



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

Office of
Inspector
General

Semiannual
Report
To **Congress**

April 1, 2012 – September 30, 2012

OIG Organization

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) employs about 1,700 professional staff members who are deployed throughout the Nation in regional and field offices and in Washington, DC, headquarters. We conduct audits, evaluations, and investigations; provide guidance to industry; and, when appropriate, impose sanctions such as civil monetary penalties (CMP) and exclude individuals and entities from participation in Federal health care programs. We collaborate with HHS and its operating and staff divisions, the Department of Justice (DOJ) and other executive branch agencies, Congress, and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds. Following are descriptions of our mission-based components.

OAS	THE OFFICE OF AUDIT SERVICES (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by 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. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.
OEI	THE OFFICE OF EVALUATION AND INSPECTIONS (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.
OI	THE OFFICE OF INVESTIGATIONS (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State and the District of Columbia, OI actively coordinates with DOJ and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, or CMPs.
OCIG	THE OFFICE OF COUNSEL TO THE INSPECTOR GENERAL (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the antikickback statute and other OIG enforcement authorities.

The organizational entities described above are supported by the Immediate Office of the Inspector General and the Office of Management and Policy.

A Message From the Inspector General

This *Semiannual Report to Congress*, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG), Department of Health and Human Services (HHS), for the 6-month period ending September 30, 2012.



Daniel R. Levinson
Inspector General

For more than 30 years, OIG's commitment to protecting the integrity of HHS programs and the health and welfare of the people they serve has not wavered. But over time, our responsibilities have increased, our priorities have expanded, and our approaches have been refined as health care programs, vulnerabilities, and practices evolve. In fiscal year 2012, we achieved record-setting monetary and enforcement results and recommended critical actions to improve HHS programs and protect beneficiaries. OIG has also expanded our outreach to health care providers and industry by launching new tools and forums for promoting compliance. We continue to capitalize on our partnerships with other law enforcement agencies and our HHS colleagues through the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to crack down on those who commit fraud and bill scarce resources from the Medicare and Medicaid programs. OIG's HEAT portfolio expanded during this reporting period to include reports on questionable billing trends in community mental health centers, retail pharmacies, and home health agencies.

The results of OIG's audit, evaluation, enforcement, and compliance work underscore that the Department continues to face significant management and performance challenges in key areas, including reducing improper payments and avoiding waste, ensuring patient safety and quality of care, and overseeing program integrity contractors. As the Department implements the Affordable Care Act and other health care reforms, it faces challenges in ensuring that these issues are not carried over to new programs and dimensions of existing programs. OIG has offered a robust collection of recommendations to help the Department meet these challenges.

Improper payments cost Federal programs billions of dollars annually. For FY 2011, the Department reported improper payments totaling more than \$64 billion in the Medicare and Medicaid programs. OIG work continues to find vulnerabilities in the Department's ability to identify and reduce improper payments and has documented improper Medicare payments for durable medical equipment and for capitated payments to Medicare Advantage organizations. OIG work also demonstrated flaws in payment methodologies that contribute to wasteful spending. We have offered a wide array of recommended actions to address payment issues.

As the purchaser of health care for over 100 million Americans, the Department faces challenges in ensuring the quality of care rendered to Federal health care program beneficiaries. OIG's work continues to address quality and patient safety vulnerabilities by revealing persistent gaps in nursing homes' plans in the event of a disaster. OIG also recommended improvements to a program that provides free vaccines to children to better ensure that vaccines are stored appropriately to maintain potency and efficacy. OIG remains

vigilant in investigating off-label promotion of drugs that can be dangerous and harmful to beneficiaries. The pharmaceutical company GlaxoSmithKline entered into a global criminal, civil, and administrative settlement and agreed to pay \$3 billion to resolve misconduct allegations; this was the largest health care fraud settlement in U.S. history.

The Centers for Medicare and Medicaid Services (CMS) at HHS places significant reliance on contractors to perform a number of administrative and program integrity functions. OIG work continues to find weaknesses in both contractor performance and CMS oversight, and we have recommended actions to improve the potential of several related CMS programs.

Since its 1976 establishment, OIG has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare and Medicaid and the more than 300 other HHS programs. I would once again like to express my appreciation to Congress and to the Department for their sustained commitment to addressing the top challenges facing HHS programs.

A handwritten signature in black ink that reads "Daniel R. Levinson". The signature is written in a cursive, flowing style.

Daniel R. Levinson
Inspector General

Highlights

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Semiannual Report to Congress* (*Semiannual Report*) describes significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. This edition addresses work completed during the second half of fiscal year (FY) 2012 (April - September) and provides summary data on key accomplishments during the period and for the year. The *Semiannual Report*, which describes OIG's output in 6-month increments, is one of OIG's three core publications. Our *Work Plan* describes work in progress and new projects that we plan to pursue during the fiscal year and beyond. Our *Compendium of Unimplemented Recommendations* describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.

Summary of Fiscal Year 2012 Accomplishments

For FY 2012, we reported expected recoveries of about \$6.9 billion consisting of \$923.8 million in audit receivables and \$6 billion in investigative receivables (which includes \$1.7 billion in non-HHS investigative receivables resulting from our work in areas such as the States' shares of Medicaid restitution). We also identified about \$8.5 billion in savings estimated for FY 2012 as a result of legislative, regulatory, or administrative actions that were supported by our recommendations. Such savings generally reflect third-party estimates (such as those by the Congressional Budget Office) of funds made available for better use through reductions in Federal spending.

We reported FY 2012 exclusions of 3,131 individuals and entities from participation in Federal health care programs; 778 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 367 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters. Following are highlights of some of the significant problems, abuses, deficiencies, activities, and investigative outcomes that are included in the Semiannual Report for the second half of FY 2012.

Health Care Fraud Prevention and Enforcement Action Team

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and the Department of Justice (DOJ) to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse.

HEAT has continued with increasing momentum to identify and hold accountable those who seek to defraud Medicare and Medicaid.

Health Care Fraud Prevention Summit

On April 4, 2012, HHS and DOJ hosted the seventh regional Health Care Fraud Prevention Summit, held in Chicago. The Summits bring together a wide array of Federal, state, and local partners, beneficiaries, providers, and other interested parties to discuss innovative ways to eliminate fraud within the U.S. health care system. The Chicago Summit focused on the latest technological advancements, including data analytics, now being used to identify, prevent, and prosecute fraud. HHS Secretary Kathleen Sebelius and Attorney General Eric Holder provided keynote remarks.

Medicare Strike Force Teams

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. The teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force began in March 2007 and is operating in nine major cities. The effectiveness of the Strike Force model is enhanced by interagency collaboration. For example, we refer credible allegations of fraud to the Centers for Medicare & Medicaid Services (CMS) so that it can suspend payments to the perpetrators. During Strike Force operations, OIG and CMS work to impose payment suspensions that immediately prevent losses from claims submitted by Strike Force targets.

- **Strike Force Accomplishments** – During FY 2012, Strike Force efforts resulted in the filing of charges against 305 individuals or entities, 181 convictions, and \$151 million in investigative receivables.
- **Nationwide Takedown** – On May 2, 2012, over 200 OIG Special Agents, Forensic Examiners and Analysts participated in Medicare Fraud Strike Force operations in 7 cities that resulted in charges against 107 individuals, including doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$452 million in false billing. The coordinated takedown involved the highest amount of Medicare false billings in a single takedown by the HEAT strike force.

Strike Force Case

Home Health Agency Owners, Co-Conspirators Sentenced (Texas) – Between April 2006 and August 2009, Family Healthcare Group, Inc. (Family Healthcare Services (FHS)), a home health agency, submitted fraudulent claims to Medicare for services that were medically unnecessary or not provided. The scheme involved co-conspirators receiving kickbacks to recruit Medicare beneficiaries to receive skilled nursing services from FHS. To date, nine individuals have been sentenced in connection with this scheme and two have been excluded from participation in Medicare, Medicaid, and Federal health care programs by OIG for 30 years.

Prescription-Drug-Related Investigations

Medicare and Medicaid are major payers of prescription drugs. Our investigations and reviews find vulnerabilities at many levels, including pharmaceutical manufacturer noncompliance, retail pharmacy and prescriber schemes, drug diversion, and flawed reimbursement methodologies.

Cases and Settlements

- **GlaxoSmithKline Agrees To Pay \$3 Billion to Resolve Violations Regarding its Marketing and Promotion Practices (Massachusetts)** – GlaxoSmithKline (GSK) entered into a global criminal, civil, and administrative settlement and agreed to pay \$3 billion to resolve its liability for its marketing and promotion practices associated with several drugs. In three False Claims Act settlement agreements, the United States alleged that GSK promoted several drugs for off-label uses and paid kickbacks to induce the prescription of certain drugs, improperly promoted certain drugs with false and misleading statements about the drugs' safety, and violated the requirements of the Medicaid drug rebate program. As part of the settlement, GSK entered into a 5-year Corporate Integrity Agreement with OIG. In addition to the settlement with the Federal government, GSK entered into separate Medicaid-related settlements with multiple States.
- **Mother and Son Sentenced to a Combined 19 Years in a Prescription Drug Fraud Scheme (Washington)** – Medical clinic owners Antoine Johnson, M.D., and his mother, Lawanda Johnson, were sentenced for health care fraud and for filing false income tax returns. According to court documents, Antoine Johnson, the sole physician for several clinics, used three clinics to write a high number of prescriptions to thousands of patients for narcotic pain medications, such as oxycodone and methadone, often while providing little or no medical care. Antoine Johnson and Lawanda Johnson were each excluded by OIG for 40 years and 30 years, respectively.

Patient Safety and Quality of Care

As purchasers of health care, Medicare and Medicaid face challenges in ensuring quality of care for their beneficiaries. Despite increased attention to patient safety, problems persist.

Nursing Home Services Found Worthless

Nursing Home Operator Sentenced to 20 Years for Providing Worthless Services (Georgia) – Former nursing home operator George Houser was sentenced to 20 years of incarceration and ordered to pay \$6.7 million in restitution after being convicted on charges of submitting claims to the Medicare and Georgia Medicaid programs for services provided to residents that were so deficient the judge determined them to be "worthless." During the trial, witnesses testified that there were food shortages, leaking roofs, virtually no nursing or housekeeping supplies, poor sanitary conditions, major staff shortages, and serious safety concerns at the three nursing homes that Houser and his wife owned and operated. This is

the first time that a defendant has been convicted after a trial in Federal court for submitting claims for payment for worthless services.

Gaps in Disaster Preparedness

Gaps Continue in Nursing Home Preparedness and Response During Disasters – We found that from 2007 to 2010, most nursing homes nationwide met Federal requirements for written emergency plans and preparedness training. However, plans lacked relevant information, including only about half of the tasks on the CMS checklist. Nursing homes faced challenges with unreliable transportation contracts, lack of collaboration with local emergency management, and residents who developed health problems. State long-term-care ombudsmen were often unable to support nursing home residents during disasters; most had no contact with residents until after the disasters. States reported making some efforts to assist nursing homes during disasters, mostly related to nursing home compliance issues and ad hoc needs. *Gaps Continue To Exist in Nursing Home Preparedness and Response During Disasters: 2007 - 2010*. OEI-06-09-00270. April 2012. [Full Text](#).

Vaccines Mismanaged in Storage

Vulnerabilities in Vaccine Storage and Management Threaten Efficacy – A June 2012 report revealed that providers in the Vaccines for Children (VFC) program exposed vaccines in storage to inappropriate temperatures, which could reduce vaccine potency and efficacy, increasing the risk that children are not provided with maximum protection against preventable diseases. The VFC program is a Medicaid benefit that provides free vaccines to eligible children. CMS delegates the program's implementation to the Centers for Disease Control and Prevention (CDC), which purchases VFC vaccines and distributes them to VFC providers. We found that vaccines stored by 76 percent of 45 selected providers were exposed to inappropriate temperatures for at least 5 cumulative hours. We also found expired vaccines stored together with nonexpired vaccines, increasing the risk of mistakenly administering the expired vaccine. The selected providers generally did not meet vaccine management requirements or maintain required documentation. *Medicaid Vaccines for Children Program: Vaccine Storage and Management*. OEI-04-10-00430. June 2012. [Full Text](#).

50-Year Exclusion for Involuntary Manslaughter

Michael Jackson's Physician Excluded from Medicare, Medicaid, and All Federal Health Care Programs for a Minimum of 50 Years (California) – Conrad Murray, pop singer Michael Jackson's doctor, was excluded from participation in Federal health care programs for a minimum of 50 years after being convicted of involuntary manslaughter. Murray was sentenced to 4 years of incarceration, ordered to pay \$101,827,871 in restitution, and ordered to cease and desist from practicing medicine in California.

Medicare Wasteful Spending

Wasteful spending occurs when Medicare's laws, policies, and methodologies fail to ensure that program costs are reasonable and appropriate and fail to reflect Medicare's role as a high-volume, prudent insurer/payer in the health care marketplace.

Flawed Payment Methodologies

- **Payments for Evaluation and Management Services Do Not Always Reflect the Actual Services Provided** – Reviews of Medicare claims for cardiovascular and musculoskeletal surgeries in 2007 revealed that Medicare's payment methodology often did not reflect the actual number of preoperative and postoperative physician evaluation and management (E/M) services actually provided to beneficiaries, resulting in wasteful spending. The physician fee schedule includes global surgery fees for the surgical service and the related E/M services provided during the global surgery period, which, for major surgeries, includes the day before the surgery, the day of the surgery, and the 90 days after the day of the surgery. In determining a global surgery fee, Medicare estimates the number of E/M services that physicians provide to typical beneficiaries receiving such surgeries and compensates physicians regardless of the E/M services actually provided. For the two types of surgeries, we estimated that Medicare paid a net \$63 million in E/M services that were not provided in 2007.

Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided. A-05-09-00054. May 2012. [Full Text](#).

Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided. A-05-09-00053. May 2012. [Full Text](#).

- **Medicare Pays Too Much for the Drug Avastin When Used in Treating Wet Age-Related Macular Degeneration** – We found that for the first quarter of 2010, physicians could purchase Avastin at 53 percent below the average Medicare payment for providing the drug in treating wet age-related macular degeneration (wet AMD) in physician office settings. Wet AMD is a leading cause of vision loss in older people. Wasteful spending has occurred because Medicare does not have a national payment amount for such use of Avastin. Medicare's payment contractors independently set the payment amounts, which differed as much as 28 percent. CMS set a national payment amount for Avastin but rescinded it in 2009. *Medicare Payments for Drugs Used to Treat Wet Age-Related Macular Degeneration.* OEI-03-10-00360. April 2012. [Full Text](#). See also OIG report [A-01-10-00514](#), September 2011.

Medicare Improper Payments and Fraudulent Billings

Improper payments in Medicare and Medicaid commonly fall into four categories: unsupported services, medically unnecessary services, incorrect billings, and other noncovered cost or error types. Some of these core payment issues result from fraudulent behavior. Many claims are questioned and disallowed because providers do not maintain

required documentation or sufficient documentation to support the services and amounts claimed.

Inpatient Rehabilitation Facilities

Overpayments Caused by Failure To Detect Late Transmissions of Patient Assessment

Instruments – A September 2012 report revealed that Medicare's contractors overpaid 88 of 108 sampled claims (about 81 percent) submitted by inpatient rehabilitation facilities (IRF). The errors occurred because the contractors failed to detect from the claims that the required patient assessment instruments (PAI) were submitted late. If PAIs are submitted late, payments should be reduced by 25 percent. We estimated that for services provided in CYs 2009 and 2010, Medicare overpaid about \$8.4 million to IRFs for claims associated with late PAIs. PAIs contain the information Medicare needs to properly administer the IRF prospective payment system. On average, IRFs transmitted the required PAIs 70 days after the deadline. *Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for Claims With Late Patient Assessment Instruments for CYs 2009 and 2010*. A-01-11-00534. September 2012. [Full Text](#).

Medical Equipment Supplier Scheme

Two Sentenced to a Combined 17 Years, Ordered To Pay Restitution (Georgia) – Arthur Manasarian and Sahak Tumanyan were sentenced in a Medicare fraud scheme. Manasarian, who opened a durable medical equipment company, Brunswick Medical Supply (BMS), stole the identities of hundreds of Medicare beneficiaries and physicians from multiple states and submitted claims to Medicare for DME that was never provided. Tumanyan also engaged in numerous fraudulent financial transactions designed to deliberately conceal the proceeds from the fraudulent Medicare claims. Manasarian was sentenced to 12 years of incarceration and ordered to pay over \$1.8 million in restitution, jointly and severally, while Tumanyan was sentenced to 5 years of incarceration and ordered to pay \$308,963 in restitution, jointly and severally. Additionally, Manasarian and Tumanyan were each excluded by OIG for 20 years and 15 years, respectively. The investigation of this scheme, which was worked jointly with U.S. Immigration and Customs Enforcement, the Federal Bureau of Investigation, and the Los Angeles County Sheriff's Office, has led to more than 35 arrests.

Noncompliant Data Used in Calculations

Diagnosis-Related Data and Documentation Used in Risk Score Calculations Did Not Comply With Federal Requirements – Reports issued in May and September 2012 revealed that two Medicare Advantage (MA) organizations were overpaid in 2007 under Medicare Part C because the diagnoses and/or supporting documentation that they submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. CMS uses risk scores to adjust the monthly capitated payments to MA organizations for the next payment period.

Risk Adjustment Data Validation of Payments Made to PacifiCare of Texas for Calendar Year 2007 (Contract Number H4590). A-06-09-00012. May 2012. [Full Text](#).

Risk Adjustment Data Validation of Payments Made to Paramount Care, Inc., for CY 2007 (Contract No. H3653). A-05-09-00044. September 2012. [Full Text](#).

Claims With Questionable Billing Characteristics

We reviewed claims for three provider types to identify those that exhibited questionable billing. Questionable billing refers to claims that exhibit certain characteristics that may indicate fraud. We identified and reviewed those that had a high percentage of claims that met at least one of the questionable billing characteristics.

- **Community Mental Health Centers** – Our report revealed that in 2010, about half of community mental health centers (CMHC) met or exceeded thresholds that indicated unusually high Medicare billing for at least one of nine questionable billing characteristics related to partial hospitalization programs (PHP). PHPs are intense, structured, outpatient mental health treatment programs. We found that about 90 percent of CMHCs with questionable billing were located in States that do not require CMHCs to be licensed or certified. *Questionable Billing by Community Mental Health Centers*. OEI-04-11-00100. August 2012. [Full Text](#).
- **Medicare Part D Retail Pharmacies** – We found that over 2,600 retail pharmacies had extremely high billing for at least 1 of the 8 measures we developed. For example, many pharmacies billed extremely high dollar amounts or numbers of prescriptions per beneficiary or per prescriber. This could mean that a pharmacy is billing for drugs that are not medically necessary or were never provided to the beneficiary. The Miami, Los Angeles, and Detroit areas were the most likely to have pharmacies with questionable billing. *Retail Pharmacies With Questionable Part D Billing*. OEI-02-09-00600. May 2012. [Full Text](#).
- **Home Health Agencies With Inappropriate and Questionable Billing** – We found that about one in every four home health agencies (HHA) exceeded a threshold that indicated unusually high billing for at least one of our six measures of questionable billing. We examined home health claims with three specific errors: overlapping with claims for inpatient hospital stays, overlapping with claims for skilled nursing facility stays, or billing for services on dates after beneficiaries' deaths. HHAs with questionable billing were located mostly in Texas, Florida, California, and Michigan. *Inappropriate and Questionable Billing by Medicare Home Health Agencies*. OEI-04-11-00240. August 2012. [Full Text](#).

Medicare Collections, Reconciliations, and Program Integrity

Uncollected Overpayments

Obstacles to Medicare's Collection of Identified Overpayments – As of October 2010, Medicare had not recovered \$332,119,044 (80 percent) of \$416,287,546 it had agreed to collect. OIG identified the overpayments in audits during FYs 2007 and 2008 and the first 6 months of FY 2009. Collection efforts were obstructed by time constraints imposed by the statute of limitations. Also, Medicare contractors lacked adequate guidance for collecting overpayments, and CMS did not have an effective system for monitoring contractors' collection efforts. We identified inaccuracies and could not verify the \$84.2 million that CMS

reported collecting. *Obstacles to Collection of Millions in Medicare Overpayments*. A-04-10-03059. May 2012. [Full Text](#).

Unreconciled Hospital Outlier Payments

Medicare Failed To Reconcile and Settle Hospital Outlier Payments – CMS did not reconcile overpayments and underpayments of hospital outlier payments associated with 292 of 305 cost reports we reviewed. Outlier payments are designed to protect hospitals from excessive losses due to unusually high-cost cases. Because CMS did not reconcile the cost reports, amounts that hospitals owed to Medicare and that Medicare owed to hospitals were unknown and outstanding at the conclusion of our fieldwork and Medicare's contractors could not settle the cost reports. Audits by the Medicare contractors before reconciliation estimated that outlier payments were due from hospitals to Medicare for 236 of the 292 cost reports (about 81 percent) and that outlier payments were due from Medicare to hospitals for the other 56 cost reports. Payments owed to Medicare by hospitals, along with associated interest, represent funds that should be returned to the Medicare Trust Fund. *CMS Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance*. A-07-10-02764. June 2012. [Full Text](#).

Zone Program Integrity Contractors

CMS's Oversight of ZPIC-Related Conflicts of Interest Inadequate – A July 2012 report revealed that some Zone Program Integrity contract (ZPIC) offerors (companies that submit proposals for ZPIC contracts) and their subcontractors failed to provide all the requisite information regarding financial interests in other entities. Also, descriptions of the conflicts of interest presented were often unclear, and some did not distinguish actual conflicts from possible conflicts. Offerors and their subcontractors often had business and contractual relationships with CMS and with other offerors, but rarely considered them to be actual conflicts. CMS does not have a written policy for reviewing conflict and financial interest information. *Conflicts and Financial Relationships Among Potential Zone Program Integrity Contractors*. OEI-03-10-00300. July 2012. [Full Text](#).

Medicare-Medicaid Data Match Program

Administrative Limitations Hinder Effectiveness – An April 2012 OIG report revealed that during 2007 and 2008, the Medicare-Medicaid (Medi-Medi) Data Match program produced limited results and few fraud referrals. The Medi-Medi program enables PSCs and participating State and Federal Government agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs to detect aberrant billing patterns that may not be evident when analyzing the data separately. Historically, data sharing between Medicare and Medicaid has been limited. Our report describes several limitations in the administration of the Medi-Medi program that may have diminished the program's potential. The program, which began as a pilot in 2001, is intended to enable Medicare and participating State and Federal Government agencies to collaboratively analyze billing trends across Medicare and Medicaid to identify potential fraud, waste, and abuse. During the period of our review, only 10 States had chosen to participate. Two of the States withdrew, finding that the program offered them minimal expenditure avoidance and recoupment of Medicaid funds. Of expenditures recouped through the program during 2007 and 2008, more than three quarters was recouped for Medicare.

The Medicare-Medicaid (Medi-Medi) Data Match Program. OEI-09-08-00370. April 2012. [Full Text.](#)

Medicaid Payments and Oversight

States have considerable flexibility in designing and operating their Medicaid programs; however, to receive a Federal share of Medicaid costs, applicable State and Federal requirements must be met.

Intermediate Care Facilities

Daily Rates for Certain State-Operated Developmental Centers May Be Excessive

(New York) – New York's Medicaid daily rate for 15 selected State-operated Intermediate Care Facilities (ICF) for individuals with intellectual and developmental disabilities (developmental centers) may not have met the Federal requirement that payments be consistent with economy and efficiency. The daily rate for Medicaid beneficiaries to reside in the selected developmental centers grew from \$195 per day in SFY 1985 to \$4,116 per day in State FY 2009, which is the equivalent of \$1.5 million per year for one Medicaid beneficiary. The developmental center rate was more than nine times the average rate for all other State-operated and privately operated ICFs in State FY 2009. The growth occurred because the State's rate-setting methodology significantly inflated the Medicaid daily rate for the developmental centers and CMS did not prevent the rate from increasing to its current levels. If the State had used prior year actual costs as the starting point in its rate methodology instead of its current method in calculating the daily rate, the Federal Government might have saved over \$700 million in reimbursements in State FY 2009. *Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive.* A-02-11-01029. May 2012. [Full Text.](#)

HCBS Waivers—Noncompliant Providers (New Jersey)

Individual Plans of Care, Documentation, Policies, and Procedures Insufficient – Three reports issued in this semiannual period revealed that claims for Federal reimbursement for Medicaid home and community-based care (HCBS) in New Jersey and New York were unallowable for not meeting certain Federal and State requirements. Policies and procedures for overseeing and administering the waiver programs were not adequate to ensure that providers claimed reimbursement only for services actually provided and maintained all the required documentation to support the services billed and to ensure that waiver program services were provided to beneficiaries only when pursuant to written plans of care. The New Jersey report revealed an estimated \$60,740,637 in improperly claimed Federal reimbursements. *Medicaid Payments for Services Under New Jersey's Section 1915c Community Care Waiver.* A-02-10-01029. April 2012. [Full Text.](#) (See also New York reports [A-02-10-01027](#) and [A-02-10-01002](#).)

