U.S. Department of Health and Human Services

Office of Inspector General

Semiannual Report to the Congress

October 2002 - March 2003

Working with Others to Promote, Preserve & Protect the Nation's Well-Being

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Message from the Inspector General

For this past six-month period, as has been the case historically, the work of the Office of Inspector General (OIG), Department of Health and Human Services, has resulted in substantial savings and significant program improvements.

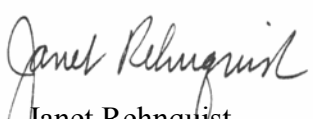
A keystone of our work continues to be targeting potential financial vulnerabilities in the federal health care programs. Among many examples are our findings regarding the payment variations between ambulatory surgical centers and hospital outpatient departments. In just this area alone, we found that because of this payment variation, Medicare is overpaying for these services by more than $1 billion.

Further substantial savings have been achieved through our work in the prescription drug industry. Recent settlements include one with a national pharmaceutical manufacturer who agreed to pay $49 million to resolve allegations of avoiding fully paying the rebates owed to the federal and state governments under the national Medicaid drug rebate program for a particular drug. More work is under way to determine the impact of the drug rebate program on the price of prescription drugs.

We continue to be vigilant in examining the payments made to providers to ensure they are accurate and based on the provision of medically necessary services. As a result of our work on the Medicare fee-for-service error rate, we estimated improper payments of $13.3 billion—about 6.3 percent of the total $212.7 billion in fee-for-service payments. Our work with CMS in an effort to further decrease the fee-for-service error rate will continue.

In light of significant international developments, our work in state and local bioterrorism preparedness is more important than ever. In recent months, we have conducted evaluations of state and local preparedness for a bioterrorism event, particularly in reference to receiving and deploying the National Pharmaceutical Stockpile. Other critical areas of OIG's review are the security measures in place at laboratories containing dangerous pathogens, both within the department and externally. These efforts involve reviewing the Centers for Disease Control and Prevention's regulatory oversight of facilities housing these pathogens, as well as the Food and Drug Administration's internal controls over anti-bioterrorism research, information and funding.

The contributions of OIG in protecting the taxpayers through our financial, quality of care, and physical security oversight are significant. While we continue to face challenges in this effort, our endeavors over the past six months illustrate the broad-ranging impact our work has on the operations of the federal health care programs and their beneficiaries. This is an organization that truly does make a difference.



Janet Rehnquist
Inspector General

Highlights

Summary Statistical Accomplishments

For the first half of fiscal year 2003, OIG reported savings of over $12 billion comprised of $11.6 billion in implemented recommendations and other actions to put funds to better use, $174 million in audit disallowances, $40 million in additional recoveries, and over $187 million in investigative receivables. (Details pp. 54, 59, and 63.)

In addition, for this reporting period, OIG reported exclusions of 1,241 individuals and entities for fraud or abuse of the federal health care programs and/or their beneficiaries, 320 convictions of individuals or entities that engaged in crimes against departmental programs, and 106 civil actions. (Details pp. 16 and 59.)

Payment Variations at Ambulatory Surgical Centers and Hospital Outpatient Departments

An OIG evaluation found that payment variations between ambulatory surgical centers (ASCs) and hospital outpatient departments have resulted in Medicare paying more than $1 billion in program payments. The study also found that failing to remove certain procedure codes from the ASC list of covered procedures has resulted in an estimated $8 million to $14 million in additional program payments. (Details p. 4.)

Bioterrorism Preparedness

The OIG conducted evaluations of state and local preparedness for a bioterrorism event, and their preparedness for receiving and deploying the National Pharmaceutical Stockpile. In response to the issues raised, CDC and HRSA have been actively working on implementing OIG's recommendations.

In addition, OIG has reviewed the security measures in place at a number of the department's laboratories and at external laboratories receiving departmental funds. Other efforts involve reviewing CDC's regulatory oversight of certain sensitive facilities and FDA's internal controls over antibioterrorism research, information, and funding. (Details pp. 32 and 33.)

Prescription Drugs

Pfizer, Inc., and two of its subsidiaries agreed to pay $49 million to the government. The settlement resolves allegations that the drug manufacturer avoided paying fully the rebates owed to the federal and state governments under the national Medicaid drug rebate program for the cholesterol-lowering drug Lipitor. (Details p. 22.)

Hospital and Health Plan

Lovelace Health Systems, Inc. (Lovelace), a New Mexico hospital and health maintenance organization, agreed to pay the government $24.5 million in the largest settlement to date against a single hospital to resolve allegations involving solely cost reporting fraud. Lovelace allegedly submitted fraudulent claims in 10 years of Medicare cost reports and reopening requests. (Details p. 19.)

Disproportionate Share Hospital Payments

The OIG continued its focus on Medicaid disproportionate share hospital (DSH) payments, which are intended to counterbalance the uncompensated costs of serving large numbers of low-income patients. Reviews in three states found that claims were duplicated or that payments exceeded the hospital-specific limits mandated by law. Over a 3-year period, one state's payments exceeded the limits by more than $511 million ($319 million federal share) as a result of inappropriate payment calculation methods and inadequate controls over the DSH program. (Details p. 11.)

Financial Accountability

Having developed and tracked the Medicare fee-for-service payment error rate for the last 7 years, OIG noted sustained improvement in fiscal year 2002. Estimated improper payments made during the year amounted to $13.3 billion, or about 6.3 percent of the total $212.7 billion in fee-for-service payments—a significant drop from the $23.2 billion first reported for fiscal year 1996. The 6.3-percent error rate matches last year's lowest-ever rate and is less than half the 13.8-percent rate in 1996.

The OIG developed the error rate in conjunction with its annual audit of the department's financial statements. For the fourth consecutive year, the department received a "clean" opinion on those statements, indicating that they fairly presented financial information. However, serious weaknesses persisted in the financial systems and processes used to produce financial statements and in Medicare information systems controls. (Details pp. 2 and 50.)

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

Centers for Medicare and Medicaid Services

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

The Medicaid program provides grants to states for medical care for qualifying people with low incomes. 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), created under the new title XXI of the Social Security Act, 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) continues to devote significant resources to investigating and monitoring the Medicare and Medicaid programs. These activities have helped ensure the cost-effective delivery of health care; improved the quality of health care; and reduced the potential for fraud, waste, and abuse. In addition, these efforts have often led to criminal, civil, and/or administrative actions against perpetrators of fraud and abuse.

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

FY 2002 FINANCIAL STATEMENT AUDIT ❖❖

To support its audit of the department's FY 2002 financial statements, OIG contracted with an independent certified public accounting firm to audit the CMS financial statements. The firm issued an unqualified, or "clean," opinion on the FY 2002 statements, which means that they were reliable and fairly presented. While substantial progress has been made in providing reliable financial information, material internal control weaknesses continued in financial systems, analyses, and oversight and in Medicare electronic data processing (EDP) controls.

The CMS was still impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. The Medicare contractors' lack of integrated, double-entry systems and use of ad hoc supporting schedules increased the risk that their reported information could be inconsistent, incomplete, or inaccurate. Additionally, numerous EDP general control weaknesses were noted at the Medicare contractors, system maintainers, and the CMS central office. Such weaknesses increase the risk of unauthorized access to and disclosure of sensitive information, malicious changes that could interrupt data processing or destroy files, improper Medicare payments, and disruption of critical operations.

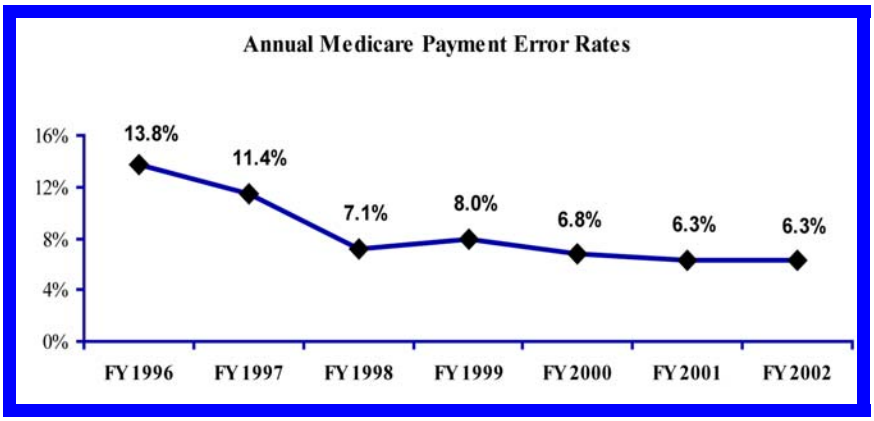
Officials of CMS agreed with these findings and are taking corrective action. Most significantly, they are proceeding with implementation of the Healthcare Integrated General Ledger Accounting System and anticipate that it will be fully operational in FY 2007. (A-17-02-02002)

FY 2002 MEDICARE ERROR RATE ❖❖

For the seventh and final year, OIG reported the extent of Medicare fee-for-service payments that did not comply with Medicare laws and regulations. Based on a statistical sample, OIG estimated that improper Medicare payments made during FY 2002 totaled $13.3 billion, or about 6.3 percent of the $212.7 billion in processed fee-for-service payments reported by CMS. These improper payments could range from reimbursement for services provided but inadequately documented to inadvertent mistakes to outright fraud and abuse. The FY 2002 estimate of improper payments is significantly less than the $23.2 billion first estimated for FY 1996. As an error rate, the current 6.3-percent estimate is the

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

same as last year's rate—which was the lowest to date—and less than half the 13.8 percent reported for FY 1996. This reduction was attributed to CMS corrective actions; efforts by health care providers to comply with Medicare reimbursement regulations; and fraud and abuse initiatives on the part of CMS, the Congress, the Department of Justice, and OIG.



Beginning in FY 2003, CMS will develop a national error rate through Comprehensive Error Rate Testing and the Hospital Payment Monitoring Program (formerly known as the Payment Error Prevention Program). The CMS initiated these programs in response to OIG's recommendation that CMS develop its own error rate process. (A-17-02-02202)

PROSPECTIVE PAYMENT SYSTEM

In this review, OIG found that routine statistical analysis and medical reviews of Prospective Payment System (PPS)-exempt inpatient services for medical necessity and reasonableness were not being conducted. Medicare paid approximately $8.7 billion to PPS-exempt hospitals in 2000. The OIG audit report, "Improper Fiscal Year 2000 Medicare Fee-for-Service Payments," attributed $800 million of improper payments to issues of medical necessity in PPS-exempt facilities.

Shortly after OIG exited with CMS regarding this report, the agency released a transmittal notifying fiscal intermediaries that they may include PPS-exempt hospitals in their reviews; however, no additional funding was provided for this expansion of review responsibility. The OIG remains concerned that, given the lack of dedicated funding and an explicit level of effort or performance

goal, the amount of oversight that will occur remains unclear. Further, to the extent that fiscal intermediaries do review PPS-exempt hospital services, the review occurs at the expense of oversight of other Part A providers, such as nursing homes and home health agencies. The OIG recommended that CMS ensure oversight of PPS-exempt hospital services. (OEI-12-02-00170)

PAYMENT PROCEDURES: OUTPATIENT DEPARTMENTS AND AMBULATORY SURGICAL CENTERS

The OIG assessed the effect of payment variation between ambulatory surgical centers (ASCs) and hospital outpatient departments (OPDs) on the Medicare program. This variation results in Medicare paying an estimated $1.1 billion more in program payments. In most cases (66 percent), OPD rates for the same service are higher than ASC rates. In addition, failing to remove certain procedure codes from the ASC list of covered procedures results in an estimated $8 to $14 million in additional program payments.

The OIG reiterated the previous recommendation, with which CMS concurred, that rates between settings should be more uniform. The OIG also recommended to CMS that: 1) rates reflect only the costs necessary for the efficient delivery of health services, 2) timely survey data be used to reevaluate ASC payment rates, and 3) procedure codes be removed from the list of ASC-covered procedures using established criteria. The CMS commented on the report, but neither concurred nor non-concurred with the recommendations. (OEI-05-00-00340)

NURSE AIDE TRAINING ❖❖

For classroom training, federal regulations require instruction in:

- Basic nursing skills
- Personal care skills
- Mental health and social service skills
- Caring for the cognitively impaired
- Basic restorative skills
- Residents' rights

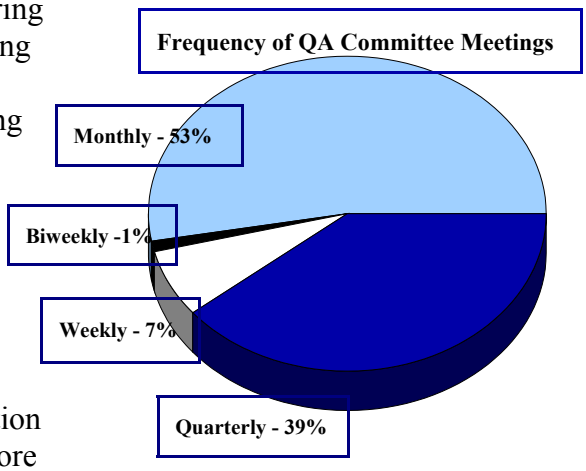
Because nurse aides are responsible for providing routine care and social support to nursing home residents, their training is crucial to improving the quality of care nursing home residents receive. In this review of factors affecting nurse aide training, OIG found that training has not kept pace with the changing needs of nursing home residents who today are more ill and require more care. Teaching methods are often ineffective, and clinical exposure is too short and unrealistic.

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

The OIG made several recommendations to improve the quality and effectiveness of nurse aide training. The CMS has agreed with the recommendations and is taking steps to determine how best to improve nurse aide training. (OEI-05-01-00030)

NURSING HOME QUALITY ASSURANCE COMMITTEES ❖❖

Nursing home quality assurance committees provide a key point of accountability for ensuring both quality of care and quality of life in nursing homes. The OIG's assessment of the role of these committees showed that nearly all nursing homes meet CMS requirements for QA committee membership and frequency of meetings. While QA committees can play a pivotal role in improving quality of care in their facilities, frequently they are not used effectively. QA committees have an array of data sources to target problem areas, but lack the ability to most effectively use the information available to them. They could benefit from more direction and guidance on to effectively use CMS quality indicators and how to conduct QA committee work. QA committees are an untapped resource for improving quality of care and quality of life in nursing homes. (OEI-01-01-00090)



NURSING HOME MEDICAL DIRECTORS SURVEY

The OIG issued the results of a survey in which medical directors and nursing home staff reported functions their facilities required of them, the amount of time spent in their facilities, and their credential status. Medical directors report numerous responsibilities in four key areas: quality improvement, patient services, residents' rights, and administration. Included in these leadership responsibilities are issues that ensure quality of care and quality of life in their facilities, including review and revision of existing medical and clinical policies, review and analysis of quality indicators for potential areas of concern, inter-

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vening with attending physicians about patient care, and ensuring appropriateness of patients' drug regimens.

While reporting that a broad array of leadership responsibilities are expected or required of them, 86 percent of the directors who responded to the survey report that they spend 8 hours or less per week in their facilities. The ability of medical directors to meet their reported responsibilities would be difficult in the limited about of time they report spending in their facilities.
(OEI-06-99-00300)

PHYSICIAN PAYMENTS

This OIG evaluation examined the differences in physician payment amounts between Medicare and private insurance companies based on a proprietary database. The study identified 217 procedure codes with consistent and substantial differences in relative value between Medicare and the proprietary database. These procedures represent 30 percent of the 681 codes analyzed. The reasons for these differences are unclear and may be attributable to errors within the relative values themselves or to population differences.

Although the Secretary is required to review codes for accuracy every 5 years, only 20 of the 217 codes identified were included in the most recent 5-year comprehensive review. The absence of these codes from the 2002 review suggests that augmenting the current system with one or more data-driven methods might help to assure appropriate relative value assessments.
(OEI-06-00-00570)

DURABLE MEDICAL EQUIPMENT ORDERS

Physicians are assigned an individual unique physician identification number (UPIN) by Medicare, although a surrogate number may be used until the individual UPIN has been assigned. This study examined a sample of services for which a surrogate number was used for claims for the purchase of durable medical equipment, prosthetics, orthotics, and supplies. The OIG found that 61 percent of services reviewed should have been ordered using the prescribing physician's permanent UPIN rather than a surrogate number. Physicians, for more than a third of services, had been issued a unique physician identification number at least 5 years prior to the dates of service on claims. The OIG also found that supporting

documentation was missing or incomplete for 45 percent of the sampled services. Medicare paid an estimated $61 million for services billed with surrogate numbers that had missing or incomplete documentation in 1999.

The OIG recommended that CMS perform targeted reviews of claims and continue to educate suppliers and ordering physicians about the use of accurate UPINs. The CMS concurred with the recommendations. (OEI-03-01-00270)

SEMI-ELECTRIC HOSPITAL BEDS

When a mattress and bedside rails are provided to a beneficiary at the same time as a semi-electric hospital bed, the suppliers are required to bill Medicare using an all-inclusive procedure code. Nationwide, Medicare reimbursement for this code during calendar year 2000 totaled $189 million. As OIG found in a prior review, fee schedule amounts for this code remain excessive when compared with combinations of other codes that cover the same equipment. The OIG estimates that using alternative coding could result in annual savings of over $34 million. Medicare beneficiaries, Medicaid programs, or supplemental insurers could also save nearly $9 million in coinsurance.

