



Semiannual Report

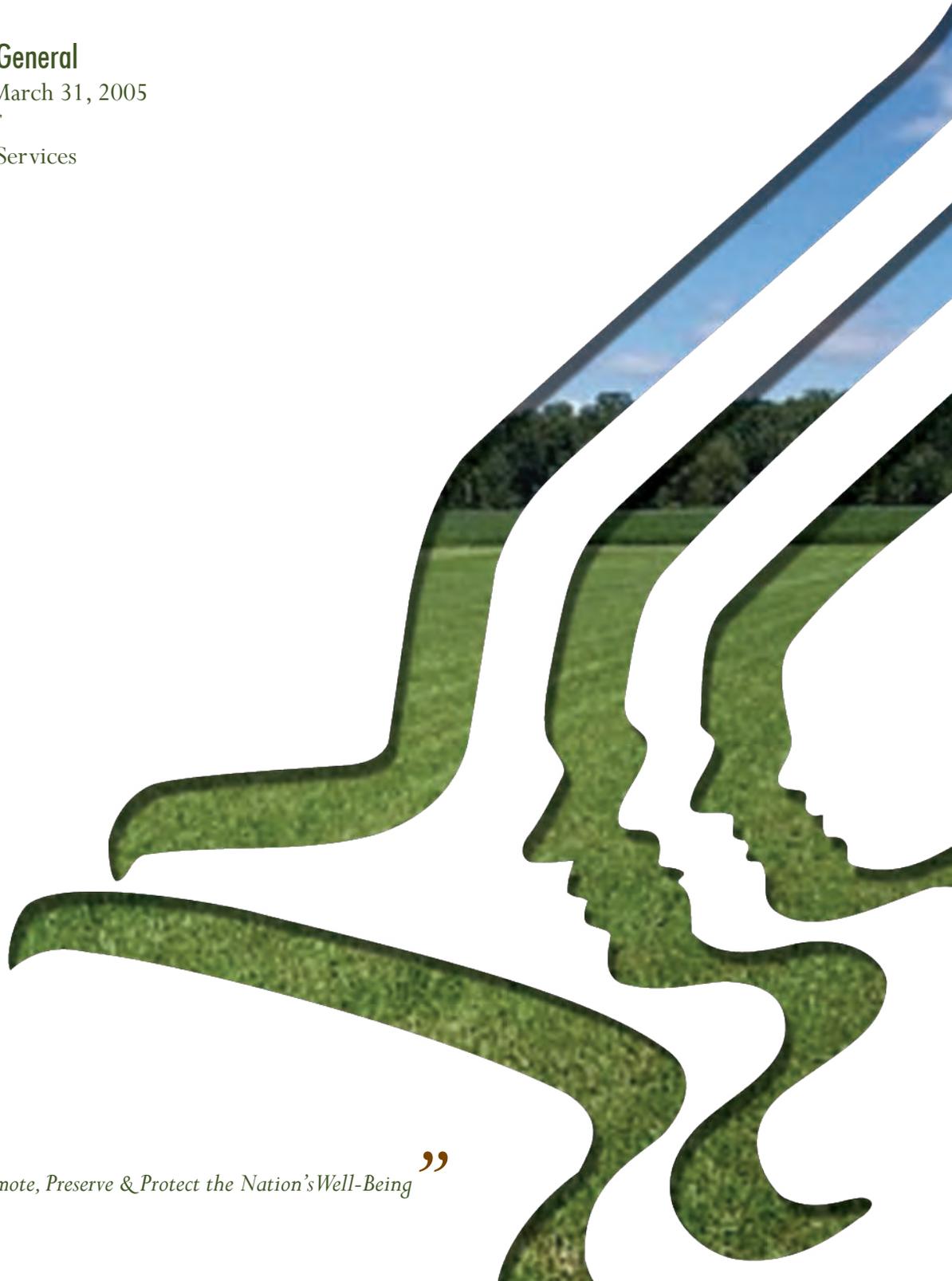
The complete Semiannual Report to Congress is also on the Internet at <http://oig.hhs.gov>

Office of Inspector General

October 1, 2004 - March 31, 2005

U.S. Department of

Health and Human Services



“ *Working Together to Promote, Preserve & Protect the Nation's Well-Being* ”

Office of Inspector General Components

OAS

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

OI

Office of Investigations conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries. Investigative efforts lead to criminal convictions, civil judgements and settlements, administrative sanctions, and/or civil monetary penalties. OI serves as liaison to the Department of Justice on all matters relating to investigations of HHS programs and personnel.

OEI

Office of Evaluation & Inspections conducts short-term management and program evaluations that focus on issues of concern to the Department, the Congress, and the public. OEI generally focuses on programs with significant expenditures of funds and services to program beneficiaries or in which important management issues have surfaced. The findings and recommendations contained in the reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. In addition, OEI oversees State Medicaid Fraud Control Units that investigate and prosecute fraud and patient abuse in the Medicaid program.

OCIG

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

OMP

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

Message from the Inspector General

I am pleased to present this semiannual report, which outlines the activities and accomplishments of the Department of Health and Human Services (HHS) Office of Inspector General (OIG) for the 6-month period ending March 31, 2005.

OIG is responsible for protecting the integrity of HHS programs, as well as the health and welfare of beneficiaries of those programs. This office provides the Secretary and program managers with objective and independent findings and recommendations to improve program efficiency and effectiveness. OIG also undertakes investigations to identify and hold accountable those who defraud HHS programs and beneficiaries.

These responsibilities have expanded with enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which establishes a voluntary drug benefit program for Medicare's 41 million beneficiaries and modifies the prices of drugs currently paid by Part B of the Medicare program.

To fulfill the specific responsibilities mandated by Congress to OIG in the area of pharmaceuticals, work is underway to monitor market prices and trends of Medicare-covered drugs, audit drug manufacturers' prices, establish a safe harbor related to the electronic transmission of drug prescriptions, assess the effects of Medicare payment rates on the availability of hematology and oncology drugs, and study prices of drugs included in the end stage renal disease composite rate.

In addition to providing new responsibilities under MMA in the prescription drug area, Congress also directed OIG to review payment methods for training residents in nonhospital settings, and to assess notices to beneficiaries relating to hospital lifetime reserve days. OIG already has met the statutory deadlines for this work and is planning additional projects as part of its commitment to prudent oversight of the new law.

At the same time, OIG has continued its important work in other areas, with accomplishments including multi-million dollar recoveries from investigations of pharmaceutical companies as well as reviews of State Medicaid financing arrangements that revealed issues with multi-billion dollar implications.

The achievements of this office would not be possible without the dedication and professionalism of all OIG employees. I am confident that this organization will continue to produce high quality work that has a significant and positive impact on the vital programs and operations of this Department.



Daniel R. Levinson
Acting Inspector General

Highlights

For the first half of fiscal year (FY) 2005, the Office of Inspector General (OIG) reported savings and expected recoveries of nearly \$17 billion: \$15.6 billion in implemented recommendations and other actions to put funds to better use, \$266 million in audit receivables, and \$1.1 billion in investigative receivables. (Details pp. [32-33](#), [35](#), and [39-42](#))

Also for this reporting period, OIG reported exclusions of 1,695 individuals and entities for fraud or abuse of Federal health care programs and/or their beneficiaries; 258 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 105 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. (Details pp. [11-14](#))

Significant Investigative Results

Gambro Healthcare, Inc.

Gambro Healthcare, Inc., owner and operator of renal dialysis clinics across the United States, agreed to pay over \$350 million in fines and penalties and entered a comprehensive corporate integrity agreement with OIG. The global settlement resolved civil and criminal allegations of health care fraud in the Medicare, Medicaid, and TRICARE programs. As part of the global resolution, Gambro agreed to pay \$310.5 million to resolve its civil liability and must allocate \$15 million to resolve potential liability with various State Medicaid programs. In addition to the civil settlement, Gambro Supply Corporation, a wholly owned subsidiary of Gambro, agreed to plead guilty to health care fraud, pay a \$25 million criminal fine, and be permanently excluded from Medicare and other Federal health care programs. (Details p. [14-15](#))

Schering-Plough Corporation

As part of a global settlement, Schering-Plough Corporation agreed to pay \$345.5 million and entered a 5-year corporate integrity agreement with OIG. Of this amount, \$293 million resolves Schering-Plough's civil and administrative liabilities in connection with alleged illegal and fraudulent pricing of its allergy drug Claritin under the Medicaid drug rebate program. In addition, the Schering Sales Corporation, a Schering-Plough subsidiary, pled guilty to a kickback charge and was sentenced to pay a \$52.5 million criminal fine for paying a kickback of almost \$2 million to keep Claritin on an HMO formulary. (Details p. [15](#))

PharMerica

In the largest OIG settlement of a civil monetary penalty kickback action, PharMerica, Inc., and PharMerica Drug Systems, Inc., (collectively, PharMerica) agreed to pay more than \$5.9 million to settle allegations that it paid unlawful kickbacks in connection with its purchase of a small Virginia pharmacy. PharMerica, a leading supplier of pharmacy services to long term care institutions, allegedly overpaid for the pharmacy in return for a commitment from the seller, who also owned 17 nursing homes, to refer its Medicare and Medicaid pharmacy business to PharMerica for 7 years. PharMerica also entered a 5-year corporate integrity agreement. (Details p. [13](#))

State Financing Mechanisms

A Review of Nursing Homes in Three States

OIG continues to review intergovernmental transfers of funds, a mechanism that some States use to maximize Federal Medicaid reimbursement. In a series of reviews, OIG studied the impact of this mechanism on three public nursing homes in the States of New York, Tennessee, and Washington. OIG found that the initial Medicaid payments made to the nursing homes were adequate to cover the facilities' Medicaid-related costs. However, because the States and/or counties required the facilities to return 90 to 96 percent of the facilities' enhanced funding (financial support in addition to the per diem payments), the nursing homes' net retained funding did not meet their operating costs. Over a 3-year period, the funding deficits at the facilities ranged from \$290,000 to \$25 million, which may have affected the quality of care at the facilities. In each of these cases, the Federal Government contributed all or almost all of the nursing homes' Medicaid funding, contrary to the Medicaid principle of Federal-State cost sharing. (Details p. [9](#))

Department Financial Statement Audit

Clean Opinion for Sixth Consecutive Year

For the sixth consecutive year, the Department received a clean opinion on its financial statement. However, auditors noted two continuing material weaknesses: deficiencies in the Department's financial systems and processes for producing financial statements, and inadequate internal controls over Medicare information systems. Material weaknesses are systemic problems that cut across a number of operating divisions or those of significant dollar amounts that affect an individual division. (Details p. [30](#))

Medicaid Fraud Control Units

A Year of Exceptional Achievement

Currently, 48 States and the District of Columbia have Medicaid Fraud Control Units (MFCUs), which investigate and prosecute (or refer for prosecution) providers charged with defrauding the Medicaid program or abusing or neglecting patients. In FY 2004, OIG provided oversight for and administration of approximately \$131 million in Federal grants to the units.

FY 2004 was a year of exceptional achievement for the 49 MFCUs. Collectively, they obtained a total of 1,160 convictions and recovered over \$572 million—more than double the \$268 million recouped in FY 2003. Most of the FY 2004 recoveries are attributable to global settlements reached with pharmaceutical companies, but the cases covered the gamut of fraud perpetrated against the Medicaid program, including billing for services not rendered, upcoding claims to indicate higher levels of service than provided, and other types of fraud. (Details p. [19](#))

Industry Guidance

Supplemental Compliance Program Guidance for Hospitals

OIG published a Supplemental Compliance Program Guidance (CPG) for Hospitals, which supplements OIG's original compliance guidance issued in 1998. The Supplemental CPG, together with the original guidance, is voluntary guidance designed to help hospitals and hospital systems prevent fraud, waste,

and abuse by promoting a high level of ethical and lawful corporate conduct. The Supplemental CPG includes an expanded risk section that highlights areas of significant risk for hospitals and offers guidance designed to help hospitals identify potential problems. In addition, the Supplemental CPG sets forth practical questions that hospitals can use to gauge the effectiveness of their compliance programs. (Details p. [10](#))

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

OIG continues to work on a variety of projects generated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known as the Medicare Modernization Act or MMA). This statute provided supplemental funding to OIG to handle substantial new oversight responsibilities including the following two mandated reports completed in this semiannual period:

Training Medical Residents in Nonhospital Settings

Teaching hospitals are permitted to count the time medical residents spend training in approved programs in nonhospital settings as long as the hospitals pay all or substantially all of the training costs. Because supervisory physicians in nonhospital settings often volunteer their time, it is difficult to determine actual costs. This report described five alternative methods for paying these training costs. OIG recommended that the Centers for Medicare & Medicaid Services (CMS) and Congress work together to analyze the current financial arrangements among teaching hospitals, nonhospital settings, and supervisory physicians; study the impact of any revisions to the current policy; and clarify the definition of “all or substantially all” of the training costs in nonhospital settings. (Details p. [2](#))

Medicare Lifetime Reserve Days

Medicare beneficiaries are entitled to coverage of 90 days of inpatient hospital care during any episode of an illness. If they need more care, the beneficiaries are eligible for 60 nonrenewable days of hospital care, called lifetime reserve days (LRDs). In this study, OIG found that 86 percent of hospitals provided written and/or verbal notices to beneficiaries who have used or will use 90 days of benefits, and that 8 percent of hospitals do not provide any information about LRDs. Beneficiaries said that the LRD election is confusing and does not affect their decisions about their care, and hospitals and beneficiaries both agreed that an additional notice would not be feasible or appropriate. In response to this OIG report, CMS will issue written clarification to hospitals to explain the LRD benefit. (Details p. [2](#))

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Centers for Medicare & Medicaid Services

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

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

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

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

CMS-Related Reports

Medicare Payment Methodologies for Training Medical Residents in Nonhospital Settings

This report, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), presented alternative Medicare payment methodologies for the costs of training medical residents in nonhospital settings. The Balanced Budget Act of 1997 allowed teaching hospitals to count the time residents spent training in approved programs in nonhospital settings for Medicare direct and indirect graduate medical education payments as long as the hospitals paid all or substantially all of the training costs. Determining the actual costs of the training programs has been difficult because supervisory physicians in nonhospital settings often volunteer their time; that is, they do not bill for the time spent supervising residents.

In the report, OIG described five alternative methodologies for paying the training costs of such residents. Each of the five payment options has positive and negative aspects.

OIG recommended that CMS work with Congress to (1) analyze the current financial arrangements and incentives among teaching hospitals, nonhospital settings, and supervisory physicians in nonhospital settings; (2) study the potential impact of any revisions to the current policy; and (3) clarify the definition of “all or substantially all” of the costs associated with training residents in nonhospital settings. OIG also recommended that CMS work with Congress to extend a moratorium in place for calendar year 2004 to allow teaching hospitals to continue to claim Medicare reimbursement for osteopathic and allopathic family practice residents who train in nonhospital settings without regard to the financial arrangements between the hospitals and the supervisory physicians who practice at those settings. (A-02-04-01012)

Medicare Lifetime Reserve Days

This report, required by MMA, focused on lifetime reserve days (LRDs). Medicare beneficiaries are entitled to coverage of 90 days of inpatient hospital care during any spell of illness. If they need more care, the beneficiaries are eligible for 60 nonrenewable days of inpatient hospital care, called LRDs.

In a survey, OIG found that 86 percent of hospitals surveyed provide written and/or verbal notices to beneficiaries who have used or will use 90 days of benefits. Eight percent of hospitals that reported that they do not notify beneficiaries about LRDs indicated that they lacked timely information about the number of LRDs beneficiaries have available. While 64 percent of hospitals believed that a second notice could be helpful, 66 percent said an additional notice would affect operational costs and staff time. For their part, beneficiaries stated that the LRD election is confusing and does not affect their decisions about their care. Hospitals and beneficiaries agree that an additional notice may not be appropriate or feasible.

In response to this OIG report, CMS will issue guidance to hospitals to clarify the LRD benefit. (OEI-09-04-00100)

Fiscal Year 2004 Hospital Payment Monitoring Program

The Hospital Payment Monitoring Program (HPMP) determines the Medicare fee-for-service paid claims error rate for inpatient acute care hospital services. For fiscal year (FY) 2004, HPMP contractors generally had appropriate controls to ensure that admission-necessity and diagnosis-related group (DRG) validation screenings and quality control reviews were performed in accordance with established procedures. Although the methodology for calculating the net error amounts was inaccurate for some of the claims that OIG reviewed, those inaccuracies were not significant in relation to the projection of erroneous Medicare payments for FY 2004.

OIG recommended that CMS direct the HPMP contractors to use the most current standard pricing information to calculate error amounts for DRGs revised by quality improvement organizations. CMS agreed with this recommendation. (A-03-04-00008)

Fiscal Year 2004 Comprehensive Error Rate Testing Program

The Comprehensive Error Rate Testing (CERT) program determines the Medicare fee-for-service paid claims error rate for Medicare services other than inpatient acute care hospital services. This review determined that the CERT contractor generally had appropriate controls in place to ensure that medical reviews were performed in accordance with established procedures and that the results of those reviews were adequately maintained, updated, and reported. However, the quality assurance program did not provide full assurance of the reliability of the claims review process. The CERT contractor completed only 984 of the required 2,587 FY 2004 quality assurance reviews by July 30, 2004. Personnel from CERT stated that because of an overwhelming backlog of initial medical record reviews, management reallocated resources to complete those reviews and delayed the completion of the required quality assurance reviews.

OIG recommended that CMS direct the CERT contractor to schedule and complete the required number of quality assurance reviews throughout the year. CMS officials agreed with the recommendation. (A-03-04-00007)

Providers' Responsiveness to Requests for Medical Records

In developing the FY 2003 CERT portion of the Medicare payment error rate, CMS experienced a significant problem because many providers did not respond to requests for medical records. The FY 2004 review of the error rate process found that nonresponses had been reduced to less than 1 percent of the total number of claims in the sample. The most common reasons for nonresponse that providers cited were that they did not receive request letters, had already provided the documentation, or did not have access to their records.

CMS concurred with OIG's recommendations to further enhance its process for ensuring the timely receipt of medical records. (A-01-04-00517)

Hospital Wage Data Used To Calculate Inpatient Prospective Payment System Wage Indices

Under the acute care hospital inpatient prospective payment system, the Medicare base rate paid to participating hospitals includes a labor-related share. To reflect labor cost variations among localities, CMS adjusts the labor-related share by the wage index applicable to the metropolitan statistical area in which the hospital is located. The wage index values are based on wage data that hospitals include on their Medicare cost reports.

An audit of a hospital in Massachusetts disclosed that the facility overstated its wage data by \$4.2 million for the FY 2000 cost report period. As a result, the FY 2004 wage index for the hospital and the two other hospitals in this metropolitan statistical area was overstated by 1.1 percent, and the average payment to the two other hospitals was overstated by about \$46 per hospital discharge.

OIG recommended that the hospital strengthen financial reporting controls to ensure that the wage data reported on its Medicare cost reports are accurate, supported, and in compliance with Medicare regulations. The hospital concurred. (A-01-04-00501)

Managed Care Payments

Medicare+Choice (redesignated as Medicare Advantage) organizations (MCOs) are responsible for providing all Medicare-covered services, except hospice care, to enrollees in return for a predetermined capitation payment. MCOs with plans for which payment rates increased under the Benefits Improvement Protection Act (BIPA) of 2000 were required to use additional amounts to reduce beneficiary premiums or cost-sharing, enhance benefits, contribute to a stabilization fund for benefits in future years, or stabilize or enhance beneficiary access to providers. In this report, OIG found that of the \$17 million capitation payment increase to one MCO, \$12.5 million was used in a manner consistent with BIPA requirements and was properly supported. However, the MCO could not document, nor could OIG determine, how much of the remaining \$4.5 million in estimated increased fee-for-service costs met BIPA requirements. Also, the MCO could not support the estimated \$4.5 million increase in fee-for-service costs in its revised proposal.

