Office of Inspector General
Semiannual Report to the Congress

April-September 2003

U.S. Department of Health and Human Services

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Message from the Inspector General

The advent of the 25th anniversary of the Inspector General Act of 1978 is an appropriate opportunity to review and renew our commitment to the mission of the Inspectors General. Established in 1976 as the first statutory Office of Inspector General (OIG), our office served as the model when Congress established OIGs throughout the Federal Government by passing the Inspector General Act of l978. As the Inspector General community has grown and evolved to perform an ever-widening array of critical functions, so, too, has this office. In so doing, we have amassed an impressive record of accomplishment.

The success of this office comes as no surprise to me. While serving as the Acting Principal Deputy Inspector General, I have been consistently impressed with the tremendous intelligence, talent and dedication of the entire staff. I am incredibly proud to be a part of this OIG team and want to share with you some of our achievements.

Our current fiscal year savings total—over $23 billion—represents a record high. We take our responsibility to the American taxpayer very seriously and our savings total demonstrates our commitment. A true measure of our success, however, must include the impact that our work has on the quality of life across the Nation. To that end, we have continued to move forward with zealous determination to protect the health and welfare of HHS program beneficiaries, ensuring that they receive high quality care and service. Areas that we have scrutinized and for which we have made significant recommendations—prescription drugs, quality of care in nursing homes, home health care, durable medical equipment, protection of patient data, and child support enforcement—all continue to be subjects of intense interest.

In light of recent world events, our vision has broadened to encompass activities that have global implications. Our bioterrorism preparedness initiative remains a priority. We are working closely with the Department and the States to eliminate security vulnerabilities and increase our capability to detect and respond to a bioterrorism threat. We have made numerous recommendations to remedy existing weaknesses, to prevent the development of further vulnerabilities, and to protect the health and safety of our citizens. And, as nations of the world have joined together to work collaboratively on other issues of global importance, we have made significant contributions in such areas as HIV/Aids and clinical trial research. We stand ready to continue to provide support appropriately.

In all, our accomplishments speak to the scope and diversity of our responsibilities, the clarity of our vision, and the depth of our commitment to OIG's mission. We celebrate this occasion with resolution to work with the Department to surpass past performance in the year to come, and we applaud all Inspectors General for their achievements over the years.

Dara Corrigan
Acting Principal Deputy Inspector General

Highlights

Summary of Accomplishments

For fiscal year 2003, OIG reported savings of over $23 billion, comprised of $21.656 billion in implemented recommendations and other actions to put funds to better use, $334 million in audit receivables, $71 million in additional recoveries, and $988 million in investigative receivables. (Details pp. 46, 51, and 55.)

In addition, for this fiscal year, OIG reported exclusions of 3,275 individuals and entities for fraud or abuse of the Federal health care programs and/or their beneficiaries, 576 convictions of individuals or entities that engaged in crimes against departmental programs, and 243 civil actions, which include all False Claim Act and unjust enrichment suits filed in district court, all Civil Monetary Penalty Law settlements and all administrative recoveries related to provider self-disclosure matters. (Details pp. 14 and 51.)

Bioterrorism

As part of its bioterrorism preparedness initiative, OIG continued to assess security at a number of departmental laboratories and at external laboratory facilities that receive HHS funds. These reviews focused on facilities that handle select agents because these substances could potentially be used in a bioterrorist attack. Additional work has been initiated in the areas of accountability for bioterrorism preparedness funding at the State and local levels, State progress in developing and implementing laboratory response networks, and State health departments' legal authorities to respond to bioterrorism. (Details p. 28.)

Prescription Drugs

Zeneca, Inc., and AstraZeneca Pharmaceuticals LP agreed to pay the Government nearly $355 million plus interest as part of a global settlement agreement to resolve its criminal and civil liabilities relating to the marketing and pricing of its prostate cancer drug Zoladex.
(Details p. 19.)

In order to resolve their respective liabilities to the Government and other entities, Bayer Corporation agreed to pay $257 million plus interest as part of a joint civil and criminal settlement, and GlaxoSmithKline agreed to pay $88 million in a civil settlement. The settlements resolved allegations that the pharmaceutical manufacturers underpaid rebates due to the States under the Medicaid drug rebate program.
(Details pp. 19 and 20.)

Nursing Home Trends

In its continuing look at nursing homes, OIG found that the average number of deficiencies per nursing home has increased from 5.1 to 6.2. However, States lack consistency in determining types and numbers of deficiencies. OIG also found that the number of nursing home complaints reported to the National Ombudsman Reporting System increased approximately 28 percent from 1996 to 2000. The most common complaint—regarding resident care—has remained consistent.

In addition, although OIG found that skilled nursing facilities generally are in compliance with Federal requirements regarding social worker credentials, issues concerning resident care plans remain.
(Details pp. 2 and 34.)

Organ Donation

An OIG inspection report documented wide variation in donor consent rates among organ transplant centers. It highlighted the potential to increase the number of organ donors. Had 18 transplant centers with the lowest consent rates obtained consent at the average rate of another 172 centers, they would have realized 130 more donors—resulting in an estimated additional 450 life-saving organs. (Details p. 29.)

Organ Donation Continued—

The University of Chicago and Northwestern Memorial hospitals entered settlement agreements to resolve allegations of improperly diagnosing, hospitalizing, and placing candidates ahead of others waiting for organs in the transplant region. (Details p. 22.)

Foster Care's Use of Medicaid Services

OIG is producing a series of inspection reports which will help determine the extent to which foster care children in different States have access to health care services provided under Medicaid. The initial report found that few of the sampled children who have coverage are receiving Medicaid services. Caseworkers and caregivers indicate that they are not informed about the Medicaid program and have received very little training in Medicaid services. (Details p. 36.)

Postacute Care Transfer Policy

The postacute care transfer policy was intended to more appropriately reimburse hospitals for short stays followed by patient transfers to postacute care settings. During the first 2 years of the policy, OIG estimated that Medicare overpaid prospective payment system hospitals by approximately $116 million. Most of these overpayments resulted from claims that were erroneously coded as discharges to home rather than transfers to postacute care. A system alert that will compare inpatient claims with subsequent postacute claims is needed as a long-term remedy. (Details p. 4.)

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Please Note: Figures throughout the text have been rounded for reporting purposes.

Centers for Medicare & Medicaid Services

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

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

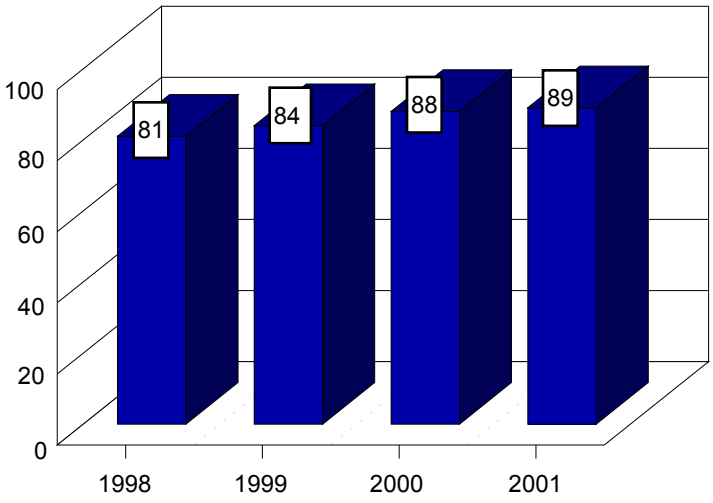
The Office of Inspector General (OIG) devotes significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care, improved its quality, and reduced the potential for fraud, waste, and abuse. In addition,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

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

NURSING HOME DEFICIENCY TRENDS ❖❖

OIG examined trends in State agency data on nursing home deficiencies and the consistency of survey and certification processes. In 2001, 89 percent of nursing homes were found to have at least one deficiency, an increase from 81 percent in 1998. Total deficiencies increased by 46 percent to over 94,000, and the average number of deficiencies per nursing home rose from 5.1 to 6.2. In addition, wide variation was found among States in the proportion of deficiency-free nursing homes and in average deficiency rates. OIG's review of the survey process revealed that States differ in how they determine numbers and types of deficiencies. Factors contributing to the variability in deficiency citation were inconsistent survey focus, unclear guidelines, the lack of a common review process for draft survey reports, and high surveyor staff turnover.

Proportion of Nursing Homes that Received Any Deficiency, 1998-2001 by Percentages



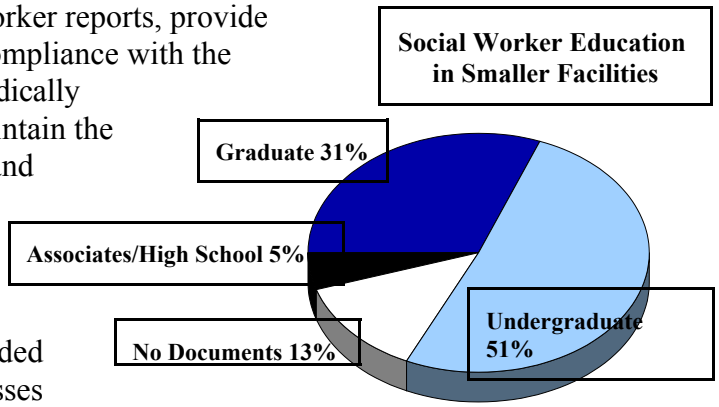
These findings indicate that further work is needed at Federal and State levels to ensure consistency of the Medicare nursing home survey and certification process. Specifically, OIG recommended that CMS continue to improve its guidance to State agencies on citing deficiencies by providing guidelines that are both clear and explicit and to work with States to develop common review criteria for draft survey reports. CMS concurred with the recommendations. (OEI-02-01-00600)

PSYCHOSOCIAL SERVICES IN NURSING FACILITIES ❖❖

This study sought to determine whether Medicare skilled nursing facility residents are receiving psychosocial services in compliance with Federal requirements. The inspection was based on a review of the medical records of 299 nursing home residents and credentials of the social workers in their facilities, interview data from social workers, nursing home administrators, and State

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

surveyors, and an analysis of Online Survey and Certification Reporting System facilities are in compliance with the Federal rule regarding social worker credentials. However, not all their residents have care plans that address all of their psychosocial needs, and 46 percent of them do not receive all the psychosocial services outlined in their care plans. OIG's medical record review data, combined with social worker reports, provide evidence that there is less than full compliance with the requirement that facilities provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. In order to address these concerns and to ensure that residents are receiving necessary and appropriate care, OIG recommended that CMS strengthen oversight processes associated with the psychosocial service portion of the resident assessment and the resulting care plans. CMS concurred. (OEI-02-01-00610)



UNIQUE PHYSICIAN/PRACTITIONER IDENTIFICATION NUMBER REGISTRY

This inspection found that over half of the providers in the active Unique Physician/Practitioner Identification Number database had at least one practice setting record with inaccurate information. It also found that 44 percent of billing numbers have never been or are no longer used to bill Medicare. Nine percent of providers could not be contacted by mail due to incorrect or insufficient address information. Record layout and data entry instructions may adversely affect the accuracy of data.

CMS intends to use these unique identifiers to enumerate the planned National Provider System. The national provider identifiers contained in this new system are expected to enhance CMS's ability to safeguard Medicare and its beneficiaries against fraud, abuse, and inappropriate payments. Inaccuracies in the current database will undermine the usefulness of the new one. OIG recommended that CMS correct inaccurate and incomplete information in the current system and deactivate practice settings that are not used. CMS concurred with the recommendations. (OEI-03-01-00380)

DIAGNOSIS-RELATED GROUP PAYMENT WINDOW

Under the inpatient prospective payment system, hospitals are reimbursed a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the classification of their illness under a diagnosis-related group. Nonphysician outpatient services, such as laboratory tests, rendered up to 3 days before the hospital admission are required to be included in the prospective payment. Although the intent of the 3-day payment "window" was to prevent separate reimbursement for preadmission services, OIG estimated that, for 10 diagnosis-related groups, Medicare reimbursed providers about $37 million for preadmission services rendered 4 to 14 days before admission. Beneficiaries paid an additional $35 million in coinsurance and deductibles for these services.

OIG therefore recommended that CMS consider proposing legislation to expand the payment window to cover preadmission services rendered up to 14 days before admission. CMS agreed but cautioned that such action could increase beneficiaries' health risks should providers perform diagnostic tests outside this payment window in order to receive separate reimbursement. (A-01-02-00503)

POSTACUTE CARE TRANSFER POLICY

To more appropriately reimburse hospitals for short inpatient stays followed by patient transfers to postacute care settings, the Balanced Budget Act of 1997 adjusted Medicare prospective payments through the postacute care transfer policy. This report points out that Medicare systems had no controls or edits to detect excessive payments to prospective payment system hospitals for claims that were erroneously coded as discharges to home rather than transfers to postacute care. As a result, based on a statistical sample, OIG estimated that Medicare paid approximately $61 million in excessive diagnosis-related group payments to hospitals in fiscal year (FY) 2000. Combining this estimate with its previous $55 million estimate for erroneous FY 1999 payments, OIG estimated that CMS overpaid hospital claims by approximately $116 million during the initial 2-year period of the postacute care transfer policy.

In addition to recommending financial adjustments and identification of overpayments made after the audit period, OIG recommended that CMS, as a long-term remedy, establish an alert mechanism in the Common Working File to compare applicable inpatient claims with subsequent postacute claims. This

will allow potentially erroneous inpatient hospital claims to be detected, reviewed, and appropriately adjusted on an ongoing basis. CMS generally concurred. (A-04-02-07005)

HOME HEALTH SERVICES AFTER HOSPITAL DISCHARGE

Under the Medicare home health prospective payment case mix adjustment, home health agencies may receive higher payments if their services were not preceded by an inpatient hospital discharge within 14 days of the home care. This report points out that home health agencies sometimes received these higher payments when they did not meet the criteria specified in the prospective payment case mix adjustment. Based on a statistical sample, OIG estimated that overpayments made by one regional home health intermediary amounted to about $1.9 million during FY 2001. The overpayments occurred, and recovery was not initiated, because home health clinicians did not always identify all facilities that had discharged the beneficiary within the 14 days preceding the home health episode and because the intermediary had not established postpayment controls to detect these incorrect claims.

OIG recommended that the intermediary recover the overpayments identified in the sampled claims, identify and recover additional overpayments in OIG's universe of claims, direct home health agencies to strengthen billing controls, and periodically analyze postpayment data to detect improperly billed claims. The intermediary generally agreed. (A-01-03-00500)

HEALTH PLAN COST REPORTS

This report points out that a cost-based health maintenance organization overstated Medicare claims in both 1999 and 2000 by about $8.2 million. In addition, the organization was not in compliance with the financial disclosure requirements for related-party administrative costs totaling about $14 million for both years.

OIG recommended that the organization file amended Medicare cost reports, decreasing the amount claimed by $8.2 million. OIG also recommended that the organization adhere to the reporting requirements for disclosing significant related-party transactions, make sure that duplicate payment controls are functioning properly, and file amended Medicare cost reports for errors affecting prior years. The organization generally concurred with the recommendations. (A-06-02-00034)

HOME DIALYSIS PAYMENTS

Medicare beneficiaries may be paying more than they need to for home dialysis. In calendar year 2000, Medicare reimbursed durable medical equipment suppliers up to $480 more for continuous cycling peritoneal dialysis kits when supplied under one method of payment as compared to other payment options. As a result, Medicare and beneficiaries paid $15.3 million more than necessary for the supply kits. Another problem relates to the fact that home dialysis beneficiaries must select a method of receiving dialysis supplies. Medicare procedures state that home dialysis claims should not be processed without documentation indicating beneficiaries' choices. However, Medicare allowed $9.5 million in claims without the documentation.

OIG recommended that CMS change reimbursement limits, ensure proper documentation exists, review claims, and collect any incorrect amounts. CMS generally concurred. (OEI-07-01-00570)

MEDICARE CONTRACTOR PENSION ASSETS

Since its inception, Medicare has paid a portion of the annual contributions made by fee-for-service contractors to their pension plans. CMS requires that contractors separately identify the pension assets for the Medicare segment of their activities. Any gains in pension assets should be credited to the Medicare program when the Medicare segment of a pension plan closes or terminates.

An OIG review of a terminated contractor in Iowa identified excess pension assets totaling $1.4 million that should be remitted to the Medicare program. The contractor disagreed with OIG's recommendation to remit the funds. At another contractor, located in Maryland, OIG found that Medicare segment assets were understated by $6.8 million. The contractor concurred with OIG's recommendation to increase its segment assets by that amount. (A-07-02-03022; A-07-02-03033)

MEDICARE PART B DATA TRANSACTIONS

OIG issued a report based on a study of whether Medicare part B providers expect to comply with the electronic data transaction standards and code sets mandated by the Health Insurance Portability and Accountability Act of

1996. Although most providers reported a moderate to high level of confidence that they will be in compliance by October 2003, 47 percent of the providers listed one or more barriers to compliance. The most common barriers are trading partners and vendors not being ready, carriers and third party payers not being compliant, and the cost of implementation. Overall, providers whose compliance date is October 16, 2003, state that they are making progress toward achieving compliance, but they remain concerned that external entities may not be fully compliant, and this would affect their ability to implement the transaction standards. (OEI-09-02-00422)

SCHOOL-BASED HEALTH SERVICES

The objective of these multistate reviews was to determine whether Medicaid payments for school-based health services and administrative claims were in accordance with Federal regulations.

Connecticut

This audit found that monthly school-based health service rates were overstated by at least 50 percent, resulting in excess Federal reimbursement of about $32.8 million for a 4-year period. In addition, the State did not have adequate procedures to verify that the cost data submitted by local education agencies were allowable and allocable for reimbursement under the program. OIG recommended a financial adjustment and procedural improvements. The State did not agree to the financial adjustment but recognized the need to change the methods used to develop reimbursement rates. (A-01-02-00006)

Massachusetts

OIG estimated that during 1 year, eight selected local education agencies submitted at least $3 million (Federal share) of ineligible claims. Problems included insufficient documentation to show that prescribed services were provided, services rendered by providers that lacked required qualifications, and claims submitted for absent students. OIG recommended, among other things, that the State improve its training and technical assistance, provide better monitoring, and refund the Federal share. The State agreed with the procedural recommendations, but disagreed with any portion of the refund related to service documentation and provider qualifications. (A-01-02-00009)

New Jersey

During a 3-year period, seven of the eight special service school districts in New Jersey were improperly reimbursed for transportation services, and the State improperly claimed an estimated $1.2 million of Federal Medicaid funds for these services. In OIG's opinion, the improper payments were caused primarily by a lack of effective administrative and prepayment controls to prevent reimbursement for transportation services. OIG recommended that the State refund the $1.2 million to the Federal Government, identify and return any improper Federal funding claimed after the audit period, and periodically review the recently implemented transportation edit to ensure that it is functioning as intended. State officials concurred. (A-02-02-01022)

Oklahoma

In this report, OIG estimated that the State claimed unallowable costs totaling $2.3 million (Federal share) of which $1.1 million was attributable to the lack of referrals for occupational and speech therapy services. OIG also could not reasonably determine whether school districts met the $2.8 million State share requirement due to calculation errors, inclusion of inappropriate expenditures, and use of inappropriate funding sources. Other areas of concern included reimbursement rates, billing agency involvement, and providers' qualifications. Recommendations called for financial adjustments and internal control improvements. The State generally agreed with the recommendations. (A-06-01-00083)

Washington

OIG estimated that the State's inadequate monitoring and improper implementation of the program resulted in unallowable claims totaling $2.3 million (Federal share) during a 1-year period. Unallowable costs were claimed for services not covered or improperly documented under Medicaid, for billing fees that were not reimbursable, and for services provided to ineligible children. In addition, the reimbursement rates included transportation costs for all special education students, regardless of whether transportation was medically necessary. OIG recommended that the State refund the Federal share, improve its methods for determining whether costs are allowable and supported, and make other procedural changes. The State generally disagreed. (A-10-02-00008)

Wisconsin

OIG estimated that the State and the school-based service providers claimed and received at least $315,000 in Federal Medicaid funding for costs not

allowed or supported by adequate documentation during a 1-year period. OIG recommended that the State work with CMS to establish the appropriate indirect cost rate, refund the overpayment, and require providers to implement effective internal controls to ensure that school-based services are properly provided, billed, and documented. The State generally agreed. (A-05-02-00023)

RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES

The objective of these reviews was to determine if controls were in place to preclude States from claiming Federal Medicaid funding for certain residents of psychiatric hospitals that are institutions for mental diseases. Federal Medicaid funding is not permitted for 21- to 64-year-old residents even if they are temporarily released to acute care hospitals for medical treatment. For residents under the age of 21, Federal funding is permitted only for inpatient psychiatric services.

Maryland

This review showed that controls were not in place to effectively preclude the State from claiming unallowable Federal funding. During a 3-year period, the State improperly claimed $1.3 million on behalf of residents at three State institutions. In addition, the State improperly claimed $801,000 for residents of 12 institutions under a Medicaid waiver which allowed expenditures, subject to certain limitations, for managed care enrollees residing in institutions for mental diseases. OIG recommended that the State refund $2.1 million and make several procedural changes. The State generally disagreed with OIG's findings and recommendations. (A-03-00-00214)

New Jersey

State policy was to not claim Federal funding for crossover claims (Medicare to Medicaid) for inpatient psychiatric services provided to 21- to 64-year-old residents of private and county-operated psychiatric hospitals that were institutions for mental diseases. However, OIG determined that from December 1, 1991, through May 20, 2002, the State improperly claimed $896,000 of Federal funding. OIG recommended that the State refund this amount to the Federal Government, identify and return any improper Federal funding claimed after the audit period, and periodically review the crossover edit to ensure that it is functioning as intended. State officials generally concurred and instituted corrective actions. (A-02-02-01017)

Texas

This review found that, during a 3-year period, the State improperly claimed $1.3 million in Federal funds for medical services provided to residents under age 21 at 37 institutions for mental diseases. The claims processing system used by the State's Medicaid contractor had no edits or mechanisms for detecting and preventing these improper claims. OIG recommended that the State refund to the Federal Government the improperly claimed funds identified by the audit, and any identified later, and work with the contractor to develop system edits. (A-06-03-00009)

MENTAL HEALTH DRUG EXPENDITURES

OIG evaluated the extent to which Medicaid pays more in net costs for mental health drugs than other Federal purchasers. The study revealed that as a result of price differences, the 10 State agencies reviewed paid, on average, between $47 million and $126 million more for the 25 drugs sampled than other Federal purchasers.