In addition to discontinuing the problematic code, OIG recommended that CMS issue a final rule on the application of its inherent reasonableness authority so that it can be used to adjust the fee schedule amounts for this code. The CMS agreed in part with the recommendations. (A-09-01-00109)

MANAGED CARE ADDITIONAL BENEFITS

The objective of this audit was to assess whether additional benefits proposed in a Medicare+Choice organization's (M+CO) contract year 2000 adjusted community rate proposal (ACRP) were available to Medicare beneficiaries as advertised and were comparable to costs actually incurred, and whether the actual additional benefits were properly valued. The review showed that the M+CO did provide the additional benefits proposed in its ACRP. However, OIG found that the M+CO distributed the incorrect prescription drug formulary guide to its Medicare enrollees, resulting in overpayment of prescription drug copayments totaling $4,000 by 104 enrollees. The organization is refunding the overpayments. (A-06-01-00048)

MEDICARE INFORMATION SYSTEMS CONTROLS

To accomplish its numerous missions, the department must rely on a distributed and open computing environment for information processing, knowledge sharing, and collaboration. Included in this network are systems at CMS headquarters and approximately 50 Medicare contractors, which together process about $255 billion in Medicare payments each year. Management therefore must ensure an integrated process to establish security policies for information technology and monitor compliance; this process is essential for an effective security program.

To assess the control environment established by management, OIG completed more than 10 reviews at CMS headquarters and its Medicare contractors. Collectively, these reviews identified hundreds of information systems control vulnerabilities, primarily at the Medicare contractors, which were reported to both the contractors and CMS. These reviews covered general and application controls, which involve access controls; the entity-wide security program; service continuity; segregation of duties; and input, output, and processing controls related to specific applications. While OIG found no evidence that these weaknesses had been exploited, they could compromise the confidentiality, integrity, reliability, and availability of key departmental systems and/or applications.
(Various reports)

MEDICARE CONTRACTORS' PENSION ASSETS

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

The OIG reviews of two terminated contractors, one in North Carolina and one in Minnesota, identified excess pension assets totaling $5.3 million and $2 million, respectively, that should be remitted to the Medicare program. While the North Carolina contractor disagreed with certain aspects of OIG's calculations, the Minnesota contractor agreed to refund the full amount recommended.
(A-07-02-03017; A-07-01-03001)

SCHOOL-BASED HEALTH SERVICES

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

Maryland

Internal control weaknesses should be corrected to ensure that Maryland's school-based payment rates are based on the actual costs of providing medical services and that providers appropriately submit and document Medicaid claims. The fee-for-service rates used to bill for school-based health care services were overstated because they included basic costs of special education, which Medicaid does not reimburse. In addition, the largest local education agency subcontracted many of its health services to private contractors at rates below what it charged Medicaid. Based on a statistical sample, OIG estimated that the eight largest local education agencies were overpaid about $20 million in federal Medicaid funds. The state concurred with OIG's recommended procedural improvements but disagreed with the financial adjustment. (A-03-01-00224)

Massachusetts

Based on a statistical sample, OIG estimated that the Boston Public School System was overpaid at least $1.2 million in federal Medicaid funds for school-based health care services. The school system inappropriately claimed the cost of these services when documentation was inadequate, when providers did not have the required qualifications, and when schools were not open to students or students were absent. Among other things, OIG recommended financial adjustment and procedural improvements. The school system concurred with some of the procedural improvements but disagreed with most of the financial adjustment. (A-01-02-00001)

New York

In this follow-up on a state audit, OIG found that although the state had recouped over $30 million (over $15 million federal share) of duplicate claims made by the New York City Board of Education, the recoupments were not made timely. In addition, for periods prior to the state audit, the board submitted and was paid for duplicate claims; subsequently, state officials identified and recouped over $27 million (over $13 million federal share) for these payments. The OIG also identified an additional

$6 million ($3 million federal share) of duplicate claims that need to be recovered. The state concurred with OIG recommendations regarding repayment. (A-02-02-01018)

Oklahoma

In looking at whether school districts billed Medicaid for school-based health services that were provided free to other students and not exempt under the Individuals with Disabilities Education Act (IDEA), OIG found that the state lacked procedures to ensure that such services were not provided free to all students. Services provided to the 100 beneficiaries selected were all incorrectly billed primarily because the services were provided free to other students and were not exempt under the IDEA program. The OIG estimated that nearly $2 million in federal funding was claimed for services not in compliance with federal guidelines and CMS policy. Among other things, OIG recommended financial adjustment and procedural improvements. The state did not concur. (A-06-01-00077)

Oregon

The OIG found that the state did not properly monitor the school-based health services administrative match program. As a result, the state did not ensure that unallowable costs were excluded from reimbursement claims and allowed invalid time studies to be used for claims. However, due to program reimbursement limits by the state, it appears that the unallowable costs were not claimed for federal funding. Oregon would have been reimbursed between $3.5 million and $5.3 million in unallowable costs if it had not limited reimbursement. The OIG made several recommendations concerning program oversight with which the state generally concurred. (A-10-02-00002)

RESIDENTS OF INSTITUTIONS FOR MENTAL DISEASES

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

California For the period July 1, 1997, through January 31, 2001, the state claimed over $3 million in unallowable federal funding. In addition to recommending financial adjustment for the audit period and other periods as well, OIG recommended that the state establish controls to prohibit improper claims in the future. State officials generally agreed with the recommendations. (A-09-02-00061)

Florida One review found that Florida did not have adequate controls to preclude claiming federal funding for medical services provided to IMD residents under the age of 21. From July 1, 1997, through December 31, 2001, unallowable claims amounted to $363,000. Another review indicated that for the period July 1, 1997, through June 30, 2001, the state inappropriately claimed $93,000 in federal funds for medical services provided to 21- to 64-year-old IMD residents. While the state agreed to make a financial adjustment in the first case, it did not in the second.
(A-04-02-02014; A-04-02-02009)

Texas For the period September 1, 1997, through August 31, 2000, OIG found that the state improperly claimed federal funding totaling about $555,000. The OIG recommended that the improperly claimed amounts be refunded to the Federal Government irrespective of whether payments are recouped from providers. (A-06-02-00026)

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

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

New Jersey Due to a contractor computer error, acute care DSH claims totaling $54.9 million ($27.5 million federal share) were duplicated from April 1, 1997, through June 30, 2001. New Jersey relied solely on the contractor to prepare and document these additional claims and, contrary to federal requirements, failed to ensure the veracity of the claims before

submitting them for federal reimbursement. The overpayment was deposited in the state's general fund and earned interest, which OIG calculated at almost $3 million. In addition to recommending financial recovery, OIG recommended that the state thoroughly review all work performed by consultants to ensure the accuracy of future claims to the Federal Government. The state generally concurred with the recommendations; however, it did not concur with the interest charge. (A-02-01-01037)

Texas

For hospital FYs 1996 through 1998, Texas made DSH payments of approximately $511.4 million ($319.2 million federal share) in excess of hospital-specific limits. These excess payments occurred because the state limited negative Medicaid shortfall amounts to zero, did not have controls to ensure that payments did not exceed the actual cost of providing services, and did not verify the accuracy of hospitals' self-reported uninsured charges and payments. The state also used a proxy method to calculate uninsured patient charges for hospitals that did not provide, or were unable to accurately determine, charge and payment data. Additionally, incorrect cost report information was used to calculate uninsured patient costs of state mental hospitals, and costs from entities that provided nonhospital services were included in the cost-to-charge ratio for some hospitals reviewed. In addition to recommending that the state work with CMS to resolve the $511.4 million in excess DSH payments, OIG recommended procedural improvements. The state generally agreed with three of the six findings. (A-06-01-00041)

Washington

The OIG found that the state made DSH payments that exceeded hospital-specific limits and were not in accordance with the approved state plan. Specifically, the state paid $43.9 million ($23.1 million federal share) in excess of hospital-specific limits and $0.4 million ($0.2 million federal share) to six hospitals ineligible for some DSH programs. This problem occurred because the state did not reconcile DSH payments to actual costs, sometimes used billed charge amounts (instead of actual costs), and included unallowable bad debt amounts in its limits calculations. Also, the state did not review hospital eligibility for all DSH programs on an annual basis. In addition to recommending financial adjustments, OIG recommended procedural improvements intended to strengthen the state's management controls. The state generally concurred with most of the findings. (A-10-01-00001)

OUTREACH

Industry Guidance

The OIG has continued to issue advisory opinions, special fraud alerts, special advisory bulletins and other guidance as part of its ongoing effort to promote the highest level of ethical and lawful conduct by the health care industry. For the period from October 1, 2002, through March 31, 2003, OIG accepted 15 advisory opinion requests and issued 8 advisory opinions.

Compliance Activities

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

The OIG has developed and released 10 compliance program guidances for: clinical laboratories, hospitals, home health agencies, third-party billing com-panies, durable medical equipment, prosthetics and orthotics suppliers, hospices, Medicare+Choice organizations that offer coordinated care plans, nursing homes, individual and small group physician practices, and ambulance service providers. The OIG is currently working on compliance guidance for the pharmaceutical industry, as well as a revised guidance for the hospital industry.

Provider Self-Disclosure Protocol

In keeping with a longstanding commitment to assist providers and suppliers in detecting and preventing fraudulent and abusive practices, OIG issued 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 "Compliance Tools" section. In addition, it can be found in 63 *Federal Register* 58,399 (October 30, 1998).

Essentially, the Protocol guides providers and suppliers through the process of structuring a disclosure to OIG of matters that are uncovered that appear to constitute potential violations of federal laws (as opposed to innocent

mistakes that may have resulted in overpayments). Pursuant to the Protocol, an appropriate submission would include a thorough internal investigation as to the nature and cause of the matters uncovered and a reliable assessment of their economic impact (e.g., an estimate of the losses to the federal health care programs). The OIG evaluates each submission to determine the appropriate course of action.

To date, OIG has received 174 submissions. Self-disclosure cases have resulted in 40 recoveries and 22 settlements collectively totaling over $60 million. The following are examples:

- ***Washington***—Inland Empire Lithotripsy, LLC, formerly known as Inland Empire Lithotripsy, Inc., (Inland), agreed to pay the government approximately $405,000 and enter into a 3-year integrity agreement to resolve its Stark and kickback liability associated with a group of contracts it entered into with Holy Family Hospital in Spokane. The OIG contended that Holy Family Hospital paid remuneration to Inland in excess of the fair market value of the lithotripter rental and the lithotripsy services provided, in exchange for Inland's referral of Medicare patients to Holy Family Hospital. In addition, OIG alleged that Inland terminated some of its physician members in retaliation for the failure of these physicians to refer a sufficient number of patients to Holy Family Hospital.

- ***Pennsylvania***—East Norriton Physician Services (ENPS), a wholly-owned subsidiary of Mercy Health System that employs and manages physician practices, agreed to pay the government $56,000 for allegedly submitting false claims to Medicare. This case involved allegations that ENPS billed for services rendered by an excluded physician. The physician was referred to ENPS by a temporary staffing agency contracted by the practice. The settlement also requires ENPS to screen for ineligible persons, provide training regarding the screening requirements, and report annually to OIG for 3 years.

- ***South Carolina***—A former employee of an ambulance company was ordered to pay $43,000 in restitution for false statements relating to health care matters. In a self-disclosure submitted to OIG, the ambulance company alleged that he and another employee falsified and destroyed ambulance trip reports to make it appear that Medicare beneficiaries were non-ambulatory. The government previously entered into a settlement agreement with the ambulance company to resolve its liability for submitting claims based on the falsified ambulance trip reports.

- ***Arizona***—American Physicians Incorporated (API) agreed to pay the government $20,000. The settlement agreement arose from a self-disclosure submitted after an internal audit showed a pattern of upcoding for certain API physicians. Investigation by API determined a transcriptionist improperly transcribed certain physicians' diagnoses to increase Medicare reimbursement. The physician practice found the transcriptionist was motivated to change codes by API's method of compensating transcriptionists based on the amount of reimbursement received from Medicare for the diagnosis codes. In addition to other measures API has taken to correct the conduct, the practice now compensates transcriptionists at a fixed rate.

TOWN HALL MEETINGS

As part of its continued outreach efforts, OIG held two regional town hall meetings in Boston and Dallas, respectively. These open meetings provided a forum by which providers could engage in a dialogue with OIG. They also served as an educational tool to explain the role of OIG to the provider community by bringing senior auditors, evaluators, investigators and counsel from OIG together to speak about their work. The presentations were followed by a discussion session during which attendees were given the opportunity to ask questions and interact with OIG staff. Based on the success of these meetings, OIG plans to hold town hall meetings in other regions throughout the coming year.

FEDERAL AND STATE PARTNERSHIP: JOINT AUDITS OF MEDICAID

One of OIG's major initiatives has been to work more closely with state auditors in reviewing the Medicaid program. The Partnership Plan was developed to foster these joint reviews and provide broader coverage of the Medicaid program. The partnership approach has been an overwhelming success in ensuring more effective use of scarce audit resources by both the federal and the state audit sectors. To date, partnerships have been developed in 25 states. Reports issued to date have resulted in identifying over $254 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.

MEDICAID AGENCIES AND U.S. TERRITORIES

The OIG assessed state Medicaid agencies' level of readiness with Health Insurance Portability and Accountability Act (HIPAA) electronic transactions and code sets as of October 2002. Under Title II of HIPAA, the Secretary of Health and Human Services has the authority to mandate the use of standards for eight health-care transactions and specify what medical and administrative code sets should be used. Covered entities include health plans, health care clearinghouses, and those providers that conduct certain transactions electronically. State Medicaid agencies are defined as health plans. The effective compliance date for covered entities that submitted an extension form to CMS is October 16, 2003.

Of the 51 state Medicaid agencies, 42 expect to be fully compliant by October 2003. Twenty-nine states have developed specific contingency plans in the event that systems are not fully compatible. Among the obstacles facing states are code set conversions, state funding, ongoing standards modifications, and potential noncompliance of small and/or rural providers.

On the other hand, only one of the five U.S. Territories anticipates being compliant by the October 2003 deadline. The territories have not developed compliance strategies, contingency plans or testing plans. The cap on federal matching funds is the major barrier to compliance.
(OEI-09-02-00420; OEI-09-02-00423)

OIG ADMINISTRATIVE SANCTIONS

During this reporting period, OIG administered 1,347 sanctions, in the form of program exclusions or civil actions for alleged fraud or abuse or other activities that posed a risk to federal health care programs and/or their beneficiaries. These sanction authorities can be found in Appendix F.

Program Exclusions

During this reporting period, OIG excluded 1,241 individuals and entities from participating in the Medicare and Medicaid programs, or other federally sponsored health care programs, most as a result of convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of licensure revocation. These included the following:

- ***Kansas***—A physician was excluded for 25 years based on his conviction for fraud which resulted in serious bodily injury. The scheme, which he perpetrated for approximately 15 years, involved defrauding Medicare and CHAMPUS/TRICARE. He did so by luring patients into surgery based on false representations and omissions of fact. The physician was also convicted of perjury. The court sentenced him to 6 years in jail, and the state suspended and then summarily revoked his medical license.

- ***Colorado***—A certified nurse aide (CNA) was recently excluded for 35 years based on his conviction for sexual abuse. The court sentenced the CNA to a term of 16 years to life in prison, and the state revoked his nurse aide certificate.

- ***California***—A law student was convicted of theft of government property for his part in an improper billing scheme that resulted in a loss of approximately $9.2 million from the Medicaid program. The student, who was aware of individuals involved in Medicaid fraud, received monies from two DME companies he knew falsely billed Medi-Cal from March 1996 until May 1998. He was ordered to pay restitution of nearly $842,000 and was excluded for 18 years.

  The OIG excluded a DME company operator for 13 years. During the period of July 1997 through at least October 1998, he had knowledge of another individual falsely billing the Medi-Cal program for supplies, procedures and services which were claimed to have been provided to Medi-Cal recipients. As a result of the false statements, the DME company wrong fully obtained approximately $515,000. The company operator pled guilty to misprision of a felony and was sentenced to approximately 1 year incarceration and ordered to pay restitution of nearly $515,000 to Medicaid.

  A physical therapist agreed to be excluded under section 1128(b)(7) of the Social Security Act for a period of 8 years for inflating the number of physical therapy services hours that the therapist and the therapists' employees provided to Medicare residents at a skilled nursing facility. The skilled nursing facility, which was unaware that the time sheets were inaccurate, included the false time sheets in its Medicare cost reports to the fiscal intermediary in California.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties and assessments against a person who submits claims to a federal health care program that the person knows or should know are false or fraudulent. Civil monetary penalties and assessments may also be levied for other conduct proscribed by statute. During this reporting period, OIG collected over $1.4 million in civil monetary penalties and assessments under the CMPL and other authorities, including the CMPL provision for kickbacks, discussed further in the Criminal and Civil Enforcement section. (This amount does not include civil monetary penalties for patient dumping, discussed below.)

Civil Penalties for Patient Dumping

Between October 1, 2002, and March 31, 2003, OIG collected civil monetary penalties of approximately $314,000 from 10 hospitals and physicians under the Emergency Medical Treatment and Labor Act, a statute designed to ensure patient access to appropriate emergency medical services. The following are examples of the alleged violations involved in the patient anti-dumping statute settlements from this reporting period:

- ***New Jersey***—Underwood Memorial Hospital agreed to pay $30,000 to resolve its liability. The OIG alleged that the hospital failed to provide an appropriate medical screening examination to a man who presented with head injury. The OIG alleged that several hours after the hospital discharged the man, he was unresponsive and was brought to another hospital, which performed an appropriate medical screening, identified an emergency medical condition, and performed necessary surgery.

