U.S. Department
of Health and
Human Services

Working Together to Promote, Preserve & Protect the Nation's Well-Being.

Semiannual Report to Congress

Oct. 1, 2003 - March 31, 2004

Office of the Inspector General

Working Together to Promote, Preserve & Protect the Nation's Well-Being.

Office of Inspector General Components

OAS

Office of Audit Services 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.

OI

Office of Investigations 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.

OEI

Office of Evaluation & Inspections 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.

OCIG

Office of Counsel to the Inspector General 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.

OMP

Office of Management and Policy 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. In addition, OMP oversees State Medicaid Fraud Control Units that investigate and prosecute fraud and patient abuse in the Medicaid program.

This semiannual report and other OIG materials
may be accessed on the Internet
at http://oig.hhs.gov

Message from the Inspector General

Over the past 6 months, the Office of Inspector General (OIG) has continued its mission to evaluate, audit and investigate fraud, waste and abuse in Federal health care programs. OIG anticipated and has already assumed many of the additional responsibilities that we now have under the newly enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act). In addition, OIG studies mandated by the Act will present an additional avenue for us to support the Department by providing the factual information and assistance necessary for them to meet their own responsibilities under the Act.

Perennial oversight by OIG is critical because our studies continue to show that the Government significantly overpays for certain drugs, and our investigations continue to reveal fraudulent activity by various drug manufacturers. In fact, our reports in the past 6 months have shown the tremendous savings, $650 million for FY 2002, that could be achieved by using alternative methodologies for pricing certain drugs.

Our prosecutions are wide-ranging and include the resolution of allegations against many and varied entities, most prominent among them the hospital chain HCA, Inc., formerly known as Columbia/HCA Healthcare Corporation. HCA paid $631 million plus interest to resolve their outstanding civil cost reporting issues with the Government. Combined with the $841 million already paid by HCA, this prosecution represents the largest total health care fraud recovery to date from a single provider.

In our audits and evaluations, we continue to find large program overpayments. For example, we have uncovered significant Medicaid overpayments in the area of school-based health services and administrative claims. The failure to provide services by appropriate professionals and/or to have documentation supporting many of the claims resulted in an overpayment of approximately $172.6 million in one State alone. OIG will continue to audit Medicaid expenditures into the future.

Not only do we suggest ways to prevent fraud, waste and abuse, we also seek to identify vulnerabilities in need of correction. One of our more important evaluations looked at the Medicare-Approved Heart Transplant Centers. Since no continuing standards for heart transplant centers existed at the time of our study, we ascertained whether the centers currently met the initial criteria for becoming Medicare-Approved. This study allowed us to provide data that will help the Department in drafting regulations to ensure the continuing quality of Medicare-Approved Heart Transplant Centers.

The successes of the past 6 months are truly a tribute to the dedicated individuals who work at OIG. It is our job to be vigilant and zealous in the pursuit of fraud, waste and abuse. It is also our job to make sure that our work is useful and results in recoveries of money, closure of loopholes in law, or changes in program operations to minimize any abuse. We take the job and the mission very seriously and will continue our efforts into the future.

Dara Corrigan
Acting Principal Deputy Inspector General

Highlights

Summary of Accomplishments

For the first half of fiscal year 2004, the Office of Inspector General (OIG) reported savings of over $16.8 billion, comprised of $15.4 billion in implemented recommendations and other actions to put funds to better use, $214 million in audit receivables, $8.3 million in additional audit recoveries, and $1.2 billion in investigative receivables. (Details pp. 50, 54, and 57.)

In addition, for this reporting period, OIG reported exclusions of 1,544 individuals and entities for fraud or abuse of Federal health care programs and/or their beneficiaries; 234 convictions of individuals or entities that engaged in crimes against departmental programs; and 107 civil actions, which include all False Claims Act and unjust enrichment suits filed in district court, all Civil Monetary Penalties Law settlements, and all administrative recoveries related to provider self-disclosure matters. (Details pp. 16 and 54.)

Medicare Prescription Drug, Improvement and Modernization Act of 2003

In early December, the President signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the Act), a measure that will bring fundamental changes to Medicare reimbursement and coverage. Among its many provisions, the Act creates a voluntary out-patient prescription drug benefit and offers additional prescription drug benefits to low-income beneficiaries. It authorizes health savings accounts and amends some of the Department's regulatory processes. In addition, the Act makes broad changes to Medicare's fee-for-service payment practices. Most of these changes will be phased in over coming years.

It is noteworthy that throughout the law, the Congress relied on prior OIG work in identifying immediate reductions in reimbursement for various items or services for which Medicare has overpaid. OIG will identify cost savings such as these in this and future semiannual reports. Also, importantly, the Act specifically enlists OIG to perform a variety

of studies that will provide independent factual information to assist the Department in revising aspects of the Medicare program to comply with the new law. For example, OIG is directed immediately to study the costs of drugs used to treat end stage renal disease and to monitor widely available market prices for drugs on an ongoing basis.

Prescription Drugs

In updating two previous studies on the prescription inhalation drugs albuterol and ipratropium bromide, OIG found that Medicare continued to pay far more for both drugs than other payers. If Medicare had been able to purchase these drugs at the Medicaid Federal Upper Payment Limit amount, savings would have reached nearly $650 million for FY 2002. And since the release of reports on this subject several years ago, the prices available to the supplier community have decreased, while the Medicare reimbursement prices have remained the same.

In the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Congress lowered payments for inhalation drugs to between 80 and 85 percent of the average wholesale price. The Congressional Budget Office estimates that this will save Medicare $4.2 billion over 10 years. (Details p. 5.)

Hospitals

HCA, Inc., formerly known as Columbia/HCA Healthcare Corporation, agreed to pay $631 million plus interest to resolve the Government's remaining civil claims against the hospital chain. When combined with an earlier settlement totaling approximately $840 million, these resolutions represent the largest total health care fraud recovery ever obtained from a single provider. (Details p. 22.)

In South Carolina, St. Francis Hospital, Inc., entered into the largest settlement ever reached solely under OIG's administrative authorities and one of the largest settled under OIG's Provider Self-Disclosure Protocol. The hospital-based home health agency, hospice, and durable medical equipment supplier agreed to pay $9.5 million after self-reporting Medicare billing improprieties to OIG. (Details p. 15.)

School-Based Health Services

In reviews of four States, OIG found large Medicaid overpayments for school-based health services and administrative activities. Most significantly, OIG estimated that New York improperly claimed $172.6 million in Federal Medicaid funds for speech services that did not meet Federal and State requirements. Many of the services claimed lacked a referral by an appropriate medical professional or were not provided by or under the direction of a qualified speech-language pathologist. In the three other States, Federal overpayments totaled an estimated $7.9 million. These unallowable claims generally occurred because States did not provide sufficient guidance to and oversight of local education agencies. OIG recommended that the States refund the overpayments to the Federal Government. (Details p. 11.)

Noncustodial Parents' Contributions to Medicaid Costs

Because medical support orders are not enforceable when noncustodial parents cannot obtain or afford employer-sponsored medical insurance, some children who receive child support are enrolled in Medicaid if they meet the income criteria. The objective of this eight-State initiative was to determine the number of such children and the potential savings to Medicaid if noncustodial parents were required to contribute toward the Federal and State Medicaid costs incurred on behalf of their children. OIG estimated that some noncustodial parents were financially able to contribute a total of $99 million, or 50 percent, of their children's Medicaid costs during a 1-year period. (Details p. 36.)

Departmental Financial Statement Audit

For the fifth year, OIG's audit found that the Department's financial statements fairly presented its financial position in all material respects. In addition, OIG's audit approach allowed the Department to successfully meet its accelerated November 15, 2003 target date for submitting the financial statements and audit results to the Office of Management and Budget. However, OIG noted two continuing material weaknesses: serious deficiencies in the Department's financial systems and processes for producing financial statements and inadequate internal controls over Medicare information systems. Material weaknesses are defined as systemic problems cutting across a number of operating divisions or significant dollar issues affecting an individual division. (Details p. 46.)

Durable Medical Equipment Suppliers

Abbott Laboratories and Abbott's Ross Products Division agreed to pay a total of $615 million as part of a global criminal, civil, and administrative settlement with the Government. The settlement resolved allegations that Ross paid kickbacks to purchasers of enteral nutrition items and services. In addition, CG Nutritionals, Inc., an Abbott subsidiary, pled guilty and was sentenced for obstructing a health care fraud investigation. (Details p. 20.)

OIG continued to focus on the investigation of fraudulent providers of power wheelchairs and other power mobility products to Medicare beneficiaries. The matters at issue involved inflated billings to Medicare, charges for equipment and supplies not delivered, the payment of kickbacks for wheelchair referrals, and the falsification of documents needed to qualify beneficiaries for wheelchairs and other equipment they often did not need. (Details p. 20.)

Table of Contents

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) net costs. In addition to issuing an opinion on the statements, auditors assess compliance with Medicare laws and regulations and the adequacy of internal controls.

CMS Financial Statement Audit ❖❖

CMS again received an unqualified opinion on its FY 2003 financial statements. However, this report noted continuing material weaknesses in financial systems and regional and central office oversight of the Medicare contractors and in Medicare electronic data processing (EDP) controls. Because the Medicare contractors lacked an integrated accounting system to accumulate and report financial information, they used ad hoc, labor-intensive reports, which increased the risk of human error, material misstatement, or omission. Also, numerous weaknesses in EDP processing controls at the Medicare contractors, as well as application control weaknesses at a contractor shared system, increased the risk of unauthorized access to and disclosure of sensitive information, malicious changes that could interrupt data processing or destroy files, improper Medicare payments, and disruption of critical operations.

CMS officials concurred with the recommendations and are taking corrective action. Most importantly, they are continuing efforts to implement the Healthcare Integrated General Ledger Accounting System, which is expected to be fully operational in 2007. (A-17-03-03003)

Comprehensive Error Rate Testing Program

CMS established a Comprehensive Error Rate Testing (CERT) program to review the appropriateness of Medicare payments made by and the reliability of claims review processes used by Medicare intermediaries. The objective of this review was to determine whether the contractor responsible for performing the CERT reviews followed established protocols. OIG's review of 105 claims found that the contractor generally followed established error rate review policies and procedures for 99 claims. However, the medical records for six claims were never received, and letters requesting medical records were often sent late. In addition, quality assurance reviews were not performed for 22 of 45 claims sampled, and the results of those reviews that were performed were not shared with medical review specialists.

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

CMS agreed with OIG's recommendation to follow established schedules in requesting medical records and to make better use of quality assurance reviews. (A-03-03-00014)

Hospital Payment Monitoring Program

The objective of this audit was to determine whether the Clinical Data Abstraction Centers that are responsible for carrying out CMS's Hospital Payment Monitoring Program (HPMP) followed the established error rate review policies and procedures. OIG's review of 90 inpatient acute care hospital claims found that the centers generally followed established error rate review policies and procedures. In addition, a review of 45 claims subject to the HPMP internal quality control process showed that controls were generally operating effectively. However, OIG did note procedural problems. For 2 of the 90 sampled claims, one center did not send followup letters requesting medical records, and for 1 of the 45 claims subject to quality control reviews, a quality control procedure was not followed.

OIG made recommendations concerning followup requests and clarification of final determinations on opposing medical screening decisions. CMS concurred with the recommendations. (A-03-03-00015)

Medicare's National Correct Coding Initiative

In January 1996, CMS implemented the National Correct Coding Initiative (CCI) designed to promote correct coding by Medicare providers and to prevent payment for improperly coded services. Under this program, payment processing edits are established to identify pairs of procedure codes that should not be billed together, either because one of the services is a component of a more comprehensive procedure, or because the two services cannot reasonably be performed together. Medicare carriers are required to apply the edits to the Part B claims they process for payment when a provider bills for more than one service for the same beneficiary on the same date of service.

OIG found that 98 percent of services targeted by CCI edits were paid appropriately by Medicare in 2001. Of the small percentage of services that met the criteria for denial based on CCI edits, 70 percent may have been paid correctly

due to adjustments made when two services in a CCI edit code pair were billed on different days. The OIG concluded that CCI edits appear to prevent Medicare payments for nearly all targeted services. (OEI-03-02-00770)

CMS Oversight of Cost-Avoidance Waivers

Generally, Medicaid State agencies decline to pay claims for beneficiaries who have other insurance, but CMS may authorize "cost-avoidance waivers" to States that demonstrate that the alternate "pay and chase" method (i.e., paying the provider's claim and then seeking recovery from the liable third party) is cost effective. In this inspection of CMS's oversight of cost-avoidance waivers, OIG found that CMS and States differed on whether States were operating under approved waivers. In addition, CMS approved waiver requests that did not meet the criteria set forth in Federal regulations. CMS does not require States to report the data necessary to determine the cost-effectiveness of waivers. Of the 34 States that had cost-avoidance waivers, 17 did not report attempted recoveries or validly denied figures to OIG. Without this data, OIG believes it would be difficult for CMS to make informed decisions concerning the cost-effectiveness of waivers. Another 17 States, however, did provide the requested data. Figures reported by 14 of those 17 States showed $307 million in outstanding payments potentially owed by liable third parties in FY 2000. This money has been paid out by Medicaid, yet the dollars associated with these claims have not been returned to the Federal Government and the States.

OIG recommended that CMS improve its oversight of the cost-avoidance waiver process and also require more extensive and accurate data on States' efforts at pay-and-chase and cost avoidance (i.e., returning the claim to the provider so that the provider can bill the liable third party). In its response to the report, CMS concurred with OIG's recommendations, but felt that the amount potentially owed to the States was significantly less than the amount stated in the report. (OEI-03-00-00031)

Terminated Medicare Contractors

OIG reviewed two insurance companies in Connecticut that processed and paid Medicare fee-for-service claims until their contractual relationships with CMS were terminated.

One company claimed nearly $2.9 million in unallowable costs: $2.5 million in termination costs and $366,000 in severance costs. Contrary to the Medicare contract's provisions, the company continued to claim subcontract lease costs for periods after the contract termination date, and certain termination costs were not allowable for reimbursement under the Federal Acquisition Regulation. The company agreed in part with OIG's recommendations for financial adjustments. (A-01-02-00508)

At the second company, OIG identified almost $1.4 million in excess pension assets that should be remitted to Medicare. Under Federal regulations and the Medicare contract, any gains in pension assets should be credited to the Medicare program when the Medicare segment of an employee pension plan closes. The company agreed to remit the excess assets. (A-07-02-03021)

Update: Excessive Medicare Reimbursements for Drugs

If Medicare had been able to reimburse for albuterol and ipratropium bromide at the Medicaid Federal Upper Limit amount, in calendar year 2002 the program would have saved nearly $650 million.

Medicare has been paying more for both albuterol and ipratropium bromide, (inhalation drugs used to treat respiratory conditions) than other payers, costing the program and its beneficiaries millions of dollars a year. If Medicare had been able to reimburse for these drugs at the Medicaid Federal Upper Limit amount, in calendar year 2002 the program would have saved nearly $650 million ($263 million for albuterol and $386 million for ipratropium bromide). Furthermore, data collected from a drug wholesaler and a group purchasing organization showed that pharmacies were able to purchase the drugs for substantially less than the Medicare reimbursement amounts. Based on the results of an earlier OIG report, the price at which both drugs are available to the supplier community decreased, while the Medicare reimbursement amount remained the same.