OIG recommended that the MCO work with CMS to determine how much of the \$4.5 million increase in fee-for-service costs was used in a manner consistent with BIPA requirements. Funds not so used should be refunded to CMS or, as an alternative, deposited in a benefit stabilization fund for use in future years. OIG also recommended that the MCO ensure that estimated costs in future proposals are properly supported. The MCO disagreed with the report's findings and recommendations. (A-09-03-00051)

Medicare Contractor Pensions

Since its inception, Medicare has paid a portion of Medicare contractors' annual contributions to their pension plans. CMS requires that contractors separately identify the pension assets for the Medicare segment of their activities.

In one report, OIG reviewed an insurance company in Texas that processed and paid Medicare fee-for-service claims until its contractual relationship with CMS was terminated. OIG found that the company had claimed \$6 million in unallowable costs for Medicare reimbursement. Contrary to requirements, the claim represented an unauthorized retroactive change in accounting practice, did not appropriately amortize the transition obligation, and sought reimbursement for deposits made to a revocable trust fund. The company did not agree with OIG's recommendation to withdraw its claim for the \$6 million. (A-07-03-03040)

Two other reports noted that a contractor in Florida had understated Medicare segment assets by \$1.3 million, had not implemented a prior OIG recommendation to increase those assets, and had understated accumulated allowable pension costs by \$2.3 million. The contractor agreed with OIG's recommendations to increase the Medicare segment assets by \$1.3 million, increase

accumulated allowable pension costs by \$2.3 million, and implement procedural controls. (A-07-04-00172; A-07-04-00179)

Revenue from Vendors at Group Purchasing Organizations and Their Members

Group purchasing organizations (GPOs) are buying consortiums designed to leverage the purchasing power of their members, primarily hospitals and other health care providers, and to allow the members to obtain discounts on medical supplies. In exchange for administrative services and the ability to sell through a GPO to its members, vendors pay administrative fees to GPOs.

The three GPOs reviewed collected \$1.8 billion in administrative fee revenue during the audit period. Of this amount, \$1.3 billion represented net revenue in excess of operating costs. The GPOs retained \$415 million and distributed the remaining \$898 million to members. OIG reviewed how 21 members, who received \$255 million of the \$898 million distributed, accounted for the net revenue distributions. In total, the 21 members offset on their Medicare cost reports \$200 million of the \$255 million of the net revenue distributed by the GPOs. OIG also reviewed how the members offset rebates totaling \$285 million received directly from vendors or passed from vendors through the GPOs. Seven of the 21 members did not offset rebates totaling about \$3 million.

OIG recommended that CMS provide specific guidance on the proper Medicare cost report treatment of net revenue distributions received from GPOs and remind institutional providers that all rebates from vendors must be shown as credits on their Medicare cost reports. CMS agreed to address the recommendations through frequently asked questions, emphasizing to providers that Medicare policy requires discounts, allowances, rebates, and refunds to be offset on cost reports and that this policy applies to offsets of net revenue distributions to GPO members. (A-05-03-00074)

Applying the National Correct Coding Initiative to Medicaid Services

OIG studied whether State Medicaid agencies apply CMS's National Correct Coding Initiative (CCI), a set of automated edits used to evaluate Medicare or Medicaid claim submissions when a provider bills more than one service for the same beneficiary and same date of service.

Although use of the CCI edits is mandatory in the Medicare program, State Medicaid agencies are not required to use these edits in processing their claims. In a 2003 survey of all State Medicaid agencies, OIG found that most States do not use the Medicare CCI edits. In fact, only seven States use all or some of these CCI edits. Our review of the 2001 claims data that were available for 39 State Medicaid agencies found that these States paid \$54 million for services that would have been detected and denied based on the CCI edits.

Because using these edits would promote correct coding by providers and reduce improper Medicaid expenditures, OIG recommended that CMS encourage States to consider using Medicare CCI edits in their Medicaid programs. CMS concurred with the recommendation. (OEI-03-02-00790)

Upper-Payment-Limit Calculations

The upper payment limit (UPL) is an estimate of the amount that would be paid for Medicaid services under Medicare payment principles. Earlier OIG reports identified situations where States were able—consistent with UPL regulations—to effectively lower State and local expenditures and yet receive increased Federal matching payments. As a result of these abuses, revised UPL regulations

created transition periods in which eligible States were allowed to make payments up to the UPL for a specific category of providers, such as non-State government facilities, plus an excess amount that must not increase during the transition period. As part of a multistate initiative that CMS requested, OIG issued three reports on UPL calculations:

- **Kansas** – Kansas followed Federal regulations and its State plan amendment when calculating the category-specific UPL for non-State government nursing homes. Contrary to Federal regulations, however, Kansas increased the excess amount during its transition period. As a result, Kansas overclaimed expenses by more than \$58.3 million (\$35 million Federal share) for the period April 1, 2001, through September 30, 2002.

OIG recommended that Kansas reduce claimed expenses on its quarterly expenditure reports by \$58.3 million, and Kansas agreed to do so. (A-07-03-02672)

- **Oregon** – Oregon did not calculate the State FYs 2002 and 2003 UPLs for non-State government nursing homes in accordance with Federal regulations and its approved State plan amendments. Instead, Oregon calculated UPLs that combined non-State government and private facilities. A change in Oregon’s calculation method caused an increase in the excess amount during the transition period. As a result, Oregon’s payments to nursing homes exceeded the UPLs by more than \$230.5 million (\$137.2 million Federal share). In addition, Oregon’s estimated Medicaid payments for 2004 and 2005 could exceed projected UPLs by \$76.3 million (\$45.9 million Federal share).

OIG recommended that Oregon reduce claimed expenses on its quarterly expenditure reports by \$230.5 million and calculate UPLs in accordance with Federal regulations to prevent future Federal overpayments of \$45.9 million. Oregon partially agreed with the first recommendation and fully agreed with the second. (A-09-03-00055)

- **Oregon** – Oregon’s calculations of the UPLs for non-State government inpatient hospitals generally complied with Federal regulations and its State plan amendment. However, Medicaid payments exceeded the UPLs by \$5.7 million (\$3.4 million Federal share) because Oregon applied a UPL rule before its effective date, did not refund a Medicaid overpayment, and used outdated Medicare rates in its UPL calculations. In addition, Oregon could not ensure that disproportionate share hospital (DSH) payments made to one hospital complied with Federal law and the State plan amendment.

OIG recommended that Oregon refund the \$3.4 million overpayment and improve its procedures for calculating UPLs and DSH limits. While the State did not concur with the recommended refund, it agreed to make procedural improvements. (A-09-04-00023)

Medicaid School-Based Health Services

A 1988 amendment to the Social Security Act allows Medicaid coverage of school-based health services for children with disabilities or special needs. During this reporting period, OIG conducted three reviews to determine whether claims for school-based services were allowable for Federal reimbursement.

- **Maine** – The State did not follow Federal regulations when it processed retroactive claims for Medicaid school-based health services. The State did not incur an expenditure because it did not

remit the Federal share received for these claims to the school districts. Rather, the State deposited the Federal share in the State's general fund. As a result, the State was overpaid \$8.8 million in Federal funds. The State made a subsequent adjustment of almost \$5.8 million to reduce the overpayment. However, the State's overpayment remains at \$3 million.

OIG recommended that Maine refund the \$3 million and ensure that it properly refunds the Federal share for uncashed or voided checks in accordance with Federal requirements. While the State did not agree to repay the overpayment, it agreed to improve its procedures for processing claims. (A-01-04-00004)

- **Massachusetts** – As a result of inadequate guidance and monitoring by the State, five of eight local education agencies reviewed did not accurately allocate administrative costs to reflect relative Medicaid benefits received. As a result, these agencies overstated their claims by almost \$5 million. Also, one of the eight agencies double-counted salaries and fringe benefits when identifying costs to be allocated, resulting in an overstatement of \$360,000.

OIG recommended that Massachusetts, in addition to making financial adjustments, provide technical assistance to ensure that local education agencies strengthen internal controls over how they compute their Medicaid share percentages and implement a monitoring system to ensure that local education agencies properly calculate claims for Medicaid reimbursement. The State agreed to make procedural improvements but did not agree to refund the entire overpayment (A-01-02-00016)

- **Vermont** – Vermont and its school districts did not have controls in place to ensure that services billed were accurate and in accordance with children's individualized education plans. On the basis of a statistical sample, OIG estimated that the State improperly claimed almost \$1.5 million in Federal funds.

OIG recommended that Vermont refund the overpayment and establish procedures to ensure that future claims are in accordance with Federal and State requirements. Vermont said that it had made program improvements to comply with OIG's recommendations and agreed to refund part of the overpayment. (A-01-03-00004)

Claims for Residents of Institutions for Mental Diseases

This report summarizes OIG's reviews of seven States' Medicaid claims for medical and ancillary services, including inpatient psychiatric services, made on behalf of 21 to 64 year-old residents of private and county-operated institutions for mental diseases. OIG found that the effectiveness of controls to prevent such improper claims for those services varied widely among the States reviewed (California, Florida, Maryland, New Jersey, New York, Texas, and Virginia). In total, the seven States improperly claimed \$6.1 million in Federal Medicaid funds.

OIG did not make any recommendations because the recommendations in a prior OIG report (A-02-03-01002) would also apply to medical and ancillary services for the excluded age group. CMS concurred with the recommendations in the prior report. (A-02-04-01034)

CMS Financial Statement Audit

The CMS FY 2004 financial statements received an unqualified audit opinion, which means that the statements were fairly presented in accordance with generally accepted accounting principles. However, auditors identified continuing material weaknesses in CMS's financial systems, analyses, and oversight of the Medicare and the health programs (Medicaid and SCHIP), as well as weaknesses in Medicare electronic data processing controls. (A-17-04-02004)

Addition of Qualified Drugs to the Medicaid Federal Upper Limit List

Under Medicaid, CMS is required to establish Federal upper payment limits for multiple source drugs. OIG found that CMS does not consistently add qualified drugs to the Federal upper limit list in a timely manner. Of the 252 first-time generic drugs approved between January 2001 and December 2003, 109 products met the statutory and regulatory criteria for inclusion on the Federal upper limit list. However, only 25 were actually added to the Federal upper limit list. Of the 25 drugs that were added, CMS took an average of 36 weeks to place the products on the Federal upper limit list once the drugs were qualified for inclusion. As of July 15, 2004, the remaining 84 drugs that were not added had been qualified for an average of 55 weeks. Had the qualified drugs been added to the Federal upper limit list in a timely manner, OIG estimated that Medicaid would have saved \$167 million between 2001 and 2003.

OIG recommended that CMS establish an administrative procedure and schedule to govern the determination and publication of Federal upper limits. CMS concurred with the OIG recommendation and stated that it had already taken steps to support this objective. However, CMS did not concur with OIG's methodology and its subsequent savings estimates. (OEI-03-04-00320)

Illinois Medicaid Disproportionate Share Hospital Payments

Medicaid requires States to make additional payments, called disproportionate share hospital (DSH) payments, to hospitals for the uncompensated costs of serving disproportionate numbers of low-income patients with special needs. OIG issued two reports on DSH payments to hospitals in Illinois.

- In one report, OIG found that DSH payments to a hospital exceeded the hospital-specific limits imposed by the Social Security Act. The State paid about \$140.3 million (Federal share) in excess of the hospital's costs of providing inpatient and outpatient services to Medicaid and uninsured patients during State FYs 1997 through 2000. The excessive payments occurred because the State did not have effective procedures to ensure compliance with the hospital-specific limits or with State plan and State Administrative Code requirements.

OIG recommended that the State refund \$140.3 million to the Federal Government; compare annual Medicaid payments with the actual cost of providing services to Medicaid and uninsured patients for all hospitals receiving DSH payments; and, if applicable, make retroactive adjustments. The State did not agree with these recommendations. However, the State agreed to provide clear guidelines on properly reporting uncompensated charity care charges. (A-05-01-00099)

- At another Illinois hospital, OIG found that DSH payments exceeded the hospital-specific limits by about \$9 million (\$4.5 million Federal share) during State FYs 1997 through 2000. The State did not use actual cost data to calculate DSH payments, did not compare Medicaid payments (including

DSH payments) with the hospital's actual Medicaid and charity care costs, and did not adjust DSH payments as required by the State plan.

OIG recommended that the State refund \$4.5 million to the Federal Government; compare annual Medicaid payments (including DSH payments) with the actual cost of providing services to Medicaid and uninsured patients for all hospitals receiving DSH payments; and, if applicable, make retroactive adjustments. The State disagreed with these recommendations. (A-05-01-00102)

State Financing Mechanisms: Nursing Homes

OIG issued three audit reports on public nursing homes in New York, Tennessee, and Washington. The objectives of these reviews were to determine whether (1) Medicaid payments to the nursing homes were adequate to cover their operating costs and (2) a link could be drawn between the quality of care provided to the facilities' residents and the amount of Medicaid funding received. The homes had received ratings from the States indicating that residents were in immediate jeopardy.

OIG found that initial Medicaid payments (which consisted of per diem and upper-payment-limit funds) to all three facilities were adequate to cover Medicaid-related costs. However, because the State and/or the county required the facilities to return 90 to 96 percent of the upper-payment-limit funding, the net Medicaid funding that the facilities were allowed to retain did not meet operating costs. Over a 3-year period, the funding deficits were \$25 million, \$22.8 million, and \$290,000 for the New York, Tennessee, and Washington facilities, respectively. In all of these cases, the Federal funds claimed by and paid to the States ultimately benefited the States more than the Medicaid beneficiaries, contrary to the Medicaid principle of Federal/State cost sharing. In addition, during the audit period, the homes experienced staffing shortages, which may have affected quality of care.

OIG recommended that the States consider revising the nursing homes' Medicaid per diem rate to more closely reflect operating costs and allow the homes to retain sufficient funding to cover the costs of providing an adequate level of care to their residents. The States did not agree with the recommendations. (A-02-03-01044; A-04-03-03023; A-10-04-00001)

Outreach

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

Advisory Opinions

In accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996, OIG, in consultation with the Department of Justice, may issue advisory opinions to outside parties regarding the interpretation and applicability of certain statutes relating to the Medicare and State health care programs. This authority allows OIG to provide case-specific formal guidance regarding the application of the anti-kickback statute and safe harbor provisions, and other OIG health care fraud and abuse sanctions. From the period October 1, 2004, through March 31, 2005, OIG received 25 advisory opinion requests and issued 14 advisory opinions.

Compliance Guidance

OIG works with the private sector to develop methods to prevent the submission of improper claims and inappropriate conduct. To date, OIG has released compliance program guidances (CPG) for clinical laboratories, hospitals, home health agencies, third-party billing companies, durable medical equipment, prosthetics, orthotics and supply industry, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, individual and small group physician practices, ambulance service providers, and pharmaceutical manufacturers. During this semiannual reporting period, OIG issued a supplemental guidance for the hospital industry and is developing a guidance for recipients of NIH research grants.

The Supplemental CPG for Hospitals builds on OIG's original compliance program guidance for hospitals issued in 1998. In conjunction with the original guidance, the Supplemental CPG is voluntary guidance designed to help hospitals and hospital systems prevent fraud, waste, and abuse by promoting a high level of ethical and lawful corporate conduct. The Supplemental CPG is the most comprehensive OIG fraud and abuse guidance available to hospitals. It includes a section on expanded risk that highlights areas of significant risk for hospitals, and offers guidance designed to help them identify potential problems.

In addition, the Supplemental CPG sets forth practical questions that hospitals can use to gauge the effectiveness of their compliance programs. Although these questions were drafted with hospitals in mind, many of them can also be used to gauge the effectiveness of compliance programs in other industry sectors. This and other OIG compliance program guidances are on the internet at <http://oig.hhs.gov> in the "Fraud Prevention & Detection" section.

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG established a set of comprehensive guidelines for voluntary self-disclosures, titled "Provider Self-Disclosure Protocol," available on the internet at <http://oig.hhs.gov> in the "Fraud Prevention & Detection" section.

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

To date, OIG has received 255 submissions. Self-disclosure cases have resulted in 53 recoveries and 40 settlements, totaling \$90.9 million collectively. Examples include the following:

- **Florida** – To resolve a matter reported under OIG's Provider Self-Disclosure Protocol, Wuesthoff Memorial Hospital, Inc., agreed to refund approximately \$312,000 to Medicare and \$1,300 to Medicaid for overpayments Wuesthoff received in connection with outpatient physician services. Wuesthoff operates a cardiology practice doing business as Brevard Cardiology Physicians, P.A. Based upon a self-assessment in accordance with the protocol's guidelines, Wuesthoff determined

that it had been overpaid for certain diagnostic tests performed by Brevard physicians. Wuesthoff incorrectly marked up the technical component of tests that it purchased from a vendor and billed to Medicare. Wuesthoff also determined that it had billed Medicare and Medicaid for a limited number of services provided “incident to” the services of a physician, when, in fact, the presence of a physician was not adequately documented in the patient’s medical records.

- **Pennsylvania** – Pursuant to the Provider Self-Disclosure Protocol, Marian Community Hospital agreed to pay \$70,000 to resolve its liability under the False Claims Act. Between 1998 and 2001, the hospital allegedly billed for electromyography neurological testing services that were not properly documented to support the claims.

Federal and State Partnership: Joint Audits of Medicaid

One of OIG’s major outreach initiatives has been to work more closely with State auditors in reviewing the Medicaid program. To this end, a partnership plan was developed to foster joint reviews and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the Federal and the State audit sectors. To date, partnerships have been developed in 25 States.

Reports issued to date have resulted in identifying over \$263 million in Federal and State savings and have led to joint recommendations for savings at the Federal and State levels, as well as improvements in internal controls and computer system operations.

OIG Administrative Sanctions

During this reporting period, OIG administered 1,702 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. A brief explanation of these sanction authorities can be found in Appendix F.

Program Exclusions

During this reporting period, OIG excluded 1,695 individuals and entities from participating in the Medicare and Medicaid programs and other federally sponsored health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. Examples include the following:

- **Oklahoma** – A pediatrician was excluded for 50 years based on his conviction for a criminal offense related to the neglect or abuse of patients in connection with the delivery of a health care item or service. The crimes on which the conviction was based occurred over a period of 4 years; however, police records indicate that the physician confessed to abusing 18 children (all under the age of 16) over an approximate 20-year period. The physician was sentenced to serve 20 years incarceration, with all but the first 15 years suspended. His license to practice as a physician in the State of Oklahoma was also permanently revoked.

- **California** – A pharmacy owner/operator was excluded for 30 years based on his conviction for a criminal offense related to the delivery of a health care item or service under the Medicare or a State health care program. He was sentenced to 33 months incarceration. He was also ordered to pay \$3.6 million in restitution jointly and severally for conspiracy to commit health care fraud and submitting false claims to Medi-Cal, California’s Medicaid program.

Also in California, a laboratory owner was excluded for 25 years based on his conviction for a criminal offense related to the delivery of an item or service under the Medicare or a State health care program. He was sentenced to 33 months incarceration and ordered to pay approximately \$2.3 million in restitution for committing health care fraud. The laboratory owner billed Medicare and Medi-Cal for laboratory tests that were never performed.

- **Florida** – A durable medical equipment (DME) sales representative was excluded for 28 years based on his conviction for a criminal offense related to the delivery of items or services under the Medicare program. He participated in a large scheme that lasted for approximately 3 years and involved the filing of false claims for medically unnecessary DME items. The false claims were filed with Medicare and resulted in millions of dollars being fraudulently paid to the sales representative and his associates. For his part in the scheme, the sales representative was sentenced to 18 months in jail and ordered to pay more than \$2 million in restitution jointly and severally.
- **South Carolina** – A medical doctor was excluded for 26 years based on his conviction for a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of controlled substances. He was also sentenced to serve 235 months in prison. The doctor was part of a large scheme that occurred over a 4-year period and involved the selling of prescriptions for OxyContin, Percocet, and various other controlled substances.
- **Mississippi** – A registered nurse was sentenced to 10 years in prison and excluded for 18 years based on his conviction for a criminal offense related to the neglect or abuse of patients. The nurse unlawfully, willfully, and feloniously sexually abused a patient who was physically helpless.