- ***California***—Encino-Tarzana Regional Medical Center agreed to pay $35,000 to resolve its liability. The OIG alleged that the hospital failed to provide appropriate stabilizing treatment, within its capability, to a patient who presented to its emergency department with a ruptured appendix. The OIG alleged that the hospital denied the appropriate treatment to this individual based on her financial status.

- ***South Carolina***—Hilton Head Medical Center and Clinics agreed to pay $17,000 to resolve its liability. The OIG alleged that the hospital failed to provide an appropriate medical screening examination to a 37-year-old pregnant woman in the process of giving birth. Additionally, the hospital allegedly inappropriately transferred the patient to another hospital.

➤ ***Florida***—Memorial Regional Hospital, Hollywood, Florida, agreed to pay $120,000 to resolve its liability. The OIG alleged that on three separate dates, the hospital, which had a psychiatric assessment center, failed to provide an appropriate medical screening examination, stabilizing treatment, or an appropriate transfer to three individuals who presented to its emergency department with symptoms of a psychiatric emergency. The OIG alleged that the hospital denied the appropriate treatment to all three individuals based on their financial status.

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 or statements. Such false claims may be pursued under the civil False Claims Act and, in appropriate cases, may also be prosecuted under federal and state criminal statutes. Enforcement authorities can be found in Appendix F. The successful resolution of these matters often reflects the combined investigative efforts and resources of OIG, the FBI and other law enforcement agencies.

One of OIG's responsibilities is to assist the Department of Justice (DOJ) in bringing and settling cases under the civil False Claims Act. Many providers elect to settle their cases prior to litigation. As part of the resolution of these cases, providers often agree to put in place compliance measures to avoid exclusions and to continue to participate in the Medicare program. The integrity programs established by these agreements are designed to prevent a recurrence of the fraudulent activities that gave rise to the case at issue.

In the six months ending March 31, 2003, the government recouped more than $156.7 million through False Claims Act civil settlements related to the Medicare and Medicaid programs. Some of these successful settlements, as well as notable criminal enforcement actions, are described below. Summaries are organized by the sector of the health care industry involved or by the nature of the offense.

Hospitals

➤ ***California***—Lovelace Health Systems, Inc. (Lovelace) agreed to pay the government $24.5 million and implement certain integrity requirements to

resolve its liability under the False Claims Act. The agreement settles allegations that Lovelace, a New Mexico hospital and health maintenance organization owned by Cigna Corporation, falsified its cost reports for the years 1988 through 1998. The investigation stemmed from a *qui tam* filed by an employee of Healthcare Financial Advisors, Inc. (HFA), a financial health care consultant that prepared and reopened cost reports for Lovelace. Among the allegations, Lovelace failed to report and reimburse over-payments identified by HFA upon reopening of certain cost reports and knowingly used inaccurate square footage measurements on certain cost reports in order to inflate reimbursement.

- ***South Carolina***—McLeod Regional Medical Center of the Pee Dee, Inc. (McLeod), agreed to pay the government $15.9 million and entered into a 5-year corporate integrity agreement to resolve allegations that McLeod violated the False Claims Act. From April 1998 through May 1999, McLeod allegedly submitted claims to Medicare, Medicaid and TRICARE for services referred, ordered, or arranged for by physicians to whom McLeod paid greater than fair market value for acquiring their medical practices, and greater than fair market value in salaries once they were employed by McLeod. In addition, McLeod improperly included costs associated with the physician practice acquisitions and certain other physician-related costs in its cost reports.

- ***South Dakota***—Rapid City Regional Hospital (RCRH) agreed to pay the government $6 million to resolve its liability for allegedly violating the Stark and anti-kickback statutes. A *qui tam* action filed against RCRH alleged that the hospital entered into an improper financial arrangement with Oncology Associates, LLP (OA), a radiation and oncology practice. In a separate settlement agreement, OA agreed to pay $525,000 for alleged upcoding of claims discovered during the course of the investigation. Both RCRH and OA entered into corporate integrity agreements.

- ***New York***—Columbia University (Columbia) entered into a stipulation and order of settlement and dismissal, agreeing to pay $5.1 million to resolve the hospital's civil liability for submitting improper claims to Medicaid. The claims allegedly were false because Columbia's employed physicians failed to appropriately document their presence during the provision of professional services by residents and interns. Columbia also agreed to enter into a 5-year, comprehensive institutional compliance agreement.

➤ ***Rhode Island***—Roger Williams Hospital and its parent Roger Williams Medical Center Corporation agreed to pay $400,000 plus interest to the government and to enter into a 3-year corporate integrity agreement to resolve its liability under the False Claims Act and the CMPL. From October 1992 through September 1995, the center allegedly improperly upcoded claims for the treatment of pneumonia.

Nursing Homes

➤ ***Mississippi***—A physician agreed to pay the government $162,000 and to enter into a 5-year integrity agreement for allegedly submitting improper claims to Medicare. From 1996 through 2000, the physician allegedly submitted claims for evaluation and management services for nursing home patients, when he did not provide the length of examination or degree of medical decision-making required for reimbursement under this code.

➤ ***Massachusetts***—Quality Care Centers of Massachusetts, Inc., doing business as Franvale Nursing Home (FNH), and its parent, PHC, Inc. (PHC), doing business as Pioneer Behavioral Health, agreed to pay the government $90,000 for allegedly submitting improper Medicare claims. From 1994 through 1996, FNH billed diapers and incontinence products provided to beneficiaries as durable medical supplies, when they were actually non-compensable services. In 1986, PHC purchased FNH, and in 1999, FNH filed for bankruptcy and ceased operations.

➤ ***Missouri***—Woodbine Healthcare and Rehabilitation Centre, a nursing home owned by Centennial HealthCare Corporation, agreed to pay $25,000 and enter into a 3-year corporate integrity agreement to resolve its civil and administrative liability for allegedly submitting false claims to Medicare and Medicaid for grossly deficient care. The case involved allegations of multiple findings of maggot-infested wounds, substandard catheter care and significant staffing shortages in 1999. The corporate integrity agreement contains comprehensive quality of care provisions, including the appointment of an independent monitor.

Prescription Drugs

- ***Texas***—Pfizer, Inc. (Pfizer), Warner-Lambert Company (Warner-Lambert) and Parke-Davis Division (Parke-Davis) agreed to pay the government $49 million to settle allegations of violating the False Claims Act. Pfizer is a pharmaceutical manufacturer that merged with Warner-Lambert in 2000. Warner-Lambert, and now Pfizer, manufacture and market the cholesterol-lowering drug Lipitor. A *qui tam* complaint alleged that in 1999, Parke-Davis, a Warner-Lambert division, offered and paid educational grants to a managed care organization (MCO) in exchange for the MCO's agreement to extend unrestricted formulary status to Lipitor. Contrary to the requirements of the Medicaid drug rebate program, the value of the grants was not reported to CMS; and, ultimately, Warner-Lambert underpaid rebates due the states by about $21 million. As part of the resolution of the case, Pfizer also agreed to enter a 5-year corporate integrity agreement.

- ***Missouri***—A former pharmacist was sentenced to 30 years in prison and ordered to pay $10 million in restitution and a $25,000 fine for tampering, adulterating and misbranding of chemotherapy drugs he prepared for cancer patients. The pharmacist diluted and tampered with the drugs Platinol and Paraplatin on an unspecified number of occasions; conspired to traffic in stolen drugs, including Taxol and Gemzar; and caused the filing of false Medicare claims by not disclosing to physicians who received the tampered and diluted drugs.

- ***Virginia***—A man was sentenced to 15 months incarceration and ordered to pay $126,000 in restitution for wire fraud and possession of a handgun by a convicted felon. He created bogus medical invoices and pharmacy receipts which he submitted to an insurance company for reimbursement.

- ***Indiana***—In connection with an investigation involving Medicaid fraud and the illegal distribution of controlled substances, five individuals were sentenced . One of the main participants in the scheme, a Medicaid recipient, was sentenced to 41 months incarceration and ordered to pay $42,000 in restitution; her husband was also sentenced for maintaining a common nuisance. Another individual was sentenced to 13 years incarceration, with 3 years suspended, for distributing OxyContin received through a chain of individuals that began with the Medicaid recipient and a physician who was sentenced to 51 months incarceration and ordered to

pay $29,000 in restitution. A fifth individual was also sentenced for maintaining a common nuisance after his grandson operated an OxyContin distribution business out of his home.

➤ ***North Carolina***—Three individuals were sentenced for Medicaid fraud. The three belonged to a group of individuals who purchased Medicaid cards from recipients and used forged prescriptions in their names to obtain OxyContin, Xanax and Valium from pharmacies.

Durable Medical Equipment Suppliers

➤ ***Pennsylvania***—Mediq Incorporated, and its subsidiaries, (collectively, Mediq), agreed to pay $1 million to resolve their civil liability under the False Claims Act. This case stemmed from a *qui tam* lawsuit filed against Mediq and its wholly-owned subsidiaries, including Mediq Mobile X-Ray Services, Inc. (MMR). Between 1992 and 1994, MMR allegedly billed Medicare for transtelephonic EKGs with rhythm strips and an interpretation when no such tests were performed.

➤ ***Florida***—In restitution for health care fraud, a DME company owner was ordered to pay $73,000. After assessing the owner an overpayment, Medicare began offsetting his claims. To avoid this, the owner solicited the help of his daughter to create a new DME company under her name. Although his daughter's name was associated with the new company and the new Medicare provider number, all other aspects of the company remained the same and under her father's direction.

➤ ***Georgia***—A physician was sentenced to 33 months incarceration, ordered to pay a $7,500 fine and to be deported upon his release from prison for obstruction of justice and mail fraud. A fugitive since 1988, the physician was employed by a DME company for the purpose of visiting Medicare beneficiaries and performing the cursory physical exam needed to justify prescriptions for transcutaneous electrical nerve stimulation (TENS) units. The physician never: 1) actually performed the thorough exam required; 2) documented the beneficiaries' medical history; 3) explained to beneficiaries how to use the TENS units; or 4) informed them of the potential danger of the units. The physician also signed blank certificates of medical necessity so that the TENS units could be billed to Medicare. His co-defendants were previously sentenced for their roles in the scheme.

Home Health

- ***New York***—Gentiva Health Services, Inc. (Gentiva), entered into a settlement agreement and release with the government. The settlement resolves allegations that Gentiva's predecessor in interest, Olsten, submitted false claims to Medicare by including non-covered costs of skilled nursing and home health aide services in cost reports. Gentiva agreed to pay $3 million to resolve its civil liability under the False Claims Act and other statutes for engaging in this alleged conduct during the period from 1995 to 1998.

- ***Missouri***—Six co-defendants were sentenced for conspiring to defraud the government through a system of kickbacks for patient referrals and the filing of false claims that resulted in overpayments from Medicare and Medicaid. The individuals sentenced included a licensed medical doctor, a registered nurse, a billing service owner, an employee who provided medical billing services, and two owners of several residential care facilities and home health agencies (HHAs). The six were ordered to pay respective restitution amounts totaling $401,000, and five were sentenced to time in prison.

- ***Louisiana***—The owner and chief executive officer of an HHA was sentenced to 15 months imprisonment and ordered to pay $37,000 in restitution and a $10,000 fine for embezzlement and theft from an employee pension plan. Acting as fiduciary over the assets of the pension plan, she used the funds for personal purchases.

Laboratories

- Dianon Systems, Inc. (Dianon), an anatomic pathology laboratory, agreed to pay the government $4.8 million and maintain a corporate compliance program to resolve allegations the company improperly charged Medicare and TRICARE. From January 1995 through July 2002, Dianon allegedly submitted claims for second opinion consultations and reports that were not performed; and, from July 1993 through July 2002, Dianon allegedly submitted claims for DNA analysis of urine cytology specimens that were not medically necessary. This case stemmed from a *qui tam* complaint filed in Connecticut alleging various billing schemes by Dianon.

- Dialysis Holdings, Inc. (DHI), agreed to pay $4.1 million to settle a *qui tam* civil action filed by the United States Attorney's Office in Massachusetts. Through its predecessor corporations, DHI entered into a joint venture agreement with another company to operate an independent clinical laboratory in Georgia. To increase profits from their joint venture, DHI allegedly conspired with the others to submit false Medicare claims in connection with medically unnecessary laboratory tests and blood draws performed on terminally-ill dialysis patients.

- A part owner of a laboratory in Indiana and Pennsylvania was sentenced to 5 months incarceration and ordered to pay $2.4 million in restitution, $1 million of which is to be paid jointly with his co-defendants, for health care fraud and mail fraud. He participated in a Medicare fraud scheme involving owners of several laboratories across the country. Their scheme included double and triple billing for laboratory services, submitting claims for tests not ordered by physicians, falsifying unique physician identification identification numbers on claims, and using lost or stolen health insurance claim numbers.

Ambulance Suppliers

- ***North Carolina***—The director of a hospital-based ambulance service was sentenced to a year and 1 day in prison and ordered to pay $77,000 in restitution for theft or bribery concerning programs receiving federal funds. The director embezzled funds from the hospital. He created false invoices to document certain goods and services as operating expenses, when the expenditures were actually for his own personal benefit.

- ***Pennsylvania*** —A joint investigation with the Pennsylvania MFCU resulted in an excluded individual being sentenced to 15 months in prison and ordered to pay $30,000 in restitution for mail fraud and failure to file a tax return. Due to his exclusion for a previous fraud conviction, the individual used a "straw party" to start two ambulance companies and receive provider numbers for them. He also billed Medicare and Medicaid for non-compensable and medically unnecessary transports; additionally, he failed to file tax returns during the period of the investigation.

Contractors

- Blue Cross of California (Blue Cross), a former Medicare fiscal intermediary, and its parent company, Wellpoint Health Networks, Inc., agreed to pay $9.3 million to resolve their potential liability under the False Claims Act and the CMPL. From 1990 through November 2000, Blue Cross allegedly falsified data regarding its performance of Medicare cost report audits while under contract with CMS. The intermediary primarily falsified audit start and completion dates entered into an audit tracking database. Blue Cross engaged in this alleged misconduct in an effort to mislead CMS regarding its performance of required audit work, to obtain a favorable annual evaluation, and to ensure renewal of its Medicare contract.

- In Missouri, a director and manager for a former Medicare contractor were sentenced for conspiring to falsify and conceal from federal auditors information about payment and other errors made by the contractor. The director was sentenced to 27 months in prison and fined $6,000; the manager was sentenced to 3 months in prison. The former executives ordered the falsification of records, beneficiary files, claims and other official documents, which, when reviewed by CMS, gave the contractor the appearance of performing at a higher level of efficiency and quality than was actually the case. This appearance of exemplary performance enabled the contractor to secure and maintain its contract with the government by being ranked for many years as one of the top 10 in the country. In June 2002, the contractor agreed to pay the government $76 million for its alleged misconduct.

Consultant

- ***Texas***—Emergency Medicine Resources (EMR) agreed to pay the government $321,000 for alleged improper claims that were submitted to federal health care programs by a billing agency, Medical Consultants, Inc., doing business as Emergency Physicians Billing Services (EPBS). A *qui tam* complaint alleged that EMR employed EPBS to bill medical claims for them under an arrangement whereby EPBS received direct payment on behalf of EMR and negotiated a percentage of the total amount collected as EPBS' fee. EPBS routinely upcoded emergency

services to an unwarranted Level IV service. As part of the resolution of this case, EMR also agreed to enter into a 3-year corporate integrity agreement.

Practitioners

- ***New York***—A psychologist and his practice entered into a stipulation and order of settlement and dismissal, agreeing to pay $4 million to the government and to be excluded for 5 years for allegedly submitting false claims to Medicare. The psychologist improperly submitted claims for psychological services by using a higher code than was necessary and/or by billing for services that could not be substantiated.

- ***Michigan***—Based on a guilty verdict handed down by a jury in his trial, a podiatrist was sentenced to 51 months confinement and ordered to pay a total of $983,000 in restitution. The podiatrist was found guilty of health care fraud and mail fraud for billing routine foot care he provided at local homes and activity centers for seniors as though he performed more invasive procedures.

- ***Connecticut***—A physician agreed to pay the government $986,000 to resolve his liability under the False Claims Act. From January 1996 through July 2002, the physician allegedly upcoded nursing home visits to a code requiring a longer and more comprehensive examination of patients than he provided. The settlement figure also includes an overpayment for services performed by another practitioner but billed to Medicare under the physician's provider number.

  A podiatrist surrendered his license and was fined almost $11,000 for wire fraud. He also agreed to pay the government $811,000 in a separate civil settlement. The podiatrist provided routine foot care to Medicare beneficiaries in various nursing homes, but electronically transmitted claims for the services as if he provided non-routine surgical procedures.

- ***Texas***—A physician was sentenced to 57 months incarceration and ordered to pay $555,000 in restitution to Medicare and Medicaid for health care fraud. The physician billed for medical procedures he had not performed. His scheme involved bringing baked goods to Medicare beneficiaries residing in a local housing complex in order to obtain their Medicare numbers and falsely bill for office visits and echocardiograms.