To safeguard the Medicaid program from excessive payments and to capitalize on potential savings, this report urged CMS to reconsider previous OIG recommendations. In past reports, OIG has recommended that CMS work with States to pursue more efficient means of purchasing pharmaceuticals and initiate a review of the Medicaid rebate program. OIG also suggested that CMS share this report with the States. (OEI-05-02-00080)

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Medicaid provides that States may make additional payments, called disproportionate share hospital (DSH) payments, to hospitals for the uncompensated costs of serving disproportionate numbers of low-income patients with special needs. The Omnibus Budget Reconciliation Act of 1993 mandates that these payments not exceed the individual hospitals' uncompensated costs.

California

OIG found that excess DSH payments totaling more than $252 million ($127 million Federal share) were made to 21 hospitals in California because the hospital-specific limits were overstated. The State used projected amounts instead of actual incurred costs and payments, did not limit total operating expenses to amounts allowable under Medicare, and inappropriately included bad debts as additional operating expenses. OIG also identified other issues pertaining to payments made to hospitals after closure, duplication of

Medicaid managed care data, and internal controls in the State's DSH operations. In addition to making other recommendations, OIG recommended financial adjustments. The State generally disagreed. (A-09-02-00054)

In a second review focused on Los Angeles County, OIG found that because the State overstated the hospital-specific limits, it made additional excess DSH payments totaling over $195 million ($98 million Federal share) to four hospitals. The same types of problems as those noted above were found in the methodology used to calculate the limits. While the State disagreed with most of the findings, it indicated a willingness to work with the Federal Government in resolving the $98 million in excess Federal DSH payments. (A-09-02-00071)

Pennsylvania

Pennsylvania made $671 million in DSH payments during the year reviewed. Although these payments generally conformed to the State plan, $533 million of the payments were for services that were not otherwise eligible for Federal Medicaid matching funds. Thus, the State was able to shift $287 million (the Federal share of $533 million) of State costs to the Federal Government. OIG was unable to determine whether the DSH payments exceeded hospital-specific limits because Pennsylvania did not provide a complete accounting of payments to each hospital and did not require hospitals to report their uncompensated costs. State officials said they had begun to correct these shortcomings. (A-03-01-00221)

Virginia

This report points out that a medical center overstated its uncompensated care costs in State FYs 1997 and 1998 by including unallowable physician practice plan costs incurred by a related entity. As a result, DSH payments exceeded uncompensated care costs by $9.2 million ($4.8 million Federal share). OIG recommended that the State refund the $4.8 million and make procedural corrections. State officials generally disagreed. (A-03-01-00226)

At a second Virginia hospital, OIG identified over $12 million in unallowable costs included in the uncompensated care costs for FYs 1997 and 1998. Unallowable costs consisted of physician practice plan costs incurred by a related entity. As a result, DSH payments for State FY 1997 exceeded uncompensated care costs by $12.2 million ($6.3 million Federal share). In addition to recommending a financial adjustment, OIG recom-

mended revision of the methodology for computing uncompensated care costs and compliance with CMS's DSH policy. The State disagreed with the findings. (A-03-01-00222)

MEDICAID MANAGED CARE PAYMENTS

This report provides the results of OIG's review of Medicaid payments made by New Mexico for enrollees of the state-wide Medicaid managed care program. The objectives of the review were to determine whether the payments were correct and for eligible members and whether Medicaid payments made under the fee-for-service program were for services already covered under the managed care program. The review found that the State made incorrect managed care and fee-for-service payments totaling about $3.6 million.

OIG recommended that the State refund the Federal share totaling about $2.6 million, maintain accurate and complete eligibility information, and consider revising its contracts with managed care organizations to allow for recovery of overpayments beyond the 24-month limitation regardless of whether the organizations provided services. The State generally agreed with the findings and is taking corrective action. (A-06-02-00038)

OUTREACH

Industry Guidance

OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins, and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from April 1, 2003, through September 30, 2003, OIG received 32 advisory opinion requests and issued 2 advisory opinions.

Compliance Activities

Because the great majority of providers are honest and wish to avoid fraud and abuse issues, OIG is actively working with the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct. OIG has already initiated significant outreach efforts with the private sector to encourage these compliance endeavors. OIG's compliance program guidelines are available on the Internet at http://oig.hhs.gov in the "Compliance Tools" and "Fraud Detection & Prevention" sections.

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

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG established a set of comprehensive guidelines for voluntary self-disclosures, titled "Provider Self-Disclosure Protocol" (the Protocol), available on the Internet at http://oig.hhs.gov in the "Compliance Tools" section. In addition, it can be found in 63 *Federal Register* 58,399 (October 30, 1998).

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

To date, OIG has received 197 submissions. Self-disclosure cases have resulted in 41 recoveries and 26 settlements collectively totaling over $63 million. An example follows:

- ***California***—City of Hope National Medical Center and City of Hope Medical Group, a physician practice, agreed to refund $1.6 million as overpayments received in connection with claims submitted to Medicare, Medi-Cal and California Children's Services. The overpayments resulted from a lack of documentation of appropriate physician supervision, inappropriate use of modifiers, and lack of documentation in the medical record to support the level of service billed. The self-disclosure covers claims submitted from October 1995 through September 1999.

FEDERAL AND STATE PARTNERSHIP: JOINT AUDITS OF MEDICAID

One of OIG's major outreach initiatives has been to work more closely with State auditors in reviewing the Medicaid program. The Partnership Plan was developed to foster these joint reviews and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 25 States. Reports issued to date have resulted in identifying over $262.8 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

New Jersey

The objectives of this joint audit were to determine whether payments to medical day care providers for health-related services were reasonable, related to the programs of the State's Department of Health and Senior Services, and properly recorded in the accounting system from July 1, 2000, to October 31, 2002. Because State regulations did not adequately define the population to be served or the types of medical conditions warranting medical day care, auditors could not determine the reasonableness of the payments. In addition, New Jersey was unaware that 78 medical day care providers had received $6 million in payments from the Department of Agriculture's Child and Adult Food program. These payments represented reimbursement of costs that were also included in the State's per diem payments to the providers. Further, as a result of inadequate controls over provider reimbursements, the State may have made approximately $619,000 (almost $310,000 Federal share) in improper payments. Additional claims totaling about $1 million ($500,000 Federal share) had potential conflicts due to inconsistencies in providers' billing methods. (A-02-02-01026)

OIG ADMINISTRATIVE SANCTIONS

During this reporting period, OIG administered 2171 (–this number was adjusted downward by 16 actions to correct an error in the number reported for the period from October 1, 2002, through March 31, 2003–) sanctions in the form of program exclusions or civil actions for alleged fraud or abuse or other activities

that posed a risk to Federal health care programs and their beneficiaries. A description of these sanction authorities can be found in Appendix F.

Program Exclusions

During this reporting period, OIG excluded 2,034 individuals and entities from participating in the Medicare and Medicaid programs, or other Federally-sponsored health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocation. Examples include the following:

- ***Missouri***—A pharmacist and his pharmacy were excluded based on their convictions for misbranding, tampering and diluting cancer drugs. The pharmacist was excluded for 50 years and the pharmacy for 25. Their convictions involved patient abuse or neglect and the submission of false claims to Medicare. They acted with reckless disregard and extreme indifference resulting in serious bodily injury that was life-threatening to multiple victims. They also knowingly caused a physician receiving the drugs to submit false claims to Medicare by not disclosing that the drugs were diluted. The court sentenced the pharmacist to 30 years in jail and ordered both defendants to pay, jointly and severally, restitution of approximately $10 million. Additionally, the pharmacist surrendered his Kansas license, and his Missouri license was revoked.

  Also in Missouri, a pathologist was indefinitely excluded after his Wisconsin license was revoked for prescribing drugs over the Internet without having performed physical examinations of the patients. This physician holds at least 29 professional health care licenses from other States and the territory of Guam. Several of those licenses have also been sanctioned by the appropriate State authorities.

- ***Alaska***—A physician was excluded for 20 years after being convicted on 234 counts ranging from forgery and theft of public funds from the Alaska State Medicaid Program to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. The Superior Court for the State of Alaska sentenced him to 7 years in prison and ordered him to pay approximately $240,000 in restitution. His license to practice medicine as a physician and surgeon was revoked in Alaska and Wisconsin.

Suspension and Debarment Actions

In addition to OIG's authority to exclude health care providers and entities, the Federal Government has the authority to disqualify other individuals and entities from participating in business with the Government. The Government may

disqualify these procurement (i.e., contractors and sub-contractors) and non-procurement (e.g., grantees, loan and scholarship recipients) individuals and entities through suspension and debarment actions.

A suspension action disqualifies a party from doing business with the Federal Government for a temporary period of time, while debarment entails a fixed period of time. Once a suspension or debarment action is taken, the individual or entity is added to a Web-based list maintained by the General Services Administration and is prohibited from receiving Federal funds.

In November 2002, OIG issued a policy directive concerning new procedures for the referral of non-health care providers and entities for potential government-wide suspension and debarment. Under this policy, OIG may refer these parties to the HHS Assistant Secretary for Administration and Management for administrative action. Since the directive's issuance, OIG referrals have resulted in the debarment of nine individuals and one company. Examples of recent debarment actions include the following:

- ***Pennsylvania***—The former director of a non-profit financial institution and his co-defendant were debarred for 8 years and 4 years, respectively. They were previously sentenced in connection with a scheme involving the misuse of HHS funds granted to the Empowerment Zone, a program designed to create sustainable communities through the use of business tax incentives and economic development programs in distressed urban communities. The director diverted program funds to his co-defendant's company and used funds for personal purchases.

- ***New York***—A company licensed to provide drug prevention training, its owner, its chief financial officer, and a printing company vendor were each debarred for 3 years. An HHS grantee, the company submitted false invoices to SAMHSA seeking reimbursement for costs associated with printing drug prevention literature that was never actually produced. All three individuals have been sentenced for their roles in the scheme.

- ***North Carolina***—A former employee of the State of North Carolina Department of Health and Human Services was debarred for 3 years. The employee caused the State to submit false claims to the HHS Title IV-E foster care program for expenses incurred by an unrelated organization with which she had a personal affiliation. She also attempted to impede the Federal investigation by concealing the fact that she had diverted grant funds intended for foster care and adoptive children to herself and the organization. In addition, she was convicted of obstruction of justice.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who submits claims to a Federal health care program that the person knows or should know are false or fraudulent. Civil monetary penalties and assessments may also be levied for other conduct proscribed by statute. During this reporting period, OIG collected $1.2 million in civil monetary penalties and assessments under the CMPL and other authorities, including the CMPL provision for patient dumping and the CMPL provision for kickbacks.

➤ ***Various States***—During the current fiscal year, six physicians agreed to pay almost $401,000 to resolve their respective liabilities associated with billings for samples of the prostate cancer drug Lupron. The physicians received the samples from TAP Pharmaceutical Products Inc. (TAP) and are alleged to have billed at least some of the samples to Medicare and other payors. Five of the physicians entered 3-year integrity agreements with OIG containing unique provisions relating to drug samples. This series of cases represents additional enforcement activity following from the global settlement with TAP in FY 2002.

Kickbacks

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

➤ ***Puerto Rico***—A physician practice and its member physicians agreed to pay the Government $200,000 to resolve their administrative liability. For over 3 years, the practice and its member physicians allegedly solicited and received loans from the owner of a DME company and a pharmacy in return for patient referrals.

➤ ***New York***—Columbia Memorial Hospital (Columbia Memorial) agreed to pay the Government $25,000 to resolve its liability under a provision of the CMPL. From 1995 until 1999, Columbia Memorial allegedly solicited and received discounts on hospital transports from an ambulance company in return for referring certain ambulance business exclusively to the company. This case represents the first civil monetary settlement with OIG of a kickback "swapping" case involving discounted ambulance services and conduct addressed by an OIG advisory opinion.

Civil Penalties for Patient Dumping

Between April 1, 2003, and September 30, 2003, OIG collected civil monetary penalties of approximately $345,000 from 14 hospitals and physicians under the Emergency Medical Treatment and Labor Act, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements involving alleged violations of the patient anti-dumping statute:

- ***California***—Kaiser Foundation Hospital-Sunset agreed to pay $20,000 to resolve allegations that it refused to accept the transfer of a patient who needed Kaiser's specialized capabilities to stabilize an emergency medical condition. The cardiac surgeon allegedly refused to accept the transfer because the patient was too unstable and was expected to die. The patient was sent to another hospital where he underwent successful surgery and was discharged.

- ***Virginia***—An obstetrician agreed to pay $15,000 to resolve allegations that he did not provide an appropriate medical screening examination or stabilizing treatment to a pregnant woman. The woman was transferred to another hospital approximately one hour away in a private vehicle. The patient delivered her baby in the vehicle prior to reaching the second hospital.

- ***Texas***—West Oaks Hospital agreed to pay $33,000 to resolve allegations that it refused to provide medical screening examinations and stabilizing treatment to two patients. The patients had psychiatric emergency medical conditions and were potentially suicidal.

- ***Oklahoma***—Griffin Memorial Hospital, a psychiatric hospital, agreed to pay $80,000 to resolve allegations that it did not provide adequate medical screening exams to several individuals who presented with psychiatric complaints. In addition, the hospital allegedly declined to accept transfer of a patient that needed the hospital's specialized services. In that case the patient was accepted the following morning.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid and other Federal health care programs involves the filing of false claims for reimbursement. Such false claims may be pursued under the civil False Claims Act and, in appropriate cases, may also be prosecuted under Federal and State criminal statutes. A description of these enforcement authorities can be

found in Appendix F. The successful resolution of these matters often reflects the combined investigative efforts and resources of OIG, the FBI and other law enforcement agencies.

One of OIG's responsibilities is to assist the Department of Justice (DOJ) in bringing and settling cases under the civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter integrity agreements with OIG in order to avoid exclusions and be permitted to continue to participate in Medicare and other programs. These agreements are monitored by OIG and require the providers to establish compliance programs. The compliance programs are designed to prevent a recurrence of the underlying fraudulent activities at issue.

In the six months ending September 30, 2003, the Government negotiated to receive more than $637 million through False Claims Act civil settlements related to the Medicare and Medicaid programs. Some of these successful settlements, as well as notable criminal enforcement actions, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Prescription Drugs

- ***Delaware***—Zeneca, Inc., and AstraZeneca Pharmaceuticals LP (AstraZeneca) agreed to pay nearly $355 million plus interest as part of a global settlement to resolve its criminal and civil liabilities relating to the marketing and pricing of its prostate cancer drug Zoladex. AstraZeneca pleaded guilty to conspiring to cause the submission of claims for payment for samples of Zoladex that had been provided free of charge to urologists. The settlement also resolved allegations that the company improperly set Average Wholesale Price and marketed the spread between reimbursement and cost, causing Medicare and Medicaid to overpay for Zoladex; that it paid illegal remuneration to induce the purchase of the drug; and that it failed to pay proper rebates owed to States under the Medicaid drug rebate program. As part of the settlement, AstraZeneca entered a comprehensive 5-year corporate integrity agreement with OIG.

- ***Connecticut***—Bayer Corporation (Bayer) paid $257 million plus interest as part of a global criminal and civil settlement relating to its sales of two drugs, Cipro and Adalat, to a large health maintenance organization. Bayer pleaded guilty to a violation of FDA reporting requirements. The settlement also resolved allegations that Bayer failed to pay proper rebates under the Medicaid drug rebate program. The program requires that

manufacturers report certain pricing information, including best price, to CMS and that they pay rebates to the State Medicaid programs based on the reported prices. The United States alleged that Bayer failed to report accurate best prices, and as a result, significantly underpaid rebates owed to States and overcharged 340B program covered entities for the drugs. As part of the total resolution, Bayer agreed to a 3-year extension of a corporate integrity agreement it entered with OIG as part of an earlier settlement and agreed to pay the 340B covered entities $9 million.

- ***North Carolina/Pennsylvania***—SmithKline Beecham Corporation, doing business as GlaxoSmithKline, agreed to pay $88 million to resolve its liability for alleged violations of Medicaid drug rebate program requirements for two of its drugs, Flonase and Paxil. Like Bayer, GlaxoSmithKline allegedly failed to report accurate best price information to CMS and, as a result, allegedly underpaid rebates owed to the States and overcharged 340B program covered entities for the drugs. GlaxoSmithKline agreed to a comprehensive compliance agreement with OIG as part of the settlement and agreed to pay the 340B covered entities $2.5 million.

- ***Florida/Texas***—Through two separate settlement agreements, Dey L.P. and Dey, Inc. (Dey), a pharmaceutical company located in California, agreed to pay the State of Texas and the Federal Government a total of $18.5 million. The settlements resolved the company's civil liabilities related to the false pricing of its respiratory-related drugs. The Government alleged that Dey falsified price reports for its products to the Texas Medicaid program, which directly led to overpayments.

- ***Ohio***—A registered nurse was sentenced to 5 years and 2 months in prison and ordered to pay a $1,400 fine for theft of drugs. While working at a medical center, she stole various types of narcotics for her own use, then altered patient charts and other records to conceal her crimes. Many of the drugs she diverted never reached the seriously ill patients for whom they were prescribed.

Durable Medical Equipment (DME) Suppliers

- ***California***—Endo Vascular Technologies, Inc. (EVT), a wholly-owned subsidiary of Guidant Corporation (Guidant), a medical device manufacturer, agreed to pay $94 million as part of a global resolution of criminal and civil liabilities. Between 1999 and 2001, EVT manufactured and allegedly introduced and delivered into interstate commerce an adulterated and misbranded medical device and caused claims to be submitted for it to the Medicare program. The device was allegedly misbranded in that

EVT failed to report, as required by law, information that the system may have caused or contributed to deaths or serious injuries or that the system had malfunctioned in a manner that would likely cause or contribute to death or serious injury. The Government further alleged that the system was misbranded because it did not bear adequate directions for use. In addition to the settlement agreement, Guidant and EVT agreed to enter into a comprehensive corporate integrity agreement. The criminal portion of this case was investigated by the Food and Drug Administration's Office of Criminal Investigations.

- ***Florida***—The owner and operator of a group of DME companies was sentenced to 7 years in prison and ordered to pay $14.8 million in restitution, jointly and severally with other co-defendants, for his role in two schemes to defraud Medicare and Medicaid. In addition, the court ordered a $14.8 million forfeiture against him in order to make restitution. He previously pleaded guilty on behalf of six DME corporations that were set up to launder money. Despite a temporary restraining order, he and his co-conspirators continued to fraudulently bill Medicare and Medicaid and launder the proceeds of the fraud through offshore bank accounts. The conspirators involved in the scheme netted in excess of $25 million. To date, 28 defendants have been prosecuted, 26 of whom have been sentenced. In addition to the DME owner/operator, five of the co-conspirators were sentenced this reporting period. The cases against the two remaining defendants will be adjudicated in the near future.

- ***Texas***—A salesperson for a Medicare provider selling custom-made shoes to diabetic patients was sentenced to 46 months in prison and ordered to pay $1.4 million in restitution for health care fraud. The salesperson forged the names of physicians on certificates of medical necessity, resulting in fraudulent Medicare payments to the company.

- ***Alabama***—Two DME owners and their companies, Med Care Rental of Alabama, Inc., (formerly known as Home Medical Mart, Inc.) and Med Care Rental of West Alabama, Inc., agreed to pay $30,000 to resolve their liability for allegedly submitting false claims to Medicare between June 1995 and December 1998. The Government alleged that the owners of the DME companies submitted false claims to Medicare when they (1) upcoded claims for certain DME, (2) failed to obtain and/or maintain certificates of medical necessity for medical equipment, (3) continued to bill for medical equipment after it had been picked up from patients, (4) attempted to obtain physician signatures for orders and certificates after claims had already been filed, and (5) forged physicians' signatures and other documentation during a "documentation party" that was held in January 1998. The DME

companies are defunct, and their owners agreed to be permanently excluded from participation in Federal health care programs.

Hospitals

- ***Illinois***—The University of Chicago and Northwestern Memorial hospitals agreed to pay the Government $115,000 and $24,000, respectively. The medical institutions entered these settlement agreements to resolve allegations of improperly diagnosing, hospitalizing, and placing candidates ahead of others waiting for organs in the transplant region.

- ***California***—Redding Medical Center, Inc. (RMC) agreed to pay $54 million for the alleged performance and billing of medically unnecessary cardiac services at the hospital. RMC is a wholly-owned subsidiary of Tenet HealthSystems Hospitals, Inc., and its parent corporation Tenet Healthcare Corporation, Inc. The settlement resolves allegations that medically unnecessary cardiac procedures and surgeries were performed at RMC and billed to Medicare, Medicaid, and TRICARE from January 1997 through December 2002.

- ***Florida***—Public Health Trust of Miami-Dade County, Florida, doing business as Jackson Health System (JHS), agreed to pay $16.8 million to resolve its liability for allegedly submitting false claims to the Florida Medicaid program. JHS operates a number of community clinics that provide health care services to economically disadvantaged areas of Miami. The Government alleged that during the period of 1999 through 2001, JHS inappropriately billed Florida's Agency for Health Care Administration for "hospital facility fees" for primary care services provided at their community clinics. In addition to the settlement agreement, JHS agreed to enter into a comprehensive 5-year corporate integrity agreement.