Civil Monetary Penalties

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person or entity that, among other reasons, submits claims to a Federal health care program that the person or entity knows or should know are false or fraudulent. During this reporting period, OIG collected \$6.6 million in civil monetary penalties and assessments. For example:

- **Michigan** – Lansing Surgery Center (LSC), a freestanding surgery clinic, agreed to pay \$76,000 and enter into a 3-year corporate integrity agreement to resolve its potential liability under the CMPL. The settlement resolved allegations that LSC submitted improper claims to Medicare and Medicaid for payment for pain management services provided by a staff physician. The physician was convicted in 1999 of felony counts of mail fraud, wire fraud, and health care fraud for providing medically unnecessary pain management services and upcoding of office visits at LSC and other Michigan hospitals.

Kickbacks

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

- **Florida** – In the largest OIG settlement to date of a civil monetary penalty kickback action, PharMerica, Inc., and PharMerica Drug Systems, Inc., (collectively, PharMerica) agreed to pay more than \$5.9 million to resolve allegations in connection with their 1997 purchase of a small Virginia pharmacy. The seller operated nursing homes and assisted living facilities with approximately 2,800 beds. OIG alleged that PharMerica paid an excessive amount for the pharmacy in return for a commitment from the seller to refer its Medicare and Medicaid pharmacy business to PharMerica for the next 7 years. OIG alleged that this transaction violated the Anti-Kickback Statute's prohibition against the payment of remuneration to induce the referral of Federal health care business. PharMerica also entered into a 5-year corporate integrity agreement. Headquartered in Florida, PharMerica is one of the country's largest institutional pharmacies and specializes in providing pharmacy supplies and services to long term care institutions. It is a wholly owned subsidiary of AmerisourceBergen Corporation.

Also in Florida, Tender Loving Care Health Care Services, Inc. (TLC), agreed to pay \$130,000 to resolve its potential liability under the CMPL relating to the anti-kickback statute. Specifically, one of TLC's franchisees allegedly paid commissions to non-employees who were providing "marketing services." TLC disclosed the potential kickback violation pursuant to an existing corporate integrity agreement. According to the disclosure, TLC allegedly made commission payments for each patient referred to TLC by independent contractor sales representatives. The alleged payments were based on the type of services utilized by the patients referred by the sales representatives (e.g., increased commissions for patients with high utilization of therapy services). Two of the sales representatives were health care providers, one of whom, a former owner of a home health agency, allegedly received the majority of the commission payments. In addition to the monetary settlement, the original corporate integrity agreement will continue to apply to TLC.

Patient Dumping

Between October 1, 2004, and March 31, 2005, OIG collected civil monetary penalties of more than \$242,000 from nine hospitals under the Emergency Medical Treatment and Labor Act, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of settlements involving alleged violations of this statute:

- **California** – Dameron Hospital Association paid \$75,000 to resolve allegations that it failed to screen 16 individuals who went to the hospital's emergency department. These individuals had a variety of complaints, including chest pain, abdominal pain, and vaginal bleeding, but left after 3 to 6 hours of waiting without being seen.

In another California case, Kaiser Foundation Hospital paid \$10,000 to resolve an allegation that it failed to provide an appropriate medical screening examination to a pregnant woman who went

to the emergency department complaining of abdominal and back pain. A labor and delivery nurse allegedly told the woman to go to the hospital where her physician had privileges.

- **Alabama** – Baptist Health, doing business as Baptist Medical Center South, paid \$45,000 to resolve an allegation that it refused to provide an appropriate medical screening examination and stabilizing treatment to a critically ill woman who went to its emergency department initially complaining of pain after having fallen on her knee. After x-rays of her knee, she was given morphine and discharged. It was alleged that while waiting for transport, she became ill and her son requested further medical assistance, but none was given. The family took the patient home, but she returned later by ambulance in respiratory arrest and died.
- **Missouri** – Bothwell Regional Health Center paid \$22,500 to resolve an allegation that it failed to provide an appropriate medical screening exam and transfer an individual experiencing a severe psychotic episode who was brought to the emergency department by a deputy sheriff. A nurse allegedly told the sheriff that the hospital did not admit psychiatric patients for involuntary treatment and provided no further assistance. The patient waited in the emergency department while the sheriff made arrangements to take him to another hospital 90 miles away, where he was admitted and treated.

Criminal and Civil Enforcement

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves the filing of false claims for reimbursement. False claims may be pursued under the civil False Claims Act and, in appropriate cases, under Federal and State criminal statutes. A description of these enforcement authorities can be found in Appendix F. The successful resolution of these matters often involves the combined investigative efforts and resources of OIG, FBI, Medicaid Fraud Control Units (MFCUs), and a variety of other law enforcement agencies.

OIG has the responsibility to assist the Department of Justice in bringing and settling cases under the civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of their settlements, providers often agree to enter integrity agreements with OIG to avoid exclusions and to be permitted to continue participation in Medicare, Medicaid, and other Federal health care programs. These agreements are monitored by OIG and require the providers to establish new or enhance existing compliance programs. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent activities.

In the 6 months ending March 31, 2005, the Government negotiated \$1 billion in civil and administrative settlements related to Medicare, Medicaid, and other Federal health care programs. Some of these successful settlements, as well as notable criminal enforcement actions, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Clinics

- **Missouri** – As part of a global settlement with the Government, Gambro Healthcare, Inc., owner and operator of renal dialysis clinics, agreed to pay over \$350 million to resolve civil and criminal fraud allegations in the Medicare, Medicaid, and TRICARE programs. To resolve its civil liability, Gambro paid \$310.5 million for allegedly submitting false Medicare claims and paying physicians

improper remuneration related to their medical director services. Gambro also agreed to allocate \$15 million to resolve potential liability related to State Medicaid program claims and entered a comprehensive corporate integrity agreement with OIG. In addition to the civil settlement, Gambro Supply Corporation (GSC), a wholly owned subsidiary of Gambro, agreed to plead guilty to health care fraud, pay a \$25 million criminal fine, and be permanently excluded from Medicare and other Federal health care programs. To circumvent prohibitions applicable to DME supply companies, GSC made false statements to Medicare, enabling Gambro allegedly to bill end stage renal disease related services and equipment at a higher amount.

Prescription Drugs

- **Pennsylvania** – Schering-Plough Corporation agreed to pay \$345.5 million as part of a global settlement with the Government and entered a 5-year corporate integrity agreement with OIG. As part of the settlement, Schering-Plough agreed to pay \$293 million to resolve its civil and administrative liabilities in connection with alleged underpayment of rebates owed for its allergy drug Claritin under the Medicaid drug rebate program. The civil portion of the case focused on Schering-Plough's alleged failure to include the value of certain incentives offered to two HMOs in the company's determination of the best price reported for purposes of the Medicaid drug rebate program. In doing so, Schering-Plough allegedly underpaid rebates due to the States and overcharged entities (such as community health centers) that purchased drugs at ceiling prices that are based on Medicaid drug rebate prices.

With regard to the criminal portion of the case, a subsidiary of Schering-Plough, the Schering Sales Corporation, pled guilty to a kickback charge and was sentenced to pay a \$52.5 million criminal fine. The Information charged that Schering Sales Corporation paid a kickback of almost \$2 million to keep Claritin on the formulary of an HMO.

- **Rhode Island** – A pharmacy owner was sentenced to 37 months in prison and ordered to pay a \$45,000 fine and \$431,000 in restitution to Medicaid and private payors in connection with a criminal plea for conspiring to sell prescription drug samples to customers at his pharmacy and committing health care fraud. Specifically, the owner engaged in a scheme through which his co-conspirator, a practitioner, diverted free drug samples to the pharmacy. The pharmacy owner filled prescriptions using these diverted drug samples and submitted fraudulent claims to payors for these prescriptions. The practitioner also pled guilty to conspiracy to sell drug samples and health care fraud and was sentenced to 37 months in prison, ordered to pay a \$45,000 fine, and held jointly responsible for the restitution amount. In a related civil action, the practitioner agreed to pay \$90,000 to resolve his civil liability under the False Claims Act for allegedly having caused false claims to be submitted to Medicaid. The same practitioner had previously been convicted of diluting vaccines administered to immigrant patients, for which he was sentenced to 10 years in prison and ordered to pay a \$465,000 fine and \$157,000 in restitution to the immigrant patients.

Hospitals

- **Pennsylvania** – Temple University Physicians (TUP) agreed to pay almost \$1.9 million for allegedly submitting false claims to the Medicare program. The Government alleged that TUP's employed physicians did not document or inadequately documented their presence during the provision of professional services by residents and interns and allegedly submitted claims for improperly upcoded evaluation and management services.

Durable Medical Equipment Suppliers

- **Illinois** – Novartis Nutrition Corporation (NNC) and OPI Properties, Inc. (OPI), wholly owned subsidiaries of Novartis Finance Corporation, which is a wholly owned subsidiary of Novartis Corporation, entered into a global criminal, civil, and administrative settlement with the Government. The settlement resolved a kickback investigation in which the Government alleged that NNC and OPI offered free enteral feeding pumps to induce others to purchase different enteral nutrition products. (Enteral therapy products are nutritional formulas that provide nourishment directly to the digestive tract of patients who cannot otherwise ingest enough calories to maintain health.) The Government also contended that NNC and OPI caused others to submit false claims to Medicare for enteral pumps and related enteral therapy products. In response to the Government's allegations, OPI agreed to pay a \$4.5 million criminal fine and to be permanently excluded from participation in all Federal health care programs, and NNC and OPI agreed to pay \$44.7 million in civil damages. In exchange for OIG's release of claims under the CMPL, NNC also agreed to pay \$160,000 for alleged conduct related to obstructing a Federal audit. In exchange for a release from OIG's permissive exclusion authority, NNC agreed to enter a 5-year corporate integrity agreement designed to reform the sales and marketing practices of its enteral nutrition operations.

In a related case from the same undercover investigation, TBC Products Inc., a wholesale distributor of enteral therapy products, and its direct parent, McKesson Medical-Surgical Minnesota Inc., also entered into a global criminal, civil, and administrative settlement with the Government. TBC agreed to pay a \$4 million criminal fine, \$3.3 million in civil damages, and to be permanently excluded from participation in all Federal health care programs. In exchange for OIG's release of claims under the CMPL, TBC agreed to pay \$100,000 for alleged conduct related to obstructing a Federal audit. The Government also alleged that TBC offered free enteral feeding pumps to induce others to purchase different enteral nutrition products and caused others to submit false claims to Medicare for medically unnecessary enteral pumps and related enteral therapy products. In exchange for a release from OIG's permissive exclusion authority, McKesson agreed to enter a 5-year corporate integrity agreement designed to reform the sales and marketing practices of its enteral feeding operations.

- **Florida** – Polymedica Corporation and its wholly owned subsidiaries Liberty Medical Supply, Inc., and Liberty Home Pharmacy Corporation (collectively, Polymedica) agreed to pay \$35 million and enter a 5-year corporate integrity agreement for allegedly violating the False Claims Act by submitting claims for diabetes and nebulizer related products without proper documentation. From 1998 to 2002, Polymedica allegedly submitted claims for these products without signed, written doctors' orders; documentation of medical necessity or treatment; dispensing orders; proof of delivery of supplies to beneficiaries; documentation of actual use of certain products prescribed and dispensed in excess of utilization guidelines; or possession of a valid assignment of benefits form.
- **Texas** – A DME company owner was sentenced to 46 months incarceration and ordered to pay \$1.8 million in restitution for conspiracy to commit health care fraud. Through her company, the owner improperly billed Medicare for power wheelchairs and accessories from December 2002 to August 2003. Her scheme entailed billing for more expensive equipment than was actually provided or for equipment not provided at all. Most of the claims that her company submitted involved certificates of medical necessity purchased from third party recruiters of Medicare beneficiaries.

- **Kentucky** – An owner of a DME company was ordered to pay a \$1,000 special assessment for knowingly and willfully paying kickbacks and bribes. The owner paid a doctor and his associate kickbacks to induce them to refer and qualify patients for oxygen and oxygen-related products from his company. In a parallel civil proceeding, the owner and his company agreed to pay \$708,000, and the owner agreed to be permanently excluded from Federal health care programs for allegations related to the kickback scheme.

Medicare Contractors

- **Connecticut and New York** – The Travelers Insurance Company and United Healthcare Insurance Company agreed to pay a total of \$20.6 million to settle civil charges of defrauding the Government in connection with cost reimbursement and other payments that the Government alleged the companies improperly sought and received under Medicare. From October 1988 to January 1995, Travelers acted under various contracts with the Government as the fiscal intermediary for the Medicare Part A program for portions of Connecticut, Michigan, and New York; the Medicare Part B carrier for Connecticut, Minnesota, Mississippi, and Virginia; the Railroad Retirement Board carrier nationwide; and the DME carrier for Region A. United Healthcare carried out the same contracts from January 1995 through December 2000. The Government alleged that beginning around October 1989, Travelers devised a scheme whereby it knowingly falsified financial information in an effort to obtain greater reimbursement and performance incentive payments. When United Healthcare took over the contracts from Travelers in 1995, the Government alleged that United Healthcare engaged in the same improper billing practices.

Home Health Agencies

- **Texas** – Four individuals were ordered to pay \$2.9 million in joint and several restitution for various offenses related to their conspiracy to defraud Medicare. Three of the four individuals were also sentenced to time in prison. One was sentenced to 102 months, and the other two were sentenced to 70 months in prison. From late 1995 through May 2002, the defendants engaged in a home health care fraud scheme through which they obtained and concealed Medicare funds to which they were not entitled.
- **Florida** – Several home health agencies (HHAs), Home Health Care, Inc., Home Health Services of South Florida, Inc. doing business as USA Home Health, Inc., Medicare Home Health Service, Inc., South Eastern Health Management Associates, Inc., and their owner agreed to pay nearly \$828,000 for allegedly submitting improper costs to Medicare on home health cost reports between 1995 and 1997. The Government alleged that the HHAs billed Medicare for medically unnecessary home health visits and consulting services purportedly performed by a former owner, when in fact the former owner did not perform the services. In addition to the settlement agreement, the HHAs and their owner agreed to enter into a 5-year corporate integrity agreement.
- **Wisconsin** – The director of nursing/administrator for an HHA was sentenced to 7 months in jail and was ordered to pay a fine and special assessment totaling \$1,600 for health care fraud. The director also agreed to pay \$40,000 as part of a civil settlement and to be excluded for 10 years from all Federal health care programs. The HHA official was the 13th defendant sentenced for involvement in a scheme to defraud the Wisconsin Medicaid program. The other 12 defendants sentenced in this case were former HHA employees also guilty of health care fraud. The defendants' scheme involved preparing fictitious time reports and charting forms indicating that personal care workers had provided home health services during periods when they had not.

Nursing Homes

- **Illinois** – Maxwell Manor Nursing Home, ABS Long-Term Care Management Co., Inc. (ABS), MBA-LTC, Inc., and four of their owners agreed to pay \$1.6 million for alleged failure of care to their nursing home residents. Maxwell Manor is no longer in operation because CMS terminated the facility as a result of the poor care. In addition to the settlement agreement, ABS and its owners agreed to enter a 5-year corporate integrity agreement that requires them to pay for an outside expert to monitor the quality of care provided to the residents of their facilities.
- **Louisiana** – The former owner of a nursing home management company was sentenced to 37 months imprisonment for health care fraud and pension fraud. The Department of Justice obtained an order for the owner to forfeit his personal residence, retirement estate, and construction equipment used at his retirement estate. The court ordered that the amount of restitution owed by the owner is limited to the net proceeds from the sale of these properties forfeited to the Government. For his own personal use, the former owner diverted Medicare and Medicaid monies paid to his three nursing homes for residents' care. Because of his diversion of these funds, the facilities were inadequately staffed and forced to do without certain medical and personal care items. In addition, he claimed on cost reports that he had paid vendors and liquidated liabilities for rehabilitation and pharmacy services when he had actually diverted these dollars for his own personal use. The former owner also failed timely to deposit funds withheld from employees' paychecks, and as administrator of the pension plan, made unauthorized loans to himself to pay the debts of his construction company and retirement estate.

Practitioners

- **Florida** – Radiology Regional Center, P.A., agreed to pay \$2.5 million and to enter a 5-year corporate integrity agreement for allegedly submitting false claims to Medicare between 1996 and 2003. The claims involved alleged billing for services that were not ordered by the treating physicians, upcoding of claims, and unbundling of services billed.
- **Ohio** – A podiatrist was sentenced to concurrent terms in prison, under which he will serve 11 years and 3 months in a Federal detention facility, and was ordered to pay \$1.8 million in restitution for conspiracy, health care fraud, false statements, and bank fraud. Following his 1998 conviction for health care fraud, the podiatrist structured and implemented a fictitious transaction for the purported sale of his podiatry practice to circumvent his exclusion and the reporting requirement of his court-ordered supervised release. He also created a management company, designating another individual as the “owner” so that he could covertly direct and receive income from the operation of both companies. The podiatrist's conviction for bank fraud resulted from materials that he submitted under false pretenses and false representations he made to a mortgage company to purchase a new home. In addition, he used fraudulently obtained Medicare funds for the down payment and monthly mortgage payments.
- **California** – A clinical psychologist was sentenced to 3 years in prison and ordered to pay \$250,000 in restitution and a \$2,000 special assessment fee. The psychologist fraudulently billed Medicare for psychological testing, psychological evaluations, and psychotherapy services not rendered to Medicare beneficiaries with developmental disabilities. He submitted claims under both his own Medicare provider identity and a fraudulent “group” provider identity that he created in an attempt

to avoid detection. He also created four fictitious businesses that he used in an elaborate scheme to claim his Medicare earnings as business expenses and avoid paying income taxes.

- **Idaho** – The owner and an employee of a mental health practice were sentenced for their roles in a scheme to bill Medicaid for services that were not provided and/or not provided in accordance with State law. The owner was sentenced for conspiracy to commit health care fraud, and the employee was sentenced to 21 months incarceration and ordered to pay \$2,600 in special assessments for health care fraud and conspiracy. They were also ordered to pay \$129,000 in joint and several restitution. The two conspired to bill Medicaid for case management services they did not render. To bill the program, they obtained Medicaid numbers from friends, neighbors, and family members.

Medicaid Fraud Control Units

Currently, 48 States and the District of Columbia have Medicaid Fraud Control Units (MFCUs), which investigate and prosecute or refer for prosecution providers charged with defrauding the Medicaid program or abusing or neglecting patients. In FY 2004, OIG provided oversight for and administration of approximately \$131 million in Federal grant awards to the units.

FY 2004 was a year of exceptional achievement for the 49 MFCUs. Collectively, they obtained a total of 1,160 convictions and recouped more than \$572 million in monetary recoveries—more than double the \$268 million recouped in FY 2003. Most of the FY 2004 recoveries are attributable to global settlements reached with pharmaceutical companies, usually working in concert with OIG and the Department of Justice. However, the MFCUs' cases cover the gamut of fraud perpetrated against the Medicaid program, including billing for services not rendered, paying kickbacks, upcoding claims to indicate higher levels of service than provided, and laundering Medicare and Medicaid proceeds obtained through the fraud.

In FY 2005, OIG is providing oversight for and administration of approximately \$143.9 million in Federal grant funds. Examples of cases worked jointly by OIG with MFCUs during this semiannual period include:

- **Florida** – The owner of a medical billing company was sentenced to 18 months in prison and ordered to pay over \$2.4 million in restitution for health care fraud. The owner submitted claims to Medicare and Medicaid for physician evaluation and management services that were not rendered and subsequently submitted false medical records to Medicare documenting that the services were provided. The claims were submitted using the provider number of a physician without his knowledge. This investigation involved OIG and the Florida MFCU.
- **Ohio** – A chiropractor was sentenced to 1 year incarceration and ordered to pay \$79,000 in restitution for health care fraud. The chiropractor committed numerous fraudulent acts against the Medicare, Medicaid, and Ohio Bureau of Workers' Compensation programs. Regardless of the actual service performed, he billed all services to Medicare as chiropractic manipulative treatments, the only service Medicare authorizes for reimbursement for chiropractors. He also had an extensive list of patients for whom he billed services but never actually treated, and provided medical excuses for patients to miss work in exchange for allowing him to bill their insurance carrier. This investigation involved OIG, the Ohio MFCU, the United States Postal Inspection Service, and the Ohio Bureau of Workers' Compensation.