- ***Mississippi***—A child psychiatrist was sentenced to 30 months in prison and fined $6,000 for money laundering. The psychiatrist's son, who was responsible for his father's electronic billing and computer record maintenance, was fined $1,000 for misprision of a felony. The two participated in a billing scheme which involved submitting claims for services the psychiatrist did not render and misrepresenting the nature of the services rendered. In addition, the psychiatrist allowed some services to be rendered by unlicensed employees.

Kickbacks

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

- ***Delaware***—Cardiology Consultants, P.A., and its member physicians agreed to pay $611,000 to resolve their liability under the CMP provisions applicable to kickbacks and physician self-referrals. This cardiology group paid hourly fees to physicians who were not members of the group to monitor cardiac stress tests at the cardiology group's testing facilities. The OIG alleged that the payments to these contracting physicians were in excess of fair market value and were not commercially reasonable. In addition to the settlement payment, the group agreed to lower its monitoring fees and entered into a 3-year integrity agreement.

- ***Georgia***—Two individuals were sentenced to respective terms of 2 years and 4 months incarceration and ordered to pay joint restitution of $427,000. They defrauded Medicare by billing for physical therapy services which were medically unnecessary and not provided by a licensed medical doctor or physical therapist. They also obtained the Medicare numbers for beneficiaries residing at certain housing developments from a state employee who was subsequently ordered to pay $20,000 in restitution and a $1,500 special assessment for receiving kickbacks.

- ***Ohio***—A comprehensive outpatient rehabilitation facility, its president and vice president were sentenced for their roles in a scheme to defraud Medicare and ordered to pay a total of $289,000 in joint restitution. The president, who was also sentenced to 4 months incarceration, submitted false claims to Medicare to bill for more physical, occupational and speech

therapy per beneficiary than authorized. He also paid kickbacks to physicians in exchange for patient referrals. The vice president's annual salary was also listed on the facility's Medicare cost report, when he actually only worked sporadically.

- ***Pennsylvania***—Pride Mobility Products Corporation, a DME company, agreed to pay $80,000 to resolve its liability for violations of the kickback provision of the CMPL. An OIG investigation revealed that, through a marketing program, the company allegedly solicited and received monthly payments from suppliers in return for referring sales leads to those suppliers. In addition to the payment under the settlement agreement, the company was also required to adopt and implement certain compliance measures.

- ***New Jersey***—Performance Plus, Inc. (Performance), a DME supplier, and its owner agreed to pay $50,000 to resolve their liability under the CMP provisions applicable to kickbacks. The OIG alleged that Performance operated a program under which it offered and provided free devices to physicians who prescribed and ordered DME from them.

- ***New Jersey/California/Colorado***—Four physicians agreed to pay approximately $250,000 collectively to resolve their liability under the CMP provisions applicable to false claims and kickbacks. The OIG alleged that the physicians received free samples of the prostate cancer drug Lupron from TAP Pharmaceutical Products Inc. and billed at least some of those samples to Medicare and other payors. Three of the four physicians also agreed to enter into integrity agreements.

MEDICAID FRAUD CONTROL UNITS

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

During FY 2003, OIG is providing oversight for and administration of approximately $118.8 million in funds to the units.

- Through a joint investigation with the California MFCU, two individuals and four laboratories were sentenced in connection with a fraudulent clinical laboratory ring. The individuals were sentenced to 3 years and 16 months prison, respectively, and ordered to pay a total of $88,000 in restitution and fines; the laboratories were ordered dissolved and to pay a total of $529,000 in restitution. The ring operated by purchasing laboratories and using stolen physician identification numbers, patient identities, and health insurance information to generate unnecessary and false laboratory billings.

- As the result of a joint investigation by OIG, the Washington MFCU, FBI and the Defense Criminal Investigative Service, a physician was ordered to pay $500,000 in restitution and a $4,000 fine for obstruction of criminal investigations of health care offenses. The investigation focused on the improper billing of surgical procedures performed by residents in training and for assistants at surgery.

- As the result of a joint investigation with the Idaho MFCU and the FBI, a dentist was ordered to pay $75,000 in restitution and a $20,000 fine for obstructing a health care fraud investigation. The dentist defrauded Medicaid by billing for services not rendered, upcoding, reusing single use dental supplies, using previously exposed X-ray film, and administering expired analgesia. During the investigation, she also instructed the deletion of computer files and alteration of medical records.

- As the result of a joint investigation with the Wisconsin MFCU, a certified nursing assistant (CNA) was sentenced in state court to a total of 6½ years in prison with an initial term of confinement of 2½ years, followed by 4 years of extended supervision, for uttering a forged instrument and operating as a registered nurse (RN) without a license. The CNA told a nursing facility that he graduated from nursing school as an RN. Once hired, he sometimes worked as the only RN at the facility. Five months elapsed before the facility verified that his credentials were forged. A previous settlement was reached with the facility for its failure to verify the CNA's credentials in a timely manner.

Public Health Agencies

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

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

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

STATE AND LOCAL BIOTERRORISM PREPAREDNESS ❖❖

The OIG's inspection of 12 state and 36 local health departments' bioterrorism preparedness included in-depth discussions with public health officials, reviews of emergency response plans, and analysis of their comprehensive self-assessments. Although the OIG found that the public health infrastructure is under-prepared to detect and respond to bioterrorism, almost all health departments are currently strengthening their bioterrorism preparedness programs. Recent increases in HHS funding, while not addressing all concerns, provide an opportunity for them to strengthen the public health infrastructure.

Summary Report Card (100 point scale)

Core Capacity Goal	*State Score*	*Local Score*
#1 Surveillance and epidemiologic investigation: The public health system monitors community health status to detect the presence of critical bioterrorism agents and characterize the public health emergency.	**61**	**64**
#2 Identification: The Laboratory Response Network for bioterrorism can rule out, refer, confirm, and characterize biological threat agents.	**83**	**65**
#3 Communication: The public health system assures that information is collected, analyzed, and communicated effectively among the response community, decision-makers, and the general public during a public health emergency.	**71**	**63**
#4 Mobilization: The public health system identifies, coordinates, and deploys public health assets to assure an effective emergency response.	**70**	**65**
#5 Intervention: The public health system implements emergency health measures to control and contain an outbreak.	**52**	**49**

These findings are evidence that further work is needed at federal, state, and local levels to ensure that the country's public health system is fully prepared to respond to bioterrorism. Specifically, OIG recommended that CDC: 1) develop a monitoring system of bioterrorism preparedness funds; 2) work with SAMHSA to address community mental health needs; and 3) work with states to address tactical decisions related to bioterrorism response. In addition, OIG recommended that the Assistant Secretary for Health (ASH) work with states on strategies to sustain public health infrastructures. The CDC has already begun taking action on the first and third recommendations and is working with states to address tactical decisions. Further, CDC agrees that mental health issues need to be examined further. The ASH and SAMHSA also concur with OIG's recommendations. (OEI-02-01-00550)

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

OTHER ANTIBIOTERRORISM ACTIVITIES

The OIG has continued to assess the security of a number of departmental assets against terrorist threats, as well as the readiness and capacity of responders at all government levels to protect the public health in case of a bioterrorist attack. Included in this initiative are reviews of the activities and programs of several departmental operating divisions, including CDC, NIH and FDA. Using Department of Justice standards for physical security and additional criteria specifically focused on laboratory security, OIG reviewed the security measures in place at a number of the department's laboratories and at certain external laboratories that receive departmental funds. These efforts focused on laboratories that work with select agents because these substances could potentially be used in a bioterrorist attack.

The OIG also reviewed CDC's regulatory oversight of facilities that transfer and receive select agents and FDA's internal controls over antibioterrorism research, information, and funding. (Various reports)

RYAN WHITE CARE ACT GRANTEES

At the request of the Senate Committee on Finance, OIG audited certain grantees and subrecipients of HRSA's Ryan White Comprehensive AIDS Resources Emergency (CARE) Act funds. The objectives were to determine whether Title I funds were used for intended purposes and in accordance with federal guidelines. Reviews of two metropolitan areas determined that both had implemented programs for the delivery of health care and support services to AIDS patients. However, improvements were needed in administrative activities, such as fiscal and programmatic monitoring of subrecipients, quality-of-care reviews, cash management, and planning council involvement in funding allocations. While audits at the subrecipient level are underway at a number of entities, one completed audit noted that the entity significantly overstated the number of clients served and did not provide supporting documentation for $15,000 of its $630,000 award for a 3-year period.
(A-15-02-20005; A-07-02-00140; A-07-02-00147)

HIV PREVENTION GRANTEE

This follow-up review of a San Francisco grantee's HIV prevention program found that the grantee had taken several positive steps to resolve issues noted in the initial review. For the period covered by the review, the grantee substantially complied with CDC guidance on submitting its AIDS-related educational materials (including curricula, workshop and event outlines, videos, advertisements, and photographs) to the local review panel for review and approval. In addition, the grantee had installed a software package to track costs by departments and by grants and was evaluating alternatives to implement an after-the-fact time and effort reporting system. In commenting on OIG's draft report, grantee officials noted that they had implemented such a reporting system to support labor charges to federal awards effective October 1, 2002. (A-09-02-01005)

TRAVEL CONDUCTED WITH HIV/AIDS FUNDS

The OIG's review of foreign travel paid for with HIV/AIDS funds revealed no evidence of substantive violations of CDC or departmental regulations by CDC personnel. However, the Office of the Secretary (OS) and the CDC Office of Global Health (OGH) were not always notified of foreign travel as required. For 81 percent of the trips tested, the OS was not notified, and for 34 percent of the trips tested, the OGH was not notified. This situation has improved since the requirement that OS approve foreign travel was implemented, but approval was still not obtained for about 5 percent of the trips tested. Additionally OIG noted problems concerning travel orders, travel vouchers, and appropriate embassy notification of travel.

The OIG recommended procedural corrections and enforcement of policies. The CDC concurred with the recommendations and is taking steps to ensure adherence to all foreign travel policies and procedures in the future. (A-04-02-04004)

DRUG MANUFACTURERS' CHARGES TO 340B ENTITIES

Administered by HRSA, the 340B discount drug program (named for its section in the Public Health Service Act) provides numerous departmental grantees, or "covered entities," with access to discounted prescription drug

purchases. The OIG estimated that five pharmaceutical manufacturers overcharged 340B-covered entities $6.1 million for 11 prescription drugs during the 1-year period ended September 30, 1999. The overcharges occurred because the manufacturers inappropriately excluded sales to health maintenance organization repackagers from their best price determinations, thereby increasing their prices. The OIG recommended that HRSA require the five drug manufacturers to identify the exact amount of the overcharges for each of the affected 340B-covered entities and apply these amounts as offsets or credits to the entities' future purchases. The HRSA concurred and developed a corrective action plan that includes determining if similar overcharges occurred in other time periods or for other drugs. (A-06-01-00060)

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES SUPERFUND

Through an agreement with the Environmental Protection Agency, the National Institute of Environmental Health Sciences receives Superfund money to carry out health-related and other activities. As required by statute, OIG audited the institute's Superfund obligations and disbursements for FY 2001. The audit determined that these funds were administered in accordance with applicable laws and regulations. (A-04-02-08003)

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 that it can to ensure repayment, some loan recipients ignore their indebtedness.

After PSC has exhausted all efforts to secure repayment of these debts, it declares the individual in default. Thereafter, the Social Security Act permits, and in some instances mandates, exclusion from Medicare, Medicaid and all federal health care programs for nonpayment of these loans. During this 6-month period, 35 individuals and related entities were excluded as a result of PSC referral of their cases to OIG.

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

After being excluded for nonpayment of their HEAL debts, a total of 1,739 individuals have taken advantage of the opportunity to enter into settlement agreements or completely repay their debts. This figure includes the 61 individuals who have entered into such a settlement agreement or completely repaid their debts during this reporting period. The amount of money being repaid through settlement agreements or through complete repayment totals almost $123 million. Of that amount, $5 million is attributable to this reporting period.

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

- A Louisiana Podiatrist—$202,000
- A California Dentist—$159,000
- A California Physician—$127,000

MISUSE OF PUBLIC HEALTH GRANT FUNDS

In Illinois, Northwestern University (Northwestern) agreed to pay the government $5.5 million to resolve allegations raised in a False Claims Act *qui tam* complaint about the university's effort reporting under NIH and other extramural research grants. The government alleged that in completing applications for the federal grants, Northwestern overstated the percentage of their researchers' work effort devoted to the grant. Northwestern also allegedly knowingly failed to comply with federal requirements that a specified percentage of the researchers' effort be devoted to the grant, and knowingly failed to ensure that total effort, broken down by activity, be reported on the university's effort certification system. The settlement, which stemmed from an OIG audit and investigation, constituted one of the largest settlements with a university for allegations of civil fraud on NIH research grants.

FINANCIAL STATEMENT AUDITS ❖❖

To support its audit of the department's financial statements, OIG contracted with independent certified public accounting firms to audit the FY 2002 financial statements of the major public health operating divisions. The following reports were issued during this semiannual period. Agency officials are taking corrective actions on most of the recommendations in these reports.

- CDC and ATSDR: The accounting firm issued an unqualified opinion on the CDC and ATSDR financial statements, which means that they were reliable and fairly presented. No material weaknesses were noted in the system of internal controls. (A-17-02-00010)

- FDA: The firm issued an unqualified opinion on the financial statements and noted no material weaknesses in the system of internal controls. (A-17-02-00008)

- HRSA: The HRSA received an unqualified opinion on its financial statements. No material weaknesses were noted in the system of internal controls. (A-17-02-00005)

- NIH: The accounting firm issued an unqualified opinion on the financial statements and noted a repeated material weakness for lack of an integrated financial system and insufficient financial analyses and reviews. (A-17-02-00009)

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

Administrations for Children and Families and on Aging

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

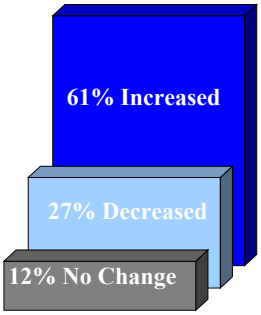
The OIG reviews those programs serving children and families. Reports have focused on ways to increase the efficient use of program dollars; to more effectively implement programs; to better coordinate programs among the Federal Government, and state and local governments; and to strengthen states' financial 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. The 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.

ACCESS AND VISITATION GRANT PROGRAMS

This inspection reviewed the extent to which mediation programs, offered through the Access and Visitation Grant Program, increased access rights, visitation, and child support payment compliance for IV-D participants in five states. In four states, OIG found that the programs appear to facilitate and increase access rights as well as actual visitation. In 76 percent of cases, parents participating in mediation developed visitation plans. In 86 percent of these cases, the plan increased noncustodial parents' allotted time with their children. In addition, parents, in 42 percent of the cases who reached an agreement, reported that actual visits increased. Finally, in 61 percent of cases, noncustodial parents increased the percent of child support they paid following mediation; this increase would have resulted in an estimated $230,000 in additional annual child support collections.

Change in Noncustodial Parent Payment Compliance After Mediation



Because the mediation programs in the fifth state focus primarily on increasing immediate visitation, as opposed to access rights, OIG analyzed their data separately. Overall, the programs in this state appear to have similarly beneficial effects for visitation and payments. (OEI-05-02-00300)

FOSTER CARE TRAINING COSTS

The OIG reported that for the 5 years ended September 30, 1999, Nebraska overcharged training costs to the federally supported Title IV-E Foster Care program by $19.3 million ($11.7 million federal share). Included in the erroneous charges were salaries and related overhead for staff who were not in training, unsupported costs, and program costs. In addition, the state did not identify and charge training costs to all benefitting programs and claimed allocated overhead costs at an unallowable enhanced federal matching rate.

The state did not agree with OIG's recommendations to make financial adjustments and to allocate costs according to the approved state plan. (A-07-02-00138)

CHILD CARE CLAIMS

At the request of ACF, OIG audited North Carolina's child care claims for the period January 1, 1996, to March 31, 1999. The objective of the audit was to determine whether the state was paid for unallowable At-Risk, Child Care and Development Block Grant, Child Care and Development Fund, and Social Services Block Grant (Other Grants) child care claims. The OIG's sample of 230 Other Grants' child care line items showed that 26 did not meet the requirements for federal funding. As a result, the state was reimbursed $18.3 million in unallowable payments. In OIG's opinion, the unallowable payments resulted from the state's inadequate review of a consultant's identification of children eligible for a specific grant. Although each grant had different requirements, the state's accounting system did not identify which grant program was used to pay for a child's care.

In addition to making procedural recommendations, OIG recommended federal reimbursement. State officials generally disagreed. (A-04-01-00006)

AUTOMATED CHILD WELFARE INFORMATION SYSTEM

The OIG determined that the majority of the $74.2 million in equipment and related costs claimed by New York for implementing and operating its Statewide Automated Child Welfare Information System (SACWIS) were allowable. However, $947,000 ($687,000 federal share) of the claimed costs should not have been claimed to the SACWIS project, and $3.9 million ($2.9 million federal share) in equipment could not be properly identified or located. The OIG recommended that the state reduce its claim by $4.9 million ($3.6 million federal share) and improve its property management system. The state generally disagreed with the financial adjustment but indicated that it was working to improve the accuracy and reliability of the SACWIS inventory system. (A-02-01-02001)

HEAD START PROGRAM ENROLLMENT ❖❖

At the request of ACF, OIG evaluated the enrollment and attendance levels of the Head Start program administered by a grantee in Connecticut from 1999 through 2001. This review found that enrollment was lower than expected

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

and that these missed enrollments had an associated value of about $6.5 million in federal funds received. Problems in the maintenance of records were also noted. Among factors contributing to the missed enrollments were inadequate recruiting methods and inefficiency in filling vacancies.