The Congressional Budget Office estimates savings on inhalation drugs to be more than $4 billion over the next 10 years. Based in part on OIG studies of these daily costs, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 provides for numerous changes in Medicare's reimbursement methodology for drugs covered under Part B, including reductions in the amount Medicare pays for albuterol and ipratropium bromide.
(OEI-03-03-00510; OEI-03-03-00520)

Medicare Reimbursement for Lupron

OIG determined the amount Medicare would save if all carriers established a "least costly alternative" policy for Lupron, a prostate cancer drug. Under such a policy, where treatments are medically equivalent, Medicare would reimburse at the rate of the least costly drug, since there would be no medical necessity for the more expensive product. This OIG study found that if carriers in 10 jurisdictions were to implement a least costly alternative policy for the drug, Medicare and its beneficiaries would save $40 million per year. In 2003, Medicare carriers in 47 of 57 jurisdictions applied a least costly alternative policy to Lupron, reimbursing $446 for 7.5 mg of the drug. In comparison, carriers in the 10 jurisdictions without a least costly alternative policy reimbursed $612 for the same amount of substance.

OIG recommended that CMS encourage all Medicare carriers to apply a least costly alternative policy to Lupron. CMS partially concurred with OIG's recommendation. (OEI-03-03-00250)

Omission of Drugs From the Federal Upper Limit List

Medicaid limits the amount of reimbursement for drugs with available generic equivalents. Federal Upper Limits were established to ensure that the Federal Government acts as a prudent payer by taking advantage of current market prices for multiple-source drugs. Ninety drug products were not included on the Federal Upper Limit List in 2001, despite meeting the criteria established by Federal law and regulation. This inspection found that Medicaid could have saved $123 million in 2001 by adding 55 of the 90 drug products to the Federal Upper Limit list. This represents 30 percent of the $411 million Medicaid reimbursed for these 55 products that year. The remaining 35 drug products met the criteria for inclusion on the Federal Upper Limit list, but did not have any associated savings.

This report recommended that CMS take steps to ensure that all drugs meeting the criteria set forth in Federal law and regulation are included on the Federal Upper Limit list. In their response to the report, CMS disagreed with OIG's savings estimates. (OEI-03-02-00670)

Payments for Enteral Nutrition

Medicare groups enteral nutrition formula products into seven categories, based on their composition; a wide variety of formulas, including the products Boost, Ensure, Isosource and Nutren, are grouped under Category I. This inspection compared the amount Medicare reimburses for Category I enteral nutrition formulas to prices available to the supplier community. The Category I formulas that were represented by code B4150 accounted for $201 million of the $311 million in Medicare Part B payments for all enteral nutrition formulas in 2001. OIG obtained 177 individual contract prices for these formulas through one national wholesaler, one group purchasing organization, and one supplier who negotiated contracts directly with two enteral nutrition formula manufacturers. Medicare's reimbursement amount for Category I formulas ($0.61 in 2001) exceeded median contract prices available to suppliers from the three sources reviewed by 70 to 115 percent. Median contract prices ranged from $0.28 per unit to $0.36 per unit. Individual contract prices varied from a low of $0.18 per unit to a high of $0.86 per unit, yet the majority (75 percent) of individual contract prices were lower than $0.42 per unit.

- **Medicare groups enteral nutrition formula products into seven codes based on their composition.**
- **Category I formulas represented by code B4150 accounted for $201 million of the $311 million in Medicare Part B payments for all enteral nutrition.**

OIG recommended that CMS consider using its inherent reasonableness authority to reduce the Medicare reimbursement amount for Category I formulas. CMS agreed with OIG's recommendation. (OEI-03-02-00700)

State Strategies to Contain Medicaid Drug Costs

Escalating Medicaid drug expenditures, combined with strained State budgets, have precipitated the development of State strategies to contain Medicaid drug costs. Federal Medicaid constraints prevent States from benefitting from some cost containment tools widely used by private purchasers. However, States

exercise their flexibility within Federal Medicaid parameters to employ three main drug cost containment strategies: (1) limiting Medicaid reimbursement for drugs (32 States); (2) shifting use from higher to lower cost drugs (39 States); and (3) limiting drug quantities (25 States).

Actual Maximum Allowable Cost Savings

State	Actual Annual Savings (millions)	Savings as Percent of States' FY 01 Drug Expenditures
NE	$22	15.7
MO	$45.8	8.5
VT	$4	4.9
WA	$15.3	4.2

Maximizing States' ability to contain drug costs can provide a significant fiscal benefit to State and Federal Medicaid budgets. However, States face significant challenges to maximizing drug cost savings, including lack of accurate drug price information and stakeholder opposition to cost containment efforts. (OEI-05-02-00680)

Resource Utilization Groups ❖❖

When a beneficiary meets certain conditions, Medicare Part A helps pay for skilled nursing facility care. Beginning with the first cost reporting period after July 1, 1998, Medicare began paying skilled nursing facilities through a case-mixed adjusted per diem prospective payment. To determine the case-mix, skilled nursing facilities classify residents into 1 of 44 resource utilization groups that are divided into seven major categories.

SEVEN MAJOR RESOURCE UTILIZATION GROUP CATEGORIES

- **Special Rehabilitation**
- **Extensive Services**
- **Special Care**
- **Clinically Complex**
- **Impaired Cognition**
- **Behavior Problems**
- **Reduced Physical Function**

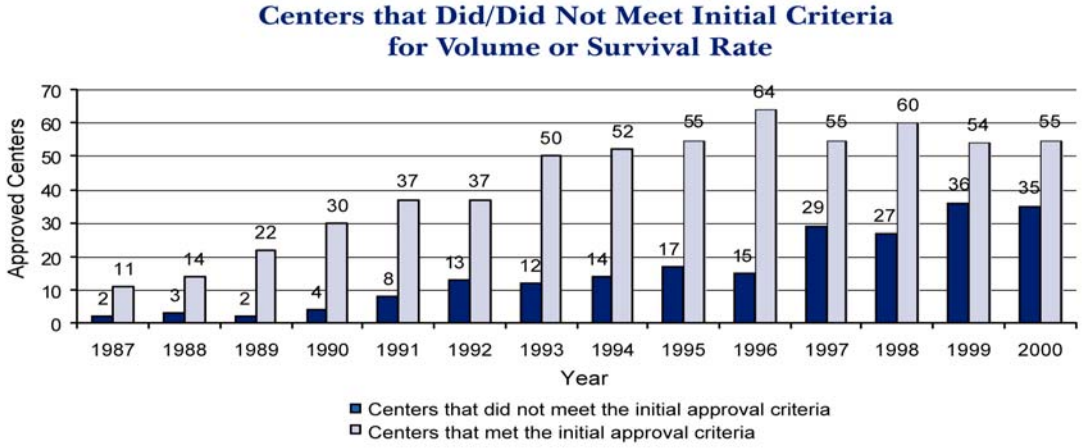
This report followed up on an earlier study mandated by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 and examined changes in the proportion of Medicare beneficiaries assigned to each resource utilization group in skilled nursing facilities between January 1999 and December 2002, given legislative changes in reimbursement levels. OIG found that minimal shifts occurred. Overall, the rehabilitation category, the largest of the resource utilization group

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

categories, remained stable. Assignment to the rehabilitation sub-categories shifted in correlation with the reimbursement changes of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. In addition, small changes were seen in other categories, including extensive care, special care, and clinically complex services. (OEI-01-03-00180)

Medicare-Approved Heart Transplant Centers ❖❖

OIG found that many Medicare-approved heart transplant centers have performed at volume and survival rates below the minimum levels required for their initial Medicare approval, sometimes for several consecutive years. Furthermore, CMS receives incomplete information from centers regarding their volume and survival rate performance and does not regularly obtain volume and survival rate data from the Scientific Registry of Transplant Recipients.



OIG recommended that CMS expedite the development of standards for continuing performance and for the reapproval of approved centers as well as guidelines for what levels of performance trigger specific responses from CMS and, in the short term, improve its oversight of centers by entering into an arrangement with HRSA for the regular exchange of volume and survival rate data. (OEI-01-02-00520)

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

Managed Care Payments for Institutionalized Beneficiaries

Medicare pays a higher monthly rate to managed care organizations for beneficiaries who are institutionalized. This report consolidated the results of a national sample of eight managed care organizations and individual audits of five others. Based on these results, OIG estimated that the organizations received $12.8 million in unallowable payments for beneficiaries incorrectly claimed as institutionalized during a 3-year period.

OIG recommended that CMS improve oversight procedures to better identify managed care organizations that inappropriately claim beneficiaries as institutionalized and instruct the organizations to repay the overpayments. CMS stated that it was considering implementing the recommendations. (A-05-02-00078)

Institutions for Mental Diseases

Federal regulations preclude Federal Medicaid funding of medical services, except inpatient psychiatric services, provided to under-21-year-old residents of institutions for mental diseases. OIG estimated that during a 4-year period, New York State improperly claimed $7.6 million in Federal funds for services provided to such residents. The State either lacked controls or did not apply existing controls to prevent Federal funds from being claimed for these residents.

In addition to recommending procedural changes, OIG recommended that the State refund the $7.6 million and identify and refund any improper Federal funds claimed after the audit period. State officials generally disagreed with OIG's findings and recommendations. (A-02-02-01024)

Clinical Diagnostic Laboratory Service Claims

Federal law limits Medicaid payments for clinical laboratory tests to the amounts payable for the same tests under the Medicare fee schedule. However, in this followup audit on the Massachusetts Medicaid laboratory billing system, OIG found that of the $29 million in hospital outpatient laboratory claims submitted by the State for the period July 1999 through March 2002, $8.2 million ($4.1 million

Federal share) exceeded the Medicare fee schedule amounts. The State's procedures were not adequate to ensure that amounts claimed for Medicaid laboratory services and submitted for Federal reimbursement complied with the Medicare fee schedule.

In addition to recommending financial adjustment, OIG recommended that the State ensure that amounts claimed for hospital laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts. The State disagreed with the findings. (A-01-02-00015)

Home Health Services Preceded by a Hospital Stay

The objective of these reviews was to determine whether home health agencies properly claimed Medicare reimbursement for services to certain beneficiaries who were previously discharged from inpatient hospitals. These claims should have been reimbursed at a lower rate but were not because the home health agencies did not accurately identify prior hospital stays on patient assessment forms. Overpayments totaled nearly $21 million.

OIG recommended that regional home health intermediaries recover the overpayments, identify and collect overpayments made following the audit period, and educate home health agencies to ensure that they accurately enter beneficiary discharge data on patient assessment forms. The three regional home health intermediaries reviewed were Palmetto Government Benefits Administrators (approximately $10 million in overpayments), Cahaba Government Benefits Administrators ($5.6 million in overpayments), and United Government Services (approximately $5.3 million in overpayments).
(A-04-03-00018, A-07-03-04021, A-09-03-00042)

School-Based Health Services

In a series of reviews, OIG determined whether Medicaid payments for school-based health services and related administrative activities complied with Federal and State requirements. Section 1903(c) of the Social Security Act was amended in 1988 to allow Medicaid coverage of health-related services for children under the Individuals with Disabilities Education Act. The Individuals with Disabilities Education Act requires States to provide appropriate special education and related services to children with disabilities or special needs.

Illinois

Based on a statistical sample, OIG estimated that the State claimed about $6.1 million in unallowable Federal reimbursement. Local education agencies improperly included claims for, among other things, services not included in the child's or family's plan and services on dates when school was closed or students were absent. In addition, the State had not fully implemented computer edits to limit payments to local agencies to the lower of billed costs or the statewide ceiling. Illinois generally agreed with OIG's findings but did not agree to refund the overpayment. (A-05-02-00049)

Iowa

Due to inadequate monitoring of Medicaid school-based administrative costs, the State improperly claimed almost $640,000 in Federal funds. Most of the improper claims concerned expenditures without the required State matching funds. The State did not agree with the recommended financial adjustment. (A-07-02-02099)

New York

Of a statistical sample of 100 speech claims, 56 did not meet Federal and/or State requirements. Many of the services claimed lacked a referral by an appropriate medical professional or were not provided by or under the direction of a qualified speech-language pathologist. Other services were not properly documented, did not meet the minimum number of services per month, or lacked individualized education or family plans. OIG estimated that the State improperly claimed $172.6 million of Federal Medicaid funds from September 1, 1993 through June 30, 2001 and recommended that the State refund this amount to the Federal Government. The State disagreed with OIG's findings and recommendations. (A-02-02-01030)

Rhode Island

As a result of inadequate oversight and monitoring of school-based services, the State reimbursed ineligible claims and disseminated private information. In addition, the State did not always disseminate or adequately explain Medicaid program guidance to the local education agencies. Based on a statistical sample covering 2 years, OIG estimated that the State claimed about $1.2 million in unallowable Federal reimbursement. Some unallowable claims were for services rendered by health care providers who did not have the qualifications required by Medicaid regulations. The State generally agreed with OIG's procedural

recommendations but disagreed with the recommended financial adjustments. (A-01-02-00014)

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. CMS guidance specifically prohibits Federal DSH funding for health care services provided to prison inmates. In a review of DSH funding in New Jersey, however, OIG found that even though the State plan prohibited funding of health care services for prison inmates, the State claimed an estimated $22.2 million ($11.1 million Federal share) for such costs. In addition to making procedural recommendations, OIG recommended financial adjustment; the State generally disagreed. (A-02-02-01028)

Outreach

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

Advisory Opinions

In accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996, OIG, in consultation with the Department of Justice, may issue advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Medicare and State health care programs. This authority allows OIG to provide additional and case-specific formal guidance regarding the application of the anti-kickback statute and safe harbor provisions, as well as other OIG health care fraud and abuse sanctions. For the period from October 1, 2003 through March 31, 2004, OIG received 33 advisory opinion requests and issued 3 advisory opinions.

In addition, OIG issued guidance entitled, "Hospital Discounts Offered to Patients Who Cannot Afford to Pay Their Hospital Bills." With this guidance, OIG offered its assurance that under the fraud and abuse laws, hospitals have the ability to provide discounts to uninsured and underinsured patients who cannot afford their hospital bills and to Medicare beneficiaries who cannot afford their Medicare cost-sharing obligations. Nothing in OIG's rules or regulations prohibits such discounts, and OIG fully supports the hospital industry's efforts to lower health care costs for those unable to afford care. The full text of the guidance, and related fraud alerts and special advisory bulletins, may be found on the OIG website.

Compliance Guidelines

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

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

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG established a set of comprehensive guidelines for voluntary self-disclosures, titled "Provider Self-Disclosure Protocol," available on the Internet at http://oig.hhs.gov in the "Fraud Prevention & Detection" section. 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). 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 212 submissions. Self-disclosure cases have resulted in 42 recoveries and 30 settlements, totaling over $74 million collectively. Examples include the following:

- ***South Carolina***—St. Francis Hospital, Inc., agreed to pay $9.5 million to resolve Medicare billing improprieties from 1997 through 1999 in its home health, hospice, and durable medical equipment programs. After conducting an internal investigation and audit, St. Francis discovered significant error rates and systematic documentation lapses in its claims submitted to Medicare. The hospital subsequently disclosed these findings to OIG under the Protocol. The settlement is the largest OIG has reached to date under the Civil Monetary Penalties Law and one of the largest reached to date under the Protocol.

  Also in South Carolina, Lexington Medical Center agreed to pay $99,000 in order to settle two separate submissions concerning claims for services rendered by two excluded individuals employed by the hospital.