Public Health Agencies

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

Public health agencies within the Department include:

National Institutes of Health (NIH)

Food and Drug Administration (FDA)

Centers for Disease Control and Prevention (CDC)

Health Resources and Services Administration (HRSA)

Indian Health Service (IHS)

Agency for Toxic Substances and Disease Registry (ATSDR)

Agency for Healthcare Research and Quality (AHRQ)

Substance Abuse and Mental Health Services Administration (SAMHSA)

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

Public Health Agency-Related Reports

Select Agent Security at Universities

In 2002, Federal regulations significantly expanded security requirements for institutions that handle deadly pathogens known as select agents. OIG is reviewing universities' implementation of those requirements, including whether the universities have (1) designated a person with authority and responsibility to implement the regulations, (2) restricted access to individuals with approved "risk assessments" from the Department of Justice, (3) developed explicit security plans based on threat and risk assessments, and (4) maintained accountability over select agents using detailed access and inventory records.

To date, OIG has issued reports to five universities. After issuing reports to all 15 schools selected for review, OIG will develop a summary report for public dissemination.

Food and Drug Administration's Bone Mass Study

In response to a request by the FDA Commissioner, OIG reviewed aspects of an FDA clinical study that examined dietary supplements' ability to increase bone mass. (FDA had halted the study because of low participation.) OIG sought to determine if FDA could do more to locate the study's allegedly missing medical folders and whether there was an accurate and supportable financial report detailing the study's transactions. Regarding the medical folders, OIG concluded that additional search would not be useful. The exact number of folders and their contents may never be known because FDA did not establish clear responsibilities for creating, updating, or filing the folders in question. The lapse also poses an ongoing risk that medical information on the subjects involved in the study could be released without their authorization. Regarding the financial accounting issue, OIG found inaccurate and unsupported entries in information that FDA provided.

OIG recommended a series of steps to correct some of the accounting deficiencies in the study. OIG also recommended that FDA develop and implement management controls to properly record and report costs of studies similar to the bone mass study. FDA concurred with OIG's recommendations to correct these issues. (A-03-03-00378)

Credentialing and Privileging at Indian Health Service Hospitals

At the request of IHS, OIG reviewed credentialing, privileging, and personnel suitability practices at three IHS-operated hospitals. Industry-wide standards and IHS policy require credentialing and privileging reviews of medical practitioners, and the Indian Child Protection and Family Violence Prevention Act requires background investigations of all IHS employees and contractors.

- For the 52 practitioners reviewed, a hospital in New Mexico did not verify the credentials for 26 practitioners to determine their current competence, did not ensure that 14 practitioners had current privileges (lapsed periods ranged from 6 days to 6 months), and did not request a background investigation of 23 practitioners. (A-06-04-00024)
- At a hospital in Oklahoma, OIG found that, for the 23 practitioners reviewed, the hospital did not verify the credentials for 7 to determine their current competence or ensure that 17 had current privileges, with lapsed periods ranging from 2 days to 34 months. (A-06-04-00038)

- At another hospital in Oklahoma, OIG's review of 34 practitioners found that the hospital did not verify the credentials for 11 practitioners before they provided patient care or ensure that 25 practitioners had current privileges, with lapsed periods ranging from 3 days to 4 years. (A-06-04-00037)

In each of these cases, the hospital's management had not ensured that the credentialing and privileging review processes received the necessary level of priority in terms of management attention and other resources. OIG recommended that IHS ensure that the hospitals establish a system to complete credentialing and privileging reviews in a timely manner and assign sufficient resources to those reviews. IHS agreed with the OIG recommendations and implemented corrective actions.

National Institute of Environmental Health Sciences Superfund

The National Institute of Environmental Health Sciences receives Superfund money to carry out training and research functions mandated by the Comprehensive Environmental Response, Compensation, and Liability Act. Pursuant to the Act, OIG audited the Institute's Superfund obligations and disbursements for FY 2003. The audit determined that these funds were administered in accordance with applicable laws and regulations. (A-04-04-01004)

Health Education Assistance Loan Defaults

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

After PSC has exhausted efforts to secure repayment of a debt, it declares the individual in default. Thereafter, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid, and all Federal health care programs for nonpayment of these loans. Exclusion means that the individual may not receive reimbursement under these programs for professional services rendered. During the period covered by this report, 44 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

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

After being excluded for nonpayment of their HEAL debts, a total of 1,892 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 49 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals \$136.6 million. Of that amount, \$4 million is attributable to this reporting period.

In the following examples, each individual entered into a settlement agreement to repay the amount indicated:

- Texas Osteopath – \$363,000
- New York Podiatrist – \$362,000
- Louisiana Osteopath – \$302,000
- Massachusetts Dentist – \$202,000
- California Dentist – \$201,000

Administration for Children and Families and Administration on Aging

The Administration for Children and Families (ACF) provides direction and funding for programs designed to promote stability, economic security, responsibility, and self-support for the Nation's families. Some of the major programs include Temporary Assistance for Needy Families (TANF), Child Support Enforcement, Foster Care, Family Preservation and Support, Head Start, and the Child Care and Development Block Grant. OIG reviews of these programs focus on ways to increase the efficient use of program dollars; to more effectively implement programs; to better coordinate programs among the Federal, State, and local governments; and to strengthen States' financial management practices.

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

Administration for Children and Families-Related Reports

Oversight of States' Subgrantee Monitoring in the Foster Care Program

OIG reviewed monitoring files and interviewed staff in six States that administer over 45 percent of the \$5 billion that ACF awards annually for the foster care program. OIG found that the monitoring systems used by three of the six States were inadequate, based on criteria OIG developed for this study. In addition, three of the six States did not communicate required information to subgrantees. Further, OIG found that oversight of States' systems for monitoring subgrantees received minimal attention by ACF. In fact, ACF's only direct tool for overseeing States' monitoring of subgrantees is the single audit (under 31 U.S.C. § 7502), and this inspection found major concerns with its scope, quality, and functioning as a tool for assessing States' subgrantee monitoring.

OIG recommended that ACF hold States accountable for adhering to grants management requirements relating to the oversight of subgrantees by developing a system for routinely communicating grants management responsibilities to States, developing specific requirements that clarify States' responsibilities for monitoring of subgrantees, and utilizing existing oversight mechanisms to ensure States have systems in place to adhere to grants management requirements. OIG also recommended that ACF work with HHS to make the single audit a more effective tool for overseeing States' monitoring of subgrantees by supporting and promoting intergovernmental initiatives to improve the single audit.

A companion report on monitoring subgrantees found that States' program monitoring typically consisted of an onsite visit to subgrantees, and fiscal monitoring typically consisted of an independent audit. All six States relied on rate setting to manage foster care expenditures. In some States, these monitoring mechanisms are minimal or not implemented as intended. Given the extent to which States appear to be using subgrantees to carry out fundamental foster care services, lax monitoring can have a significant impact.

OIG suggested that States with limited monitoring systems consider bolstering their program and fiscal monitoring. Also, ACF could consider assisting States by providing expertise and guidance on subgrantee monitoring and facilitating communication among States.

A third report outlined measurable criteria OIG developed in order to assess States' monitoring of foster care subgrantees. The report explained the process OIG undertook to develop these criteria, which was based on Federal grants management requirements. It also explained the methodology that OIG used to apply the criteria to States' monitoring of subgrantees in the foster care program. OIG anticipates that this protocol might be useful to ACF, as well as other grants managers in HHS, in their efforts to oversee and assess States' subgrantee monitoring.

In response to the reports, ACF concurred with the objectives of the OIG's recommendations and noted its intended actions. (OEI-05-03-00060; OEI-05-03-00061; OEI-05-03-00062)

Title IV-E Training Costs in Maine

Maine did not comply with guidelines for claiming Federal reimbursement for maintenance, administrative, and training costs for the Title IV-E foster care and adoption assistance programs. Specifically, State officials did not follow ACF's policies on allocating training costs and calculating the Federal share of

indirect costs and did not establish correct procedures for claiming costs. As a result, the State made a net overstatement of \$3 million in its Federal claim.

OIG recommended that Maine make a \$3 million adjustment, comply with ACF guidance on cost calculation and allocation, and improve its procedures for preparing claims. The State agreed with the recommendations. (A-01-03-02503)

Child Support Enforcement

The detection, investigation, and prosecution of noncustodial parents who fail to pay court-ordered child support is a priority for OIG. Working with the Office of Child Support Enforcement (OCSE), the Department of Justice, U.S. Attorneys' Offices, U.S. Marshals Service, and other Federal, State, and local partners, OIG develops ways to expedite the collection of child support. Since 1995, OIG has opened 2,844 investigations of child support cases nationwide, which have resulted in 1,043 convictions and court-ordered restitution and settlements of \$53 million.

Task Forces

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

Task Force Table

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

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

At this point, the task force units have received over 8,350 cases from the States. As a result of the work of the task forces, 517 Federal arrests have been executed and 489 individuals sentenced. The total ordered amount of restitution related to Federal investigations is \$24.1 million. There have been 358 arrests at the State level and 323 convictions or civil adjudications to date, resulting in \$17.9 million in restitution being ordered.

Investigations

OIG investigations of child support cases, nationwide, resulted in 62 convictions and court-ordered restitution and settlements of \$2.4 million during this semiannual period. Examples of the Federal arrests, convictions, and sentences for failure to pay child support include the following:

- **Missouri** – A man was sentenced to 2 years in prison, 1 year probation, and ordered to pay \$63,000 in restitution for failure to pay child support for his two children since his 1990 divorce. To disguise his location and income, the individual used numerous aliases and Social Security numbers. He had been steadily employed since his divorce and in the last few years had earned annual incomes of approximately \$100,000. He was also the co-owner of real property worth over \$400,000, had received payouts from his 401(k) plan, and was part owner in an Internet art decal company.
- **Kentucky** – A man was sentenced to 18 months incarceration with credit for time served while in Federal custody, 1 year supervised release, and ordered to pay \$50,000 in restitution for failure to pay child support. The individual, whose child resides with the custodial parent in Virginia, moved and changed jobs frequently to avoid paying support. For over a year, he evaded two warrants from the State of Kentucky before his June 2004 arrest on a Federal warrant.
- **Alabama** – A man was sentenced to 6 months home detention, 2 years probation, and ordered to pay \$35,000 in restitution for failure to pay child support. While earning income in Alabama as a subcontractor and log home builder, he failed to pay support for his two children who live in Virginia.
- **Ohio** – A man was sentenced to 5 years probation and ordered to pay \$30,000 in restitution. In March 2003, he was charged in Ohio with failure to pay child support and later arrested in Arizona where he was living. At the time of his arrest, he was a self-employed document courier, although he previously worked as an optometrist. He had not made a support payment since July 1989.
- **West Virginia** – A man was sentenced to 4 months imprisonment with credit toward his sentence for time served and 1 year supervised release for failure to pay child support. The individual, who is licensed by the State of Pennsylvania as a psychologist, was also ordered to pay \$25,000 in restitution to the custodial parent of his four children.

General Oversight

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

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

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

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

General Oversight-Related Reports

Departmental Financial Statement Audit

The Chief Financial Officers Act (the Act) of 1990, as amended, requires OIG or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards. Pursuant to the Act, auditors provided an unqualified opinion on the FY 2004 HHS consolidated/combined financial statements. This means that for the sixth consecutive year, the statements were reliable and fairly presented. However, the report on internal controls noted two continuing material weaknesses:

- **Financial Systems and Processes** – While the auditors observed some progress in preparing financial statements, the lack of an integrated financial management system(s) and weaknesses in internal controls made it difficult for HHS to prepare timely and reliable financial statements. Substantial manual processes, significant adjustments to reported balances, and numerous accounting entries recorded outside HHS’s general ledger system were necessary. In addition, deficiencies were noted in the oversight of managed care organizations and financial data provided by the States for the Medicaid program.
- **Medicare Information Systems Controls** – To administer the Medicare program and to process and account for Medicare expenditures, CMS relies on extensive information systems operations at its central office and Medicare contractor sites. Although improvement since the FY 2003 audit was noted, numerous general and application control weaknesses were identified in areas such as entity-wide security programs and access and change controls.

As discussed in the financial statement report on compliance with laws and regulations, these material weaknesses also represented departures from certain Federal requirements. (A-17-04-00001)

Departmental Service Organizations

To support the audit of the Department’s FY 2004 financial statements, OIG contracted for examinations of several service organizations that provide common administrative, data processing, and accounting services to the operating divisions. In accordance with Statement on Auditing Standards No. 70, independent certified public accounting firms examined the organizations’ controls and tested their operating effectiveness. The results follow:

- **Division of Payment Management, Program Support Center** – Controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-04-00009)
- **Division of Financial Operations, Program Support Center** – Controls were suitably designed and operating with sufficient effectiveness, with the exception of controls over the Information Technology Service Center’s security program. (A-17-04-00011)
- **Human Resources Service, Program Support Center** – Controls were suitably designed and operating with sufficient effectiveness, with the exception of password controls on the computer network and certain deficiencies in the entity-wide security program. (A-17-04-00012)

- **Center for Information Technology, National Institutes of Health** – Controls were suitably designed and operating with sufficient effectiveness, with the exception of documentation and logging of change requests, authorizations, testing, and approval on Windows host platforms. (A-17-04-00010)

[Note: NIH is currently evaluating alternatives for correcting the Windows host deficiencies.]

Non-Federal Audits

OMB Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities are required to have an annual organization-wide audit 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 entity's management of Federal funds. In the first half of FY 2004, OIG's National External Audit Review Center reviewed 1,117 reports that covered \$772.7 billion in audited costs. Federal dollars covered by these audits totaled \$230.3 billion, about \$113 billion of which was HHS money.

OIG's oversight of non-Federal audit activity informs Department managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs that require formal resolution by Federal officials. OIG identifies entities for high-risk monitoring, alerts program officials to any trends that could indicate problems in HHS programs, and profiles non-Federal audit findings of a particular program or activity over time to identify systemic problems. OIG also provides training and technical assistance to grantees and the auditing profession.

OIG maintains a quality control review process to assess the quality of the non-Federal reports received and the audit work that supports selected reports. The non-Federal audit reports reviewed and issued during this reporting period are categorized in the box below.

Reports issued:	
Without changes or with minor changes	988
With major changes	90
With significant inadequacies	39
Total:	1,117

The 1,117 reports included recommendations for HHS program officials to take action on cost recoveries totaling \$816,000, as well as 4,555 recommendations for improving management operations. In addition, these audit reports provided information for 83 special memorandums that identified concerns for increased monitoring by departmental management.

Resolving Recommendations

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

Table 1: Reports with Questioned Costs

Reports	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
For which no management decision had been made by the beginning of the reporting period ¹	498	\$1,882,675,000	\$1,537,931,000
Issued during the reporting period	91	\$417,678,000	\$7,475,000
Total Section 1	589	\$2,300,353,000	\$1,545,406,000
Section 2			
For which a management decision was made during the reporting period ^{2,3}			
Disallowed costs		\$265,990,000	\$601,000
Costs not disallowed ⁴		\$178,418,000	\$0
Total Section 2	161	\$444,408,000	\$601,000
Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	428	\$1,855,945,000	\$1,544,805,000
Section 4			
For which no management decision was made within 6 months of issuance ⁵	340	\$1,450,505,000	\$301,141,000

* Details concerning footnotes can be found in Appendix D.

Table 2: Funds Recommended to be Put to Better Use

Reports	Number of Reports	Dollar Value
Section 1		
For which no management decision had been made by the beginning of the reporting period ¹	66	\$7,657,216,000
Issued during the reporting period	11	\$346,000,000
Total Section 1	77	\$8,003,216,000
Section 2		
For which a management decision was made during the reporting period		
Value of recommendations that were agreed to by management		
Based on proposed management action	9	\$510,765,000
Based on proposed legislative action		
Value of recommendations that were not agreed to by management	2	\$168,023,000
Total Section 2	11	\$678,788,000
Section 3		
For which no management decision had been made by the end of the reporting period ²		
Total Section 1 minus Total Section 2	66	\$7,324,428,000

* Details concerning footnotes can be found in Appendix D.

Legislative and Regulatory Review and Development

Regulatory Review Functions

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

During this reporting period, OIG participated in the review and clearance of regulations relating to various provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), including the Medicare Part D Prescription Drug Benefit, the Medicare Advantage program, and the electronic prescribing initiative. OIG offered comments and recommendations relating to potential fraud and abuse issues

Regulatory Development

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

- Published revised final regulations addressing OIG's authority to impose civil money penalties against endorsed sponsors under the Medicare prescription drug discount card program that knowingly engage in false or misleading marketing practices, overcharge program enrollees, or misuse transitional assistance funds.
- Finalized and published revised Healthcare Integrity and Protection Data Bank regulations addressing data collection reporting requirements. The rule specifically clarified the types of personal numeric identifiers that may be reported to the data bank in connection with adverse actions.
- In accordance with section 431, developed interim final regulations establishing regulatory standards for a new safe harbor under the Federal anti-kickback statute for certain goods, items, services, donations, and loans provided by individuals and entities to certain health centers funded under section 330 of the Public Health Service Act.

In addition, during this period, OIG continued to develop and publish Federal Register notices that serve to reflect OIG policy and procedures with regard to compliance program guidance and other OIG administrative matters. During this semiannual period, OIG:

- Developed and published final Supplemental Compliance Program Guidance for Hospitals that provides voluntary guidelines to assist hospitals and hospital systems in identifying significant risk areas and in evaluating and, as necessary, refining ongoing compliance efforts (see p. [10](#)).

- In accordance with section 205 of the Health Insurance Portability and Accountability Act, published OIG's annual solicitation notice soliciting proposals and recommendations for developing new and modifying existing safe harbor provisions under the Federal anti-kickback statute, as well as developing new OIG Special Fraud Alerts.
- Developed and cleared a Federal Register notice setting forth specific revisions to part A, chapter AF of OIG's Statement of Organization, Functions, and Delegations of Authority. The revised organizational statement reflects a recent realignment of certain functions for carrying out the statutory requirements for operating OIG.

Employee Fraud and Misconduct

Most individuals employed by HHS are dedicated, honest civil servants. Occasionally, however, individuals violate their ethical and fiduciary responsibilities. OIG conducts or oversees investigations of serious allegations of wrongdoing by Department employees. For example:

- **South Dakota** – A former IHS medical records technician was fined \$6,000 for false statements involving Federal health care programs. In an apparent attempt to save time and avoid workload backlogs, the technician falsified diagnosis codes and electronic patient information for patients treated by health care providers at the IHS hospital where she worked. The majority of these patients were Medicare and Medicaid beneficiaries.

Prosecutions

During this semiannual reporting period, OIG investigations resulted in 258 successful criminal actions. Also during this semiannual period, 755 cases were presented for criminal prosecution to the Department of Justice and, in some instances, to State and local prosecutors. Criminal charges were brought by prosecutors against 268 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, \$1.1 billion was ordered or returned as a result of OIG investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.

Appendix

Appendix A

Savings Achieved Through Policy and Procedural Changes Resulting From Audits, Investigations, and Inspections October 1, 2004, Through March 31, 2005

This schedule highlights savings resulting from the Office of Inspector General (OIG) efforts to prevent unnecessary obligations for expenditures of agency funds or to improve agency systems and operations. These achievements depend greatly on the contributions of and actions by others, such as departmental officials and Congress. The amounts shown represent funds or resources that will be available to be used more efficiently as a result of documented measures taken in response to OIG audits, investigations, and inspections. Those include actual reductions in unnecessary budget outlays; deobligations of funds; reductions in costs incurred or preaward reductions in grants or contracts; and reduction and/or withdrawal of the Federal portion of interest subsidies on loans or loan guarantees, insurance, or bonds.

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

Total savings from these sources amount to \$15,593.8 million for this semiannual period.