Although the grantee made a credible effort to improve by the end of 2001, OIG believes that additional action is warranted and made several recommendations accordingly. The grantee did not agree with the recommendations. (A-01-02-02500)

HEAD START GRANTEE

After noting deficiencies during a performance review at a Head Start grantee in Puerto Rico, ACF requested that OIG review the grant expenditures for the fiscal year ended February 28, 1999. The review disclosed that the grantee had incorrectly charged $522,000 to the Head Start program because the method of allocating utility and rental costs to Head Start and other programs did not result in an equitable distribution. In addition, the grantee charged Head Start for estimated instead of actual costs, claimed unsupported costs, and failed to credit the program for purchase orders that were subsequently cancelled.

The OIG recommended that the grantee refund the overpayment to the Federal Government and develop a comprehensive cost allocation plan. The grantee disagreed with the refund but agreed that a cost allocation plan should be developed. (A-02-01-02002)

REFUNDING AFDC OVERPAYMENTS

As part of a nationwide initiative, OIG determined whether three states properly refunded Aid to Families with Dependent Children (AFDC) overpayments collected after the AFDC program was replaced by Temporary Assistance to Needy Families (TANF). States are required to pursue AFDC overpayments made before October 1, 1996, and to make appropriate refunds to the Federal Government. Collections of overpayments occurring after that date are to be used to offset TANF expenditures in the year collected.

The OIG found that the states had not refunded the government's proportionate share of overpayments collected. The OIG recommended that

Michigan return $15.3 million to the Federal Government, that Nebraska return an estimated $2 million, and that New York return $1.8 million for collections by five counties. While New York agreed to make the refund, the other states did not. (A-05-02-00060; A-07-02-03013; A-02-02-02001)

CHILD SUPPORT ENFORCEMENT

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

Since 1995, OIG has opened 2,181 investigations of child support cases nationwide, which have resulted in 1,727 convictions and court-ordered criminal restitution and settlements of almost $39 million.

Task Forces

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

Central to the task forces are the screening units located in each task force region and staffed by analysts and auditors from OIG and OCSE. The units receive child support cases from the states, conduct preinvestigative analyses of 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 brought to fruition. A table of the task forces appears on the following page.

Task Force Table

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

At this point, the task force units have received over 6,100 cases from the states. As a result of the work of the task forces, 342 federal arrests have been executed and 290 individuals sentenced. The total ordered amount of restitution related to federal investigations is over $16 million. There have been 316 arrests at the state level and 290 convictions or civil adjudications to date, resulting in over $10 million in restitution being ordered.

Investigations

During this period, OIG investigations of child support cases, nationwide, resulted in 120 convictions and court-ordered criminal restitution of almost $6 million. Examples of the federal arrests, convictions and sentences for failure to pay child support include the following:

- ***Virginia***—A man was sentenced to 18 months imprisonment, 1 year of supervised release, and ordered to pay $245,000 in restitution. In 1988, he was ordered to pay $1,000 (later reduced to $800) a month in support of his five children, but he never made any voluntary payments. To evade his obligation, he remained underemployed and frequently changed jobs.

- ***California***—A man was sentenced to 5 years probation and ordered to pay $160,000 in restitution. In 1993, he was ordered to pay $743 a month in support for his three children. Although he demonstrated income in excess of $40,000 a year, he never made any payments.

- ***Illinois***—A former stockbroker was sentenced to 2 years in prison and ordered to pay $125,000 in restitution. He failed to pay child support even though he had in excess of $100,000 in unreported income in several different checking accounts.

- ***North Carolina***—A man was sentenced to 5 months incarceration, as well as 5 months home detention, 1 year supervised release, and ordered to pay $91,000 in restitution. Employed as an attorney until his disbarment in 1996, the man remained unemployed but received monthly income from a pension.

- ***Iowa***—In Iowa, the first person to be tried, convicted and sentenced to prison on state charges of failure to pay child support was sentenced at the federal level based on the same conduct. He was sentenced to 27 months incarceration, with 12 months subtracted for time served in connection with the state conviction, 1 year supervised release, and ordered to pay $87,000 in restitution. The father of seven children, the man left his position as a mathematics professor to avoid paying support through a wage withholding order.

- ***Wyoming***—A man was sentenced to 5 years supervised probation and ordered to pay his arrearage of $57,000. In addition to this sentence, the judge ordered him to pay the court-ordered child support owed his second wife for their three children; his arrearage totals over $30,000.

- ***Arizona***—A man was sentenced to 2 years supervised probation. Prior to appearing in court, he fully paid his restitution of $32,000. Following court proceedings, he also made a $450 child support payment for the months of October, November and December 2002.

- ***Ohio***—In one of the state's most egregious cases, a man was sentenced to 5 years probation with confinement in jail every weekend for a year, ordered to pay $23,000 in restitution, required to continue alcohol and drug treatment, and to participate in an outpatient mental health program.

MISUSE OF ACF AND AoA GRANT FUNDS

- ***Pennsylvania***—As the result of an OIG audit and investigation, the former director of a non-profit financial institution was sentenced to 2 years imprisonment and ordered to pay $348,000 in restitution for conspiracy, theft and embezzlement from an organization receiving federal funds, mail fraud and obstruction of a federal audit. The director misused HHS grant funds intended for a program to create sustainable communities through the use of business tax incentives and economic development programs in distressed urban communities.

- ***Montana***—The former assistant director and contract bookkeeper for an agency funded by AoA were sentenced. The agency received AoA funds to provide aging services to Native American tribes. For more than 4 years, the two embezzled funds from the agency by issuing themselves checks. The contract bookkeeper also created a fraudulent work contract and submitted claims falsely indicating that work had been performed. The assistant director was ordered to pay $107,000 for embezzlement and tax fraud; and the contract bookkeeper was sentenced to 18 months incarceration and ordered to pay $216,000 in restitution for embezzlement and tax evasion.

GRANTS AWARENESS TRAINING

In October 2002, during a two-week period, 300 team leaders and program and grant specialists at 10 different sites throughout the country received fraud awareness training concerning the Head Start program. A program administered by HHS' Administration for Children and Families, Head Start provides developmental and social services for low-income, preschool children from birth to 5 years old. The training was developed and conducted by Head Start officials and OIG auditors and investigators. The two-hour training session included discussion of the elements of fraud, the environment for fraud, and the strategies to detect fraud.

FINANCIAL STATEMENT AUDIT ❖❖

To support its audit of the department's FY 2002 financial statements, OIG contracted with an independent certified public accounting firm to audit ACF's financial statements. The firm issued an unqualified opinion on the FY 2002 statements, which means that they were reliable and fairly presented. No material weaknesses were noted in ACF's system of internal controls. (A-17-02-00003)

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

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 acquisitions 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.

The OIG has oversight responsibility for these activities at the departmental level. A related major responsibility flows from Office of Management and Budget (OMB) Circular A-133, under which HHS is the cognizant agency to audit the majority of federal funds awarded to major research schools, state and local government cost allocation plans, and separate indirect cost plans of state agencies and local governments. Also, OIG oversees the work of nonfederal 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. The OIG is also responsible for auditing the department's financial statements.

AUDIT OF THE DEPARTMENT'S FINANCIAL STATEMENTS ❖❖

As required by the Government Management Reform Act of 1994, OIG audited the department's consolidated/combined financial statements for FY 2002 and issued three reports: the audit opinion, the report on internal controls, and the report on compliance with laws and regulations. This effort encompassed individual audits of nine operating divisions' financial statements and reviews of four service organizations by independent certified public accounting firms.

Included in OIG's reports, which can be found in the department's *Performance and Accountability Report*, was a "clean," or unqualified, opinion on the financial statements. This means that, for the fourth consecutive year, the statements were reliable and fairly presented.

However, OIG noted two continuing material internal control weaknesses—defined as problems that are systemic across a number of operating divisions or significant dollar issues affecting an individual division. First, serious weaknesses persisted in the department's financial systems and processes for producing financial statements. These weaknesses related to financial management systems, financial analyses and reporting, and grant accounting. Second, Medicare information systems lacked adequate controls to ensure the security and integrity of data processing operations and data files. As discussed in OIG's report on compliance with laws and regulations, weaknesses in the department's financial management systems and in Medicare information systems also represented departures from certain federal requirements. (A-17-02-00001)

DEPARTMENTAL SERVICE ORGANIZATIONS ❖❖

To support its audit of the department's FY 2002 financial statements, OIG contracted for examinations of four service organizations that provide common administrative, data processing, and accounting services to the operating divisions. In accordance with Statement on Auditing Standards No. 70, independent certified public accounting firms examined the organizations' controls and tested their operating effectiveness.

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

- Center for Information Technology, National Institutes of Health: The accounting firm concluded that controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-02-00012)

- Human Resources Service, Program Support Center: The firm concluded that controls were suitably designed and operating with sufficient effectiveness except for certain weaknesses in access controls and application development and change controls. (A-17-02-00014)

- Division of Financial Operations, Program Support Center: The firm concluded that controls were suitably designed and operating with sufficient effectiveness but noted exceptions in access and system software controls. (A-17-02-00014)

- Division of Payment Management, Program Support Center: According to the firm, controls were suitably designed and operating with sufficient effectiveness. No significant exceptions were noted. (A-17-02-00013)

GOVERNMENT INFORMATION SECURITY REFORM ACT

As required by the Government Information Security Reform Act (GISRA), OIG conducted independent evaluations of information systems security programs at 13 HHS operating and staff divisions. The results were reported to management and summarized in a report to the Office of Management and Budget.

While progress had been made in securing critical systems, numerous general control weaknesses were identified in entity-wide security program planning and management, access controls, service continuity, and segregation of duties. The OIG noted that about two-thirds of the findings from the previous year had not been resolved and that several of the identified weaknesses were considered to be significant under GISRA guidelines. The underlying cause for most weaknesses was that the department did not have an effective information security management program structure in place to ensure that sensitive data and critical operations received adequate attention and that appropriate security controls were implemented to protect them. For the most part, the operating and staff divisions concurred with the findings and recommendations and are developing corrective action plans. (Various reports)

NONFEDERAL AUDITS

The OMB Circular A-133 establishes audit requirements for state and local governments, colleges and universities, and nonprofit organizations receiving federal awards. Under this circular, covered entities are required to have an annual organization-wide audit which includes all federal money they receive. These annual audits are conducted by nonfederal auditors, such as public accounting firms and state auditors. As cognizant auditor, OIG reviews the quality of these audits and assesses the adequacy of the entity's management of federal funds. In the first half of FY 2003, OIG's National External Audit Review Center reviewed about 1,300 reports that covered $526.5 billion in audited costs. Federal dollars covered by these audits totaled $104.4 billion, about $43.9 billion of which was HHS money.

The OIG's oversight of nonfederal audit activity not only provides department managers with assurances about the management of federal programs but also identifies any significant areas of internal control weakness, noncompliance, and questioned costs that require formal resolution by federal officials. By taking a proactive stance, OIG identifies entities for high-risk monitoring and any trends that could indicate problems in HHS programs. In addition, OIG profiles nonfederal audit findings of a particular program or activity over time to identify systemic problems. As a further enhancement of audit quality, OIG provides training and technical assistance to grantees and the auditing profession.

To rely on the work of nonfederal auditors, OIG maintains a quality control review process which assesses the nonfederal reports received and the audit work that supports selected reports. The nonfederal audit reports reviewed and issued during this reporting period fall into the following categories:

Reports issued:	
Without changes or with minor changes	***1,180***
With major changes	***69***
With significant inadequacies	***51***
Total	***1,300***

The 1,300 reports included recommendations for HHS program officials to take action on cost recoveries totaling $5.6 million, as well as 5,220 recommendations for improving management operations. In addition, these audit reports provided information for 91 special memoranda which identified concerns for increased monitoring by departmental management.

RESOLVING RECOMMENDATIONS

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

In Table 1, "Dollar Value Questioned" costs are those challenged because of violation of law, regulation, grant conditions, etc. "Dollar Value Unsupported" costs are those not supported by adequate documentation. Additional audit recoveries are discussed on page 59.

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

*Table 1: Reports With Questioned Costs**

Reports	*Number of Reports*	*Dollar Value Questioned*	*Dollar Value Unsupported*
Section 1			
For which no management decision had been made by the beginning of the reporting period[1]	477	$1,503,561,000	$250,653,000
Issued during the reporting period	144	$311,849,000	$19,303,000
Total Section 1	**621**	**$1,815,410,000**	**$269,956,000**
Section 2			
For which management decision was made during the reporting period[2,3,4]			
Disallowed costs		$174,294,000	$12,263,000
Costs not disallowed		$19,251,000	$377,000
Total Section 2	**140**	**$193,545,000**	**$12,640,000**
Section 3			
For which no management decision had been made by the end of the reporting period			
Total Section 1 minus Total Section 2	**481**	**$1,621,865,000**	**$257,316,000**
Section 4			
For which no management decision was made within 6 months of issuance[5]	**346**	**$1,345,827,000**	**$134,582,300**

*Details concerning footnotes can be found in Appendix D.

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

Reports	*Number of Reports*	*Dollar Value*
Section 1		
For which no management decision had been made by the beginning of reporting period[1]	53	$8,362,486,000
Issued during the reporting period	9	$517,772,000
Total Section 1	**62**	**$8,880,258,000**
Section 2		
For which management decision was made during the reporting period		
Value of recommendations that were agreed to by management		
Based on proposed management action	5	$233,086,000
Based on proposed legislative action	0	$0
Value of recommendations that were not agreed to by management	2	$2,816,000
Total Section 2	**7**	**$235,902,000**
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	**55**	**$8,644,356,000**

*Details concerning footnotes can be found in Appendix D.

LEGISLATIVE AND REGULATORY REVIEW AND DEVELOPMENT

Review Functions

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

Development Functions

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

- Published, in coordination with the Centers for Disease Control and Prevention, interim final regulations that serve to implement the requirements set forth in Public Law 107-88, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002. Specifically, OIG's portion of this interim final rulemaking amends 42 CFR part 1003 by adding new CMPs for violations relating to the possession, use, or transfer of certain designated biological agents and toxins.
(December 13, 2002; 67 FR 76886)

- Continued to develop final rulemaking designed to expand the existing safe harbor for certain waivers of beneficiary coinsurance and deductible amounts to benefit the policyholders of Medicare SELECT supplemental insurance. Specifically, this regulation is intended to protect waivers of coinsurance and deductible amounts under Part A or Part B of the Medicare program owed by beneficiaries covered by a Medicare SELECT policy issued in accordance with section 1882(t)(1) of the Social Security Act, if the waiver is in accordance with a price reduction agreement covering such policyholders between the Medicare SELECT issuer and the provider

or supplier offering the waiver. The OIG proposed rulemaking was published in the *Federal Register* (67 FR 60202) on September 25, 2002.

- Continued to develop draft proposed rulemaking to revise OIG's authority to propose the imposition of CMPs and assessments, by reorganizing and simplifying existing regulatory text and eliminating obsolete references contained in the current regulations. Among the proposed revisions, this rule would establish separate subparts within 42 CFR part 1003 for various categories of violations; modify the current definition for the term "claim;" update various references to managed care organization authorities; and clarify the application of section 1140 of the Act with respect to the misuse of certain departmental symbols, emblems, or names through Internet and e-mail communications.

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

- Published draft "Compliance Program Guidance for Pharmaceutical Manufacturers." Through this draft, OIG set forth its general views on the value and fundamental principles of compliance programs for pharmaceutical manufacturers and the specific elements that pharmaceutical manufacturers should consider when developing and implementing a compliance program.
(October 3, 2002; 67 FR 62057)

- Published a notice of intent to develop regulations, in accordance with section 205 of the Health Insurance Portability and Accountability Act of 1996, that solicits proposals and recommendations for developing new and modifying existing safe harbors provisions under the anti-kickback statute, as well as developing new OIG Special Fraud Alerts. In addition, this notice solicited specific comments on developing possible guidance to address certain hospital credentialing practices.
(December 9, 2002; 67 FR 72894)

- Published a notice soliciting comments on the possible development of exceptions under section 1128A(a)(5) of the Social Security Act, the CMP prohibition on offering inducements to Medicare and Medicaid beneficiaries to influence their selection of a provider, practitioner, or supplier. Specifically, the notice focused on complimentary local transportation,

inducements related to clinical trials, and inducements of nominal value. (December 9, 2002; 67 FR 72892)

- Published a newly-developed Special Fraud Alert addressing telemarketing practices by durable medical equipment (DME) suppliers. This notice specifically highlights the statutory provision prohibiting DME suppliers from making unsolicited telephone calls, either directly or indirectly, to Medicare beneficiaries regarding the furnishing of a covered item. (March 4, 2003; 68 FR 10254)

- Developed and published the final "Compliance Program Guidance for Ambulance Suppliers." The Guidance sets forth OIG's general views and the value and fundamental principles for ambulance providers and suppliers that are developing compliance programs. (March 24, 2003; 68 FR 14245)

EMPLOYEE FRAUD AND MISCONDUCT

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

➤ ***Montana***—A former IHS nurse was sentenced for dispensing a Schedule II controlled substance without a written prescription. She was the last of seven defendants sentenced for her involvement in a prescription drug fraud scheme. As part of this scheme, a former IHS nurse practitioner over-prescribed and prescribed unnecessary narcotics for others, then had all or a portion of the narcotics returned for her personal use.