- ***Pennsylvania***—Albert Einstein Healthcare Network (AEHN), a teaching hospital, agreed to pay $2 million to resolve its liability for submitting inappropriate claims to the Medicare program. The claims allegedly were false because AEHN's employed physicians did not appropriately document their presence during the provision of professional services by residents and interns, and they submitted claims for improperly upcoded evaluation and management services.

- ***Massachusetts*** —The General Hospital Corporation, doing business as Massachusetts General Hospital and Massachusetts General Physician's Organization (collectively MGH), agreed to pay $75,000 to resolve False

Claims Act liability. The Government alleged that MGH improperly billed and received reimbursement from Medicare for procedures performed by resident physicians when an attending physician was not physically present to supervise the procedures.

Nursing Homes

➤ ***Wisconsin***—A registered nurse was sentenced to 33 months imprisonment and ordered to pay $352,000 in restitution for health care fraud and illegal kickback activity. While excluded for a State Medicaid fraud conviction, the woman owned and operated staffing agencies that supplied temporary employees to nursing homes and other facilities treating Medicaid and Medicare residents. The nurse also provided services while excluded and bribed schedulers at various nursing homes to obtain business.

Home Health

➤ ***Colorado***—Poudre Valley Health Care, Inc., doing business as Poudre Valley Hospital (Poudre Valley), agreed to pay $2.9 million for allegedly submitting false cost reports to Medicare. From January 1992 through December 1997, Poudre Valley owned and operated a hospital-based and a freestanding home health agency. During that time, Poudre Valley allegedly submitted cost reports that included inflated costs and failed to disclose related party transactions involving the two agencies.

Practitioners

➤ ***Pennsylvania***—An orthopedic surgeon and his billing company agreed to pay the Government a total of $1.6 million to resolve their liability for billing for surgery performed by residents when the surgeon was not in the operating room. In addition, the surgeon and his company entered into a comprehensive 5-year compliance agreement.

➤ ***Texas***—An internal medicine physician agreed to pay the Government $900,000 and to enter into a 6-year compliance agreement for allegedly submitting false claims to Medicare. From January 1997 through December 2001, the physician allegedly billed for medical services that were not performed and were not medically necessary and allegedly submitted claims that did not accurately reflect the services performed.

- ***New York***—A man was sentenced to 4 months in prison and ordered to pay $233,000 in restitution for health care fraud. Though he never completed medical school, he claimed to be a physician and practiced medicine.

MEDICAID FRAUD CONTROL UNITS

At present, 47 States and the District of Columbia have established Medicaid Fraud Control Units (MFCUs) that investigate and prosecute providers charged with defrauding the Medicaid program or abusing or neglecting patients. Three States—Idaho, Nebraska and North Dakota—have sought and received waivers from the requirement that all States operate MFCUs. OIG annually certifies each MFCU as eligible to receive Federal grant funds.

During FY 2003, OIG provided oversight for and administration of approximately $119.8 million in funds to the units. Examples of cases worked jointly with MFCUs are the following:

- ***OIG, the California MFCU, the Defense Criminal Investigative Service, and the FBI***—An otolaryngologist agreed to pay the Government $1 million and to be excluded for 15 years to resolve his civil liability for improperly billing Medicare, Medicaid, TRICARE and the Federal Employee Health Benefits Program. He also pleaded guilty to mail fraud in connection with the scheme. During a 5-year period, the otolaryngologist routinely billed for surgical endoscopies that were not performed or were upcoded from diagnostic endoscopies. In addition, he billed for medically unnecessary allergy, breathing and hearing tests.

- ***OIG and the Wyoming MFCU***—A pharmacist was required to permanently surrender his license and ordered to pay $53,000 in fines and penalties after pleading guilty to State charges of obtaining property by false pretenses. Prior to sentencing, the pharmacist made restitution of $104,000 to the State Medicaid program. As owner and operator of a retail pharmacy, he failed to maintain proper documentation for his Medicaid billings and billed Medicaid for brand name prescriptions when he actually provided generic medications.

- ***OIG, the Ohio MFCU, and the FBI***—A podiatrist was ordered to pay a total of $65,000 in fines and restitution for false statements related to health care matters. He used multiple fraudulent billing schemes, including upcoding, billing for services not rendered, billing the services of massage

therapists as physical therapists, and forging documents to conceal fraud. While at several nursing homes, he also stole Medicare and Medicaid numbers to submit fraudulent billings.

- ***OIG and the Illinois MFCU***—A pharmacist was ordered to pay $30,000 in restitution for misprision of a felony for his role in stealing the drug Serostim from a clinic, then selling it to bodybuilders in Missouri. The drug had been ordered for AIDS patients and billed through the Illinois Department of Public Aid.

Public Health Agencies

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

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

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

CALIFORNIA BIOTERRORISM PREPAREDNESS FUNDS

Under the Public Health Preparedness and Response for Bioterrorism Program, CDC provides grants to States and major local health departments to improve their bioterrorism preparedness. This review found that, contrary to the cooperative agreement with CDC, California did not account for its $4.9 million grant award by focus area for the 2 years ended August 30, 2001. In addition, the State could not adequately support program expenditures on financial status reports submitted to CDC. These problems were attributable to shortcomings in the accounting system, procedures, and controls, as well as inadequate monitoring of subrecipients.

OIG recommended, among other things, that the State determine, in coordination with CDC, the amount of program funds expended in each focus area, identify unallowable costs and unexpended amounts, adjust current and future awards to provide appropriate levels of preparedness by focus area, and make accounting system improvements. The State concurred. (A-09-02-01007)

OTHER ANTIBIOTERRORISM ACTIVITIES

As part of a broad bioterrorism preparedness initiative, OIG has assessed security at facilities that handle select agents, which could potentially be used in a bioterrorist attack. Security reviews at laboratory facilities operated by CDC, NIH, and FDA and at college and university laboratories have been completed. This work included an evaluation of universities' compliance with the USA Patriot Act of 2001, which prohibits access to select agents by "restricted persons." Reviews to date reveal problems in each of the four security areas specified in Department of Justice standards. In addition, a report on CDC's implementation of the regulation governing facilities that transfer and receive select agents noted the need for improvement.

Accountability for bioterrorism preparedness funding has also received attention. OIG is assessing 17 States' and localities' systems to account for funds under both HRSA's Hospital Bioterrorism Program and CDC's Bioterrorism Cooperative Grant. OIG also developed a model audit assessment tool for States to use in determining how well their jurisdictions account for these funds. Additional work is underway on State progress in developing and implementing laboratory response networks; reportable disease surveillance; State health

departments' legal authorities to respond to bioterrorism; and, at the Department's request, progress in strengthening security at departmental laboratory facilities. (Various reports)

VARIATION IN ORGAN DONATION AMONG TRANSPLANT CENTERS ❖❖

OIG compared data on patients who were medically eligible to be organ donors against the number of donors for whom consent to donate was given. For 190 of the nation's 255 transplant centers, OIG found that the rate of consent varied widely at the national level, within geographic regions, and at the organ procurement organization service area level. OIG found a slightly higher consent rate in hospitals with a larger number of transplant programs and operations.

However, of 190 transplant centers in the analysis, 18 had a donor consent rate below 30 percent, compared to a national average of 51 percent. Had these 18 transplant centers obtained consent at the average rate of the other 172 centers (54 percent), they would have realized 130 more donors beyond their current performance, resulting in an estimated additional 450 life-saving organs. (OEI-01-02-00210)

National Variation in Consent Rate Among Transplant Centers (8/01-11/02)

Consent Rate	Number of Centers	Percentage of Total
0-9.9%	2	1.1%
10-19.9%	4	2.1%
20-29.9%	12	6.3%
30-39.9%	22	11.6%
40-49.9%	35	18.4%
50-59.9%	45	23.7%
60-69.9%	40	21.1%
70-79.9%	17	8.9%
80-89.9%	8	4.2%
90-100%	5	2.6%
Total	190	100.0%

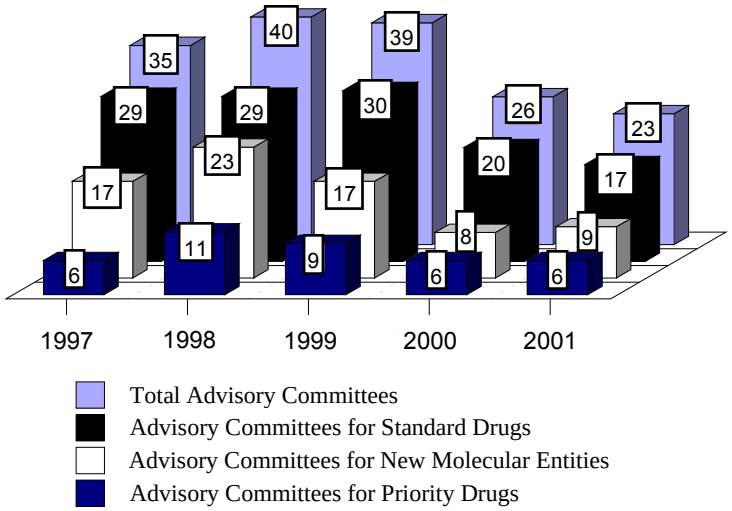
NEW DRUG APPLICATIONS

OIG issued a report on FDA's review process for new drug applications (NDAs) carried out by the Center for Drug Evaluation and Research. This report is significant, particularly in light of the recent reauthorization of the Prescription Drug User Fee Act that allows FDA to collect user fees for the review of NDAs for another 5 years and establishes time lines for their review. OIG found that the NDA review process has several strengths contributing significantly to its effectiveness. Both reviewers and sponsors have confidence in the decisions FDA makes. Review times have dropped considerably. FDA works more collaboratively with sponsors and has taken several steps to enhance efficiency.

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

However, OIG also found that workload pressures increasingly challenge effectiveness of the review process. These pressures make it difficult for reviewers to conduct in-depth reviews, hold advisory committee meetings, raise scientific disagreements, participate in professional development, and conduct research

Number of Advisory Committees Held by FDA's Center for Drug Evaluation and Research for New Drug Applications



on drug development. Three other factors also challenging the effectiveness of the process are the rush to finalize drug labels at the end of the review process, reviewer uncertainty about what types of postmarketing commitments to request from sponsors, and limited public disclosure regarding the basis for FDA's decisions on NDAs. OIG made multiple recommendations, including that FDA take full advantage of the opportunities presented in the Prescription Drug User Fee Act, which calls for FDA to conduct several studies aimed at improving the process. FDA generally concurred. (OEI-01-01-00590)

HEMOPHILIA TREATMENT CENTERS

Administered by HRSA, the 340B program provides numerous Federal grantees, including hemophilia treatment centers, with access to discounted prescription drugs. The centers earn program income by purchasing discounted blood-clotting factor and related drugs and reselling them to patients. OIG's review, which was conducted at HRSA's request, determined that the six centers visited generally used program income for patient care and related activities and had established policies allowing patients to purchase drugs from the vendor of their choice. However, one center inappropriately used program income and

overcharged Medicaid $613,000 because it did not adhere to Federal regulations limiting reimbursement to the acquisition cost plus a reasonable dispensing fee established by the State.

OIG recommended that HRSA develop program guidelines on the disposition of 340B program funds, better monitor centers participating in the program, emphasize the need to follow Federal Medicaid reimbursement regulations, and work with CMS to recover the overpayment. HRSA generally agreed with the findings and recommendations. (A-03-01-00350)

HEALTH EDUCATION ASSISTANCE LOAN DEFAULTS

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

After PSC has exhausted all efforts to secure repayment of a debt, it declares the individual in default. Thereafter, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all Federal health care programs for nonpayment of these loans. During the 6-month period from April 1, 2003, to September 30, 2003, 47 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements whereby the exclusion is stayed while they pay specified amounts each month to satisfy their debt. If they default on these settlement agreements, they can then be excluded until their entire debt is repaid, and they cannot appeal these exclusions. Some health professionals, upon being notified of their exclusion, immediately repay their HEAL debts.

After being excluded for nonpayment of their HEAL debts, a total of 1,776 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 73 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals almost $126 million. Of that amount, $5 million is attributable to this reporting period. In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- A New York Dentist—$297,000
- A South Carolina Physician—$263,000
- A California Dentist—$250,000
- An Ohio Dentist—$200,000
- A Utah Chiropractor—$199,000

FINANCIAL STATEMENT AUDIT ❖❖

To support its audit of the Department's FY 2002 financial statements, OIG contracted with independent certified public accounting firms to audit the financial statements of the major public health operating divisions. During this semiannual period, the accounting firm issued an unqualified opinion on SAMHSA's FY 2002 financial statements, which means that they were reliable and fairly presented. No material weaknesses were noted in the system of internal controls. (A-17-02-00004)

MISUSE OF PUBLIC HEALTH GRANT FUNDS

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

- ***New Mexico***—The former chief financial officer for an HHS and IHS grantee was sentenced to 57 months in prison and ordered to pay $218,000 in restitution to the grantee's insurance provider for theft or bribery concerning programs receiving Federal funds. During his employment, the officer embezzled funds by charging improper and unauthorized expenses to an official credit card and making unauthorized and improper withdrawals or payments.

- ***Louisiana***—A former employee of a university was ordered to pay $11,000 in restitution for embezzling NIH grant monies. The employee was responsible for wire transferring grant funds for the study of malaria in infants and small children from the university's stateside account to their school abroad. On six occasions, the employee instead transferred the money into her personal bank account.

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

Administrations for Children and Families and on Aging

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families. Some of the major programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant.

OIG reviews these programs. Reports focus on ways to increase the efficient use of program dollars; to more effectively implement programs; to better coordinate programs among the Federal, State, and local governments; and to strengthen States' financial management practices.

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

STATE OMBUDSMAN DATA: NURSING HOME COMPLAINTS ❖❖

Based on an analysis of nursing home complaint data reported in the National Ombudsman Reporting System (NORS), this study found that, nationwide, from 1996 to 2000, the number of nursing home complaints reported into NORS increased approximately 28 percent. However, the types of complaints have not changed significantly. The highest frequency of nursing home complaints involve resident care. Local ombudsmen do not report all nursing home complaints into NORS, and they do not report complaints uniformly. This is, in part, due to laws and policies which are not within AoA's or the ombudsman's control. As a result, NORS data are not comprehensive and should not be used to compare States to one another with respect to the volume and types of complaints. OIG believes the consistency of NORS data would be improved if AoA shares the results of this report with State ombudsmen and continues to clarify and refine the NORS process.

TOP COMPLAINT CATEGORIES BY GROWTH

Complaint	1996 Total	2000 Total	Percent Growth
Staff Turnover	330	1,015	207.6%
Dehydration	1,122	2,219	97.8%
Infection Control	562	1,074	91.1%
Supervision	1,825	3,326	82.2%
Exercise Choice &/or Civil Rights	2,211	3,803	72.0%

In their comments on OIG's draft report, AoA agreed that a lack of uniformity exists in States' reporting under NORS. AoA agreed with OIG's recommendation to distribute the final report to the State ombudsmen and highlight the complaint trends. AoA also plans to conduct regional and State training on the use of complaint codes. (OEI-09-02-00160)

REFUNDING AID TO FAMILIES WITH DEPENDENT CHILDREN OVERPAYMENTS

Current Federal regulations require that States pursue Aid to Families with Dependent Children overpayments before October 1, 1996, and make appropriate refunds to the Federal Government. This review, which was part of a nationwide

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

initiative found that California did not follow program instructions issued September 1, 2000, and had not refunded the Federal share of program recoveries collected by Los Angeles County.

The State agreed with OIG's recommendations to refund $24 million to the Federal Government and to repay the Federal share of any overpayments recovered after the audit period. (A-09-02-00072)

CHILD SUPPORT ENFORCEMENT CUSTOMER SERVICE ❖❖

An OIG inspection described parent perceptions of child support enforcement customer service, based on telephone and office visit experiences of parent respondents in four States. Due to a shifting client base and the performance initiatives under the Government Performance and Results Act, the Office of Child Support Enforcement has recently placed greater emphasis on States providing effective customer service to parents.

OIG analyzed responses from 487 custodial and 196 noncustodial parents in the four States. Respondents reported a number of problems with service, especially experienced by noncustodial parents, and only a modest level of satisfaction. OIG found that nearly all respondents had contacted the agency through telephone calls and office visits, most often to gain information about their cases. OIG also found that direct contact with agency staff, whether by telephone or in person, resulted in more positive experiences. (OEI-06-02-00250)

NONCUSTODIAL PARENTS' CONTRIBUTIONS TO MEDICAID COSTS ❖❖

The objective of this eight-State initiative was to determine the number of children under the child support enforcement program whose noncustodial parents could contribute toward the children's Medicaid costs and the amount they could contribute. The reviews focused on noncustodial parents for whom private medical insurance was unavailable or unaffordable. Federal legislation does not require that such individuals provide medical support for their children. To date, reports have been issued on three States.

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

Connecticut

OIG identified an estimated 12,500 children whose noncustodial parents could have contributed toward part or all of their children's Medicaid costs during a 1-year period. About $9.3 million could have been collected from these parents, covering 67 percent of the Medicaid costs incurred by the State and Federal Governments. Although Connecticut law requires noncustodial parents to pay the costs of Medicaid benefits when private insurance is unavailable or too costly, the State has encountered obstacles, such as conflicting court orders written under prior laws. The State agreed with OIG's suggestions for overcoming these obstacles. (A-01-02-02502)

North Carolina

Over a 1-year period, an estimated $17.4 million could have been collected from the noncustodial parents of 31,000 children to partially offset the Medicaid costs incurred by the State and Federal Governments. Since North Carolina currently has no mechanisms to require such payments, OIG recommended that the State include this requirement in its child support laws. The State was receptive and planned to explore possible approaches. (A-04-02-00013)

Texas

OIG estimated that the noncustodial parents of more than 60,000 children could have contributed $16.6 million toward Medicaid costs totaling $36.9 million during a 1-year period. The State recently strengthened its laws to require that custodial parents apply for benefits under Medicaid and that noncustodial parents contribute medical support payments for their children's Medicaid costs. Court orders written under prior laws, however, do not require such contributions. Accordingly, OIG recommended that the State ensure that prior orders are revised as they come up for modification, and the State agreed. (A-06-02-00053)

FOSTER CARE'S USE OF MEDICAID SERVICES ❖❖

OIG assessed whether foster care children are receiving Medicaid health care services in New Jersey—the first of eight States being evaluated. An analysis of 2 years of Medicaid claims for 50 foster children in New Jersey showed that few of these children are receiving Medicaid services, particularly Early and Periodic Screening Diagnosis and Treatment (EPSDT) services, although all the children have coverage. In addition, interviews with caseworkers and caregivers

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

revealed that they are not informed about the Medicaid program, and they have received very little training in Medicaid services. Also, most caseworkers and caregivers did not receive their foster child's medical information and reported difficulty finding Medicaid providers.

OIG recommended that ACF work with the State to provide more training to caseworkers and caregivers on the Medicaid program, EPSDT, and managed care. OIG also recommended that ACF and CMS work with the State to promote communication and to address the concerns of caseworkers and caregivers regarding the lack of access to Medicaid providers. Both ACF and CMS agreed with the recommendations. (OEI-02-00-00360)

CHILD SUPPORT ENFORCEMENT

OIG has made the detection, investigation and prosecution of absent parents who fail to pay court-ordered child support a priority. OIG continues to work with the Office of Child Support Enforcement (OCSE), DOJ, U.S. Attorneys' Offices, U.S. Marshals Service, and other Federal, State and local partners to develop procedures to expedite the collection of child support and to bring to justice those who willfully disregard their obligations.

Since 1995, OIG has opened 2394 investigations of child support cases nationwide, which have resulted in 812 convictions and court-ordered criminal restitution and settlements of over $42.5 million.*

Task Forces

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

Central to the task forces are the screening units located in each task force region and staffed by analysts and auditors from OIG and OCSE. The units receive child support cases from the States, conduct preinvestigative analyses of

**Please note that in the OIG Semiannual Report covering the period from October 1, 2002, through March 31, 2003, the figure given for convictions (1,727) was stated incorrectly. The number should have been reported as 727.*

these cases through the use of databases, and then forward the cases to the investigative task force units where they are assigned and investigated. The task force approach streamlines the process by which the cases best suited for criminal prosecution are identified, investigated and resolved.

At this point, the task force units have received over 6750 cases from the States. As a result of the work of the task forces, 392 Federal arrests have been executed and 331 individuals sentenced. The total ordered amount of restitution related to Federal investigations is over $17.5 million. There have been 319 arrests at the State level and 292 convictions or civil adjudications to date, resulting in over $12.3 million in restitution being ordered.

Task Force Table

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

Investigations

OIG investigations of child support cases, nationwide, resulted in 85 convictions and court-ordered criminal restitution of over $3.9 million during this period. Examples of the Federal arrests, convictions and sentences for failure to pay child support include the following:

- ***Arizona***—The author of a book that teaches readers how to avoid or reduce child support obligations was sentenced to 16 months in prison and ordered to pay $165,000 in restitution. His book also explains how to make one-self appear poor, disappear completely, and resurface under a new identity. For over 9 years, he used his own vanishing techniques to avoid his obligation.

- ***New Jersey***—A man was sentenced to 6 months home confinement, 5 years probation and ordered to pay $69,000 in restitution. A licensed pharmacist who earned over $50,000 a year, the man owed support for his two children. He also failed to pay support or medical expenses for a third child prior to the child's death.

- ***Iowa***—A man was sentenced to 4 months home confinement, 5 years probation and ordered to pay $35,000 in restitution. Prior to sentencing, he paid $10,000 toward his arrearage of $45,000.

