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,040,501
CIN: A-03-13-00023	REVIEW OF NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$957,921
CIN: A-02-12-02003	ECONOMIC OPPORTUNITY COMMISSION OF NASSAU CO., INC. CLAIMED SOME UNALLOWABLE HEAD START COSTS, SEP 2013, \$879,876
CIN: A-02-11-02020	REVIEW OF ACTION FOR A BETTER COMMUNITY, INC. CSBG ARRA COSTS CLAIMED BY NEW YORK STATE, SEP 2013, \$795,608
CIN: A-02-11-02005	LIMITED HEAD START REVIEW OF INCLUDED EDUCATIONAL SERVICES, JUL 2012, \$588,830
CIN: A-09-11-01007	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR HCAP, FEB 2013, \$513,649
CIN: A-01-11-02505	NEON - HEAD START LIMITED SCOPE REVIEW - ALLOCATING OF COSTS - ARRA, JAN 2012, \$406,434
CIN: A-07-12-06035	REVIEW OF MEDICARE PART D PAYMENTS FOR INCARCERATED BENEFICIARIES, JAN 2014, \$325,903
CIN: A-01-11-02510	REVIEW OF CT CSBG RECOVERY ACT COSTS CLAIMED, APR 2013, \$314,605
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, \$293,870
CIN: A-02-11-02015	REVIEW OF INSEC, INC. CSBG ARRA COSTS CLAIMED BY THE COMMONWEALTH OF PUERTO RICO, APR 2013, \$285,412
CIN: A-05-12-00023	REVIEW OF CDC'S OVERSIGHT OF PEPFAR FUNDS PROVIDED TO SOUTHERN AFRICAN CATHOLIC BISHOPS' CONFERENCE FOR JUNE 1, 2009 TO MAY 31, 2010, JUL 2013, \$235,130

CIN: A-09-09-00045	RISK ADJUSTMENT DATA VALIDATION OF PAYMENTS MADE TO PACIFICARE OF CALIFORNIA FOR CALENDAR YEAR 2007 (CONTRACT H0543), NOV 2012, \$224,388
CIN: A-06-12-00057	CHILD CARE DEVELOPMENT FUND: TARGETED FUNDS REVIEW IN LOUISIANA, SEP 2013, \$221,578
CIN: A-05-12-00012	REVIEW OF IL CSBG RECOVERY ACT COSTS CLAIMED - ROCKFORD, JUL 2013, \$205,296
CIN: A-05-12-00024	NATIONAL HEALTH LABORATORY SERVICE DID NOT ALWAYS MANAGE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS OR MEET PROGRAM GOALS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2013, \$185,768
CIN: A-06-09-00012	RISK ADJUSTMENT DATA VALIDATION - PACIFICARE H4590, MAY 2012, \$183,247
CIN: A-04-11-01004	NORTHEAST FLORIDA COMMUNITY ACTION AGENCY, INC.'S CSBG FUNDS AWARDED UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, SEP 2012, \$165,795
CIN: A-04-11-01008	FLORIDA'S ADMINISTRATION OF CSBG RECOVERY ACT PROGRAM AND COSTS CLAIMED BY CENTRAL FLORIDA COMMUNITY ACTION AGENCY, INC., APR 2013, \$160,404
CIN: A-04-11-03538	HEAD START HIGH RISK GRANTEE - MOBILE COMMUNITY ACTION AGENCY, INC., DEC 2011, \$147,587
CIN: A-07-11-02766	REVIEW OF WY CSBG RECOVERY ACT COSTS CLAIMED - CARBON COUNTY, AUG 2013, \$143,588
CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, \$124,046
CIN: A-09-11-01013	REVIEW OF OREGON'S HOUSING AND COMMUNITY SERVICES DEPARTMENT, APR 2013, \$115,911
CIN: A-06-11-00058	REVIEW OF CSBG ARRA COSTS CLAIMED BY CROWLEY'S RIDGE DEVELOPMENT COUNCIL, AUG 2012, \$115,420
CIN: A-07-12-02779	REVIEW OF NATRONA COUNTY CSBG RECOVERY ACT COSTS CLAIMED, JUN 2013, \$104,971
CIN: A-05-12-00022	THE SOUTH AFRICAN NATIONAL DEPARTMENT OF HEALTH DID NOT ALWAYS MANAGE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS OR MEET PROGRAM GOALS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2013, \$77,790
CIN: A-06-11-00057	AUDIT DEVELOPMENT - VIETNAM PEPFEAR REVIEWS, JUN 2013, \$47,708
CIN: A-09-12-01000	REVIEW OF CSBG RECOVERY ACT ADMINISTRATIVE COSTS CLAIMED BY HI OFFICE OF COMMUNITY SERVICES, JUN 2012, \$34,861
CIN: A-02-11-02000	DIRECT COST REVIEW - SUNY ALBANY, OCT 2011, \$27,384
CIN: A-09-11-01014	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR THE HAWAII COUNTY ECONOMIC OPPORTUNITY COUNCIL, JUL 2012, \$22,602
CIN: A-04-13-04005	REVIEW OF UNIVERSITY TEACHING HOSPITAL-ZAMBIA COOPERATIVE AGREEMENT 5U2GPS001932-2, MAR 2014, \$13,554