- ***North Carolina***—Cumberland County Hospital System, Inc., doing business as Cape Fear Valley Home Health and Hospice, agreed to pay the Government $1 million to resolve its liability for identified misconduct. In July 1998, Cape Fear self-disclosed to OIG suspected documentation and billing irregularities with respect to Medicare and Medicaid claims for home health services that were provided to patients who were not homebound and for services that were not properly certified or properly ordered by a physician.

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 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

OIG Administrative Sanctions

During this reporting period, OIG administered 1,651 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 brief explanation of these sanction authorities can be found in Appendix F.

Program Exclusions

During this reporting period, OIG excluded 1,544 individuals and entities from participating in the Medicare and Medicaid programs and other federally sponsored health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocation. Examples include the following:

- ***Unproven Opiate Detoxification Procedure***—A physician was excluded for an indefinite period of time based on the loss of his license to practice medicine in the State of New Jersey. The physician and his partner provided an opiate detoxification procedure to patients addicted to opiates. The addiction procedure is neither medically established nor recognized. Six patients died and numerous other patients were hospitalized after undergoing this procedure in the physician's office.

- ***Multiple Convictions***—A licensed practical nurse in Arkansas was excluded permanently from participation in all Federal health care programs because she was convicted on three separate occasions for crimes related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service, and crimes related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. While working at a nursing and rehabilitation center, she stole controlled substances by signing out the drugs on the narcotics log. Sometimes she indicated the drugs were given to a specific patient, when they were not; and sometimes she only gave the patient a portion of the medication. At other times, she did not chart the drugs to any patient. Additionally, she was convicted for forging prescriptions in two separate jurisdictions.

- ***Child Molestation***—In California, a marriage, family, and child counselor was excluded for 30 years based on his conviction for performing lewd and lascivious acts upon several of his male patients under the age of 14. He was also sentenced to 22 years of incarceration, and the State Board of Behavior Sciences revoked his license

- ***Kickbacks and False Blood Tests***—Also in California, a physician and co-operator of a medical clinic was excluded for 20 years after being found guilty of health care fraud and aiding and abetting. The physician submitted fraudulent claims to Medi-Cal as a result of a financial kickback arrangement with several laboratories to which he made referrals. His scheme involved using blood drawn from his employees to pair with false Medi-Cal beneficiary information and recruiting individuals to provide blood in exchange for payment. He was sentenced to 18 months of imprisonment and ordered to pay $1.1 million in restitution.

- ***Illegal Prescription of Controlled Substances***—A doctor of osteopathy was excluded for 30 years after being convicted on multiple counts of insurance fraud, delivery of a controlled substance, prescribing a controlled substance contrary to legal requirements, and practicing osteopathic medicine and surgery without a license. The court sentenced him to 30 to 120 years of imprisonment for insurance fraud and 14 to 28 years for the drug convictions. Despite operating on both an expired and suspended medical license, the osteopath continued to engage in the practice of medicine in Pennsylvania.

Civil Monetary Penalties

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. During this reporting period, OIG collected over $9 million in civil monetary penalties and assessments. For example:

- ***Contracting With an Excluded Individual***—Community Residences, Inc., a nonprofit provider of community-based physical disability, mental health, and mental retardation services in Virginia, agreed to pay the Government $25,000. The settlement resolved allegations of contracting with an individual who had been excluded from participation in Federal health care programs. Based on a credentialing audit and subsequent investigation, the provider self-disclosed to OIG that it had engaged an excluded individual as the medical director for two of its facilities.

Kickbacks

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

- ***Cardiologist and Hospital***—Good Samaritan Hospital in Nebraska agreed to pay the Government $1.2 million and entered a 5-year corporate integrity agreement to settle alleged violations of the statutory prohibition on physician self-referrals (the Stark law) and the Federal anti-kickback statute. The hospital allegedly provided a cardiologist with inducements, including underwriting a loan, paying practice consultants, and providing free or reduced price drugs and medical equipment, in exchange for patient referrals. The cardiologist had been previously sentenced to 1 year and 1 day in prison for health care fraud.

Patient Dumping

Between October 1, 2003 and March 31, 2004, OIG collected civil monetary penalties of approximately $297,000 from 9 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 this statute:

- ***Burn Patient***—Jackson Memorial Hospital in Florida agreed to pay $50,000 to resolve allegations that it failed to accept the appropriate transfer of a burn patient who needed its specialized capabilities to treat burn victims.

- ***Patient Unable to Pay***—Also in Florida, St. Mary's Medical Center agreed to pay $40,000 to resolve allegations that it did not provide an appropriate medical screening examination to an individual who presented to its emergency department for evaluation. He was allegedly refused such treatment based on his inability to pay.

- ***Multiple Patients***—SouthPointe Hospital in Missouri agreed to pay $100,000 to resolve allegations that it failed to provide medical screening examinations and/or stabilizing treatment to four individuals who presented to its emergency department. One individual presented with a blood alcohol level of .43, another with lacerations on both her wrists, another with high blood pressure and dizziness, and the last complained of depression, stating she had been raped.

- ***Patient Sent to Another Hospital***—In California, Mercy San Juan Medical Center agreed to pay $25,000 to resolve allegations that it failed to provide an appropriate medical screening examination, stabilizing treatment, or an appropriate transfer to a woman who presented to its emergency department by order of her physician. Instead, for insurance-related reasons, she was directed to seek treatment at another hospital.

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

In the 6 months ending March 31, 2004, the Government negotiated more than $995 million in 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.

Durable Medical Equipment (DME) Suppliers

- ***Enteral Nutrition***—In Illinois, Abbott Laboratories and Abbott's Ross Products Division entered a global criminal, civil, and administrative settlement totaling $615 million with the Government. The settlement resolved allegations that Ross paid kickbacks to purchasers of enteral nutrition items and services by: conditioning the sale of enteral nutrition sets on the purchase of enteral nutrition feeding pumps; failing to collect rental payments for the sets and pumps; and paying "conversion bonuses" that bore no relation to the actual cost of converting from one manufacturer to another. As part of the settlement, CG Nutritionals, Inc., an Abbott subsidiary, was sentenced based on its guilty plea to obstructing a health care fraud investigation and agreed to be permanently excluded. Abbott also agreed to enter into a company-wide, comprehensive 5-year corporate integrity agreement.

- ***Power Wheelchairs***—In Florida, four individuals were sentenced for their involvement in a DME fraud scheme. Along with three others previously sentenced for their roles in the scheme, the four were charged with conspiring to defraud Medicare in connection with fraudulent claims for the

cost of power wheelchairs and accessories purportedly supplied by two DME companies. All seven defendants pled guilty prior to trial. The two organizers of the conspiracy were sentenced to prison terms of 87 months and 53 months, respectively. The other five defendants were sentenced to prison terms ranging from 1 year and 1 day to 78 months. The organizers and their top patient recruiter were ordered to pay $1.7 million in joint and several restitution. The four other defendants were held responsible for paying restitution in amounts ranging from $406,000 to $867,000, as a portion of the joint restitution figure.

Also in Florida, a man was sentenced to 37 months in prison and ordered to pay $1 million in restitution for health care fraud. From 1999 to 2002, he operated and controlled four different DME companies using "straw nominee" owners to conceal his true identity. He submitted claims to Medicare for power wheelchairs that were either not provided, were used or refurbished but billed as new, or were exchanged for less expensive scooters. He also billed for unnecessary repairs of the equipment and paid kickbacks for wheelchair referrals. In 1997, he was convicted in State court of Medicaid provider fraud in connection with using the same DME scheme.

➤ ***Medically Unnecessary Equipment***—Unity Health Services, LLC, in Missouri agreed to pay $877,000 for allegedly submitting claims for DME that lacked the required medical necessity documentation. OIG's investigation into the improper billings stemmed from Unity's initial disclosure to the Department of Justice. The DME included wheelchairs, hospital beds, oxygen, enterals, and continuous positive airway pressure devices.

➤ ***Orthotics and Incontinence Supplies***—Two former owners of a DME company were ordered to pay $195,000 in joint restitution for fraudulently billing Medicare and Medicaid for expensive orthotics and incontinence supplies. One was also sentenced to 46 months in prison and ordered to pay a special assessment of $4,600 for health care fraud, conspiracy to launder money, money laundering, and procuring U.S. citizenship contrary to law. The other was sentenced to 1 year and 1 day in prison for health care fraud and conspiracy to commit health care fraud. She transported patients to doctors' offices and offered them gifts to obtain prescriptions for DME.

Hospitals

➤ ***HCA***—Following an OIG audit and investigation, HCA, Inc., formerly known as Columbia/HCA Healthcare Corporation, agreed to enter a settlement and pay $631 million, plus interest. The settlement resolved allegations that HCA knowingly submitted false costs reports to Medicare; entered into improper referral arrangements with physicians that violated the anti-kickback statute and the Stark law; and submitted false claims for wound care services provided at 56 HCA hospitals. HCA also agreed to pay the Government $5 million to resolve its civil and administrative liability relative to allegations concerning claims for patients transferred to other facilities.

In a separate administrative settlement, HCA agreed to pay CMS $250 million to resolve administrative overpayments in connection with its cost reports. In December 2000, HCA paid approximately $840 million in criminal fines, civil restitution, and penalties to resolve a separate set of allegations and entered into a comprehensive 8-year corporate integrity agreement. In combination with the earlier settlement, this criminal, civil, and administrative resolution represents the largest health care fraud recovery ever obtained by the Government.

➤ ***Metropolitan***—In Michigan, Metropolitan Hospital, an acute care facility, and several related entities, agreed to pay $6.2 million to settle allegations of submitting false claims to Medicare. Metropolitan allegedly engaged in prohibited financial relationships with various physicians through whom the hospital received Medicare reimbursement for services to patients referred by those physicians. Metropolitan also allegedly submitted claims for services rendered in its detoxification unit for which medical necessity was not documented and allegedly billed for wound care claims at a higher level of evaluation and management service than was documented.

➤ ***Coast Plaza***—Coast Plaza Doctors Hospital, a 123-bed acute care facility in California, agreed to pay the Government $4.1 million to settle allegations that it falsified its Medicare cost reports for the years 1994 through 1999. A *qui tam* lawsuit alleged that the hospital included charges on its

cost reports not related to patient care. Signed by the hospital's late chief executive officer (CEO), the cost reports included charges for golf clubs, jewelry, crystal, clothing, and entertainment. The CEO had misappropriated funds from the hospital in order to maintain an extravagant lifestyle. During the time under consideration, the hospital also saved substantial funds through the CEO's business practice of failing to pay hospital vendors the full amount they were owed. Despite the savings, Coast Plaza did not adjust its Medicare cost reports to reflect the fact that it had not paid these vendor charges. As part of the settlement, Coast Plaza entered into a com- prehensive 5-year integrity agreement with OIG. An additional $757,000 is also being recovered administratively by the fiscal intermediary's audit function.

➤ ***University of Illinois***—The University of Illinois agreed to pay $2.3 million to settle its liability under the False Claims Act. The settlement stemmed from a whistleblower complaint concerning the hospital's liver transplantation programs, as well as those at both the University of Chicago and Northwestern Memorial Hospital. The allegations related to care provided to liver transplant patients who did not need hospitalization prior to surgery. Specifically, from 1995 through 1998, the university hospital allegedly admitted liver transplant-eligible patients to the hospital and/or the intensive care unit when such care was not medically necessary; billed for the medically unnecessary hospitalizations and service; falsely diagnosed patients to justify their placement on the transplant eligibility list; and falsely identified their status to make them eligible for liver transplants before other patients. Separate settlements were reached earlier with the other two hospitals.

➤ ***Charleston Area Medical Center, Inc.***—A multi-facility, non-profit hospital group in West Virginia, agreed to pay $1.3 million and to enter a 5-year corporate integrity agreement for allegedly submitting false claims to Medicare and Medicaid from 1999 through 2001. The Government alleged that the group submitted claims for individual physical therapy when group physical therapy was actually provided. The group also allegedly submitted claims for more units of therapy than actually provided, therapy without sufficient documentation of treatment, and therapy provided by unqualified Medicare and Medicaid providers.

Nursing Homes

➤ ***Corporate Fraud***—Integrated Health Services, Inc., a nationwide chain of nursing homes, long-term care hospitals, and providers of ancillary services to nursing homes, entered into a global settlement to resolve False Claims Act liability and administrative claims. Because the firm is currently in bankruptcy and unable to pay more, the chain agreed to pay $19.1 million. The settlement covered five whistleblower lawsuits and two other fraud cases involving a variety of allegations. The primary fraud allegations included such improper billing and cost reporting practices as overcharging Medicare by billing for unnecessary and nonrendered services and wrongfully depreciating various equipment on its cost report. The company also agreed to enter two 5-year corporate integrity agreements, one for its long-term care division and one for its mobile diagnostic division, both of which are being sold to other companies as part of its bankruptcy reorganization.

➤ ***Money Laundering***—An Oklahoma nursing home owner/operator was sentenced to 63 months in prison for money laundering. The former Deputy Commissioner of Health conspired with the owner/operator to provide preferential treatment by the Oklahoma State Department of Health to the owner/operator's nursing homes. The former Deputy Commissioner also used Department employees in the illegal transfer of nursing home residents to homes belonging to the owner/operator. In return, the owner/operator paid the former Deputy Commissioner through an investment account specifically set up to make the payments. In August 2003, the former Deputy Commissioner was sentenced to serve an additional 2 years in prison for conspiracy.

➤ ***Overstating Services***—A Michigan physician agreed to pay the Government $233,000 and a private insurer $9,000 to settle his liability for allegedly submitting improper claims to Medicare. The physician routinely billed in excess of 100 nursing home patient visits a day and also routinely upcoded the visits without appropriate documentation. As part of the settlement, he also entered an integrity agreement with OIG.

➤ ***False Statements***—Two respiratory therapists in Georgia were ordered to pay restitution of $8,000 and $3,000, respectively, for false statements relating to health care. The therapists caused the nursing home where they

worked to submit Medicare claims for services that were not rendered or were not medically necessary. While records indicated they were working at the nursing home, the therapists were also clocked in as working at area hospitals.

Home Health

- ***Patients Not Homebound***—Visiting Nurse Association of Central Pennsylvania agreed to pay $685,000 and to enter a comprehensive 5-year corporate integrity agreement. The settlement resolved allegations of submitting false claims to Medicare between January 1995 and December 1999. The agency allegedly billed for home care nursing services provided to patients without properly assessing and/or reporting the homebound status of the patients as required by Medicare.

- ***Personal Expenses***—The owner/administrator of a home health agency in Minnesota was sentenced to 1 year of incarceration and ordered to pay $256,000 in restitution for health care fraud and income tax evasion. The owner/administrator put personal expenses, including charges for clothing, jewelry, flowers, and travel abroad, on his Medicare cost reports.

- ***Unlicensed Nursing Services***—In Idaho, a former home health agency owner/operator was ordered to pay $20,000 in restitution for executing a scheme to defraud the Medicare and Medicaid programs. The woman submitted claims for services performed by a nurse who had lost her license and for services by a nursing assistant who failed the State background check. The owner/operator attempted to hide the identity of the nurse performing the services by having a licensed nurse sign the progress notes. The owner/operator also made false statements regarding the results of the nursing assistant's background check.