➤ ***New York*** —A former department employee was sentenced to 27 months in prison, 3 years probation and ordered to cooperate in the collection of DNA and participate in a sex offender treatment program for possession of child pornography in a federally-controlled building. He is also subject to regular monitoring of computer use and is barred from jobs, activities, or events in which minors participate. The employee used his federally-owned computer to find sexually explicit material on the Internet; and the investigation revealed that the hard drives from both his work and home computers contained images of child pornography.

- ***Maryland***—A former NIH employee was sentenced to 18 months in prison, with all but one month suspended, and ordered to pay $4,600 in restitution for theft. The employee submitted false travel vouchers to the Office of Workers Compensation that included trips to the doctor that never occurred and inflated the number of miles to doctors' offices.

- ***South Dakota***—A tribal court sentenced a former IHS employee for theft. The employee took possession of an IHS-owned cellular telephone during her employment and used the telephone service for a 4-month period after her employment with the government had been terminated.

ADDITIONAL AUDIT RECOVERIES

Based on OIG recommendations, the department realized $40 million in additional recoveries, beyond the disallowances reported in Table 1 (p. 54), during this semiannual period. In one instance, Pennsylvania refunded $39 million in overcharges for Medicaid supplementation payments to county nursing homes. In another, California refunded $1 million that state hospitals had overcharged for Medicare Part B services. (A-03-00-00211; A-09-98-00072)

INVESTIGATIVE PROSECUTIONS

During this semiannual reporting period, OIG investigations resulted in 320 successful criminal actions. Also during this period, 782 cases were presented for criminal prosecution to DOJ and, in some instances, to state and local prosecutors. Criminal charges were brought by prosecutors against 357 individuals and entities.

In addition to terms of imprisonment and probation imposed in the judicial processes, over $187 million was ordered or returned as a result of OIG investigations during this reporting period. Civil settlements from investigations resulting from audit findings are included in this figure.

Appendices

Appendix A
Savings Achieved through Policy and Procedural Changes Resulting from Audits, Investigations and Inspections
October 1, 2002, through March 31, 2003

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

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

Total savings from these sources amount to $11,675 million for this reporting period.

OIG Recommendation	*Status*	*Savings (millions)*
Centers for Medicare and Medicare Services		
Medicare Part A Payments for Skilled Nursing Facilities: Services should be bundled into Medicare and Medicaid's payments to nursing homes; Part B payments for services normally included in the extended care benefit should continue to be examined for appropriateness; and a legislative recommendation should be developed to prohibit entities other than the skilled nursing facility (SNF) from seeking coverage 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 (PPS) and consolidated billing. (OEI-03-94-00790; OEI-06-92-00863; OEI-06-92-00864; A-17-95-00096; A-14-98-00350)	Section 4432 of the BBA of 1997 (as amended by the BBRA of 1999 and the BIPA of 2000) required a PPS for Part A SNF care. Covered services include Part A SNF benefits and all services for which payment may be made under Part B (except physician, certain other professional services, and other specifically excluded items or services) during the period when the beneficiary is provided covered Part A SNF care.	$3,760
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 *continued—*	On January 12, 2001, CMS issued revisions to the upper payment limit regulations which, among other	$2,500

State Enhanced Payments Under Medicaid Upper Payment Limit Requirements (*continued*): for each class of service do not exceed the amount that would have been paid under Medicare cost principles. The OIG found that states' use of intergovernmental transfers maximized federal Medicaid reimbursements. The 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)	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.	
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)	The database capacity was achieved through the authorization of a data exchange between the Social Security Administration and the Centers for Medicare and Medicaid Services (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.	$2,110
Capital-Related Costs of Hospital Services: Extend congressionally mandated reductions in hospital costs. The 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)	Section 4402 of the BBA of 1997 provided for rebasing of capital payment rates for an additional reduction in the rate of 2.1 percent.	$1,220
Medicare Payments for Oxygen: The CMS should reduce Medicare payments for oxygen concentrators and ensure that beneficiaries receive necessary care and support in connection with their oxygen therapy. (OEI-03-91-00711; OEI-03-91-001710)	Section 4552(a) of the BBA of 1997 reduced Medicare reimbursement for oxygen 25 percent until 1999 and by 30 percent for each subsequent year; section 4552(c) mandated that the Secretary develop service standards for oxygen provided in the home.	$700
Medicare Laboratory Reimbursements: In July 1989, OIG recommended that CMS take advantage of economies of scale present in the laboratory industry by considering competitive bidding or making reductions to the fee schedule amounts. In January 1990, OIG recommended that CMS seek legislation to allow across the board adjustments in Medicare laboratory fee schedules, bringing them in line with the prices which *continued—*	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.	$700

Medicare Laboratory Reimbursements (*continued*): laboratories charge physicians in a competitive marketplace. In a January 1996 follow-up, 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)		
Payments for Durable Medical Equipment: Excessive Medicare Part B payments for enteral and parenteral nutrition, equipment and supplies should be reduced, or competitive acquisition strategies should be employed. (OEI-03-94-00021; OEI-06-92-00866; OEI-03-96-00230; OEI-06-92-00861)	Section 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.	$400
Medicare Payments to Hospitals for Bad Debt: The CMS should seek legislative authority to modify the bad debt payment policy. (A-14-90-00039)	Section 4451 of the BBA of 1997 reduced bad debt payment to providers by 25 percent in FY 1998, 40 percent in FY 1999, and 45 percent in later years. The Benefits Improvement and Protection Act of 2000 subsequently reduced the reduction to 30 percent.	$150
Medicaid Drug Rebates-Sales to Repackagers Excluded from Best Price Determinations: Medicaid rebates were lost because sales to HMOs were improperly excluded from drug manufacturers' best price determinations in FYs 1998 and 1999. The 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)	The CMS issued Medicaid Drug Rebate Program Release #47 in July 2000 to make it clear to manufacturers to not inappropriately exclude other prices from best prices, as required by section 1927 of the Social Security Act.	$80.7
Medicare Payments for Prescription Drugs: The CMS should reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. (OEI-03-95-00420; OEI-03-94-00390; OEI-03-97-00290)	Section 4556 of the BBA of 1997 reduced Medicare payments for drugs, which are paid based on the average wholesale price, by 5 percent.	$30

Various Operating Divisions

Results of Investigations: In addition to any restitution, fines, settlements or judgments, or other monetary amounts resulting from successful investigations, additional monetary losses are avoided through timely communication of the investigative results to the operating division.	The operating division takes action based on the results of OIG investigation to suspend or terminate payments to the offending individual or entity.	$24.3

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

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

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

OIG Recommendation	*Status*	*Savings (millions)*
Centers for Medicare and Medicaid Services		
Excessive Medicare Payments for Prescription Drugs: The CMS should examine its Medicare drug reimbursement methodologies. (OEI-03-00-00310; OEI-03-97-00292; OEI-03-97-00293; OEI-03-97-00390; OEI-03-95-00420; OEI-03-94-00390)	The CMS concurred; they have attempted administrative remedies to lower payments for some drugs using "inherent reasonableness," but Congress suspended use of this authority pending issuance of a final rule.	$1,900
Medicare Coverage of State and Local Government Employees: The CMS should require Medicare coverage and hospital insurance contributions for all state and local employees, including those hired prior to April 1, 1986. If this proposal is not enacted, CMS should seek legislation making Medicare the secondary payer for retirees of exempt state and local government agencies. (A-09-88-00072)	In responding to OIG's report, CMS agreed with the recommendation to mandate Medicare coverage for all state and local government employees. However, this proposal was not included in the President's FY 2003 budget. The CMS did not agree with the recommendation to make Medicare the secondary payer.	$1,559
Clinical Laboratory Tests: The 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)	The CMS initially agreed with the first recommendation but not the second. The BBA required the Secretary to contract with the Institute of Medicine for a study of Part B laboratory test payments. The CMS may use the results to develop new payment methodologies.	$1,130*
Hospital Capital Costs: The CMS should determine the extent that capital reductions are needed to fully account for hospitals' *continued—*	The CMS did not agree with the recommendation. Although the BBA of	$820

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

Hospital Capital Costs (*continued*): excess bed capacity and report the percentage to the Congress. (A-09-91-00070; A-14-93-00380)	1997 reduced capital payments, it did not include the effect of excess bed capacity and other elements included in the base-year historical costs. The President's FY 2001 budget would have reduced capital payments and saved $630 million in FY 2001 through FY 2005.	
Ensure Appropriateness of Medicare Payments for Mental Health Services: The CMS should ensure mental health services are medically necessary, reasonable, accurately billed, and ordered by an authorized practitioner by using a comprehensive program of targeted medical reviews, provider education, improved documentation requirements, and increased surveillance of mental health services. (OEI-02-99-00140; OEI-03-99-00130; A-04-98-02145; A-01-99-00507; A-01-99-00530)	The CMS concurred and has initiated some efforts, particularly regarding community mental health centers.	$676
Payment Policy for Medicare Bad Debts: The OIG presented four options for CMS to consider, including the elimination of a separate payment for bad debts, the offset of Medicare bad debts against beneficiary Social Security payments, the limitation of bad debt payments to prospective payment system hospitals that are profitable, and the inclusion of a bad debt factor in the diagnosis-related group (DRG) rates. The CMS should seek legislative authority to further modify bad debt policies. (A-14-90-00339)	In responding to OIG's report, CMS agreed with the recommendation to include a bad debt factor in the DRG rates. The BBA of 1997 provided for some reduction of bad debt payments to providers. The Benefits Improvement and Protection Act (BIPA) of 2000 subsequently increased bad debt reimbursement. However, additional legislative changes are needed to implement the modifications that OIG recommended.	$340
Review Cost Effectiveness of "Pay and Chase" Methods for Medicaid Pharmacy Third-Party Liability Recoveries: The CMS should determine whether states' cost-avoidance waivers for pharmacy claims are meeting the cost-effectiveness criterion. The CMS can ascertain cost effectiveness by requiring states to track dollars that they pay and chase and the amounts that they recover. The CMS should also review states' policies to determine if they are paying and chasing pharmacy claims without waivers. (OEI-03-00-00030)	The CMS agreed that states' cost-avoidance waivers should be reexamined and is directing the regional offices to reevaluate the waivers and determine if states are paying and chasing claims without waivers. In addition, CMS is working with states that currently cost-avoid pharmacy claims and is developing guidance to assist them in implementing cost-avoidance.	$185
Graduate Medical Education: The 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 *continued—*	The CMS did not concur with the recommendations. Although the BBA of 1997 and the BBRA of 1999 contained provisions to slow the growth in Medicare spending on GME, OIG believes that	$157.3

Graduate Medical Education (*continued*): legislative proposal to compute Medicare's percentage of participation under the former, more comprehensive system. (A-06-92-00020)	its recommendations should be implemented and that further savings can be achieved.	
Review Medicaid Reimbursement Methodology for HIV/AIDS Drugs: The CMS should review the current reimbursement methodology and work with states to more accurately estimate pharmacy acquisition costs for 16 HIV/AIDS drugs examined and initiate a review of Medicaid rebates for them. (OEI-05-99-00611)	The CMS no longer believes the recommended change is necessary and believes that reimbursement changes will occur through revised AWPs, based on the President's budget proposal for a legislative change that would base the Medicaid drug rebate on the difference between AWP and the best price for a drug.	$140
Medicaid Drug Rebate Program: The best price calculation in the Medicaid drug rebate program should be indexed to the consumer price index-urban. (A-06-94-00039)	Disagreeing with the recommendation, CMS believes that savings will be achieved through the President's budget proposal to enact a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug.	$123
Identify Medical Equipment/Supply Claims Lacking Valid, Active UPINs: The 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)	The CMS concurred. The agency planned to implement an edit to reject claims listing a deceased physician's UPIN beginning in April 2002 and later expand this to include all inactive and invalid UPINs.	$91
Expansion of the DRG Payment Window: The CMS should propose legislation to expand the DRG payment window to at least 7 days immediately prior to the day of admission. (A-01-92-00521)	The CMS did not concur with the recommendation, and no legislative proposal was included in the President's budget for any fiscal year.	$83.5
Inpatient Psychiatric Care Limits: The 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)	The CMS agreed with OIG's findings but stated that further analysis would be required before any legislative changes could be supported.	$47.6
Medicare Orthotics: The CMS should take action to improve Medicare billing for orthotic devices. The 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)	Although CMS concurred with OIG's original recommendations, problems continue.	$43

Reimbursement for Hospital Beds: The CMS should take immediate steps to reduce Medicare payments for hospital beds used in the home. This should include seeking legislation to eliminate the higher reimbursement rate currently paid during the first 3 months of rental. (A-06-91-00080; OEI-07-96-00221; OEI-07-96-00222)	The CMS concurred and is considering options to determine the best approach to achieve a fair price for hospital beds. The CMS is examining payment allowances and methodologies at other payers and is review-data to determine if Medicare payments are excessive. The BIPA of 2000 increased DME payments by 3.7 percent for 2001.	$40
End Stage Renal Disease Payment Rates: The CMS should reduce the payment rates for outpatient dialysis treatments to reflect current efficiencies and economies in the marketplace. (A-14-90-00215)	The CMS agreed that the composite payment rates should reflect the costs of outpatient dialysis treatment in efficiently operated facilities, and the BBA of 1997 required the Secretary to audit the cost reports of each dialysis provider at least once every 3 years. The BBRA of 1999 increased each composite rate payment for dialysis services furnished during 2000 by 1.2 percent above the payment for services provided on December 31, 1999. The BIPA of 2000 increased the rate for services provided in 2001 by 2.4 percent and required the Secretary to develop a composite rate that includes, to the extent feasible, payment for clinical diagnostic laboratory tests and drugs that are routinely used in dialysis treatments but are currently separately billable.	$22**
Reclassify Respiratory Assist Devices with a Back-Up Rate: The CMS should reclassify bi-level respiratory assist devices with a back-up rate from the "frequent and substantial servicing" category to the "capped rental" category under the durable medical device benefit. (OEI-07-99-00440)	The CMS concurred.	$11.5
Medicare Claims for Railroad Retirement Beneficiaries: The CMS should discontinue use of a separate carrier to process Medicare claims for railroad retirement beneficiaries. (A-14-90-02528)	The President's FY 2002 and 2003 budgets did not include this type of legislative proposal.	$9.1
Indirect Medical Education: The CMS should reduce the indirect medical *continued—*	The CMS agreed with the recommendation, and the BBA of 1997, as amended by the	TBD***

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

****To be determined.*

Indirect Medical Education (continued): education (IME) adjustment factor to the level supported by CMS' empirical data and initiate further studies to determine whether different adjustment factors are warranted for different types of teaching hospitals. (A-07-88-00111)	BBRA of 1999, reduced the IME adjustment to 5.5 percent in 2002 and thereafter. The OIG believes the factor should be further reduced to eliminate any overlap with the disproportionate share adjustment.	
Medicare Secondary Payer—End Stage Renal Disease Time Limit: The CMS should extend the Medicare secondary payer (MSP) provisions to include end stage renal disease (ESRD) beneficiaries without a time limitation. (A-10-86-62016)	The CMS was concerned that an indefinite MSP provision might encourage insurers to drop uneconomical services, namely facility dialysis and transplantation. The OIG continues to advocate that when Medicare eligibility is due solely to ESRD, the group health plan should remain primary until the beneficiary becomes entitled to Medicare based on age or disability. At that point, Medicare would become the primary payer.	TBD
Home Health Agencies: The CMS should revise Medicare regulations to require the physician to examine the patient before ordering home health services. (OEI-04-93-00262; OEI-04-93-0026; OEI-12-94-00180; OEI-02-94-00170; A-04-95-01103; A-04-95-01104; A-04-94-02087; A-04-94-02078; A-04-96-02121; A-04-97-01169; A-04-97-01166; A-04-97-01170; A-04-99-01195)	Although the BBA of 1997 included provisions to restructure home health benefits, CMS still needs to revise Medicare regulations to require that physicians examine Medicare patients before ordering home health services. Subsequent to the BBA, OIG's four-state review found that unallowable services continued to be provided because of inadequate physician involvement. While agreeing in principle, CMS said it would continue to examine both coverage rules and conditions of participation to develop the discipline necessary for ensuring proper certification. Also, CMS provided additional payments for physician care plan oversight and education for physicians and beneficiaries.	TBD
Connection Between the Calculation of Medicaid Drug Rebates and Drug Reimbursement: The CMS should seek legislation that would require participating manufacturers to pay Medicaid drug rebates based on average wholesale price (AWP) or study other viable alternatives to the current program of using average manufacturer price (AMP) to calculate the rebates. This legislation would have resulted in about $1.15 billion in additional rebates for 100 brand-name drugs with the highest total Medicaid reimbursements in calendar years 1994-96. (A-06-97-00052)	The CMS agreed to pursue a change in the rebate program similar to that recommended. The President's FY 2003 budget proposed a legislative change that would base the drug rebate on the difference between the AWP and the best price for a drug.	TBD

Various Operating Divisions

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

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

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

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

OIG Recommendation	***Status***
Centers for Medicare and Medicaid Services	
Accountability Over Billing and Collection of Medicaid Drug Rebates: The CMS should ensure that states implement accounting and internal control systems in accordance with applicable 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)	The CMS concurred with the recommendation. States will now be required to maintain detailed supporting records of all rebate amounts invoiced to drug companies using a formal accounts receivable system. The CMS issued a notice of proposed rulemaking in FY 1996.
Fairly Presenting the Medicare Accounts Receivable Balance: The 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)	The CMS hired consultants to assist in validating the FY 1999 accounts receivable activity and balance, as well as the activity for the first 6 months of FY 2000. The President's FY 2001 budget included funding to establish financial management controls at the contractors and to hire contractor staff to implement the controls. For the long term, CMS is developing an integrated general ledger system as the cornerstone of its financial management controls.
Safeguards Over Medicaid Managed Care Programs: The CMS should consider safeguards available to reduce the risk of insolvency and to ensure consistent and uniform state oversight. (A-03-93-00200)	Although CMS initially concurred with some specific recommendations, the agency believes that section 4706 of the BBA of 1997 sets forth congressional expectations on this issue in specifically requiring managed care organizations to meet the solvency standards established by the state for private health maintenance organizations.
Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program: The CMS should survey manufacturers to identify the various calculation methods used to determine average manufacturer price (AMP). The CMS should also develop a more specific policy for calculating AMP *continued—*	The CMS did not concur, stating that the drug law and the rebate agreements already established a methodology for computing AMP. The OIG disagreed because the rebate law and agreement defined AMP but did not provide specific written methodology for computing AMP.