CIN: A-05-11-00053 THE COLUMBUS URBAN LEAGUE CLAIMED SOME UNALLOWABLE COSTS TO HEAD START, SEP 2012, \$13,102

CIN: A-03-12-00250 AUDIT OF LANCASTER COUNTY COMMUNITY ACTION PROGRAM, NOV 2013, \$2,813

TOTAL NUMBER OF REPORTS: 61

TOTAL AMOUNT: \$365,266,000

Table 2 End Notes

¹The opening balance was adjusted upward by \$ 16.8 million because of reevaluation of previously issued recommendations.

²Because of administrative delays, some of which were beyond management control, 7 of the 12 audits open at the end of the period were not resolved within 6 months of issuance of reports. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-01-12-00507 ACUTE-CARE INPATIENT HOSPITAL TRANSFERS TO INPATIENT HOSPICE CARE, MAY 2013, \$602,519,187

CIN: A-07-11-05017 NATIONWIDE REVIEW OF PART D INVESTMENT INCOME, APR 2013, \$111,244,413

CIN: A-06-10-00059 REVIEW OF HOSPICE COVERED DRUGS NATIONWIDE, JUN 2012, \$33,638,137

CIN: A-07-12-05024 REVIEW OF MEDICARE PAYMENTS FOR VACUUM ERECTION DEVICES, DEC 2013, \$18,000,000

CIN: A-04-12-06154 REVIEW OF HOSPITAL OUTPATIENT PAYMENTS FOR ESTABLISHED PATIENTS, MAR 2014, \$7,536,964

CIN: A-05-06-00023 UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS - MN, SEP 2006, \$28,240

CIN: A-09-09-01007 REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, \$17,764

TOTAL NUMBERS OF REPORTS: 7

TOTAL AMOUNT: \$772,984,705

Appendix C: Peer review results

The Inspector General Act of 1978, as amended, requires OIGs to report the results of peer reviews of their operations conducted by other OIGs, the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted of the OIG by 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 Investigations peer review results

During this semiannual reporting period, HHS OIG's Office of Investigations (OI) conducted a peer review of the Treasury Inspector General for Tax Administration (TIGTA). A peer review of OI was not conducted during this reporting period. Listed below is information concerning OI's peer review of TIGTA.

The system of internal safeguards and management procedures for the investigative function of TIGTA, in effect through June 2014, were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

OI	Date	Reviewing Office	Office Reviewed
	June 2014	HHS-OIG, OI	TIGTA

Appendix D: Summary of sanction authorities

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

Program exclusions

The Social Security Act, § 1128 (42 U.S.C. § 1320a-7), provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid, and other Federal health care programs. Exclusions are required for individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felonies for other health care fraud; and (4) felonies for illegal manufacture, distribution, prescription, or dispensing of controlled substances.

OIG is authorized to exclude individuals and entities on several other grounds, including misdemeanors for other health care fraud (other than Medicare or Medicaid) or for illegal manufacture, distribution, prescription, or dispensing of controlled substances; suspension or revocation of a license to provide health care for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submission of false or fraudulent claims to a Federal health care program; or engaging in unlawful kickback arrangements.

ACA added another basis for imposing a permissive exclusion, that is, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program, including managed care programs under Medicare and Medicaid, as well as Medicare's prescription drug program.

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

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) of the Social Security Act, § 1128A (42 U.S.C. § 1320a-7a), authorizes OIG to impose 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 or services that the person knows or should know is false or fraudulent is subject to a penalty of up to \$10,000 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion.

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

The ACA added more grounds for imposing civil monetary penalties (CMPs). These include, among other conduct, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program (including Medicare and

Medicaid managed care programs and Medicare Part D). The ACA authorizes a penalty of up to \$50,000 for each such false statement. The ACA also authorizes the imposition of CMPs for activities relating to fraudulent marketing by managed care organizations, their employees, or their agents.

Patient dumping

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

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

OIG is authorized to collect CMPs of up to \$25,000 against small hospitals (fewer than 100 beds) and up to \$50,000 against larger hospitals (100 beds or more) for each instance in which the hospital negligently violated any of the section 1867 requirements. In addition, OIG may collect a penalty of up to \$50,000 from a responsible physician for each negligent violation of any of the section 1867 requirements and, in some circumstances, may exclude a responsible physician.