Prescription Drugs

- ***OxyContin***—A Pennsylvania physician was sentenced to 16 months of incarceration and ordered to pay $54,000 in restitution and fines for charges related to prescription drug fraud. The physician wrote prescriptions for OxyContin (a powerful painkiller) knowing the prescriptions were not

medically necessary and the patients would not take the pills. He instructed patients to present the prescriptions to local pharmacies, obtain the drug, pay for the pills using their Medicaid benefits, and deliver the Oxycontin back to him for dispensing to others.

➤ ***Unlicensed Pharmacist***—A man who purported to be a licensed pharmacist in Massachusetts was sentenced for furnishing false information in records required to be made, kept, and filed under the Controlled Substances Act. From 1982 through 2001, he worked in a hospital's pharmacy department, though he was never a licensed pharmacist during that time. He was ordered to pay restitution of $40,000 to the hospital and a $5,000 fine.

Practitioners

➤ ***False Tax Returns and Other Documents***—A Florida physician was sentenced to 54 months imprisonment and ordered to pay $1.7 million in restitution for conspiracy to defraud the United States. He was involved with a business associate in filing false tax returns with the IRS, causing the filing of a materially false statement—a Medicare provider/supplier enrollment application—and providing false and fraudulent documents to assist another individual in receiving authorization to remain and work in the United States under a certain visa waiver process. The physician, who had been excluded for 10 years, held a majority ownership interest in a medical clinic that received reimbursement from Medicare; but, the Medicare provider enrollment application fraudulently omitted his association with the clinic.

➤ ***Misrepresentation of Services Provided***—In Georgia, The Physicians' Pain & Rehabilitation Specialists of Georgia, P.C., and certain of its member physicians agreed to pay $900,000 and to enter a 3-year corporate integrity agreement for allegedly submitting false claims to Medicare between 1996 and 1999. The firm and the physicians submitted claims to Medicare for different procedures than were actually performed and improperly billed for the technical component of certain procedures.

➤ ***Services Not Rendered***—A licensed clinical social worker in Georgia was sentenced to 1 year and 1 day of incarceration and ordered to pay $74,000 in restitution for submitting false claims to Medicare. The social worker submitted claims for psychotherapy services not rendered, billed for services

totaling more than 24 hours in a day, and submitted over 300 claims for dates of service when he was actually out of town. He also solicited business by going to door-to-door and telling beneficiaries he could provide them with free "social services," such as transportation to doctors' appointments and meal deliveries.

- ***Dental Services***—A Michigan dentist was sentenced to 1 year and 1 day of incarceration, ordered to pay restitution of $740,000, and fined $3,000 for mail fraud. He billed insurance programs for nonrendered and upcoded dental services.

- ***Substandard Renal Care***—In South Dakota, a renal facility charge nurse was sentenced for false statements relating to health care matters. Her indictment stemmed from an OIG investigation into allegations that the facility provided substandard care to Medicare and Medicaid patients. The nurse altered patient records and shredded or ordered the shredding of patient care records to conceal life-threatening treatment errors; she also documented patient files for medications not given.

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 fiscal year 2004, OIG is providing oversight for and administration of approximately $128.2 million in funds to the units. Examples of cases worked jointly by OIG with MFCUs include the following:

- ***Indiana***—The owner/operator of a DME and pharmaceutical supplier was sentenced to 51 months imprisonment and ordered to pay $1.9 million in restitution for health care fraud, kickbacks, and mail fraud. The woman must forfeit her assets, including an exclusive home, mink coats, diamonds, investment accounts, and assets of two related businesses. The supplier billed Medicare, Medicaid, and TRICARE for injectible solutions, intra-

venous therapies, and other selected services and supplies in highly excessive quantities, often billing more per week than patients could use in a year. In addition to the owner/operator's sentencing, her husband pled guilty to obstruction of justice for conduct related to this matter, and a sales representative was ordered to pay $20,000 in restitution for mail fraud in connection with the scheme. This investigation also involved the FBI, and the Defense Criminal Investigative Service.

➤ ***New York***—A physician was ordered to pay $652,000 in restitution. The physician upcoded evaluation and management codes and billed for vital capacity tests that were not performed.

In another New York joint investigation, a man was sentenced to 4.5 years of incarceration for criminal possession of a controlled substance. He participated in a scheme that involved recruiting, paying, and transporting Medicaid beneficiaries to a physician, and then to a pharmacy, in order to acquire medications for the purpose of illegal distribution.

➤ ***Illinois***—A man was sentenced to 9 years in prison and ordered to pay $201,000 in restitution, including $63,000 to the Medicaid program. Upon completion of his sentence, the court also recommended he be denied citizenship and deported. The man submitted fraudulent claims to the Illinois Department of Human Services, Home Services Program, using falsified social security cards, drivers' licenses, and records of rehabilitation services rendered. He also engaged in other fraudulent activity including the use of arson and false claims to defraud a number of private insurance companies. This investigation also involved the Illinois State Police and the Bureau of Alcohol, Tobacco, Firearms and Explosives.

➤ ***Maryland***—A former employee of a clinic serving the developmentally challenged was found guilty on 9 counts of a 41-count indictment for her involvement in a Medicaid fraud and drug distribution scheme. On one count alone, she was ordered as part of her sentence to be incarcerated for 10 years without the possibility of parole; she was also ordered to pay $100,000 in restitution to the Medicaid program. The employee used her position to gain access to prescription pads and a document stamp used to authenticate the prescriptions. She was the last of three defendants to be sentenced in this scheme.

Public Health Agencies

The activities conducted and supported by HHS public health agencies represent this country's primary defense against acute and chronic diseases and disabilities. These programs provide the foundation for the Nation's efforts in promoting and enhancing the continued good health of the American people. Agencies within the Department include 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 and are cost effective. These activities include preaward and recipient capability audits and evaluations. This oversight work has provided valuable recommendations to program managers for strengthening the integrity of agency policies and procedures and improving program performance.

State Bioterrorism Preparedness Funds

Under the Public Health Preparedness and Response for Bioterrorism Program, State and major local health departments received funding from CDC and HRSA to improve their bioterrorism preparedness. Reviews of 18 grantees (14 States and 4 local governments) generally found that they had accounted for the funds in accordance with CDC and HRSA cooperative agreements. However, OIG noted significant unobligated (unspent and uncommitted) grant fund balances in several States. Grantees stated that these unobligated balances resulted from delays or difficulties in recruiting and hiring personnel, coordinating the startup of new activities, executing contracts, issuing requests for proposals and bids for procurement, and purchasing equipment and supplies. (Various reports)

Ryan White Care Act Grantee

At the request of the Senate Committee on Finance, OIG continued its audit activities at grantees and subrecipients of HRSA's Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds. In this review of funds claimed by a nonprofit hospital under contract with HRSA's grantee in San Juan, Puerto Rico, OIG found that the hospital was reimbursed $352,000 for services that were not reasonable, allocable, or allowable. Contrary to Federal cost requirements, the hospital billed—and the grantee reimbursed for—unreasonable costs and fees on medications, unallocable surcharges for laboratory services, medications dispensed without valid prescriptions, and client services for which the CARE Act was not the payer of last resort. OIG recommended a refund to the Federal Government of the $352,000 and procedural improvements. The grantee concurred with OIG's findings and recommendations. (A-02-02-05001)

HIV Prevention Grantees

In a series of reviews at CDC grantees that provide HIV prevention education and outreach, OIG found that these community-based organizations needed to improve their methods for managing and accounting for Federal funds in accordance with Office of Management and Budget Circular A-122, "Cost

Principles for Nonprofit Organizations." In several cases, the grantees could not demonstrate that personnel costs were charged to Federal grants based on employees' actual level of effort because the grantees had not established after-the-fact time and effort reporting systems. In other instances, grantees charged unallowable costs, such as costs of items not benefiting the federally funded prevention program, to the CDC grants. In these cases, OIG recommended refunds to the Federal Government. The grantees generally agreed with the findings and are working with CDC to resolve the recommendations. (Various reports)

CDC Indirect Costs

In this report, OIG found that, until FY 2003, CDC had not implemented a system to allocate its organization-wide indirect costs on a reasonable and consistent basis as required by Federal accounting standards. The agency had made a commitment in 1997 to implement such a system for use in FY 2000. Instead, CDC relied on traditional allocation methodologies that resulted in overcharges and undercharges affecting almost all programs and activities. Due to allocation modifications made in 1998, CDC was able to reduce some of the erroneous charges. Agency projections showed, however, that the HIV/AIDS program, the focus of this audit, was charged about $11.9 million for excessive indirect costs during FYs 2000 and 2001—resulting in reduced funds available to meet program objectives.

In FY 2003, CDC fully implemented a more simplified indirect costing system. OIG believes that the new system represents a significant improvement in CDC's allocation of indirect costs and provision of accurate information on the full costs of programs and activities. (A-04-02-08001)

Construction Costs for NIH's Clinical Research Center

In 1995, NIH initially estimated that construction of its clinical research center would cost $380 million, but this estimate has increased about 33 percent to a current total estimate of $504.5 million. To facilitate the project, NIH employed a fast-track construction delivery method. Under this delivery method, intended to save time by overlapping design and construction activities, construction began before a firm project price had been established. NIH's February 2002

request for an additional $144.5 million appears to be sufficient to complete the project. OIG noted that the project had yielded several lessons to help strengthen controls and improve accountability on future construction projects: use an independent cost estimator, limit the use of the fast-track construction delivery method, and prepare routine status reports for key decisionmakers. (A-03-02-00371)

Health Education Assistance Loan Defaults

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

After PSC has exhausted 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. Exclusion means that the individual may not receive reimbursement under these programs for professional services rendered. During the 6-month period from October 1, 2003 to March 31, 2004, 39 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

Individuals who have been excluded as a result of their default may enter into settlement agreements, whereby the exclusion is stayed while they pay specified amounts each month to satisfy the debt. If they default on these settlement agreements, they can then be excluded until the 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 1,812 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 53 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 settle-

ment agreements or through complete repayment totals almost $129 million. Of that amount, $3.5 million is attributable to this reporting period. In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- California Medical Doctor—$139,000
- New York Optometrist—$119,000
- Pennsylvania Chiropractor—$94,000
- Idaho Optometrist—$85,000

National Institute of Environmental Health Sciences Superfund

Through an agreement with the Environmental Protection Health Protection Agency, the National Institute of Environmental Health Sciences receives Superfund money to carry out health-related and other activities. As required by statute, OIG audited the Institute's Superfund obligations and disbursements for FY 2002. The audit determined that these funds were administered in accordance with applicable laws and regulations. (A-04-03-08009)

Financial Statement Audit ❖❖

To support its audit of the Department's FY 2003 financial statements, OIG contracted with independent certified public accounting firms to audit the financial statements of the major public health operating divisions. During this reporting period, an accounting firm issued an unqualified opinion on FDA's FY 2003 financial statements, which means that they were reliable and fairly presented. No material weaknesses were noted in the system of internal controls. (A-17-03-00003)

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

Administrations for Children and Families and on Aging

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

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

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

Increased Qualifications for Head Start Teachers ❖❖

This report found that Head Start programs increased the proportion of teachers with appropriate degrees, as mandated by the Community Opportunities, Accountability, and Training and Educational Services (COATS) Act of 1998. According to ACF, 51 percent of Head Start teachers held appropriate degrees in enrollment year 2002, effectively meeting the COATS Act mandate. However, disparities exist in individual program's progress in meeting ACF's self-imposed goal that each program strive to achieve 50 percent degreed teaching staff. To meet the COATS Act mandate, programs hired more degreed teachers, helped non-degreed teaching staff earn degrees, and used Quality Improvement funds to increase salaries and benefits and further support teaching staff. The lack of attainment of ACF's self-imposed goal was particularly acute in 15 States. Also, OIG noted 72 counties with multiple Head Start programs, where at least one program met ACF's self-imposed goal and at least one did not.

States With Over 90 Percent of Programs at or Above 50% Degreed Teachers

- **Hawaii**
- **New Hampshire**
- **Rhode Island**
- **Vermont**
- **New York**

OIG recommended that ACF provide targeted assistance to those programs where the level of degreed teaching staff is below 50 percent. The first priority should be to assist programs that are having the most difficulty. Special attention also must be focused on American Indian and Alaska Native, migrant, and Early Head Start programs that experience special challenges. (OEI-07-01-00560)

Noncustodial Parents' Contributions to Medicaid Costs ❖❖

This eight-State initiative was designed 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 their parents could contribute. (Reports on three States were issued in the previous semiannual reporting period.) The reviews focused on noncustodial parents for

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

whom private medical insurance was unavailable or unaffordable. States have an opportunity to increase the number of noncustodial parents providing medical support for their children and reduce Medicaid costs to States and the Federal Government. Based on statistical samples in the eight States, OIG estimated that certain noncustodial parents were financially able to contribute $99 million, or 50 percent of the combined Federal and State Medicaid costs incurred in a 1-year period.

Indiana

OIG estimated that the noncustodial parents of 4,808 children could have contributed about $3 million toward the costs paid by Medicaid. OIG recommended that Indiana consider the results of the study and pursue collecting the Medicaid costs incurred by the children of noncustodial parents who have medical support orders and the ability to pay. The State is pursuing innovative ways to recover the costs. (A-05-02-00075)

Michigan

Noncustodial parents of an estimated 35,000 children could have contributed an aggregate of $10.5 million toward total Medicaid costs of $26.8 million for their children's medical expenses. OIG made recommendations similar to those for Indiana. The State said it would implement enhancements to its child support enforcement system before evaluating the cost effectiveness of the recommendations. (A-05-02-00077)

New Jersey

OIG estimated that almost 6,000 children had noncustodial parents who could have contributed an aggregate of $2.5 million toward total Medicaid costs of $11.8 million. OIG recommended that the State determine whether existing child support guidelines should be modified to require noncustodial parents to contribute toward the Medicaid costs of their dependent children. State officials did not respond to this specific recommendation. (A-02-02-02004)

New York

The noncustodial parents of an estimated 41,000 children could have contributed $32.8 million toward total Medicaid costs of $56.1 million. OIG suggested that the State continue working with local social services districts to implement new legislation and use the results of OIG's review to assess additional actions that may be taken to recover fee-for-service

costs. State officials indicated that they would consider the suggestion. (A-02-02-02003)

Virginia

OIG estimated that more than 15,000 children had noncustodial parents who could have contributed an aggregate of $6.8 million toward total Medicaid costs of $11.3 million. OIG recommended that the State determine whether existing child support guidelines should be modified to require noncustodial parents to contribute toward the Medicaid costs of their dependent children. The State supported the objective of this review. (A-03-02-00204)

Aid to Families With Dependent Children Overpayment Collections

OIG's objective was to determine whether California had refunded the Federal share of Aid to Families with Dependent Children (AFDC) overpayments collected by San Diego County from October 1, 1996, when the AFDC program was repealed and replaced by the Temporary Assistance for Needy Families program, through June 30, 2002. The State refunded the Federal share of AFDC overpayments collected during October and November 1996, but not an estimated $5.3 million collected between December 1, 1996 and June 30, 2002.

OIG recommended that the State refund the $5.3 million to the Federal Government and establish procedures to identify and refund the Federal share of the county's AFDC overpayments collected after the audit period. The State concurred. (A-09-02-00094)

Costs Claimed by Protection and Advocacy Organization

OIG reviewed the costs claimed by a nonprofit organization in Kansas whose purpose is to protect and advocate for the rights of persons with disabilities. The objective was to determine whether unallowable consultant and legal fees and selected health insurance costs were paid to, or on behalf of, the organization's board of directors and charged to Federal grants. OIG found that during a 7-year period, the organization paid $492,000 in such unallowable fees and costs.