- ***South Dakota***—A woman was sentenced to 6 months home confinement, 5 years supervised probation and ordered to pay $12,000 in restitution. She was indicted in August 2002 after failing to make any support payments since 1998.

- ***Virginia***—A former professional basketball player was sentenced for failure to pay child support in two separate cases. In the first case, he was sentenced to 1 year supervised probation and ordered to pay his remaining restitution of $2,000. In the second case, he was sentenced to 2 years probation and fined $1,000. Since the beginning of the investigation, he has paid almost $58,000 to satisfy both child support arrearages. Although he earned over $685,000 between 1999 and 2002, he had not made any support payments since September 2000.

MISUSE OF ACF GRANT FUNDS

In addition to investigating the misuse of public health grant funds (details page 32), OIG also investigates cases involving the misuse of ACF grant funds. Resolution of charges involving the improper use of these funds occurred in the following examples during this reporting period:

- ***West Virginia***—A former employee of the West Virginia Department of Health and Human Resources was sentenced to 3½ years incarceration and ordered to pay $302,000 in restitution for mail fraud. The employee embezzled more than $302,000 in funds, most of which came from Temporary Assistance for Needy Families grants.

  Also in West Virginia, a former payroll specialist for an HHS grantee was sentenced to 5 months imprisonment and ordered to pay $42,000 in restitution for theft from an organization receiving Federal funds. The employee embezzled funds by writing herself checks from the grantee's Head Start account.

- ***South Dakota***—The director of an HHS grantee that received funds to care for children and their health was ordered to pay $4,000 in restitution for embezzlement and theft from an Indian tribe and Indian tribal organization. The director embezzled program funds by falsifying travel vouchers.

- ***Michigan***—A daycare center administrator was sentenced to 2 years incarceration and ordered to pay $1 million in restitution for mail fraud. The administrator fraudulently used block grant funds provided by TANF and the Child Care and Development Fund intended for operating daycare facilities. The investigation found that several of the daycare centers billed for children who were not in the center when claimed and that one center billed for child care when it was actually closed.

General Oversight

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

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

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

RESULTS ACT ❖❖

The Government Performance and Results Act (GPRA) of 1993 mandates that Federal agencies establish strategic planning and prepare annual performance plans. These plans set measurable goals for the year's accomplishments, and annual reports compare actual performance with those goals. OIG's work focuses on measures related to mission-critical issues and areas at high risk of fraud, waste, and abuse and includes assessments of data collection methods and controls over the systems that produce performance data. An ongoing objective of OIG's audits, inspections, and investigations is to identify performance results and recommend improvements.

OIG's reviews of Medicare fee-for-service payment errors relate directly to assessment of CMS-generated financial performance data. CMS has used OIG's annual estimate of the error rate as a basis for setting performance goals and measuring performance. For FY 2002, when CMS's goal was to reduce the error rate to 5 percent, OIG reported an estimated 6.3-percent rate. Beginning in FY 2003, CMS has assumed responsibility for developing the error rate through Comprehensive Error Rate Testing and the Hospital Payment Monitoring Program, and OIG will assess the validity and reliability of the estimate.

Additional OIG work focuses on programs and activities linked to other HHS strategic goals. For example, numerous reviews are evaluating the effectiveness of the Department's bioterrorism preparedness efforts. The results of these reviews should prove useful in measuring progress toward the HHS goal to enhance the ability of the Nation's public health system to effectively respond to bioterrorism and other public health challenges. To assess the Department's efforts to improve the quality of health care services, OIG plans to review, among other things, hospital quality oversight processes, hospital reporting of restraint-related deaths, and the extent and type of patient safety data available to State medical boards that could be shared with CMS and health care facilities to reduce preventable medical errors. As a final example, OIG has several reviews planned that address the HHS goal to improve the stability and healthy development of our Nation's children and youth. Review areas include the child support enforcement program, Head Start, and the foster care program.

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

FLORIDA PENSION FUND

This review found that during the 3 years ended June 30, 2002, Florida used funds designated as retirement contributions solely to pay pension-related expenses. However, these contributions exceeded the amounts reasonable and necessary to fully fund benefits by about $3 billion ($267 million Federal share). The State attributed the surplus primarily to exceptional investment performance and took several steps to reduce the surplus. However, the State's rate stabilization mechanism, established by statute, prevents the entire surplus from being available for contribution rate reductions or benefit enhancements. OIG believes that the long-term continuation of this surplus violates Federal cost principles.

OIG recommended that the State reduce contribution rates to a level necessary to fully fund pension expenses over the long term and amend, as necessary, its rate stabilization mechanism. As an alternative, the State may repay the $267 million to the Federal Government and identify and repay the Federal share of excess contributions for participating employers not included in OIG's review. State officials generally disagreed with the findings and recommendations. (A-04-02-00012)

INTERNATIONAL MERCHANT PURCHASE AUTHORIZATION CARD PROGRAM ❖❖

This inspection sought to determine whether HHS employees properly used the International Merchant Purchase Authorization Card (IMPAC) and followed HHS guidelines and agency procedures. OIG reviewed agency-specific procedures as well as documentation for 400 randomly-selected IMPAC transactions. The report did not identify any transactions that clearly indicated misuse or purchases converted to personal use. However, 44 percent of all IMPAC trans- actions had either no evidence of approving official review, insufficient purchase documentation, or lacked a recorded object class code. Some cardholders' and approving officials' actions demonstrated a lack of understanding of agency procedures.

OIG recommended that the Office of the Assistant Secretary for Administration and Management (ASAM), working through agency program coordinators, ensure that cardholders and approving officials are in compliance with the established guidelines, develop guidance where none exists, and provide targeted training for cardholders and approving officials. In its response to the

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

Sample Control Weaknesses Increasing the Risk of Improprieties:

Inappropriately open accounts—accounts for 1,390 lost or expired cards remained open ■

Infrequent card usage—790 of 6,823 accounts had no activity during CY 2001 ■

Relationship of cardholders to approving officials—7 accounts have the same person listed as the cardholder and the approving official ■

Span of control of approving officials—19% of approving officials have responsibility for 5 or more accounts ■

Approving official and cardholders not co-located—17% of accounts have approving officials with zip codes different from those of the corresponding cardholders ■

report, ASAM noted that it would work closely with the Office of Management and Budget to improve internal controls highlighted in the report. (OEI-07-02-00510)

NON-FEDERAL AUDITS

OMB Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have an annual organization-wide audit which includes all Federal money they receive. These annual audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of Federal funds. In the second half of FY 2003, OIG's National External Audit Review Center reviewed 918 reports that covered $685.5 billion in audited costs. Federal dollars covered by these audits totaled $198 billion, about $92.2 billion of which was HHS money.

OIG's oversight of non-Federal audit activity not only provides Department managers with assurances about the management of Federal programs but also identifies any significant areas of internal control weakness, noncompliance, and questioned costs that require formal resolution by Federal officials. By taking a proactive stance, OIG identifies entities for high-risk monitoring and alerts program officials to any trends that could indicate problems in HHS programs. In addition, OIG profiles non-Federal audit findings of a particular program or

activity over time to identify systemic problems. As a further enhancement of audit quality, OIG provides training and technical assistance to grantees and the auditing profession.

To rely on the work of non-Federal auditors, OIG maintains a quality control review process which assesses the non-Federal reports received and the audit work that supports selected reports. The non-Federal audit reports reviewed and issued during this reporting period fall into the categories in the box below.

Reports issued:	
Without changes or with minor changes	***779***
With major changes	***95***
With significant inadequacies	***44***
Total	***918***

The 918 reports included recommendations for HHS program officials to take action on cost recoveries totaling $86.6 million, as well as 3,927 recommendations for improving management operations. In addition, these audit reports provided information for 61 special memoranda which identified concerns for increased monitoring by departmental management.

RESOLVING RECOMMENDATIONS

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

In Table 1, "Dollar Value Questioned" costs are those challenged because of violation of law, regulation, grant conditions, etc. "Dollar Value Unsupported" costs are those not supported by adequate documentation. Additional audit recoveries are discussed on page 51.

Table 2 summarizes recommendations that funds be put to better use through cost avoidances, budget savings, etc. These costs are separate from the amount ordered or returned as a result of OIG investigations.

*Table 1: Reports With Questioned Costs**

Reports	*Number of Reports*	*Dollar Value Questioned*	*Dollar Value Unsupported*
Section 1			
For which no management decision had been made by the beginning of the reporting period[1]	474	$1,710,947,000	$251,166,000
Issued during the reporting period	101	$456,243,000	$82,025,000
Total Section 1	**575**	**$2,167,190,000**	**$333,191,000**
Section 2			
For which management decision was made during the reporting period[2,3,4]			
Disallowed costs		$160,274,000	$4,400,000
Costs not disallowed		$18,035,000	$6,900,000
Total Section 2	**85**	**$178,309,000**	**$11,300,000**
Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	**490**	**$1,988,881,000**	**$321,891,000**
Section 4			
For which no management decision was made within 6 months of issuance[5]	**392**	**$1,519,932,000**	**$151,993,200**

*Details concerning footnotes can be found in Appendix D.

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

Reports	*Number of Reports*	*Dollar Value*
Section 1		
For which no management decision had been made by the beginning of reporting period[1]	57	$9,163,001,000
Issued during the reporting period	10	$321,171,000
Total Section 1	**67**	**$9,484,172,000**
Section 2		
For which management decision was made during the reporting period		
Value of recommendations that were agreed to by management		
Based on proposed management action	4	$531,993,000
Based on proposed legislative action	0	$0
Value of recommendations that were not agreed to by management	0	$0
Total Section 2	**4**	**$531,993,000**
Section 3		
For which no management decision had been made by the end of the reporting period[2]		
Total Section 1 minus Total Section 2	**63**	**$8,952,179,000**

*Details concerning footnotes can be found in Appendix D.

LEGISLATIVE AND REGULATORY REVIEW AND DEVELOPMENT

Review Functions

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

Development Functions

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

- Published proposed rulemaking designed to clarify the Secretary's authority to exclude providers and suppliers from Medicare and Medicaid that charge the programs substantially in excess of their usual charges to other customers. The proposed rule specifically amends OIG exclusion regulations at 42 CFR § 1001 by setting forth definitions for the terms "substantially in excess" and "usual charges," and by clarifying the "good cause" exception now contained in the regulations.

- Continued to develop final rulemaking designed to expand the existing safe harbor for certain waivers of beneficiary coinsurance and deductible amounts to benefit the policyholders of Medicare SELECT supplemental insurance. OIG proposed rulemaking was published in the *Federal Register* on September 25, 2002 (67 FR 60202).

In addition, during this period, OIG continued to develop and publish several *Federal Register* notices that reflect OIG policy and procedures with regard to compliance program guidance, Special Fraud Alerts, Special Advisory Bulletins and continued OIG regulations development. Specifically, during this period, OIG:

- Published final Compliance Program Guidance for Pharmaceutical Manufacturers. Through this final guidance, OIG set forth its general views on the value and fundamental principles of compliance programs for pharmaceutical manufacturers and the specific elements that they should consider when developing and implementing a compliance initiative. (May 5, 2003; 68 FR 23731)

- Developed and published a new OIG Special Advisory Bulletin addressing contractual joint venture arrangements for the provision of items and services previously identified as suspect in an earlier Special Fraud Alert on Joint Venture Arrangements. (April 30, 2003; 68 FR 23148)

- In accordance with the Department's Healthcare Integrity and Protection Data Bank regulations, published a *Federal Register* notice setting forth an adjustment in the user fees charged for queries submitted by authorized entities to access the data bank. (April 22, 2003; 68 FR 19838)

- In accordance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, published a *Federal Register* notice concerning information collection activities related to the recertification application and annual reporting requirements by State Medicaid Fraud Control Units. (March 26, 2003; 68 FR 14668)

- In compliance with requirements established by the Homeland Security Act of 2002, published revisions to OIG's Privacy Act Systems of Records, amending both OIG's "Criminal Investigative Files" and "Civil and Administrative Investigative Files"—to add a new routine use provision allowing for the disclosure of information to authorized officials within the PCIE who are charged with the responsibility of conducting assessment reviews of investigative operations. (June 19, 2003; 68 FR 36827)

- Developed and published a *Federal Register* notice soliciting input and recommendations for developing OIG compliance program guidance for recipients of National Institutes of Health research grants. (September 5, 2003; 68 FR 52783)

- Continued development of draft revised OIG compliance program guidance for the hospital industry to provide additional recommendations on best practices for establishing an effective compliance program in the hospital setting.

- Continued development of an OIG *Federal Register* notice setting forth revised standards for assessing the performance of State Medicaid Fraud Control Units. These revised standards will be used in the certification and recertification of each unit and to determine if a unit is effectively and efficiently carrying out its duties and responsibilities.

EMPLOYEE FRAUD AND MISCONDUCT

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

➤ ***Montana***—As the result of a joint investigation with the Department of Interior, OIG, a former maintenance leader/supervisor for the Indian Health Service (IHS), a former accounting technician for the Bureau of Indian Affairs (BIA), and a former BIA supervisor were sentenced in Montana this reporting period. The two participated in a scheme involving Government contractors and the misuse of government-issued credit cards. As part of the scheme, IHS and BIA employees accepted kickbacks in exchange for giving preferential treatment to, and purchasing unnecessary and overpriced supplies and services from, two Government contractors. Government credit card purchases were also structured by employees to avoid the individual credit card daily purchase limit and to eliminate the need to obtain competitive bids. To date, a total of two civilian Government contractors, three former IHS employees, and two BIA employees have been sentenced in connection with the investigation. In addition to the seven people already convicted in this case, a BIA employee was charged with accepting a bribe as a public official and arrested in South Dakota, and a ninth BIA employee was charged in Wyoming with receipt of a gratuity by a public official. IHS also took administrative action against six employees due to their lack of oversight in regard to purchasing or for misuse of a Government credit card.

➤ ***Maryland***—A former HHS file room clerk was sentenced to 1 year in prison and ordered to pay $79,000 in restitution for conspiracy to commit fraud in connection with identification information. The employee conspired with her boyfriend to assume the identities of numerous HHS

employees by using their personal information to apply for and obtain credit at various merchants. The boyfriend was also sentenced for his role in the scheme.

- ***New Mexico***—An IHS procurement officer was ordered to pay $10,000 in restitution for embezzlement. During a 7-month period, the employee used her Government credit card to make purchases for personal gain.

- ***South Dakota***—Two former IHS employees were each ordered to pay $3,000 in restitution for false claims and aiding and abetting in the submission of false claims. The two submitted travel vouchers claiming mileage for a personally owned vehicle and for individual lodging expenses when they actually traveled together in a Government-owned vehicle and shared lodging.

ADDITIONAL AUDIT RECOVERIES

Based on OIG recommendations, the Department realized $31.8 million in additional recoveries, beyond the disallowances reported in Table 1, during this semiannual period. As a result of an audit of Mutual of Omaha's oversight of Medicare acute care providers receiving periodic interim payments, CMS issued a memorandum to all fiscal intermediaries summarizing OIG's findings and requiring them to determine whether cost report settlements were calculated properly. In response, the fiscal intermediaries collected an additional $31.8 million in overpayments. (A-07-01-02616)

INVESTIGATIVE PROSECUTIONS

During this semiannual reporting period, OIG investigations resulted in 256 successful criminal actions. Also during this period, 740 cases were presented for criminal prosecution to DOJ and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 285 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over $801 million was ordered or returned as a result of OIG investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.

Appendices

Appendix A
Savings Achieved through Policy and Procedural Changes Resulting from Audits, Investigations and Inspections
April 1, 2003, through September 30, 2003

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

Legislative savings are annualized amounts based on Congressional Budget Office (CBO) estimates consistent with CBO savings. In keeping with OIG policy, savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect CBO estimates for related provisions of the Balanced Budget Refinement Act (BBRA) of 1999 and BIPA of 2000. Administrative savings are calculated by OIG using departmental figures, where available, for the year in which the change is effected or for multiple years, if applicable.

Total savings from these sources amount to $9,981.8 million for this period.

OIG Recommendation	*Implementing Action*	*Savings (millions)*
Centers for Medicare & Medicare Services		
Medicare Home Health Payments: CMS should restructure the payment system for home health care to eliminate inappropriate incentives which unnecessarily increase cost and utilization; prevent unscrupulous providers from gaining entry into the program; and improve program controls, such as eligibility deter minations and approval of plans of care and services. (OEI-04-93-00260; OEI-09-96-00110; A-04-96-02121)	Chapter I of Subtitle G of the BBA of 1997 (as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998), which pertains to home health benefits, addresses OIG's concerns regarding the need to restructure and control the payment system for these services. For example, it mandates that a prospective payment system be developed and that the total payments in fiscal year (FY) 2000 be equal to the amount that would have been paid under the prior system if cost limits were reduced by 15 percent. It also eliminated periodic interim payments to home health agencies.	$5,340
Medicare Indirect Medical Education: CMS should base the indirect medical education adjustment factor on the level support by CMS's empirical data. (A-07-88-00111)	Section 4621 of the BBA (as amended by the BBRA of 1999) reduced the indirect teaching adjustment factor from 7.7 percent in FY 1997 to 7.0 percent in FY 1998; 6.5 percent in FY 1999; 6.0 percent in FY 2000; and 5.5 percent in FY 2001 and thereafter.	$1,990

Medicaid Enhanced Payments to Local Providers: CMS should reconsider capping the aggregate upper payment limit at 100 percent for all facilities rather than the 150 percent allowance for non-State-owned Government hospitals. (A-03-00-00216))	On January 18, 2002, CMS issued a final rule that modified the Medicaid upper payment limit (UPL) provisions to remove the 150 percent UPL for services furnished by non-State government-owned or operated hospitals. The rule became effective on May 15, 2002.	$1,300
Hospital Outpatient Policy: Congressionally mandated reductions in hospital costs should be extended. Hospitals should limit outpatient department facility fees to the applicable ambulatory surgical center (ASC) rate or reduce payments for outpatient department services to bring them in line with ASC payments. (A-14-89-00221; A-09-91-00070; OEI-85-09-0046; OEI-09-88-01003)	Section 1351 of the Omnibus Budget Reconciliation Act (OBRA) of 1993 mandated a reduction of 10 percent for outpatient capital costs. Sections 4521-4523 of the BBA of 1997 eliminated formula-driven overpayments in FY 1998, extended reductions in payments for costs of hospital outpatient services, and established a prospective payment system for hospital outpatient services beginning FY 1999.	$640
Graduate Medical Education Payments: CMS should reevaluate Medicare's policy of paying graduate medical education (GME) costs for all physician specialities and should consider submitting legislation to reduce Medicare's investment in GME to arrive at a more representative and accurate sharing of GME costs. (A-06-92-00020)	Sections 4623 and 4626 of the BBA provided for limits in the number of residents counted for purposes of Medicare GME payments and offered payments for voluntary reductions in the number of residents to limit Medicare's share of GME costs.	$390
Hospice Certification: CMS should restructure hospice benefit policies to curb inappropriate growth in the program, particularly with regard to the fourth benefit period. (OEI-05-95-00250; A-05-96-00023)	Sections 4441-4449 of the BBA contained provisions to control hospice payments and practices, such as replacing the current unlimited fourth benefit period with an unlimited number of 60-day benefit periods (each requiring recertification).	$80
Fraud and Abuse Provisions of the Balanced Budget Act: CMS should require durable medical equipment (DME) suppliers and home health agencies to provide Social Security numbers and employee identification numbers (OEI-04-96-00240; OEI-09-96-00110); refuse to enter into a provider agreement with any home health agency whose owners *continued—*	Subtitle D of the BBA contained a number of provisions that corresponded to and were supported by OIG work. For example, the BBA authorized the Secretary to collect Social Security numbers and employer identification numbers from entities under Medicare, Medicaid and Title V; authorized the Secretary to refuse to enter into contracts with physicians or suppliers that have been convicted of felonies; authorized the exclusion of entities owned or controlled by the family or household members of excluded individuals; authorized CMS to	$70

Fraud and Abuse Provisions of the Balanced Budget Act (continued): or principals have prior criminal records or are the relatives of owners of a provider that had defrauded the Medicare program (OEI-09-96-00110); apply "inherent reasonableness" provisions when assessing the appropriateness of Medicare payments (OEI-03-94-00392); authorize competitive bidding as a means of providing Medicare services (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230); and require DME suppliers and home health agencies to post surety bonds as a condition of participation. (OEI-04-96-00240; OEI-09-96-00110). Also, clarify which general and administrative and fringe benefit costs at hospitals and home health agencies are related to patient care; specifically, distinguish between employee benefits and/or perquisites to entertainment and patient care, and specify that cost of entertainment, goods or services for personal use, alcohol, all fines and penalties and associated interest, dues, and membership costs associated with civic and community organizations are not allowable. (A-03-92-00017; A-04-93-02067)	make inherent reasonableness adjustments up to 15 percent to all Part B services except physician services; authorized up to five demonstration projects to be completed by December 31, 2002, (one must be oxygen and oxygen equipment) which can have multiple sites, to allow competitive bidding; and prohibited "reasonable cost" payments for items such as entertainment, gifts and donations, education expenses, and personal use of automobiles. The BBA also required DME suppliers, home health agencies, and others to post surety bonds of a minimum of $50,000.	
Hospital Sales: CMS should eliminate the requirement that Medicare adjust for gains and losses when hospitals undergo changes of ownership. (OEI-03-96-00170)	Section 4404 of the BBA eliminated the requirement that Medicare make adjustments by setting the Medicare capital asset sales price equal to the net book value.	$60
Rural Health Clinics: The oversight and functioning of the current cost reimbursement system should be improved by implementing caps on provider-based rural health clinics and allowing States to do so, or finding other ways to make reimbursement between provider-based and independent clinics more equitable. In addition, the certification process should be modified to increase State involvement and ensure more strategic *continued—*	Section 4205 of the BBA extended the per-visit payment limits to provider-based clinics and stipulated that the shortage area requirements designation be reviewed triennially.	$60

Rural Health Clinics (continued): placement of the clinics. Recertification should be required within a specific time limit (for example, 5 years), applying new criteria to document the need and impact on access. (OEI-05-94-00040)		
Medicare Disproportionate Share: The disproportionate share adjustment should be reduced, if not eliminated, without redistribution of the funds to prospective payment system hospitals. (A-04-87-01004)	Section 4403 of the BBA provided for the reduction of disproportionate share payments that hospitals would otherwise receive by 1 percent in FY 1998, 2 percent in FY 1999, 3 percent in FY 2000, 4 percent in FY 2001, 5 percent in FY 2002, and 0 percent thereafter.	$20
Payments for Ambulance Services: CMS should seek legislative authority to develop a fee schedule for ambulance transportation and examine the inherent reasonableness of current allowable charges. (OEI-05-95-00300)	Section 4531 of the BBA of 1997 made interim reductions in ambulance payments by limiting the allowed rate of increase and mandated the establishment of a fee schedule by January 1, 2000. Such fee schedule is to be set so that aggregate payments are reduced by 1 percent.	$10

Administration for Children and Families

Availability of Health Insurance for Title IV-D Children: Connecticut should either implement policies and procedures to require noncustodial parents to pay all or part of the Medicaid costs for their dependent children or establish a state-wide health insurance plan that provides reasonably priced comprehensive coverage for children, with costs paid by noncustodial parents. (A-01-97-02506)	The BBA of 1997 established Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), to enhance Medicaid coverage provided to children and allow States to create insurance options for families who exceed Medicaid resource and income limits. Connecticut received CMS approval in April 1998 to initiate a child health program. Under Connecticut law, applicants include noncustodial parents under court orders to provide health insurance.	$5.7

Various Operating Divisions

Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.	The operating division takes action, based on the results of the OIG investigation, to suspend or terminate payments to the offending individual or entity.	$16.1

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

This schedule represents potential annual savings or one-time recoveries which could be realized if Office of Inspector General (OIG) recommendations were enacted by the Congress and the Administration through legislative or regulatory action, or policy determinations by management. (In many cases, these recommendations are beyond the direct authority of the departmental operating division.) It should be noted, however, that the Congress normally develops savings over a budget cycle which results in far greater dollar impact statements. Savings are based on preliminary OIG estimates and reflect economic assumptions which are subject to change. The magnitude of the savings may also increase or decrease as some of the proposals could have interactive effects if enacted together.