Anti-kickback statute and civil False Claims Act enforcement authorities

The anti-kickback statute – This statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers, or pays remuneration, in cash or in kind, to induce or in return for (1) referring an individual to a person or an entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Federal health care programs or (2) purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering, of any good, facility, service, or item payable under the Federal health care programs. 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 anti-kickback statute; a CMP under OIG's authority pursuant to the Social Security Act, § 1127(a)(7) (42 U.S.C. § 1320a-7a); and/or program exclusion under OIG's permissive exclusion authority under the Social Security Act, § 1128(b)(7) (42 U.S.C. § 1320a-7(b)(7)).

False Claims Act – Under the False Claims Act (FCA) (31 U.S.C. §§ 3729–3733), a person is liable for up to treble damages and a penalty between \$5,500 and \$11,000 for each false claim knowingly submitted, or caused to be submitted, to a Federal program. Similarly, a person is liable under the FCA if knowingly making, using, or causing 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.

Appendix E: Reporting requirements in the Inspector General Act of 1978

The reporting requirements of the Inspector General Act of 1978, as amended, are listed in the following table along with the location of the required information.

Section	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	"Other HHS-Related Issues" section
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout this report
(a)(3)	Prior significant recommendations on which corrective action has not been completed	<i>OIG Compendium of Priority Recommendations</i>
(a)(4)	Matters referred to prosecutive authorities	"Legal and Investigative Activities" section
(a)(5)	Summary of instances in which information requested by OIG was refused	None
(a)(6)	List of audit reports	Submitted to the Secretary under separate cover
(a)(7)	Summary of significant reports	Throughout this report
(a)(8)	Statistical Table 1 – Reports With Questioned Costs	Appendix B
(a)(9)	Statistical Table 2 – Funds Recommended To Be Put to Better Use	Appendix B
(a)(10)	Summary of previous audit reports without management decisions	Appendix B
(a)(11)	Description and explanation of revised management decisions	Appendix B
(a)(12)	Management decisions with which the	None

Section	Requirement	Location
	Inspector General disagrees	
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	Reported annually in the spring <i>Semiannual Report to Congress</i> , "Other HHS-Related Issues" section
(a)(14)-(16)	Results of peer reviews of HHS-OIG conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by HHS-OIG of other OIGs.	Appendix C

Other reporting requirements

Section	Requirement	Location
845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for fiscal year 2008 (P.L. No. 110-181), § 845.	"Other HHS-Related Issues" section
205	Pursuant to the Health Insurance Portability and Accountability Act (P.L. No. 104-191), § 205, the Inspector General is required to solicit proposals annually via a <i>Federal Register</i> notice for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b), and for developing special fraud alerts. The Inspector General is also required to report annually to Congress on the status of the proposals received related to new or modified safe harbors.	Reported annually in the fall <i>Semiannual Report</i> . Appendix F
1553	Pursuant to the American Recovery and Reinvestment Act of 2009, § 1553, OIG reports to Congress the retaliation complaint investigations it decided not to conduct or continue during the period.	"Other HHS-Related Issues" section

Appendix F: Anti-kickback statute—Safe harbors

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), § 205, the Inspector General is required to solicit proposals annually via a *Federal Register* notice for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b), and for developing special fraud alerts. The Inspector General is also required to report annually to Congress on the status of the proposals received related to new or modified safe harbors.

In crafting safe harbors for a criminal statute, it is incumbent upon the OIG to engage in a complete and careful review of the range of factual circumstances that may fall within the proposed safe harbor subject area to uncover all potential opportunities for fraud and abuse by unscrupulous providers. Having done so, OIG must then determine, in consultation with DOJ, whether it can develop effective regulatory limitations and controls not only to foster beneficial or innocuous arrangements but also to protect the Federal health care programs and their beneficiaries from abusive practices.

Public proposals for new and modified safe harbors

In response to the 2013 annual solicitation, OIG received the following proposals related to safe harbors:

Proposal	OIG Response
A new safe harbor protecting free continuing medical education (CME) programs offered by hospitals to physicians.	OIG is not adopting this suggestion. The concept of free programs could vary greatly and should be addressed on a case-by-case basis, such as under the advisory opinion process.
A new safe harbor that would permit health care providers and suppliers in certain circumstances to compensate individuals in clinical trials and to provide services related to the clinical trials at no cost, including the waiver of cost-sharing obligations.	OIG is considering the adoption of a safe harbor that would protect the waiver of cost-sharing obligations and possibly other incentives to participants in clinical trials sponsored by certain Federal Government entities.

Proposal	OIG Response
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A new safe harbor protecting clinically integrated networks' (CINs) entry into contracts with commercial third party payors for value-based payments, including pay-for-performance bonuses and shared savings awards for high quality and cost-effective health care.

The issues raised in the proposal require further study.