OIG Recommendation	Implementing Action	Savings (millions)
CENTERS FOR MEDICARE & MEDICAID SERVICES		
<p>State Enhanced Payments Under Medicaid Upper Payment Limit Requirements: States are allowed to make enhanced payments to local government providers as long as aggregate State payments for each class of service do not exceed the amount that would have been paid under Medicare cost principles. OIG found that States' use of intergovernmental transfers maximized Federal Medicaid reimbursements. OIG also found that enhanced payments were not based on the cost of providing the service, nor did OIG find a direct relationship in the use of these funds to increase the quality of care. (A-03-00-00216)</p>	<p>On January 12, 2001, CMS issued revisions to the upper payment limit regulations which, among other things, created new payment limits for local government-owned providers. This final rule will significantly affect a State's ability to reap windfall revenues by reducing the available funding pool from which to make enhanced payments to local government-owned providers.</p>	\$5,100

OIG Recommendation	Implementing Action	Savings (millions)
<p>Medicare Part A Payments for Skilled Nursing Facilities: Services should be bundled into Medicare and Medicaid’s payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and legislation should prohibit entities other than the skilled nursing facility (SNF) from seeking payment on behalf of persons in Part A covered SNF stays for enteral nutrition, incontinence care, and surgical dressings, and limit Medicare coverage of these services to Part A. In 1997 congressional testimony, OIG supported establishing a prospective payment system and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; A-17-95-00096; A-14-98-00350)</p>	<p>Section 4432 of the BBA of 1997 (as amended by the BBRA of 1999) established a prospective payment for SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered SNF care.</p>	<p>\$4,550</p>
<p>Medicare Secondary Payer Extensions: Establish a centralized database of information about private insurance coverage of Medicare beneficiaries. Extend the Medicare secondary payer (MSP) provision to include end stage renal disease (ESRD) beneficiaries as long as the individual has employer-based coverage available. (OEI-07-90-00760; OEI-03-90-00763; A-10-86-62016; A-09-89-00100; A-09-91-00103; A-14-94-00391; A-14-94-00392)</p>	<p>The database capacity was achieved through the authorization of a data exchange between the Social Security Administration and CMS and between the Internal Revenue Service and CMS. Section 4631 of the BBA of 1997 permanently extended current MSP policies for beneficiaries who are disabled and have ESRD. For ESRD beneficiaries, the statute also increased the time period Medicare is secondary payer from 18 to 30 months.</p>	<p>\$2,340</p>
<p>Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in rehospital costs. CMS should seek legislative authority to continue mandated reductions in capital payments; excess capacity was not considered in the capital cost policy. (A-09-91-00070; A-07-95-01127)</p>	<p>Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.</p>	<p>\$1,220</p>
<p>Medicare Payments for Oxygen: CMS should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711; OEI-03-91-001710)</p>	<p>Section 4552(a) of the BBA of 1997 reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.</p>	<p>\$900</p>

OIG Recommendation	Implementing Action	Savings (millions)
<p>Medicare Laboratory Reimbursements: In July 1989, OIG recommended that CMS take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that CMS seek legislation to allow across-the-board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices that laboratories charge physicians in a competitive marketplace. In a January 1996 followup, OIG found that Medicare continued to pay more to clinical laboratories than physicians for the same tests. Although the Omnibus Budget Reconciliation Act of 1993 reduced the fee schedule to 76 percent of the average in 1996, OIG recommended that CMS periodically evaluate the national fee schedule to ensure that it is in line with the prices physicians pay for the same clinical laboratory services. (OEI-02-89-01910; A-09-89-00031; A-09-93-00056)</p>	<p>Section 4553 of the BBA of 1997 provided for reducing fee schedule payments by lowering the cap to 74 percent of the median for payment amounts, with no inflation update for 1998 through 2002. The MMA of 2003 mandated that the annual adjustment to the clinical laboratory fee schedule for 2007 through 2008 shall be 0 percent.</p>	<p>\$700</p>
<p>Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment, and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)</p>	<p>Section 4551(b) of the BBA of 1997 froze Medicare payments for enteral and parenteral nutrition and supplies for 1998 through 2002 and simplified the process used to reduce inherently unreasonable prices by 15 percent.</p>	<p>\$500</p>
<p>Medicare Payments to Hospitals for Bad Debt: CMS should seek legislative authority to modify the bad debt payment policy. (A-14-90-00039)</p>	<p>Section 4451 of the BBA of 1997 reduced bad debt payment to providers by 25 percent in FY 1998, 40 percent in FY 1999, and 45 percent in later years. The Benefits Improvement and Protection Act of 2000 subsequently reduced the reduction to 30 percent.</p>	<p>\$160</p>
<p>Medicaid Drug Rebates—Sales to Repackagers Excluded From Best Price Determinations: Medicaid rebates were lost because sales to HMOs were improperly excluded from drug manufacturers' best price determinations in FYs 1998 and 1999. CMS should require drug manufacturers who excluded sales to HMOs from their best price calculations to repay the rebates and evaluate the policy guidance relating to exclusion of sales to other (non-HMO) repackagers from best price determinations. (A-06-00-00056)</p>	<p>CMS issued Medicaid Drug Rebate Program Release #47 in July 2000 to make it clear to manufacturers not to inappropriately exclude other prices from best prices, as required by section 1927 of the Social Security Act.</p>	<p>\$80.7</p>

OIG Recommendation	Implementing Action	Savings (millions)
<p>Medicare Payments for Prescription Drugs: CMS should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)</p>	<p>Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.</p>	<p>\$30</p>
<p>VARIOUS OPERATING DIVISIONS</p>		
<p>Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.</p>	<p>The operating division took action, based on the results of OIG investigations, to suspend or terminate payments to the offending individual or entity.</p>	<p>\$13.1</p>

Appendix B

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

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

More detailed information may be found in OIG’s “Red Book.” (See <http://oig.hhs.gov>.)

OIG Recommendation	Status	Savings (millions)
CENTERS FOR MEDICARE & MEDICAID SERVICES		
<p>Clinical Laboratory Tests: CMS should develop a methodology and legislative proposal to pay for tests ordered as custom panels at substantially less than the full price for individual tests and study reinstating the beneficiary coinsurance and deductible provisions for laboratory services as a means of controlling utilization. (A-09-89-00031; A-09-93-00056)</p>	<p>CMS initially agreed with the first recommendation but not the second. The BBA required the Secretary to request that the Institute of Medicine (IOM) study Part B laboratory test payments. As a result of IOM’s recommendations, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 mandates that CMS conduct a demonstration that applies competitive bidding for clinical laboratory services. The initial report to Congress is due by December 31, 2005.</p>	\$1,130*
<p>Outpatient Surgery Rates: CMS should seek authority to set rates that are consistent across sites and reflect only the costs necessary for the efficient delivery of health services and remove the procedure codes that meet its criteria for removal from the Ambulatory Surgery Center list of covered procedures. (A-14-89-00221; A-14-98-00400; OEI-05-00-00340)</p>	<p>CMS agreed to consider seeking authority to set rates that are consistent across sites as it develops its legislative program. CMS also issued a notice of proposed rulemaking, which has not been finalized, that would remove certain procedure codes from the ASC list of covered procedures.</p>	\$1,100

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

OIG Recommendation	Status	Savings (millions)
<p>Medicare Payments for Mental Health Services: CMS should ensure that mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance of mental health services. (OEI-02-99-00140; OEI-03-99-00130; A-04-98-02145; A-01-99-00507; A-01-99-00530)</p>	<p>CMS concurred and has initiated some efforts, particularly regarding community mental health centers. OIG is reviewing this area to determine if substantial errors are still present.</p>	<p>\$676</p>
<p>Payment Policy for Medicare Bad Debts: OIG presented four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group rates. CMS should seek legislative authority to further modify bad debt policies. (A-14-90-00339)</p>	<p>The BBA of 1997 provided for some reduction of bad debt payments to providers. The BIPA of 2000 subsequently adjusted upwards the percentage of total hospital bad debt that would be reimbursed. However, additional legislative changes are needed to implement the modifications that OIG recommended.</p>	<p>\$340</p>
<p>Cost Effectiveness of “Pay and Chase” Methods for Medicaid Pharmacy Third-Party Liability Recoveries: CMS should determine whether States’ cost-avoidance waivers for pharmacy claims are meeting the cost-effectiveness criterion. CMS can ascertain cost-effectiveness by requiring States to track dollars that they pay and chase and the amounts that they recover. CMS should also review States’ policies to determine if they are paying and chasing pharmacy claims without waivers. (OEI-03-00-00030)</p>	<p>CMS agreed that States’ cost-avoidance waivers should be reexamined and has made a concerted effort to track States’ pay-and-chase activities. The CMS central office asked the regional offices to identify any waivers that have been granted, any pending waiver requests, and situations where a State is using pay-and-chase without an approved waiver. CMS is also working with States that cost-avoid pharmacy claims and with the National Association of Chain Drug Stores in developing guidance to assist States in implementing cost avoidance.</p>	<p>\$185</p>
<p>Graduate Medical Education: CMS should revise the regulations to remove from a hospital’s allowable graduate medical education (GME) base-year costs any cost center with little or no Medicare utilization and submit a legislative proposal to compute Medicare’s percentage of participation under the former, more comprehensive system. (A-06-92-00020)</p>	<p>CMS did not concur with the recommendations. Although the BBA of 1997 and the BBRA of 1999 contained provisions to slow the growth in Medicare spending on GME, OIG believes that its recommendations should be implemented and that further savings can be achieved.</p>	<p>\$157.3</p>

OIG Recommendation	Status	Savings (millions)
<p>Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (A-06-94-00039)</p>	<p>CMS continues to disagree with the recommendation. OIG continues to monitor the drug rebate program; audits will continue to focus on enhancing the collection of rebates and providing potential savings to the rebate program.</p>	<p>\$123</p>
<p>Inappropriate Payments for Nail Debridement: CMS should require Medicare carriers to recoup the overpayments found in OIG's sample and to carefully scrutinize payments for nail debridement services through medical reviews, require podiatrists to adequately document the medical necessity of all nail debridement services, and require CMS regional offices and carriers to educate podiatrists on Medicare payment policies for nail debridement claims. (OEI-04-99-00460)</p>	<p>CMS concurred; the agency planned to continue to maximize the effectiveness of its medical review strategy, collect the overpayments identified in OIG's sample, and educate podiatrists on Medicare policy for paying nail debridement claims.</p>	<p>\$96.8</p>
<p>Medical Equipment/Supply Claims Lacking Valid, Active UPINs: CMS should create edits to identify medical equipment and supply claims that do not have a valid and active unique physician identification number (UPIN) listed for the ordering physician. (OEI-03-01-00110)</p>	<p>CMS concurred and implemented an edit to reject claims listing a deceased physician's UPIN beginning in April 2002. CMS decided not to implement edits for inactive and invalid UPINs. Instead, the agency initiated provider education efforts and issued two program memorandums.</p>	<p>\$91</p>
<p>Medicare Orthotics: CMS should take action to improve Medicare billing for orthotic devices. CMS should also require standards for suppliers of custom-molded and custom-fabricated orthotic devices. (OEI-02-95-00380; OEI-02-99-00120; OEI-02-99-00121)</p>	<p>CMS generally concurred with OIG's original recommendations. The agency is working on a proposed rule regarding orthotics and intends to put in place standards for custom orthotics.</p>	<p>\$43</p>
<p>Expansion of the DRG Payment Window: CMS should propose legislation to expand the DRG payment window to at least 7 days immediately before the day of admission. (A-01-02-00503)</p>	<p>CMS did not concur with the recommendation and has not pursued a legislative proposal.</p>	<p>\$37</p>

OIG Recommendation	Status	Savings (millions)
<p>End Stage Renal Disease Payment Rates: CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (A-14-90-00215)</p>	<p>CMS agreed, and the BIPA of 2000 required the Secretary to develop a composite rate that includes, to the extent feasible, payment for laboratory tests and drugs that are routinely used in dialysis treatments but are now separately billable. MMA requires the Secretary to establish a case-mix adjusted composite rate for 2005 and to conduct a demonstration of a bundled case-mix adjusted prospective payment system. The Act also directs CMS to use the results of an OIG study on separately billable end stage renal disease drug payments and costs to set the 2005 composite payment rate.</p>	<p>\$22**</p>
<p>Respiratory Assist Devices With a Backup Rate: CMS should reclassify bilevel respiratory assist devices with a backup rate from the “frequent and substantial servicing” category to the “capped rental” category under the durable medical device benefit. (OEI-07-99-00440)</p>	<p>CMS concurred and published a proposed rule in August 2003 clarifying that bilevel respiratory assist devices with a backup rate be paid as capped rental items.</p>	<p>\$11.5</p>
<p>Indirect Medical Education: CMS should reduce the indirect medical education (IME) adjustment factor to the level supported by CMS’s empirical data and initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (A-07-88-00111)</p>	<p>CMS agreed with the recommendation. The BBA of 1997, as amended by the BBRA of 1999, reduced the IME adjustment to 5.5 percent in 2002 and thereafter. OIG believes that the factor should be further reduced to eliminate overlap with the disproportionate share adjustment.</p>	<p>TBD***</p>
<p>Medicare Secondary Payer—End Stage Renal Disease Time Limit: CMS should extend the Medicare secondary payer (MSP) provisions to include end stage renal disease beneficiaries without a time limitation. (A-10-86-62016)</p>	<p>CMS was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. OIG continues to advocate that, when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare based on age or disability. At that point, Medicare would become the primary payer.</p>	<p>TBD</p>

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

***To be determined

OIG Recommendation	Status	Savings (millions)
<p>Inpatient Psychiatric Care Limits: CMS should develop new limits to deal with the high cost and changing utilization patterns of inpatient psychiatric services and apply a 60-day annual and a 190-day lifetime limit to all psychiatric care regardless of the place of service. (A-06-86-62045)</p>	<p>CMS agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.</p>	<p>TBD</p>
<p>Hospital Capital Costs: CMS should determine the extent that capital reductions are needed to fully account for hospitals' excess bed capacity and report the percentage to Congress. (A-09-91-00070; A-14-93-00380)</p>	<p>CMS did not agree with the recommendation. Although the BBA of 1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs.</p>	<p>TBD</p>
<p>Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: CMS should seek legislation that would require participating manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price to calculate the rebates. This legislation would have resulted in about \$1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-1996. (A-06-97-00052)</p>	<p>CMS agreed to pursue a change in the rebate program similar to that recommended. The President's FY 2003 budget proposed a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug. That legislative change was ultimately dropped, and none of the subsequent Presidential budgets included a similar proposal.</p>	<p>TBD</p>
<p>Home Health Agencies: CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-04-93-00262; OEI-04-93-0026; OEI-12-94-00180; OEI-02-94-00170; A-04-95-01103; A-04-95-01104; A-04-94-02087; A-04-94-02078; A-04-96-02121; A-04-97-01169; A-04-97-01166; A-04-97-01170; A-04-99-01195)</p>	<p>Although the BBA of 1997 included provisions to restructure home health benefits, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to the BBA, OIG's four-State review found that unallowable services continued to be provided because of inadequate physician involvement. CMS agreed in principle, stating that it recognized the need for physician involvement in home health care planning and was considering new approaches to fostering the coordination of home health care across disciplines, including physicians, in the Medicare home health conditions of participation. CMS also provided additional payments for physician care plan oversight and education for physicians and beneficiaries.</p>	<p>TBD</p>

OIG Recommendation	Status	Savings (millions)
VARIOUS OPERATING DIVISIONS		
<p>Recharge Center Costs: The Assistant Secretary for Administration and Management should propose changes to OMB Circular A-21 to improve guidance on the financial management of recharge centers. The revision should include criteria for establishing, monitoring, and adjusting billing rates to eliminate accumulated surpluses and deficits; preventing the use of recharge funds for unrelated purposes and excluding unallowable costs from the calculation of recharge rates; ensuring that Federal projects are billed equitably; and excluding recharge costs from the recalculation of facilities and administrative cost rates. (A-09-96-04003)</p>	<p>The Department concurred and has worked with OMB on a revision to A-21. The proposed revision, which was published in the Federal Register in August 2002, would require that adjustments to a recharge center's billing rate take into account overrecoveries and/or underrecoveries from previous periods. Rate adjustments would be required at least every 2 years. The final circular was issued in May 2004.</p>	<p>\$1</p>

Appendix C

Unimplemented Office of Inspector General Program and Management Improvement Recommendations

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

More detailed information can be found in OIG’s “Orange Book,” which can be found on the Internet at <http://oig.hhs.gov>.

OIG Recommendation	Status
CENTERS FOR MEDICARE & MEDICAID SERVICES	
<p>Accountability Over Billing and Collection of Medicaid Drug Rebates: CMS should ensure that States implement accounting and internal control systems in accordance with Federal regulations for the Medicaid drug rebate program. Such systems must provide for accurate, current, and complete disclosure of drug rebate transactions and provide CMS with the financial information it needs to effectively monitor and manage the Medicaid drug rebate program. (A-06-92-00029)</p>	<p>CMS concurred with the recommendation and set up a reporting mechanism to capture rebate information. The agency still needs to ensure that States establish adequate accounting and internal control systems to obtain reliable information. Current audit results have shown that this remains a problem in most States.</p>
<p>Fairly Presenting the Medicare Accounts Receivable Balance: CMS should require Medicare contractors to implement or improve internal controls and systems to ensure that reported accounts receivable are valid and documented. (A-17-95-00096; A-17-97-00097; A-17-98-00098; A-17-00-00500; A-17-00-02001; A-17-01-02001; A-17-02-02002; A-17-03-03003)</p>	<p>CMS hired consultants to assist in validating accounts receivable reported by Medicare contractors and provided comprehensive instructions to contractors. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.</p>
<p>Guidance to Drug Manufacturers To Better Implement the Medicaid Drug Rebate Program: CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). CMS should also develop a more specific policy for calculating this price that would protect the interests of the Government and that would be equitable to the manufacturers. (A-06-91-00092)</p>	<p>CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. OIG disagrees because the rebate law and agreements defined AMP but did not provide specific written methodology for computing it.</p>

OIG Recommendation	Status
<p>Accuracy of Carrier Payment Data: CMS should conduct a review of carriers’ claims processing data to examine the scheduled date of payment entered on claims sent to the Common Working File (CWF). If there is no correlation between the claims payment date variable and the actual date of payment, CMS should define what data should be entered into this field and how it should be calculated, and/or revise the current variable definition to clarify for National Claims History data users that the scheduled date of payment is not an accurate reflection of the actual claim payment date. CMS should also review the carriers’ claims processing data to determine the accuracy of the information contained in the CROWD system. (OEI-03-00-00350)</p>	<p>CMS stated that a review is under way to compare data contained in the National Claims History File with data at the carrier level. CMS has also approved two new edits, which will enforce the payment floor standards on claims sent to the CWF.</p>
<p>Duplicate Payments for the Same Service by Multiple Carriers: CMS should revise CWF edits to detect and deny duplicate billings to individual carriers or to more than one carrier, or increase postpayment reviews if such edits are determined not to be cost effective. (OEI-03-00-00090; OEI-03-00-00091)</p>	<p>CMS concurred with OIG’s recommendations and will reexamine existing criteria regarding duplicate editing in the CWF system to determine the cost- effectiveness of including the carrier number in the match criteria. CMS entered a contract to study duplicate billing.</p>
<p>Inappropriate Payments for Blood Glucose Test Strips: CMS should alert suppliers of the importance of properly completed documentation to support their claims for test strips; require suppliers to indicate actual and accurate “start” and “end” dates on claim forms; promote supplier concurrence and cooperation with OIG’s recently issued compliance guidelines; and advise beneficiaries to report any instances of fraudulent or abusive practices involving their home blood glucose monitors, test strips, or related supplies to their Durable Medical Equipment Regional Contractors (DMERCs). (OEI-03-98-00230)</p>	<p>CMS concurred with the recommendations and noted a number of initiatives that have reduced the incidence of improper payments in recent years.</p>
<p>Educating Beneficiaries on Reducing Financial Liability for Durable Medical Equipment: CMS should educate beneficiaries on ways to reduce financial liability for medical equipment and supplies and reevaluate Medicare fee schedules for ostomy supplies. (OEI-07-99-00510)</p>	<p>CMS concurred with OIG’s recommendations and has undertaken a number of efforts to increase beneficiary education and awareness about the consequences of assigned and nonassigned claims.</p>