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

OIG Recommendation	*Status*	*Savings (millions)*
Centers for Medicare & Medicaid Services		
Excessive Medicare Payments for Prescription Drugs: CMS should examine its Medicare drug reimbursement methodologies. (OEI-03-00-00310; OEI-03-97-00292; OEI-03-97-00293; OEI-03-97-00390; OEI-03-95-00420; OEI-03-94-00390)	CMS concurred; it has attempted administrative remedies to lower payments for some drugs using "inherent reasonableness," but Congress suspended use of this authority pending issuance of Federal rule-making. In addition, legislation passed on December 21, 2002, requires GAO to complete a comprehensive drug-pricing study before CMS can begin using average wholesale pricing as a way to lower prices for certain drugs.	$1,900
Medicare Coverage of State and Local Government Employees: CMS should require Medicare coverage and hospital insurance contributions for all State and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, CMS should seek legislation making Medicare the secondary payer for retirees of exempt State and local government agencies. (A-09-88-00072)	CMS agreed with the recommendation to mandate Medicare coverage for all State and local government employees. However, this proposal was not included in the President's FY 2003 budget. CMS did not agree with the recommendation to make Medicare the secondary payer.	$1,559
Clinical Laboratory Tests: CMS should develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (A-09-89-00031; A-09-93-00056)	CMS initially agreed with the first recommendation but not the second. The BBA required the Secretary to request that the Institute of Medicine study Part B laboratory test payments. CMS may use the results to develop new payment methodologies.	$1,130*

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

Hospital Capital Costs: CMS should determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to the Congress. (A-09-91-00070; A-14-93-00380)	CMS did not agree with the recommendation. Although the BBA of 1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs. The President's FY 2001 budget would have reduced capital payments and saved $630 million in FY 2001 through FY 2005.	$820
Medicare Payments for Mental Health Services: CMS should ensure mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance of mental health services. (OEI-02-99-00140; OEI-03-99-00130; A-04-98-02145; A-01-99-00507; A-01-99-00530)	CMS concurred and has initiated some efforts, particularly regarding community mental health centers.	$676
Payment Policy for Medicare Bad Debts: OIG presented four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. CMS should seek legislative authority to further modify bad debt policies. (A-14-90-00339)	CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act (BIPA) of 2000 subsequently increased bad debt reimbursement. However, additional legislative changes are needed to implement the modifications that OIG recommended.	$340
Cost Effectiveness of "Pay and Chase" Methods for Medicaid Pharmacy Third-Party Liability Recoveries: CMS should determine whether States' cost-avoidance waivers for pharmacy claims are meeting the cost-effectiveness criterion. CMS can ascertain cost effectiveness by requiring States to track dollars that they pay and chase and the amounts that they recover. CMS should also review States' policies to determine if they are paying and chasing pharmacy claims without waivers. (OEI-03-00-00030)	CMS agreed that States' cost-avoidance waivers should be reexamined and is directing the regional offices to reevaluate the waivers and determine if States are paying and chasing claims without waivers. In addition, CMS is working with States that currently cost-avoid pharmacy claims and is developing guidance to assist them in implementing cost avoidance.	$185
Graduate Medical Education: CMS should revise the regulations to remove from a hospital's allowable graduate medical education (GME) base-year costs any cost center with little or no Medicare utilization and submit a legislative *continued—*	CMS did not concur with the recommendations. Although the BBA of 1997 and the BBRA of 1999 contained provisions to slow the growth in Medicare spending on GME, OIG believes that	$157.3

Graduate Medical Education (continued): proposal to compute Medicare's percentage of participation under the former, more comprehensive system. (A-06-92-00020)	its recommendations should be implemented and that further savings can be achieved.	
Medicaid Reimbursement Methodology for HIV/AIDS Drugs: CMS should review the current reimbursement methodology and work with States to more accurately estimate pharmacy acquisition costs for 16 HIV/AIDS drugs examined and initiate a review of Medicaid rebates for them. (OEI-05-99-00611)	CMS no longer believes the recommended change is necessary and believes that reimbursement changes will occur through revised AWPs, based on the President's budget proposal for a legislative change that would base the Medicaid drug rebate on the difference between AWP and the best price for a drug.	$140
Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (A-06-94-00039)	Disagreeing with the recommendation, CMS believes that savings will be achieved through the President's budget proposal to enact a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug.	$123
Medical Equipment/Supply Claims Lacking Valid, Active UPINs: CMS should create edits to identify medical equipment and supply claims that do not have a valid and active unique physician identification number (UPIN) listed for the ordering physician. (OEI-03-01-00110)	CMS concurred. The agency planned to implement an edit to reject claims listing a deceased physician's UPIN beginning in April 2002 and later expand this to include all inactive and invalid UPINs.	$91
Inpatient Psychiatric Care Limits: CMS should develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services and apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (A-06-86-62045)	CMS agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.	$47.6
Medicare Orthotics: CMS should take action to improve Medicare billing for orthotic devices. CMS should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-95-00380; OEI-02-99-00120; OEI-02-99-00121)	CMS generally concurred with OIG's original recommendations. The agency is working on a proposed rule regarding orthotics and intends to put in place standards for custom orthotics.	$43
Reimbursement for Hospital Beds: CMS should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include the elimination of the *continued—*	CMS concurred and is considering options to determine the best approach to achieve a fair price for hospital beds. The agency is examining payment allowances and method-	$40

Reimbursement for Hospital Beds (continued): first 3 months of rental. (A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)	ologies at other payers and is reviewing data to determine if Medicare payments are excessive. The BIPA of 2000 increased DME payments by 3.7 percent for 2001.	
Expansion of the DRG Payment Window: CMS should consider proposing legislation to expand the DRG payment window to include admission-related services rendered up to 14 days before an inpatient admission. (A-01-02-00503)	CMS agreed but cautioned that such action could increase beneficiaries' health risks. OIG acknowledges the need to assess such risks before proposing a legislative change.	$37
End Stage Renal Disease Payment Rates: CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (A-14-90-00215)	CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the BBA of 1997 required the Secretary to audit the cost reports of each dialysis provider at least once every 3 years. The BBRA of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999. The BIPA of 2000 increased the rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable. CMS has reported on the feasibility phase of the project to develop a composite rate. Currently, work is focused on developing options for a bundled composite rate.	$22*
Respiratory Assist Devices With a Back-Up Rate: CMS should reclassify bi-level respiratory assist devices with a back-up rate from the "frequent and substantial servicing" category to the "capped rental" category under the durable medical device benefit. (OEI-07-99-00440)	CMS concurred.	$11.5
Medicare Claims for Railroad Retirement Beneficiaries: CMS should discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (A-14-90-02528)	The President's FY 2003 budget did not include such a proposal.	$9.1

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

Indirect Medical Education: CMS should reduce the indirect medical education (IME) adjustment factor to the level supported by CMS's empirical data and initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (A-07-88-00111)	CMS agreed with the recommendation, and the BBA of 1997, as amended by the BBRA of 1999, reduced the IME adjustment to 5.5 percent in 2002 and thereafter. OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.	TBD**
Medicare Secondary Payer—End Stage Renal Disease Time Limit: CMS should extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (A-10-86-62016)	CMS was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare based on age or disability. At that point, Medicare would become the primary payer.	TBD
Home Health Agencies: CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-04-93-00262; OEI-04-93-0026; OEI-12-94-00180; OEI-02-94-00170; A-04-95-01103; A-04-95-01104; A-04-94-02087; A-04-94-02078; A-04-96-02121; A-04-97-01169; A-04-97-01166; A-04-97-01170; A-04-99-01195)	Although the BBA of 1997 included provisions to restructure home health benefits, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to the BBA, OIG's four-State review found that unallowable services continued to be provided because of inadequate physician involvement. While agreeing in principle, CMS said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. Also, CMS provided additional payments for physician care plan oversight and education for physicians and beneficiaries.	TBD
Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: CMS should seek legislation that would require participating manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about $1.15 billion in *continued—*	CMS agreed to pursue a change in the rebate program similar to that recommended. The President's FY 2003 budget proposed a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug.	TBD

***To be determined.*

Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement (continued): additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-96. (A-06-97-00052)		

Various Operating Divisions

Medicare Rates for Indian Health Service Contracted Health Services: The Indian Health Service (IHS) should revise its legislative proposal to incorporate OIG's updated savings figures and should identify elements to be included in the implementing regulations. Also, IHS should continue to pursue the most favorable rates at hospitals that have previously offered less than Medicare rates and should strategically identify and pursue other opportunities where lower rates may be negotiated. (A-15-97-50001)	IHS concurred with OIG's recommendations. However, the proposal was not included in the President's FY 2003 budget.	$8.2
Recharge Center Costs: The Assistant Secretary for Administration and Management should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (A-09-96-04003)	The Department concurred and is working with OMB on a revision to A-21. The proposed revision, which was published in the *Federal Register* in August 2002, would require that adjustments to a recharge center's billing rate take into account overrecoveries and/or underrecoveries from previous periods. Rate adjustments would be required at least every 2 years. The final rule was expected to be issued in FY 2003.	$1

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

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

More detailed information may be found in OIG's *Orange Book* which can be accessed on the Internet at http://oig.hhs.gov.

OIG Recommendation	***Status***
Centers for Medicare & Medicaid Services	
Accountability Over Billing and Collection of Medicaid Drug Rebates: CMS should ensure that States implement accounting and internal control systems in accordance with Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current, and complete disclosure of drug rebate transactions and provide CMS with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (A-06-92-00029)	CMS concurred with the recommendation and set up a reporting mechanism to capture rebate information. The agency still needs to ensure that States establish adequate accounting and internal control systems to obtain reliable information.
Fairly Presenting the Medicare Accounts Receivable Balance: CMS should require Medicare contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (A-17-95-00096; A-17-97-00097; A-17-98-00098; A-17-00-00500; A-17-00-02001; A-17-01-02001; A-17-02-02002)	CMS hired consultants to assist in validating accounts receivable reported by Medicare contractors and provided comprehensive instructions to contractors. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.
Safeguards Over Medicaid Managed Care Programs: CMS should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform State oversight. (A-03-93-00200)	Although CMS initially concurred with some specific recommendations, the agency believes that section 4706 of the BBA of 1997 sets forth congressional expectations on this issue in specifically requiring managed care organizations to meet the solvency standards established by the State for private health maintenance organizations.
Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). CMS should also develop a more specific policy for calculating AMP which would protect the interests of the Government and which would be equitable to the manufacturers. (A-06-91-00092)	CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. OIG disagrees because the rebate law and agreements defined AMP but did not provide specific written methodology for computing AMP.

Accuracy of Carrier Payment Data: CMS should conduct a review of carriers' claims processing data to examine the scheduled date of payment entered on claims sent to the Common Working File (CWF). If there is no correlation between the claims payment date variable and the actual date of payment, CMS should define what data should be entered into this field and how it should be calculated, and/or revise the current variable definition to clarify for National Claims History data users that the scheduled date of payment is not an accurate reflection of the actual claim payment date. CMS should also review the carriers' claims processing data to determine the accuracy of the information contained in the CROWD system. (OEI-03-00-00350)	CMS stated that a review is under way to compare data contained in the National Claims History File with data at the carrier level. In addition, CMS has approved two new edits which will enforce the payment floor standards on claims sent to the CWF.
Duplicate Payments for the Same Service by Multiple Carriers: CMS should revise CWF edits to detect and deny duplicate billings to individual carriers or to more than one carrier, or increase post-payment reviews if such edits are determined not to be cost effective. (OEI-03-00-00090; OEI-03-00-00091)	CMS concurred with OIG's recommendations and will re-examine existing criteria regarding duplicate editing in the CWF system to determine the cost effectiveness of including the carrier number in the match criteria. CMS entered a contract to study duplicate billing.
Inappropriate Payments for Blood Glucose Test Strips: CMS should alert suppliers of the importance of properly completed documentation to support their claims for test strips; require suppliers to indicate actual and accurate "start" and "end" dates on claim forms; promote supplier concurrence and cooperation with OIG's recently issued compliance guidelines; and advise beneficiaries to report any instances of fraudulent or abusive practices involving their home blood glucose monitors, test strips, or related supplies to their DMERCs. (OEI-03-98-00230)	CMS concurred with the recommendations and noted a number of initiatives that have reduced the incidence of improper payments in recent years.
Educating Beneficiaries on Reducing Financial Liability for DME: CMS should educate beneficiaries on ways to reduce financial liability for medical equipment and supplies and re-evaluate Medicare fee schedules for ostomy supplies. (OEI-07-99-00510)	CMS concurred with OIG's recommendations and has undertaken a number of efforts to increase beneficiary education and awareness about the consequences of assigned and nonassigned claims.
Resident Assessment Instruments: CMS should more clearly define minimum data set (MDS) elements and work with States to train nursing home staff. OIG also recommend that CMS establish an audit trail to validate the 108 MDS elements that affect facility reimbursement by Medicare. (OEI-02-99-00040; OEI-02-99-0041)	CMS generally concurred with OIG's recommendations for improved data definitions and training, but did not concur with the recommendation to establish an audit trail.

Assessments of Mental Illness: OIG recommended that CMS work with States to improve the assessment of persons with serious mental illness and use survey and certification to monitor compliance. OIG also recommended that CMS define specialized services that are to be provided by the State to nursing home residents with mental illness. (OEI-05-99-00700)	CMS concurred with most of OIG's recommendations and has made revisions to its training curriculum for nursing home surveyors.
Nursing Home Residents With Serious Mental Illness: CMS should improve the quality and usefulness of its data sources by requiring the use of a unique provider number across systems, requiring reporting of resident data by age and diagnosis, and encouraging States to use these data in demonstrating their progress in placing disabled persons in the most integrated settings. OIG also recommends training to improve data collection and accurate coding. (OEI-05-99-00701)	Except for reporting MDS records by primary, secondary, and tertiary diagnoses, CMS concurred with most of OIG's recommendations. CMS does not feel that adding space to the MDS to record diagnoses would solve the problem.
Payments for Mental Health Services: CMS should promote provider awareness of documentation and medical necessity requirements, develop a comprehensive list of psychological testing tools that can be correctly billed, target problematic services for pre-payment edits or post-payment medical review, and encourage carriers to take advantage of the MDS, especially for its assessment of patient cognitive level. (OEI-03-99-00130; OEI-02-99-00140)	CMS generally concurred with the recommendations and plans to explore a variety of educational efforts and will refer the reports to the carrier clinical workgroup on psychiatric services. Carriers will conduct data analysis of psychological testing and psychotherapy claims and will conduct medical review, if indicated.
Organ Donation: CMS should revise the Medicare conditions for coverage for Organ Procurement Organizations (OPOs) to make them more accountable for implementing the new donation rule and require OPOs to provide hospital-specific data on referrals and on organ recovery. HRSA should require that OPOs submit hospital-specific data on referrals and on organ recovery and support demonstration projects on how to effectively train and make use of designated requestors. (OEI-01-99-00020)	CMS concurred with the recommendations and indicated it will explore ways in which additional data can be used to assess OPO effectiveness and hospital compliance with the donation rule. HRSA also concurred with the recommendations.

Various Public Health Agencies

Oversight of Tissue Banking: FDA should expedite publication of its regulatory agenda requiring registration of tissue banks, enhanced donor suitability screening and testing the use of good tissue practices. FDA should set a realistic, yet aggressive date by which it would complete an initial *continued—*	The Deputy Secretary concurred that FDA should expedite its planned rulemaking activities related to tissues, specifically the final rule to require registration of tissue banks. The Department also found "considerable merit" in OIG's recommendation for an intensified inspection program directed towards entities

Oversight of Tissue Banking (continued): inspection of all tissue banks. FDA should determine the appropriate minimum cycle for tissue bank inspections, and work with States and professional associations to determine in what areas oversight activities could be coordinated. (OEI-01-00-00441)	that procure, process, and store human tissues. In congressional testimony, FDA said that all three of the proposed rules have been published, and one rule (Establishment Registering and Listing) was finalized. FDA also worked to inspect all 36 identified, uninspected tissue banks.
Effectiveness of FDA's Adverse Event Reporting System for Dietary Supplements: OIG recommends that FDA (1) facilitate greater detection of adverse events by requiring dietary supplement manufacturers to report serious events to FDA for some products, (2) obtain more information on adverse event reports by requiring manufacturers to register themselves and their products with FDA, (3) notify manufacturers when FDA receives a serious adverse event report and develop a new computer database to track and analyze adverse event reports, (4) expedite the development and implementation of good manufacturing practices for dietary supplement manufacturers, and (5) disclose more useful information to the public about dietary supplement adverse events. (OEI-01-00-00180)	FDA agreed with the majority of OIG's recommendations and has taken several important steps to implement them. In June 2003, FDA implemented a new adverse event reporting system called the Center for Food Safety and Applied Nutrition (CFSAN) Adverse Events Reporting System (CAERS). The CAERS replaces the old system, and FDA will use it to identify potential public health issues associated with the use of a particular product. FDA now notifies manufacturers of a receipt an adverse event alleged to be caused by their product. And in March 2003, FDA published proposed good manufacturing practices for dietary supplements.
Protection for Research Subjects in Foreign Clinical Trials: FDA should examine ways to obtain more information about the performance of non-U.S. Institutional Review Boards (IRBs) and help those inexperienced IRBs build their capacities; encourage all non-U.S. investigators participating in research to sign attestations upholding human subject protections; and develop a database to track the growth and location of foreign research. OHRP should exert leadership in developing strategies to ensure adequate human subject protections for non-U.S. clinical trials funded by the Federal Government and those that contribute data to new drug applications. (OEI-01-00-00190)	FDA supported OIG's recommendations, but noted that in most cases it did not have the resources to implement the recommendations. OHRP concurs with the recommendations and emphasized that its new Office of International Activities "will serve as a focal point and coordinating center" for the Department's efforts to improve human subject protection. FDA has also contributed to international guidance, standards-development, and training through World Health Organization, Pan American Health Organization, and several foreign regulatory authorities.
Managed Care Organizations Reporting to the National Practitioner Data Bank: The Agency for Healthcare Research and Quality should devote attention to the kind of educational and remedial efforts that could be directed to practitioners who have been experiencing performance problems. HRSA should conduct an outreach program to inform managed care organizations of their reporting responsibilities, and CMS should examine its practitioner monitoring systems. (OEI-01-99-00690)	HRSA awarded a contract to PricewaterhouseCoopers to look at the feasibility study for assessing compliance with the NPDB reporting requirements. The feasibility study addresses reporting by both hospitals and managed care organizations.

Administration for Children and Families

Child Support Orders for Low-Income Noncustodial Parents: ACF's Office of Child Support Enforcement should work with States to emphasize parental responsibility and improve the ability of low-income noncustodial parents to meet their obligations. ACF should facilitate and support State experiments to test the payment effects of using various periods of retroactivity in determining the amount of support owed; facilitate and support State experiences to test negotiating child support debt owed to the States in exchange for improved payment compliance. (OEI-05-99-00391)	ACF is helping 10 States test approaches to serving young, never-married fathers who may have obstacles to employment and who do not have a child support order. ACF has granted a contract to determine how computerized income data can be used by local child support offices to independently verify the income of noncustodial parents and be used in the establishment or modification of child support orders where income documentation or verification is lacking or incomplete.