Part B Premiums—Claims for Federal Share of State-Paid Premiums (Nevada)

Documentation and Eligibility Issues Associated With State's Improper Part B Premium Payments. Nevada did not always comply with Federal requirements when claiming Federal reimbursement for Medicare Part B program (Part B) premiums that it paid on behalf of Medicaid beneficiaries. Federal law allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. The buy-in program allows a participating State Medicaid program to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in Part B and to pay the monthly premiums on their behalf. The State may then claim the monthly premium expenditures for Federal reimbursement. We identified numerous improper claims for Federal reimbursement by Nevada and set aside additional amounts for resolution. *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid on Behalf of Medicaid Beneficiaries.* A-09-11-02024. July 2012. [Full Text](#).

Onsite Review of Medicaid Fraud Control Unit

Onsite Review of Medicaid Fraud Control Unit (New York) – OIG is responsible for overseeing the activities of all State Medicaid Fraud Control Units (MFCU or Unit) and publishes periodic onsite review reports. From fiscal years 2008 to 2010, the New York MFCU filed criminal charges against more than 400 defendants, obtained more than 400 convictions, and was awarded more than \$750 million in recoveries. Our review found a number of noteworthy practices, including the Unit's approach to patient abuse and neglect cases, its list of ongoing investigations (created to avoid conflicts among investigating agencies), and its use of technology. Our report includes findings and recommendations with respect to staff size, training, file maintenance, and policies and procedures. *Medicaid New York State Medicaid Fraud Control Unit: 2011 Onsite Review.* OEI-02-11-00440. June 2012. [Full Text](#).

Public Health and Human Services Reviews

Our public health and human services work reflects some of HHS's top management challenges related to administration of contracts and grants management. OIG also plays a significant role in child support enforcement activities.

HRSA's Health Center Program

Multiple Issues Found With a Grantee's Claims and Financial Performance – The Health Center Program is administered by the Health Resources and Services Administration (HRSA). Our September 2012 report revealed that for selected grants and budget periods, Soundview Health Care Network, a nonprofit grantee organization that operates a network of five health centers, claimed Federal grant expenditures totaling \$113,603 that were unallowable because of deficiencies in its internal controls. We could not determine the allowability of an additional \$5,211,598 claimed. Some of the funds were not accounted for separately from other operational funds, the grantee's cash balances were significantly lower than the recommended 60-day minimum, and there were indications the grantee did not have enough cash on hand to pay its short-term liabilities. We also found problems with the

grantee's liquidity, accounts receivable collections and found a decline and net loss in earnings. *Soundview Health Care Network Did Not Meet Select Financial Performance Measures and Claimed Unallowable Federal Grant Expenditures*. A-02-11-02004. [Full Text](#).

Head Start Program Eligibility

The Administration for Families and Children (ACF) Strengthened Its Oversight of Head Start Program Eligibility Between FY 2010 and FY 2011 – ACF altered its FY 2011 triennial reviews to determine whether grantees kept on file the source documents proving children's eligibility and began performing unannounced reviews. ACF promulgated draft regulations that, once final, will require grantees to keep eligibility documents on file. We found that ACF was not consistent in issuing findings to grantees missing eligibility information in FY 2011 and that, in FY 2012, ACF took action to reduce this variation when issuing findings. Also, ACF developed an online complaint process for the Head Start program to capture complaints that could help the agency uncover problems with grantees. Our review was a followup to Government Accountability Office (GAO) testimony at a May 2010 congressional hearing about potential eligibility fraud at eight Head Start grantees. At the same hearing, ACF committed to improving its oversight of eligibility. Our report did not contain recommendations. *Memorandum Report: ACF Strengthened Its Oversight of Head Start Eligibility in Fiscal Year 2011*. OEI-05-11-00140. June 2012. [Full Text](#).

Child Support Enforcement

Former NFL Player Andre Rison Sentenced for Failing To Pay Child Support (Arizona) – One of OIG's most wanted deadbeat parents, Andre Rison, was sentenced to 5 years of probation and ordered to pay restitution of \$322,992 for failure to pay child support. Rison, a former National Football League (NFL) wide receiver, was ordered by a court in May 1999 to make monthly child support payments of \$2,358 for his son. Despite earning an NFL salary for more than a decade, Rison admitted that he willfully and unlawfully failed to pay child support for more than 5 years.

OIG Participation in Congressional Hearings

9-20-2012 John Hagg, Director of Medicaid Audits, testified before two subcommittees of the U.S. House of Representatives (House) Committee on Oversight and Government Reform on Medicaid payment rates for State-operated developmental centers in New York. [Testimony.](#)



*John Hagg, Director,
Medicaid Audits*

6-14-2012 Ann Maxwell, Regional Inspector General for Evaluation and Inspections, testified before the United States Senate (Senate) Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, on saving taxpayer dollars by curbing waste and fraud in Medicaid. [Testimony.](#)



*Ann Maxwell, Regional
Inspector General for
Evaluation and
Inspections, Chicago*

6-08-2012 Robert A. Vito, Regional Inspector General for Evaluation and Inspections, testified before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, on Medicare contractors' efforts to fight fraud. [Testimony.](#)



*Robert A. Vito, Regional
Inspector General for
Evaluation and
Inspections, Philadelphia*

6-07-2012 Ann Maxwell, Regional Inspector General for Evaluation and Inspections, testified before the House Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency and Financial Management, on assessing Medicare and Medicaid program integrity. [Testimony.](#)



*Ann Maxwell, Regional
Inspector General for
Evaluation and
Inspections, Chicago*

4-24-2012 Daniel R. Levinson, Inspector General, testified before the Senate Committee on Finance on the anatomy of a fraud bust from investigation to conviction. [Testimony.](#)



*Daniel R. Levinson,
Inspector General*

Contents

Medicare Program Reviews -----	1
Avoid Wasteful Spending-----	1
Evaluation and Management Services -----	1
Part B Drugs—Avastin -----	2
Part B Drugs—Average Sales Price -----	2
Laboratory Tests -----	3
Identify and Reduce Improper Payments -----	3
Hospitals—Outpatient Payments Exceeding Charges-----	3
Hospitals—Outpatient Billings Associated With Inpatient Stays -	4
Inpatient Rehabilitation Facilities—Reductions for Late	
Transmissions -----	5
Community Mental Health Centers—Partial Hospitalization	
Programs -----	6
Home Health Agencies—Unusually High Billings-----	6
Physicians—Evaluation and Management Services -----	7
Medical Equipment and Supplies—Unsupported Claims -----	7
Medical Equipment and Supplies—Diabetes-Related Supplies ---	8
Medical Equipment and Supplies—Vacuum Erection Systems ----	8
Part B Drugs—Billing of Incorrect Units of Service (Herceptin) --	9
Medicare Reconciliations and Collections-----	10
Unreconciled Hospital Outlier Payments -----	10
Uncollected Overpayments—Obstacles to Collection -----	11
Uncollected Overpayments— Home Health Agencies -----	11
Program Integrity Initiatives and Contractors -----	12
Medicare-Medicaid Data Match Program-----	12
Zone Program Integrity Contractors—Conflicts of Interest-----	12
Medicare Part C – Medicare Advantage -----	13
Part C— Risk Score Calculations -----	13
Medicare Part D (Prescription Drug Benefit) -----	14
Part D—Retail Pharmacies-----	14
Part D—Schedule II Drugs -----	15
Part D—Duplicate Payments for Hospice-Covered Drugs -----	15
Part D—TrOOP Miscalculations -----	16
Part D Formularies—Dual Eligible Beneficiaries -----	16

Patient Safety and Quality of Care-----	17
Nursing Homes—Inadequate Resident Assessments and Care Plans-----	17
Nursing Homes—Disaster Preparedness and Response -----	18
Other CMS-Related Reviews-----	18
Electronic Health Records—Coding of Evaluation and Management Services-----	18
Contract Administration—Retirement Plan, Termination Costs -	19
End Stage Renal Disease Program Networks -----	19
Medicaid Program Reviews -----	21
Medicaid Wasteful Spending -----	21
Developmental Centers—Excessive Daily Rates -----	21
Rebates—Medicaid Managed Care -----	22
Improper State Claims for Federal Reimbursement-----	22
HCBS Waivers—Room-and-Board Costs -----	23
HCBS Waivers—Noncompliant Providers-----	23
Personal Care Services—Noncompliant Providers-----	24
Adult Mental Health Rehabilitation—Multiple Deficiencies -----	25
Family Planning—Pharmacy and Sterilization Claims -----	25
Part B Premiums—Claims for State-Paid Premiums -----	26
Medicare Deductibles and Coinsurance—State Plan Rates -----	27
Administrative Costs—Unallowable Provider Training Costs ----	27
Quarterly Statements and Adjustments -----	27
Adjustments Made at Improper Rate -----	28
Calculation, Documentation Errors-----	28
Adjustments for Excess Contractor Profits-----	28
Adjustments for State Collections of Overpayments -----	29
Overpayments Not Fully Reported -----	29
Federal Share of Collections Improperly Retained -----	30
Managed Care—Federal Share of Excess Capitation Payments --	30
Prevent and Detect Medicaid Fraud and Abuse -----	31
Program Integrity—Audit Medicaid Integrity Contractors-----	31
Program Integrity—Excluded Individuals in Managed Care-----	32
Program Integrity—State Medicaid Fraud Control Units-----	32
Medicaid Beneficiary Safety and Quality of Care -----	33
Quality of Care for Waiver Program Beneficiaries -----	33
Children’s Health Insurance Program -----	34
CHIP—Concurrent Enrollments-----	34
CHIP—Inadequate Cost Tracking, Reconciliation Errors -----	34

Legal and Investigative Activities Related to Medicare and Medicaid-----	37
Investigative Outcomes-----	37
Advisory Opinions and Other Industry Guidance-----	39
Health Care Fraud Prevention and Enforcement Action Team Activities-----	39
HEAT Provider Compliance Training-----	39
Medicare Fraud Strike Force Activities -----	40
Other Criminal and Civil Enforcement Activities -----	41
Special Assistant U.S. Attorney Program-----	41
Most Wanted Fugitives Listed on OIG’s Website -----	42
Most Wanted Deadbeat Parents-----	42
Recently Completed Cases and Settlements -----	43
Medical Equipment and Supplies -----	43
Pharmaceutical Companies -----	44
Quality of Care-----	46
Laboratories -----	46
Clinics -----	47
Hospitals -----	47
Physicians -----	48
Home Health Agencies -----	48
Hospice Care-----	49
Managed Care -----	49
Physical Therapy-----	50
Identity Theft-----	50
Misuse of Grant Funds -----	51
Medicaid Fraud Control Units-----	51
Funding and Accomplishments -----	51
Joint Investigations -----	51
Sanction Authorities and Related Administrative Actions -----	53
Program Exclusions -----	53
Corporate Integrity Agreements -----	55
Civil Monetary Penalties Law-----	55
Patient Dumping -----	56
Provider Self-Disclosure Protocol-----	56
Public Health Reviews -----	59
Public Health Agencies’ Management and Program Oversight---	59
CDC—Vaccines Mismanaged in Storage -----	59

FDA—Medical Devices -----	59
HRSA—Health Center Program -----	60
NIH—Grants and Contract Management -----	61
NIH—Superfund Appropriations -----	61
NIH—Compliance With Appropriations Laws -----	62
Public Health-Related Legal Actions and Investigations -----	63
Health Education Assistance Loan Program -----	63
HEAL Exclusions -----	63
Human Services Reviews -----	64
Administration for Children and Families -----	64
Oversight of Head Start Eligibility -----	64
Child Support Enforcement -----	64
Investigative Outcomes -----	65
Engaging the Public in Capturing Deadbeat Parents -----	65
Administration for Community Living -----	65
Senior Medicare Patrol Projects -----	65
Other HHS-Related Reviews -----	66
Compliance With Executive Orders -----	66
HHS High-Dollar Improper Payments -----	66
Non-Federal Audits -----	67
Recovery Act Retaliation Complaint Investigations -----	68
Contract Audits -----	68
Legislative and Regulatory Reviews -----	69

List of Appendixes

- Appendix A Cost Savings Supported by
OIG Recommendations (p. 71)
- Appendix B Questioned Costs and Funds To Be
Put to Better Use (p. 76)
- Appendix C Peer Review Results (p. 84)
- Appendix D Summary of Sanction Authorities
(p. 86)
- Appendix E Reporting Requirements (p. 89)
- Appendix F Anti-Kickback Statute—Safe Harbors
(p. 91)

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Medicare Program Reviews

Selected acronyms and abbreviations used in this major section:

AMP	average manufacturer price	HHA	home health agency
ASP	average sales price	HHS	U.S. Department of Health and Human Services
CMS	Centers for Medicare & Medicaid Services	MA	Medicare Advantage (Part C)
E/M	evaluation and management (services)	PDP	prescription drug plan

Avoid Wasteful Spending

Wasteful spending occurs when Medicare's laws, policies, and methodologies fail to ensure that program costs are reasonable and appropriate and fail to reflect Medicare's role as a high-volume, prudent insurer/payer in the health care marketplace.

Evaluation and Management Services

Payments in Global Surgery Periods Do Not Always Reflect the Actual Services Provided – Reviews of Medicare claims for cardiovascular and musculoskeletal surgeries in 2007 revealed that Medicare's payment methodology often did not reflect the actual number of preoperative and postoperative physician evaluation and management (E/M) services actually provided to beneficiaries, resulting in wasteful spending. For the two types of surgeries, we estimated that Medicare paid a net \$63 million in E/M services that were not provided in 2007.

The physician fee schedule includes global surgery fees for the surgical service and the related E/M services provided during the global surgery period, which for major surgeries, includes the day before the surgery, the day of the surgery, and the 90 days after the day of the surgery. In determining a global surgery fee, CMS estimates the number of E/M services that physicians provide to typical beneficiaries receiving such surgeries and compensates physicians regardless of the E/M services actually provided.

Recommendations—Medicare could realize savings by adjusting the estimated number of E/M services within global surgery fees to reflect the actual number of such services being provided to beneficiaries or by using the results of this audit during the annual update of the physician fee schedule.

Report 1—*Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided.* A-05-09-00054. April 2012. [Full Text](#).

Report 2—*Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided*. A-05-09-00053. May 2012. [Full Text](#).

Part B Drugs—Avastin

Medicare Pays Too Much for the Drug Avastin When Used in Treating Wet Age-Related Macular Degeneration. We found that for the first quarter of 2010, physicians could purchase Avastin at 53 percent below the average Medicare payment for providing the drug in treating wet age-related macular degeneration (wet AMD) in physician office settings. Wet AMD is a leading cause of vision loss in older people. Wasteful spending has occurred because Medicare does not have a national payment amount for such use of Avastin. Medicare's payment contractors independently set the payment amounts, which differed as much as 28 percent.

The Centers for Medicare & Medicaid Services (CMS) set a national payment amount for Avastin but rescinded it in 2009 because of concern that the new policy could cause physicians to switch from Avastin to a substantially more expensive (but not more effective) drug, Lucentis, resulting in even higher Medicare payments and beneficiary coinsurance. Although physicians could purchase both Avastin and Lucentis at prices below their Medicare payment amounts, acquisition costs for Lucentis, which has a national payment amount, were just 5 percent below Medicare's payments. The National Eye Institute found Avastin to be as effective as Lucentis in treating wet AMD. Both Avastin and Lucentis are manufactured by Genentech.

Recommendations—To avoid wasteful spending for Avastin, CMS should establish a national payment code and a reasonable national payment amount when the drug is used for the treatment of wet AMD and educate physicians about clinical and payment issues related to Lucentis and Avastin. *Medicare Payments for Drugs Used To Treat Wet Age-Related Macular Degeneration*. OEI-03-10-00360. April 2012. [Full Text](#). (See also [A-01-10-00514](#). September 2011.)

Part B Drugs—Average Sales Price

Exercising a Statutory Option Would Reduce Payments – This statutorily mandated review identified Medicare Part B prescription drugs with average sales prices (ASP) that exceed average manufacturer prices (AMP) by at least 5 percent. When the ASP of a drug exceeds the AMP or another designated pricing point by a certain threshold (currently 5 percent), the Secretary of Health and Human Services (HHS) shall disregard the ASP for the drug when setting reimbursement amounts. The review estimated that Medicare would have saved \$4.6 million in the second quarter of 2012 by lowering reimbursement amounts for drugs that met the 5-percent threshold to 103 percent of the AMPs. The review also examined the potential effect of a July 2012 proposed rule that, among other things, specifies the circumstances under which CMS will make AMP-based price substitutions.

The report does not contain recommendations. However, similar Office of Inspector General (OIG) pricing comparisons have contained recommendations, which we continue to support. We have issued 21 quarterly pricing comparisons since the ASP reimbursement methodology for Part B drugs was implemented in January 2005. *Comparison of Fourth-Quarter 2011 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Second Quarter 2012*. OEI-03-12-00410. August 2012. [Full Text](#).

Laboratory Tests

Genetic Testing Coverage and Payment Information Provided – Wasteful spending can occur when CMS does not have sufficient information to establish appropriate payment rates. A June 2012 report, which responds to a CMS request, presents information provided to OIG through surveys and interviews in the areas of coverage policies, payment methods, and payment rates for genetic laboratory tests. Genetic tests for predictive purposes are not covered by Medicare. However, genetic tests used to diagnose or determine treatment in the presence of signs and symptoms of disease can be covered by Medicare. We provided the results of our review for CMS's use in setting Medicare coverage and payment policies for genetic tests. Because State Medicaid programs and private health insurance plans closely monitor Medicare's coverage and reimbursement decisions, CMS's formulation of reimbursement rates for genetic tests may be useful to them also.

The report does not contain recommendations. *Medicare Memorandum Report: Coverage and Payment for Genetic Laboratory Tests*. OEI-07-11-00011. June 2012. [Full Text](#).

Identify and Reduce Improper Payments

An improper payment is any payment that should not have been made or that was made in an incorrect amount and includes overpayments and underpayments. Improper payments occur when Medicare does not effectively identify and reduce erroneous and inappropriate billing by providers and suppliers prior to payment. Commonly, the items or services billed are not supported by the documentation in the providers' medical files, are not medically necessary, or were not covered by Medicare. Also, administrative errors may be associated with the claims.

Hospitals—Outpatient Payments Exceeding Charges

Payments Significantly Exceeding Charges Prone to Errors, Improper Payments – Three reviews of outpatient line items for which Medicare payments significantly exceeded billed charges revealed frequent errors, including incorrect units of services, incorrect codes, a combination of those, billing for unallowable services, and inadequate supporting documentation,

causing Medicare's payments for the services to be improper. Millions of dollars in overpayments occurred in part because key Medicare systems did not have sufficient edits in place during our audit periods to identify line item payments that exceed billed charges by a prescribed amount to prevent the overpayments.

Billed charges are the prices that a provider sets for its services. Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges generally do not affect the Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Recommendations—Medicare should recover the overpayments we identified (see individual reports below). To reduce future overpayments, Medicare should implement the system edits we specified and use the results of our audits in provider education activities.

Report 1—Of 424 selected line items, 205 (about 48 percent) were incorrect, with \$1.5 million in overpayments identified for recovery. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation but Transitioned to Highmark Medicare Services in Jurisdiction 12 for the Period January 1, 2006, through June 30, 2009.* A-07-11-04184. April 2012. [Full Text](#).

Report 2—Of 2,197 selected line items, 1,609 (about 73 percent) were incorrect; \$6.2 million in overpayments identified for recovery. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation in Jurisdiction 5, for the Period January 1, 2006, Through June 30, 2009.* A-07-11-04174. July 2012. [Full Text](#).

Report 3—Of 344 selected line items, 280 (about 81 percent) were incorrect; \$2.2 million in overpayments identified for recovery. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by WPS but Transitioned to Palmetto GBA in Jurisdiction 1 From January 1, 2006, through June 30, 2009.* A-07-11-04182. August 2012. [Full Text](#).

Hospitals—Outpatient Billings Associated With Inpatient Stays

Medicare Paid Twice for Outpatient Billings for Services Provided Within 3 Days Prior to or During Inpatient Stays – Hospital outpatient providers improperly submitted to Medicare claims for services provided to beneficiaries within 3 days prior to or during (excluding date of discharge) hospital inpatient prospective payment system (IPPS) stays. We found that of 127 services we reviewed, 61 (about 48 percent) were paid twice—as part of the IPPS and again under Part B. Outpatient providers' controls failed to prevent or detect incorrect billings. In some instances, providers were unaware that beneficiaries had been inpatients at other facilities or were unaware of or did not understand Medicare requirements. Overpayments

also occurred because Medicare's claims processing contractors were not aware of incoming system alerts because CMS did not notify them it had changed the location of this information, existing system edits did not prevent or detect certain incorrect payments, and the contractors incorrectly overrode certain edits or took no action to recover or offset overpayments when they received system alerts. The errors we identified occurred during calendar years 2008 and 2009.

Recommendations—CMS should instruct its contractors to recover the \$340,073 in overpayments we identified, resolve an estimated \$6.1 million in potential overpayments set aside for further analysis, and recover the overpaid amounts. To reduce future overpayments, contractors should reject claims or recoup overpayments identified by edits and remind hospitals of the importance of adequate controls to prevent incorrect billing for services. CMS should also communicate with Medicare contractors about changes to systems, modify existing edits to prevent payments for ambulance services provided during inpatient stays, and prevent payments that are already included in the basic prospective payment rate for nonphysician outpatient services. *Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay*. A-01-10-00508. June 2012. [Full Text](#).

Inpatient Rehabilitation Facilities—Reductions for Late Transmissions

Medicare's Failure To Detect Late Transmissions of Patient Assessment Instruments Caused Overpayments – A September 2012 report revealed that of 108 claims submitted by inpatient rehabilitation facilities (IRF), 88 (about 81 percent) were overpaid. The errors occurred because Medicare contractors failed to detect from the claims that the required patient assessment instruments (PAI) were transmitted to CMS late and did not impose the required 25-percent reductions for late transmissions. We estimated that for services provided in CYs 2009 and 2010, Medicare overpaid about \$8.4 million to IRFs for claims associated with late PAIs. PAIs contain the information Medicare needs to properly administer the IRF prospective payment system. On average, IRFs transmitted the required PAIs 70 days after the deadline. A prior OIG review for CYs 2006 and 2007 had similar findings and we estimated about \$20.2 million in overpayments. (OIG report [A-01-09-00507](#), June 2010.) IRFs are paid under a prospective payment system.

Recommendations—CMS should adjust the \$696,000 in overpayments we identified and resolve nonsampled claims with estimated potential overpayments of \$7.7 million. To reduce future overpayments, CMS should continue to educate IRFs on the importance of correct PAI transmission dates on claims, complete a process to allow systems to interface and identify claims with incorrect PAI transmission dates, and support Medicare contractors' efforts to conduct periodic postpayment reviews of IRF claims. *Medicare Overpaid Inpatient Rehabilitation Facilities Millions of Dollars for*

Claims With Late Patient Assessment Instruments for CYs 2009 and 2010.
A-01-11-00534. September 2012. [Full Text](#).

Community Mental Health Centers—Partial Hospitalization Programs

Claims With High Billings and Questionable Characteristics – In 2010, about half of community mental health centers (CMHC) met or exceeded thresholds that indicated unusually high Medicare billing for at least one of nine questionable billing characteristics related to partial hospitalization programs (PHP). The presence of the characteristics raises questions about the appropriateness of the PHP claims submitted. PHPs are intense, structured, outpatient mental health treatment programs. About 90 percent of CMHCs with questionable billing were located in States that do not require CMHCs to be licensed or certified. In the absence of licensing and certification requirements, dishonest individuals have an opportunity to establish CMHCs and improperly bill Medicare for PHP services. During 2010, 206 CMHCs received an estimated \$218.6 million for providing PHP services to approximately 25,000 Medicare beneficiaries.

Recommendations—To reduce the potential for improper payments, CMS should increase its monitoring of CMHCs' Medicare billing and fraud prevention controls, enforce the requirement that certifying physicians be listed on CMHCs' partial hospitalization program claims, finalize and implement the proposed conditions of participation for CMHCs, and review and take appropriate action against CMHCs with questionable billing that we identified. *Questionable Billing by Community Mental Health Centers.* OEI-04-11-00100. August 2012. [Full Text](#).

Home Health Agencies—Unusually High Billings

Billings With Questionable Characteristics Identified – We found that about one in every four home health agencies (HHA) exceeded a threshold that indicated unusually high billing for at least one of our six measures of questionable billing. In 2010, Medicare inappropriately paid an estimated \$5 million for home health claims with three specific errors—overlapping with claims for inpatient hospital stays, overlapping with claims for skilled nursing facility stays, or billing for services on dates after beneficiaries' deaths. HHAs with questionable billing were located mostly in Texas, Florida, California, and Michigan.

Recommendations—To reduce the potential for improper payments, CMS should implement claims processing edits or improve existing edits to prevent inappropriate payments for three specific errors we reviewed, increase monitoring of billing for home health services, enforce and consider lowering the 10-percent cap on the total outlier payments an HHA may receive annually, consider imposing a temporary moratorium on new HHA enrollments in Florida and Texas, and take appropriate action regarding the inappropriate payments we identified and HHAs with questionable billing.

Inappropriate and Questionable Billing by Medicare Home Health Agencies.
OEI-04-11-00240. August 2012. [Full Text](#).

Physicians—Evaluation and Management Services

Increase in Use of Service Codes That Result in Higher Reimbursements.