OIG Recommendation	Status
<p>Resident Assessment Instruments: CMS should more clearly define minimum data set (MDS) elements and work with States to train nursing home staff. OIG recommended that CMS establish an audit trail to validate the 108 MDS elements that affect facility reimbursement by Medicare. (OEI-02-99-00040; OEI-02-99-0041)</p>	<p>CMS generally concurred with OIG’s recommendations for improved data definitions and training, but did not concur with the recommendation to establish an audit trail.</p>
<p>Assessments of Mental Illness: CMS should work with States to improve the assessment of persons with serious mental illness and use survey and certification to monitor compliance. OIG also recommended that CMS define specialized services that are to be provided by the State to nursing home residents with mental illness. (OEI-05-99-00700)</p>	<p>CMS concurred with most of OIG’s recommendations and has made revisions to its training curriculum for nursing home surveyors.</p>
<p>Nursing Home Residents With Serious Mental Illness: CMS should improve the quality and usefulness of its data sources by requiring the use of a unique provider number across systems, requiring reporting of resident data by age and diagnosis, and encouraging States to use these data in demonstrating their progress in placing disabled persons in the most integrated settings. OIG also recommended training to improve data collection and accurate coding. (OEI-05-99-00701)</p>	<p>Except for reporting MDS records by primary, secondary, and tertiary diagnoses, CMS concurred with most of OIG’s recommendations. CMS does not feel that adding space to the MDS to record diagnoses would solve the problem.</p>
<p>Payments for Mental Health Services: CMS should promote provider awareness of documentation and medical necessity requirements, develop a comprehensive list of psychological testing tools that can be correctly billed, target problematic services for prepayment edits or postpayment medical review, and encourage carriers to take advantage of the MDS, especially for its assessment of patient cognitive level. (OEI-03-99-00130; OEI-02-99-00140)</p>	<p>CMS generally concurred with the recommendations, plans to explore a variety of educational efforts, and will refer the reports to the carrier clinical workgroup on psychiatric services. Carriers will conduct data analysis of psychological testing and psychotherapy claims and will conduct medical review, if indicated.</p>

OIG Recommendation	Status
<p>Organ Donation: CMS should revise the Medicare conditions for coverage for organ procurement organizations (OPOs) to make them more accountable for implementing the new donation rule and require OPOs to provide hospital-specific data on referrals and on organ recovery. HRSA should require that OPOs submit hospital-specific data on referrals and on organ recovery and support demonstration projects on how to effectively train and make use of designated requestors. (OEI-01-99-00020)</p>	<p>CMS concurred with the recommendations and indicated that it will explore ways in which additional data can be used to assess OPO effectiveness and hospital compliance with the donation rule. CMS published a Notice of Proposed Rule-Making (NPRM) on February 4, 2005, establishing new conditions of coverage regarding OPOs. That proposed regulation requires OPOs to report hospital-specific organ donation, including organ donor potential and the number of actual donors, at least annually to the public. HRSA, through its contract for operation of the Organ Procurement and Transplantation Network, requires OPOs to submit hospital-specific data on organ recovery.</p>
PUBLIC HEALTH AGENCIES	
<p>Oversight of Tissue Banking: FDA should expedite publication of its regulatory agenda requiring registration of tissue banks, enhanced donor suitability screening, and testing the use of good tissue practices. FDA should set a realistic yet aggressive date by which it would complete an initial inspection of all tissue banks. FDA should determine the appropriate minimum cycle for tissue bank inspections and work with States and professional associations to determine in what areas oversight activities could be coordinated. (OEI-01-00-00441)</p>	<p>The Deputy Secretary concurred that FDA should expedite its planned rulemaking activities related to tissues, specifically the final rule to require registration of tissue banks. The Department also found “considerable merit” in OIG’s recommendation for an intensified inspection program directed toward entities that procure, process, and store human tissues. In congressional testimony, FDA said that all three of the proposed rules have been published, and one rule (Establishment Registration and Listing) was finalized. FDA has completed contacting the 36 uninspected tissue banks. The results were: 31 inspections were completed, 3 firms were out of business, 1 firm could not be located, and 1 firm was not an FDA obligation because it handled only vascularized organs. In 2004, FDA finalized donor eligibility and good tissue practices regulations, which will become effective on May 25, 2005. This completes the rule making activities related to human tissues.</p>

OIG Recommendation	Status
<p>Effectiveness of FDA’s Adverse Event Reporting System for Dietary Supplements:</p> <p>FDA should (1) facilitate greater detection of adverse events by requiring dietary supplement manufacturers to report serious events to FDA for some products, (2) obtain more information on adverse event reports by requiring manufacturers to register themselves and their products with FDA, (3) notify manufacturers when FDA receives a serious adverse event report and develop a new computer database to track and analyze adverse event reports, (4) expedite the development and implementation of good manufacturing practices for dietary supplement manufacturers, and (5) disclose more useful information to the public about dietary supplement adverse events. (OEI-01-00-00180)</p>	<p>FDA has addressed a number of the recommendations from the OIG report. The Center for Food Safety and Applied Nutrition (CFSAN) is continuing to improve its Adverse Events Reporting System (CAERS), a new single system for entering adverse event and consumer complaint reports involving foods, cosmetics, and dietary supplements. CAERS has been operational in a limited manner since June 2003, and CAERS staff work closely with program experts as well as external stakeholders. CFSAN also plans to improve data links to the FDA Center for Drug Evaluation’s adverse event reporting system. FDA published proposed current Good Manufacturing Practices regulations for dietary supplements in March 2003 and as in 2004 is now preparing the final regulation. Pursuant to the requirement for food facility registration in the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, FDA requires facilities that manufacture, process, pack, or hold dietary supplements to be registered with FDA. FDA strives to inform the public of current developments with respect to dietary supplements through its dietary supplement Web site.</p>
<p>Protection for Research Subjects in Foreign Clinical Trials:</p> <p>FDA should examine ways to obtain more information about the performance of non-U.S. Institutional Review Boards (IRBs) and help those inexperienced IRBs build their capacities, encourage all non-U.S. investigators participating in research to sign attestations upholding human subject protections, and develop a database to track the growth and location of foreign research. The Office for Human Research Protections (OHRP) should exert leadership in developing strategies to ensure adequate human subject protections for non-U.S. clinical trials funded by the Federal Government and those that contribute data to new drug applications. (OEI-01-00-00190)</p>	<p>FDA supported OIG’s recommendations, but noted that in most cases it did not have the resources to implement the recommendations. FDA has published a proposed rule to revise its regulations pertaining to foreign clinical studies that are not conducted under an Investigational New Drug Application. The proposed revision would require that studies be conducted in accordance with good clinical practice (GCP), including review and approval by an independent ethics committee. The proposed rule also specifically recommends that sponsors collect attestations by clinical investigators that the studies were conducted in compliance with GCP. OHRP provides quality improvement consultation and research ethics training to domestic and foreign institutions involved in international biomedical and behavioral research to help ensure that recognized ethical protections are afforded to persons participating in research conducted in countries outside the United States.</p>

OIG Recommendation	Status
ADMINISTRATION FOR CHILDREN AND FAMILIES	
<p>Child Support Orders for Low-Income Noncustodial Parents: ACF's Office of Child Support Enforcement should work with States to emphasize parental responsibility and improve the ability of low-income noncustodial parents to meet their obligations. ACF should facilitate and support State experiments to test the payment effects of using various periods of retroactivity in determining the amount of support owed and facilitate and support State experiences to test negotiating child support debt owed to the States in exchange for improved payment compliance. (OEI-05-99-00391)</p>	<p>ACF is helping nine States test approaches to serving young, never-married fathers who may have obstacles to employment and who do not have a child support order. ACF has granted a contract to determine how computerized income data can be used by local child support offices to independently verify the income of noncustodial parents and be used in the establishment or modification of child support orders where income documentation or verification is lacking or incomplete.</p>
GENERAL OVERSIGHT	
<p>Cost Principles for Federally Sponsored Research Activities: The Department should modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (A-01-92-01528)</p>	<p>The Department circulated several draft iterations of the hospital cost principles to internal users for comment. Many of the policies in the outdated document have been updated in the draft regulation. The target date for issuing the draft regulation as a notice of proposed rulemaking was December 31, 2004. Once the formal notice and rulemaking process is complete, the updated cost principles will be issued.</p>

Appendix D

Notes to Tables 1 and 2

Notes to Table 1

¹The opening balance was adjusted upward \$70.3 million.

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

CIN: A-03-00-00002	TRIGON PT-A AND TERMINATION: The recommended disallowance for \$700,885 was included in a global settlement.
CIN: A-06-01-00039	REV OF THE TX STAR PLUS MEDICAID MANAGED CARE PROGRAM: Additional documentation was provided by the State supporting \$15,483 of questioned costs.
CIN: A-02-02-69503	PUERTO RICO DEPT. OF THE FAMILY: Additional documentation was provided by State supporting \$121,569 of questioned costs.

³Included are management decisions to disallow \$41.9 million that was identified in nonfederal audit reports.

⁴Most of these nonconcurrences relate to a series of reports where, after our reports were issued, the OPDIV decided to reexamine existing policy and therefore concluded it would not be appropriate to collect identified overpayments.

⁵A.

Due to administrative delays, many of which are beyond management control, resolution of the following 340 audits were not completed within 6 months of issuance; however, based upon discussions with management, resolution is expected before the end of the next semiannual reporting period:

CIN: A-04-00-02171	REV. AL M'CAID INTERGOV'TAL TRANSFERS-HOSP. ENHANC, MAY 2001, \$236,983,528
CIN: A-02-02-01030	REVIEW OF SPEECH SCHOOL HEALTH CLAIMS - REST OF STATE, FEB 2004, \$172,553,831
CIN: A-09-02-00054	AUDIT OF STATE OF CALIFORNIA DSH PROGRAM FOR FY 1998, MAY 2003, \$128,269,448
CIN: A-04-99-05561	AUDIT ADMIN COST PROPOSALS FY95-98, BCBSFL, JAX, JUL 2002, \$101,671,328
CIN: A-09-02-00071	AUDIT OF CA DSH PROGRAM FOR FY 1998 - LA COUNTY, MAY 2003, \$98,190,042
CIN: A-02-03-01008	REVIEW OF TRANSPORTATION SCHOOL HEALTH CLAIMS - REST OF STATE, AUG 2004, \$53,037,302
CIN: A-04-00-01220	IMPLE. M'CARE'S POSTACUTE CARE TRANSFER POLICY, OCT 2001, \$52,311,082
CIN: A-05-01-00058	OHIO MEDICAID HOSPITAL-SPECIFIC DSH PAYMENT LIMITS, JUN 2004, \$47,000,000
CIN: A-04-01-02006	MEDICAID DISPROPORTIONATE SHARE PAYMENTS IN ALABAMA, JUN 2004, \$45,763,327

CIN: A-07-01-02093	MISSOURI DSH - UNALLOWABLE COSTS, AUG 2002, \$36,200,000
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES - CT, MAY 2003, \$32,780,146
CIN: A-07-01-00125	TRANSAMERICA (TOLIC) - PENSION SEGMENT CLOSING AUDIT, MAY 2002, \$20,227,001
CIN: A-03-01-00224	MEDICAID SCHOOL-BASED SERVICES/MARYLAND, MAR 2003, \$19,954,944
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEP 2002, \$19,446,435
CIN: A-05-01-00052	DME REVIEW IN INDIANA, OCT 2001, \$16,377,560
CIN: A-06-01-00035	COLLECTION OF AFDC OVERPAYMENTS, JAN 2002, \$13,800,000
CIN: A-01-01-02502	REVIEW OF UNCOLLECTED AFDC OVERPAYMENTS, AUG 2001, \$12,400,000
CIN: A-07-02-03032	MEDICARE SEGMENT CLOSING AUDIT OF TRAILBLAZERS, JUN 2004, \$11,152,093
CIN: A-02-02-01028	REVIEW OF RETRO ACUTE CARE HOSPITAL DSH CLAIMS FOR INMATE COSTS, JAN 2004, \$11,114,820
CIN: A-05-02-00031	AFDC OVERPAYMENTS - WISCONSIN, AUG 2002, \$10,711,338
CIN: A-01-01-00513	MEDICARE PT B PMT FOR DME I/P PRTL MNTH STAYS SNF, OCT 2001, \$10,500,000
CIN: A-06-02-00034	REV OF COST REPORTS & MEDICARE FEE-FOR-SERVICE PYMTS @ SCOTT & WHITE, MAY 2003, \$8,229,574
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEP 2002, \$7,999,212
CIN: A-02-02-01024	IMD UNDER 21 AUDIT IN NEW YORK, FEB 2004, \$7,642,194
CIN: A-09-97-44262	STATE OF CALIFORNIA, APR 1997, \$7,300,000
CIN: A-07-02-03033	CAREFIRST SEGMENTATION AUDIT, MAY 2003, \$6,788,644
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM -- NATIONAL, MAR 1993, \$6,529,545
CIN: A-03-01-00222	MEDICAL COLLEGE OF VIRGINIA/DSH/MEDICAID, APR 2003, \$6,324,796
CIN: A-05-02-00049	MEDICAL SERVICE COSTS UNDER ILLINOIS SCHOOL-BASED MEDICAID, DEC 2003, \$6,067,669
CIN: A-02-04-02006	REVIEW OF IFCP DRAWDOWNS AND FINANCIAL POSITION, JUL 2004, \$5,696,132
CIN: A-07-03-04021	HOME HEALTH PPS SYSTEM CONTROLS 14 DAY PAYMENT, MAR 2004, \$5,675,661
CIN: A-03-99-00052	ALLEGHENY/CHESAPEAKE ORF, SEP 2001, \$5,540,344
CIN: A-04-00-02161	MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOV 2001, \$5,344,160
CIN: A-01-02-00016	MEDICAID SCHOOL-BASED HEALTH SERVICE ADMINISTRATIVE CLAIMING REVIEW-MASSACHUSETTS, SEP 2004, \$5,312,447
CIN: A-09-03-00042	REVIEW OF HHA PRECEEDING HOSPITAL STAY UNDER PPS - UGS, FEB 2004, \$5,306,825
CIN: A-06-02-00060	REVIEW PACIFICARE OK BIPA MODIFICATIONS TO CY 2001 ACRP, JUN 2004, \$5,204,042

CIN: A-05-03-00096 REVIEW OF ADMINISTRATIVE COSTS FOR ADMINASTAR FEDERAL, AUG 2004, \$5,000,598

CIN: A-01-97-00516 ADMIN. COSTS-PART A&B, RAILROAD RETIRE BOARD, JUN 1999, \$4,939,184

CIN: A-03-01-00226 UVA MEDICAL CENTER/DSH/MEDICAID/VIRGINIA, MAY 2003, \$4,760,385

CIN: A-05-01-00023 ADMINISTRATIVE COSTS REVIEW - ADMINASTAR FEDERAL, JAN 2002, \$4,694,863

CIN: A-02-00-01047 DEMO BSWNY - FINANCIAL, MAR 2002, \$4,505,051

CIN: A-07-98-01263 DENVER CMHC, MAY 2000, \$4,447,607

CIN: A-07-02-00144 IV-E FOSTER CARE ADMINISTRATIVE COSTS CLAIMED, AUG 2003, \$4,335,542

CIN: A-01-02-00015 REVIEW OF MA MEDICAID USE OF REVISED FEE SCHEDULES FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES, JAN 2004, \$4,100,000

CIN: A-07-04-03053 REVIEW OF CAHABA'S UNFUNDED PENSION COSTS, FEB 2004, \$4,006,541

CIN: A-03-01-00225 VIRGINIA IMD UNDER 21, MAR 2004, \$3,948,532

CIN: A-05-01-00068 PARTNERSHIP PLAN - ILLINOIS PHYSICIAN BILLING-FAMILY DYNAMICS, JUL 2002, \$3,790,846

CIN: A-04-01-05002 AUDIT MEDICAID PAYMENTS FOR CLINICAL LABORATORIES, JAN 2002, \$3,522,639

CIN: A-02-95-01019 STAFF BUILDERS HOME OFFICE MEDICARE COST REV. ORT, AUG 1998, \$3,434,274

CIN: A-01-02-00525 MAINE ANTHEM BCBS - MEDICARE ADMINISTRATIVE COSTS, APR 2004, \$3,389,716

CIN: A-07-99-01298 DATE OF DEATH - 2, MAY 2001, \$3,200,000

CIN: A-05-98-00042 ADMINISTAR INS. CO.--ADMIN. COSTS AUDIT, SEP 1999, \$3,111,728

CIN: A-09-02-00061 REVIEW OF MEDICAL CLAIMS FOR PRIVATE IMD PATIENTS, DEC 2002, \$3,083,389

CIN: A-04-01-00005 MEDICAID FFS PAYMENTS TO LEA'S IN NORTH CAROLINA, MAY 2004, \$3,066,806

CIN: A-07-02-03007 COSTS CLAIMED FOR POST RETIREMENT BENEFITS BY TOLIC, MAY 2002, \$3,060,873

CIN: A-07-03-03046 TRAILBLAZERS - REVIEW OF PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, JUL 2004, \$3,023,483

CIN: A-09-98-50183 STATE OF CALIFORNIA, MAR 1998, \$3,000,000

CIN: A-01-02-00508 REVIEW OF MEDICARE CONTRACT TERMINATION COSTS - UNITED HEALTHCARE, NOV 2003, \$2,894,010

CIN: A-01-96-00508 MEDICARE ADMIN COSTS PARTS A&B AND RRB - TRAVELERS, MAR 1996, \$2,803,260

CIN: A-05-02-00085 MEDICAID FFS PAYMENTS FOR OHIO BENEFICIARIES ENROLLED IN MEDICARE MCOS, JUN 2004, \$2,700,000

CIN: A-01-04-78839 STATE OF NEW HAMPSHIRE, JUN 2004, \$2,631,648

CIN: A-07-03-03039 CAREFIRST OF MARYLAND UNFUNDED PENSION COSTS, MAY 2003, \$2,611,100

CIN: A-05-97-00005	ADMINISTRATIVE COSTS CLAIMED UNDER MEDICARE A & B, FEB 1998, \$2,569,067
CIN: A-05-03-00062	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF NORIDIAN MUTUAL INSURANCE COMPANY, JUN 2003, \$2,400,000
CIN: A-09-02-72300	STATE OF CALIFORNIA, JUL 2002, \$2,400,000
CIN: A-02-91-01006	BLUE SHIELD OF WESTERN NY MEDICARE ADM CTS PORTER, SEP 1991, \$2,379,239
CIN: A-04-04-01001	INTERIM CONTRACT AUDIT, AUG 2004, \$2,352,388
CIN: A-03-99-00038	EDGEWATER PSYC HOSPITAL, MAR 2001, \$2,348,604
CIN: A-06-01-00083	AUDIT OF MEDICAID SCHOOL-BASED SERVICES IN OKLAHOMA, APR 2003, \$2,332,774
CIN: A-07-97-01247	DUPLICATE PAYMENTS - HMO/FFS, OCT 1999, \$2,300,000
CIN: A-10-02-00008	REVIEW OF WASHINGTON STATE'S MEDICAL ASSISTANCE COSTS CLAIMED FOR SCHOOL-BASED HEALTH SERVICES, JUL 2003, \$2,279,752
CIN: A-04-02-07007	MEDICAID FEE FOR SERVICE PAYMENTS FOR DUALY ELIGIBLE MEDICARE MANAGED CARE ENROLLEES, FEB 2003, \$2,231,100
CIN: A-04-97-01170	REVIEW HOME HLTH SRVCS BY MEDCARE HOME HLTH SRVCS, APR 1999, \$2,200,000
CIN: A-09-01-00056	PACIFICARE-CALIFORNIA JAN 1998 INSTITUTIONAL PMTS, SEP 2001, \$2,158,577
CIN: A-05-03-00041	HOSPITAL TRANSFERS NORTH CAROLINA, MAY 2004, \$2,151,055
CIN: A-05-03-00063	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF MEDICARE NORTHWEST (BLUE CROSS BLUE SHIELD OF OREGON),OCT 2003, \$2,100,000
CIN: A-07-04-00162	AUDIT OF BCBS NORTH CAROLINAS CLAIM FOR POST RETIREMENT BENEFIT COSTS TO BE INCURRED AFTER TERMINATION OF ITS MEDICARE CONTRACT AND CLOSING OF ITS MEDICARE SEGMENT, JUN 2004, \$2,074,473
CIN: A-07-01-03001	BCBS OF MN PENSION SEGMENT CLOSING, JAN 2003, \$2,003,341
CIN: A-05-00-00034	PROVENA ST. JOSEPH HOSPITAL-O/P PSYCH SERVICES, NOV 2000, \$1,978,583
CIN: A-05-02-00048	REVIEW OF MEDICAID DME CLAIMS - TEXAS, SEP 2002, \$1,969,704
CIN: A-01-03-00500	HOME HEALTH PPS SYSTEM CONTROLS 14 DAY PAYMENT-WHEN PRECEDED BY A HOSPITAL DISCHARGE, JUL 2003, \$1,861,857
CIN: A-05-97-00014	GROUP HEALTH PLAN INC.(HEALTHPARTNERS) INST. BENES, JUN 1998, \$1,808,308
CIN: A-05-03-00071	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ANTHEM HEALTH PLANS OF MAINE, INC., OCT 2003, \$1,800,000
CIN: A-01-02-00516	REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES UNITED GOVERNMENT SERVICES, MAR 2003, \$1,768,783