Guidance to Drug Manufacturers to Better Implement the Medicaid Drug Rebate Program (*continued*): which would protect the interests of the government and which would be equitable to the manufacturers. (A-06-91-00092)	
Ensure Accuracy of Carrier Payment Data: The 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 schedule date of payment is not an accurate reflection of the actual claim payment date. The 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)	The CMS stated that a review is under way to compare data contained in the National Claims History File with data at the carrier level. In addition, CMS has approved two new edits which will enforce the payment floor standards on claims sent to the CWF.
Prevent Duplicate Payments for the Same Service by Multiple Carriers: The CMS should revise CWF edits to detect and deny duplicate billings to individual carriers or to more than one carrier, or increase post-payment reviews if such edits are determined not to be cost effective. (OEI-03-00-00090; OEI-03-00-00091)	The CMS concurred with OIG's recommendations and will re-examine existing criteria regarding duplicate editing in the CWF system to determine the cost effectiveness of including the carrier number in the match criteria. The CMS entered a contract to study duplicate billing.
Prevent Inappropriate Payments for Blood Glucose Test Strips: The CMS should alert suppliers of the importance of properly completed documentation to support their claims for test strips; require suppliers to indicate actual and accurate "start" and "end" dates on claim forms; promote supplier concurrence and cooperation with OIG's recently issued compliance guidelines; and advise beneficiaries to report any instances of fraudulent or abusive practices involving their home blood glucose monitors, test strips, or related supplies to their DMERCs. (OEI-03-98-00230)	The CMS concurred with the recommendations and noted a number of initiatives that have reduced the incidence of improper payments in recent years.
Educate Beneficiaries on Reducing Financial Liability for DME: The CMS should educate beneficiaries on ways to reduce financial liability for medical equipment and supplies and re-evaluate Medicare fee schedules for ostomy supplies. (OEI-07-99-00510)	The 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 non-assigned claims.

Improve Resident Assessment Instruments: The CMS should more clearly define minimum data set (MDS) elements and work with states to train nursing home staff. The OIG also recommend that CMS establish an audit trail to validate the 108 MDS elements that affect facility reimbursement by Medicare. (OEI-02-99-00040; OEI-02-99-0041)	The 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.
Improve Assessments of Mental Illness: The OIG recommended that CMS work with states to improve the assessment of persons with serious mental illness and use survey and certification to monitor compliance. The 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)	The CMS concurred with most of OIG's recommendations and has made revisions to its training curriculum for nursing home surveyors.
Identify Nursing Home Residents with Serious Mental Illness: The CMS should improve the quality and usefulness of these 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. The OIG also recommends training to improve data collection and accurate coding. (OEI-05-99-00701)	Except for reporting MDS records by primary, secondary, and tertiary diagnoses, CMS concurred with most of OIG's recommendations. The CMS does not feel that adding space to the MDS to record diagnoses would solve the problem.
Eliminate Inappropriate Payments for Mental Health Services: The CMS should promote provider awareness of documentation and medical necessity requirements, develop a comprehensive list of psychological testing tools that can be correctly billed, target problematic services for pre-payment edits or post-payment medical review, and encourage carriers to take advantage of the MDS, especially for its assessment of patient cognitive level. (OEI-03-99-00130; OEI-02-99-00140)	The CMS generally concurred with the recommendations and plans to explore a variety of educational efforts and will refer the reports to the carrier clinical workgroup on psychiatric services. Carriers will conduct data analysis of psychological testing and psychotherapy claims and will conduct medical review, if indicated.
Increase Organ Donation: The 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. The 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)	The CMS concurred with the recommendations and indicated it will explore ways in which additional data can be used to assess OPO effectiveness and hospital compliance with the donation rule. The HRSA also concurred with the recommendations.

Various Public Health Agencies

Improve Oversight of Tissue Banking: The FDA should expedite publication of its regulatory agenda requiring registration of tissue banks, enhanced donor suitability screening and testing, and the use of good tissue practices. The FDA should set a realistic, yet aggressive, date by which it would complete an initial inspection of all tissue banks. The FDA should determine the appropriate minimum cycle for tissue bank inspections, and work with states and professional associations to determine in what areas oversight activities could be coordinated. (OEI-01-00-00441)	The Deputy Secretary concurred that FDA should expedite its planned rulemaking activities related to tissues, specifically the final rule to require registration of tissue banks. The department also found "considerable merit" in OIG's recommendation for an intensified inspection program directed towards entities that procure, process, and store human tissues. In congressional testimony, FDA said that all three of the proposed rules have been published, and one rule (Establishment Registering and Listing) was finalized. The FDA also worked to inspect all 36 identified, uninspected tissue banks.
Improve Effectiveness of the FDA's Adverse Event Reporting System for Dietary Supplements: The OIG recommends that 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)	The FDA agreed with the majority of OIG's recommendations. The Center for Food Safety and Applied Nutrition (CFSAN) indicated that it has embarked on significant efforts to enhance its adverse event reporting system through development of a new system called the CFSAN Adverse Event Reporting System.
Improve Protection for Research Subjects in Foreign Clinical Trials: The 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 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)	The FDA supported OIG's recommendations, but noted that in most cases it did not have the resources to implement the recommendations. The OHRP concurs with the recommendations and emphasized that its new Office of International Activities "will serve as a focal point and coordinating center" for the department's efforts to improve human subject protection.

Improve Managed Care Organizations Reporting to the National Practitioner Data Bank: The Agency for Health Care Research and Quality should devote attention to the kind of educational and remedial efforts that could be directed to practitioners who have been experiencing performance problems. The HRSA should conduct an outreach program to inform managed care organizations of their reporting responsibilities, and CMS should examine its practitioner monitoring systems. (OEI-01-99-00690)	The HRSA awarded a contract to Pricewaterhouse-Coopers to look at the feasibility study for assessing compliance with the NPDB reporting requirements. The feasibility study addresses both hospital and managed care organizations reporting.

Administration for Children and Families

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

General Oversight

Cost Principles for Federally Sponsored Research Activities: The department should modernize and strengthen cost principles applicable to hospitals by either revising existing guidelines to conform with Office of Management and Budget (OMB) Circular A-21 or working with OMB to extend Circular A-21 coverage to all hospitals. (A-01-92-01528)	The department intends to update its regulations to be consistent with changes in OMB cost principles found in A-21, A-87, and A-122, as appropriate. Upon final issuance of the revised OMB cost principles, the department will propose appropriate changes in a notice of proposed rulemaking.

Appendix D
Notes to Tables 1 and 2

Notes to Table 1

[1.] The opening balance was adjusted upward $52 million.

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

CIN: A-06-97-00055 Review of Medicaid Payments Made For Dual Eligible Beneficiary: Based on additional documentation, additional funds were recovered. The Cost Question amended amount is $118,490.

CIN: A-06-00-62271 New Mexico Human Services Department: Based on additional work with external auditors, additional funds will be recovered. The Cost Question amended amount is $20,053.

[3.] Included are management decisions to disallow $19.7 million that was identified in nonfederal audit reports.

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

[5.] A. Due to administrative delays, many of which are beyond management control, resolution of the following 345 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 MEDICAID INTERGO'TAL TRANSFERS-HOSP. ENHANC, MAY 2001, $236,983,528
CIN: A-06-00-00041	INCORRECTLY REPORTED PPS TRANSFERS-CMS/OIG PROJECT, NOVEMBER 2001, $163,900,000
CIN: A-06-00-00056	MEDICAID DRUGS-REVIEW OF REPACKAGED DRUGS EX FROM, MARCH 2001, $108,000,000
CIN: A-04-99-05561	AUDIT ADMIN COST PROPOSALS FY95-98, BCBSFL, JAX, JULY 2002, $101,671,328
CIN: A-04-00-01220	IMPLE. MEDICARE'S POSTACUTE CARE TRANSFER POLICY, OCTOBER 2001, $52,311,082
CIN: A-04-98-00123	REVIEW FOSTER CARE PAYMENTS-CHILD CARE IN NC, APRIL 2001, $48,183,445
CIN: A-01-00-00538	NATIONAL IDENTIFICATION OF SNF CONSOLIDATED BILLNG, JUNE 2001, $47,633,686
CIN: A-07-01-02086	CARMICHAEL CPA REPORT- GALIC MEDICARE ADMIN COSTS, APRIL 2002, $42,481,466
CIN: A-07-01-02093	MISSOURI DSH - UNALLOWABLE COSTS, AUGUST 2002, $36,200,000
CIN: A-01-00-00509	M/C PART B PMTS FOR DME PROVIDED TO SNF PATIENTS, JULY 2001, $35,000,000
CIN: A-04-00-65030	STATE OF SOUTH CAROLINA, JULY 2000, $31,755,510
CIN: A-07-01-00125	TRANSAMERICA (TOLIC) - PENSION SEGMENT CLOSING AUDIT, MAY 2002, $20,227,001
CIN: A-09-01-00098	AUDIT OF KERN MEDICAL CENTER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR FY 1998, SEPTEMBER 2002, $19,446,435
CIN: A-07-99-01279	OUTPATIENT PSYCH, JANUARY 2001, $18,515,190

CIN: A-06-00-00051	AUDIT OF MEDICARE REHAB AGENCY COSTS IN TX, RHS, I, JUNE 2001, $18,394,465
CIN: A-05-01-00101	OHIO - TITLE IV-A AFDC OVERPAYMENTS, JUNE 2002, $17,184,240
CIN: A-05-01-00052	DME REVIEW IN INDIANA, OCTOBER 2001, $16,377,560 (Related Table II recommendation of $4,400,000 is also outstanding.)
CIN: A-05-94-00064	MI BLUE CROSS/BLUE SHIELD, AUDIT OF ADMIN COSTS, JUNE 1996, $15,609,718
CIN: A-06-01-00035	COLLECTION OF AFDC OVERPAYMENTS, JANUARY 2002, $13,800,000
CIN: A-01-01-02502	REVIEW OF UNCOLLECTED AFDC OVERPAYMENTS, AUGUST 2001, $12,400,000
CIN: A-07-96-01176	MEDICARE EXCESS PENSION ASSETS - BC MICH, NOVEMBER 1996, $11,904,263
CIN: A-05-02-00031	AFDC OVERPAYMENTS - WISCONSIN, AUGUST 2002, $10,711,338
CIN: A-01-01-00513	MEDICARE PT B PMT FOR DME I/P PRTL MNTH STAYS SNF, OCTOBER 2001, $10,500,000
CIN: A-05-00-00045	OIG PARTNERSHIP: STATE AUDITOR REPORT ON MEDICAID, MAY 2000, $8,500,000
CIN: A-09-01-00085	AUDIT OF UCSDMC DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR SFYE 1998, SEPTEMBER 2002, $7,999,212
CIN: A-09-97-44262	STATE OF CALIFORNIA, APRIL 1997, $7,300,000
CIN: A-03-91-00552	INDEPENDENT LIVING PROGRAM -- NATIONAL, MARCH 1993, $6,529,545 (Related Table II recommendation of $10,161,742 is also outstanding.)
CIN: A-03-99-00052	ALLEGHENY/CHESAPEAKE ORF, SEPTEMBER 2001, $5,540,344 (Related Table II recommendation of $467,646 is also outstanding.)
CIN: A-04-00-02161	MEDICAID SCHOOL-BASED SERVICES IN NORTH CAROLINA, NOVEMBER 2001, $5,344,160
CIN: A-07-99-02537	BLUE CROSS & BLUE SHIELD OF MASSACHUSETTS, NOVEMBER 1999, $5,270,461
CIN: A-05-96-00058	CLOSE-OUT AUDIT OF MEDICARE CONTRACT-BCBS-MI, DECEMBER 1997, $5,226,443
CIN: A-01-00-00506	DIAGNOSIS-RELATED GROUP PAYMENT WINDOW, JULY 2001, $5,042,207
CIN: A-01-97-00516	ADMIN. COSTS-PART A&B, RAILROAD RETIRE BOARD, JUNE 1999, $4,939,184
CIN: A-05-01-00023	ADMINISTRATIVE COSTS REVIEW - ADMINASTAR FEDERAL, JANUARY 2002, $4,694,863
CIN: A-02-00-01047	DEMO BSWNY - FINANCIAL, MARCH 2002, $4,505,051
CIN: A-07-96-02001	MEDICARE PART B ADMIN COSTS AT BC/BS COLORADO, DECEMBER 1996, $4,483,104
CIN: A-07-98-01263	DENVER CMHC, MAY 2000, $4,447,607
CIN: A-07-00-00108	RURAL HEALTH CENTER REVIEW, OCTOBER 2001, $4,088,929
CIN: A-05-01-00068	PARTNERSHIP PLAN - ILLINOIS PHYSICIAN BILLING-FAMILY DYNAMICS, JULY 2002, $3,790,846
CIN: A-04-01-05002	AUDIT MEDICAID PAYMENTS FOR CLINICAL LABORATORIES, JANUARY 2002, $3,522,639
CIN: A-07-00-00109	MEDICARE CONTRACT TERM. & SEG. CLOSING- GALIC, SEPTEMBER 2000, $3,505,560
CIN: A-03-00-00002	TRIGON PT-A AND TERMINATION, SEPTEMBER 2001, $3,464,705
CIN: A-02-95-01019	STAFF BUILDERS HOME OFFICE MEDICARE COST REV. ORT, AUGUST 1998, $3,434,274
CIN: A-05-93-00054	IL-ASSOCIATED INSURANCE GROUP-CONTRACT AUDIT, OCTOBER 1993, $3,355,560