A review of coding trends for Medicare evaluation and management (E/M) services claims revealed that from 2001 to 2010 physicians increased their billing of higher level, more complex and expensive E/M codes and reduced their billing of lower level, less complex and expensive E/M codes in all 15 visit types we reviewed. In 2010, about 1,700 physicians (representing less than 1 percent of physicians) billed higher level, more complex and expensive E/M codes at least 95 percent of the time. Between 2001 and 2010, payments for E/M services increased by 48 percent (from \$22.7 billion to \$33.5 billion) compared to 43 percent for Part B goods and services generally. Several factors contributed to the overall increases, including increases in the number of services provided, increases in the average payment rate for E/M services, and changes in physicians' billing of E/M codes. CMS's *Improper Medicare Fee-For-Service Payments Report – May 2008* found that certain E/M visit types had the most improper payments of all Medicare Part B services.

Recommendations—To reduce the potential for improper payments, CMS should encourage its contractors to review physicians' billing for E/M services, continue to educate physicians on proper billing for such services, and review physicians who bill higher level E/M services for appropriate actions. *Medicare Coding Trends of Medicare Evaluation and Management Services*. OEI-04-10-00180. May 2012. [Full Text](#).

Medical Equipment and Supplies—Unsupported Claims

Claims With KX Modifiers Not Supported by Required Documentation – A review of Medicare claims for four selected types of medical equipment in calendar year (CY) 2007 revealed claims that were unallowable because the suppliers did not maintain supporting documentation as required. Suppliers enter a service code modifier called the "KX modifier" on claims to indicate that the services meet Medicare coverage criteria and the suppliers have the required documentation on file. Of the 400 items with 2007 dates of service and KX modifiers, 237 (about 59 percent) did not have the required documentation on file. We estimated that Medicare paid about \$316.4 million to suppliers for insufficiently documented claims with KX modifiers. While suppliers must have a written physician's order and proof of delivery for all medical equipment and supplies, they must have additional documentation on file for certain items, such as therapeutic shoes for diabetics, continuous positive airway pressure systems, respiratory assist devices, and pressure reducing support surfaces (the four categories we reviewed).

Recommendations—CMS should recover the improper payments we identified and take appropriate action for suppliers in our sample that did

not meet proof-of-delivery standards. To reduce future overpayments, CMS should develop an alternative mechanism to help Medicare contractors ensure that suppliers maintain required documentation, and issue a special alert emphasizing the documentation that suppliers must have in their files to support use of the KX modifier. *Claim Modifier Did Not Prevent Medicare From Paying Millions in Unallowable Claims for Selected Durable Medical Equipment*. A-04-10-04004. April 2012. [Full Text](#).

Medical Equipment and Supplies—Diabetes-Related Supplies

One or More Documentation Deficiencies Found in 76 Percent of Claims –

A July 2012 OIG rollup report of four reviews concluded that suppliers of diabetes-related supplies (home blood-glucose test strips and lancets) did not always comply with Federal requirements when they billed Medicare. Of the 400 sampled claims for test strips and/or lancets that we identified as high utilization claims, 303 (76 percent) amounting to about \$209 million had 1 or more deficiencies. We found that the quantity of supplies that exceeded utilization guidelines was not supported with documentation of the reasons for the additional supplies. We found insufficient documentation for the actual frequencies of testing and the treating physicians' required evaluation of the patients' diabetic control within 6 months before ordering the supplies. Also, there sometimes was no supporting documentation indicating that refill requirements had been met and physician orders were missing or incomplete or proof-of-delivery records were missing.

Recommendations—To reduce the potential for improper payments, CMS should ensure that contractors implement system edits recommended in our individual reports, ensure that contractors are enforcing Medicare documentation requirements for claims for test strips and/or lancets, and consider the results of our reviews when developing and evaluating coverage and reimbursement policies related to test strips and lancets. *Medicare Contractors Lacked Controls To Prevent Millions in Improper Payments for High Utilization Claims for Home Blood-Glucose Test Strips and Lancets*. A-09-11-02027. June 2012. [Full Text](#).

Additional recommendations were identified in the four source reports. (See reports [A-09-08-00043](#), [A-09-08-00044](#), [A-09-08-00045](#), and [A-09-08-00046](#).)

Medical Equipment and Supplies—Vacuum Erection Systems

Documentation Deficiencies Caused a 51-Percent Overpayment Rate – One selected medical equipment supplier did not meet documentation requirements for 51 of 100 sampled claims to Medicare for male vacuum erection systems, resulting in projected overpayments of \$4.2 million during the period January 1, 2008, through December 31, 2009. For 50 of the claims, the supplier did not maintain proof of delivery in its files. The supplier lacked adequate internal controls to ensure that it collected and maintained the required documentation. To be paid for a Medicare medical equipment and supplies claim, including VES, the supplier must maintain

proof-of-delivery documents; documentation from the patient's medical records to substantiate the necessity for the items ordered; and a signed, detailed written physician's order. Nonsurgical systems known as male vacuum erection systems (VES), used in the treatment of erectile dysfunction, are designated as durable medical equipment and as such may be claimed and paid under Medicare.

Recommendations—The supplier should refund to Medicare the \$4.2 million in overpayments and develop and implement policies and procedures to help ensure that it collects and maintains the required documentation.

POS-T-VAC Medical Did Not Meet Medicare Documentation Requirements for Over Half of Sampled Claims for Male Vacuum Erection Systems.

A-07-11-05016. June 2012. [Full Text](#).

Part B Drugs—Billing of Incorrect Units of Service (Herceptin)

Most Full-Vial Billings Improper – Three reports issued in July and August 2012 revealed that most payments that the Medicare contractors we reviewed made to health care providers for full vials of Herceptin were incorrect (78 percent, 81 percent, and 80 percent). Herceptin (trastuzumab) is a Medicare-covered biological drug used to treat breast cancer that has spread to other parts of the body. The payments were improper because the billing providers reported the units of service for the entire content of 1 or more vials, each containing 440 milligrams of Herceptin, rather than reporting the units of service for the amount actually administered.

Medicare's supporting systems did not have sufficient edits in place during our audit period to prevent or detect the improper billings. In some instances, providers' supporting documentation was inadequate, and in some cases, providers could not store unused doses for later use because their pharmacies incorrectly reconstituted the Herceptin. When this occurred, the providers improperly billed Medicare for the entire vial, including waste.

Recommendations—The Medicare contractors should recover the identified overpayments (see individual reports below). To reduce future improper payments, Medicare's contractors should implement or update system edits that identify line items for multiuse-vial drugs with units of service equivalent to one or more entire vials, review the items to identify billing errors, and use the results of the audits in provider education activities.

Report 1—Of 3,966 line items, 3093 (78 percent) were incorrect; \$3,351,807 in overpayments identified for recovery. *The Medicare Contractor's Payments in Jurisdictions 6, 8, and 15 to Providers for Full Vials of Herceptin Were Often Incorrect.* A-05-10-00091. July 2012. [Full Text](#).

Report 2 – Of 2,507 line items, 2,029 (about 81 percent) were incorrect; \$2,397,839 in overpayments identified for recovery. *Medicare Contractor's Payments to Providers in Jurisdiction 11 for Full Vials of Herceptin Were Often Incorrect.* A-03-11-00013. August 2012. [Full Text](#).

Report 3 – Of 1,454 line items, 1,165 (80 percent) were incorrect; \$1,576,374 in overpayments identified for recovery. *Medicare Contractors' Payments to Providers in Four States in Jurisdiction 12 for Full Vials of Herceptin Were Often Incorrect.* A-03-11-00014. July 2012. [Full Text](#).

Medicare Reconciliations and Collections

Medicare contractors reconcile hospital outlier payments to ensure that these estimated payments made throughout the year were at the appropriate level. Overpayments identified during reconciliation should be repaid to Medicare. Similarly, when CMS makes a management decision to collect other identified overpayments (such as costs questioned in audits), the amounts should be repaid to Medicare. When reconciliations and collections are delayed or not pursued, Medicare loses funds and possibly interest it otherwise would have recouped.

Unreconciled Hospital Outlier Payments

Medicare Failed To Reconcile and Settle Overpayments and Underpayments of Outlier Payments Made Prospectively – CMS did not reconcile hospital outlier payments associated with 292 of 305 cost reports that were referred to it for that purpose by selected Medicare payment contractors. Outlier payments are designed to protect hospitals from excessive losses due to unusually high-cost cases. The 292 cost reports had about \$664 million in associated unreconciled outlier payments. Because CMS did not reconcile the payments, amounts that hospitals owed to Medicare and that Medicare owed to hospitals were unknown and outstanding at the conclusion of our fieldwork. Therefore, Medicare's contractors could not settle the cost reports. Audits by the Medicare contractors before reconciliation estimated that outlier payments were due from hospitals to Medicare for 236 of the 292 cost reports (about 81 percent) and that outlier payments were due from Medicare to hospitals for the other 56 cost reports.

Overpayments owed to Medicare by hospitals, along with associated interest, represent funds that should be returned to the Medicare Trust Fund. Delayed processing of underpayments owed to hospitals by Medicare, along with associated interest, could affect the hospitals' financial viability.

Recommendations—CMS should ensure that its contractors reconcile outlier payments and perform final settlement of the cost reports we reviewed and similarly reconcile payments and settle all cost reports submitted after our audit period. CMS should implement an automated system that will recalculate outlier claims to facilitate reconciliations and work with its contractors to develop and maintain a complete, accurate list of cost reports with outlier payments requiring reconciliation. *CMS Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance.* A-07-10-02764. June 2012. [Full Text](#).

Uncollected Overpayments—Obstacles to Collection

Medicare Failed To Recover Identified Overpayments - As of October 2010, Medicare had not recovered the majority of overpaid amounts OIG identified in audit reports during fiscal years (FY) 2007 and 2008 and the first 6 months of FY 2009. Collection efforts were obstructed by time constraints imposed by the statute of limitations. Also, Medicare contractors lacked adequate guidance for collecting overpayments and CMS did not have an effective system for monitoring contractors' collection efforts. We identified inaccuracies and could not verify \$84.2 million that CMS reported collecting.

Recommendations—To reduce future Medicare losses from uncollected improper payments, CMS should pursue legislation to extend the statute of limitations for collections, ensure that its Audit Tracking and Reporting System (ATARS) is accurately updated, ensure that CMS staff record collections information consistently in ATARS;; collect sustained amounts related to OIG recommendations made after the audit period; verify that the \$84.2 million reported as collected has actually been collected, and provide specific guidance to its contractors as specified in our report. *Obstacles to Collection of Millions in Medicare Overpayments*. A-04-10-03059. May 2012. [Full Text](#).

Uncollected Overpayments— Home Health Agencies

Surety Bond Requirement Remains Unimplemented. As of February 29, 2012, over 2,000 HHAs still owed CMS a total of approximately \$408 million for \$590 million in overpayments that the agency identified for these HHAs between 2007 and 2011. CMS could have recovered at least \$39 million between 2007 and 2011 if it had required each HHA to obtain a \$50,000 surety bond. Of 2,004 HHAs, 21 percent still had overpayment amounts, excluding interest, of more than \$50,000 each, and more than a quarter of these HHAs had outstanding overpayments of greater than \$500,000. In January 1998, CMS promulgated a final rule requiring each HHA to obtain a surety bond in the amount of \$50,000, or 15 percent of the annual amount paid to the HHA by Medicare, whichever is greater. However, this regulation remains unimplemented after nearly 15 years.

The surety bond requirement is an important program integrity tool that provides a sentinel effect of keeping fraudulent providers out of the program and a means for Medicare to guarantee recoupment of some overpayments.

Recommendations—CMS should implement the HHA surety bond requirement. To recoup a higher percentage of overpayments made to HHAs, CMS should consider increasing surety bond amounts above \$50,000 for those HHAs with high overall Medicare payment amounts. *Surety Bonds Remain an Unused Tool To Protect Medicare from Home Health Overpayments*. OEI-03-12-00070. September 2012. [Full Text](#).

Program Integrity Initiatives and Contractors

CMS contracts with several entities, including Program Safeguard Contractors, Medicare Drug Integrity Contractors, Recovery Audit Contractors, and Zone Program Integrity Contractors (ZPIC), to perform many Medicare integrity functions. It also establishes and oversees special program integrity initiatives, such as the Medicare-Medicaid Data Match (Medi-Medi) program described below.

Medicare-Medicaid Data Match Program

Effectiveness of Medi-Medi Program Questioned – An April 2012 OIG report revealed that during 2007 and 2008, Medi-Medi data match program produced only limited results and few fraud referrals. Our report describes several limitations in the administration of the Medi-Medi program that may have diminished the program's potential.

The program, which began as a pilot in 2001, is intended to enable Medicare and participating State and Federal agencies to collaboratively analyze billing trends across Medicare and Medicaid to identify potential fraud, waste, and abuse. During the period of our review, only 10 States had chosen to participate. Two of the States withdrew, finding that the program offered them minimal expenditure avoidance and recoupment of Medicaid funds. Of expenditures recouped through the program during 2007 and 2008, more than three quarters was recouped for Medicare compared to Medicaid.

Recommendations—CMS should reevaluate the goals, structure, and operations of the Medi-Medi program to determine what aspect of the program, if any, should be part of CMS's overall program integrity strategy. *The Medicare-Medicaid (Medi-Medi) Data Match Program*. OEI-09-08-00370. April 2012. [Full Text](#).

Zone Program Integrity Contractors—Conflicts of Interest

CMS's Oversight of ZPIC-Related Conflicts of Interest Inadequate – A July 2012 report revealed that some ZPIC contract offerors (companies that submit proposals for ZPIC contracts) and their subcontractors failed to provide all the requisite information regarding financial interests in other entities. Also, descriptions of the conflicts of interest presented were often unclear, and some did not distinguish actual conflicts from possible conflicts. Offerors and their subcontractors often had business and contractual relationships with CMS and with other offerors, but rarely considered them to be actual conflicts. Offerors, subcontractors, and CMS identified 1,919 business and contractual relationships as possible conflicts and 16 as actual conflicts. CMS does not have a written policy for reviewing conflict and financial interest information.

While the existence of conflicts of interest does not necessarily indicate that improper activity is taking place among CMS contractors, the public trust in CMS and its contractors could come into question if conflicts are not explicitly and openly disclosed as well as properly mitigated. Conflicts of interest could introduce bias, which in turn could influence ZPICs' efforts to reduce fraud, waste, and abuse in the Medicare program.

Recommendations—CMS should provide clear guidance to offerors and subcontractors regarding which business and contractual relationships should be identified as actual versus possible conflicts; require offerors and subcontractors to distinguish between actual and possible conflicts; state whether they need to report certain data elements; create a standardized format for reporting information and require its use; and develop a formal, written policy outlining how conflict-of-interest information provided by offerors should be reviewed by CMS staff. *Conflicts and Financial Relationships Among Potential Zone Program Integrity Contractors*. OEI-03-10-00300. July 2012. [Full Text](#).

Medicare Part C – Medicare Advantage

Medicare Part C, called Medicare Advantage (MA), was established to offer beneficiaries optional ways to receive benefits. Organizations that participate in the MA program include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. CMS makes monthly capitated payments to MA organizations for beneficiaries enrolled in the organizations' health care plans. Payments to MA organizations are risk-adjusted on the basis of the health status of each beneficiary.

Part C— Risk Score Calculations

Diagnosis-Related Data and Documentation Used in Risk Score Calculations Did Not Comply With Federal Requirements – Reports issued in May and September 2012 revealed that two MA organizations were overpaid in 2007 under Medicare Part C because the diagnoses and/or supporting documentation that they submitted to CMS for use in CMS's risk score calculations did not always comply with Federal requirements. CMS uses risk scores to adjust the monthly capitated payments to MA organizations for the next payment period.

The first MA organization did not submit documentation to support the diagnosis or the diagnoses were unconfirmed. As a result, the organization received approximately \$183,000 in overpayments from CMS. On the basis of our sample results, we estimated that the organization was overpaid about \$115.4 million for 2007. The second MA organization did not submit documentation to support the diagnoses, the documentation was incomplete or missing, or the diagnoses were unconfirmed, causing CMS's risk scores to be invalid. As a result of the unsupported diagnoses, the organization

received about \$206,000 in overpayments from CMS. On the basis of our sample results, we estimated that the organization was overpaid approximately \$18.2 million for 2007.

The organizations did not have written policies and procedures for obtaining, processing, and submitting diagnoses to CMS, and their practices were not effective in ensuring that the diagnoses it submitted complied with Federal requirements.

Recommendations—The MA organizations should refund to the Federal Government overpayments identified for sampled beneficiaries (see individual reports below) and work with CMS to determine the correct contract-level adjustment for the projected overpayments. Other recommendations that apply as indicated in the specific reports include implementing written policies and procedures for obtaining, processing, and submitting valid risk adjustment data; monitoring the effectiveness of the written policies and procedures; and improving practices to ensure compliance with Federal requirements.

Report 1—*Risk Adjustment Data Validation of Payments Made to PacifiCare of Texas for Calendar Year 2007 (Contract Number H4590)*. A-06-09-00012. May 2012. [Full Text](#).

Report 2—*Risk Adjustment Data Validation of Payments Made to Paramount Care, Inc., for CY 2007 (Contract No. H3653)*. A-05-09-00044. September 2012. [Full Text](#).

Medicare Part D (Prescription Drug Benefit)

Medicare beneficiaries generally have the option to enroll in a Part D prescription drug plan (PDP) and receive all other Medicare benefits on a fee-for-service basis or to enroll in a Part C Medicare Advantage prescription drug plan (MA-PD) and receive all of their Medicare benefits, including prescription drug coverage, through managed care. PDPs and MA-PDs are referred to collectively as "Part D plans."

Part D—Retail Pharmacies

Questionable Part D Billing by Retail Pharmacies – Retail pharmacies each billed Part D an average of nearly \$1 million for prescriptions in 2009. Over 2,600 of the pharmacies had questionable billing, i.e., had extremely high billing for at least one of the eight measures that we developed. For example, many pharmacies billed extremely high dollar amounts or numbers of prescriptions per beneficiary or per prescriber, which could mean that they were billing for drugs that were not medically necessary or were never provided to the beneficiary. Although some of this billing may be legitimate, pharmacies that bill for extremely high amounts warrant further scrutiny. The Miami, Los Angeles, and Detroit areas were the most likely to have pharmacies with questionable billing.

Recommendations—CMS should strengthen the Medicare Drug Integrity Contractors' monitoring of pharmacies and ability to identify pharmacies for further review; provide additional guidance to sponsors on monitoring pharmacy billing; require sponsors to refer potential fraud and abuse incidents that may warrant further investigation; develop risk scores for pharmacies; further strengthen its compliance plan audits; and follow up on the pharmacies identified as having questionable billing. *Medicare Retail Pharmacies With Questionable Part D Billing*. OEI-02-09-00600. May 2012. [Full Text](#).

Part D—Schedule II Drugs

Inappropriate Refills of Schedule II Controlled Substances – Medicare Part D inappropriately paid \$25 million for Schedule II drugs billed as refills in 2009. Schedule II drugs include narcotics commonly used to relieve pain and stimulants. Sponsors should not have paid for any of these drugs because Federal law prohibits the refilling of Schedule II controlled substances. Some of these drugs may have been inaccurately billed. It is possible that some long-term-care pharmacies incorrectly billed these drugs as refills when they were partial fills.

Partial fills occur when a pharmacist does not dispense all doses of the prescribed medication at one time. Several concerns exist, however, if partial fills are inaccurately billed as refills. Moreover, over 25,000 Schedule II refills had invalid prescribers. Three-quarters of Part D sponsors paid for Schedule II drugs billed as refills, indicating that many sponsors do not have adequate controls to prevent these refills. Schedule II drugs have the highest potential for abuse of any prescription drugs legally available in the United States and cannot be dispensed without a prescription that contains the name, address, and signature of the prescriber.

Recommendations—To reduce the potential for improper payments, CMS should issue guidance to sponsors to prevent billing of Schedule II refills and to ensure accurate billing of partial fills; exclude Schedule II refills when calculating payments to sponsors; monitor sponsors to ensure that they validate prescriber numbers for Schedule II drugs; and follow up on sponsors, pharmacies, and prescribers with high numbers of refills. *Inappropriate Medicare Part D Payments for Schedule II Drugs Billed as Refills*. OEI-02-09-00605. September 2012. [Full Text](#).

Part D—Duplicate Payments for Hospice-Covered Drugs

Medicare Paying Twice for Prescription Drugs for Hospice Beneficiaries – During calendar year 2009, Medicare Part D paid for prescription analgesic, antinausea, laxative, and antianxiety drugs, as well as prescription drugs used to treat chronic obstructive pulmonary disease and amyotrophic lateral sclerosis, that likely should have been covered under the per diem payments made to hospice organizations. As a result, the Medicare program could be paying twice for prescription drugs for hospice beneficiaries—once under the Medicare Part A hospice per diem payments and again under Medicare

Part D. To be eligible for Medicare hospice care, a beneficiary must be entitled to Part A of Medicare and be certified as terminally ill (i.e., having a medical prognosis that life expectancy is 6 months or less if the disease runs its normal course). Under Medicare Part D, individuals entitled to benefits under Part A may obtain voluntary coverage for prescription drugs.

Recommendations—CMS should educate sponsors, hospices, and pharmacies that it is inappropriate for Medicare Part D to pay for drugs related to hospice beneficiaries' terminal illnesses; perform oversight to ensure that Part D is not paying for drugs that Medicare has already covered under the per diem payments made to hospice organizations; and require sponsors to develop controls that prevent Medicare Part D from paying for drugs that are already covered under the hospice per diem payments.

Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice. A-06-10-00059. June 2012. [Full Text](#).

Part D—TrOOP Miscalculations

TrOOP Miscalculations Caused Sponsor To Underpay Share of Costs -

WellPoint, Inc. (a Part D drug plan sponsor), underpaid its share of drug costs because it did not always calculate true out-of-pocket (TrOOP) costs in accordance with Federal requirements for CYs 2008 and 2009. We estimated that enrollees and Medicare paid \$17.7 million more than the enrollees' 5-percent share in the catastrophic phase because of the sponsor's miscalculations.

TrOOP costs are prescription drug costs paid by the enrollee, or by specified third parties on their behalf, that count toward the annual out-of-pocket threshold that enrollees must meet before their catastrophic drug coverage begins. Once an enrollee's incurred costs exceed the annual out-of-pocket threshold, the enrollee's cost-sharing is the greater of either the copayments designated by the enrollee's plan or 5 percent of actual cost (which is known as "coinsurance"). Medicare Part D sponsors are required to track enrollees' TrOOP costs to properly adjudicate enrollee claims.

Recommendations—WellPoint should calculate TrOOP costs in accordance with Federal requirements, enhance communication with other plans to ensure that TrOOP balances are transferred properly, implement system edits to ensure that each claim is processed according to its plan benefits, and implement system edits to ensure that prescription drug event records are adjusted to accurately update TrOOP balances. *WellPoint, Inc., Did Not Always Calculate Enrollees' True-Out-Of-Pocket Costs in Accordance with Federal Requirements.* A-05-11-00018. May 2012. [Full Text](#).

Part D Formularies—Dual Eligible Beneficiaries

Drugs Commonly Used by Dual Eligible Beneficiaries Generally Available Under

Part D - A June 2012 report revealed that with some variation, Part D plan formularies generally included 191 of the 200 drugs most commonly used by beneficiaries who are eligible for both Medicare and Medicaid (dual eligibles). Nine drugs were excluded from coverage by law. Formularies are

lists of drugs covered by the plans. On average, Part D plan formularies included 96 percent of the 191 commonly used drugs. Also, 61 percent of the commonly used drugs are included by all Part D plan formularies. These results are largely unchanged from OIG's findings for formularies reported in a related 2011 annual report.

Also, plan formularies increased the number of unique drugs subject to utilization management tools from 2011 to 2012. Such tools include prior authorization, quantity limits, and step therapy. Step therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective or safest drug therapy and progressing if necessary to more costly or risky drug therapy. Most of the increase was due to an increase in the use of quantity limits by plan formularies. This annual review is required pursuant to the Affordable Care Act. This is the second report the OIG has produced to meet this mandate.

The report does not contain recommendations. *Medicare Part D Plans Generally Include Drugs Commonly Used by Dual Eligibles: 2012.* OEI-05-12-00060. June 2012. [Full Text](#).

Patient Safety and Quality of Care

As purchasers of health care, Medicare and Medicaid face challenges in ensuring quality of care for their beneficiaries. Despite increased attention to patient safety, problems persist.

Nursing Homes—Inadequate Resident Assessments and Care Plans

Elderly Residents Receiving Atypical Antipsychotic Drugs At Risk – A July 2012 report revealed that nearly all (99 percent) of nursing facility records for elderly residents receiving atypical antipsychotic drugs failed to meet one or more Federal requirements for resident assessments and/or care plans. Nursing facility staff are required to assess each resident's functional capacity upon admission to the facility and periodically thereafter. Staff must specify in a written care plan made on the basis of the assessments the services that each resident needs.

We found that provider records did not contain evidence of compliance with Federal requirements for care plan development. One-third did not contain evidence of compliance regarding resident assessments. Eighteen percent of records did not contain evidence to indicate that planned interventions for antipsychotic drug use occurred.

Recommendations—CMS should improve the detection of noncompliance with Federal requirements for resident assessments and care plans for residents receiving antipsychotic drugs, take appropriate action to address noncompliance, and provide methods for nursing facilities to enhance the

development and usefulness of resident assessments and care plans. *Nursing Facility Assessments and Care Plans for Residents Receiving Atypical Antipsychotic Drugs*. OEI-07-08-00151. July 2012. [Full Text](#).