CIN: A-09-00-00127 BLUE CROSS OF CALIF - MEDICARE ADMIN COSTS, DEC 2002, \$1,677,822

CIN: A-03-00-00215 ANNABURG MANOR NURSING HOME COST REPORT, MAR 2002, \$1,582,079

CIN: A-04-01-05011 REVIEW OF FLORIDA MEDICAID PAYMENTS FOR SERVICES PROVIDED TO INMATES, OCT 2002, \$1,450,077

CIN: A-07-02-03021 ANTHEM BCBS OF CT - PENSION SEGMENT CLOSING, FEB 2004, \$1,351,284

CIN: A-05-95-00042 BCBSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DEC 1995, \$1,333,598

CIN: A-04-03-02024 REVIEW OF BCBSFL RESPONSE TO SET-ASIDE COSTS IN PRIOR FACP AUDIT, APR 2003, \$1,277,247

CIN: A-05-01-00064 REVIEW OF OUTPATIENT REHABILITATION CLAIMS REIMBURSED BY MEDICARE DURING CALENDAR YEAR 1999, FEB 2002, \$1,235,892

CIN: A-03-01-00251 AFDC OVERPAYMENTS - VIRGINIA, MAR 2003, \$1,221,494

CIN: A-04-02-72903 STATE OF TENNESSEE, SEP 2002, \$1,213,353

CIN: A-05-00-00004 NEW CENTER COMMUNITY MENTAL HEALTH CENTER, JUN 2000, \$1,181,000

CIN: A-04-03-01000 REVIEW OF HOME HEALTH SERVICES CLAIMED BY LIFELINE HEALTH GROUP, INC, JUN 2004, \$1,173,330

CIN: A-05-00-00049 PARTNERSHIP PLAN - IL HOSPITAL TRANSFERS, JUN 2001, \$1,150,113

CIN: A-02-97-01026 EDDY VNA (#337152) HHA ELIGIBILITY REVIEW, SEP 1999, \$1,131,593

CIN: A-05-98-00050 FOLLOW-UP MEDICAID CLINICAL LABORATORIES, JUL 1999, \$1,097,036

CIN: A-09-02-01004 USC GRANTS MANAGEMENT REVIEW, JUL 2004, \$1,082,554

CIN: A-09-98-00052 CALIFORNIA MEDICAL REVIEW INC. (CA. PRO), JAN 1999, \$1,067,991

CIN: A-05-01-00037 BC/BS OF MN. ADMIN COSTS--LEON SNEAD & CO., JUN 2001, \$1,037,090

CIN: A-01-98-00500 PAYMENT EDITS FOR PSYCHIATRIC AT MA PART B CARRIER, SEP 1998, \$1,000,000

CIN: A-02-04-77762 MONTCLAIR CHILD DEVELOPMENT CENTER INC., MAR 2004, \$992,617

CIN: A-09-94-01010 CLOSEOUT AUDIT--CONT NO. N01-ES-75196 (STRATAGENE), MAR 1994, \$983,208

CIN: A-05-01-00059 ILLINOIS MEDICAID HOSPITAL-SPECIFIC DSH PAYMENT LIMITS, AUG 2004, \$972,810

CIN: A-06-02-00027 TEXAS MEDICARE BAD DEBT COLLECTIONS, OCT 2002, \$919,331

CIN: A-05-92-00060 CONTRACTOR AUDIT - BCBS - ADMIN, FEB 1993, \$879,609

CIN: A-05-04-77356 TRI-VALLEY OPPORTUNITY COUNCIL INC., FEB 2004, \$866,666

CIN: A-07-98-02533 TRAVELERS FACP, DEC 1998, \$854,214

CIN: A-04-01-05004 REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MAR 2002, \$836,711

CIN: A-02-98-01040 NIAGARA CTY DEPT. OF HLTH-#337001-HHS ELIG REVIEW, DEC 1999, \$807,679

CIN: A-05-04-00032 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF PREMERA BLUE CROSS, AUG 2004, \$786,442

CIN: A-06-03-00013	MEDICARE ADMINISTRATIVE COST PROPOSAL-ARKANSAS BCBS, OCT 2003, \$759,748
CIN: A-07-99-00981	ASSIST REVIEW OF MEDICARE A/R HCFA RO DENVER, JAN 2000, \$754,926
CIN: A-01-04-76290	STATE OF MAINE, JAN 2004, \$735,765
CIN: A-05-02-00041	INDIANA MEDICAID HOSPITAL PATIENT TRANSFERS, JAN 2003, \$730,061
CIN: A-09-00-00103	PACIFICARE HMO - MEDICARE DUAL ELIGIBLES, MAY 2001, \$720,858
CIN: A-09-03-00046	AUDIT OF ORGAN ACQUISITION COSTS AT ST VINCENT, JUL 2004, \$683,315
CIN: A-06-01-00090	PREAWARD-APASS MAINTAINER DATA PROCESSING SERVICES-ABCBS, SEP 2001, \$678,651
CIN: A-05-00-64226	NA-ILLINOIS DEPT. OF PUBLIC AID, MAY 2000, \$654,017
CIN: A-06-03-00032	AUDIT OF ADMIN COSTS PART A & PART B OF MEDICARE PROGRAM-TRAILBLAZERS, APR 2004, \$622,078
CIN: A-01-99-00535	AUDIT OF M/C PART A ADMIN COSTS-ANTHEM BC/BS CT, AUG 2000, \$621,256
CIN: A-04-00-00138	MEDICAID ESCHEATED WARRANTS - FLORIDA, JAN 2002, \$613,891
CIN: A-06-98-00066	ORT REVIEW OF ULTIMATE HOME HEALTH CARE INC., OCT 1999, \$602,982
CIN: A-07-04-00170	REVIEW OF PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT FOR VERITUS, AUG 2004, \$594,806
CIN: A-04-94-01078	MONITORING ADMIN COST - AUDIT M'CARE P.B BCBSSC, JUL 1994, \$594,092
CIN: A-04-93-01069	MONITORG ADMIN COST AUDIT MCARE PART A BCBSSC, JUL 1994, \$590,844
CIN: A-04-01-01007	GABCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOV 2001, \$575,471
CIN: A-05-04-00033	REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF BLUE CROSS AND BLUE SHIELD OF KANSAS, INC., JUN 2004, \$559,282
CIN: A-09-01-00055	REVIEW OF IMD CLAIMS - STATE OF CALIFORNIA, MAR 2002, \$551,394
CIN: A-07-02-03015	BCBS OF MN PENSION COSTS CLAIMED FOR MEDICARE REIMBURSEMENT, FEB 2003, \$550,083
CIN: A-05-02-72811	COMMUNITY ACTION OF GREATER INDIANAPOLIS INC., AUG 2002, \$547,899
CIN: A-05-99-00062	AMERICARE PHYSICAL THERAPY SERVICES, DEC 2000, \$503,619
CIN: A-09-99-56858	HAWAII DEPT. OF HUMAN SERVICES, FEB 1999, \$502,000
CIN: A-03-92-16229	STATE OF PENNSYLVANIA, MAR 1992, \$496,876
CIN: A-02-02-01004	MEDICAID PPS TRANSFERS, MAY 2003, \$493,158
CIN: A-05-01-67384	MICHIGAN DEPT. OF COMMUNITY HEALTH, FEB 2001, \$481,693
CIN: A-01-04-00506	REVIEW OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS CLAIMED BY SAINT MARY'S HOSPITAL FOR FISCAL YEAR ENDING DECEMBER 31, 2002, MAY2004, \$433,502
CIN: A-07-01-00120	REVIEW OF UNFUNDED PENSION COCST AT BCBS OF OK, JUL 2001, \$413,800

CIN: A-05-03-00053	ESRD PRICING ERRORS AT INDEPENDENT FACILITIES, NOV 2003, \$407,300
CIN: A-02-01-67912	STATE OF NEW YORK, MAR 2001, \$389,536
CIN: A-05-00-00030	CONTRACTED AUDIT-NATIONWIDE INS.-MEDICARE ADMIN., OCT 2000, \$385,081
CIN: A-01-02-73084	STATE OF MAINE, SEP 2002, \$362,326
CIN: A-07-03-02653	REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION BC/BS ARKANSAS, JAN 2003, \$344,883
CIN: A-10-01-00005	AUDIT OF ADMIN COSTS AT MEDICARE NORTHWEST, SEP 2001, \$332,274
CIN: A-07-01-02630	REVIEW OF MUTUAL'S SETTLEMENT OF HHA COST REPORTS, JAN 2002, \$319,949
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$319,355
CIN: A-09-03-00032	BLUE CROSS OF CALIFORNIA, MEDICARE, TERMINATION COSTS, OCT 2003, \$319,187
CIN: A-05-02-00023	SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MAR 2003, \$315,474
CIN: A-06-01-00028	AUDIT OF OBSERVATION SERVICE BILLINGS BY PPS HOSPITALS, FEB 2002, \$298,549
CIN: A-09-03-01017	REVIEW OF RYAN WHITE TITLE I SF CONTRACTOR - BAKER PLACES, AUG 2004, \$297,237
CIN: A-09-03-00050	OREGON MEDICAID REIMBURSEMENT RATE FOR NURSING FACILITY ADMINISTRATIVE COSTS, OCT 2003, \$290,769
CIN: A-01-04-00522	THE MID COAST HOSPITAL IN MANIE DSH PAYMENT, SEP 2004, \$289,936
CIN: A-05-96-00069	CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEB 1998, \$280,515
CIN: A-09-94-30178	STATE OF ARIZONA, JUN 1994, \$267,021
CIN: A-05-02-00047	UNITED GOVERNMENT SERVICES, MEDICARE PART A ADMIN. COSTS FY 1999-2001, JUN 2003, \$260,831
CIN: A-07-03-02662	REVIEW OF MULTIPLE ASC PROCEDURES IN THE SAME SESSION NORDIAN, DEC 2002, \$258,112
CIN: A-02-03-04001	AUDIT OF RUTGERS CONTRACT NO. SPO 103-96-D-0016/0001, AUG 2003, \$249,381
CIN: A-01-03-01503	NORTHEASTERN UNIVERSITY DHHS CONTRACT COSTS - GRANT #59307, JUN 2004, \$245,174
CIN: A-06-04-79691	GULF COAST COMMUNITY SERVICES ASSOCIATION, AUG 2004, \$230,618
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCT 2002, \$229,656
CIN: A-04-00-01222	CAPITAL HLTH PLAN, COST-BASED MANAGED CARE PLAN, SEP 2001, \$221,952
CIN: A-01-00-00549	BETH ISRAEL AUDIT OF OUTPATIENT PHARMACY SVC, MAR 2001, \$221,905
CIN: A-05-99-00067	WPS PART B ADMINISTRATIVE COSTS, NOV 2000, \$221,644

CIN: A-02-03-04006 GRANT REVIEW DAAG55-97-1-0281, MAR 2004, \$221,365

CIN: A-02-01-65217 PUERTO RICO DEPT. OF THE FAMILY, DEC 2000, \$213,264

CIN: A-05-01-00103 PAYMENTS FOR SERVICES TO DECEASED BENEFICIARIES - MICHIGAN, OCT 2003, \$211,894

CIN: A-02-01-01019 DEMO BSWNY - CASH MANAGEMENT, OCT 2002, \$208,271

CIN: A-05-04-00058 REVIEW OF INELIGIBLE SNF PAYMENTS UNDER THE ADMINISTRATIVE RESPONSIBILITY OF ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC., JUL 2004, \$206,495

CIN: A-01-04-00504 REVIEW OF MEDICARE INPATIENT REHABILITATION FACILITY PROSPECTIVE PAYMENTS AT WELDON REHABILITATION HOSPITAL FOR FISCAL YEAR 2003, JUL 2004, \$202,872

CIN: A-07-03-02656 REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION KANSAS, DEC 2002, \$190,106

CIN: A-04-04-78917 STATE OF FLORIDA, AUG 2004, \$186,096

CIN: A-03-01-00555 PDPI INC. -- HEAD START, JUN 2001, \$185,577

CIN: A-07-02-03016 TRANSAMERICA SUPPLEMENTAL PENSION PLAN COSTS, MAR 2002, \$180,244

CIN: A-07-01-02094 SURVEY OF OUTPATIENT OBSERVATION SERVICES, OCT 2002, \$165,125

CIN: A-03-98-00034 FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MAR 1999, \$156,987

CIN: A-07-03-02664 REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION TRAILBLAZERS, DEC 2002, \$140,202

CIN: A-08-03-74616 OGLALA SIOUX TRIBAL DEPT. OF PUBLIC SAFETY, MAR 2003, \$136,764

CIN: A-02-98-01002 IPRO CLOSEOUT AUDIT - CPA CONTRACT MONITORING, DEC 1998, \$135,492

CIN: A-05-00-00060 MEDICA FOLLOW-UP, REIMB. RATES FOR INSTI. BENES, JUN 2001, \$133,795

CIN: A-07-04-03051 MEDICAID PROVIDER OVERPAYMENTS IN UTAH, AUG 2004, \$132,749

CIN: A-06-00-00014 REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCAR, JUN 2000, \$132,238

CIN: A-07-03-02661 REVIEW OF MULTIPLE ASC PROCEDURES IN SAME SESSION NHIC, JAN 2003, \$129,748

CIN: A-05-03-00067 ADMINISTRATIVE COSTS - WI MEDICAID WAIVERS, JUN 2004, \$129,663

CIN: A-02-01-04000 INTERIM AUDIT OF RUTGER'S CONTRACT NO.SP0103-96-D-, JAN 2002, \$125,415

CIN: A-01-03-00010 MEDICAID SCHOOL-BASED HEALTH SERVICES ADMINISTRATIVE CLAIMING REVIEW - RHODE ISLAND, JUN 2004, \$123,010

CIN: A-05-01-00069 MERITER - MC/MA CREDIT BALANCES, JUL 2002, \$122,713

CIN: A-02-02-69503 PUERTO RICO DEPT. OF THE FAMILY, SEP 2002, \$121,569

CIN: A-05-01-00091 PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, \$121,023

CIN: A-09-99-52846 INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEB 1999, \$119,099

CIN: A-02-02-71384 STATE OF NEW YORK, MAR 2002, \$118,773

CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JAN 1998, \$114,631
CIN: A-09-02-71247	WATTSHEALTH FOUNDATION INC., APR 2002, \$113,000
CIN: A-01-02-00527	REVIEW OF ANTHEM BLUE CROSS/BLUE SHIELD MEDICARE CONTRACT TERMINATION AND SEVERANCE COSTS, SEP 2003, \$104,468
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, \$100,692
CIN: A-04-03-06007	NURSING HOME QUALITY OF CARE SANCTIONS - FLORIDA, FEB 2004, \$99,957
CIN: A-05-00-65775	STATE OF WISCONSIN, SEP 2000, \$98,586
CIN: A-05-02-00067	REVIEW OF MEDICARE FEE-FOR-SERVICE PAYMENTS & COST REPORTS @ WELBORN, JUN 2003, \$97,623
CIN: A-09-97-00066	WALTER MCDONALD - INDIRECT COST RATE AUDIT, MAR 1998, \$95,733
CIN: A-10-97-00003	BCWAAK-ADM COSTS REMOTE NETWORK ACTIVITIES FY93&94, FEB 1998, \$94,643
CIN: A-06-03-00021	CMS FY 02 MEDICARE ERROR RATE - TRAILBLAZER REPORT QTR 1 (NOV-DEC), JUL 2003, \$93,863
CIN: A-05-02-00074	IL PARTNERSHIP PLAN - TRANSPORTATION DURING AN INPATIENT STAY, APR 2003, \$89,147
CIN: A-05-01-00090	PAYMENTS TO AETNA OF FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, \$87,516
CIN: A-07-00-00118	REVIEW OF KANSAS RURAL HEALTH CENTER, MAY 2001, \$87,493
CIN: A-08-99-56914	RURAL AMERICA INITIATIVES, JUL 1999, \$87,468
CIN: A-04-01-01006	MBCBS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOV 2001, \$87,042
CIN: A-01-04-77722	STATE OF RHODE ISLAND & PROVIDENCE PLANTATIONS, JAN 2004, \$86,792
CIN: A-05-01-00071	PAYMENTS TO HUMANA-K.C. FOR INSTITUTIONAL BENEFICIARIES, DEC 2001, \$84,808
CIN: A-02-03-74061	PUERTO RICO DEPT. OF THE FAMILY, AUG 2003, \$80,001
CIN: A-05-01-00089	ADDITIONAL BENEFITS REVIEW ON MANAGED CARE ORGANIZATION, OCT 2002, \$77,000
CIN: A-01-99-00530	NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DEC 2000, \$75,413
CIN: A-05-03-00085	NURSING HOME QUALITY OF CARE SANCTIONS - ILLINOIS, MAY 2004, \$69,892
CIN: A-01-03-75448	STATE OF NEW HAMPSHIRE, APR 2003, \$65,917
CIN: A-08-03-74429	PORCUPINE CLINIC, JUL 2003, \$65,027
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, \$62,432
CIN: A-05-04-78989	STATE OF WISCONSIN, JUL 2004, \$61,505
CIN: A-05-99-00045	KAISER HEALTH PLAN OF OHIO - INSTITUTIONAL STATUS, MAY 2000, \$61,177

CIN: A-05-02-72716 SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND, SEP 2002, \$60,378

CIN: A-05-96-00072 MI DEPT. OF COMMUNITY HEALTH/MEDICAID LAB SERVICES, AUG 1997, \$59,956

CIN: A-01-96-00505 CFO AUDIT OF HCFA'S FINANCIAL STATEMENTS, JUL 1997, \$59,327

CIN: A-03-99-00036 VERITUS MEDICARE SERVICES/Y2K COST AUDIT, DEC 1999, \$53,267

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

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

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

CIN: A-05-02-00054 UNITED GOVERNMENT SERVICES, Y2K COSTS FY 1998 & 1999, APR 2003, \$49,923

CIN: A-02-99-58263 PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD, JUL 1999, \$49,684

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

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

CIN: A-06-03-75523 UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JUN 2003, \$48,400

CIN: A-02-04-76883 UNIV. OF PUERTO RICO-SYSTEM, OCT 2003, \$47,532

CIN: A-03-03-00378 REVIEW OF FDA'S USNA BONE MASS CLINICAL STUDY, SEP 2004, \$46,907

CIN: A-03-02-00373 REVIEW OF US HELPING US, DEC 2003, \$45,558

CIN: A-07-00-00106 PENSION SEGMENTATION AUDIT AT BCBS OF OKLAHOMA, JUL 2001, \$45,508

CIN: A-10-03-00004 REVIEW OF OUTLIER PAYMENTS MADE TO VIRGINIA MASON MEDICAL CENTER, OCT 2003, \$44,631

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

CIN: A-07-01-00121 REV. OF PEN. COSTS FOR MED. REIMB. FOR BCBS OF OK, JUL 2001, \$42,463

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

CIN: A-01-03-01500 REVIEW OF CDC HIV PROGRAMS AT GREATER BRIDGEPORT ADOLESCENT PREGNANCY PROGRAM, JUL 2003, \$41,088

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

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

CIN: A-10-03-00003 REVIEW OF DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTS AT REGENCE BLUESHIELD OF IDAHO, OCT 2003, \$39,660