OIG recommended that this amount be refunded to the applicable Federal programs. The law firm that commented on the draft report on the organization's

behalf indicated that it could not respond to the validity of the facts and reasonableness of the recommendations because of the lack of records. The law firm also indicated that the organization would cooperate fully with the Federal agencies involved to resolve this matter. (A-07-03-02008)

Recipient Capability Audits

OIG's objective was to determine the adequacy of three grantees' accounting and administrative systems and their financial capabilities to satisfactorily manage and account for Federal funds. Two grantees were not in compliance with Federal regulations on maintaining written accounting policies and procedures and establishing after-the-fact time and effort reporting systems to support the distribution of salaries and wages. Internal controls at the third grantee were inadequate with regard to segregation of duties, and its written policies and procedures did not adequately document Federal requirements for competitive bidding in the hiring of consultants.

OIG recommended that ACF designate two of the organizations as high-risk grantees and require all three grantees to prepare quality improvement plans, including the dates for correction of deficiencies.
(A-02-03-02015; A-02-03-02017; A-02-03-02016)

Health Care Services for Children in Foster Care ❖❖

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

Texas

All 50 sampled children in the program received Medicaid services, and the majority received their most recent required Early and Periodic Screening, Diagnosis, and Treatment medical examinations. However, the study found a low percentage of children received the required initial medical

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

and dental screenings. In addition, compliance with guidelines for vision and hearing screenings was undocumented. Furthermore, case plans were not completed within required timeframes for over half of the children sampled, and foster care providers for almost half of the children never received a written medical history for the children in their care. OIG recommended that ACF work with the State to increase the number of (1) initial medical and dental screenings that are received within required timeframes, (2) initial case plans that are completed within required timeframes, and (3) foster care providers who are supplied available medical information for the children in their care, as required by Federal regulations. OIG also recommended that CMS work with the State to evaluate the need for documentation to ensure compliance with routine vision and hearing screening guidelines. ACF noted that it is working with the State to accomplish goals established in a program improvement plan. CMS concurred with the recommendations and indicated that they are available to provide technical assistance to the State to promote provider education regarding the frequency of schedule requirements and appropriate documentation of vision and hearing screenings. (OEI-07-00-00641)

Illinois

All 50 of the children sampled received Medicaid services, and nearly all received their most recent required medical and dental examinations and initial health examination upon entry into foster care. However, less than half received a comprehensive health care evaluation and mental health screening. Less than half of the case files contained the required medical history, and several children received duplicate services. Excluding the recommendation regarding vision and hearing tests, OIG recommendations were similar to those made for Texas, above. OIG also recommended that CMS work with the State to prevent duplicate services resulting in unnecessary costs to the Medicaid program. CMS agreed, in part, with the recommendations. ACF is working with the State to achieve program improvement plan goals. (OEI-07-00-00642)

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), the Department of Justice, 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 2,580 investigations of child support cases nationwide, which have resulted in 895 convictions and court-ordered criminal restitution and settlements of over $46.7 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.

Task Force Table

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

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

At this point, the task force units have received over 8,000 cases from the States. As a result of the work of the task forces, 435 Federal arrests have been executed and 363 individuals sentenced. The total ordered amount of restitution related to Federal investigations is over $21.7 million. There have been 348 arrests at the State level and 309 convictions or civil adjudications to date, resulting in over $14.3 million in restitution being ordered.

Investigations

OIG investigations of child support cases, nationwide, resulted in 83 convictions and court-ordered criminal restitution of over $4.4 million during this period. Examples of the Federal arrests, convictions, and sentences for failure to pay child support include the following:

- ***Pennsylvania***—A former professional football player was sentenced to 6 months in a Federal work release facility for failure to pay child support. He is to begin paying support from his prison wages and continue during 1 year of supervised release. He was also ordered to pay $142,000 in support to his former wife and $110,000 in a separate case to a woman with whom he had another child. His last football contract was a 1-year deal worth $1.1 million.

- ***Georgia***—A man was sentenced to 15 months of incarceration, 1 year supervised probation and ordered to pay $137,000 in restitution. From December 1990 through March 2003, he made only two voluntary payments totaling $300, plus $700 received through garnishment of his income tax refund, toward the support of his two children.

- ***Oregon***—A man was sentenced to 5 years probation and ordered to pay not less than $1,230 a month until his restitution of $129,000 is paid in full. In accordance with his plea agreement, he also paid $5,000 toward his arrearage at sentencing. Since his arrest, he has obtained steady

employment and has started making regular monthly child support payments.

- ***Nevada***—A man pled guilty and was fined $5,000 for failure to pay child support. He also paid $63,000 to satisfy his arrearage in full. Since 1990, he concealed his assets through his business partner and other associates. Over a 2-year period, he wired over $450,000 from business to personal accounts in an effort to avoid his child support obligation.

- ***North Carolina***—A man was sentenced to 3 years probation and ordered to pay $17,000 in restitution. Despite earning income of over $100,000 yearly, he failed to pay support for his two children who suffer from health issues.

Misuse of ACF Grant Funds

One of OIG's responsibilities is investigating 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:

- ***Texas***—The former executive director of an HHS grantee receiving Head Start funds was sentenced to 63 months in prison and ordered to pay $805,000 in restitution and a $20,000 fine for his role as the mastermind of an embezzlement scheme. He and four others devised a variety of schemes to defraud the grantee and HHS. Each scheme entailed a plan to submit invoices to the grantee for supplies and services never provided. One scheme included submitting invoices to the grantee for equipment, supplies, and services purportedly provided to Head Start centers when they were actually provided to the executive director's restaurant. Another scheme involved instructing a contractor to make and submit fraudulent invoices for repairs and/or renovations to Head Start centers that were never done. For their involvement in the embezzlement scheme, the four co-defendants were sentenced to an average prison time of 12.5 months and ordered to pay a total of $381,000 in restitution

- ***Puerto Rico***—The executive director of two Head Start programs run by a concessionary agency funded directly through Head Start was sentenced to 30 days imprisonment and ordered to pay $141,000 in restitution to ACF

for bank fraud. The executive director and the agency's council president had signature authority for all program disbursements. The executive director forged the council president's signature on approximately 24 checks. When the bank did not cash two of the checks, the executive director instructed the fiscal manager to wire transfer the funds to his personal account.

Fraud Training Initiative

In addition to its investigations, OIG has been working with Departmental grant officials to increase fraud awareness within the grant programs. For example, in FY 2003, in a combined effort with respect to Head Start, over 300 program officials throughout the country received fraud awareness training. Additionally, in cooperation with State officials, the Child Care Bureau, and the Foster Care program officials, OIG identified areas vulnerable to fraud and developed training for State and Federal officials to heighten fraud awareness to prevent and detect fraud in the child care program.

General Oversight

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

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

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

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

Departmental Financial Statement Audit ❖❖

As required by the Government Management Reform Act of 1994, OIG audited the Department's consolidated/combined financial statements for FY 2003 and issued an audit opinion, a report on internal controls, and a report on compliance with laws and regulations. OIG's audit approach allowed the Department to successfully meet its accelerated November 15, 2003 target date for submitting the financial statements and audit results to the Office of Management and Budget.

The audit report, which appears in the Department's FY 2003 "Performance and Accountability Report," included a "clean," or unqualified, opinion on the financial statements. This means that, for the fifth consecutive year, the statements were reliable and fairly presented. However, the report noted two continuing material internal control weaknesses—that is, problems that are systemic across a number of operating divisions, as well as significant dollar issues affecting only one division. First, serious weaknesses persisted in the Department's financial systems and processes for producing financial statements. These weaknesses related to financial statement preparation, financial management systems, and financial analyses and reporting. Second, Medicare information systems lacked adequate controls to ensure the security and integrity of data processing operations and data files. As discussed in OIG's report on compliance with laws and regulations, weaknesses in the Department's financial management and Medicare information systems also represented departures from certain Federal requirements. (A-17-03-00001)

Federal Information Security Management Act

As required by the Federal Information Security Management Act, OIG conducted independent evaluations of information systems security programs at six HHS operating and staff divisions. These divisions accounted for more than 95 percent of HHS's critical infrastructure as defined by Presidential Decision Directive 63 and the Critical Infrastructure Assurance Office Project Matrix Report. The results of the reviews were reported to management and summarized in a report to the Office of Management and Budget.

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

While progress had been made in securing critical systems, OIG identified fundamental security program weaknesses that inhibited the Department's ability to create a more mature security environment. In total, OIG identified 71 deficiencies (34 significant), of which 26 had been noted in prior years. The cause of most weaknesses was that the Department did not have an effective information security management program structure to ensure that sensitive data and critical operations received adequate attention and that appropriate security controls were implemented to protect them. (Various reports)

Departmental Service Organizations ❖❖

To support its audit of the Department's FY 2003 financial statements, OIG contracted for examinations of four service organizations that provide common administrative, data processing, and accounting services to the operating divisions. In accordance with Statement on Auditing Standards No. 70, independent certified public accounting firms examined the organizations' controls and tested their operating effectiveness. The results are as follow:

- Human Resources Service, Program Support Center: Controls were suitably designed and operating with sufficient effectiveness except for certain weaknesses in segregation of duties. (A-17-03-00012)

- Division of Financial Operations, Program Support Center: Controls were suitably designed and operating with sufficient effectiveness but demonstrated exceptions in access and system software controls. (A-17-03-00011)

- Division of Payment Management, Program Support Center: Controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-03-00009)

- Center for Information Technology, National Institutes of Health: Controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-03-00010)

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

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 first half of FY 2004, OIG's National External Audit Review Center reviewed 1,218 reports that covered $819.7 billion in audited costs. Federal dollars covered by these audits totaled $285.4 billion, about $131.1 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 are categorized in the box below.

Reports issued:

Without changes or with minor changes	***1,098***
With major changes	***94***
With significant inadequacies	***26***
Total	***1,218***

The 1,218 reports included recommendations for HHS program officials to take action on cost recoveries totaling $3.6 million, as well as 4,617 recommendations for improving management operations. In addition, these audit reports provided information for 83 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.

*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]	560	$1,979,110,000	$320,541.000
Issued during the reporting period	102	$292,073,000	$74,000
Total Section 1	**662**	**$2,271,183,000**	**$320,615,000**
Section 2			
For which management decision was made during the reporting period[2,3,4]			
Disallowed costs		$214,545,000	$60,212,000
Costs not disallowed		$102,992,000	$246,000
Total Section 2	**194**	**$317,537,000**	**$60,458.000**
Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	**468**	**$1,953,646,000**	**$260,157,000**
Section 4			
For which no management decision was made within 6 months of issuance[5]	**375**	**$1,667,189,000**	**$166,718,000**

*Details concerning footnotes can be found in Appendix D.

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

Reports	*Number of Reports*	*Dollar Value*
Section 1		
For which no management decision had been made by the beginning of reporting period[1]	61	$8,929,373,000
Issued during the reporting period	12	$78,386,000
Total Section 1	**73**	**$9,007,759,000**
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	5	$267,227,000
Based on proposed legislative action	0	0
Value of recommendations that were not agreed to by management	1	$306,000
Total Section 2	**6**	**$267,533,000**
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	**67**	**$8,740,226,000**

*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:

- Developed, in accordance with section 1860D-31 of the Social Security Act, interim final rulemaking setting forth OIG's new authority for imposing civil money penalties against endorsed sponsors under the Medicare prescription drug discount card program that knowingly (1) engage in false or misleading marketing practices; (2) overcharge program enrollees in violation of the terms of an endorsement contract; or (3) misuse transitional assistance funds. In each instance, OIG may impose CMPs of no more than $10,000 for each violation.

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

- Published a *Federal Register* notice soliciting recommendations and proposals for developing new and modifying existing safe harbor provisions under the Federal and State health care programs' anti-kickback statute, as well as developing new OIG Special Fraud Alerts. (68 FR 69366; December 12, 2003)

- In compliance with the requirements of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, published a final *Federal Register* notice setting forth OIG's summary of information collection activities with regard to State Medicaid Fraud Control Units' recertification and application and annual reports, as required by 42 CFR 1007.15 and 1007.17 of OIG regulations. (69 FR 2147; January 14, 2004)

- 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:

➤ ***Maryland***—Two NIH employees were ordered to pay close to $9,000 in restitution and fines for theft of Government property. Procurement agents, the employees used their Government issued Visa IMPAC cards to make purchases for themselves and others.

Also in Maryland, a former NIH employee was sentenced to 18 months of incarceration for knowingly receiving child pornography. As conditions of his supervised probation upon his release, he must also participate in a mental health treatment program, register as a sex offender, and not access a computer or the Internet without prior approval from the Division of Probation.

Additional Audit Recoveries

Based on an OIG recommendation, the Department realized $8.3 million in additional recoveries, beyond the disallowances reported in Table 1, during this semiannual period. OIG recommended that Clarion Health Partners, Inc., determine whether errors identified in a review of medical education payments occurred in prior Medicare cost reports and coordinate with the fiscal intermediary to make the necessary financial adjustments. As a result of this recommendation, the fiscal intermediary adjusted the provider's cost reports for the 2 years preceding the year audited. (A-05-02-00026)

Investigative Prosecutions

During this semiannual reporting period, OIG investigations resulted in 234 successful criminal actions. Also during this period, 701 cases were presented for criminal prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 288 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over $1.2 billion 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
October 1, 2003 Through March 31, 2004

The following schedule highlights savings resulting from the 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 and actions by others, such as departmental officials and the Congress. The amounts shown represent funds or resources that will be available to be used more efficiently as a result of documented measures taken in response to OIG audits, investigations, and inspections. Those include actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or pre-award reductions in grants or contracts; and reduction and/or withdrawal of the Federal portion of interest subsidies 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. Savings from the Medicare provisions of the Balanced Budget Act (BBA) of 1997 were adjusted downward to reflect related provisions of the Balanced Budget Refinement Act (BBRA) of 1999. Administrative savings are calculated based on departmental estimates, where available, for the year in which the change is effected and for subsequent years, if applicable.

Total savings from these sources amount to $15,427 million for this period.