Nursing Homes—Disaster Preparedness and Response

More Detailed Guidance Needed for Nursing Homes, Surveyors, and Ombudsmen – We found that from 2007 to 2010, although most nursing homes nationwide met Federal requirements for written emergency plans and preparedness training, emergency plans lacked about half of the tasks on CMS’s recommended checklist. Nursing homes faced challenges with unreliable transportation contracts, lack of collaboration with local emergency management, and residents who developed health problems. Long-term-care ombudsmen were often unable to support nursing home residents during disasters; most had no contact with residents until after the disasters. States reported making some efforts to assist nursing homes during disasters, related mostly to nursing home compliance issues and ad hoc needs. We identified similar issues in a 2006 review.

Recommendations—CMS should revise Federal regulations to include specific requirements for emergency plans and training, update the State Operations Manual to provide detailed guidance for surveyors assessing compliance with Federal regulations for nursing home emergency planning and training, and promote use of the checklists it issued. AoA should develop model policies and procedures for long-term-care ombudsmen to protect residents during and after disasters. *Gaps Continue To Exist in Nursing Home Preparedness and Response During Disasters: 2007 - 2010*. OEI-06-09-00270. April 2012. [Full Text](#). (See also [OEI-06-09-00271](#). April 2012.)

Other CMS-Related Reviews

CMS has many peripheral oversight functions, such as those related to the integration of electronic health record systems, management of appropriated funds, cost-based contracts, and general contract administration.

Electronic Health Records—Coding of Evaluation and Management Services

Physicians’ Use of Electronic Health Records in Coding Evaluation and Management Services – This review of physicians’ use of electronic health record (EHR) systems, which responded to a request from the Office of the National Coordinator for Health Information Technology, revealed that although many electronic health record systems can assist physicians in assigning codes for E/M services, most Medicare physicians manually assigned E/M codes. Twenty-two percent first began using EHR systems to

document E/M services in 2011 (the year that CMS commenced its EHR incentive program). Three of every four physicians with EHR systems used a certified EHR system to document E/M services. Fifty-seven percent of Medicare physicians used an EHR system at their primary practice locations in 2011.

This report does not contain recommendations. *Use of Electronic Health Record Systems in 2011 Among Medicare Physicians Providing Evaluation and Management Services*. OEI-04-10-00184. June 2012. [Full Text](#).

Contract Administration—Retirement Plan, Termination Costs

Certain Contractor Retirement Plan Costs, Termination Claim Unallowable – Blue Cross Blue Shield of Tennessee (BCBS Tennessee), a Medicare contractor, claimed approximately \$1 million of unallowable supplemental executive retirement plan (SERP) costs for Medicare reimbursement for FYs 2005 through 2009. In addition, BCBS Tennessee's entire SERP termination claim of \$365,000 was unallowable for Medicare reimbursement. BCBS Tennessee administered Medicare Part A operations under cost reimbursement contracts with CMS until the contractual relationship was terminated effective August 1, 2009.

Recommendations—BCBS Tennessee should revise its final administrative cost proposals for FYs 2005 through 2009 to reduce its claimed SERP costs by \$1 million and withdraw its termination claim of \$365,000 for SERP costs associated with the Medicare Part A contracts. *Blue Cross Blue Shield of Tennessee Overclaimed Supplemental Executive Retirement Plan Costs for Fiscal Years 2005 Through 2009*. A-07-12-00391. September 2012. [Full Text](#).

End Stage Renal Disease Program Networks

Contractor Claimed Unallowable and Unsupported Costs – Southern California Renal Disease Council, Inc., a nonprofit Medicare contractor, claimed unallowable and unsupported costs because it did not have adequate controls to account for costs claimed under Federal contracts. CMS contracts with end stage renal disease (ESRD) network organizations to administer the ESRD program for each State, territory, and the District of Columbia. The networks are responsible for conducting activities in the areas of quality improvement, community information and resources, administration, and information management. The networks work with consumers, ESRD facilities, and other providers of ESRD services to refine care delivery systems to ensure that ESRD patients get the right care at the right time.

Recommendations—The Council should strengthen its controls to account for costs claimed under Federal contracts, refund to the Federal Government the unallowable costs we identified, work with CMS to determine the allowability of costs that we set aside, and refund any amount that is determined to be unallowable. *Southern California Renal Disease Council, Inc., Claimed Unallowable and Unsupported Costs Under Medicare Contract*

Number HHSM-500-2006-018C. A-09-11-02044. May 2012. [Full Text](#). (See also [A-09-10-02045](#), March 2012, and [A-09-11-02005](#), April 2012.)

Medicaid Program Reviews

Selected Acronyms and Abbreviations Used in This Major Section

CMS—Centers for Medicare & Medicaid Services	Form CMS-64—Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program
FFP—Federal financial participation	HCBS—Home and community-based services
FMAP—Federal medical assistance percentages	

Medicaid Wasteful Spending

Wasteful spending occurs when Medicaid’s laws, policies, and methodologies fail to ensure that program costs are reasonable and appropriate in the health care marketplace and fail to reflect Medicaid’s role as a high-volume, prudent insurer/payer.

Developmental Centers—Excessive Daily Rates

Reimbursement Rates for Certain State-Operated Developmental Centers Not Aligned With Rates for Other Intermediate Care Facilities - The Medicaid daily rate in New York for 15 selected State-operated Intermediate Care Facilities (ICF) for individuals with intellectual and developmental disabilities (developmental centers) may not have met the Federal requirement that payments be consistent with economy and efficiency. For State fiscal year (SFY) 2009, New York claimed Federal reimbursement for care of beneficiaries at the developmental centers of nearly \$2.27 billion (\$1.13 billion Federal share). In contrast, the State’s actual costs for the developmental centers totaled about \$578 million. The developmental centers’ daily rate was more than nine times the average rate for all other State-operated and privately operated ICFs in SFY 2009.

The daily rate for Medicaid beneficiaries to reside in the selected developmental centers grew from \$195 per day in SFY 1985 to \$4,116 per day in State FY 2009, which is the equivalent of \$1.5 million per year for one Medicaid beneficiary. The growth occurred because the State’s rate-setting methodology significantly inflated the Medicaid daily rate for the developmental centers and CMS did not prevent the rate from increasing to its current levels. If the State had used prior year actual costs as the starting point in its rate methodology instead of its current method in calculating the daily rate, the Federal Government might have saved over \$700 million in reimbursements in SFY 2009.

Recommendations—CMS should work with the New York to ensure that the State’s Medicaid daily rate for State-operated developmental centers meets the Federal requirement that payment for services be consistent with efficiency and economy. On the basis of this report and previous audits of

payments to public providers in other States, OIG recommended in testimony before a congressional committee that payments to public providers be limited to the actual cost of providing services. *Medicaid Rates for New York State-Operated Developmental Centers May Be Excessive*. A-02-11-01029. May 2012. [Full Text](#). [Testimony](#).

Rebates—Medicaid Managed Care

Some States May Fail To Collect All the Manufacturer Rebates They Are Due.

Of the 22 States that paid for prescription drugs through managed care organizations (MCO) for the second quarter of 2010 through the second quarter of 2011, 10 did not invoice manufacturers and collect the rebates they were due. Failure to collect rebates results in net program costs being higher than they should be. The actions were not taken because, for example, States had to complete programming changes to the systems that process MCO claims. The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) expanded the Medicaid rebate requirement to include drugs paid for through MCOs. To realize the full savings under the expansion, States must collect accurate drug utilization data from MCOs and invoice and collect rebate payments from manufacturers.

Eighteen of the 22 States collected all the data needed to invoice drug manufacturers for rebates; 3 collected data from a portion of their MCOs; and 1 did not collect any drug utilization data. Twelve of the 22 States invoiced manufacturers and collected rebates. All but one of the States performed some type of data verification check of the utilization data they obtained.

Recommendation—CMS should follow up with the 10 States that had not collected rebates for drugs dispensed to Medicaid MCO beneficiaries and take action to enforce rebate collection if necessary. *States' Collection of Medicaid Rebates for Drugs Paid Through Medicaid Managed Care Organizations*. OEI-03-11-00480. September 2012. [Full Text](#).

Improper State Claims for Federal Reimbursement

The Federal and State Governments jointly fund and administer the Medicaid program. Federal medical assistance percentages (FMAP) are used to determine the amount of Federal financial participation (FFP)—also called matching funds or Federal share—for State expenditures in Medicaid and certain other social services. States do not always effectively identify and reduce erroneous and inappropriate billing by providers and suppliers that the States claim to CMS for Federal reimbursement. Items or services reflected on provider billings sometimes are not supported by documentation in the providers' medical files as required, are not medically necessary, or do not meet other Federal and State requirements.

HCBS Waivers—Room-and-Board Costs

Unallowable Room-and-Board Costs Claimed by South Carolina –

South Carolina improperly claimed about \$4.8 million Federal share of unallowable room-and-board costs under a home and community-based services (HCBS) intellectual and related disabilities waiver program. The State's controls were inadequate to ensure that applicable Federal law and State guidance were followed. The State did not detect errors or misstatements on local participating entities' cost reports. Also, the State did not prescribe a uniform format for the local entities to follow when preparing cost reports. Rather, each local entity prepared its cost reports in its own format, making it difficult to identify when unallowable costs were claimed.

Recommendations—South Carolina should refund to the Federal Government the improperly claimed \$4,832,975 Federal share. The State should remove room-and-board related administrative and general costs from future waiver program cost reports, develop a uniform cost reporting process and require that participating entities follow the process, and strengthen cost report review procedures. *South Carolina Claimed Some Unallowable Room and Board Costs Under the Intellectual and Related Disabilities Waiver*. A-04-11-04012. September 2012. [Full Text](#).

HCBS Waivers—Noncompliant Providers

Individual Plans of Care, Documentation, Policies and Procedures Insufficient –

Three reports revealed that claims for Federal reimbursement for Medicaid HCBS in New Jersey and New York were unallowable for not meeting certain Federal and State requirements. Policies and procedures for overseeing and administering the waiver programs were not adequate to ensure that providers claimed reimbursement only for services actually provided and maintained all the required documentation to support the services billed and to ensure that waiver program services were provided to beneficiaries only when rendered pursuant to written plans of care. For example, at one provider, beneficiaries' plans of care were not reviewed by a physician every 60 days as required.

Report 1 Recommendations—New Jersey should refund to the Federal Government the estimated \$60,740,637 in improperly claimed Federal reimbursements; ensure that providers bill only for documented, allowable CCW program services that are provided only to beneficiaries for whom there are completed and approved individual habilitation plans; and ensure and document that all beneficiaries approved for services have been assessed and certified to need the designated level of care. *Medicaid Payments for Services Under New Jersey's Section 1915c Community Care Waiver*. A-02-10-01029. April 2012. [Full Text](#).

Report 2 Recommendations—New York should refund to the Federal Government an estimated \$7,772,807 in improper Federal share and strengthen policies and procedures to ensure that providers bill only for services actually provided, maintain the required documentation,

and provide services pursuant to written plans of care. *New York Claimed Unallowable Costs for Services by NYC Providers Under the State's Developmental Disabilities Waiver Program*. A-02-10-01027. August 2012. [Full Text](#).

Report 3 Recommendations—New York should refund the improperly paid \$8,177,970 Federal share and improve its monitoring of the reviewed provider and its other contracted home health providers to ensure compliance with Federal and State requirements. *Review of Selected Medicaid Home Health Services Claims Made by Jewish Home and Hospital Lifecare Community Services – Manhattan LTHHCP*. A-02-10-01002. April 2012. [Full Text](#).

Personal Care Services—Noncompliant Providers

Inadequate Certifications, Inadequate Documentation, Other Errors Found in Provider Claims to States – New Mexico, New Jersey, and Missouri improperly claimed Federal reimbursement for personal care services claims submitted by providers that did not comply with certain Federal and State requirements; the claims were therefore ineligible for Federal reimbursement. The deficiencies included inadequate personal care attendant qualifications and certifications and various documentation deficiencies, including no documentation of supervisory visits, unsupported units of service claimed, no documentation of physician authorization, and lack of State approval for personal care services provided by certain caregivers. Personal care services may be provided to individuals who are not inpatients at a hospital or residents of a nursing facility, an Intermediate Care Facility for Individuals with Intellectual Disabilities, or an Institution for Mental Diseases. Examples of personal care services include, but are not limited to, meal preparation, shopping, grooming, and bathing.

Report 1 Recommendations—New Mexico should refund to the Federal Government the estimated \$404,817 Federal share paid for unallowable personal care services and ensure that personal care services providers maintain evidence that they complied with Federal and State requirements. *Review of New Mexico Medicaid Personal Care Services Provided by Clovis Homecare, Inc.* A-06-09-00117. June 2012. [Full Text](#).

Report 2 Recommendations—New Mexico should refund to the Federal Government the Federal share, estimated at \$4,483,492, of the State's payments for unallowable personal care services and ensure that personal care services providers maintain evidence that they comply with Federal and State requirements. *Review of New Mexico Medicaid Personal Care Services Provided by Heritage Home Healthcare*. A-06-09-00063. May 2012. [Full Text](#).

Report 3 Recommendations—New Jersey should refund an estimated \$774,274 to the Federal Government and direct the provider to ensure that all of its offices comply with Federal and State requirements. *New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services*

Made by Bayada Nurses, Inc., in Accordance With Federal and State Requirements. A-02-10-01001. September 2012. [Full Text](#).

Report 4 Recommendations—Missouri should refund an estimated \$26,953,855 to the Federal Government, implement procedures to ensure that it adequately supports the costs claimed for personal care services and maintains the supporting documentation, and improves its policies and procedures for monitoring the personal care services program for compliance with Federal and State requirements. *Missouri Claimed Federal Reimbursement for Unallowable Personal Care Services Claims.* A-07-11-03171. September 2012. [Full Text](#).

Adult Mental Health Rehabilitation—Multiple Deficiencies

Guidance, Monitoring Needed To Curb Deficiencies – New Jersey improperly claimed Federal reimbursement for adult mental health rehabilitation claims that were unallowable because community residence rehabilitation (CRR) providers failed to comply with Federal and State requirements. We found the following seven types of deficiencies: provider staff did not meet education and training requirements; service plan requirements were not met; the providers' staffing levels were not consistent with the required level of care or the provider claimed a higher level of care than was recommended; weekly progress notes were not documented; a registered nurse did not conduct a face-to-face visit within the required time period; services were not documented, supported, or allowable; and nursing assessment requirements were not met.

Recommendations—New Jersey should refund to the Federal Government an estimated \$30,589,719 in improper Federal reimbursements, give CRR providers guidance to help ensure that they comply with Medicaid State plan requirements, and improve monitoring of providers' claims to ensure compliance with Federal and State requirements. *Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey.* A-02-09-01028. May 2012. [Full Text](#).

Family Planning—Pharmacy and Sterilization Claims

Inadequate Documentation and Controls Render Claims Unallowable – Reviews of North Carolina and Wyoming Medicaid revealed that the States did not always claim Medicaid family planning reimbursement for pharmacy and sterilization costs in accordance with Federal and State requirements. States furnish family planning services and supplies to individuals of childbearing age who are eligible under the State Medicaid plan and who desire such services and supplies. The Federal Government is authorized to reimburse States for expenditures in family planning services at an FMAP of 90 percent (enhanced rate). Claims lacked supporting documentation, and the States' controls did not ensure that costs were claimed pursuant to Federal and State requirements.

Report 1 Recommendations—North Carolina should refund to the Federal Government the pharmacy claim amounts (estimated at \$1,383,713) and

sterilization claim amounts (estimated at \$3,665) that were improperly reimbursed at the enhanced rate for family planning and improve its controls to ensure that it claims the enhanced rate only for contraceptive drugs that physicians prescribe for family planning purposes and to ensure that sterilization consent forms are completed in accordance with Federal regulations. *North Carolina Incorrectly Claimed Enhanced Federal Reimbursement For Some Medicaid Services That Were Not Family Planning*. A-04-10-01089. June 2012. [Full Text](#).

Report 2 Recommendations—Wyoming should refund \$1,348,942 in improper Federal reimbursements, review costs for inpatient sterilization procedures for quarterly reporting periods after our audit period and refund any overpayments, and strengthen internal controls to ensure that costs for Medicaid family planning sterilization procedures are claimed in accordance with Federal and State requirements. *Wyoming Incorrectly Claimed Enhanced Reimbursement for Medicaid Family Planning Sterilization Costs*. A-07-11-01100. August 2012. [Full Text](#).

Part B Premiums—Claims for State-Paid Premiums

Documentation and Eligibility Issues Associated With State's Improper Part B Premium Payments – Nevada did not always comply with Federal requirements when claiming Federal reimbursement for Medicare Part B program premiums that it paid on behalf of Medicaid beneficiaries. Federal law allows State Medicaid programs to enter into an arrangement with CMS known as the buy-in program. The buy-in program allows a participating State Medicaid program to enroll certain dual eligibles (individuals who are entitled to both Medicare and some form of Medicaid benefits) in Part B and to pay the monthly premiums on their behalf. The State may then claim the monthly premium expenditures for Federal reimbursement. We identified numerous improper State claims for Federal reimbursement and set aside additional amounts for resolution involving public welfare additions (i.e., individuals added to a State's buy-in list on the basis of a Social Security Administration notice to CMS that the individuals appear to be eligible for Medicaid).

Recommendations—Nevada should refund to the Federal Government \$194,891 Federal share of unallowable Part B premiums claimed, identify any portion of the \$878,263 in Part B premiums claimed for public welfare additions that was unallowable and refund the Federal share, identify the Part B premiums for which the State did not have adequate supporting documentation and refund the Federal share, delete ineligible individuals from the buy in program and refund the Federal share of the Part B premiums claimed, identify ineligible individuals added through the public welfare addition procedure and take appropriate corrective action, establish procedures to reduce the number of erroneous public welfare additions, and ensure that it can support the Federal share claimed for each Part B premium. *Nevada Improperly Claimed Federal Reimbursement for Medicare Part B Premiums Paid On Behalf of Medicaid Beneficiaries*. A-09-11-02024. July 2012. [Full Text](#).

Medicare Deductibles and Coinsurance—State Plan Rates

Lack of Policies and Procedures Fostered Noncompliance – Montana did not always claim Medicaid payments for Medicare Part B deductibles and coinsurance for services whose payments are limited to State Medicaid plan rates in accordance with Federal requirements and the approved State plan. Specifically, for 79 of the 100 claims in our sample, Montana did not limit payment of Medicare Part B deductibles and coinsurance to State Medicaid plan rates as required under the State plan. Montana did not compare the Medicare payment to the State Medicaid plan rate because it did not have policies and procedures requiring it to do so.

Recommendations—Montana should refund to the Federal Government an estimated \$1,113,789 in unallowable Medicaid payments and develop and implement policies and procedures to ensure that it compares the Medicare payment to the State Medicaid plan rate to determine the allowable Medicare Part B deductibles and coinsurance. *Montana Did Not Properly Pay Medicare Part B Deductibles and Coinsurance for Outpatient Services.* A-07-11-03172. June 2012. [Full Text](#).

Administrative Costs—Unallowable Provider Training Costs

Training Activities Did Not Qualify as Administrative Costs – Pennsylvania did not comply with Federal requirements when it claimed Medicaid administrative costs for the Pennsylvania Restraint Reduction Initiative (Initiative). The claimed costs were for training nursing home providers and not for administering the Medicaid program. CMS explicitly prohibits claiming provider training as Medicaid administrative costs. Accordingly, Pennsylvania's claims for Federal reimbursement of Initiative costs for State fiscal years 1996-1997 through 2010-2011 as administrative costs were unallowable. In 1996, Pennsylvania launched the Initiative to train nursing home providers to reduce the use of physical restraints in compliance with Federal regulations. The Initiative subsequently introduced provider training to address other quality-of-life issues in nursing homes.

Recommendations—Pennsylvania should refund \$3,001,536 in Federal funds for unallowable administrative costs, refund the Federal share of unallowable Initiative costs claimed as administrative costs after our audit period, and discontinue all future claims of such costs. *Pennsylvania Claimed Medicaid Administrative Costs for Provider Training Under Its Restraint Reduction Initiative.* A-03-11-00209. July 2012. [Full Text](#).

Quarterly Statements and Adjustments

States report Medicaid expenditures to CMS on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). The report must be submitted to CMS within 30 days after the end of each quarter. This form shows Medicaid expenditures for the

quarter being reported and any prior-period adjustments. It also accounts for any overpayments, underpayments, and refunds received by the State.

Adjustments Made at Improper Rate

Incorrect Rate Applied to Adjustments – Maine did not always use the correct FMAP when processing claim adjustments reported on the Form CMS-64. The Federal Government reimbursed Maine \$166 million Federal share for 1 million Medicaid claims that the State originally paid and subsequently adjusted through the Form CMS-64 for calendar years 2005 through 2009. Of that amount, \$9,179,777 was incorrect. Errors occurred when the State subsequently processed entirely new claims, including the adjustment amounts, as current expenditures at the current FMAP.

Recommendations—Maine should refund to the Federal Government \$9,179,777 it improperly claimed for Medicaid claim adjustments and ensure that it processes future adjustments using the correct FMAP.

Maine Did Not Always Make Correct Medicaid Claim Adjustments.

A-01-12-00001. July 2012. [Full Text](#).

Calculation, Documentation Errors

Calculations Improper and Documentation Not Properly Retained –

The U.S. Virgin Islands claimed Federal Medicaid reimbursement for expenditures that were improperly calculated because employees lacked policies and procedures for correctly preparing the Form CMS-64. The amounts claimed were not adequately documented by reported expenditures. Supporting documentation could not be located because a record retention policy had not been established.

Recommendations—The Virgin Islands should refund to the Federal Government \$393,316 in improperly calculated expenditures and establish policies and procedures for correctly preparing Form CMS-64. *Review of Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program in the U.S. Virgin Islands for the Quarter Ended September 30, 2009.*

A-02-11-01004. April 2012. [Full Text](#).

Adjustments for Excess Contractor Profits

Federal Share Understated and Required Project Approvals Not Obtained –

A review of quarterly statements of expenses that Texas submitted to CMS revealed that Texas did not correctly report a Medicaid Management Information System (MMIS) contractor's profits that were in excess of the 11 percent allowed by the contract. The State's calculation erroneously understated the Federal share of the excess profits.

Apart from this issue, we found that although the sampled MMIS expenditures Texas claimed for Federal reimbursements were allowable and claimed at the appropriate reimbursement rates, for two projects in the sample, Texas did not obtain required prior approvals from CMS. Such projects include designing, developing, and operating the MMIS. Federal

regulations require States to seek prior approval from CMS to claim Federal reimbursement for MMIS project costs estimated to exceed certain thresholds. We also identified 16 other projects, which were not in the sample, that did not have the required approvals.

Recommendations—Texas should refund \$2,634,568 related to the Federal share of excess contractor profits, obtain retroactive approval for the projects that did not have the required prior Federal approval from CMS, and ensure that prior approval is obtained on future projects as required by Federal regulations. *Texas Did Not Report Excess Contractor Profits in Accordance With Federal Regulations*. A-06-10-00062. August 2012. [Full Text](#).

Adjustments for State Collections of Overpayments

Collections Understated and Federal Share Miscalculated – Delaware did not comply with Federal requirements to report all Medicaid overpayment collections. State officials said that they believed the overpayments had been netted out of reported Medicaid expenditures but did not provide support for such adjustments. The State did not properly report its collections for Medicaid overpayments because it did not develop and implement effective internal controls to ensure accurate reporting on Form CMS-64. Also, Delaware reported on Form CMS-64 collections for overpayments that it identified as recoveries resulting from fraud and abuse investigations but calculated a Federal share based on an incorrect FMAP. Using the correct FMAP, the State should have reported a higher Federal share.

Recommendations—Delaware should include \$16,272,518 of unreported Medicaid overpayment collections on the next Form CMS-64 and refund \$10,080,378 to the Federal Government, identify and report any unreported Medicaid overpayments collected before and after our audit period, account for the incorrectly calculated Federal share for the collections resulting from fraud and abuse investigations by refunding \$2,391, apply the correct FMAP when reporting Medicaid overpayments on Form CMS-64, and develop and implement internal controls that will enable the State to correctly report and refund the Federal share of Medicaid overpayments on Form CMS-64. *Delaware Did Not Comply With Federal Requirements To Report All Medicaid Overpayment Collections*. A-03-11-00203. June 2012. [Full Text](#).

Overpayments Not Fully Reported

Some Overpayments Not Correctly Reported – For Federal fiscal years 2008 and 2009, New Jersey did not report Medicaid overpayments totaling \$2.8 million (\$1.4 million Federal share) in accordance with Federal requirements. Federal law requires the State to refund the Federal share of Medicaid overpayments at the end of the 60-day period following the date of discovery, whether or not the State has recovered the overpayment. Of the 180 overpayments we reviewed, 14 were only partially reported or not reported on Form CMS-64. The remaining 166 were reported correctly. The State also did not report all Medicaid provider overpayments within the

60-day time requirement. The State did not properly report these overpayments because it had not developed and implemented policies to ensure that overpayments were reported correctly on Form CMS-64.

Recommendations—New Jersey should include unreported Medicaid overpayments of \$2,812,968 on the CMS-64 and refund \$1,406,486 to the Federal Government and develop and implement policies to ensure that future Medicaid overpayments are reported on the correct Form CMS-64 in accordance with Federal requirements. *New Jersey Generally Reported Medicaid Overpayments in Accordance With Federal Regulations.* A-02-10-01009. September 2012. [Full Text](#).