CIN: A-03-03-00211 MEDICAID DENIAL OF PAYMENT REMEDY FOR SANCTIONED NURSING HOMES - PA, JUN 2004, \$39,074

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

CIN: A-06-03-00020 CMS FY 02 MEDICARE ERROR RATE - TRAILBLAZER REPORT QTR 3 (APR-JUN), JUL 2003, \$35,474

CIN: A-02-00-65502 ABYSSINIAN DEVELOPMENT CORP., AUG 2000, \$34,737

CIN: A-06-03-74833 AMIGOS VOLUNTEERS IN EDUCATION & SERVICES INC. AV, APR 2003, \$31,180

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

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

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

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

CIN: A-04-02-72213 STATE OF FLORIDA, JUN 2002, \$28,612

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

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

CIN: A-05-03-00097 MEDICARE OUTPATIENT CARDIAC REHAB - NORTHFIELD HOSPITAL, NOV 2003, \$27,013

CIN: A-04-03-01004 OUTPATIENT CARDIAC REHAB SERVICES - HEALTHSOUTH SEA PINES REHAB HOSPITAL, DEC 2003, \$26,279

CIN: A-07-02-00150 PAYMENTS TO COVENTRY--PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUN 2003, \$26,000

CIN: A-01-04-78952 STATE OF CONNECTICUT, AUG 2004, \$24,457

CIN: A-06-02-70732 UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JAN 2002, \$23,483

CIN: A-04-00-01206 BCBSNC - M' CARE PART A ADMIN COST AUDIT-CARMICHAEL, SEP 2000, \$21,302

CIN: A-05-01-00078 PAYMENTS TO HEALTH NET-TUCSON, AZ.- FOR INSTITUTIONAL BENEFICIARIES, APR 2002, \$21,233

CIN: A-02-03-04004 CONTRACT CLOSING - NAS 9-19441, JUL 2003, \$20,595

CIN: A-05-02-72480 HANSEL NEIGHBORHOOD SERVICE CENTER INC., SEP 2002, \$20,266

CIN: A-05-02-00079 MEDICAID FFS PAYMENTS FOR MEDICAID MANAGED CARE ENROLLEES, SEP 2003, \$20,165

CIN: A-05-02-70624 STATE OF OHIO, JAN 2002, \$19,970

CIN: A-04-01-67441 CATAWBA INDIAN NATION, APR 2001, \$19,204

CIN: A-08-04-76779 COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, \$18,925

CIN: A-05-01-00100 PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED VIMI M' CARE PRO CONTRACT AUDIT, SEP 1997, \$18,758

CIN: A-05-01-00095 PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL REVIEW OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, JUN 2003, \$18,400

CIN: A-10-04-76879 STATE OF ALASKA, DEC 2003, \$18,226

CIN: A-04-04-78287 MONTGOMERY COMMUNITY ACTION COMMITTEE INC., APR 2004, \$18,175

CIN: A-01-02-01504 REVIEW OF CDC'S HIV PROGRAMS AT FENWAY COMMUNITY HEALTH CENTER, JUN 2003, \$18,028

CIN: A-05-03-00037 NURSING HOME QUALITY OF CARE SANCTIONS - OHIO, MAY 2004, \$17,796

CIN: A-05-03-00052 NURSING HOME QUALITY OF CARE SANCTIONS - MICHIGAN, APR 2004, \$17,564

CIN: A-03-97-00007 NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MAR 1997, \$17,045

CIN: A-07-00-00117 REV. OF PENSION COSTS FOR MED. REIMB. BC/BS OF ND, JAN 2001, \$16,863

CIN: A-05-03-75408 MICHIGAN DEPT. OF COMMUNITY HEALTH, APR 2003, \$16,645

CIN: A-01-99-55594 STATE OF VERMONT, NOV 1998, \$16,623

CIN: A-01-97-44143 BRANDEIS UNIV., JAN 1997, \$16,602

CIN: A-06-01-68297 NATIVE AMERICAN CENTER OF RECOVERY INC., MAY 2001, \$16,314

CIN: A-03-03-00006 CARDIAC REHABILITATION--WASHINGTON ADVENTISIT HOSPITAL, AUG 2003, \$15,946

CIN: A-03-04-77692 AMERICAN ASSOCIATION OF POISON CONTROL CENTERS INC, FEB 2004, \$15,060

CIN: A-06-04-77400 UNIV. OF ARKANSAS FOR MEDICAL SCIENCES, JAN 2004, \$14,989

CIN: A-05-01-00044 MINNESOTA MEDICAID PERSONAL CARE SERVICES REVIEW, APR 2002, \$14,844

CIN: A-03-97-00008 NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MAR 1997, \$14,596

CIN: A-05-03-73921 NATIONAL ASSOCIATION OF LOCAL BOARDS OF HEALTH, NOV 2002, \$13,317

CIN: A-03-03-72847 DISTRICT OF COLUMBIA DEPT. OF HEALTH, OCT 2002, \$12,850

CIN: A-08-03-74361 PORCUPINE CLINIC, JUL 2003, \$12,611

CIN: A-04-04-79536 STATE OF SOUTH CAROLINA, AUG 2004, \$12,154

CIN: A-05-03-00012 FROEDTERT MEDICAID CREDIT BALANCES, FEB 2003, \$12,066

CIN: A-03-04-76133 MINORITY ACCESS INC., OCT 2003, \$11,141

CIN: A-05-01-00070 PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JAN 2002, \$11,089

CIN: A-03-01-00513 IRSA - KOSOVO ASSISTANCE GRANT 90-ZK-0002/01, DEC 2001, \$10,913

CIN: A-03-02-71608 SUPPORTIVE CHILD ADULT NETWORK INC., APR 2002, \$10,561

CIN: A-03-04-75382 NATIONAL HISPANIC MEDICAL ASSOCIATION, JAN 2004, \$10,505

CIN: A-05-92-00026 ASSOCIATED INSURANCE CO. - MEDICARE ADMIN, FEB 1992, \$10,000

CIN: A-09-02-71757 PYRAMID LAKE PAIUTE TRIBE, MAY 2002, \$9,857

CIN: A-10-97-00002 GROUP HEALTH INSTITUTIONALIZED, NOV 1997, \$9,769

CIN: A-06-02-00032 CMS FY 01 MEDICARE ERROR RATE - ARK BC/BS REPORT, NOV 2002, \$9,655

CIN: A-03-03-00004 MEDICARE AUDIT CARDIAC REHABILITATION CENTERS-SHADY GROVE, OCT 2003, \$9,127

CIN: A-02-01-66887 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEB 2001, \$9,000

CIN: A-05-01-67360 MICHIGAN FAMILY INDEPENDENCE AGENCY, FEB 2001, \$8,708

CIN: A-02-02-70019 SENECA NATION OF INDIANS, DEC 2001, \$8,706

CIN: A-03-03-74002 MINORITY ACCESS INC., NOV 2002, \$8,113

CIN: A-03-02-72715 DISTRICT OF COLUMBIA DEPT. OF HEALTH, JUL 2002, \$7,851

CIN: A-06-03-00040 LONG-TERM CARE TEXAS MEDICAID PAYMENTS FOR DUAL ELIGIBLES, MAR 2004, \$7,801

CIN: A-05-01-68270 LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, \$7,614

CIN: A-03-03-00007 CARDIAC REHABILITATION---HOLY CROSS HOSPITAL, NOV 2003, \$7,470

CIN: A-01-97-49174 BRANDEIS UNIV., AUG 1997, \$7,068

CIN: A-04-04-77116 MOORE COMMUNITY HOUSE INC., JAN 2004, \$6,521

CIN: A-07-95-01167 PENSION COSTS CLAIMED NEBRASKA BC/BS, JAN 1996, \$6,075

CIN: A-06-97-48062 SER-JOBS FOR PROGRESS NATIONAL INC., MAY 1997, \$5,924

CIN: A-15-02-20006 REVIEW OF CDC COOPERATIVE AGREEMENT AND HRSA RYAN WHITE ACTIVITIES AT HEALTH EDUCATION RESOURCE ORGANIZATION (HERO), INC. (BALTIMORE EMA/BALTIMORE CITY HEALTH DEPT), MAR 2003, \$5,010

CIN: A-04-03-01006 OUTPATIENT CARDIAC REHAB SERVICES AT MORTON PLANT HOSPITAL, JAN 2004, \$4,426

CIN: A-07-03-00158 REVIEW OF CARDIAC REHABILITATION SERVICES--SPENCE IOWA, JAN 2004, \$4,026

CIN: A-07-02-04001 FY-2002 CFO/CMS MEDICARE ERROR RATE NORIDIAN (ND B/C), OCT 2002, \$3,999

CIN: A-02-02-01035 EVALUATION OF BID PROPOSAL - MEDICARE HELP LINE, AUG 2002, \$3,760

CIN: A-05-03-00084 MEDICARE OUTPATIENT CARDIAC REHAB - NORTHERN MICHIGAN HOSPITAL, OCT 2003, \$3,738

CIN: A-09-01-00067 EAST BAY NEPHROLOGY MEDICAL GROUP, AUG 2001, \$3,418

CIN: A-02-04-04001 GRANT REVIEW N00014-93-1-1380, MAY 2004, \$3,376

CIN: A-03-01-03303 JOHNS HOPKINS UNIVERSITY/KPMG/NIDA/N01DA-3-7301, FEB 2001, \$3,347

CIN: A-02-01-66889 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEB 2001, \$3,103

CIN: A-03-95-03318 TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996, \$3,016

CIN: A-02-01-66888 PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEB 2001, \$2,883

CIN: A-07-98-02502 CT. BC/BS PENSION COSTS CLAIMED, MAR 1998, \$2,725

CIN: A-03-98-51505 ALLIEDSIGNAL TECHNICAL SERVICES CORP., APR 1998, \$2,722

CIN: A-01-97-45487 ABT ASSOCIATES INC., JAN 1997, \$2,596

CIN: A-02-03-04002 GRANT REVIEW DAAH04-93-G-0234, SEP 2003, \$2,576

CIN: A-04-03-01002 OUTPATIENT HOSPITAL CARDIAC REHAB - MEMORIAL HOSPITAL JACKSONVILLE, NOV 2003, \$2,123

CIN: A-04-03-01005 OUTPATIENT CARDIAC REHAB SERVICES CENTRAL FL REGIONAL HOSPITAL, NOV 2003, \$2,003

CIN: A-05-97-00013 PACIFICARE OF CA-HMO INSTITUTIONAL STATUS PROJECT, APR 1998, \$2,000

CIN: A-02-03-01026 MEADOWLANDS HOSPITAL MEDICAL CENTER CARDIAC REHAB SERVICES, JAN 2004, \$1,703

CIN: A-04-04-02002	MEDICAID PAYMENTS TO SNFS FOR MEDICARE COVERED SERVICES, AUG 2004, \$1,554
CIN: A-09-03-00043	AUDIT OF OUTPATIENT CARDIAC REHABILITATION SERVICES AT REDDING MEDICAL CENTER, OCT 2003, \$1,239
CIN: A-09-04-79874	TULARE COMMUNITY HEALTH CLINIC INC., SEP 2004, \$1,173
CIN: A-05-03-00070	MEDICARE OUTPATIENT CARDIAC REHAB - ST.CHARLES MERCY HOSP, OCT 2003, \$1,158
CIN: A-03-03-00393	AUDIT OF CDC HIV/AIDS GRANT TO SEXUAL MINORITY YOUTH ASSISTANCE LEAGUE, OCT 2003, \$1,155
CIN: A-01-03-00514	REVIEW OF CARDIAC REHABILITATION SERVICES- BERKSHIRE MEDICAL CENTER, DEC 2003, \$1,138
CIN: A-07-00-02082	REVIEW OF A COST HMO - IOWA, FEB 2002, \$1,006

⁴B.

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

CIN: A-05-95-00042	BCBSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DECEMBER 1995, \$1,333,598
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Notes to Table 2

¹The opening balance was adjusted upward by \$368.4 million.

²Management decision has not been made within 6 months on 66 reports.

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

CIN: A-03-00-00203	PA/INTERGOVERNMENTAL TRANSFERS/MEDICAID, FEB 2001, \$3,700,000,000
CIN: A-05-00-00056	MEDICAID INTERGOVERNMENTAL TRANSFERS - IDPA, MAR 2001, \$1,870,000,000
CIN: A-10-00-00011	MEDICAID INTERGOVERNMENTAL TRANSFERS - WA STATE, MAR 2001, \$475,000,000
CIN: A-06-01-00069	EVALUATION OF LEGISLATION TO INCREASE MEDICAID HOSP-SPEC DSH PYMT LIMITS, DEC 2001, \$380,000,000
CIN: A-06-01-00041	'AUDIT OF THE TX DISPROPORTIONATE SHARE HOSP PROG PAYMENT METHODOLOGY, FEB 2003, \$319,200,000
CIN: A-04-00-02165	REVIEW OF AL MEDICAID INTERGOVERNMENTAL TRANSFERS, MAR 2001, \$147,500,000
CIN: A-04-00-02169	REV. AL M'CAID INTERGOV'TAL TRANSFERS-HOSPITAL ENHANCE, MAY 2001, \$63,000,000
CIN: A-01-99-00530	NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DEC 2000, \$56,936,287

CIN: A-07-98-02534	EMPIRE BC/BS PENSION PLAN TERMINATION, MAR 2000, \$38,626,351
CIN: A-01-02-00503	FURTHER EXPANSION OF THE DRG PAYMENT WINDOW, AUG 2003, \$37,000,000
CIN: A-02-01-67912	STATE OF NEW YORK, MAR 2001, \$19,000,000
CIN: A-05-02-00078	ROLLUP OF MEDICARE PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS, FEB 2004, \$12,764,202
CIN: A-06-99-00060	REVIEW OF AN HMO UNDERPAYMENT CLAIM OF 21 MILLION, JUN 2001, \$12,191,579
CIN: A-01-00-00502	REV OF EXORBITANT MEDICARE PMTS FOR O/P SVCS, MAY 2001, \$12,100,000
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM -- NATIONAL, MAR 1993, \$10,161,742
CIN: A-01-99-00506	FOLLW-UP REVIEW OF SEPRTY BILLABLE ESRD LAB TESTS, JAN 2001, \$6,100,000
CIN: A-05-02-00077	MICHIGAN MEDICAID/SCHIP REVIEW, NOV 2003, \$5,908,350
CIN: A-01-97-02506	REVIEW OF THE AVAIL OF MEDICAL COVERAGE/CSE SUPORT, JUN 1998, \$5,704,585
CIN: A-05-02-00076	MICHIGAN SCHIP REVIEW, AUG 2004, \$5,623,491
CIN: A-03-02-00203	VIRGINIA - SCHIP/TITLE IV - D SURVEY, JUL 2004, \$5,402,491
CIN: A-05-02-00073	INDIANA SCHIP REVIEW, AUG 2004, \$4,824,112
CIN: A-05-01-00052	DME REVIEW IN INDIANA, OCT 2001, \$4,400,000
CIN: A-06-00-00073	REV OF MGR CARE ADDTL BENEFITS FOR CY 00 OF NYLCAR, MAR 2002, \$4,000,000
CIN: A-04-98-01188	REVIEW ADMIN. COSTS @ M'CARE MANAGED RISK PLAN, AUG 1999, \$2,559,357
CIN: A-05-00-00083	REVIEW OF MEDICAID DME CLAIMS - MICHIGAN, OCT 2001, \$2,500,000
CIN: A-05-02-00066	REVIEW OF RFP CMS-02-001/ELH1, MAY 2002, \$1,885,793
CIN: A-05-02-00075	INDIANA MEDICAID/SCHIP REVIEW, NOV 2003, \$1,885,708
CIN: A-09-95-00095	HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DEC 1995, \$1,389,723
CIN: A-05-01-00031	WI MEDICAID - DME, OCT 2001, \$1,250,000
CIN: A-07-99-01298	DATE OF DEATH - 2, MAY 2001, \$700,000
CIN: A-05-02-00082	BID PROPOSAL FOR 1-800 MEDICARE HOTLINE ADMINISTRATION, AUG 2002, \$609,950
CIN: A-05-02-00080	SINAI - MC/MA CREDIT BALANCES, JAN 2003, \$515,942
CIN: A-05-03-00021	CIMRO PRO PRE-AWARD AUDIT FOR NEBRASKA, NOV 2002, \$504,650
CIN: A-03-99-00052	ALLEGHENY/CHESAPEAKE ORF, SEP 2001, \$467,646
CIN: A-05-00-00057	REVIEW OF MEDICAID MUTUALLY EXCLUSIVE CODES - OH, NOV 2001, \$450,000
CIN: A-05-01-00074	REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUN 2001, \$282,049
CIN: A-05-03-00052	NURSING HOME QUALITY OF CARE SANCTIONS - MICHIGAN, APR 2004, \$280,879

CIN: A-03-99-00038 EDGEWATER PSYC HOSPITAL, MAR 2001, \$208,731

CIN: A-01-02-73084 STATE OF MAINE, SEP 2002, \$149,082

CIN: A-05-02-00023 SCHOOL-BASED MEDICAID ADMIN & SERVICE COSTS - WISCONSIN, MAR 2003, \$144,909

CIN: A-05-03-00059 ESRD #9 PRE-AWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, \$139,816

CIN: A-04-03-08013 ESRD NETWORK COST PROPOSAL, MAY 2003, \$116,085

CIN: A-05-01-00087 ST. VINCENT HOSPITAL-SPECIFIC DSH PAYMENT LIMITS, MAR 2004, \$115,000

CIN: A-05-03-00060 ESRD #10 PREAWARD AUDIT (RFP-CMS-03-001/JAC), MAY 2003, \$114,289

CIN: A-05-01-00070 PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JAN 2002, \$98,698

CIN: A-02-96-02001 INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JAN 1998, \$90,528

CIN: A-05-02-00089 REVIEW OF RFP CMS-500-97-0408/0008, NOV 2002, \$84,457

CIN: A-05-02-00084 MEDICARE OUTPATIENT CARDIAC REHAB - ST.LUKE'S MEDICAL CENTER, JUL 2003, \$47,247

CIN: A-04-04-76753 PUTNAM COUNTY BOARD OF EDUCATION, DEC 2003, \$19,925

CIN: A-05-96-00069 CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEB 1998, \$17,555

CIN: A-01-97-00526 PSYCHIATRIC OUTPATIENT SERVICES, MAR 1998, \$7,245

CIN: A-03-03-00378 REVIEW OF FDA'S USNA BONE MASS CLINICAL STUDY, SEP 2004, \$6,144

CIN: A-06-03-00041 REVIEW OF WILSON N JONES MEDICAL CENTER CARDIAC REHABILITATION SERVICE, NOV 2003, \$4,656

CIN: A-06-03-00033 REVIEW OF GOOD SHEPHERD MEDICAL CENTER CARDIAC REHABILITATION SERVICE, JUL 2003, \$3,737

CIN: A-01-98-00506 PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY HOSPITAL, MAR 1998, \$1,120

Appendix E

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

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

Section of the Act	Requirement	Page
Section 4(a)(2)	Review of legislation and regulations	34
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	Appendixes B & C
(a)(4)	Matters referred to prosecutive authorities	35
(a)(5)	Summary of instances where information was refused	None
(a)(6)	List of audit reports	Under separate cover
(a)(7)	Summary of significant reports	Throughout
(a)(8)	Statistical Table 1—Reports With Questioned Costs	32
(a)(9)	Statistical Table 2—Funds Recommended To Be Put to Better Use	33
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	None

Appendix F

Summary of Sanction Authorities

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

Program Exclusions

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

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

Patient Dumping

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

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

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

Civil Monetary Penalties Law

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

For the purposes of the CMPL, “should know” is defined to mean that the person acted in reckless disregard or deliberate ignorance of the truth or falsity of the claim. The CMPL also authorizes actions for a variety of other violations, including submission of claims for items or services furnished by an excluded person, requests for payment in violation of an assignment agreement, 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)).

Summary of Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

Anti-Kickback Statute

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

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

False Claims Act

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

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