OIG Recommendation	*Implementing Action*	*Savings (millions)*
Centers for Medicare & Medicare Services		
Medicare Part A Payments for Skilled Nursing Facilities: Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and legislation should prohibit entities other than the skilled nursing facility (SNF) from seeking payment on behalf of persons in part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a prospective payment system and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; A-17-95-00096; A-14-98-00350)	Section 4432 of the BBA of 1997 (as amended by the BBRA of 1999) established a prospective payment for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.	$4,140
State Enhanced Payments Under Medicaid Upper Payment Limit Requirements: States are allowed to make enhanced payments to local government providers as long as aggregate State payments for each class of service do not exceed the amount that would have been paid under Medicare payment principles. OIG found that States' use of intergovernmental transfers maximized Federal Medicaid reimbursements. OIG also found that enhanced payments were not based on the cost *continued—*	On January 12, 2001, CMS issued revisions to the upper payment limit regulations which, among other things, created new payment limits for local government-owned providers. This final rule will significantly affect a State's ability to reap windfall revenues by reducing the	$3,800

State Enhanced Payments Under Medicaid Upper Payment Limit Requirements (*continued*): of providing services, nor did OIG find a direct relationship in the use of these funds to increase the quality of care. (A-03-00-00216)	available funding pool from which to make enhanced payments to local government-owned providers.	
Medicare Secondary Payer Extensions: CMS should establish a centralized database of information about private insurance coverage of Medicare beneficiaries and extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries as long as the individual has employer based coverage available. (OEI-07-90-00760; OEI-03-90-00763; A-10-86-62016; A-09-89-00100; A-09-91-00103; A-14-94-00391; A-14-94-00392)	The database capacity was achieved through the authorization of data exchanges between CMS, the Social Security Administration, and the Internal Revenue Service. Section 4631 of the BBA of 1997 permanently extended current MSP policies for beneficiaries who are disabled and have ESRD. For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.	$2,220
Medicare Outlier Payments: To prevent future inappropriate outlier payments, CMS should focus its attention on (i) determining how to limit, if not eliminate, the policy which allows for the use of the statewide rate in place of a hospital-specific rate, (ii) dramatically reducing the time lag between the payment of outliers and the actual closing of a specific hospital's cost report, particularly for the hospitals that the fiscal intermediary identify as having significantly increased their charges, and (iii) eliminating the hospital's ability to construct and manipulate charges in order to determine whether an outlier payment is warranted in a specific medical case without regard to the actual costs involved in that case. (A-07-02-04007)	CMS issued new regulations on June 9, 2003. As a result of the new regulations, the Medicare program is estimated to save at least $9 billion over the next 5 years.	$1,800
Capital-Related Costs of Hospital Services: CMS should seek legislative authority to continue mandated reductions in capital payments since excess capacity was not considered in the capital cost policy. (A-09-91-00070; A-07-95-01127)	Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.	$1,190
Medicare Payments for Oxygen: CMS should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711; OEI-03-91-001710)	Section 4552(a) of the BBA of 1997 reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.	$800

Medicare Laboratory Reimbursements: In July 1989, OIG recommended that CMS take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that CMS seek legislation to allow across the board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which laboratories charge physicians in a competitive marketplace. In a January 1996 followup, OIG found that Medicare continued to pay more to clinical laboratories than physicians for the same tests. Although the Omnibus Budget Reconciliation Act of 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that CMS periodically evaluate the national fee schedule to ensure that it is in line with the prices physicians pay for the same clinical laboratory services. (OEI-02-89-01910; A-09-89-00031; A-09-93-00056)	Section 4553 of the BBA of 1997 provided for reducing fee schedule payments by lowering the cap to 74 percent of the median for payment amounts, with no inflation update for 1998 through 2002.	$800
Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)	Section 4316 of the BBA of 1997 froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002.	$400
Medicare Payments to Hospitals for Bad Debt: CMS should seek legislative authority to modify the bad debt payment policy by eliminating the Medicare payment for bad debts, offsetting Medicare bad debts against beneficiary Social Security payments, limiting bad debt payments to profitable prospective payment hospitals, or including a bed debt factor in the diagnosis-related group rates. (A-14-90-00039)	Section 4451 of the BBA of 1997 reduced bad debt payment to providers by 25 percent in FY 1998, 40 percent in FY 1999, and 45 percent in later years. The Benefits Improvement and Protection Act of 2000 subsequently decreased the reduction to 30 percent.	$150
Medicaid Drug Rebates-Sales to Repackagers Excluded from Best Price Determinations: Medicaid rebates were lost because sales to HMOs were improperly excluded from some drug manufacturers' best price determinations in FYs 1998 and 1999. CMS should require drug manufacturers who excluded sales to HMOs from their best price calculations to repay the rebates and evaluate the policy guidance relating to exclusion of sales to other (non-HMO) repackagers from best price determinations. (A-06-00-00056)	CMS issued Medicaid Drug Rebate Program Release #47 in July 2000 to make it clear to manufacturers to not inappropriately exclude HMO and other prices from their calculation of best prices, as required by section 1927 of the OBRA of 1990.	$80.7

Medicare Payments for Prescription Drugs: CMS should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)	Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.	$40

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 OIG investigation to suspend or terminate payments to the offending individual or entity.	$6.4

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

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

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

OIG Recommendation	***Status***	***Savings (millions)***
Centers for Medicare & Medicaid Services		
Clinical Laboratory Tests: CMS should develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests, and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (A-09-89-00031; A-09-93-00056)	CMS 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. As a result of the Institute of Medicine's recommendations, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 mandates that CMS conduct a demonstration that applies competitive bidding for clinical laboratory services. The initial report to Congress is due by December 31, 2005.	$1,130*
Outpatient Surgery Rates: CMS should seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and remove the procedure codes that meet its criteria for removal from the ASC list of covered procedures. (A-14-89-00221; A-14-98-00400; OEI-09-88-01003; OEI-05-00-00340)	CMS has agreed to consider seeking authority to set rates that are consistent across sites as it develops its legislative program. The agency has also issued a notice of proposed rulemaking which would remove certain procedure codes from the ASC list of covered procedures. This rule has not yet been finalized.	$1,100
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.	$820

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

APPENDIX B

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. However, these efforts were affected by industry court actions. These claims may receive additional attention as targeted Medical reviews are increased as part of payment safeguard contractor operations.	$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)	The BBA of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act 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 has made a concerted effort to track States' pay-and-chase activities. CMS central office asked the regional offices to identify any waivers that have been granted, any pending waiver requests, and situations where a State is using pay-and-chase without an approved waiver. CMS has also conducted conference calls with third party liability coordinates in an effort to develop potential guidelines and criteria for the review of waiver requests.	$185
Graduate Medical Education: CMS should revise the regulations to remove from a hospital's allowable graduate medical education (GME) base-year costs any cost center with little or no Medicare utilization and submit a legislative proposal to compute Medicare's percentage of participation under the former, more comprehensive system. (A-06-92-00020)	CMS did not concur with the recommendations. Although the BBA of 1997 and the BBRA of 1999 contained provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.	$157.3

Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (A-06-94-00039)	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
Inappropriate Payments for Nail Debridement: CMS should require Medicare carriers to recoup the overpayments found in OIG's sample and to carefully scrutinize payments for nail debridement services through medical reviews, require podiatrists to adequately document the medical necessity of all nail debridement services, and require CMS regional offices and carriers to educate podiatrists on Medicare payment policies for nail debridement claims. (OEI-04-99-00460)	CMS concurred; the agency planned to continue to maximize the effectiveness of its medical review strategy, collect the overpayments identified in OIG's sample, and educate podiatrists on Medicare policy for paying nail debridement claims.	$96.8
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 implemented an edit to reject claims listing a deceased physician's UPIN beginning in April 2002. They plan to 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
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

APPENDIX B

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, and the BIPA of 2000 required the Secretary to develop a composite rate that includes, to the extent composite rate that includes, to the extent feasible, payment for laboratory tests and drugs that are routinely used in dialysis treatments but are now separately billable. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 requires the Secretary to establish a case-mix adjusted composite rate for 2005 and to conduct a demonstration of a bundled case-mix adjusted prospective payment system. The Act also directs CMS to use the results of an OIG study on separately billable ESRD drug payments and costs to set the 2005 composite payment 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 and published a proposed rule in August 2003 clarifying that bi-level respiratory assist devices with back-up rate be paid as capped rental items.	$11.5
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

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

****To be determined.*

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) to calculate the rebates. This legislation would have resulted in about $1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-96. (A-06-97-00052)	CMS agreed to pursue a change in the rebate program similar to that recommended. The President's FY 2003 budget proposed a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug. That legislative change was ultimately dropped, and none of the subsequent Presidential budgets included a similar proposal.	TBD

Various Operating Divisions

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 has worked 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 is expected to be issued in FY 2004.	$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. Current audit results have shown that this remains a problem in most States.
Fairly Presenting the Medicare Accounts Receivable Balance: CMS should require Medicare contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (A-17-95-00096; A-17-97-00097; A-17-98-00098; A-17-00-00500; A-17-00-02001; A-17-01-02001; A-17-02-02002)	CMS hired consultants to assist in validating accounts receivable reported by Medicare contractors and provided comprehensive instructions to contractors. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.
Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). CMS should also develop a more specific policy for calculating this price which would protect the interests of the Government and which would be equitable to the manufacturers. (A-06-91-00092)	CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. OIG disagrees because the rebate law and agreements defined AMP but did not provide specific written methodology for computing it.
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 *continued—*	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.

Accuracy of Carrier Payment Data (continued): 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)	
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 Durable Medical Equipment: 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 recommended that CMS establish an audit trail to validate the 108 MDS elements that affect facility reimbursement by Medicare. (OEI-02-99-00040; OEI-02-99-0041)	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: CMS should work with States to improve the assessment of persons with serious mental illness and use survey and certification to monitor compliance. OIG also recommended that CMS define specialized services that are to be provided by the State to nursing home residents with mental illness. (OEI-05-99-00700)	CMS concurred with most of OIG's recommendations and has made revisions to its training curriculum for nursing home surveyors.

Nursing Home Residents With Serious Mental Illness: CMS should improve the quality and usefulness of its data sources by requiring the use of a unique provider number across systems, requiring reporting of resident data by age and diagnosis, and encouraging States to use these data in demonstrating their progress in placing disabled persons in the most integrated settings. OIG also recommended training to improve data collection and accurate coding. (OEI-05-99-00701)	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, 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. CMS has prepared a draft regulation that would address many of OIG's concerns; the regulation is currently passing through HHS clearance. HRSA also concurred with the recommendations.

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 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)	The Deputy Secretary concurred that FDA should expedite its planned rulemaking activities related to tissues, specifically the final rule to require registration of tissue banks. The Department also found "considerable merit" in OIG's recommendation for an intensified inspection program directed towards entities that procure, process, and store human tissues. In congressional testimony, FDA said that all three of the proposed rules have been published, and one rule (Establishment Registering and Listing) was finalized. FDA also worked to inspect all 36 identified, uninspected tissue banks. As of March 2004, FDA has not issued the final regulation on good manufacturing practices.

APPENDIX C

Effectiveness of FDA's Adverse Event Reporting System for Dietary Supplements: FDA should (1) facilitate greater detection of adverse events by requiring dietary supplement manufacturers to report serious events to FDA for some products, (2) obtain more information on adverse event reports by requiring manufacturers to register themselves and their products with FDA, (3) notify manufacturers when FDA receives a serious adverse event report and develop a new computer database to track and analyze adverse event reports, (4) expedite the development and implementation of good manufacturing practices for dietary supplement manufacturers, and (5) disclose more useful information to the public about dietary supplement adverse events. (OEI-01-00-00180)	FDA agreed with the majority of OIG's recommendations and has taken several important steps to implement them. In March 2003, FDA published proposed good manufacturing practices for dietary supplements. In June 2003, FDA implemented a new adverse event reporting system called the Center for Food Safety and Applied Nutrition Adverse Events Reporting System. This 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.
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. investi- gators 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)	Under contract to HRSA, PricewaterhouseCoopers recently completed a study on hospital and managed care reporting to the NPDB. The study recommended that HRSA should try to facilitate reporting by: seeking legislative authority and funding for conducting compliance reviews of clinical privileges reporting including authority to access peer review records; developing a strategy for communicating key stakeholders including trade associations and accrediting organizations (AMA, AHA, etc.); linking communica-tion strategies to quality of care and patient safety initiatives; consider focus groups as a vehicle for garnering support for the NPDB. HRSA did not agree with the recommendation to do compliance reviews; however, HRSA has taken steps to implement the other recommendations. HRSA and AHRQ plan to address outreach issues at a conference in the Fall of 2004.

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 9 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 document have been updated in the draft regulation. The target date for issuing the draft regulation as a notice of proposed rulemaking is December 31, 2004. Once the formal notice and rulemaking process is complete, the updated cost principles will be issued.

Appendix D
Notes to Tables 1 and 2

Notes to Table 1

[1] The opening balance was adjusted downward $9.8 million.

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

CIN: A-04-01-01009	**Assistance at USF**: Grantee withdrew its appeal and the recommended dollar amount of $2,104,603 was sustained.
CIN: A-05-03-00015	**Review of Ineligible SNF Payments Processed at BCBS of Tennessee**: CMS determined that it is not appropriate to recover overpayments since the ineligible payments totaling $11.6 million were not the fault of the skilled nursing facility.
CIN: A-05-02-00088	**Review of Ineligible SNF Payments Processed at Palmetto GBA**: CMS determined that it is not appropriate to recover overpayments since the ineligible payments totaling $14.1 million were not the fault of the skilled nursing facility.

Not detailed are revisions to previously disallowed management decisions totaling $11.1 million.

[3]Included are management decisions to disallow $7.5 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 375 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 INTERGOVERMENTAL 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-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, $128,269,448
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, BCBSFL, JAX, JULY 2002, $101,671,328
CIN: A-09-02-00071	AUDIT OF CA DSH PROGRAM FOR FY 1998 - LA COUNTY, MAY 2003, $98,190,042
CIN: A-04-00-01220	IMPLE. MEDICARE'S POSTACUTE CARE TRANSFER POLICY, OCTOBER 2001, $52,311,082
CIN: A-01-00-00538	NATIONAL IDENTIFICATION OF SNF CONSOLIDATED BILLNG, JUNE 2001, $47,633,686
CIN: A-05-02-00083	REVIEW OF INELIGIBLE SNF PAYMENTS PROCESSED AT MUTUAL OF OMAHA, MARCH 2003, $41,500,000

APPENDIX D

CIN: A-07-01-02093	MISSOURI DSH - UNALLOWABLE COSTS, AUGUST 2002, $36,200,000
CIN: A-01-00-00509	M/C PART B PMTS FOR DME PROVIDED TO SNF PATIENTS, JULY 2001, $35,000,000
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES - CT, MAY 2003, $32,780,146
CIN: A-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-03-01-00224	MEDICAID SCHOOL-BASED SERVICES/MARYLAND, MARCH 2003, $19,954,944
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEPTEMBER 2002, $19,446,435
CIN: A-06-00-00051	AUDIT OF MEDICARE REHAB AGENCY COSTS IN TX, RHS, I, JUNE 2001, $18,394,465
CIN: A-05-01-00052	DME REVIEW IN INDIANA, OCTOBER 2001, $16,377,560
CIN: A-05-94-00064	MI BLUE CROSS/BLUE SHIELD, AUDIT OF ADMIN COSTS, JUNE 1996, $15,609,718
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-07-96-01176	MEDICARE EXCESS PENSION ASSETS - BC MICH, NOVEMBER 1996, $11,904,263
CIN: A-05-02-00031	AFDC OVERPAYMENTS - WISCONSIN, AUGUST 2002, $10,711,338
CIN: A-01-01-00513	MEDICARE PT B PMT FOR DME I/P PRTL MNTH STAYS SNF, OCTOBER 2001, $10,500,000
CIN: A-05-03-00022	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTARTIVE RESPONSIBILITY OF EMPIRE BLUE CROSS, MAY 2003, $9,700,000
CIN: A-06-02-00034	REV OF COST REPORTS & MEDICARE FEE-FOR-SERVICE PYMTS @ SCOTT & WHITE, MAY 2003, $8,229,574
CIN: A-05-03-00026	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF CARE FIRST (MARYLAND), MARCH 2003, $8,100,000
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEPTEMBER 2002, $7,999,212
CIN: A-09-97-44262	STATE OF CALIFORNIA, APRIL 1997, $7,300,000
CIN: A-07-02-03033	CAREFIRST SEGMENTATION AUDIT, MAY 2003, $6,788,644
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM - NATIONAL, MARCH 1993, $6,529,545
CIN: A-03-01-00222	MEDICAL COLLEGE OF VIRGINIA/DSH/MEDICAID, APRIL 2003, $6,324,796
CIN: A-05-03-00035	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF VERITUS MEDICARE SERVICES, JULY 2003, $6,300,000
CIN: A-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	BLUE CROSS & BLUE SHIELD OF MASSACHUSETTS, NOVEMBER 1999, $5,270,461
CIN: A-05-96-00058	CLOSE-OUT AUDIT OF MEDICARE CONTRACT-BCBS-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-03-01-00226	UVA MEDICAL CENTER/DSH/MEDICAID/VIRGINIA, MAY 2003, $4,760,385
CIN: A-05-01-00023	ADMINISTRATIVE COSTS REVIEW - ADMINASTAR FEDERAL, JANUARY 2002, $4,694,863
CIN: A-02-00-01047	DEMO BSWNY - FINANCIAL, MARCH 2002, $4,505,051
CIN: A-07-98-01263	DENVER CMHC, MAY 2000, $4,447,607
CIN: A-07-02-00144	IV-E FOSTER CARE ADMINISTRATIVE COSTS CLAIMED, AUGUST 2003, $4,335,542
CIN: A-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-02-02-01014	UNLICENSED PROVIDERS IN PUERTO RICO, SEPTEMBER 2003, $3,607,820