General Oversight

Cost Principles for Federally Sponsored Research Activities: The Department should modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (A-01-92-01528)	The Department circulated several draft iterations of the hospital cost principles to internal users for comment. Many of the policies in the outdated principles have been incorporated and updated in the draft regulation. The target date for issuing the draft regulation as a notice of proposed rulemaking was no later than September 30, 2002. Once issued in final, revised principles were to be issued.

Appendix D
Notes to Tables 1 and 2

Notes to Table 1

[1]The opening balance was adjusted upward $89 million.

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

CIN: A-06-00-00026 Review of LA Compliance With Medicaid Hospital Specific: Documentation supporting the $4,150,405 in LSU Medical School overhead costs was submitted.

CIN: A-02-01-65217 Puerto Rico Dept of the Family: The Department of the Family (DOF) requested a reconsideration of our disallowance. The DOF auditors performed a review of the delegate agencies and provided the Regional Office with documentation to support the findings in the amount of $295,070.

Not detailed are revisions to previously disallowed management decisions totaling $396,215.

[3]Included are management decisions to disallow $61.1 million that was identified in non-Federal audit reports.

[4]During this reporting period, DCAA did not issue reports with monetary recommendations.

[5]A.

Due to administrative delays, many of which are beyond management control, resolution of the following 392 audits was not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

CIN: A-04-00-02171	REV AL MEDICAID INTERGOVERNMENTAL TRANSFERS-HOSP ENHANC, MAY 2001, $236,983,528
CIN: A-06-00-00041	INCORRECTLY REPORTED PPS TRANSFERS-CMS/OIG PROJECT, NOVEMBER 2001, $163,900,000
CIN: A-06-00-00056	MEDICAID DRUGS-REVIEW OF REPACKAGED DRUGS EX FROM, MARCH 2001, $108,000,000
CIN: A-04-99-05561	AUDIT ADMIN COST PROPOSALS FY95-98, BC/BS FL, JAX, JULY 2002, $101,671,328
CIN: A-04-00-01220	IMPLE MEDICARE'S POSTACUTE CARE TRANSFER POLICY, OCTOBER 2001, $52,311,082
CIN: A-04-98-00123	REVIEW FOSTER CARE PAYMENTS-CHILD CARE IN NC, APRIL 2001, $48,183,445
CIN: A-01-00-00538	NATIONAL IDENTIFICATION OF SNF CONSOLIDATED BILLNG, JUNE 2001, $47,633,686
CIN: A-07-01-02086	CARMICHAEL CPA REPORT- GALIC MEDICARE ADMIN COSTS, APRIL 2002, $42,481,466
CIN: A-05-02-00083	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT MUTUAL OF OMAHA, MARCH 2003, $41,500,000
CIN: A-07-01-02093	MISSOURI DSH - UNALLOWABLE COSTS, AUGUST 2002, $36,200,000
CIN: A-01-00-00509	M/C PART B PAYMENTS FOR DME PROVIDED TO SNF PATIENTS, JULY 2001, $35,000,000
CIN: A-04-00-65030	STATE OF SOUTH CAROLINA, JULY 2000, $31,637,429
CIN: A-02-01-01037	REVIEW OF DUPLICATE DHS PAYMENTS TO NEW JERSEY ACUTE CARE HOSPITALS, FEBRUARY 2003, $30,420,823
CIN: A-05-02-00086	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT ADMINASTAR FEDERAL, MARCH 2003, $25,300,000

CIN: A-05-02-00087	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT UNITED GOVERNMENT SERVICES, MARCH 2003, $23,300,000
CIN: A-10-01-00001	REVIEW OF WA COMPLIANCE W/MEDICAID HOSP DSH PYMT, OCTOBER 2002, $23,291,531
CIN: A-07-01-00125	TRANSAMERICA (TOLIC) - PENSION SEGMENT CLOSING AUDIT, MAY 2002, $20,227,001
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEPTEMBER 2002, $19,446,435
CIN: A-06-00-00051	AUDIT OF MEDICARE REHAB AGENCY COSTS IN TX, RHS, I, JUNE 2001, $18,394,465
CIN: A-04-01-00006	AUDIT OF AT-RISK, CCDBG, CCDF & SSBG PAYMENTS FOR CHILD CARE - NC, OCTOBER 2002, $18,275,715
CIN: A-05-01-00101	OHIO - TITLE IV-A AFDC OVERPAYMENTS, JUNE 2002, $17,184,240
CIN: A-05-01-00052	DME REVIEW IN INDIANA, OCTOBER 2001, $16,377,560
CIN: A-05-94-00064	MI BC/BS, AUDIT OF ADMIN COSTS, JUNE 1996, $15,609,718
CIN: A-05-02-00060	MICHIGAN TITLE IV-A AFDC OVERPAYMENT RECOVERIES, MARCH 2003, $15,289,444
CIN: A-06-01-00035	COLLECTION OF AFDC OVERPAYMENTS, JANUARY 2002, $13,800,000
CIN: A-01-01-02502	REVIEW OF UNCOLLECTED AFDC OVERPAYMENTS, AUGUST 2001, $12,400,000
CIN: A-05-02-00031	AFDC OVERPAYMENTS - WISCONSIN, AUGUST 2002, $10,711,338
CIN: A-01-01-00513	MEDICARE PT B PMT FOR DME I/P PRTL MNTH STAYS SNF, OCTOBER 2001, $10,500,000
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEPTEMBER 2002, $7,999,212
CIN: A-09-97-44262	STATE OF CALIFORNIA, APRIL 1997, $7,300,000
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM - NATIONAL, MARCH 1993, $6,529,545
CIN: A-03-99-00052	ALLEGHENY/CHESAPEAKE ORF, SEPTEMBER 2001, $5,540,344
CIN: A-04-00-02161	MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOVEMBER 2001, $5,344,160
CIN: A-07-99-02537	BC/BS OF MASSACHUSETTS, NOVEMBER 1999, $5,270,461
CIN: A-05-96-00058	CLOSE-OUT AUDIT OF MEDICARE CONTRACT - BC/BS-MI, DECEMBER 1997, $5,226,443
CIN: A-01-00-00506	DIAGNOSIS-RELATED GROUP PAYMENT WINDOW, JULY 2001, $5,042,207
CIN: A-01-97-00516	ADMIN COSTS-PART A&B, RAILROAD RETIRE BOARD, JUNE 1999, $4,939,184
CIN: A-05-01-00023	ADMINISTRATIVE COSTS REVIEW - ADMINASTAR FEDERAL, JANUARY 2002, $4,694,863
CIN: A-02-00-01047	DEMO BSWNY - FINANCIAL, MARCH 2002, $4,505,051
CIN: A-07-96-02001	MEDICARE PART B ADMIN COSTS AT BC/BS COLORADO, DECEMBER 1996, $4,483,104
CIN: A-07-98-01263	DENVER CMHC, MAY 2000, $4,447,607
CIN: A-07-00-00108	RURAL HEALTH CENTER REVIEW, OCTOBER 2001, $4,088,929
CIN: A-05-01-00068	PARTNERSHIP PLAN - ILLINOIS PHYSICIAN BILLING-FAMILY DYNAMICS, JULY 2002, $3,790,846
CIN: A-02-01-02001	REVIEW OF SACWIS STATEWIDE PART II, FEBRUARY 2003, $3,554,919
CIN: A-04-01-05002	AUDIT MEDICAID PAYMENTS FOR CLINICAL LABORATORIES, JANUARY 2002, $3,522,639
CIN: A-07-00-00109	MEDICARE CONTRACT TERM. & SEG. CLOSING - GALIC, SEPTEMBER 2000, $3,505,560
CIN: A-03-00-00002	TRIGON PT-A AND TERMINATION, SEPTEMBER 2001, $3,464,705
CIN: A-02-95-01019	STAFF BUILDERS HOME OFFICE MEDICARE COST REV ORT, AUGUST 1998, $3,434,274

CIN: A-05-93-00054	IL-ASSOCIATED INSURANCE GROUP-CONTRACT AUDIT, OCTOBER 1993, $3,355,560
CIN: A-07-99-01283	HMO - AFTER DEATH PAYMENTS, FEBRUARY 2000, $3,250,000
CIN: A-07-99-01298	DATE OF DEATH - 2, MAY 2001, $3,200,000
CIN: A-05-98-00042	ADMINISTAR INS CO - ADMIN. COSTS AUDIT, SEPTEMBER 1999, $3,111,728
CIN: A-06-99-00057	AUDIT OF MEDICARE REHAB AGENCY SERVICES IN TX, RHS, IN, JANUARY 2001, $3,097,201
CIN: A-09-02-00061	REVIEW OF MEDICAL CLAIMS FOR PRIVATE IMD PATIENTS, DECEMBER 2002, $3,083,389
CIN: A-07-02-03007	COSTS CLAIMED FOR POST RETIREMENT BENEFITS BY TOLIC, MAY 2002, $3,060,873
CIN: A-05-93-00013	MI-BC/BS-CONTRACT MEDICARE AUDIT, APRIL 1993, $3,010,916
CIN: A-09-98-50183	STATE OF CALIFORNIA, MARCH 1998, $3,000,000
CIN: A-07-01-00132	INDEPENDENCE BC - PENSION SEGMENT CLOSING AUDIT, FEBRUARY 2002, $2,913,129
CIN: A-02-02-01018	FOLLOW-UP OF NYS OSC REPORT ON DUPLICATE SCHOOL HEALTH CLAIMS - NYC BOE, DECEMBER 2002, $2,821,459
CIN: A-01-96-00508	MEDICARE ADMIN COSTS PARTS A&B AND RRB - TRAVELERS, MARCH 1996, $2,803,260
CIN: A-06-02-00038	CAPITATION PAYMENTS MADE UNDER NM MEDICAID PROGRAM, MARCH 2003, $2,600,000
CIN: A-05-97-00005	ADMINISTRATIVE COSTS CLAIMED UNDER MEDICARE A & B, FEBRUARY 1998, $2,569,067
CIN: A-05-92-00026	ASSOCIATED INSURANCE CO - MEDICARE ADMIN, FEBRUARY 1992, $2,530,409
CIN: A-09-02-72300	STATE OF CALIFORNIA, JULY 2002, $2,400,000
CIN: A-02-91-01006	BS OF WESTERN NY MEDICARE ADM CTS PORTER, SEPTEMBER 1991, $2,379,239
CIN: A-04-00-01209	OUTPATIENT PSYCHIATRIC SERVICES AT HOLLYWOOD PAV HOSP, APRIL 2001, $2,366,287
CIN: A-03-99-00038	EDGEWATER PSYC HOSPITAL, MARCH 2001, $2,348,604
CIN: A-04-97-01166	REV HOME HEALTH SERVICES BY STAFF BUILDERS HOME HEALTH, APRIL 1999, $2,300,000
CIN: A-07-97-01247	DUPLICATE PAYMENTS - HMO/FFS, OCTOBER 1999, $2,300,000
CIN: A-04-02-07007	MEDICAID FEE FOR SERVICE PAYMENTS FOR DUALLY ELIGIBLE MEDICARE MANAGED CARE ENROLLEES, FEBRUARY 2003, $2,231,100
CIN: A-04-97-01170	REVIEW HOME HEALTH SERVICES BY MEDCARE HOME HEALTH SERVICES, APRIL 1999, $2,200,000
CIN: A-09-01-00056	PACIFICARE-CALIFORNIA JAN 1998 INSTITUTIONAL PAYMENTS, SEPTEMBER 2001, $2,158,577
CIN: A-07-01-68554	STATE OF NEBRASKA , JUNE 2001, $2,113,388
CIN: A-03-00-00214	MEDICAID CLAIMS FOR RESIDENTS OF IMDS - MD, MARCH 2003, $2,093,729
CIN: A-04-00-02162	REVIEW TREATMENT OF QUALIFIED DISCHRGS @ FCSO, FEBRUARY 2001, $2,042,060
CIN: A-07-01-03001	BC/BS OF MN PENSION SEGMENT CLOSING, JANUARY 2003, $2,003,341
CIN: A-05-00-00034	PROVENA ST JOSEPH HOSPITAL-O/P PSYCH SERVICES, NOVEMBER 2000, $1,978,583
CIN: A-05-02-00048	REVIEW OF MEDICAID DME CLAIMS - TEXAS, SEPTEMBER 2002, $1,969,704
CIN: A-04-97-01169	REVIEW HOME HEALTH SERVICES BY MEDTECH HOME HEALTH SERVICES, APRIL 1999, $1,900,000
CIN: A-06-96-00009	NEW MEXICO BC/BS ADMIN COST - CONTRACTED, NOVEMBER 1997, $1,879,366

CIN: A-01-02-72211	STATE OF CONNECTICUT, JUNE 2002, $1,860,148
CIN: A-02-02-01005	HORIZON BC/BS - REVIEW OF TERMINATION COST, JANUARY 2003, $1,832,896
CIN: A-05-97-00014	GROUP HEALTH PLAN INC (HEALTHPARTNERS) INST BENES, JUNE 1998, $1,808,308
CIN: A-05-95-00059	AUDIT OF ADMINISTRATIVE COSTS - BC/BS MICHIGAN, JANUARY 1997, $1,787,345
CIN: A-01-02-00516	REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES UNITED GOVERNMENT SERVICES, MARCH 2003, $1,768,783
CIN: A-09-00-00127	BC OF CALIF - MEDICARE ADMIN COSTS, DECEMBER 2002, $1,677,822
CIN: A-03-00-00007	REVIEW OF 1-DAY DISCHARGES - PA, APRIL 2001, $1,649,411
CIN: A-04-99-01196	OIG-HCFA JOINT REVIEW OF JMV MEDICAL CORP, DECEMBER 2000, $1,600,417
CIN: A-03-00-00215	ANNABURG MANOR NURSING HOME COST REPORT, MARCH 2002, $1,582,079
CIN: A-03-96-00012	BC/BS M PT-B NON-RENEWAL COSTS, AUGUST 1998, $1,557,459
CIN: A-04-01-05011	REVIEW OF FLORIDA MEDICAID PAYMENTS FOR SERVICES PROVIDED TO INMATES, OCTOBER 2002, $1,450,077
CIN: A-07-02-03022	WELLMARK PENSION SEGMENT CLOSING, MARCH 2003, $1,353,036
CIN: A-09-96-00064	ORT - HOSPICE - CALIFORNIA, MARCH 1997, $1,350,000
CIN: A-10-91-00011	WPS - KEYSTONE COMPUTER ACQUISITION, OCTOBER 1992, $1,346,681
CIN: A-09-02-00057	REVIEW OF MEDICARE BAD DEBTS AT THE UNIV OF CA SAN FRANCISCO, JULY 2002, $1,338,058
CIN: A-05-95-00042	BC/BSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DECEMBER 1995, $1,333,598
CIN: A-05-01-00064	REVIEW OF OUTPATIENT REHABILITATION CLAIMS REIMBURSED BY MEDICARE DURING CALENDAR YEAR 1999, FEBRUARY 2002, $1,235,892
CIN: A-03-01-00251	AFDC OVERPAYMENTS - VIRGINIA, MARCH 2003, $1,221,494
CIN: A-09-02-00073	CA MEDICARE SETTLEMENT OF CROSSOVER BAD DEBTS - UGS, NOVEMBER 2002, $1,221,035
CIN: A-04-02-72903	STATE OF TENNESSEE, SEPTEMBER 2002, $1,213,353
CIN: A-05-00-00004	NEW CENTER COMMUNITY MENTAL HEALTH CENTER, JUNE 2000, $1,181,000
CIN: A-05-00-00049	PARTNERSHIP PLAN - IL HOSPITAL TRANSFERS, JUNE 2001, $1,150,113
CIN: A-02-97-01026	EDDY VNA (#337152) HHA ELIGIBILITY REVIEW, SEPTEMBER 1999, $1,131,593
CIN: A-05-98-00050	FOLLOW-UP MEDICAID CLINICAL LABORATORIES, JULY 1999, $1,097,036
CIN: A-06-01-00044	AUDIT OF ADMINISTRATIVE COSTS PART A & PART B - TRAILBLAZER BC/BS, APRIL 2002, $1,091,848
CIN: A-02-94-01029	HOSPICE ELIGIBILITY RVW IN PR - SAN GERMAN - ORT, JUNE 1995, $1,070,814
CIN: A-09-98-00052	CALIFORNIA MEDICAL REVIEW INC (CA PRO), JANUARY 1999, $1,067,991
CIN: A-05-94-00047	NATIONWIDE INS, MEDICARE PART B ADMIN COSTS, SEPTEMBER 1995, $1,049,309
CIN: A-05-01-00037	BC/BS OF MN ADMIN COSTS - LEON SNEAD & CO, JUNE 2001, $1,037,090
CIN: A-01-98-00500	PAYMENT EDITS FOR PSYCHIATRIC AT MA PART B CARRIER, SEPTEMBER 1998, $1,000,000
CIN: A-09-94-01010	CLOSEOUT AUDIT - CONT NO N01-ES-75196 (STRATAGENE), MARCH 1994, $983,208
CIN: A-06-02-00027	TEXAS MEDICARE BAD DEBT COLLECTIONS, OCTOBER 2002, $919,331

CIN: A-02-02-01017	IMD - REVIEW OF INPATIENT PSYCHIATRIC CLAIMS AT NJ'S PRIVATE AND COUNTY PSYCH HOSPITALS, MARCH 2003, $896,072
CIN: A-04-00-01210	REVIEW TREATMENT - QUALIFIED DISCHRGS-BC/BS GA, DECEMBER 2000, $891,000
CIN: A-05-92-00060	CONTRACTOR AUDIT - BC/BS - ADMIN, FEBRUARY 1993, $879,609
CIN: A-02-97-01034	DR PILA FOUNDATION HOME CARE PROGRAM (PONCE), SEPTEMBER 1999, $857,208
CIN: A-07-98-02533	TRAVELERS FACP, DECEMBER 1998, $854,214
CIN: A-04-01-05004	REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MARCH 2002, $836,711
CIN: A-06-99-00013	MEDICARE PART A ADMIN NM BC/BS, DECEMBER 1999, $817,487
CIN: A-02-98-01040	NIAGARA CTY DEPT OF HEALTH-#337001 - HHS ELIG REVIEW, DECEMBER 1999, $807,679
CIN: A-09-01-00094	PACIFICARE CORPORATE JANUARY 1998 MEDICARE INSTITUTIONAL STATUS, FEBRUARY 2002, $786,003
CIN: A-05-01-00073	REVIEW OF ADMINISTRATION OF RYAN WHITE (AIDS) FUNDS - INDIANA, MAY 2002, $784,499
CIN: A-07-99-00981	ASSIST REVIEW OF MEDICARE A/R HCFA RO DENVER, JANUARY 2000, $754,926
CIN: A-06-01-00027	REVIEW PALMETTO'S HH-PPS RAP POLICIES & PROCEDURES, SEPTEMBER 2001, $743,917
CIN: A-05-02-00041	INDIANA MEDICAID HOSPITAL PATIENT TRANSFERS, JANUARY 2003, $730,061
CIN: A-09-00-00103	PACIFICARE HMO - MEDICARE DUAL ELIGIBLES, MAY 2001, $720,858
CIN: A-05-91-00136	COMMUNITY MUTUAL INS CO ADMIN COSTS, AUGUST 1992, $720,668
CIN: A-07-02-03035	COSTS CLAIMED FOR PRB'S BY WELLMARK, FEBRUARY 2003, $717,106
CIN: A-03-02-72100	EAST COAST MIGRANT HEAD START PROJECT, JUNE 2002, $701,523
CIN: A-09-97-00078	PHYSICIAN BILLINGS DR SPENCER, JANUARY 1999, $683,264
CIN: A-02-01-01007	REVIEW OF ADMINISTRATIVE COST AT COOPERATIVA (CARMICHAEL & CO, CPA), MAY 2002, $679,487
CIN: A-06-01-00090	PREAWARD - APASS MAINTAINER DATA PROCESSING SERVICES-ABC/BS, SEPTEMBER 2001, $678,651
CIN: A-05-00-64226	NA-ILLINOIS DEPT OF PUBLIC AID, MAY 2000, $654,017
CIN: A-01-98-00503	PSYCHIATRIC OUTPT SERVICES AT THE FRANKLIN MED CTR, NOVEMBER 1998, $646,517
CIN: A-01-99-00535	AUDIT OF M/C PART A ADMIN COSTS - ANTHEM BC/BS CT, AUGUST 2000, $621,256
CIN: A-07-03-02660	REVIEW OF MULTIPLE PROCEDURES IN THE SAME SESSION NHIC-CAL, JANUARY 2003, $618,273
CIN: A-04-00-00138	MEDICAID ESCHEATED WARRANTS - FLORIDA, JANUARY 2002, $613,891
CIN: A-06-98-00066	ORT REVIEW OF ULTIMATE HOME HEALTH CARE INC, OCTOBER 1999, $602,982
CIN: A-04-94-01078	MONITORING ADMIN COST - AUDIT MEDICARE P B BC/BS SC, JULY 1994, $594,092
CIN: A-04-93-01069	MONITORG ADMIN COST AUDIT MEDICARE PART A BC/BS SC, JULY 1994, $590,844
CIN: A-04-01-01007	GA BC/BS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, $575,471
CIN: A-09-00-00067	COLLEGE HOSPITAL - O/P PSYCH SERVICES, APRIL 2001, $567,888
CIN: A-06-02-00026	REV OF MEDICAID CLAIMS MADE FOR AGED 21-64 YR OLD RESIDENTS, JANUARY 2003, $555,341
CIN: A-09-01-00055	REVIEW OF IMD CLAIMS - STATE OF CALIFORNIA, MARCH 2002, $551,394