Federal Share of Collections Improperly Retained

Federal Share of Medicaid Collections To Be Recalculated in 35 States. We identified 35 States that improperly retained the Federal share of collections (e.g., from overpayments to providers), which reduce States' expenditures in FFP calculations. Effective with the quarter ending December 31, 2008, the American Recovery and Reinvestment Act of 2009 (Recovery Act) temporarily increased the percentage of State Medicaid expenditures paid by the Federal Government (i.e., the FMAP). When CMS calculated the additional funding for the first Recovery Act quarter, it did not include States' collections in that calculation. As a result, States improperly retained increased funding. CMS retroactively provided additional Federal funds for the first Recovery Act quarter by applying the increased percentage to expenditures each State had already submitted. A CMS official stated that recalculating the Federal share of collections using the Recovery Act FMAP was the States' responsibility.

Recommendations— CMS should recoup from 35 States \$25,012,996 in retained funding; review States' Federal share calculations for collections reported in subsequent Recovery Act quarters and recoup any overpayments related to the Recovery Act FMAPs; and emphasize that States should calculate the Federal share of collections for which they originally received amounts calculated at higher, fixed-reimbursement percentages using those same percentages. *States Inappropriately Retained Federal Funds Related to Medicaid Collections for the First Recovery Act Quarter.* A-06-11-00064. June 2012. [Full Text](#).

Managed Care—Federal Share of Excess Capitation Payments

Poor Controls, Commingling of Funds Impact Federal Share Adjustments – Pennsylvania did not develop and implement effective internal controls to identify and return to the Federal Government the Federal share of excess managed care capitation payments recouped from counties' Risk and Contingency and Reinvestment funds. Pennsylvania recouped excess capitation payments from 12 of 24 counties we reviewed but did not refund the full Federal share in accordance with Federal requirements. Also, the State was unable to identify the amount of State-only funds recouped from Philadelphia County because Philadelphia County's reinvestment account

commingled excess capitation payments for both Federal Medicaid and State General Assistance enrollees.

Recommendations—Pennsylvania should refund \$7,950,454 Federal share of excess capitation payments returned by Philadelphia County and develop procedures to ensure that it refunds the Federal share of excess capitation payments recouped from the Risk and Contingency and Reinvestment funds. *Pennsylvania Did Not Refund the Full Federal Share of Recouped Excess Capitation Payments From the Medicaid Behavioral HealthChoices Program.* A-03-10-00204. June 2012. [Full Text](#).

Prevent and Detect Medicaid Fraud and Abuse

Medicaid faces multiple challenges in preventing and detecting fraud, including identifying questionable patterns of billing, overpayments, and high rates of improper payments. Federal and State Medicaid agencies monitor fraud through data analysis, audits, and investigations.

Program Integrity—Audit Medicaid Integrity Contractors

Status of Previously Identified Audit Targets – In an April 2012 report, we supplemented information in a February 2012 report in which we identified concerns with the quality of claims analyses by “Review Medicaid Integrity Contractors” (Review MIC). ([OEI-05-10-00200](#).) Two types of CMS contractors—Review MICs and Audit MICs—are tasked with identifying Medicaid overpayments. Review MICs analyze State Medicaid claims data, identify potential overpayments, and refer their analyses to CMS. After CMS evaluates them, CMS selects certain providers as audit targets and assigns them to Audit MICs who conduct provider audits and identify actual overpayments.

Our April 2012 addendum report provides information and insights on 161 of 244 audit targets that CMS had assigned to Audit MICs. We found that as of February 1, 2012, Audit MICs had completed 127 of the 161 assigned audits of providers. An average of 10 months elapsed between the dates CMS assigned the audits to Audit MICs and the dates the Audit MICs reported their findings to CMS. Twenty-five of the completed audits identified overpayments. The remaining 102 completed audits found no overpayments. Thirty-four of the assigned audits had not been completed and were ongoing.

The report does not contain recommendations. *Status of 244 Provider Audits Identified Using Review Medicaid Integrity Contractor Analysis.* OEI-05-10-00201. April 2012. [Full Text](#).

Program Integrity—Excluded Individuals in Managed Care

Few Excluded Individuals Found in Medicaid Managed Care – Of 248,869 individuals listed on employee rosters we requested from sampled providers, we identified 16 individuals who were excluded from participation in Federal health care programs. Exclusions are typically imposed on the basis of convictions for program-related fraud, patient abuse, or license revocations. The 16 individuals were found among the employees of 14 sampled providers. Incorrect names and failure of contractors to follow procedures contributed to the employment of the excluded individuals.

Most providers reported using a variety of safeguards to ensure that they do not employ excluded individuals, but identified costs and resource burdens as challenges in executing those safeguards. Seven percent of providers in the 12 selected Medicaid managed care entities (MCE) do not check the exclusions status of their employees; most of these providers lacked knowledge regarding exclusions.

The report does not contain recommendations. *Excluded Individuals Employed by Providers Enrolled in Medicaid Managed Care Entities*. OEI-07-09-00632. September 2012. [Full Text](#).

Program Integrity—State Medicaid Fraud Control Units

OIG oversees the operation and performance of all Medicaid Fraud Control Units (MFCU or Unit). As part of this oversight, OIG conducts periodic onsite reviews of all Units. The reviews assess the Units' performance in accordance with the 12 MFCU performance standards, monitor Unit compliance with Federal grant requirements, and highlight noteworthy practices. For the three State reviews completed in this semiannual period, OIG found no evidence of significant noncompliance with applicable laws, regulations, or policy transmittals.

New York MFCU – From fiscal years 2008 to 2010, the New York MFCU filed criminal charges against more than 400 defendants, obtained more than 400 convictions, and was awarded more than \$750 million in recoveries. Our review found a number of noteworthy practices, including the Unit's approach to patient abuse and neglect cases, its list of ongoing investigations (created to avoid conflicts among investigating agencies), and its use of technology. Our report includes findings and recommendations with respect to staff size, training, file maintenance, and policies and procedures. *Medicaid New York State Medicaid Fraud Control Unit: 2011 Onsite Review*. OEI-02-11-00440. June 2012. [Full Text](#).

Missouri MFCU – For FYs 2008 through 2010, the Missouri Unit reported recoveries of \$135 million, 13 convictions, and 36 civil settlements. The Unit exercised proper fiscal controls over its resources. The Unit expanded its definition of referrals and changed its process for closing older cases during FYs 2008 through 2010. The report includes findings and recommendations with respect to training, documentation, and records oversight. *Medicaid*

Missouri State Medicaid Fraud Control Unit: 2011 Onsite Review. OEI-07-11-00750. July 2012. [Full Text](#).

Kansas MFCU – For FYs 2009 through 2011, the Unit reported combined civil and criminal recoveries of nearly \$66 million and 44 convictions. The Unit increased referrals through education and outreach efforts. Our report includes findings and recommendations with respect to internal controls, reporting, training, documentation, and reviews. *Kansas State Medicaid Fraud Control Unit: 2012 Onsite Review.* OEI-07-12-00200. September 2012. [Full Text](#).

Medicaid Beneficiary Safety and Quality of Care

Quality of Care for Waiver Program Beneficiaries

Additional Federal Guidance, Onsite Reviews, Other Oversight Measures Needed – Of 25 States we reviewed, 7 States did not have adequate systems to ensure the quality of care provided to beneficiaries of the States' HCBS waiver programs. Although CMS renewed the waiver programs in all seven of these States, three did not adequately correct identified problems. Not only did the States fail to correct the problems before renewal of their programs, but also they had not adequately addressed the problems long after renewal.

Also, CMS did not consistently use the few tools it has to ensure that States correct problems related to quality of care. States must operate their HCBS waiver programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, States must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries.

Recommendations—CMS should provide additional guidance to States for meeting the required assurances, require States that do not meet one or more assurances to develop corrective action plans, require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits, develop a broader array of approaches to ensure compliance with each of the assurances, and make information about State compliance with the assurances available to the public. *Oversight of Quality of Care in Medicaid Home- and Community-Based Services Waiver Programs.* OEI-02-08-00170. June 2012. [Full Text](#).

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) allows States to provide health care coverage to uninsured children in families whose incomes are too high to qualify for Medicaid but too low to afford private health care coverage. Federal medical assistance percentages (FMAP) are used to determine the amount of Federal financial participation (FFP) (i.e., matching funds or Federal share) for State expenditures in Medicaid and certain other social services, such as CHIP.

CHIP—Concurrent Enrollments

Alabama Improperly Claimed FFP for Concurrently Enrolled Individuals – Alabama improperly claimed CHIP FFP for individuals who had Medicaid or other health insurance coverage from October 1, 2009, through September 30, 2010. States may not claim CHIP FFP for individuals who are concurrently enrolled in CHIP and Medicaid or who have other health insurance coverage. Alabama's internal controls were not adequate to prevent or promptly correct concurrent enrollments. The errors occurred because State policy allowed for a coordination of benefits between CHIP and other health insurance coverage.

Recommendations—We recommend that Alabama refund \$1.5 million for FFP claimed on behalf of individuals who were concurrently enrolled in CHIP and Medicaid, refund \$153,000 (Federal share) for FFP claimed on behalf of individuals enrolled in CHIP who had other health insurance coverage, develop additional policies and procedures to prevent or promptly recoup CHIP payments made on behalf of individuals who are identified as enrolled concurrently in Medicaid, and revise the current policy that allows for a coordination of benefits between CHIP and other health insurance coverage. *Alabama Improperly Claimed Federal Funds for Children's Health Insurance Program Enrollees Who Had Medicaid or Other Health Insurance Coverage.* A-04-11-08008. September 2012. [Full Text](#).

CHIP—Inadequate Cost Tracking, Reconciliation Errors

Improvements Address Past Deficiencies – Not all of the State Children's Health Insurance Program (SCHIP) expenditures that Colorado claimed for Federal reimbursement during FYs 1998 through 2006 were allowable pursuant to Federal requirements. However, for FY 2007, Colorado correctly claimed SCHIP expenditures. The overpayments in prior years occurred because the State did not adequately track unclaimed costs, fully correct a premium collection error, or adequately reconcile quarterly Federal reimbursements to its submitted quarterly reports. The State implemented internal control improvements that would, going forward, correct the deficiencies. SCHIP was renamed the "Children's Health Insurance Program" in 2009, after our audit period.

Recommendation—Colorado should refund the incorrectly claimed \$2,837,860 Federal share of SCHIP expenditures. *Not All of Colorado's Claimed State Children's Health Insurance Program Expenditures Were Allowable*. A-07-12-02780. July 2012. [Full Text](#).

<https://oig.hhs.gov>

Legal and Investigative Activities Related to Medicare and Medicaid

Selected acronyms and abbreviations used in this major section:

CIA	corporate integrity agreement	EMTALA	Emergency Medical Treatment and Labor Act of 1986
CMP	civil monetary penalty	FCA	False Claims Act Amendments
CMPL	Civil Monetary Penalties Law	HEAT	Health Care Fraud Prevention and Enforcement Action Team
CMS	Centers for Medicare & Medicaid Services		

Investigative Outcomes

For this semiannual period, we reported 687 criminal and 360 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported \$4.3 billion in investigative receivables due the U.S. Department of Health and Human Services (HHS) and \$1.7 billion in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs.

The Office of Inspector General's (OIG) investigations often involve the combined efforts and resources of our office and other Federal and State law enforcement agencies. One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, in appropriate cases, under the False Claims Act Amendments of 1986 (FCA), as further amended in 2009.

Depending on the types of fraud or other violations involved, OIG investigations may culminate in criminal or civil court judgments and decisions, administrative sanctions and decisions, and/or negotiated settlement agreements. Investigative outcomes take many forms, including incarceration, restitution, fines, penalties, forfeitures, assessments, and exclusion of individuals or entities from participation in all Federal health care programs. Frequently used exclusion and penalty authorities are described in Appendix D of this *Semiannual Report to Congress* and on our Web site at: <https://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

The following charts show the investigative outcomes that OIG reported for all HHS programs over a 5-year period.

Chart 1- Actions: All HHS Programs

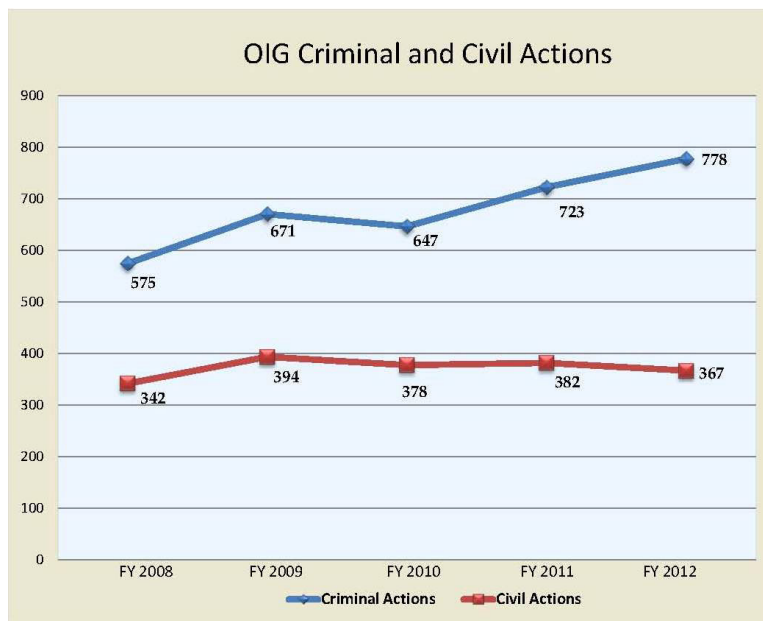
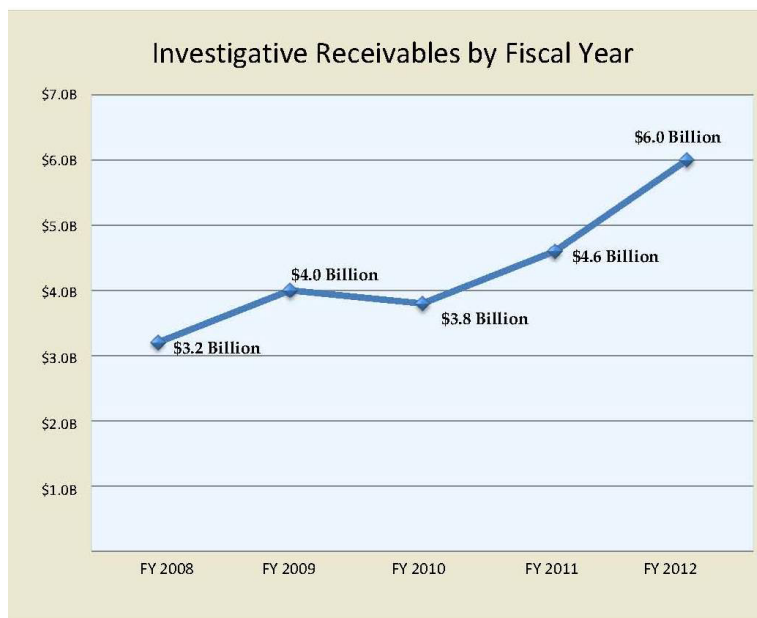


Chart 2 – Receivables: All HHS Programs



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

Advisory Opinions and Other Industry Guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with the Department of Justice (DOJ), are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. From April 1 through September 30, 2012, we received 35 requests for advisory opinions. We issued 11 opinions and 1 modification of an earlier opinion.

Health Care Fraud Prevention and Enforcement Action Team Activities

On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an interagency effort focused specifically on combating health care fraud. HEAT includes senior officials from DOJ and HHS who are strengthening programs, as well as investing in new resources and technologies to prevent and combat fraud, waste, and abuse.

HEAT Provider Compliance Training

OIG provides free training on our Web site for health care providers, compliance professionals, and attorneys. OIG's Provider Compliance Training was an outreach initiative developed as part of HEAT in 2011 that continues to reach the health care community with OIG's message of compliance and prevention via free, downloadable comprehensive training materials and podcasts. The following are links to OIG's provider compliance training resources:

https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp

https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp#modules

<https://oig.hhs.gov/compliance/provider-compliance-training/index.asp#materials>

Medicare Fraud Strike Force Activities

The Medicare Fraud Strike Force (Strike Force) is a key component of HEAT. The Strike Force was established in March 2007 and is operating in nine cities—Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas. Strike Force teams coordinate joint law enforcement operations conducted by Federal, State, and local law enforcement entities. These teams have a proven record of success in analyzing data to quickly identify fraud and bring prosecutions. During this reporting period, Strike Force efforts resulted in the filing of charges against 204 individuals or entities, 85 convictions, and \$100.1 million in investigative receivables.

Health Care Fraud Takedown With Highest False Medicare Billings in Strike Force History

In May 2012, Medicare Fraud Strike Force teams in 7 cities executed a nationwide operation that resulted in charges against 107 individuals, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$452 million in false billing. The coordinated operation involved the highest amount of false Medicare billings in a single takedown in Strike Force history. As part of the operation, HHS also suspended or took other administrative actions against 52 providers following a data-driven analysis and credible allegations of fraud.

Additional Examples of Strike Force Efforts

Texas – Princewill Njoku, Ezinne Ubani, and Clifford Ubani were each sentenced in a Medicare fraud scheme. According to court records, Princewill Njoku, Ezinne Ubani, and Clifford Ubani were joint-owners of Family Healthcare Group, Inc., d/b/a Family Healthcare Services (FHS), a home health care provider. Between April 2006 and August 2009, FHS submitted fraudulent claims to Medicare for services that were medically unnecessary or were not provided. The scheme involved other co-conspirators receiving kickbacks to recruit Medicare beneficiaries to receive skilled nursing services from FHS. Njoku and other co-conspirators created false patient files to make it appear that Medicare patients were qualified for and received the services.

During this reporting period, Njoku was sentenced to 9 years of incarceration and ordered to pay \$5.1 million in restitution, jointly and severally; Clifford Ubani was sentenced to 9 years of incarceration and ordered to pay \$4.2 million in restitution, jointly and severally; and Ezinne Ubani was sentenced to 8 years and 1 month of incarceration and ordered to pay \$2.5 million in restitution, jointly and severally. Clifford and Ezinne Ubani were each excluded from participation in Medicare, Medicaid, and Federal health care programs by OIG for 30 years. To date, nine individuals have been sentenced in connection with this scheme.

Florida – Jose Abel Rodriguez was sentenced to 5 years and 10 months of incarceration and ordered to pay over \$4.3 million in restitution, jointly and severally, after pleading guilty to conspiracy to commit health care fraud. On the basis of the conviction, Rodriguez was also excluded from participation in the Medicare, Medicaid, and other Federal health care programs for 25 years. According to court documents, Rodriguez conspired with Isaac Castro, who owned DME companies Alju Medical Equipment, Inc.; PMCME, Inc.; JVZ Medical Equipment, Inc.; and Premier Quality Equipment Rentals, Inc. Among other things, Rodriguez recruited nominee owners for Castro's companies. Between October 2005 and June 2010, Rodriguez, Castro, and their co-conspirators used the DME companies to submit false and fraudulent claims to Medicare for items and services that were not prescribed by doctors or provided, as claimed. The co-conspirators diverted proceeds from the fraudulent claims for their own personal use and benefit.

Castro was previously sentenced to 1 year and 11 months of incarceration and ordered to pay over \$1.6 million in restitution, as well as being excluded by OIG for a period of 10 years on the basis of the conviction. Additionally, co-conspirators Oscar Hernandez and Ricardo Manchuat Gil were respectively sentenced to 4 years and 9 months and 3 years and 1 month of incarceration for their roles in the scheme. Hernandez was also ordered to pay \$316,749 in restitution, jointly and severally, and Gil was ordered to pay \$644,911 in restitution. Hernandez was excluded by OIG for 15 years.

Michigan – Tariq Mahmud, owner of Comprehensive Rehabilitation Services, Inc. (CRS), was sentenced to 7 years of incarceration and ordered to pay \$1.8 million in restitution, jointly and severally, in a health care fraud scheme. According to court documents, between January 2003 and February 2007, Mahmud purchased falsified physical and occupational therapy files from other therapy and rehabilitation companies and used them to fraudulently bill Medicare. Mahmud also paid kickbacks and gave prescription drugs to Medicare beneficiaries in exchange for their signatures on forms, as well as the use of their Medicare beneficiary numbers. Additionally, Mahmud and his co-conspirators signed false physical therapy notes claiming that therapy services were provided, resulting in the submission of false claims to Medicare for services never rendered. Mahmud was excluded by OIG for 25 years. Several of Mahmud's co-conspirators were previously sentenced for their roles in the scheme.

Other Criminal and Civil Enforcement Activities

Special Assistant U.S. Attorney Program

During this reporting period, DOJ and OIG continued their participation in a program in which OIG attorneys, some of whom are Special Agents, serve as Special Assistant U.S. Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, such as

assignments to the Medicare Fraud Strike Force. Other attorneys prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the Departments in their efforts to fight fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to medical equipment and supplies, infusion therapy, physical therapy, and other types of Medicare and Medicaid fraud.

Most Wanted Fugitives Listed on OIG's Website

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

In addition, the Web site features recently captured fugitives, including Atalier Moncho Avila, who was apprehended during this reporting period. Avila was indicted in March 2009 on charges of health care fraud; he allegedly billed Medicare for more than \$1.5 million for the cost of medical equipment and supplies and services that were not prescribed by doctors or provided, as claimed. Avila was arrested on July 28, 2012, at Miami International Airport after arriving from Havana, Cuba. He is in custody and awaiting a court appearance.

Most Wanted Deadbeat Parents

Because of the success of OIG's Most Wanted Fugitives Web site, OIG recently launched its Most Wanted Deadbeat Parents Web site at: <https://oig.hhs.gov/fraud/child-support-enforcement/index.asp>.

The site highlights parents who fail to pay court-ordered child support for the care of their children and put an unnecessary strain on the custodial parent and the children, as well as on agencies tasked with enforcing these matters. The Web site lists deadbeat parents and is updated frequently. The site includes information on OIG's role in pursuing parents who fail to pay court-ordered child support, and it has a reporting button to turn in deadbeat parents. At the top of the Most Wanted Deadbeat Parents list is Robert Sand, who owes more than \$1 million in child support payments for his three children. Sand has made several attempts to elude his child support obligations, including underreporting his income and moving from New York to Florida and then to Thailand.

Recently Completed Cases and Settlements

Investigative work often requires more than a year to yield results. As a consequence, many of the cases summarized in this section reflect the results of our Medicare- and Medicaid-related work over several years that culminated in the second half of fiscal year (FY) 2012.

The following represent various types of cases concluded during this semiannual period. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Medical Equipment and Supplies

Georgia – As part of an organized crime ring takedown, Arthur Manasarian and Sahak Tumanyan were sentenced in a Medicare fraud scheme. Manasarian opened a durable medical equipment company, Brunswick Medical Supply (BMS), in Brunswick, Georgia. According to court documents, once BMS was operational, Manasarian stole the identities of hundreds of Medicare beneficiaries and physicians from multiple States and submitted claims to Medicare for medical equipment that was never provided. In addition, Tumanyan engaged in numerous fraudulent financial transactions designed to deliberately conceal the proceeds from the fraudulent Medicare claims.

Manasarian was sentenced to 12 years of incarceration and ordered to pay over \$1.8 million in restitution, jointly and severally, for conspiracy to commit health care fraud and aggravated identity theft. Tumanyan was sentenced to 5 years of incarceration and ordered to pay \$308,963 in restitution, jointly and severally, on charges of money laundering conspiracy. Tumanyan, an Armenian national, will be deported after his incarceration. Additionally, Manasarian and Tumanyan were each excluded by OIG for 20 years and 15 years, respectively. This case was jointly investigated with U.S. Immigration and Customs Enforcement, the Federal Bureau of Investigation (FBI), and the Los Angeles County Sheriff's Office. The investigation of this scheme has led to more than 35 arrests.

Tennessee – AmMed Direct, LLC (AmMed), agreed to pay \$18 million to resolve allegations that it violated the False Claims Act. From September 2008 to January 2010, AmMed, a supplier of diabetic testing supplies and other DME, allegedly billed Medicare and Tennessee Medicaid for diabetic testing supplies sold to beneficiaries through telephonic cold calls, in violation of the Social Security Act, 1834(a)(17), which prohibits unsolicited telephone contact by suppliers. AmMed advertised and offered free cookbooks without any mention of diabetic testing supplies or without stating that AmMed was a DME supplier. When beneficiaries called to claim the cookbook, AmMed allegedly sold them diabetic testing supplies and submitted claims to Medicare and Tennessee Medicaid. The settlement also resolves AmMed's failure to refund Medicare and Medicaid for supplies that

were returned to the company. AmMed disclosed the unpaid refunds to the Government during the investigation.

California – Camillus Ehigie, co-owner of two Los Angeles-area health care companies, was sentenced to 3 years and 6 months of incarceration and ordered to pay \$7 million in restitution, jointly and severally, for his conviction stemming from a 9-year Medicare fraud scheme. Ehigie and co-defendant Evans Oniha were the founders and operators of Prosperity Home Health Services, Inc. (Prosperity), a home health agency, and Caravan Medical Supplies, Inc. (Caravan), a durable medical equipment company. According to court documents, between October 2002 and February 2011, Ehigie, Oniha, and their co-conspirators paid individuals, referred to as “marketers,” for Medicare beneficiary information and doctors’ prescriptions that were acquired fraudulently by the marketers. This information was then used by Prosperity and Caravan to submit false claims to Medicare for services that were not medically necessary or were not provided. Oniha was previously sentenced to 8 years of incarceration and ordered to pay \$7 million in restitution, jointly and severally. Oniha was also excluded by OIG for 30 years.