CIN: A-04-01-05002	AUDIT MEDICAID PAYMENTS FOR CLINICAL LABORATORIES, JANUARY 2002, $3,522,639
CIN: A-02-95-01019	STAFF BUILDERS HOME OFFICE MEDICARE COST REV. ORT, AUGUST 1998, $3,434,274
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-BLUE CROSS/BLUE SHIELD-CONTRACT MEDICARE AUDIT, APRIL 1993, $3,010,916
CIN: A-09-98-50183	STATE OF CALIFORNIA, MARCH 1998, $3,000,000
CIN: A-01-02-00009	MEDICAID PAMYENTS FOR SCHOOL-BASED HEALTH SERVICES - MASSACHUSETTS DEPARTMENT OF MEDICAL ASSISTANCE - JUL 1999 - JUNE 2001, JULY 2003, $2,997,268
CIN: A-01-96-00508	MEDICARE ADMIN COSTS PARTS A&B AND RRB - TRAVELERS, MARCH 1996, $2,803,260
CIN: A-07-03-03039	CAREFIRST OF MARYLAND UNFUNDED PENSION COSTS, MAY 2003, $2,611,100
CIN: A-06-02-00038	CAPITATION PYMTS 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-07-92-00579	BC/BS OF MICHIGAN INC - UNFUNDED PENSION COSTS, OCTOBER 1992, $2,535,698
CIN: A-05-92-00026	ASSOCIATED INSURANCE CO. - MEDICARE ADMIN, FEBRUARY 1992, $2,530,409
CIN: A-09-02-72300	STATE OF CALIFORNIA , JULY 2002, $2,400,000
CIN: A-05-03-00062	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF NORIDIAN MUTUAL INSURANCE COMPANY, JUNE 2003, $2,400,000
CIN: A-02-91-01006	BLUE SHIELD OF WESTERN NY MEDICARE ADM CTS PORTER, SEPTEMBER 1991, $2,379,239
CIN: A-04-00-01209	OUTPATIENT PSYCHIATRIC SERVICES AT HOLLYWOOD PAV. HOSP, APRIL 2001, $2,366,287
CIN: A-02-03-70760	PUERTO RICO DEPT. OF THE FAMILY, MAY 2003, $2,350,100
CIN: A-03-99-00038	EDGEWATER PSYC HOSPITAL, MARCH 2001, $2,348,604
CIN: A-06-01-00083	AUDIT OF MEDICAID SCHOOL-BASED SERVICES IN OKLAHOMA, APRIL 2003, $2,332,774
CIN: A-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-10-02-00008	REVIEW OF WASHINGTON STATE'S MEDICAL ASSISTANCE COSTS CLAIMED FOR SCHOOL-BASED HEALTH SERVICES, JULY 2003, $2,279,752
CIN: A-04-02-07007	MEDICAID FEE FOR SERVICE PAYMENTS FOR DUALLY ELIGIBLE MEDICARE MANAGED CARE ENROLLEES, FEBRUARY 2003, $2,231,100
CIN: A-04-97-01170	REVIEW HOME HEALTH SERVICES BY MEDICARE HOME HEALTH SERVICES, APRIL 1999, $2,200,000
CIN: A-02-03-74060	PUERTO RICO DEPT. OF THE FAMILY, JULY 2003, $2,180,261
CIN: A-09-01-00056	PACIFICARE-CALIFORNIA JAN 1998 INSTITUTIONAL PMTS, SEPTEMBER 2001, $2,158,577
CIN: A-04-00-02162	REVIEW TREATMENT OF QUALIFIED DISCHRGS @ FCSO, FEBRUARY 2001, $2,042,060
CIN: A-07-01-03001	BCBS OF MN PENSION SEGMENT CLOSING, JANUARY 2003, $2,003,341
CIN: A-05-00-00034	PROVENA ST. JOSEPH HOSPITAL-O/P PSYCH SERVICES, NOVEMBER 2000, $1,978,583
CIN: A-05-02-00048	REVIEW OF MEDICAID DME CLAIMS - TEXAS, SEPTEMBER 2002, $1,969,704
CIN: A-04-97-01169	REVIEW HOME HEALTH SERVICES BY MEDTECH HOME HEALTH SERVICES, APRIL 1999, $1,900,000

APPENDIX D

CIN: A-01-03-00500	HOME HEALTH PPS SYSTEM CONTROLS 14 DAY PAYMENT - WHEN PRECEDED BY A HOSPITAL DISCHARGE, JULY 2003, $1,861,857
CIN: A-01-02-72211	STATE OF CONNECTICUT , JUNE 2002, $1,860,148
CIN: A-02-02-01005	HORIZON BLUE CROSS BLUE SHIELD - 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-06-02-00012	CONSOLIDATION OF UNIV HOSP & MEDICAL CNTR OF LA @ NEW ORLEANS, JUNE 2003, $1,800,000
CIN: A-05-95-00059	AUDIT OF ADMINISTRATIVE COSTS - BCBS 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	BLUE CROSS 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	BCBSM 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-05-93-00057	MI-BLUE CROSS & BLUE SHIELD OF MI-CONTRACT AUDIT, JULY 1993, $1,409,954
CIN: A-07-02-03022	WELLMARK PENSION SEGMENT CLOSING, MARCH 2003, $1,353,036
CIN: A-05-95-00042	BCBSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DECEMBER 1995, $1,333,598
CIN: A-04-03-02024	REVIEW OF BCBSFL RESPONSE TO SET-ASIDE COSTS IN PRIOR FACP AUDIT, APRIL 2003, $1,277,247
CIN: A-05-01-00064	REVIEW OF OUTPATIENT REHABILITATION CLAIMS REIMBURSED BY MEDICARE DURING CALENDAR YEAR 1999, FEBRUARY 2002, $1,235,892
CIN: A-02-02-01022	REVIEW OF TRANSPORTATION CLAIMS MADE BY SPECIAL SERVICE SCHOOL DISTRICTS, APRIL 2003, $1,223,426
CIN: A-03-01-00251	AFDC OVERPAYMENTS - VIRGINIA, MARCH 2003, $1,221,494
CIN: A-04-02-72903	STATE OF TENNESSEE , SEPTEMBER 2002, $1,213,353
CIN: A-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-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-05-92-00060	CONTRACTOR AUDIT - BCBS - ADMIN, FEBRUARY 1993, $879,609
CIN: A-02-97-01034	DR. PILA FOUNDATION HOME CARE PRORAM (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-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-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-07-02-03035	COSTS CLAIMED FOR PRB'S BY WELLMARK, FEBRUARY 2003, $717,106
CIN: A-09-97-00078	PHYSICIAN BILLINGS DR. SPENCER, JANUARY 1999, $683,264
CIN: A-06-01-00090	PREAWARD-APASS MAINTAINER DATA PROCESSING SERVICES - ABCBS, SEPTEMBER 2001, $678,651

CIN: A-05-00-64226	NA-ILLINOIS DEPT. OF PUBLIC AID, MAY 2000, $654,017
CIN: A-01-98-00503	PSYCHIATRIC OUTPT SERVICES AT THE FRANKLIN MED CENTER, 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-02-02-01025	NEW YORK NURSING HOME DUPLICATE PAYMENTS, SEPTEMBER 2003, $606,403
CIN: A-06-98-00066	ORT REVIEW OF ULTIMATE HOME HEALTH CARE INC., OCTOBER 1999, $602,982
CIN: A-04-94-01078	MONITORING ADMIN COST - AUDIT MEDICARE P.B BCBSSC, JULY 1994, $594,092
CIN: A-09-01-00083	MEDICARE PART B SERVICES BILLED BY DR FARB, MAY 2003, $593,177
CIN: A-04-93-01069	MONITORG ADMIN COST AUDIT MCARE PART A BCBSSC, JULY 1994, $590,844
CIN: A-04-01-01007	GABCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, $575,471
CIN: A-09-01-00055	REVIEW OF IMD CLAIMS - STATE OF CALIFORNIA, MARCH 2002, $551,394
CIN: A-07-02-03015	BCBS OF MN PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEBRUARY 2003, $550,083
CIN: A-05-02-72811	COMMUNITY ACTION OF GREATER INDIANAPOLIS INC. , AUGUST 2002, $547,899
CIN: A-07-02-03029	WELLMARK - PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEBRUARY 2003, $547,053
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-02-02-01004	MEDICAID PPS TRANSFERS, MAY 2003, $493,158
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-05-01-67384	MICHIGAN DEPT. OF COMMUNITY HEALTH , FEBRUARY 2001, $481,693
CIN: A-07-03-03037	SERP COSTS CLAIMED BY BCBS OF MA, APRIL 2003, $444,413
CIN: A-05-03-74102	STATE OF OHIO, MARCH 2003, $439,556
CIN: A-07-01-00120	REVIEW OF UNFUNDED PENSION COSTS AT BCBS OF OK, JULY 2001, $413,800
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-06-03-75545	STATE OF LOUISIANA, MAY 2003, $374,003
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 HOSPITAL 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-01-03-76134	UNIV. OF MASSACHUSETTS, AUGUST 2003, $338,877
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

APPENDIX D

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-05-02-00047	UNITED GOVERNMENT SERVICES, MEDICARE PART A ADMIN. COSTS FY 1999-2001, JUNE 2003, $260,831
CIN: A-07-03-02662	REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DECEMBER 2002, $258,112
CIN: A-02-03-04001	AUDIT OF RUTGERS CONTRACT NO. SPO 103-96-D-0016/0001, AUGUST 2003, $249,381
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCTOBER 2002, $229,656
CIN: A-04-00-01222	CAPITAL HEALTH PLAN, COST-BASED MANAGED CARE PLAN, SEPTEMBER 2001, $221,952
CIN: A-01-00-00549	BETH ISRAEL AUDIT OF OUTPATIENT PHARMACY SVC, MARCH 2001, $221,905
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-02-01-01019	DEMO BSWNY - CASH MANAGEMENT, OCTOBER 2002, $208,271
CIN: A-06-96-00064	ORT SNF RESEARCH AT METHODIST HOSPITAL, JANUARY 1997, $200,000
CIN: A-07-01-02631	REVIEW OF HOSPITAL OBSERVATION BEDS, MAY 2002, $197,773
CIN: A-07-03-02656	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION KANSAS, DECEMBER 2002, $190,106
CIN: A-03-01-00555	PDPI INC. - HEAD START, JUNE 2001, $185,577
CIN: A-07-02-03016	TRANSAMERICA SUPPLEMENTAL PENSION PLAN COSTS, MARCH 2002, $180,244
CIN: A-05-02-73374	STATE OF OHIO, SEPTEMBER 2002, $179,797
CIN: A-02-03-75530	COMMUNITY ACTION PLANNING COUNCIL OF JEFFERSON COU, AUGUST 2003, $166,959
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-07-03-74746	GRACE HILL SETTLEMENT HOUSE, APRIL 2003, $159,617
CIN: A-03-98-00034	FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MARCH 1999, $156,987
CIN: A-06-03-75523	UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JUNE 2003, $152,465
CIN: A-01-02-01504	REVIEW OF CDC'S HIV PROGRAMS AT FENWAY COMMUNITY HEALTH CENTER, JUNE 2003, $151,912
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-01-02-00524	REVIEW OF OUTPATIENT HOSPITAL/INDEPENDENT AMBULATORY SURGICAL CENTER AND PHYSICIAN CODING FOR AMBULATORY SURGERIES, JULY 2003, $146,000
CIN: A-07-03-02664	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION TRAILBLAZERS, DECEMBER 2002, $140,202
CIN: A-08-03-74616	OGLALA SIOUX TRIBAL DEPT. OF PUBLIC SAFETY, MARCH 2003, $136,764
CIN: A-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-05-00-00060	MEDICA FOLLOW-UP, REIMB. RATES FOR INSTITUTIONAL BENEFICIARIES, JUNE 2001, $133,795
CIN: A-06-00-00014	REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCAR, JUNE 2000, $132,238
CIN: A-07-02-00148	PAYMENTS FOR COVENTRY - K.C. FOR INSTITUTIONAL BENEFICIARIES, APRIL 2003, $132,000
CIN: A-07-03-02661	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION NHIC, JANUARY 2003, $129,748
CIN: A-02-01-04000	INTERIM AUDIT OF RUTGER'S CONTRACT NO.SP0103-96-D-, JANUARY 2002, $125,415
CIN: A-05-01-00069	MERITER - MC/MA CREDIT BALANCES, JULY 2002, $122,713
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEPTEMBER 2002, $121,023