CIN: A-07-02-03015	BC/BS OF MN PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEBRUARY 2003, $550,083
CIN: A-05-02-72811	COMMUNITY ACTION OF GREATER INDIANAPOLIS INC , AUGUST 2002, $547,899
CIN: A-07-02-03029	WELLMARK - PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEBRUARY 2003, $547,053
CIN: A-10-01-00011	REVIEW OF WASHINGTON MEDICAID SCHOOL BASED HEALTH SERVICES - REIMBURSMENT OF ADMINISTRATION CLAIMS, MAY 2002, $527,102
CIN: A-05-02-00063	REVIEW OF MEDICAID DME PAYMENTS - KENTUCKY, MARCH 2003, $511,397
CIN: A-05-00-00011	LIBERTYVILLE MANOR SNF - THERAPY SERVICES, SEPTEMBER 2001, $506,937
CIN: A-05-99-00062	AMERICARE PHYSICAL THERAPY SERVICES, DECEMBER 2000, $503,619
CIN: A-09-99-56858	HAWAII DEPT OF HUMAN SERVICES, FEBRUARY 1999, $502,000
CIN: A-03-92-16229	STATE OF PENNSYLVANIA, MARCH 1992, $496,876
CIN: A-05-02-72298	STATE OF WISCONSIN , AUGUST 2002, $491,120
CIN: A-01-02-73084	STATE OF MAINE , SEPTEMBER 2002, $489,321
CIN: A-07-01-03004	TRIGON BC/BS - PENSION SEGMENT CLOSING AUDIT, JULY 2002, $487,254
CIN: A-05-01-67384	MICHIGAN DEPT OF COMMUNITY HEALTH , FEBRUARY 2001, $481,693
CIN: A-05-03-74102	STATE OF OHIO, MARCH 2003, $439,556
CIN: A-07-01-00120	REVIEW OF UNFUNDED PENSION COST AT BC/BS OF OK, JULY 2001, $413,800
CIN: A-05-97-00013	PACIFICARE OF CA-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, $407,784
CIN: A-04-03-74904	EAST COAST MIGRANT HEAD START PROJECT, FEBRUARY 2003, $394,443
CIN: A-02-01-67912	STATE OF NEW YORK, MARCH 2001, $389,536
CIN: A-05-00-00030	CONTRACTED AUDIT-NATIONWIDE INS-MEDICARE ADMIN, OCTOBER 2000, $385,081
CIN: A-04-00-01208	OUTPATIENT CLINIC COSTS, CORAL GABLES HOSPITAL, FL, FEBRUARY 2001, $384,295
CIN: A-04-02-02014	MEDICAID CLAIMS FOR IMD RESIDENTS UNDER AGE 21, FEBRUARY 2003, $362,931
CIN: A-06-01-00087	AUDIT OF OBSERVATION SERVICE BILLING BY PRESBYTERIAN HOSP OF DALLAS, JUNE 2002, $361,832
CIN: A-05-02-70413	SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND, JUNE 2002, $345,125
CIN: A-07-03-02653	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION BC/BS ARKANSAS, JANUARY 2003, $344,883
CIN: A-01-99-00518	PSYCHIATRIC OUTPATIENT SERVICES AT DANBURY HOSPITAL, MAY 2000, $342,168
CIN: A-10-01-00005	AUDIT OF ADMIN COSTS AT MEDICARE NORTHWEST, SEPTEMBER 2001, $332,274
CIN: A-07-01-02630	REVIEW OF MUTUAL'S SETTLEMENT OF HHA COST REPORTS, JANUARY 2002, $319,949
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $319,355
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MARCH 2003, $315,474
CIN: A-03-03-72652	NATIONAL ASSOCIATION FOR EQUAL OPPORTUNITY IN HIGH, OCTOBER 2002, $313,256
CIN: A-02-02-01026	NEW JERSEY PARTNERSHIP - NURSING HOME DAY CARE SERVICES, MARCH 2003, $309,500

CIN: A-06-01-00028	AUDIT OF OBSERVATION SERVICE BILLINGS BY PPS HOSPITALS, FEBRUARY 2002, $298,549
CIN: A-07-01-02625	CLAIMS FOR MULTIPLE PROCEDURES PERFORMED IN THE SAME OPERATIVE SESSION (ASC), FEBRUARY 2003, $291,715
CIN: A-02-02-01031	MEDICARE BAD DEBTS AT MONTEFIORE MEDICAL CENTER, JANUARY 2003, $283,345
CIN: A-05-96-00069	CPA AUDIT OF HOOPER HOLMES HHA G&A - OI CASE OPEN, FEBRUARY 1998, $280,515
CIN: A-06-97-00015	NEW MEXICO PRO CLOSE OUT AUDIT, SEPTEMBER 1999, $268,844
CIN: A-09-94-30178	STATE OF ARIZONA, JUNE 1994, $267,021
CIN: A-09-00-00089	COMMUNITY URGENT CARE MEDICAL GROUP, NOVEMBER 2001, $266,236
CIN: A-05-02-00026	REVIEW OF GME/IME COSTS IN INDIANA, DECEMBER 2002, $263,884
CIN: A-03-98-00027	KHPW/INSTITUTIONAL STATUS/MEDICARE, NOVEMBER 1998, $263,573
CIN: A-07-03-02662	REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DECEMBER 2002, $258,112
CIN: A-04-02-00010	AUDIT OF EWCDC'S OFFICE OF COMMUNITY SERVICES DISCRETIONARY GRANT, AUGUST 2002, $250,000
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCTOBER 2002, $229,656
CIN: A-04-00-01222	CAPITAL HEALTH PLAN, COST-BASED MANAGED CARE PLAN, SEPTEMBER 2001, $221,952
CIN: A-01-00-00549	BETH ISRAEL AUDIT OF OUTPATIENT PHARMACY SERVICES, MARCH 2001, $221,905
CIN: A-05-99-00067	WPS PART B ADMINISTRATIVE COSTS, NOVEMBER 2000, $221,644
CIN: A-01-01-00523	REVIEW OF OUTPATIENT PHARMACY SERVICES AT NOBLE HOSPITAL, NOVEMBER 2001, $216,797
CIN: A-02-01-65217	PUERTO RICO DEPT OF THE FAMILY, DECEMBER 2000, $213,264
CIN: A-10-03-73757	STATE OF ALASKA, OCTOBER 2002, $211,272
CIN: A-02-01-01019	DEMO BSWNY - CASH MANAGEMENT, OCTOBER 2002, $208,271
CIN: A-05-96-00052	ORT ASSIST-ANCILLARY COSTS - NW COM HOSP, JUNE 1997, $206,508
CIN: A-06-96-00064	ORT SNF RESEARCH AT METHODIST HOSPITAL, JANUARY 1997, $200,000
CIN: A-07-01-02631	REVIEW OF HOSPITAL OBSERVATION BEDS, MAY 2002, $197,773
CIN: A-02-02-69503	PUERTO RICO DEPT OF THE FAMILY, SEPTEMBER 2002, $190,123
CIN: A-07-03-02656	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION KANSAS, DECEMBER 2002, $190,106
CIN: A-04-01-00002	TITLE IV-E FOSTER CARE PAYMENTS - CHILD CARE CLAIMS-NC-2, NOVEMBER 2001, $186,282
CIN: A-03-01-00555	PDPI INC - HEAD START, JUNE 2001, $185,577
CIN: A-07-02-03016	TRANSAMERICA SUPPLEMENTAL PENSION PLAN COSTS, MARCH 2002, $180,244
CIN: A-05-02-73374	STATE OF OHIO, SEPTEMBER 2002, $179,797
CIN: A-04-01-07004	OI ASSIST: SELF DISCLOSURE AUDIT OF HEALTHPRIME, INC, APRIL 2002, $169,401
CIN: A-10-01-00006	REVIEW OF OREGON MEDICAID SCHOOL BASED HEALTH SERVICES - REIMBURSEMENT OF DIRECT SERVICES, AUGUST 2002, $166,671
CIN: A-07-01-02094	SURVEY OF OUTPATIENT OBSERVATION SERVICES, OCTOBER 2002, $165,125
CIN: A-03-98-00034	FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MARCH 1999, $156,987
CIN: A-01-02-00515	REVIEW OF MEDICARE BAD DEBTS AT THE BAYSTATE MEDICAL CENTER, JANUARY 2003, $151,787
CIN: A-09-01-00084	VISTA DEL MAR NEPHROLOGY GROUP, NOVEMBER 2001, $151,566

CIN: A-07-03-02664	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION TRAILBLAZERS, DECEMBER 2002, $140,202
CIN: A-05-00-00031	CONTRACTED AUDIT OF UGS - MEDICARE ADMIN COSTS, NOVEMBER 2000, $138,182
CIN: A-08-03-74616	OGLALA SIOUX TRIBAL DEPT OF PUBLIC SAFETY, MARCH 2003, $136,764
CIN: A-09-99-52846	INTER-TRIBAL COUNCIL OF CALIFORNIA INC, FEBRUARY 1999, $136,360
CIN: A-02-98-01002	IPRO CLOSEOUT AUDIT - CPA CONTRACT MONITORING, DECEMBER 1998, $135,492
CIN: A-02-00-01019	HORIZON BC/BS (LEON SNEAD & CO, CPA, SEPTEMBER 2001, $134,584
CIN: A-05-00-00060	MEDICA FOLLOW-UP, REIMB RATES FOR INSTI BENES, JUNE 2001, $133,795
CIN: A-06-00-00014	REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCAR, JUNE 2000, $132,238
CIN: A-07-03-02661	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION NHIC, JANUARY 2003, $129,748
CIN: A-02-01-04000	INTERIM AUDIT OF RUTGER'S CONTRACT # SP0103-96-D-, JANUARY 2002, $125,415
CIN: A-03-01-00219	NATIONAL ASSOCIATION OF POTECTION & ADVOACY -NAPAS, SEPTEMBER 2001, $123,280
CIN: A-02-03-70759	PUERTO RICO DEPT OF THE FAMILY, NOVEMBER 2002, $122,718
CIN: A-05-01-00069	MERITER - MC/MA CREDIT BALANCES, JULY 2002, $122,713
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEPTEMBER 2002, $121,023
CIN: A-02-02-71384	STATE OF NEW YORK , MARCH 2002, $118,773
CIN: A-05-97-00023	KAISER FOUNDATION-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, $116,096
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, $114,631
CIN: A-03-99-00003	AETNA-US HEALTHCARE/INSTITUTIONAL STATUS/MEDICARE, JULY 1999, $113,993
CIN: A-09-02-71247	WATTSHEALTH FOUNDATION INC, APRIL 2002, $113,000
CIN: A-03-01-00001	EASTERN SHORE AMBULANCE CO, AUGUST 2001, $110,417
CIN: A-07-03-02665	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION WISCONSIN PHY SERVICES, JANUARY 2003, $106,363
CIN: A-03-02-00202	MD MEDICAID ESCHEATED WARRANTS, JANUARY 2003, $102,453
CIN: A-02-99-58263	PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD, JULY 1999, $101,199
CIN: A-09-01-00080	NEPHROLOGY ASSOCIATES MEDICAL GROUP - RIVERSIDE, NOVEMBER 2001, $100,788
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, $100,692
CIN: A-07-03-02658	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION EMPIRE, JANUARY 2003, $100,600
CIN: A-05-00-65775	STATE OF WISCONSIN, SEPTEMBER 2000, $98,586
CIN: A-07-99-01287	WELLMARK ADMIN COSTS 98, NOVEMBER 1999, $95,990
CIN: A-09-97-00066	WALTER MCDONALD - INDIRECT COST RATE AUDIT, MARCH 1998, $95,733
CIN: A-09-01-00096	AUDIT OF VERMONT SLAUSON ECONOMIC DEVELOPMENT CORP GRANT AWARD NUMBER 90EE0153, DECEMBER 2001, $95,560
CIN: A-09-98-00065	CSBG DISC GRANT #90EE004901 - LATINO RESOURCES, JANUARY 1999, $95,102
CIN: A-01-99-00507	NAT-WIDE REF OPNT PSYCH SERVICES AT ACUTE CARE HOSPITALS, MARCH 2000, $94,716

CIN: A-10-97-00003	BCWAAK-ADM COSTS REMOTE NETWORK ACTIVITIES FY93&94, FEBRUARY 1998, $94,643
CIN: A-04-02-02009	MEDICAID IMDS - PRIVATE FACILITIES IN FLORIDA, SEPTEMBER 2002, $92,726
CIN: A-07-95-01164	MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER 1995, $89,929
CIN: A-06-00-00013	REVIEW OF INFUSION THERAPY CLAIMS @ SPRING CREEK N, JUNE 2000, $89,288
CIN: A-03-02-03307	CONTRACT CLOSE OUT AUDIT OF CDC CONTRACT # 200-91-0901, NOVEMBER 2002, $88,929
CIN: A-01-01-00503	REVIEW OF O/P MEDICAL SUPPLIES AT MERCY HOSPITAL, JULY 2001, $88,904
CIN: A-05-01-00090	PAYMENTS TO AETNA OF FOR INSTITUTIONAL BENEFICIARIES, JULY 2002, $87,516
CIN: A-07-00-00118	REVIEW OF KANSAS RURAL HEALTH CENTER, MAY 2001, $87,493
CIN: A-08-99-56914	RURAL AMERICA INITIATIVES, JULY 1999, $87,468
CIN: A-04-01-01006	MBC/BS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, $87,042
CIN: A-04-02-72118	STATE OF NORTH CAROLINA , MAY 2002, $84,932
CIN: A-05-01-00071	PAYMENTS TO HUMANA-KC FOR INSTITUTIONAL BENEFICIARIES, DECEMBER 2001, $84,808
CIN: A-10-01-67562	KENAITZE INDIAN TRIBE , MARCH 2001, $79,533
CIN: A-04-94-02080	FINALIZATION OF BCBSFL DATA MATCH, JUNE 1995, $79,316
CIN: A-04-01-02003	REVIEW FLORIDA MEDICAID CLAIMS - IMDS, MARCH 2002, $78,880
CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCTOBER 2002, $77,000
CIN: A-04-96-01137	PARTIC PART OF HCFA SURVTEAM - DAYTONA NURSG-ORT, DECEMBER 1996, $76,130
CIN: A-01-99-00530	NATIONWIDE REV OF O/P PSYCH SERVICES @ PSYCH HOSPITALS, DECEMBER 2000, $75,413
CIN: A-04-02-72213	STATE OF FLORIDA, JUNE 2002, $73,239
CIN: A-01-00-00503	REVIEW OF MEDICARE OUTLIER PAYMENTS-MASS GENERAL, DECEMBER 2000, $73,019
CIN: A-04-01-02008	ANCILLARY CLAIMS PAID FOR MEDICAID BENEFICIARIES WHILE IN IMDS, JULY 2002, $71,406
CIN: A-05-02-72301	STATE OF INDIANA, JULY 2002, $69,889
CIN: A-04-03-73667	MANATEE OPPORTUNITY COUNCIL INC, OCTOBER 2002, $63,321
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
CIN: A-05-99-00045	KAISER HEALTH PLAN OF OHIO - INSTITUTIONAL STATUS, MAY 2000, $61,177
CIN: A-05-02-72716	SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND, SEPTEMBER 2002, $60,378
CIN: A-05-96-00072	MI DEPT OF COMMUNITY HEALTH/MEDICAID LAB SERVICES, AUGUST 1997, $59,956
CIN: A-06-01-68876	STATE OF LOUISIANA, JUNE 2001, $59,914
CIN: A-01-96-00505	CFO AUDIT OF HCFA'S FINANCIAL STATEMENTS, JULY 1997, $59,327
CIN: A-02-00-62534	CITY OF NEW YORK NEW YORK, JANUARY 2000, $58,309
CIN: A-05-96-00051	ORT ASSIST-ANCILLARY COSTS - ST JOSEPH, JUNE 1997, $58,008
CIN: A-09-97-00059	HEALTH SERVICES ADVISORY GROUP, INC PRO - AZ, MAY 1997, $57,925
CIN: A-07-97-01206	PENSION - WASHINGTON/ALASKA - UNFUNDED, MARCH 1997, $54,000
CIN: A-01-02-00507	REVIEW OF OUTLIER PAYMENTS MADE TO EASTERN MAINE MEDICALCENTER, JANUARY 2003, $53,091

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

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

CIN: A-04-00-01223 REV MGMT FEES - ONCOLOGY CLINIC-PKWY REG'L M'CAL, OCTOBER 2001, $52,000

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

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

CIN: A-02-02-70019 SENECA NATION OF INDIANS, DECEMBER 2001, $50,083

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

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

CIN: A-03-03-72398 CHILD WELFARE LEAGUE OF AMERICA INC, OCTOBER 2002, $48,589

CIN: A-07-00-00106 PENSION SEGMENTATION AUDIT AT BC/BS OF OKLAHOMA, JULY 2001, $45,508

CIN: A-05-03-73739 STATE OF OHIO, NOVEMBER 2002, $43,836

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

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

CIN: A-07-01-00121 REV OF PEN COSTS FOR MED REIMB FOR BC/BS OF OK, JULY 2001, $42,463

CIN: A-01-02-71892 STATE OF VERMONT, APRIL 2002, $42,037

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

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

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

CIN: A-05-03-72703 TRI-COUNTY OPPORTUNITIES COUNCIL, NOVEMBER 2002, $38,374

CIN: A-07-98-53295 WINNEBAGO TRIBE OF NEBRASKA, SEPTEMBER 1998, $36,808

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

CIN: A-03-00-00010 PS GEISINGER HMO/INSTITUTIONAL STATUS/MEDICARE, JANUARY 2001, $35,639

CIN: A-10-03-74366 FIRST AME CHILD & FAMILY CENTER, JANUARY 2003, $35,162

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

CIN: A-09-01-00050 BALBOA NEPHROLOGY MEDICAL GROUP, APRIL 2001, $32,568

CIN: A-03-99-00008 BC/BS OF DELAWARE - PART A, JANUARY 2000, $32,176

CIN: A-07-97-01199 BC/BS NEW MEXICO UNFUNDED PENSION COST, FEBRUARY 1997, $31,372

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

CIN: A-05-03-74268 BCMW COMMUNITY SERVICES INC, JANUARY 2003, $30,796

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

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

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

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

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

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

CIN: A-10-02-69837 NATIVE VILLAGE OF TYONEK, DECEMBER 2001, $26,848

CIN: A-06-00-00020 REV OF INFUSION THERAPY CLAIMS @ VISTA CONTINUING, JUNE 2000, $25,008

CIN: A-05-03-70349 MICHIGAN FAMILY INDEPENDENCE AGENCY, MARCH 2003, $24,949

CIN: A-03-00-00004 GUTHRIE CLINIC/PHYSICIAN CREDIT BALANCES/MEDICARE, DECEMBER 1999, $23,759

CIN: A-06-02-70732	UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JANUARY 2002, $23,483
CIN: A-06-02-71744	SENECA-CAYUGA TRIBE OF OKLAHOMA, MARCH 2002, $21,376
CIN: A-04-00-01206	BC/BS NC - MEDICARE PART A ADMIN COST AUDIT-CARMICHAEL, SEPTEMBER 2000, $21,302
CIN: A-05-01-00078	PAYMENTS TO HEALTH NET-TUCSON, AZ - FOR INSTITUTIONAL BENEFICIARIES, APRIL 2002, $21,233
CIN: A-05-02-72480	HANSEL NEIGHBORHOOD SERVICE CENTER INC, SEPTEMBER 2002, $20,266
CIN: A-09-02-00092	CA MEDICARE SETTLEMENT OF CROSSOVER BAD DEBTS - MUTUAL OF OMAHA, JANUARY 2003, $20,248
CIN: A-06-02-72610	STATE OF OKLAHOMA, AUGUST 2002, $19,992
CIN: A-05-02-70624	STATE OF OHIO, JANUARY 2002, $19,970
CIN: A-04-01-67441	CATAWBA INDIAN NATION, APRIL 2001, $19,204
CIN: A-05-01-00100	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842
CIN: A-04-97-01163	VIMI MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, $18,758
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, $18,645
CIN: A-03-01-00018	WASHINGTON HOSPITAL CENTER GRADUATE MEDICAL EDUCATION COSTS, MAY 2002, $18,000
CIN: A-03-97-00007	NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MARCH 1997, $17,045
CIN: A-07-00-00117	REV OF PENSION COSTS FOR MED REIMB BC/BS OF ND, JANUARY 2001, $16,863
CIN: A-01-99-55594	STATE OF VERMONT, NOVEMBER 1998, $16,623
CIN: A-01-97-44143	BRANDEIS UNIV, JANUARY 1997, $16,602
CIN: A-03-03-74306	HEBREW HOME OF GREATER WASHINGTON INC, DECEMBER 2002, $16,441
CIN: A-06-01-68297	NATIVE AMERICAN CENTER OF RECOVERY INC, MAY 2001, $16,314
CIN: A-01-02-70440	UNIV OF MASSACHUSETTS, JANUARY 2002, $16,031
CIN: A-10-00-59080	NORTON SOUND HEALTH CORP, DECEMBER 1999, $15,000
CIN: A-05-01-00044	MINNESOTA MEDICAID PERSONAL CARE SERVICES REVIEW, APRIL 2002, $14,844
CIN: A-06-00-65680	STATE OF TEXAS, AUGUST 2000, $14,698
CIN: A-03-97-00008	NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MARCH 1997, $14,596
CIN: A-09-00-00104	PACIFICARE OF CALIFORNIA - INSTITUTIONAL STATUS, MARCH 2001, $14,278
CIN: A-09-96-00050	CFO - HCFA 1996, NOVEMBER 1997, $13,924
CIN: A-02-01-01009	HORIZON BC/BS - REVIEW OF FACP, JANUARY 2003, $13,651
CIN: A-05-03-73921	NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NOVEMBER 2002, $13,317
CIN: A-03-03-72847	DISTRICT OF COLUMBIA DEPT OF HEALTH, OCTOBER 2002, $12,850
CIN: A-06-03-74511	SOUTHERN UNIV SYSTEM, FEBRUARY 2003, $12,693
CIN: A-07-02-04002	FY 2002 CFO/CMS/MEDICARE ERROR RATE MUTUAL OF OMAHA, OCTOBER 2002, $12,070
CIN: A-05-03-00012	FROEDTERT MEDICAID CREDIT BALANCES, FEBRUARY 2003, $12,066
CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JANUARY 2002, $11,089
CIN: A-03-01-00513	IRSA - KOSOVO ASSISTANCE GRANT 90-ZK-0002/01, DECEMBER 2001, $10,913
CIN: A-05-02-00037	REVIEW OF FOSTER CARE PLACEMENT AGENCY ADMINISTRATIVE COSTS, FEBRUARY 2003, $10,609
CIN: A-03-02-71608	SUPPORTIVE CHILD ADULT NETWORK INC, APRIL 2002, $10,561