Rhode Island – Sonja Ascoli was sentenced to 3 years’ probation and ordered to pay \$70,358 in restitution, jointly and severally, after pleading guilty to health care fraud. According to court records, Ascoli worked as a sales representative for Planned Eldercare, Inc., a nationwide supplier of durable medical equipment. To induce beneficiaries to attend her sales presentations, Ascoli advertised “no cost” custom fit shoes for diabetics and medical equipment for individuals suffering from arthritis. Ascoli obtained beneficiaries’ Medicare and physician information and then suggested products that could help with their ailments. Ascoli then ordered as many DME products as possible for those beneficiaries without regard to whether they requested the products or had a medical need for the equipment. When beneficiaries complained about receiving items that they did not order, Ascoli allegedly told them to keep the products in the closet until they need them. Gary Winner, president of Planned Eldercare, was previously sentenced to 3 years and 1 month of incarceration and ordered to pay more than \$2.2 million in restitution after pleading guilty to health care fraud, money laundering, and introduction of an adulterated and misbranded medical device into interstate commerce.

Pharmaceutical Companies

Massachusetts – In the largest health care fraud settlement in U.S. history, GlaxoSmithKline (GSK) entered into a global criminal, civil, and administrative settlement and agreed to pay \$3 billion to resolve its liability for its marketing and promotion practices associated with several drugs. In three False Claims Act settlement agreements, the United States alleged that GSK promoted several drugs, including Paxil, Wellbutrin, Advair, Lamictal, and Zofran, for off-label uses and paid kickbacks to induce the prescription of certain drugs; improperly promoted the drugs Avandia, Advandmet, and Avandaryl with false and misleading statements about the drugs’ safety; and

violated the requirements of the Medicaid drug rebate program. As part of the settlement, GSK also entered into a 5-year corporate integrity agreement (CIA) with OIG that includes enhanced compliance provisions designed to promote accountability and transparency in GSK's business practices. In addition, the CIA requires that GSK maintain its "Patient First" program, which is designed to compensate sales representatives on the basis of the quality of services they provide to physicians instead of the volume of sales in their territories. In addition, GSK must establish and maintain a financial recoupment program for executives.

The investigation involved collaboration across several Government agencies, including the Food and Drug Administration (FDA), FBI, Defense Criminal Investigative Service, Office of Personnel Management, Department of Veterans Affairs, Department of Labor, TRICARE, and the Postal Service. In addition, GSK entered into separate Medicaid-related settlement agreements with multiple States.

Massachusetts – Pharmaceutical manufacturer Merck, Sharp & Dohme (Merck) agreed to pay over \$628 million to resolve allegations that it violated the FCA by improperly marketing and promoting the drug Vioxx. Between May 1999 and September 2004, Merck allegedly promoted Vioxx improperly for the treatment of rheumatoid arthritis; made statements about the cardiovascular safety of Vioxx that were inaccurate, misleading, and inconsistent with the FDA-approved labeling for the drug; and made false statements about the safety of Vioxx to State Medicaid agencies. The settlement agreement is part of a global criminal, civil, and administrative settlement under which Merck paid a total of \$950 million plus interest; pled guilty to a misdemeanor violation of the Food, Drug, and Cosmetic Act; and entered into a comprehensive 5-year CIA with OIG. In addition, Merck is expected to enter into separate Medicaid-related settlement agreements with 44 States.

New Jersey – McKesson Corporation agreed to pay \$187 million plus interest to resolve allegations that it inflated pricing information for its prescription drugs. McKesson is a wholesaler of pharmaceutical products. The United States alleged that McKesson provided inflated average wholesale pricing figures—up to 25-percent markups—to First Data Bank, a publisher of discount pricing. First Data Bank's information was then used by State Medicaid programs for determining reimbursements and fee schedules for McKesson's prescription drugs. As a result of McKesson's alleged provision of artificially inflated wholesale pricing, State Medicaid programs reimbursed higher amounts for prescription medications than should have been paid between August 2001 and December 2009. In addition, McKesson agreed to pay over \$151 million to 29 States and the District of Columbia to resolve its liability to the States affected by the alleged price manipulation scheme.

Michigan – Walgreens agreed to pay \$7.9 million to resolve its liability under the False Claims Act. The United States alleged that Walgreens offered and provided improper inducements in the forms of gift cards, gift checks, and

similar promotions to beneficiaries of Government health care programs to induce the beneficiaries to transfer their prescriptions to Walgreens.

Quality of Care

Georgia - Former nursing home operator George Houser was sentenced to 20 years of incarceration and ordered to pay \$6.7 million in restitution after being convicted of conspiracy to commit health care fraud. Houser submitted claims to the Medicare and Georgia Medicaid programs for services provided to residents that were so deficient that the judge determined them to be “worthless.” During the trial, witnesses testified that there were food shortages, leaking roofs, virtually no nursing or housekeeping supplies, poor sanitary conditions, major staff shortages, and serious safety concerns at the three nursing homes in Georgia that Houser and his wife owned and operated from 2003 to 2007. Evidence included testimony from employees, whose paychecks regularly bounced, who also purportedly incurred substantial personal debt buying food and beverages to keep the residents from starving.

The court found that Houser was aware of the conditions at the nursing homes, but rather than make a good faith effort to remedy the situation, he chose instead to divert significant nursing home funds toward his real estate development ventures and for other personal expenses. The court concluded that the conditions at the nursing homes were so poor that, in essence, any services that Houser actually provided were of no value to the residents. This is the first time that a defendant has been convicted after a trial in Federal court for submitting claims for payment for “worthless services.”

Laboratories

Indiana – Physician Adolph Yaniz and Medway Diagnostic Laboratories operator Munir Chaudhry were each sentenced after health care fraud convictions. The Government contended that, between January 2008 and February 2009, Chaudhry worked with Yaniz to perform unnecessary blood tests on Yaniz’s patients and then billed Medicare and Medicaid for the services. Chaudhry also allegedly paid the monthly rent for Chaudhry’s medical practice in exchange for Yaniz’s sending all his patients’ specimens to Medway Diagnostic Laboratories for analysis. In addition, Yaniz admitted that he knowingly dispensed hydrocodone and alprazolam to patients who had no medical need for the medications. Yaniz was sentenced to 5 years of incarceration and ordered to pay restitution of \$71,577. As part of his plea agreement, Yaniz agreed to forfeit his medical license. He further agreed to a lifetime ban from participating in any federally or State funded health care program. Chaudhry was previously sentenced to 2 years and 3 months of incarceration and ordered to pay \$31,000 in restitution, jointly and severally.

Clinics

Michigan – Miami-area resident and manager of a Detroit-area health clinic Alejandro Haber and his son and clinic-owner, Emilio Haber, were sentenced after pleading guilty to conspiracy to commit health care fraud. According to court documents, the Habers conceived and oversaw fraud schemes involving Ritecare LLC. Between August 2007 and October 2009, the Habers and their co-conspirators billed Medicare for medically unnecessary tests and services performed by Ritecare. The Government contended that they used patient recruiters to offer kickbacks to patients and coach patients to feign symptoms, which were used as justification for the clinic's physicians to order unnecessary diagnostic tests. Alejandro Haber was sentenced to 3 years and 4 months of incarceration and ordered to pay over \$5.3 million in restitution, jointly and severally. Emilio Haber was sentenced to 5 years of incarceration and ordered to pay \$6.3 million in restitution, jointly and severally.

Michigan – Brother and sister Henry and Marieva Briceno and Marieva's daughter, Karina Hernandez, were all sentenced in a Medicare fraud scheme. The trio, along with co-conspirators Isaac Carr and Daron Elder, fraudulently organized and operated three diagnostic testing clinics in Eastern Michigan: Alpha & Omega MC, Blessed MC, and Manuel MC. According to court documents, between May 2007 and January 2010, the three clinics submitted false claims to Medicare for medically unnecessary services. The defendants paid drivers to recruit, drive, and pay kickbacks to Medicare beneficiaries to induce them to visit the clinics. The United States alleged that the beneficiaries were recruited from soup kitchens and paid to sign paperwork indicating they had received diagnostic testing, including nerve conduction testing, that was medically unnecessary. Marieva Briceno was sentenced to 5 years of incarceration and ordered to pay \$2.9 million in restitution, jointly and severally. Additionally, Marieva was excluded by OIG for 10 years. Henry Briceno was sentenced to 24 months of incarceration and ordered to pay \$592,813 in restitution, jointly and severally. Hernandez was sentenced to 3 years of incarceration. Elder and Carr were each sentenced to 1 year of incarceration and ordered to pay \$2.99 million and \$1.2 million in restitution, respectively, jointly and severally.

Hospitals

New Jersey – AHS Hospital Corp., Atlantic Health System, Inc., and Overlook Hospital (collectively, AHS) agreed to pay \$8.9 million to resolve allegations that it violated the FCA. AHS allegedly admitted to the hospital patients who did not meet medical necessity criteria, but, instead, required only observation and evaluation. AHS billed Medicare for the more expensive inpatient services. In addition, AHS agreed to enter into a 5-year CIA with OIG that requires independent reviews of AHS's medical necessity decisions regarding inpatient admissions and lengths of inpatient stays.

Physicians

Washington – Antoine Johnson, M.D., and his mother, Lawanda Johnson, were sentenced for health care fraud and filing false income tax returns. The pair owned and operated four medical clinics in Washington that operated under the names Broadway Clinic and Johnson Family Practice. According to court documents, Antoine Johnson, the sole physician for the clinics, used three of them to write a high number of prescriptions to thousands of patients for narcotic pain medications, such as oxycodone and methadone, often while providing little or no medical care. Lawanda Johnson was the business manager and supervisor of the nonmedical staff. The Johnsons' primary business plan was to provide prescriptions for controlled substances, thereby cultivating patients who returned to the clinics each month to get new prescriptions.

The Johnsons collected significant sums for these visits and further inflated the treatment code levels when billing these visits to the health care programs. In January 2009, the pair fled to Madagascar after search warrants were executed. The U.S. State Department worked with the Federal Bureau of Investigation and Madagascar authorities, resulting in the return of the Johnsons to the United States, where they were arrested and held for trial. Antoine Johnson was sentenced to 12 years and 7 months of incarceration and ordered to pay \$1.28 million in restitution, jointly and severally. Lawanda Johnson was sentenced to 7 years and 3 months of incarceration and ordered to pay \$1.22 million in restitution, jointly and severally. Additionally, Antoine and Lawanda were each excluded by OIG for 40 years and 30 years, respectively.

Colorado – Steven Spillers, M.D., agreed to pay \$747,013 to settle allegations that he submitted improper claims to Medicare. Spillers is a neurologist who performs intraoperative monitoring (IOM) for companies throughout the United States. IOM involves remote monitoring of a patient's nervous system during surgery. Under Medicare rules, a physician is permitted to bill for the professional component of IOM as a telehealth service but the physician is required to bill for the actual time spent on a per-hour basis, regardless of the number of cases simultaneously being monitored. The United States alleged that Spillers routinely conducted multiple IOM services simultaneously in his office and billed Medicare on an hourly basis for each patient he was monitoring concurrently, instead of on an hourly basis overall. Consequently, Spillers billed in excess of 24 hours per day. Spillers agreed to enter into a 5-year Integrity Agreement with OIG in addition to the settlement agreement.

Home Health Agencies

Florida – Marietha Morales and Eduardo Dominguez were sentenced in a multimillion-dollar fraud scheme. Morales was president and Dominguez an employee of Prime Home Health Services, Inc., a Florida home health agency that purported to provide home health care and physical therapy services to eligible Medicare beneficiaries. According to court documents, between

February 2005 and April 2011, Morales and her co-conspirators paid kickbacks and bribes to patient recruiters through Dominguez. In return, the recruiters provided patients to Prime Home Health, as well as prescriptions, plans of care (POC), and certifications for medically unnecessary therapy and home health services. Prime Home Health employees falsified patient files for Medicare beneficiaries to appear as though they qualified for the services. Morales used these prescriptions, POCs, and medical certifications to fraudulently bill Medicare for home health care services. Morales and Dominguez were sentenced to 9 years and 3 years and 10 months of incarceration, respectively. In addition, Morales was ordered to pay \$14 million in restitution, jointly and severally, and Dominguez was ordered to pay over \$2 million in restitution.

Hospice Care

Kansas – Hospice Care of Kansas (HCOK) agreed to pay \$6.1 million plus interest to resolve allegations that it violated the False Claims Act. Between January 2004 and December 2008, HCOK, a wholly owned subsidiary of Voyager HospiceCare, Inc., allegedly submitted claims to Medicare for services provided to beneficiaries that did not meet hospice eligibility requirements. Specifically, HCOK allegedly engaged in certain business practices that contributed to submission of claims for patients who did not have terminal prognoses of 6 months or less if their diseases ran their normal course, including providing compensation to staff based on patient admissions and census, pressuring staff to meet admissions and census targets, adopting procedures that delayed and discouraged discharges of ineligible patients, instructing staff to inaccurately or misleadingly document patients' medical conditions, and implementing an inadequate compliance program to review patients for hospice eligibility.

Arizona – Hospice Family Care, Inc. (HFC), agreed to pay \$3.7 million to resolve its liability for alleged violations of the False Claims Act. HFC, which was owned by registered nurses Nancy Smith and Nancy Turner, provided hospice care under Medicare's hospice benefit. To be eligible for hospice care, the patient's attending physician and the hospice's medical director must certify that the patient is terminally ill. Medicare reimbursement is based on the level of care provided by the hospice. According to court records, HFC allegedly submitted claims to Medicare for the care of patients who were completely or partially hospice ineligible or were provided a higher level of hospice care than was necessary or allowable. As part of the agreement, Smith and Turner agreed to be excluded from participation in Federal health care programs for 7 years.

Managed Care

Florida – WellCare Health Plans, Inc., agreed to pay \$137.5 million to the Federal Government and nine States to resolve four lawsuits involving alleged violations of the False Claims Act. The Government alleged that WellCare falsely retained payments from Florida Medicaid, Florida Healthy Kids, and Illinois Medicaid for behavioral health services; falsely retained

payments from Florida Medicaid for newborns; submitted falsely inflated performance data for call centers; knowingly permitted Florida Medicaid to rely on overpriced encounter data for future premium rate setting and other uses; operated a sham Special Investigative Unit that failed to properly audit WellCare providers; upcoded risk scores for Medicare plans; and engaged in sales and marketing abuses, including “cherrypicking” of healthy patients to avoid future costs. Five former WellCare executives, including former chief executive officer **Todd Farha**, were indicted in March 2011 and are awaiting trial. WellCare entered into a 5-year CIA with enhanced oversight and reporting obligations, in addition to the settlement.

California – SCAN Health Plan, Senior Care Action Network, and Scan Group (collectively, SCAN) agreed to pay \$322 million to resolve allegations that it violated the False Claims Act. SCAN is a Medicare Advantage (i.e., Medicare Part C) plan, which is focused on providing services to beneficiaries who are dually eligible for Medicare and Medicaid. The United States alleged that SCAN provided misleading information about beneficiaries’ diagnoses, resulting in inflated capitation payments, and improperly retained overpayments.

Physical Therapy

Oregon – Victoria Vestal agreed to pay \$231,928, plus interest, to resolve allegations that she submitted false claims to Medicare. Vestal is a licensed physical therapist, who owns two physical therapy clinics in Oregon and Washington State. Vestal, through her companies Pacific Crest Physical Therapy, Inc., and Ocean Beach Physical Therapy, Inc., allegedly billed Medicare improperly for services, including ultrasounds, e-stimulations, and exercise treatments, which were provided by physical therapy assistants.

Identity Theft

New York – Tikran Takvoryan was sentenced to 8 years and 1 month of incarceration and ordered to forfeit \$10,000 after pleading guilty to racketeering charges. Takvoryan was involved with the Mirzoyan-Terdjanian crime organization, which was purportedly responsible for credit card fraud, extortion, and Medicare fraud between 2006 and 2010. Takvoryan knowingly obtained the identities of doctors and beneficiaries, which were used to defraud Medicare. Takvoryan also assisted with the computer and technological needs of the organization in furtherance of the fraud.

New Jersey – Patrick Lynch was sentenced to 4 years of incarceration and ordered to pay \$40,048 in restitution for health care fraud and fraud with identification documents. Lynch jointly owned Visiting Doctors of New Jersey, LLC, but the company was dissolved after he allegedly failed to pay his business partner for his services. According to the investigation, Lynch then began rendering home medical care to Medicare patients on his own, including writing prescriptions, even though he was not a licensed practitioner. Additionally, Lynch stole his former partner’s identification and

used his National Provider Identifier number to bill Medicare for the services he provided.

Misuse of Grant Funds

New York – District Council 1707, Local 95 Head Start Employees Welfare Fund (welfare fund), agreed to pay over \$4.8 million to resolve allegations that it violated the False Claims Act. Head Start is a Federal program that provides grants to local public and private agencies to provide comprehensive child development services to economically disadvantaged children and families. The welfare fund administers the hospitalization insurance provided to employees carrying out the Head Start programs and submits invoices to the New York City Administration for Children's Services (ACS) for reimbursement for hospitalization insurance premiums. ACS reimbursed the welfare fund for the insurance premiums with Head Start grant money. According to court documents, the welfare fund allegedly charged ACS higher rates for hospital insurance premiums than it ultimately paid for the premiums.

Medicaid Fraud Control Units

Funding and Accomplishments

Medicaid Fraud Control Units (MFCU) are key partners in the fight against fraud, waste, and abuse in State Medicaid programs. In FY 2011, HHS awarded \$156.7 million in Federal grant funds to 50 MFCUs (including 1 in Washington, DC), which employed a total of 1,833 individuals. Collectively, in FY 2011, MFCUs reported 14,819 investigations, of which 10,685 were related to Medicaid fraud and 4,134 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges against or indictments of 1,408 individuals, including 1,011 for fraud and 397 for patient abuse and neglect, including patient funds cases. In total, 1,230 convictions were reported in FY 2011, of which 824 were related to Medicaid fraud and 406 were related to patient abuse and neglect, including patient funds cases.

Joint Investigations

Virginia – Universal Health Services, Inc. (UHS), and its subsidiaries, Keystone Education and Youth Services, LLC, and Keystone Marion, LLC, d/b/a Keystone Marion Youth Center, agreed to pay over \$6.85 million to resolve allegations that it submitted false and fraudulent claims to Medicaid. Between October 2004 and March 2010, the entities allegedly provided substandard psychiatric counseling and treatment to adolescents in violation of Medicaid requirements. The United States alleged that UHS falsely represented Keystone Marion Youth Center as a residential treatment facility providing inpatient psychiatric services to Medicaid-enrolled

children when in fact it was a juvenile detention facility. The United States further alleged that neither a medical director nor licensed psychiatrist provided the required direction for psychiatric services or for the development of initial or continuing treatment plans. The settlement further resolved allegations that the entities filed false records or statements to Medicaid when they filed treatment plans that falsely represented the level of services that would be provided to the patients. This was a joint investigation with the Virginia MFCU.

North Carolina – Thomas Hunter and Janet Johnson-Hunter, owners and operators of Coastline Care, Inc., an ambulance and medical transport company, entered into a settlement agreement for \$950,178. The settlement resolved allegations that, between January 2002 and October 2006, the Hunters submitted Medicare and Medicaid claims for nonemergency dialysis-patient ambulance transports that were not medically necessary because the patients were ambulatory and/or not bed-confined. Specifically, the Hunters allegedly instructed employees to omit the true condition of patients from the ambulance call reports when they did not meet the Medicare and Medicaid reimbursement requirements. As part of the settlement, Janet Johnson-Hunter agreed to an exclusion of 15 years based on her conviction of conspiracy to make false statements relating to health care matters. In the criminal case, she was sentenced to 2 years and 4 months of incarceration and ordered to pay \$475,089 in restitution. This was a joint investigation with the North Carolina MFCU.

California – Dr. Norman Buetow was sentenced to 5 years of probation and ordered to pay over \$1.9 million in restitution, jointly and severally, after pleading guilty to making a false statement to a Government agency. Buetow was a licensed physician who purported to be the owner and physician in charge of three clinics in California that were established and operated by Rudik Avakyan. According to court documents, the defendants conspired to offer and make payments to Medicare patients in exchange for their Medicare numbers. In addition, the defendants paid “cappers” for the referral of Medicare patients to the clinics. The defendants submitted fraudulent claims to Medicare for services that were not performed, were not performed as billed, or were performed by persons other than the provider under whose identification those services were billed.

The defendants also falsely stated that the clinics would be owned and operated by a licensed physician when, in fact, the true owner was Avakyan, who was not a physician. During the investigation, Buetow knowingly made false statements to OIG agents, deliberately trying to conceal his role and relationship to the co-defendants. Buetow was excluded by OIG for 5 years on the basis of the conviction. Avakyan was previously sentenced to 3 years and 3 months of incarceration and ordered to pay more than \$2 million in restitution, jointly and severally. This was a joint investigation with the FBI, DOJ, and the Bureau of Medi-Cal Fraud and Elder Abuse.

Sanction Authorities and Related Administrative Actions

Various Federal laws provide authorities to impose administrative sanctions for fraud and abuse, as well as other activities that pose a risk to Federal health care programs and their beneficiaries. (See Appendix D for a summary of frequently used sanction authorities.)

Sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties (CMP) for submitting false and fraudulent claims to a Federal health care program or for violating the anti-kickback statute; the Stark Law; or the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), also known as the anti-patient-dumping law.

During this semiannual reporting period, OIG imposed 1,911 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. Exclusion and penalty authorities are described in Appendix D and on our Web site at:
<https://www.oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program Exclusions

During this semiannual reporting period, OIG excluded 1,867 individuals and entities from Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. OIG is also responsible for reinstating providers who apply and have met the requirements of their exclusions. For a list of excluded individuals and entities, see <https://exclusions.oig.hhs.gov/>.

For example:

Texas – Kimberly Saenz was excluded from participation in Federal health care programs for 60 years after she was sentenced to life in prison without parole for capital murder. In April 2008, Saenz was a nurse at a dialysis center in Lufkin, Texas, which served Medicare beneficiaries. During the time of her employment, the facility had an unusual rate of patients who went into cardiac arrest while undergoing dialysis. According to court records, on April 28, 2008, two patients saw Saenz draw bleach into a syringe and inject it into the dialysis lines of patients, causing them to suffer distress and respiratory arrest. It was determined that because Saenz injected bleach into patients' dialysis lines or directly into their bloodstreams at least five died and five others suffered cardiac arrest that did not result in death.

California – Conrad Murray, pop singer Michael Jackson's doctor, was excluded for a minimum of 50 years after being convicted of involuntary

manslaughter. According to court documents, Murray administered Propofol, an anesthetic drug used to induce and maintain anesthesia, to Jackson each night for over 2 months. On June 25, 2009, Murray administered Propofol, along with another drug, to Jackson and then abandoned him. When Murray returned, he found that Jackson was not breathing. According to court records, Murray waited at least 20 minutes before calling emergency personnel. In November 2011, a jury convicted Murray of involuntary manslaughter in Jackson's death. Murray was sentenced to 4 years of incarceration, ordered to pay \$101,827,871 in restitution, and ordered to cease and desist from practicing medicine in California.

Massachusetts – Pharmacist Aloysius Nsonwu was excluded for a minimum of 15 years after his convictions in Federal and State courts for conspiracy to defraud the Government with respect to claims, Medicaid false claims, larceny by false pretenses, and conspiracy. According to court documents, between approximately December 2004 and February 2010, Nsonwu paid customers to bring in their Medicare and Medicaid cards so he could submit false claims for HIV/AIDS medications without dispensing the medications. Many of these individuals were not even HIV positive. In addition, Nsonwu obtained valid prescriptions from Medicaid beneficiaries who were HIV positive, but instead of dispensing their medications, he paid them in cash for the prescriptions. Nsonwu was sentenced to 4 years and 1 day of incarceration and ordered to pay approximately \$555,500 in restitution on his State conviction. He was also ordered to pay approximately \$147,700 in restitution on his Federal conviction. In addition, his license to practice as a pharmacist was revoked by the Massachusetts State Board of Pharmacy.

Arizona – Emilio Luna, an Arizona pediatrician, was excluded indefinitely on the basis of the revocation of his license by the Arizona Medical Board. According to court records, an FBI agent from the Innocent Images Unit signed into a file-sharing program on the Internet and came into contact with a person later identified as Luna, who was sharing approximately 10,000 files. The FBI agent selected and downloaded files from Luna for investigation and found that they contained multiple images of child pornography. Luna was arrested and charged with distributing child pornography in interstate commerce, and he was prohibited from practicing medicine. The Medical Board of California revoked Luna's license. The Texas Medical Board also revoked his license. On September 2010, while on house confinement, Luna removed his electronic monitoring unit and fled. He remains a fugitive.