CIN: A-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-09-02-71247	WATTSHEALTH FOUNDATION INC., APRIL 2002, $113,000
CIN: A-03-01-00001	EASTERN SHORE AMBULANCE CO., AUGUST 2001, $110,417
CIN: A-01-02-00527	REVIEW OF ANTHEM BLUE CROSS/BLUE SHIELD MEDICARE CONTRACT TERMINATION AND SEVERANCE COSTS, SEPTEMBER 2003, $104,468
CIN: A-01-02-01502	NORTHEASTERN UNIVERSITY DHHS CONTRACT COSTS, JUNE 2003, $102,378
CIN: A-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-05-02-00067	REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS & COST REPORTS @ WELBORN, JUNE 2003, $97,623
CIN: A-09-97-00066	WALTER MCDONALD - INDIRECT COST RATE AUDIT, MARCH 1998, $95,733
CIN: A-01-99-00507	NAT-WIDE REF - OUTPATIENT PSYCH SVC 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-06-03-00021	CMS FY 02 MEDICARE ERROR RATE - TRAILBLAZER REPORT QTR 1 (NOV-DEC), JULY 2003, $93,863
CIN: A-04-02-02009	MEDICAID IMD'S - 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-05-02-00074	IL PARTNERSHIP PLAN - TRANSPORTATION DURING AN INPATIENT STAY, APRIL 2003, $89,147
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	MBCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, $87,042
CIN: A-05-01-00071	PAYMENTS TO HUMANA - K.C. FOR INSTITUTIONAL BENEFICIARIES, DECEMBER 2001, $84,808
CIN: A-02-03-74061	PUERTO RICO DEPT. OF THE FAMILY, AUGUST 2003, $80,001
CIN: A-10-01-67562	KENAITZE INDIAN TRIBE, MARCH 2001, $79,533
CIN: A-04-01-02003	REVIEW FLORIDA MEDICAID CLAIMS - IMD'S, MARCH 2002, $78,880
CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCTOBER 2002, $77,000
CIN: A-01-99-00530	NATIONWIDE REV OF OUTPATIENT PSYCH SERVICES @ PSYCHIATRIC HOSPITALS, DECEMBER 2000, $75,413
CIN: A-04-01-02008	ANCILLARY CLAIMS PAID FOR MEDICAID BENEFICIARIES WHILE IN IMDS, JULY 2002, $71,406
CIN: A-01-03-75448	STATE OF NEW HAMPSHIRE, APRIL 2003, $65,917
CIN: A-08-03-74429	PORCUPINE CLINIC, JULY 2003, $65,027
CIN: A-04-03-73667	MANATEE OPPORTUNITY COUNCIL INC., OCTOBER 2002, $63,321
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
CIN: A-05-99-00045	KAISER HEALTH PLAN OF OHIO - INSTITUTIONAL STATUS, MAY 2000, $61,177
CIN: A-05-02-72716	SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND, SEPTEMBER 2002, $60,378
CIN: A-05-96-00072	MI DEPT. OF COMMUNITY HEALTH/MEDICAID LAB SERVICES, AUGUST 1997, $59,956
CIN: A-06-01-68876	STATE OF LOUISIANA, JUNE 2001, $59,914
CIN: A-01-96-00505	CFO AUDIT OF HCFA'S FINANCIAL STATEMENTS, JULY 1997, $59,327
CIN: A-09-97-00059	HEALTH SERVICES ADVISORY GROUP, INC PRO-AZ, MAY 1997, $57,925

APPENDIX D

CIN: A-04-02-72118	STATE OF NORTH CAROLINA, MAY 2002, $52,912
CIN: A-06-00-00053	OIG HCFA NEBULIZER PROJECT - NATIONAL ERROR RATE, OCTOBER 2001, $52,550
CIN: A-08-00-60687	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, NOVEMBER 1999, $52,536
CIN: A-04-02-68936	STATE OF TENNESSEE, JUNE 2002, $50,717
CIN: A-01-02-00518	REVIEW OF OUTLIER PAYMENTS MADE TO MERCY HOSPITAL OF PORTLAND MAINE UNDER THE OUTPATIENT PPS, APRIL 2003, $50,280
CIN: A-05-00-00059	TITLE XIX - MEDICAID ESCHEATED WARRANTS, MARCH 2001, $50,162
CIN: A-05-02-00054	UNITED GOVERNMENT SERVICES, Y2K COSTS FY 1998 & 1999, APRIL 2003, $49,923
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-07-00-00106	PENSION SEGMENTATION AUDIT AT BCBS OF OKLAHOMA, JULY 2001, $45,508
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 BCBS 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-01-03-01500	REVIEW OF CDC HIV PROGRAMS AT GREATER BRIDGEPORT ADOLESCENT PREGNANCY PROGRAM, JULY 2003, $41,088
CIN: A-10-02-72331	IDAHO MIGRANT COUNCIL INC., JULY 2002, $40,541
CIN: A-05-00-00017	INDIANA MEDICAID TRANSPORTATION SERVICES, MARCH 2001, $39,735
CIN: A-08-00-65136	STATE OF SOUTH DAKOTA, JUNE 2000, $36,380
CIN: A-06-03-00020	CMS FY 02 MEDICARE ERROR RATE - TRAILBLAZER REPORT QTR 3 (APR-JUN), JULY 2003, $35,474
CIN: A-10-03-74366	FIRST A.M.E. 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-06-03-74833	AMIGOS VOLUNTEERS IN EDUCATION & SERVICES INC. AV, APRIL 2003, $31,180
CIN: A-05-02-69155	STATE OF WISCONSIN, DECEMBER 2001, $30,900
CIN: A-04-01-01005	REVIEW DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTS AT CAPITAL HEALTH PLAN, NOVEMBER 2001, $30,293
CIN: A-06-02-00018	GRADUATE MEDICAL EDUCATION COST AT METHODIST 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-04-02-72213	STATE OF FLORIDA, JUNE 2002, $28,612
CIN: A-08-03-73541	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JANUARY 2003, $28,573
CIN: A-03-98-03301	AAUAP - INCURRED COST REVIEW - HHS 105-95-7011, APRIL 1998, $28,289
CIN: A-10-02-69837	NATIVE VILLAGE OF TYONEK, DECEMBER 2001, $26,848
CIN: A-07-02-00150	PAYMENTS TO COVENTRY - PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUNE 2003, $26,000
CIN: A-06-00-00020	REV OF INFUSION THERAPY CLAIMS @ VISTA CONTINUING, JUNE 2000, $25,008
CIN: A-06-02-70732	UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JANUARY 2002, $23,483
CIN: A-04-03-03018	ASSIST AUDIT OF CMS' FY 2002 FINANCIAL STMTS. AT PGBA, 4TH QTR. (JULY-SEPT. 2001), APRIL 2003, $21,614
CIN: A-06-02-71744	SENECA-CAYUGA TRIBE OF OKLAHOMA, MARCH 2002, $21,376
CIN: A-04-00-01206	BCBSNC - MEDICARE PART A ADMIN COST AUDIT - CARMICHAEL, SEPTEMBER 2000, $21,302
CIN: A-05-01-00078	PAYMENTS TO HEALTH NET - TUCSON, AZ - FOR INSTITUTIONAL BENEFICIARIES, APRIL 2002, $21,233
CIN: A-02-03-04004	CONTRACT CLOSING - NAS 9-19441, JULY 2003, $20,595
CIN: A-05-02-72480	HANSEL NEIGHBORHOOD SERVICE CENTER INC., SEPTEMBER 2002, $20,266
CIN: A-09-02-00092	CA MEDICARE SETTLEMENT OF CROSSOVER BAD DEBTS - MUTUAL OF OMAHA, JANUARY 2003, $20,248
CIN: A-05-02-00079	MEDICAID FFS PAYMENTS FOR MEDICAID MANAGED CARE ENROLLEES, SEPTEMBER 2003, $20,165

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-08-03-76453	WILLISTON PUBLIC SCHOOL DISTRICT NO. 1, SEPTEMBER 2003, $18,929
CIN: A-05-01-00100	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842
CIN: A-04-97-01163	VIMI MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, $18,758
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, $18,645
CIN: A-07-03-00151	REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUNE 2003, $18,400
CIN: A-03-97-00007	NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MARCH 1997, $17,045
CIN: A-09-03-73329	CENTER FOR HEALTH TRAINING, APRIL 2003, $17,000
CIN: A-07-00-00117	REV. OF PENSION COSTS FOR MED. REIMB. BC/BS OF ND, JANUARY 2001, $16,863
CIN: A-05-03-75408	MICHIGAN DEPT. OF COMMUNITY HEALTH, APRIL 2003, $16,645
CIN: A-01-99-55594	STATE OF VERMONT, NOVEMBER 1998, $16,623
CIN: A-01-97-44143	BRANDEIS UNIV., JANUARY 1997, $16,602
CIN: A-06-01-68297	NATIVE AMERICAN CENTER OF RECOVERY INC., MAY 2001, $16,314
CIN: A-03-03-00006	CARDIAC REHABILITATION - WASHINGTON ADVENTISIT HOSPITAL, AUGUST 2003, $15,946
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-01-03-75589	STATE OF CONNECTICUT, JULY 2003, $14,605
CIN: A-03-97-00008	NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MARCH 1997, $14,596
CIN: A-09-00-00104	PACIFICARE OF CALIFORNIA - INSTITUTIONAL STATUS, MARCH 2001, $14,278
CIN: A-05-03-73921	NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NOVEMBER 2002, $13,317
CIN: A-03-03-72847	DISTRICT OF COLUMBIA DEPT. OF HEALTH, OCTOBER 2002, $12,850
CIN: A-06-03-74511	SOUTHERN UNIV. SYSTEM, FEBRUARY 2003, $12,693
CIN: A-08-03-74361	PORCUPINE CLINIC, JULY 2003, $12,611
CIN: A-07-02-04002	FY 2002 CFO/CMS/MEDICARE ERROR RATE MUTUAL OF OMAHA, OCTOBER 2002, $12,070
CIN: A-05-03-00012	FROEDTERT MEDICAID CREDIT BALANCES, FEBRUARY 2003, $12,066
CIN: A-04-03-03020	ASSIST AUDIT OF CMS' FY 2002 FINANCIAL STATEMENTS AT PGBA 2ND QTR. (JAN. - MAR. 2002), APRIL 2003, $11,893
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-02-01-01007	REVIEW OF ADMINISTRATIVE COST AT COOPERATIVA (CARMICHAEL & CO, CPA), MAY 2002, $10,778
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-02-02-70019	SENECA NATION OF INDIANS, DECEMBER 2001, $8,706
CIN: A-03-03-74002	MINORITY ACCESS INC., NOVEMBER 2002, $8,113
CIN: A-07-97-01231	PROWEST-DOSHI WASHINGTON, JUNE 1997, $8,027
CIN: A-03-02-72715	DISTRICT OF COLUMBIA DEPT. OF HEALTH, JULY 2002, $7,851
CIN: A-05-01-68270	LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, $7,614
CIN: A-03-98-00045	TEMPLE UNIV/PHYSICIAN CREDIT BALANCES/MEDICARE, JULY 1999, $7,280
CIN: A-10-03-74448	K-12 WASHINGTON EDUCATION SYSTEM, JULY 2003, $7,180
CIN: A-01-97-49174	BRANDEIS UNIV., AUGUST 1997, $7,068
CIN: A-01-03-75708	GENERAL HOSPITAL CORP., AUGUST 2003, $6,314

APPENDIX D

CIN: A-07-95-01167	PENSION COSTS CLAIMED NEBRASKA BC/BS, JANUARY 1996, $6,075
CIN: A-06-97-48062	SER-JOBS FOR PROGRESS NATIONAL INC., MAY 1997, $5,924
CIN: A-04-03-75509	STATE OF NORTH CAROLINA, MAY 2003, $5,880
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-02-03-74893	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-02-03-04002	GRANT REVIEW DAAH04-93-G-0234, SEPTEMBER 2003, $2,576
CIN: A-03-97-43996	ACTUARIAL RESEARCH CORP., OCTOBER 1996, $2,561
CIN: A-05-97-00013	PACIFICARE OF CA-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, $2,000
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-BLUE CROSS & BLUE SHIELD OF MI-CONTRACT AUDIT, JULY 1993, $1,409,954

Notes to Table 2

[1]The opening balance was adjusted downward by $22.8 million.

[2]Management decision has not been made within 6 months on 56 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/INTERGOVERNMENTALTRANSFERS/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 HOSPITAL PROGRAM PAYMENT METHODOLOGY, FEBRUARY 2003, $319,200,000
CIN: A-01-99-00507	NAT-WIDE REF OUPATIENT PSYCHIATRIC 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 INTERGOVERNMENTAL TRANSFERS - HOSPITAL ENHANCE, MAY 2001, $63,000,000
CIN: A-01-99-00530	NATIONWIDE REV OF OUTPATIENT PSYCHIATRIC SERVICES AT PSYCHIATRIC HOSPITALS, DECEMBER 2000, $56,936,287
CIN: A-07-98-02534	EMPIRE BC/BS PENSION PLAN TERMINATION, MARCH 2000, $38,626,351
CIN: A-01-02-00503	FURTHER EXPANSION OF THE DRG PAYMENT WINDOW, AUGUST 2003, $37,000,000
CIN: A-02-03-73313	CITY OF NEW YORK ADMINISTRATION FOR CHILDRENS SERVICES, JANUARY 2003, $22,203,439
CIN: A-02-01-67912	STATE OF NEW YORK, MARCH 2001, $19,000,000
CIN: A-06-99-00060	REVIEW OF AN HMO UNDERPAYMENT CLAIM OF 21 MILLION, JUNE 2001, $12,191,579
CIN: A-01-00-00502	REV OF EXORBITANT MEDICARE PAYMENTS FOR OUTPATIENT 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 MICHIGAN, NOVEMBER 1996, $8,978,998
CIN: A-06-99-00045	MEDICARE LEFT AGAINST MEDICAL ADVICE DISCHARGES, MARCH 2002, $6,800,000
CIN: A-03-00-00007	REVIEW OF 1-DAY DISCHARGES - PA., APRIL 2001, $6,300,000
CIN: A-01-99-00506	FOLLWUP REVIEW OF SEPARATELY BILLABLE ESRD LAB TESTS, JANUARY 2001, $6,100,000
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 ADDITIONAL 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 AT 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-05-01-00074	REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUNE 2001, $282,049
CIN: A-03-99-00038	EDGEWATER PSYCHIATRIC HOSPITAL, MARCH 2001, $208,731
CIN: A-07-97-01230	OFMQ - DOSHI OKLAHOMA, JUNE 1997, $203,510
CIN: A-07-97-01231	PROWEST - DOSHI WASHINGTON, JUNE 1997, $163,552
CIN: A-01-02-73084	STATE OF MAINE, SEPTEMBER 2002, $149,082
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MARCH 2003, $144,909
CIN: A-05-03-00059	ESRD #9 PRE-AWARD AUDIT (RFP-CMS-03001/JAC), MAY 2003, $139,816
CIN: A-04-03-08013	ESRD NETWORK COST PROPOSAL, MAY 2003, $116,085
CIN: A-05-03-00060	ESRD #10 PREAWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, $114,289

APPENDIX D

CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JANUARY 2002, $98,698
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, $90,528
CIN: A-05-02-00089	REVIEW OF RFP CMS-500-97-0408/0008, NOVEMBER 2002, $84,457
CIN: A-05-02-00084	MEDICARE OUTPATIENT CARDIAC REHAB - ST.LUKE'S MEDICAL CENTER, JULY 2003, $47,247
CIN: A-07-97-01232	PROWEST - DOSHI ALASKA, JUNE 1997, $21,218
CIN: A-05-96-00069	CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEBRUARY 1998, $17,555
CIN: A-07-95-01164	MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER1995, $16,632
CIN: A-01-97-00526	PSYCHIATRIC OUTPATIENT SERVICES, MARCH 1998, $7,245
CIN: A-06-03-00033	REVIEW OF GOOD SHEPHERD MEDICAL CENTER CARDIAC REHABILITATION SERVICE, JULY 2003, $3,737
CIN: A-01-98-00506	PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY 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	52
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	54
(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	50
(a)(9)	Statistical Table 2—Funds Recommended to Be Put to Better Use	51
(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.

APPENDIX F

Civil Monetary Penalties Law

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

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

CMS Financial Statement Audit
Resource Utilization Groups
Medicare-Approved Heart Transplant Centers

Public Health Agencies:

Financial Statement Audit

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

Increased Qualifications for Head Start Teachers
Noncustodial Parents' Contributions to Medicaid Costs
Health Care Services for Children in Foster Care

General Oversight:

Departmental Financial Statement Audit
Departmental Service Organizations

U.S. Department of Health
and Human Services

"Working Together to Promote, Preserve & Protect the Nation's Well-Being"

Office of Inspector General
330 Independence Avenue, S.W.
Washington, D.C. 20201