CIN: A-09-02-71757	PYRAMID LAKE PAIUTE TRIBE, MAY 2002, $9,857
CIN: A-10-97-00002	GROUP HEALTH INSTITUTIONALIZED, NOVEMBER 1997, $9,769
CIN: A-06-02-00032	CMS FY 01 MEDICARE ERROR RATE - ARK BC/BS REPORT, NOVEMBER 2002, $9,655
CIN: A-02-01-02003	FORDHAM UNIVERSITY - DISCRETIONARY GRANT REVIEW, MAY 2002, $9,451
CIN: A-02-01-66887	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001, $9,000
CIN: A-05-01-67360	MICHIGAN FAMILY INDEPENDENCE AGENCY, FEBRUARY 2001, $8,708
CIN: A-03-03-74002	MINORITY ACCESS INC, NOVEMBER 2002, $8,113
CIN: A-07-97-01231	PROWEST-DOSHI WASHINGTON, JUNE 1997, $8,027
CIN: A-03-02-72715	DISTRICT OF COLUMBIA DEPT OF HEALTH, JULY 2002, $7,851
CIN: A-05-01-68270	LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, $7,614
CIN: A-03-98-00045	TEMPLE UNIV/PHYSICIAN CREDIT BALANCES/MEDICARE, JULY 1999, $7,280
CIN: A-01-97-49174	BRANDEIS UNIV, AUGUST 1997, $7,068
CIN: A-06-01-69130	STATE OF TEXAS, SEPTEMBER 2001, $6,484
CIN: A-07-95-01167	PENSION COSTS CLAIMED NEBRASKA BC/BS, JANUARY 1996, $6,075
CIN: A-01-02-00502	REVIEW OF INTERNAL CONTROL PROCEDURES A RENEX DIALYSIS CLINICS OF NORTH ANDOVER AND AMESBURY FOR THE ADMINISTRATION OF EPOGEN FOR CALENDAR YEAR 1999, SEPTEMBER 2002, $6,016
CIN: A-06-97-48062	SER-JOBS FOR PROGRESS NATIONAL INC, MAY 1997, $5,924
CIN: A-01-03-74569	CYTEL SOFTWARE CORP, JANUARY 2003, $5,089
CIN: A-01-02-72476	UNIV OF MASSACHUSETTS, SEPTEMBER 2002, $5,012
CIN: A-15-02-20006	REVIEW OF CDC COOPERATIVE AGREEMENT AND HRSA RYAN WHITE ACTIVITIES AT HEALTH EDUCATION RESOURCE ORGANIZATION (HERO), INC (BALTIMORE EMA/BALTIMORE CITY HEALTH DEPT), MARCH 2003, $5,010
CIN: A-01-00-60299	INDIAN TOWNSHIP TRIBAL GOVERNMENT PASSAMAQUODDY TR, JANUARY 2000, $4,597
CIN: A-02-03-73189	UNIVERSIDAD CENTRAL DEL CARIBE INC, FEBRUARY 2003, $4,543
CIN: A-05-03-73584	ERIE-HURON COUNTIES COMMUNITY ACTION COMMISSION IN, DECEMBER 2002, $4,480
CIN: A-04-01-68839	STATE OF FLORIDA, JUNE 2001, $4,169
CIN: A-02-03-74893	WOMENS COALITION OF ST CROIX INC, MARCH 2003, $4,113
CIN: A-07-02-04001	FY-2002 CFO/CMS MEDICARE ERROR RATE NORIDIAN (ND B/C), OCTOBER 2002, $3,999
CIN: A-04-97-01162	HMSA MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, $3,871
CIN: A-09-01-00067	EAST BAY NEPHROLOGY MEDICAL GROUP, AUGUST 2001, $3,418
CIN: A-03-01-03303	JOHNS HOPKINS UNIVERSITY/KPMG/NIDA/N01DA-3-7301, FEBRUARY 2001, $3,347
CIN: A-05-02-69215	ONEIDA TRIBE OF INDIANS OF WISCONSIN, OCTOBER 2001, $3,109
CIN: A-02-01-66889	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001, $3,103
CIN: A-03-95-03318	TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996, $3,016
CIN: A-02-01-66888	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001, $2,883
CIN: A-07-98-02502	CT BC/BS PENSION COSTS CLAIMED, MARCH 1998, $2,725
CIN: A-03-98-51505	ALLIEDSIGNAL TECHNICAL SERVICES CORP, APRIL 1998, $2,722
CIN: A-01-97-45487	ABT ASSOCIATES INC, JANUARY 1997, $2,596
CIN: A-03-97-43996	ACTUARIAL RESEARCH CORP, OCTOBER 1996, $2,561
CIN: A-09-01-00068	ROLLUP REPORT CALIFORNIA INPATIENT HEMODIALYSIS SERVICES, MARCH 2002, $1,858

CIN: A-07-97-01232 PROWEST - DOSHI ALASKA, JUNE 1997, $1,473
CIN: A-07-00-02082 REVIEW OF A COST HMO - IOWA, FEBRUARY 2002, $1,006

[5]B.

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

CIN: A-07-96-01176 MEDICARE EXCESS PENSION ASSETS - BC MICH, NOVEMBER 1996, $11,904,263
CIN: A-07-92-00579 BC/BS OF MICHIGAN INC - UNFUNDED PENSION COSTS, OCTOBER 1992, $2,535,698
CIN: A-05-93-00057 MI-BC & BS OF MI-CONTRACT AUDIT, JULY 1993, $1,409,954

Notes to Table 2

[1]The opening balance was adjusted upward by $51.9 million.

[2]Management decision has not been made within 6 months on 28 reports.

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

CIN: A-03-00-00203 PA/INTERGOVERNMENTAL TRANSFERS/MEDICAID, FEBRUARY 2001, $3,700,000,000
CIN: A-05-00-00056 MEDICAID INTERGOVERNMENTAL TRANSFERS - IDPA, MARCH 2001, $1,870,000,000
CIN: A-06-00-00023 MEDICAID PHARMACY/PHYSICIAN ACTUAL ACQUISITION COS, AUGUST 2001, $1,080,000,000
CIN: A-10-00-00011 MEDICAID INTERGOVERNMENTAL TRANSFERS - WA STATE, MARCH 2001, $475,000,000
CIN: A-06-01-00069 EVALUATION OF LEGISLATION TO INCREASE MEDICAID HOSP-SPEC DSH PAYMENT LIMITS, DECEMBER 2001, $380,000,000
CIN: A-06-01-00041 AUDIT OF THE TX DISPROPORTIONATE SHARE HOSP PROG PAYMENT METHODLOGY, FEBRUARY 2003, $319,200,000
CIN: A-01-99-00507 NAT-WIDE REF OPNT PSYCH SERVICES AT ACUTE CARE HOSPITALS, MARCH 2000, $224,466,692
CIN: A-04-00-02165 REVIEW OF AL MEDICAID INTERGOVERNMENTAL TRANSFERS, MARCH 2001, $147,500,000
CIN: A-06-00-00053 OIG HCFA NEBULIZER PROJECT - NATIONAL ERROR RATE, OCTOBER 2001, $133,960,552
CIN: A-04-00-02169 REV AL MEDICAID INTERGOVERNMEN'TAL TRANSFERS-HOSPITAL ENHANCE, MAY 2001, $63,000,000
CIN: A-01-99-00530 NATIONWIDE REV OF O/P PSYCH SERVICES @ PSYCH HOSPITALS, DECEMBER 2000, $56,936,287
CIN: A-07-98-02534 EMPIRE BC/BS PENSION PLAN TERMINATION, MARCH 2000, $38,626,351

CIN: A-02-03-73313	CITY OF NEW YORK ADMINISTRATION FOR CHILDRENS SERVICES, JANUARY 2003, $22,203,439
CIN: A-02-01-67912	STATE OF NEW YORK, MARCH 2001, $19,000,000
CIN: A-01-99-00506	FOLLOW-UP REVIEW OF SEPRTLY BILLABLE ESRD LAB TESTS, JANUARY 2001, $12,200,000
CIN: A-06-99-00060	REVIEW OF AN HMO UNDERPAYMENT CLAIM OF 21 MILLION, JUNE 2001, $12,191,579
CIN: A-01-00-00502	REV OF EXORBITANT MEDICARE PAYMENTS FOR O/P SERVICES, MAY 2001, $12,100,000
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM - NATIONAL, MARCH 1993, $10,161,742
CIN: A-07-96-01177	MEDICARE POST RETIREMENT CLAIM BC MICH, NOVEMBER 1996, $8,978,998
CIN: A-06-99-00045	MEDICARE LEFT AGAINST MEDICAL ADVICE DISCHARGES, MARCH 2002, $6,800,000
CIN: A-03-00-00007	REVIEW OF 1-DAY DISCHARGES - PA, APRIL 2001, $6,300,000
CIN: A-01-97-02506	REVIEW OF THE AVAIL OF MEDICAL COVERAGE/CSE SUPPORT, JUNE 1998, $5,704,585
CIN: A-05-01-00052	DME REVIEW IN INDIANA, OCTOBER 2001, $4,400,000
CIN: A-06-00-00073	REV OF MGR CARE ADDTL BENEFITS FOR CY 00 OF NYLCAR, MARCH 2002, $4,000,000
CIN: A-02-02-01026	NEW JERSEY PARTNERSHIP - NURSING HOME DAY CARE SERVICES, MARCH 2003, $3,500,000
CIN: A-04-98-01188	REVIEW ADMIN COSTS @ MEDICARE MANAGED RISK PLAN, AUGUST 1999, $2,559,357
CIN: A-05-00-00083	REVIEW OF MEDICAID DME CLAIMS - MICHIGAN, OCTOBER 2001, $2,500,000
CIN: A-05-02-00066	REVIEW OF RFP CMS-02-001/ELH1, MAY 2002, $1,885,793
CIN: A-09-95-00095	HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DECEMBER 1995, $1,389,723
CIN: A-05-01-00031	WI MEDICAID - DME, OCTOBER 2001, $1,250,000
CIN: A-07-99-01298	DATE OF DEATH - 2, MAY 2001, $700,000
CIN: A-05-02-00082	BID PROPOSAL FOR 1-800 MEDICARE HOTLINE ADMINISTRATION, AUGUST 2002, $609,950
CIN: A-05-02-00080	SINAI - MC/MA CREDIT BALANCES, JANUARY 2003, $515,942
CIN: A-05-03-00021	CIMRO PRO PRE-AWARD AUDIT FOR NEBRASKA, NOVEMBER 2002, $504,650
CIN: A-03-99-00052	ALLEGHENY/CHESAPEAKE ORF, SEPTEMBER 2001, $467,646
CIN: A-05-00-00057	REVIEW OF MEDICAID MUTUALLY EXCLUSIVE CODES - OH, NOVEMBER 2001, $450,000
CIN: A-03-00-00010	PS GEISINGER HMO/INSTITUTIONAL STATUS/MEDICARE, JANUARY 2001, $306,269
CIN: A-05-01-00074	REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUNE 2001, $282,049
CIN: A-03-99-00038	EDGEWATER PSYC HOSPITAL, MARCH 2001, $208,731
CIN: A-07-97-01230	OFMQ - DOSHI OKLAHOMA, JUNE 1997, $203,510
CIN: A-07-97-01231	PROWEST-DOSHI WASHINGTON, JUNE 1997, $163,552
CIN: A-01-02-73084	STATE OF MAINE , SEPTEMBER 2002, $149,082
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MARCH 2003, $144,909
CIN: A-07-02-00143	MEDICAID REVIEW OF DECEASED RECIPIENTS- MISSOURI, MARCH 2003, $118,362
CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JANUARY 2002, $98,698
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, $90,528

CIN: A-05-02-00089	REVIEW OF RFP CMS-500-97-0408/0008, NOVEMBER 2002, $84,457
CIN: A-03-01-00022	UNITED HOSPITAL CENTER BAD DEBT REVIEW, JULY 2002, $42,328
CIN: A-07-97-01232	PROWEST - DOSHI ALASKA, JUNE 1997, $21,218
CIN: A-05-96-00069	CPA AUDIT OF HOOPER HOLMES HHA G&A - OI CASE OPEN, FEBRUARY 1998, $17,555
CIN: A-07-95-01164	MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER 1995, $16,632
CIN: A-01-97-00526	PSYCHIATRIC OUTPATIENT SERVICES, MARCH 1998, $7,245
CIN: A-01-98-00506	PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY HOSPITAL, MARCH 1998, $1,120

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

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

Section of the Act	*Requirement*	*Page*
Section 4(a)(2)	Review of legislation and regulations	48
Section 5		
(a)(1)	Significant problems, abuses and deficiencies	Throughout
(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	Throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	Appendices B & C
(a)(4)	Matters referred to prosecutive authorities	51
(a)(5)	Summary of instances where information was refused	None
(a)(6)	List of audit reports	Under separate cover
(a)(7)	Summary of significant reports	Throughout
(a)(8)	Statistical Table 1—Reports With Questioned Costs	46
(a)(9)	Statistical Table 2—Funds Recommended to Be Put to Better Use	47
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	None

Appendix F
Summary of Sanction Authorities

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

Program Exclusions

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

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

Patient Dumping

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

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

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

Civil Monetary Penalties Law

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

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

Anti-Kickback Statute

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

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

False Claims Act

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

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

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

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

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

In response to the 2002 annual solicitation, OIG received the following proposals related to safe harbors:

Proposal	***OIG Response***
New safe harbor for certain practices related to "economic credentialing" of physicians by hospitals.	OIG received a substantial number of public comments from a cross-section of interested parties in response to OIG's specific solicitation of comments on this topic. The public comments variously suggest issuance of different types of guidance; some comments suggest that OIG take no action. OIG is reviewing the comments.
New safe harbor for "refill reminder" and other pharmacy compliance programs funded by pharmaceutical manufacturers.	OIG is not adopting this suggestion. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures. Several of the matters raised in the suggestions are addressed in OIG's recent Compliance Program Guidance (CPG) for Pharmaceutical Manufacturers.
New safe harbor for continuing medical education (CME) and non-CME programs sponsored by medical societies, but financed by pharmaceutical manufacturers.	OIG is not adopting this suggestion. The arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures. Pharmaceutical manufacturer-funded educational programs are addressed in OIG's recent CPG for Pharmaceutical Manufacturers.
New safe harbor for programs that assist patients and providers with cost-sharing amounts owed for costly drug therapies. *continued—*	OIG is not adopting this suggestion. Existing OIG guidance makes clear that a provider's non-routine, unadvertised waiver of coinsurance based on an individualized, good faith assessment of a patient's financial need is permissible. However, having reviewed several other kinds of coinsurance support

	arrangements, OIG has determined that such arrangements may pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures.
Modification of the ambulatory surgical center (ASC) safe harbor to address protection of start-up multi-specialty ASCs that otherwise comply with the current safe harbor conditions.	OIG is considering this suggestion.
Modification of the Medicare SELECT safe harbor to cover (i) coinsurance waivers for inpatient services negotiated between a hospital and an ERISA employee welfare benefit plan that covers retirees and (ii) Part B waivers for employer group plans.	These suggestions require further study. In September 2002, OIG issued a notice of proposed rulemaking to make certain modifications to the safe harbor. The public comments to that rulemaking are under review.
New safe harbor for inducements offered to beneficiaries that fit in an exception to the beneficiary inducements statute at section 42 U.S.C. §1320a-7a(a)(5).	OIG is considering this suggestion.
Modification of the existing shared risk exception to cover (i) second tier contractors of Federally-qualified health centers (FQHCs) and (ii) the TriCare program.	OIG is considering this suggestion.
Modification of the discount safe harbor to include a discount obtained by a commercial health plan that does not file claims with the Federal health care programs, where the discount otherwise meets the safe harbor conditions.	OIG is considering this suggestion.
Modification of the managed care safe harbors at 42 C.F.R. 1001.952(l) and (m) to cover coordinated care plans, private fee-for-service plans, and entities contracting under risk-based demonstration authorities.	OIG is not adopting this suggestion. The issues raised in the suggestion were considered in connection with the interim final safe harbor for shared risk arrangements. Managed care arrangements that do not fit in an existing safe harbor may pose a risk of abuse and are best addressed on a case-by-case basis, such as through the advisory opinion procedures.
Modification of the safe harbor for waivers of beneficiary coinsurance to cover routine waivers of coinsurance for emergency ambulance services reimbursed under the Medicare ambulance fee schedule.	OIG is not adopting this suggestion. The arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures. Moreover, except in limited circumstances, the suggestion appears contrary to the Medicare coverage and payment rules for emergency ambulance services.
New safe harbor for transfers of remuneration between entities under common ownership or control.	OIG is not adopting this suggestion. The arrangements described pose a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion procedures. In addition, given the range of potential arrangements covered by the suggestion, it would not be feasible to craft an appropriate set of safeguards.

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

Proposal	***OIG Response***
New safe harbor for *de minimis* gifts to beneficiaries who refer new customers.	OIG is not adopting this suggestion because of the risk of abuse, particularly in light of the statutory prohibition against offering inducements to Medicare or Medicaid beneficiaries in section 1128A(a)(5) of the Social Security Act.
New safe harbor for certain fee-for-service arrangements between FQHCs and other providers, practitioners, and suppliers.	OIG is developing a proposed rule on this suggestion.
Modification of the existing safe harbors to conform them to the final regulations under the physician self-referral statute published by CMS on January 4, 2001.	OIG is considering this suggestion with respect to the group practice safe harbor. With respect to other safe harbors, the statutes generally serve somewhat different purposes and conforming the safe harbors to the self-referral exceptions may not be appropriate. OIG may consider making some conforming changes, if appropriate, once the self-referral regulations are completed in their entirety.
New safe harbors analogous to the new self-referral exceptions created by the above-referenced CMS regulations (*e.g.*, compliance training, incidental benefits, non-monetary compensation).	OIG is considering this suggestion.
New safe harbor for isolated transactions matching the exception in the physician self-referral statute.	OIG will consider this suggestion after CMS issues final self-referral regulations on the subject.
Modification of the existing shared risk exception to cover second tier contractors of FQHCs.	As noted in the preceding table, OIG is considering this suggestion.
Modification of the safe harbor for ASCs jointly owned by hospitals and physicians to add conditions under which a hospital would not be in a position to make or influence referrals.	OIG is considering this suggestion.
Modification of the ASC safe harbor to clarify whether an ASC can require investors to comply with safe harbor conditions.	OIG is considering this suggestion.
Modification of the ASC safe harbor to clarify (i) the use of "pass-through" entities to hold ownership interests and (ii) the treatment of physician investors who invest at different times.	OIG is considering these suggestions.
New safe harbor for rural health networks operating pursuant to the Medicare Rural Hospital Flexibility Program.	This suggestion requires further study.

New safe harbor for arrangements that comply with section 513 of the IRS Code pertaining to the provision of certain supporting goods and services by tax-exempt hospitals to other tax-exempt hospitals.	This suggestion requires further study.
Modification of the discount safe harbor to clarify its application to discounts applied to a manufacturer's full product line.	This suggestion requires further study.
Modification of the discount safe harbor's reporting requirements.	This suggestion requires further study.

Appendix H
Performance Measures

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

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

Centers for Medicare & Medicaid Services:

Nursing Home Deficiency Trends
Psychosocial Services in Nursing Facilities

Public Health Agencies:

Variation in Organ Donation Among Transplant Centers
Financial Statement Audit

***Administrations for Children and Families and on Aging*:**

State Ombudsman Data: Nursing Home Complaints
Child Support Enforcement Customer Service
Foster Care's Use of Medicaid Costs

General Oversight:

Results Act
International Merchant Purchase Authorization Card Program

Appendix I
Office of Inspector General Components

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

Office of Investigations (OI)—conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries. Investigative efforts lead to criminal convictions, civil judgements and settlements, administrative sanctions, and/or civil monetary penalties. OI serves as liaison to the Department of Justice on all matters relating to investigations of HHS programs and personnel. OI also oversees State Medicaid Fraud Control Units that investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Evaluation & Inspections (OEI)—conducts short-term management and program evaluations that focus on issues of concern to the Department, the Congress and the public. OEI generally focuses on programs with significant expenditures of funds and services to program beneficiaries or in which important management issues have surfaced. The findings and recommendations contained in the reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability and effectiveness of departmental programs.

Office of Counsel to the Inspector General (OCIG)—provides legal services to OIG, rendering advice and opinions on HHS programs and operations, imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. OCIG also represents OIG in the global settlement of cases arising under the civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, and renders advisory opinions on sanctions to the health care community.

Office of Management and Policy (OMP)—provides mission support services to the IG and other components. OMP formulates and executes the budget, develops policy, disseminates OIG information to the news media and public, liaises with the Department, Congress, and external organizations and manages information technology resources. OMP also conducts and coordinates reviews of existing and proposed legislation and regulations to assess implications and economic consequences for HHS programs and operations.