Illinois – Husband and wife Robby and Monica Owens, owners of Great Kids, Inc., a day care center, were each excluded for a minimum of 10 years on the basis of their convictions of attempt to evade or defeat tax. Great Kids participated in the HHS-funded Child Care Resource and Referral Program. According to court documents, the Owenses concealed their correct income by using Great Kids' account and funds for personal expenses. They dealt primarily in cash to avoid the creation of records. They withheld taxes from employees' payroll checks and then failed to pay the employment-related

taxes. Monica Owens also caused Great Kids to fraudulently obtain funds under a Federal program involving a grant, contract, subsidy, loan, guarantee, insurance, or other form of Federal assistance. The Owensens were each sentenced to 2 years and 1 month of incarceration and ordered to pay approximately \$169,263 in restitution, jointly and severally.

Corporate Integrity Agreements

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

Example of a CIA Violation – On July 3, 2012, OIG imposed penalties totaling \$100,000 on Church Street Health Management, a network of dental providers, for material breach of its CIA.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who, among other things, submits, or causes to be submitted, claims to a Federal health care program that the person knows or should know are false or fraudulent. During this semiannual reporting period, OIG concluded cases involving more than \$6.7 million in CMPs and assessments. The following are among the CMP actions resolved during this reporting period:

Massachusetts – Baypointe Rehabilitation and Skilled Care Center, a nursing home, agreed to pay \$351,255 to resolve its liability under the CMPL. Baypointe employed an excluded nurse as its assistant director of nursing from January 2006 through July 2009. OIG excluded the nurse after the Mississippi Board of Nursing revoked her license following a positive preemployment drug test. The Government contended that Baypointe should have known that the nurse was excluded.

Missouri – Cooperative Home Care agreed to pay \$121,000 to resolve its liability under the CMPL for employing an excluded individual. From February 2009 to August 2010, Cooperative employed an excluded physician in an administrative position. The Government contended that Cooperative knew or should have known that the individual was excluded.

Massachusetts – Stephan Babirak and Metabolic Leader, LLC, agreed to pay \$17,087 to resolve liability under the CMPL for improperly submitting claims to Medicare. According to court records, Babirak and Metabolic Leader allegedly billed Medicare for new-patient evaluation and management (E/M) office visits for current patients, upcoded E&M visits, and upcoded "incident

to” services provided by nurse practitioners and billed under Babirak’s provider number while Babirak was not in the office.

Iowa – Hy-Vee, Inc., a pharmacy, agreed to pay \$831,870 to resolve its liability under the CMPL. From 2006 through 2011, Hy-Vee employed an excluded individual. The Government contended that Hy-Vee should have known that the individual was excluded.

Patient Dumping

Some of the CMPL cases that OIG resolved between April 1, 2012, and September 30, 2012, were pursued under EMTALA, a statute designed to prevent hospitals from denying emergency care to patients and to ensure patient access to appropriate emergency medical services. The following are examples of settlements under this statute:

Minnesota – Hendricks Community Hospital agreed to pay \$20,000 to resolve allegations that it violated EMTALA. The Government alleged that Hendricks failed to provide a medical screening examination and stabilizing treatment for a 72-year-old man who arrived at the emergency room with complications after a medical procedure. A triage nurse did not examine the man and told him to drive to a hospital that was 40 miles away.

Texas – Texas County Memorial Hospital (TCMH) agreed to pay \$20,000 to resolve allegations that it violated EMTALA. The Government alleged that TCMH failed to provide a medical screening examination to a minor who arrived at TCMH’s emergency room with an emergency medical condition. A screening examination was not done, and a TCMH clerk advised the family to take the patient to her primary care physician.

Provider Self-Disclosure Protocol

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

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws. After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact. OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. The self-disclosure guidelines

are available on the OIG Web site at
<https://www.oig.hhs.gov/fraud/selfdisclosure.asp>.

During this reporting period, self-disclosure cases resulted in \$53.3 million in HHS receivables. The following are examples:

Georgia – Tenet Healthcare Corporation, an investor-owned health care delivery system, agreed to pay \$42,750,000 and enter into a CIA to resolve allegations that, from May 2005 through December 2007, it violated the FCA and CMPL by submitting claims to Medicare for inpatient rehabilitation facilities (IRF) patient admissions when the medical and rehabilitative needs of the patient did not meet Medicare coverage criteria for IRF admission. Tenet operates 50 hospitals and 99 outpatient centers in 11 States. Tenet self-disclosed to OIG through the Self-Disclosure Protocol that one of its IRF hospitals did not properly assess patients prior to admission and failed to determine whether IRF coverage criteria had been met for purposes of complying with the Medicare payment rules. OIG, DOJ, and the U.S. Attorney's Office for the Northern District of Georgia extended the investigation to all Tenet IRF hospitals.

Pennsylvania – Animas Corporation agreed to pay \$1,683,000 to resolve its liability under the CMPL. Animas self-disclosed that it submitted claims for reimbursement to Medicare and Medicaid for infusion pumps and supplies that were based on signed written orders from physicians, which had been altered without the physicians' approval.

New York – Good Samaritan Hospital Medical Center and South Bay OB/GYN agreed to pay \$1,753,447 to resolve their liability under the CMPL. Good Samaritan and South Bay disclosed that Good Samaritan paid salary and benefits under a contract for clinical teaching, administrative, and supervisory services to five physicians associated with South Bay. The salary and benefits were above fair market value and violated the Stark Law and the Anti-Kickback Statute. This case was resolved jointly with New York State's Office of Medicaid Inspector General.

Utah – Billings Clinic, an integrated nonprofit health care organization, agreed to pay \$284,098 to resolve its liability under the CMPL. Billings self-disclosed to OIG that, from August 2005 until October 2011, it employed an excluded individual as a licensed practical nurse.

<https://oig.hhs.gov>

Public Health Reviews

Selected organizational abbreviations used in this section:

CDC	Centers for Disease Control and Prevention
FDA	Food and Drug Administration
HRSA	Health Resources and Services Administration
NIH	National Institutes of Health

Public Health Agencies’ Management and Program Oversight

CDC—Vaccines Mismanaged in Storage

Vulnerabilities in Vaccine Storage and Management Threaten Efficacy –

A June 2012 report revealed that providers in the Vaccines for Children (VFC) program exposed some vaccines in storage to inappropriate temperatures, which could reduce vaccine potency and efficacy, increasing the risk that children are not provided with maximum protection against preventable diseases. The VFC program is a Medicaid benefit that provides free vaccines to eligible children. CMS delegates the program’s implementation to the Centers for Disease Control and Prevention (CDC), which purchases VFC vaccines and distributes them to VFC providers. We found that some vaccines stored by 76 percent of 45 selected providers were exposed to inappropriate temperatures for at least 5 cumulative hours. We also found expired vaccines stored together with nonexpired vaccines, increasing the risk of mistakenly administering the expired vaccine. The selected providers generally did not meet vaccine management requirements or maintain required documentation.

Recommendations—CDC should work with VFC grantees and providers to ensure that VFC vaccines are stored according to requirements, expired vaccines are identified and separated from nonexpired vaccines, grantees better manage providers’ vaccine inventories, and grantees meet oversight requirements. *Medicaid Vaccines for Children Program: Vaccine Storage and Management*. OEI-04-10-00430. June 2012. [Full Text](#).

FDA—Medical Devices

Resolving Scientific Disagreements on Regulatory Decisions – We reviewed 36 medical device submissions for which FDA’s Center for Devices and Radiological Health (CDRH) had scientific disagreements on regulatory decisions between 2008 and 2010 and found a number of challenges associated with the resolution process. CDRH annually processes about

6,000 submissions for approval of medical devices that require regulatory decisions. Scientific disagreements are defined as being consequential to a regulatory decision where taking one position on an issue would lead to a different decision than taking another position. CDRH did not start formally tracking such disagreements until 2010. We found that CDRH faces broad challenges in identifying and resolving scientific disagreements because of uncertainty about regulatory definitions and processes and staff perceptions about expressing differences of opinion. The nature and resolutions of the 36 disagreements we reviewed varied widely. The disagreements often involved multiple issues, and most of their resolutions did not lead directly to the approval or clearance of devices. Most administrative files related to the disagreements contained required documentation, but accountability for file completeness was unclear. Also, not all of CDRH's managers and reviewers had received training on the new procedures implemented in 2009.

Recommendations—FDA should define more clearly its requirements for documenting and resolving scientific disagreements, train all reviewers and managers on the new policies and procedures for resolving scientific disagreements, and more clearly assign accountability for the contents of the administrative files of all submissions. *Discretionary Scientific Disagreements Regarding Medical Device Regulatory Decisions*. OEI-01-10-00470. June 2012. [Full Text](#).

HRSA—Health Center Program

Multiple Issues Found With a Grantee's Claims and Financial Performance –

We reviewed a grantee that received funding pursuant to the Health Center Program administered by the Health Resources and Services Administration (HRSA). Our September 2012 report revealed that for selected grants and budget periods, Soundview Health Care Network, a nonprofit grantee organization that operates a network of five health centers, claimed Federal grant expenditures totaling \$113,603 that were unallowable because of deficiencies in the grantee's internal controls. We could not determine the allowability of an additional \$5,211,598 claimed. Some of the funds were not accounted for separately from other operational funds. Regarding performance measures, the grantee's cash balances were significantly lower than the recommended 60-day minimum and there were indications the grantee did not have enough cash on hand to pay its short-term liabilities. We found problems with the grantee's liquidity, accounts receivable collections and a decline and net loss in earnings.

Recommendations—HRSA should impose special award conditions to address shortcomings in financial performance measures; ensure that the grantee refunds the unallowable amount we calculated and the \$5,211,598 set aside (or determine whether any of the costs set aside were allowable); impose specified award conditions; ensure that the grantee develops policies and procedures for determining the reasonableness, allocability, and allowability of expenditures; and educate the grantee on Federal requirements for after-the-fact certifications and the proper period to charge

costs. *Soundview Health Care Network Did Not Meet Select Financial Performance Measures and Claimed Unallowable Federal Grant Expenditures.* A-02-11-02004. [Full Text](#).

NIH—Grants and Contract Management

Unallowable Transactions at Florida State University – The university charged unallowable transactions to HHS grants, contracts, and other agreements (awards) during fiscal years 2009 and 2010. In addition to receiving its regular funding through grants and contracts, the university was awarded 28 grants with funding provided by the American Recovery and Reinvestment Act of 2009. In our sample of 100 salary transactions, 53 were allowable but 47 were not, and in our sample of 100 nonsalary transactions, 55 were allowable but 45 were not.

The unallowable transactions occurred because the university did not provide adequate oversight to ensure consistent compliance with Federal regulations. Although its finance and accounting procedures often incorporated text from Federal regulations, the university largely left it to the discretion of its individual colleges, departments, and principal investigators to interpret the procedures correctly and to comply with Federal regulations. In addition, the university did not review transactions to ensure that they complied with Federal regulations.

Recommendations—Florida State University should refund the amounts we designated to the Federal Government and enhance oversight of charges to Federal awards to ensure consistent compliance with Federal regulations. *Florida State University Did Not Always Claim Selected Costs Charged Directly to HHS Awards in Accordance With Federal Regulations and NIH Guidelines.* A-04-11-01095. July 2012. [Full Text](#).

NIH—Superfund Appropriations

Superfund-Related Financial Activities at the National Institute of Environmental Health Sciences Found Compliant – During FY 2011, the National Institute of Environmental Health Sciences (NIEHS) administered its annual Superfund appropriations in accordance with applicable laws and regulations. NIEHS obligated approximately \$79 million and disbursed approximately \$76 million in Superfund resources during FY 2011. The Superfund is used to respond to emergency environmental conditions that are hazardous to health and to pay for the removal of toxic substances. The Federal law that established the Hazardous Substance Response Trust Fund (Superfund) required that the Inspectors General of Federal organizations with Superfund responsibilities audit all uses of the Superfund.

The report has no recommendations. *Superfund Financial Activities at the National Institute of Environmental Health Sciences, Fiscal Year 2011.* A-04-12-01013. July 2012. [Full Text](#).

NIH—Compliance With Appropriations Laws

Antideficiency Act Violations – We found issues in two contracts administered by the National Institute of Allergy and Infectious Diseases (NIAID) that violated the Antideficiency Act or the bona fide needs rule. The Antideficiency Act prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by law. Federal statutes specify that a fiscal year appropriation may be obligated only to meet a legitimate (bona fide) need arising in or continuing to exist in the appropriation's period of availability. From November 2008 through February 2009, an HHS internal review group assessed 176 HHS contracts, including 21 NIH contracts. Our reviews of the NIH contracts assessed compliance with the purpose, time, and amounts requirements specified in appropriations statutes. Recommendations included making monetary adjustments and reporting Antideficiency Act violations as appropriate.

Report 1 Recommendations—NIAID should record expenditures for each program year against the appropriate fiscal year appropriations; deobligate \$7.3 million of fiscal year 2003 funds and return those canceled funds to the Treasury; resolve its bona fide needs violations; report an Antideficiency Act violation for obligating fiscal year funds in advance of an appropriation for all program years reviewed, if not previously reported; report an Antideficiency Act violation if \$10.3 million (estimated) of fiscal year 2008 funds, sufficient fiscal year 2009 funds, and \$20.2 million of current fiscal year funds are unavailable, if not previously reported; and report, in accordance with 31 U.S.C. § 1554, any adjustment to the Contract using current fiscal year appropriations. *Appropriations Funding for National Institute of Allergy and Infectious Diseases Contract N01-AI-30068 With PPD Development, LP. A-03-10-03116. September 2012.* [Full Text](#)

Report 2 Recommendations—NIAID should record expenditures for each program year against the appropriate fiscal year appropriations; resolve its bona fide needs violations; report an Antideficiency Act violation for obligating fiscal year 2005 funds in advance of an appropriation, if not previously reported; report an Antideficiency Act violation if NIAID does not have \$16.5 million (estimated) of fiscal year 2008 funds, \$6.9 million of current fiscal year funds, and, if needed, appropriate fiscal years 2010 and 2011 funds for expenditures recorded after our review, if not previously reported; and report, in accordance with 31 U.S.C. § 1554, any adjustment to the Contract using current fiscal year appropriations. *Appropriations Funding for National Institute of Allergy and Infectious Diseases Contract HHSN266-2005-00022C With PPD Development, LP. A-03-10-03118. September 2012.* [Full Text](#).

Public Health-Related Legal Actions and Investigations

Health Education Assistance Loan Program

Under the Health Education Assistance Loan (HEAL) program, the HHS Health Resources and Services Administration guarantees commercial loans to students seeking education in health-related fields. The students are allowed to defer repayment of the loans until after they graduate and begin to earn income. Although HHS's Program Support Center (PSC) takes steps to ensure repayment, some loan recipients do not resolve their indebtedness. After PSC has exhausted efforts to secure repayment of a debt, it declares an individual in default. Thereafter, the Social Security Act permits exclusion from Medicare, Medicaid, and all other 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, nor can any other provider receive reimbursement for services ordered or prescribed by the individual. OIG is responsible for excluding individuals who have defaulted on HEAL loans from participation in Federal health care programs.

HEAL Exclusions

During this semiannual reporting period, 34 individuals and related entities were excluded as a result of PSC referral of their cases to OIG. Individuals who have been excluded as a result of default may enter into settlement agreements whereby the exclusions are stayed while they pay specified amounts each month to satisfy their debts. If they default on these settlement agreements, they may be excluded until the entire debts are repaid and they may not appeal the exclusions.

After being excluded for nonpayment of their HEAL debts, a cumulative 2,449 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 56 individuals who entered into such settlement agreements or completely repaid their debts during this semiannual reporting period. The amount of money being repaid through settlement agreements or through complete repayment is \$187 million. Of that amount, \$5.9 million is attributable to this semiannual reporting period.

Practitioners in the following states entered into settlement agreements to repay the amounts indicated:

- **Louisiana** – Podiatrist (\$1,097,762)
- **Pennsylvania** – Dentist (\$277,324)
- **Arizona** – Osteopath (\$190,290)
- **California** – Dentist (\$173,181)

- **California – Dentist (\$167,700)**

Human Services Reviews

Administration for Children and Families

Oversight of Head Start Eligibility

Improvements in Oversight of Program Eligibility – The Administration for Children and Families (ACF) strengthened its oversight of Head Start program eligibility between FYs 2010 and FY 2011. ACF altered its FY 2011 triennial reviews to determine whether grantees kept on file the source documents proving children’s eligibility and began performing unannounced reviews. ACF promulgated draft regulations that, once final, will require grantees to keep eligibility documents on file. We found that ACF was not consistent in issuing findings to grantees missing eligibility information in FY 2011. In FY 2012, ACF took action to reduce this variation when issuing findings. Also, ACF developed an online complaint process for the Head Start program to capture complaints that could help the agency uncover problems with grantees. Our review was a followup to Government Accountability Office (GAO) testimony at a May 2010 congressional hearing about potential eligibility fraud at eight Head Start grantees. At the same hearing, ACF committed to improving its oversight of eligibility.

The report had no recommendations. *Memorandum Report: ACF Strengthened Its Oversight of Head Start Eligibility in Fiscal Year 2011.* OEI-05-11-00140. June 2012. [Full Text](#).

Child Support Enforcement

Congress annually appropriates funds to OIG to investigate noncustodial parents who fail to pay court-ordered child support. OIG works closely with the Office of Child Support Enforcement (OCSE); DOJ; U.S. Attorneys Offices; the U.S. Marshals Service; and other Federal, State, and local partners to expedite the collection of child support.

In 1998, OIG and OCSE initiated Project Save Our Children, a child support initiative that united the efforts of multiagency, multijurisdictional investigative collaborations for child support enforcement. OCSE receives child support cases from the States; conducts preinvestigative analyses; and forwards the cases to OIG, where they are assigned and investigated. This approach streamlines the process by which the cases best suited for criminal prosecution are identified, investigated, and resolved. OIG also receives referrals directly from the States.

Investigative Outcomes

OIG investigations of child support cases nationwide resulted in 33 convictions and court-ordered restitution and settlements of \$2.4 million during this semiannual period. Examples of OIG's enforcement results for failure to pay child support included the following:

Arizona – One of OIG's most wanted deadbeat parents, Andre Rison, was sentenced to 5 years of probation and ordered to pay restitution of \$322,992 for failure to pay child support. Rison, a former NFL wide receiver, was ordered by a court in May 1999 to make monthly child support payments of \$2,358 for his son. Despite earning an NFL salary for more than a decade, Rison admitted that he willfully and unlawfully failed to pay child support for more than 5 years.

Texas – Frederick Leroy Borden was sentenced to 5 years' probation and ordered to pay restitution of \$243,055 for failure to pay child support. Borden purportedly is a homeopathic medicine practitioner who was living in Connecticut. According to court records, in August 2004, Borden was ordered to pay \$2,400 per month in child support to the custodial parent of his seven children, who live in Texas. At the time of his arrest in February 2012, Borden had not made any of the payments.

South Dakota – Jason Child was sentenced to 5 years' probation and ordered to pay \$33,869 in restitution for failure to pay child support. According to court records, Child, who lives in Oklahoma, willfully and unlawfully failed to pay past due child support obligations dating to June 2008.

Engaging the Public in Capturing Deadbeat Parents

The OIG Child Support Enforcement Web site continues to enlist the public's help in bringing some of OIG's most wanted child support fugitives to justice. The site includes photographs and other information on these deadbeat parents. It also has an online tip form and OIG's hotline number (1-888-476-4453) to report deadbeat-parent-related information in English or Spanish, 24 hours a day, 365 days a year. The site is available at <https://oig.hhs.gov/fraud/child-support-enforcement/>.

Administration for Community Living

Senior Medicare Patrol Projects

Projects May Not Be Receiving Full Credit for Savings Attributable to Their Work – In 2011, the 54 Senior Medicare Patrol Projects had 5,671 active volunteers, a 14-percent increase from 2010. The projects receive grants from the Administration for Community Living (ACL), Administration on Aging (AoA), to recruit retired professionals to serve as educators and resources in helping beneficiaries to detect and report fraud, waste, and abuse in the Medicare program. Project volunteers conducted 66,303 one-on-one counseling sessions and 11,109 group education sessions.

In 2011, 431,128 beneficiaries attended group education sessions, an increase from 298,097 in 2010. Medicare funds recovered that were attributable to the projects were \$19,283 in 2011. Total savings to Medicare, Medicaid, beneficiaries, and others were \$32,941. Additionally, cost avoidance on behalf of the Medicare program, the Medicaid program, beneficiaries, and others, totaled \$247,850.

We continue to emphasize that referrals to Medicare contractors or law enforcement from beneficiaries who have learned to detect fraud, waste, and abuse from the Senior Medicare Patrol Projects cannot be always be tracked. Therefore, the projects may not be receiving full credit for savings attributable to their work. In addition, the sentinel effect whereby fraud and errors are reduced by Medicare beneficiaries' scrutiny of their bills cannot be quantified.

The report had no recommendations. *Performance Data for the Senior Medicare Patrol Projects: June 2012 Performance Report*. OEI-02-12-00190. June 2012. [Full Text](#).

Other HHS-Related Reviews

Compliance With Executive Orders

HHS High-Dollar Improper Payments

Incomplete Reporting Hinders Assessment of Risk – HHS did not fully comply with Executive Order 13520, *Reducing Improper Payments and Eliminating Waste in Federal Programs*. In its FY 2010 quarterly reports on high-dollar improper payments, HHS did not report all identified high-dollar improper payments made by the Medicare Parts A and B programs. In addition, for Medicare Parts C and D, Head Start, and five State-administered programs, we were unable to determine whether the Department reported all high-dollar improper payments. As a result, HHS's quarterly reports were incomplete and cannot be used to adequately assess the level of risk of each of HHS's programs or to determine the extent of necessary oversight.

Recommendations—HHS should develop a comprehensive list of overpayments for all of its high-priority programs that takes into account each potential source of an improper payment and that can be analyzed to determine whether there are any high-dollar improper payments for the five State-administered programs that should be reported. *HHS Did Not Fully Comply With Executive Order 13520 When Reporting FY 2010 High-Dollar Improper Payments*. A-02-11-01007. July 2012. [Full Text](#).

Non-Federal Audits

In this semiannual period, OIG's National External Audit Review Center reviewed 1,328 reports covering \$2.23 trillion in audited costs. Federal dollars covered by these audits totaled \$812.1 billion, about \$349 billion of which was HHS money.

Office of Management and Budget (OMB) Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities must conduct annual organizationwide "single audits" of all Federal money they receive. These audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entities' management of Federal funds. OIG's oversight of non-Federal audit activity informs Federal managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs for resolution or followup.

We identify entities for high-risk monitoring, alert program officials to any trends that could indicate problems in HHS programs, and profile non-Federal audit findings of a particular program or activity over time to identify systemic problems. We also provide training and technical assistance to grantees and members of the auditing profession. OIG maintains a process to assess the quality of the non-Federal reports received and the audit work that supports the selected reports. The non-Federal audit reports reviewed and issued during this reporting period are categorized in the following table.

Table – Non-Federal Audits, October 1, 2011, Through March 31, 2012

OIG reports issued:	
Not requiring changes or having minor changes	1,219
Requiring major changes	101
Having significant technical inadequacies	8
Total	1,328

The 1,328 reports included 3,842 recommendations for improving management operations. In addition, these audit reports provided information for 40 special memorandums that identified concerns for increased monitoring by management.

Recovery Act Retaliation Complaint Investigations

Recovery Act Retaliation Complaint Investigation

Section 1553 of the Recovery Act prohibits non-Federal employers that have received Recovery Act funding from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds. Section 1553 also requires OIGs to include in their semiannual reports to Congress the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. During this reporting period, OIG discontinued one Recovery Act whistleblower retaliation complaint investigation. The complaint was against a private health care entity in the southeastern United States.

Contract Audits

The National Defense Authorization Act for FY 2008, § 845, requires each Inspector General appointed under the Inspector General Act of 1978 to submit, as part of the semiannual report submitted to Congress pursuant to section 5 of such Act, information on final, completed contract audit reports issued to the contracting activity containing significant audit findings issued during the period covered by the semiannual report concerned.

We found issues in two NIH contracts that potentially violated the Antideficiency Act or the bona fide needs rule. The Antideficiency Act prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by law. Details of the audits are provided in the NIH section (NIH's Compliance With Appropriation Laws).

- *Appropriations Funding for National Institute of Allergy and Infectious Diseases Contract N01-AI-30068 With PPD Development, LP.* A-03-10-03116. September 2012. [Full Text](#)
- *Appropriations Funding for National Institute of Allergy and Infectious Diseases Contract HHSN266-2005-00022C With PPD Development, LP.* A-03-10-03118. September 2012. [Full Text](#)

Legislative and Regulatory Reviews

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

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

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

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List of Appendixes

- Appendix A Cost Savings Supported by
OIG Recommendations (p. 71)
- Appendix B Questioned Costs and Funds To Be
Put to Better Use (p. 76)
- Appendix C Peer Review Results (p. 84)
- Appendix D Summary of Sanction Authorities
(p. 86)
- Appendix E Reporting Requirements (p. 89)
- Appendix F Anti-Kickback Statute—Safe Harbors
(p. 91)

<https://oig.hhs.gov>

Appendix A

Cost Savings Supported by OIG Recommendations

After laws involving Department of Health and Human Services (HHS) programs are enacted, the Office of Inspector General (OIG) analyzes them to identify provisions that were supported by our recommendations and the associated cost savings. A similar process occurs with respect to administrative changes implemented by HHS management through regulations or other directives.

The savings reported in this appendix generally reflect third-party estimates of funds made available for better use through reductions in Federal spending, deobligation of funds, and/or avoidance of unnecessary expenditures. To identify administrative savings, we use estimates developed by or in consultation with HHS operating or staff divisions.

To identify legislative savings, we use estimates that the Congressional Budget Office (CBO) prepares to inform Congress of the potential impact of legislation under consideration. CBO projects the annual increases and/or reductions in Federal spending that it expects would result from enacting legislation. Implemented legislative and administrative actions reflect not only OIG's recommendations, but also the contributions of others, such as HHS staff and operating divisions and the Government Accountability Office (GAO). Savings estimated for fiscal year (FY) 2012 that were supported by OIG recommendations totaled \$8,548 million (\$8.5 billion).

Centers for Medicare & Medicaid Services

OIG Recommendation	Implementing Action	Savings (millions)
Payment Reform for Part B Drugs and Biologicals. Reexamine drug reimbursement methodologies based on average wholesale price (AWP) with the goal of reducing payments in both Medicare and Medicaid. The recommendation relates to findings in the following OIG reports: OEI-03-96-00420 OEI-03-97-00290 OEI-03-00-00310 OEI-03-97-00293 A-06-00-00023 A-06-01-00053 A-06-02-00041	Sections 303 through 305 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) revised the current payment methodology for Part B-covered drugs and biologicals that were not paid on a cost or prospective payment basis. Since January 1, 2005, most drug prices have been based on the average sales price or competitive acquisition instead of AWP. CBO estimated savings of \$2.7 billion for FY 2012.	\$2,700

OIG Recommendation	Implementing Action	Savings (millions)
Medicare Secondary Payer. Ensure sufficient resources and contractor training for retroactively examining paid claims to identify other payer sources and initiating recovery action on all related overpayments. The recommendation related to findings in the following OIG reports: A-02-98-01036 A-04-92-02057 A-09-89-00162 A-10-86-62005	Section 301 of the MMA clarifies the Secretary’s authority to make certain reimbursable conditional payments and to take recovery actions against all responsible entities, including collection of damages, under Medicare Secondary Payer provisions. This section builds on other program improvements implemented by the Balanced Budget Act of 1997 (BBA), Omnibus Budget Reconciliation Act (OBRA) 1993, OBRA 1990, and OBRA 1989. CBO estimated savings of \$1.2 billion for FY 2012.	\$1,200
Clinical Diagnostic Laboratory Tests. Seek legislation to allow across-the-board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices that laboratories charge physicians in a competitive marketplace, and periodically evaluate the national fee schedule levels. The recommendation related to findings in the following OIG reports: A-09-89-00031 A-09-93-00056	Section 628 of the MMA froze annual updates for FY 2004 through FY 2008. This action builds on prior legislative actions in the BBA, OBRA 1993, OBRA 1990, and legislation in 1984 that were also responsive to OIG’s recommendations to curb excessive clinical laboratory test reimbursements by Medicare. CBO estimated savings of \$1.2 billion for FY 2012.	\$1,200
Medicare Home Health Payments. Reduce the Home Health Agency (HHA) update factor to account for the high error rate found in OIG’s review. The annual update was defined as the home health market basket percentage increase. The recommendation related to findings in OIG report number A-04-99-01194.	Section 701 of the MMA changed the updates of home health rates from fiscal year to calendar year beginning in 2004, with the update for the last three quarters of 2004 equal to the market basket increase minus 0.8 percent. CBO estimated savings of \$1 billion for FY 2012.	\$1 billion
Payments for Durable Medical Equipment. Take steps to reduce payments for a variety of durable medical equipment (DME) and related supplies. The recommendation related to findings in the following OIG reports:	Section 302 of the MMA froze payments for certain DME items, including prosthetics and orthotics, effective January 1, 2004. CBO estimated savings of \$900 million for FY 2012.	\$900

OIG Recommendation	Implementing Action	Savings (millions)
OEI-03-01-00680 OEI-03-02-00700 OEI-07-96-00221 OEI-03-96-00230 OEI-03-94-00021 OEI-06-92-00861 OEI-06-92-00866		
Payment for Services Furnished in Ambulatory Surgical Centers. Set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and establish parity among ambulatory surgical centers (ASC) and outpatient departments. The recommendation related to findings in the following OIG reports: OEI-05-00-00340 OEI-09-88-01003 A-14-98-00400 A-14-89-00221	Section 626 of the MMA limited the ASC update starting April 1, 2004, then froze updates for a period beginning the last quarter of FY 2005, effectively reducing the payment advantage to ASCs for those procedure codes that are paid at a higher rate for the surgical center compared to the rate for outpatient departments. Section 626 also mandated that CMS implement a new payment system that takes into account disparities in the costs of procedures performed in ASCs and in hospital outpatient departments. CBO estimated savings of \$500 million for FY 2012.	\$500
Additional Rebates for Brand-Name Drugs With Multiple Versions. OIG recommended that CMS continue to seek legislative authority to modify the rebate formula calculation to ensure that manufacturers cannot circumvent additional rebates by bringing new versions of existing brand-name drugs to market. The recommendation related to findings in OIG report number A-06-09-00033.	Section 2501(d) of the Patient Protection and Affordable Care Act (Affordable Care Act), as amended by section 1206(a) of the Health Care and Education Reconciliation Act of 2010, addresses this issue. CBO estimated savings of \$300 million for FY 2012.	\$300
Part B Drugs Average Sales Price. Adopt an alternate calculation of volume-weighted average sales price (ASP) that is consistent with the results set forth in section 1847A(b)(3) of the Social Security Act. The recommendation related to findings in OIG report number OEI-03-05-00310.	Section 112 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 establishes a revised method for calculating volume weighted average sales prices for Medicare Part B drugs that comports with OIG's recommendation. CBO estimated savings of \$200 million for FY 2012.	\$200

OIG Recommendation	Implementing Action	Savings (millions)
Capped Rental Durable Medical Equipment. Eliminate the semiannual maintenance payment allowed for capped rental DME, pay only for repairs when needed, eliminate the 15-month rental option, and convert rentals to purchases after the 13 th month. The recommendation related to findings in report number OEI-03-00-00410.	Section 5101 of the DRA revised the payment rules for capped rental DME to require that ownership of the item transfer to the beneficiary after the 13 th month and that Medicare pay for maintenance services on a cost-reimbursement basis. CBO estimated savings of \$200 million for FY 2012.	\$200
Medicaid Third Party Liability. Determine whether legislation is needed to explicitly include pharmacy benefit management companies in the Medicaid definition of a third party, require third parties to match their eligibility files with Medicaid's eligibility files, and allow Medicaid up to 3 years to recover payments from liable third parties. The recommendations related to findings in OIG report number OEI-03-00-00030.	Section 6035 of the DRA made several changes to strengthen Medicaid's third-party liability provisions, including clarification regarding pharmacy benefit managers. The section also includes requiring States to ensure that health insurers provide requested coverage data; accept the State's right of recovery; and agree, conditionally, not to deny a claim solely on the basis of date of submission of the claim when the claim is submitted by the State within a 3-year period beginning on the date of service. CBO estimated \$210 million in savings for FY 2012.	\$210
Medicare Secondary Payer. Implement stronger followup procedures for employers who fail to respond to data requests, exercise civil monetary penalty (CMP) authority, and seek necessary legislative authority for mandatory data reporting. The recommendations related to findings in the following OIG reports: A-02-98-01036 A-02-02-01037 A-02-02-01038 A-04-01-07002 A-09-89-00100	Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 amended the Medicare secondary payer provisions of the Social Security Act, § 1862(b), to provide for mandatory reporting for various categories. CBO estimated savings of \$100 million for FY 2012.	\$100
Rebates for Physician-Administered Drugs. Encourage States to take action to collect rebates on	Section 6002 of the DRA requires States to provide for the collection and submission of utilization data needed	\$15

OIG Recommendation	Implementing Action	Savings (millions)
physician-administered drugs, especially single-source drugs. States should either use National Drug Codes (NDC) instead of procedure codes or link procedure codes to NDCs for single-source drugs. The recommendations related to findings in OIG report number OEI-03-02-00660.	to secure rebates for physician-administered drugs and provides that the utilization data for single source and specified multiple-source physician-administered drugs be submitted using NDC numbers (unless the Secretary specifies an alternative coding system). CBO estimated savings of \$15 million for FY 2012.	

Administration for Children and Families

OIG Recommendation	Implementing Action	Savings (millions)
Triennial Reviews of Child Support Orders and Medical Support by Parents. Ensure that more periodic reviews are initiated and take action to increase medical support by parents. The recommendations related to findings in OIG report number OEI-05-98-00100.	Section 7302 of the DRA required States to adjust child support orders of families enrolled in the Temporary Assistance for Needy Families program every 3 years. CBO estimated savings of \$16 million for 2012. Section 7307 of the DRA requires States to assess the ability of either or both parents to provide medical support for their children. CBO estimated savings of \$7 million for FY 2012. The combined projected savings for FY 2012 is \$23 million.	\$23

Appendix B

Questioned Costs and Funds To Be Put to Better Use

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

Audit Reports With Questioned Costs

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

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

Table 1 follows.

Table 1 – Audit Reports With Questioned Costs

	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period ¹	191	\$726,372,000	\$50,411,000
Reports issued during the reporting period	147	\$404,576,000	\$11,215,000
Total Section 1	338	\$1,130,948,000	\$61,626,000
Section 2			
Reports for which management decisions were made during the reporting period ^{2,3}			
Disallowed costs	185	\$440,689,000*	\$1,398,000
Costs not disallowed	7	\$40,256,000	\$19,247,000
Total Section 2	192	\$480,945,000	\$20,645,000
Section 3			
Reports for which no management decisions had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	146	\$650,003,000	\$40,981,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance ⁴	45	\$376,988,000	\$29,766,000

* Audit receivables (expected recoveries).

Audit Reports With Funds Recommended To Be Put to Better Use

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

Table 2 – Audit Reports With Funds To Be Put to Better Use

	Number of Reports	Dollar Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period ¹	16	\$727,123,000
Reports issued during the reporting period	12	\$1,434,015,000
Total Section 1	28	\$2,161,138,000
Section 2		
Reports for which management decisions were made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	6	\$494,591,000
Based on proposed legislative action		
Value of recommendations not agreed to by management	3	\$155,000,000
Total Section 2	9	\$649,591,000
Section 3		
Reports for which no management decisions had been made by the end of the reporting period ² (Sec. 1 minus Sec. 2)	19	\$1,511,547,000

End Notes

Table 1 End Notes

¹ The opening balance was adjusted upward by \$21.6 million because of a reevaluation of previously issued recommendations.

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

- A-01-08-00505, Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006; A-01-08-00528, Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006; A-01-09-00503, Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007; and A-05-08-00022, Review of High-Dollar Payments for Services Processed by

Wisconsin Physicians Service for the Period January 1, 2004 Through December 31, 2006. CMS determined that it could not recoup disallowances totaling \$48,288,435 associated with these audits because Federal regulations at 42 CFR 405.980(b) prevented it from reopening claims beyond 4 years after the date of its initial determination.

- A-02-02-01009, *OIG's Partnership Plan – New York State Comptroller Report on Administration of the Medicaid Drug Rebate Program*. CMS increased its original disallowance by \$3.9 million to reflect additional drug rebate payments received.
- A-10-10-95482, *State of Oregon*. CMS reduced its original disallowance associated with this non-Federal audit by \$1,982,061 to reflect the full amount of questioned costs that were recovered.

Not detailed are net reductions to previously reported disallowances totaling \$1,832,095.

³ Included are management decisions to disallow \$118.6 million in questioned costs that were identified by non-Federal auditors in audits of State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards conducted in accordance with Office of Management and Budget (OMB) Circular A-133. By law, OIG is responsible for ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

⁴ Because of administrative delays, some of which were beyond management control, resolution of the following 45 audits was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations before the end of the next semiannual reporting period:

CIN: A-05-08-00098	REVIEW OF OHIO DEPARTMENT OF JOB AND FAMILY SERVICES CLAIMS FOR COSTS REPORTED BY THE HAMILTON COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, JAN 2011, \$58,987,755
CIN: A-03-07-00560	PA FOSTER CARE MAINTENANCE PAYMENTS - PHILADELPHIA - UNDER \$300, MAY 2008, \$56,513,439
CIN: A-09-06-00023	REVIEW OF LOS ANGELES COUNTY APPROVAL PROCESS OF RELATIVE FOSTER FAMILY HOMES, OCT 2009, \$45,520,603
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL-BASED HEALTH SERVICES - CT, MAY 2003, \$32,780,146
CIN: A-03-08-00554	AUDIT OF PENNSYLVANIA TITLE IV-E FOSTER CARE ALLEGHENY COUNTY, JAN 2011, \$28,307,142

CIN: A-02-08-01009	REVIEW OF MEDICAID ADMINISTRATIVE COSTS CLAIMED BY NEW JERSEY FOR STATE FISCAL YEARS 2005 AND 2006, MAR 2012, \$22,481,421
CIN: A-04-09-03524	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN GEORGIA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2011, \$22,212,932
CIN: A-01-10-00513	NATIONWIDE REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY PART B CONTRACTORS FOR CY 2008, SEP 2011, \$19,270,689
CIN: A-07-10-06004	REVIEW OF PART D DRUGS PRESCRIBED BY EXCLUDED PROVIDERS, DEC 2011, \$15,079,608
CIN: A-03-06-00564	PA FOSTER CARE MAINTENANCE PAYMENT - PHILADELPHIA - OVER \$300/DAY, DEC 2007, \$11,693,989
CIN: A-03-05-00550	AUDIT OF PA FOSTER CARE MAINTENANCE PAYMENTS - CASTILLE SAMPLE, SEP 2007, \$11,611,822
CIN: A-01-10-00516	NATIONWIDE REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY PART B CONTRACTORS FOR CY 2009, SEP 2011, \$9,498,443
CIN: A-03-09-00019	REVIEW OF MEMBERHEALTH'S 2006 AND 2007 DIRECT AND INDIRECT REMUNERATION REPORTS, OCT 2010, \$9,339,013
CIN: A-04-08-03521	AUDIT OF UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS IN TN FOR THE PERIOD OCTOBER 1, 1998 TO DECEMBER 31, 2007, FEB 2009, \$5,768,243
CIN: A-01-08-00511	REVIEW OF SEPARATELY BILLED CLINICAL LABORATORY SERVICES PROVIDED TO ESRD BENEFICIARIES BY FMCNA, MAR 2010, \$5,410,712
CIN: A-02-07-01050	REVIEW OF MEDICAID CONTINGENCY FEE CONTRACT WITH MAXIMUS – COMMUNITY MENTAL HEALTH PROVIDERS – RPT#1 NOV 2011, \$5,023,626
CIN: A-04-08-03523	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN FL FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2009, \$4,413,264

CIN: A-01-11-02500	REVIEW OF MASSACHUSETTS' TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, AUG 2011, \$4,242,540
CIN: A-07-11-03163	REVIEW OF CHILDCARE AND DEVELOPMENT TARGETED FUNDS IN IOWA, MAR 2012, \$2,654,238
CIN: A-06-08-00021	TX SUBRECIPIENT CDC BIOTERRORISM - CORPUS CHRISTI, DEC 2011, \$1,053,247
CIN: A-07-11-00366	REVIEW OF PENSION SEGMENTATION AT A TERMINATED DURABLE MEDICAL EQUIPMENT REGINAL CARRIER CONTRACTOR, HEALTHNOW NY, INC, MAR 2012, \$946,065
CIN: A-04-10-00067	A MEDICARE CONTRACTOR'S CLAIMED ADMINISTRATIVE COSTS WERE GENERALLY ALLOWABLE, MAR 2012, \$691,433
CIN: A-01-10-00014	MEDICAID PAYMENTS FOR SCHOOL-BASED HEALTH SERVICES IN MANCHESTER, NEW HAMPSHIRE - CYS 2006 - 2008, JAN 2012, \$494,738
CIN: A-01-11-02505	NEON - HEAD START LIMITED SCOPE REVIEW - ALLOCATING OF COSTS - ARRA, JAN 2012, \$406,434
CIN: A-06-06-00072	REVIEW OF COST FOR TEXAS MEDICAL FOUNDATION AUDITEE, MAY 2008, \$403,581
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, \$293,870
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MICHIGAN, AUG 2006, \$257,859
CIN: A-01-11-02508	REVIEW OF VERMONT'S TITLE IV-E ADMINISTRATIVE AND TRAINING COSTS, FEB 2012, \$242,233
CIN: A-01-11-02507	REVIEW OF GREAT LAWRENCE COMMUNITY ACTION COUNCIL, INC. RECOVERY ACT COSTS CLAIMED, MAR 2012, \$224,110
CIN: A-07-06-01035	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION - IOWA, OCT 2007, \$208,974
CIN: A-04-11-03538	HEAD START HIGH RISK GRANTEE - MOBILE COMMUNITY ACTION AGENCY, INC., DEC 2011, \$147,587

CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, \$124,046
CIN: A-04-07-01045	COSTS CLAIMED FOR ESRD NETWORK 6 OPERATIONS, AUG 2009, \$116,728
CIN: A-01-10-02503	RESULTS OF LIMITED SCOPE REVIEW AT COMMUNITY ACTION COMMITTEE OF DANBURY, INC., APR 2011, \$98,806
CIN: A-02-11-02000	DIRECT COST REVIEW - SUNY ALBANY, OCT 2011, \$80,439
CIN: A-03-08-00011	REVIEW OF DUPLICATE PAYMENTS TO PHARMACIES FOR MEDICARE PART D DRUGS (PDE-DEMO): BARON DRUGS, SEP 2009, \$79,489
CIN: A-02-06-01023	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION - NEW YORK, MAR 2008, \$77,358
CIN: A-09-06-00039	MEDICARE INTEGRITY - AUDIT OF QUALITY IMPROVEMENT ORGANIZATION - WASHINGTON STATE, FEB 2008, \$73,636
CIN: A-06-11-00035	RECIPIENT CAPABILITY AUDIT OF THE GALVESTON COUNTY COMMUNITY ACTION COUNCIL, INC., OCT 2011, \$34,700
CIN: A-04-06-00023	REVIEW OF QUALITY IMPROVEMENT ORGANIZATIONS - TENNESSEE, JUL 2008, \$30,654
CIN: A-08-03-73541	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JAN 2003, \$28,573
CIN: A-03-10-03110	CONTRACT HHSN267-2007-00014C, OCT 2011, \$27,707
CIN: A-08-04-76779	COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, \$18,925
CIN: A-05-06-00043	REVIEW OF OHIO KEPRO, INC., FEB 2008, \$11,874
CIN: A-01-11-00005	REVIEW OF MEDICAID HOSPICE PAYMENTS MADE BY RHODE ISLAND, MAR 2012, \$5,748

TOTAL NUMBER OF REPORTS: 45

TOTAL AMOUNT: \$376,988,439

Table 2 End Notes

¹The opening balance was adjusted downward by \$16.5 million because of reevaluation of previously issued recommendations.

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

CIN: A-01-10-02501 REVIEW OF 83 EARLY HEAD START APPLICANTS UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT, NOV 2011, \$31,000,000

CIN: A-05-05-00033 UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MI, AUG 2006, \$4,397,133

CIN: A-04-09-03524 REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN GEORGIA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2011, \$2,842,653

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

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

TOTAL NUMBER OF REPORTS: 5

TOTAL AMOUNT: \$38,285,790

Appendix C

Peer Review Results

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

Office of Audit Services Peer Review Results

During this semiannual reporting period, two peer reviews involving the Office of Audit Services (OAS) were completed.

OAS	Date	Reviewing Office	Office Reviewed
	June 2012	Department of Homeland Security	HHS OIG, OAS

The system of quality control for the audit organization of HHS OIG in effect for the year ending September 30, 2011, has been suitably designed and complied with to provide HHS OIG with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Federal audit organizations can receive a rating of pass, pass with deficiencies, or fail. HHS OIG received a peer review rating of pass.

OAS	Date	Reviewing Office	Office Reviewed
	May 2012	HHS OIG, OAS	U. S. Environmental Protection Agency (EPA)

The system of quality control for the audit organization of EPA OIG in effect for the year ending September 30, 2011, has been suitably designed and complied with to provide EPA OIG with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Federal audit organizations can receive a rating of pass, pass with deficiencies, or fail. EPA OIG received a peer review rating of pass.

Office of Investigations Peer Review Results

During this semiannual reporting period, the U.S. Postal Service (USPS) Office of Inspector General conducted a peer review of HHS OIG's Office of Investigations (OI). OI did not conduct a peer review of another OIG during this reporting period. Listed below is information concerning OI's peer review activities during this and prior reporting periods.

OI	Date	Reviewing Office	Office Reviewed
	August 2012	USPS-OIG	HHS-OIG, OI

The system of internal safeguards and management procedures for the investigative function of HHS-OIG in effect for the year ending September 30, 2012, were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

OI	Date	Reviewing Office	Office Reviewed
	July 2011	HHS-OIG, OI	DoD-OIG

The system of internal safeguards and management procedures for the investigative function of DoD-OIG in effect through July 2011 were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

OI	Date	Reviewing Office	Office Reviewed
	January 2011	HHS-OIG, OI	Department of Housing and Urban Development (HUD) OIG

The system of internal safeguards and management procedures for the investigative function of HUD-OIG in effect through February 2011 was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Appendix D

Summary of Sanction Authorities

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

Program Exclusions

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

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

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

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

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) of the Social Security Act, 1128A (42 U.S.C. § 1320a-7a), imposes penalties, assessments, and exclusion from participation in Federal health care programs for engaging in certain activities. For example, a person who submits, or causes to be submitted, to a Federal health care program a

claim for items and services that the person knows or should know is false or fraudulent is subject to a penalty of up to \$10,000 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion.

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

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

Patient Dumping

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

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

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

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

The Anti-Kickback Statute – 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 an entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Federal health care programs or (2) purchasing; leasing; ordering; or arranging for or recommending the purchasing, leasing, or ordering of any good, facility, service, or item payable under the Federal health care programs of the Social Security Act, § 1128B(b) (42 U.S.C. § 1320a-7b(b)).

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

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

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

Appendix E

Reporting Requirements

The Inspector General Act of 1978

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

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

Section	Requirement	Location
	management decisions	
(a)(12)	Management decisions with which the Inspector General disagrees	None
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	Reported annually in the spring <i>Semiannual Report to Congress</i> , Other HHS-Related Reviews section
(a)(14)-(16)	Results of peer reviews of HHS-OIG conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by HHS OIG of other OIGs.	Appendix C

Other Reporting Requirements

Section	Requirement	Location
845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for fiscal year 2008 (P.L. No. 110-181), § 845.	Other HHS-Related Reviews section
205	Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) (P.L. No. 104-191), § 205, the Inspector General is required to solicit proposals annually via a <i>Federal Register</i> notice for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b), and for developing special fraud alerts. The Inspector General is also required to report annually to Congress on the status of the proposals received related to new or modified safe harbors.	Reported annually in the fall <i>Semiannual Report</i> . Appendix F
1553	Pursuant to the American Reinvestment and Recovery Act of 2010, § 1553, OIG reports to Congress the retaliation complaint investigations it decided not to conduct or continue during the period.	Other HHS-Related Reviews section

Appendix F

Anti-Kickback Statute—Safe Harbors

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

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

Public Proposals for New and Modified Safe Harbors

In response to the 2011 annual solicitation, OIG received the following proposals related to safe harbors:

Proposal	OIG Response
New safe harbor protecting remuneration associated with the distribution of durable medical equipment by physicians who have been certified by the American Board of Sleep Medicine to Medicare patients for use in the treatment of obstructive sleep apnea and a corresponding waiver of the application of the physician self-referral law.	OIG is not adopting the suggestion to promulgate a new safe harbor. The arrangements described are subject to abuse and should be evaluated on a case-by-case basis, such as under the advisory opinion process. Development of a physician self-referral law regulatory exception or waiver is beyond OIG's scope of authority.
Modify the safe harbor for EHR arrangements to remove the sunset provisions and make it a permanent safe harbor.	OIG is considering whether to extend the sunset date.

Proposal	OIG Response
New safe harbor protecting free continuing medical education programs offered by hospitals to physicians.	OIG is not adopting this suggestion. The concept of “free programs” could vary greatly and should be addressed on a case-by-case basis, such as under the advisory opinion process.
New safe harbor protecting certain motivational incentives offered to patients by Federally Qualified Health Centers (FQHCs) or FQHC look-alikes to either encourage patients to obtain medically necessary treatment, reward compliance with a treatment plan, or reward achievement of treatment-related goals.	OIG is considering this suggestion.
Modify the safe harbor for referral services to allow payments to entities serving as referral services to be based on the volume or value of referrals with respect to patients seeking dental services.	OIG is not adopting this suggestion. The arrangement described poses a risk of abuse under the anti-kickback statute and should be evaluated on a case-by-case basis, such as under the advisory opinion process.
Modify the safe harbor for waiver of beneficiary coinsurance and deductible amounts to extend protection to reductions or waivers offered to American Indians and Alaskan Natives (AI/ANs) eligible for Indian Health Service services.	OIG is considering modifying this safe harbor or proposing a new safe harbor to address the concerns described in this proposal.
New safe harbor protecting exchanges or transfers of value among Indian health care providers; transfers of value from an Indian health care provider to an AI/AN eligible for or receiving services from that provider; arrangements for the exchange, transfer, or sharing of medical care facilities and resources between an Indian health care provider and other health care providers; and certain transfers of goods, items, services, donations, or loans from an individual or entity to an Indian health care provider.	OIG is considering whether to promulgate a safe harbor that would address the concerns described in this proposal.