CIN: A-07-99-01283 HMO - AFTER DEATH PAYMENTS, FEBRUARY 2000, $3,250,000
CIN: A-07-99-01298 DATE OF DEATH - 2, MAY 2001, $3,200,000 (Related Table II recommendation of $700,000 is also outstanding.)
CIN: A-05-98-00042 ADMINISTAR INS. CO.– ADMIN. COSTS AUDIT, SEPTEMBER 1999, $3,111,728
CIN: A-06-99-00057 AUDIT OF MEDICARE REHAB AGENCY SERVICES IN TX, JANUARY 2001, $3,097,201
CIN: A-07-02-03007 COSTS CLAIMED FOR POST RETIREMENT BENEFITS BY TOLIC, MAY 2002, $3,060,873
CIN: A-05-93-00013 MI-BLUE CROSS/BLUE SHIELD-CONTRACT MEDICARE AUDIT, APRIL 1993, $3,010,916
CIN: A-09-98-50183 STATE OF CALIFORNIA, MARCH 1998, $3,000,000
CIN: A-07-01-00132 INDEPENDENCE BLUE CROSS - PENSION SEGMENT CLOSING AUDIT, FEBRUARY 2002, $2,913,129
CIN: A-01-96-00508 MEDICARE ADMIN COSTS PARTS A&B AND RRB - TRAVELERS, MARCH 1996, $2,803,260
CIN: A-05-97-00005 ADMINISTRATIVE COSTS CLAIMED UNDER MEDICARE A & B, FEBRUARY 1998, $2,569,067
CIN: A-07-92-00579 BC/BS OF MICHIGAN INC - UNFUNDED PENSION COSTS, OCTOBER 1992, $2,535,698
CIN: A-05-92-00026 ASSOCIATED INSURANCE CO. - MEDICARE ADMIN, FEBRUARY 1992, $2,530,409
CIN: A-09-02-72300 STATE OF CALIFORNIA , JULY 2002, $2,400,000
CIN: A-02-91-01006 BLUE SHIELD OF WESTERN NY MEDICARE ADM CTS PORTER, SEPTEMBER 1991, $2,379,239
CIN: A-04-00-01209 OUTPATIENT PSYCHIATRIC SERVICES AT HOLLYWOOD PAV.HOSP, APRIL 2001, $2,366,287
CIN: A-03-99-00038 EDGEWATER PSYC HOSPITAL, MARCH 2001, $2,348,604 (Related Table II recommendation of $208,731 is also outstanding.)
CIN: A-04-97-01166 REV. HOME HEALTH SERVICES BY STAFF BUILDERS HOME HEALTH, APRIL 1999, $2,300,000
CIN: A-07-97-01247 DUPLICATE PAYMENTS - HMO/FFS, OCTOBER 1999, $2,300,000
CIN: A-04-97-01170 REVIEW HOME HEALTH SERVICES BY MEDICARE HOME HEALTH SERVICES, APRIL 1999, $2,200,000
CIN: A-09-01-00056 PACIFICARE-CALIFORNIA JAN 1998 INSTITUTIONAL PMTS, SEPTEMBER 2001, $2,158,577
CIN: A-07-01-68554 STATE OF NEBRASKA, JUNE 2001, $2,113,388
CIN: A-04-00-02162 REVIEW TREATMENT OF QUALIFIED DISCHRGS @ FCSO, FEBRUARY 2001, $2,042,060
CIN: A-05-00-00034 PROVENA ST. JOSEPH HOSPITAL-O/P PSYCH SERVICES, NOVEMBER 2000, $1,978,583
CIN: A-05-02-00048 REVIEW OF MEDICAID DME CLAIMS - TEXAS, SEPTEMBER 2002, $1,969,704
CIN: A-03-00-00003 XACT PT-B ADMIN COSTS, APRIL 2002, $1,922,950
CIN: A-04-97-01169 REVIEW HOME HEALTH SERVICES BY MEDTECH HOME HEALTH SERVICES APRIL 1999, $1,900,000
CIN: A-06-96-00009 NEW MEXICO BC/BS ADMIN COST - CONTRACTED, NOVEMBER 1997, $1,879,366
CIN: A-01-02-72211 STATE OF CONNECTICUT, JUNE 2002, $1,860,148
CIN: A-05-01-00105 REVIEW OF MEDICAID DME CLAIMS - PENNSYLVANIA, SEPTEMBER 2002, $1,813,649
CIN: A-05-97-00014 GROUP HEALTH PLAN INC.(HEALTHPARTNERS) INST. BENES, JUNE 1998, $1,808,308

CIN: A-05-95-00059	AUDIT OF ADMINISTRATIVE COSTS --BC/BS MICHIGAN, JANUARY 1997, $1,787,345
CIN: A-03-00-00007	REVIEW OF 1-DAY DISCHARGES--PA., APRIL 2001, $1,649,411 (Related Table II recommendation of $6,300,000 is also outstanding.)
CIN: A-04-97-02143	REVIEW THERAPY SERVICES IN LIFE CARE SNF'S IN TN, DECEMBER 1999, $1,638,025
CIN: A-02-97-01039	MEDASSIST - ORT ORTHOTICS PROVIDER TARGET, NOVEMBER 1999, $1,616,222
CIN: A-04-99-01196	OIG-HCFA JOINT REVIEW OF JMV MEDICAL CORP., DECEMBER 2000, $1,600,417
CIN: A-03-00-00215	ANNABURG MANOR NURSING HOME COST REPORT, MARCH 2002, $1,582,079
CIN: A-03-96-00012	BC/BSM PT-B NON-RENEWAL COSTS, AUGUST 1998, $1,557,459
CIN: A-05-93-00057	MI-BLUE CROSS & BLUE SHIELD OF MI-CONTRACT AUDIT, JULY 1993, $1,409,954
CIN: A-09-96-00064	ORT - HOSPICE - CALIFORNIA, MARCH 1997, $1,350,000
CIN: A-10-91-00011	WPS - KEYSTONE COMPUTER ACQUISITION, OCTOBER 1992, $1,346,681
CIN: A-09-02-00057	REVIEW OF MEDICARE BAD DEBTS AT THE UNIV. OF CA SAN FRANCISCO, JULY 2002, $1,338,058
CIN: A-05-95-00042	BC/BSA ADMINISTRATIVE COSTS - CONTRACTED AUDIT, DECEMBER 1995, $1,333,598
CIN: A-07-01-02089	MISSOURI DSH DUPLICATE COSTS AND ACCOUNTING ERRORS, MAY 2002, $1,300,000
CIN: A-05-01-00064	REVIEW OF OUTPATIENT REHABILITATION CLAIMS REIMBURSED BY MEDICARE DURING CALENDAR YEAR 1999, FEBRUARY 2002, $1,235,892
CIN: A-04-02-72903	STATE OF TENNESSEE, SEPTEMBER 2002, $1,213,353
CIN: A-05-00-00004	NEW CENTER COMMUNITY MENTAL HEALTH CENTER, JUNE 2000, $1,181,000
CIN: A-05-00-00049	PARTNERSHIP PLAN - IL HOSPITAL TRANSFERS, JUNE 2001, $1,150,113
CIN: A-02-97-01026	EDDY VNA (#337152) HHA ELIGIBILITY REVIEW, SEPTEMBER 1999, $1,131,593
CIN: A-05-98-00050	FOLLOW-UP MEDICAID CLINICAL LABORATORIES, JULY 1999, $1,097,036
CIN: A-06-01-00044	AUDIT OF ADMINISTRATIVE COSTS PART A & PART B - TRAILBLAZER BC/BS, APRIL 2002, $1,091,848
CIN: A-02-94-01029	HOSPICE ELIGIBILITY RVW IN PR - SAN GERMAN - ORT, JUNE 1995, $1,070,814
CIN: A-09-98-00052	CALIFORNIA MEDICAL REVIEW INC. (CA. PRO), JANUARY 1999, $1,067,991
CIN: A-05-01-00037	BC/BS OF MN. ADMIN COSTS – LEON SNEAD & CO., JUNE 2001, $1,037,090
CIN: A-04-99-01199	REV. PSYCHIATRIC OUTPATIENT SRVCS-CORAL GABLES HOSPITAL, APRIL 2001, $1,031,497
CIN: A-01-98-00500	PAYMENT EDITS FOR PSYCHIATRIC AT MA PART B CARRIER, SEPTEMBER 1998, $1,000,000
CIN: A-09-94-01010	CLOSEOUT AUDIT – CONT NO. N01-ES-75196 (STRATAGENE), MARCH 1994, $983,208
CIN: A-04-00-01210	REVIEW TREATMENT-QUALIFIED DISCHRGS-BC/BSGA, DECEMBER 2000, $891,000
CIN: A-05-92-00060	CONTRACTOR AUDIT - BCBS - ADMIN, FEBRUARY 1993, $879,609
CIN: A-02-97-01034	DR. PILA FOUNDATION HOME CARE PRORAM (PONCE), SEPTEMBER 1999, $857,208
CIN: A-07-98-02533	TRAVELERS FACP, DECEMBER 1998, $854,214
CIN: **A-04-01-05004**	REVIEW MEDICARE CLAIMS FOR DEPORTED BENEFICIARIES, MARCH 2002, $836,711
CIN: A-06-99-00013	MEDICARE PART A ADMIN NM BLUE CROSS BLUE SHIELD, DECEMBER 1999, $817,487

CIN: **A-02-98-01040**	NIAGARA CTY DEPT. OF HLTH-#337001-HHS ELIG REVIEW, DECEMBER 1999, $807,679
CIN: A-09-01-00094	PACIFICARE CORPORATE JANUARY 1998 MEDICARE INSTITUTIONAL STATUS, FEBRUARY 2002, $786,003
CIN: A-05-01-00073	REVIEW OF ADMINISTRATION OF RYAN WHITE (AIDS) FUNDS - INDIANA, MAY 2002, $784,499
CIN: A-07-99-00981	ASSIST REVIEW OF MEDICARE A/R HCFA RO DENVER, JANUARY 2000, $754,926
CIN: A-06-01-00027	REVIEW PALMETTO'S HH-PPS RAP POLICIES & PROCEDURES, SEPTEMBER 2001, $743,917
CIN: A-09-00-00103	PACIFICARE HMO - MEDICARE DUAL ELIGIBLES, MAY 2001, $720,858
CIN: A-05-91-00136	COMMUNITY MUTUAL INS CO. ADMIN COSTS, AUGUST 1992, $720,668
CIN: A-03-02-72100	EAST COAST MIGRANT HEAD START PROJECT , JUNE 2002, $701,523
CIN: A-09-97-00078	PHYSICIAN BILLINGS DR. SPENCER, JANUARY 1999, $683,264
CIN: A-02-01-01007	REVIEW OF ADMINISTRATIVE COST AT COOPERATIVA (CARMICHAEL & CO, CPA), MAY 2002, $679,487
CIN: A-06-01-00090	PREAWARD-APASS MAINTAINER DATA PROCESSING SERVICES - ABC/BS, SEPTEMBER 2001, $678,651
CIN: A-01-02-73084	STATE OF MAINE, SEPTEMBER 2002, $677,855 (Related Table II recommendation of $149,082 is also outstanding.)
CIN: A-05-00-64226	ILLINOIS DEPT. OF PUBLIC AID, MAY 2000, $654,017
CIN: A-01-98-00503	PSYCHIATRIC OUTPT SERVICES AT THE FRANKLIN MED CENTER, NOVEMBER 1998, $646,517
CIN: A-02-02-69503	PUERTO RICO DEPT. OF THE FAMILY, SEPTEMBER 2002, $629,136
CIN: A-01-99-00535	AUDIT OF M/C PART A ADMIN COSTS-ANTHEM BC/BS CT, AUGUST 2000, $621,256
CIN: A-04-00-00138	MEDICAID ESCHEATED WARRANTS - FLORIDA, JANUARY 2002, $613,891
CIN: A-06-98-00066	ORT REVIEW OF ULTIMATE HOME HEALTH CARE INC., OCTOBER 1999, $602,982
CIN: A-04-94-01078	MONITORING ADMIN COST - AUDIT MEDICARE P.B BC/BSSC, JULY 1994, $594,092
CIN: A-04-93-01069	MONITORING ADMIN COST AUDIT MCARE PART A BC/BSSC, JULY 1994, $590,844
CIN: A-04-01-01007	ABC/BS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, $575,471
CIN: A-09-00-00067	COLLEGE HOSPITAL - O/P PSYCH SVCS, APRIL 2001, $567,888
CIN: A-01-02-70271	STATE OF MAINE, DECEMBER 2001, $561,697
CIN: A-09-01-00055	REVIEW OF IMD CLAIMS - STATE OF CALIFORNIA, MARCH 2002, $551,394
CIN: A-05-02-72811	COMMUNITY ACTION OF GREATER INDIANAPOLIS INC., AUGUST 2002, $547,899
CIN: A-10-01-00011	REVIEW OF WASHINGTON MEDICAID SCHOOL BASED HEALTH SERVICES - REIMBURSEMENT OF ADMINISTRATION CLAIMS, MAY 2002, $527,102
CIN: A-01-01-00542	REVIEW OF CLAIMS FOR ANESTHESIA, PHARMACY, AND SUPPLY SERVICES USED INCIDENT TO OTHER OUTPATIENT DIAGNOSTIC SERVICES PROCESSED BY ASSOCIATED HOSPITAL SERVICE, JUNE 2002, $518,981
CIN: **A-05-00-00011**	LIBERTYVILLE MANOR SNF - THERAPY SERVICES, SEPTEMBER 2001, $506,937
CIN: A-05-99-00062	AMERICARE PHYSICAL THERAPY SERVICES, DECEMBER 2000, $503,619
CIN: A-09-99-56858	HAWAII DEPT. OF HUMAN SERVICES, FEBRUARY 1999, $502,000
CIN: A-03-92-16229	STATE OF PENNSYLVANIA, MARCH 1992, $496,876
CIN: A-05-02-72298	STATE OF WISCONSIN, AUGUST 2002, $491,120

CIN: **A-07-01-03004**	TRIGON BC/BS - PENSION SEGMENT CLOSING AUDIT, JULY 2002, $487,254
CIN: A-05-01-67384	MICHIGAN DEPT. OF COMMUNITY HEALTH, FEBRUARY 2001, $481,693
CIN: **A-04-98-01192**	REVIEW AMERICA'S BEHAV. HEALTH CARE'S PART.HOSPITALIZ, DECEMBER 1999, $452,928
CIN: A-07-01-00120	REVIEW OF UNFUNDED PENSION COCST AT BCBS OF OK, JULY 2001, $413,800
CIN: A-05-97-00013	PACIFICARE OF CA-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, $407,784
CIN: A-02-01-67912	STATE OF NEW YORK , MARCH 2001, $389,622 (Related Table II recommendation of $19,000,000 is also outstanding.)
CIN: A-05-00-00030	CONTRACTED AUDIT-NATIONWIDE INS.-MEDICARE ADMIN., OCTOBER 2000, $385,081
CIN: A-04-00-01208	OUTPATIENT CLINIC COSTS, CORAL GABLES HOSPITAL, FL, FEBRUARY 2001, $384,295
CIN: A-06-01-00087	AUDIT OF OBSERVATION SERVICE BILLING BY PRESBYTERIAN HOSPITAL OF DALLAS, JUNE 2002, $361,832
CIN: A-05-02-70413	SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND, JUNE 2002, $345,125
CIN: **A-01-99-00518**	PSYCHIATRIC OUTPATIENT SVCS AT DANBURY HOSPITAL, MAY 2000, $342,168
CIN: A-10-01-00005	AUDIT OF ADMIN COSTS AT MEDICARE NORTHWEST, SEPTEMBER 2001, $332,274
CIN: A-07-01-02630	REVIEW OF MUTUAL'S SETTLEMENT OF HHA COST REPORTS, JANUARY 2002, $319,949
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $319,355
CIN: A-06-01-00028	AUDIT OF OBSERVATION SERVICE BILLINGS BY PPS HOSPITALS, FEBRUARY 2002, $298,549
CIN: A-05-96-00069	CPA AUDIT OF HOOPER HOLMES HHA G&A -OI CASE OPEN, FEBRUARY 1998, $280,515 (Related Table II recommendation of $17,555 is also outstanding.)
CIN: A-06-97-00015	NEW MEXICO PRO CLOSE OUT AUDIT, SEPTEMBER 1999, $268,844
CIN: A-09-94-30178	STATE OF ARIZONA, JUNE 1994, $267,021
CIN: A-09-00-00089	COMMUNITY URGENT CARE MEDICAL GROUP, NOVEMBER 2001, $266,236
CIN: A-03-98-00027	KHPW/INSTITUTIONAL STATUS/MEDICARE, NOVEMBER 1998, $263,573
CIN: A-04-02-00010	AUDIT OF EWCDC'S OFFICE OF COMMUNITY SERVICES DISCRETIONARY GRANT, AUGUST 2002, $250,000
CIN: A-03-01-00010	CAREFIRST OF MD - PT-A ADMIN - FYS 1996-1999, FEBRUARY 2002, $225,302
CIN: A-04-00-01222	CAPITAL HEALTH PLAN, COST-BASED MANAGED CARE PLAN, SEPTEMBER 2001, $221,952
CIN: A-01-00-00549	BETH ISRAEL AUDIT OF OUTPATIENT PHARMACY SVC, MARCH 2001, $221,905
CIN: A-05-99-00067	PART B ADMINISTRATIVE COSTS, NOVEMBER 2000, $221,644
CIN: A-01-01-00523	REVIEW OF OUTPATIENT PHARMACY SERVICES AT NOBLE HOSPITAL, NOVEMBER 2001, $216,797
CIN: A-02-01-65217	PUERTO RICO DEPT. OF THE FAMILY, DECEMBER 2000, $213,264
CIN: A-05-96-00052	ORT ASSIST-ANCILLARY COSTS-NW COM. HOSP., JUNE 1997, $206,508
CIN: A-06-96-00064	ORT SNF RESEARCH AT METHODIST HOSPITAL, JANUARY 1997, $200,000
CIN: A-07-01-02631	REVIEW OF HOSPITAL OBSERVATION BEDS, MAY 2002, $197,773

CIN: A-04-01-00002	TITLE IV-E FOSTER CARE PMTS-CHILD CARE CLAIMS-NC-2, NOVEMBER 2001, $186,282
CIN: A-03-01-00555	PDPI INC. -- HEAD START, JUNE 2001, $185,577
CIN: A-06-02-72614	STATE OF TEXAS, AUGUST 2002, $183,400
CIN: A-07-02-03016	TRANSAMERICA SUPPLEMENTAL PENSION PLAN COSTS, MARCH 2002, $180,244
CIN: A-05-02-73374	STATE OF OHIO, SEPTEMBER 2002, $179,797
CIN: A-02-00-01020	BC/BS OF WESTERN NY (CARMICHAEL & CO., CPA, APRIL 2001, $171,631
CIN: A-04-01-07004	OI ASSIST: SELF DISCLOSURE AUDIT OF HEALTHPRIME, INC., APRIL 2002, $169,401
CIN: A-10-01-00006	REVIEW OF OREGON MEDICAID SCHOOL BASED HEALTH SERVICES - REIMBURSEMENT OF DIRECT SERVICES, AUGUST 2002, $166,671
CIN: A-03-98-00034	FREESTATE HP/INSTITUTIONAL STATUS/MEDICARE, MARCH 1999, $156,987
CIN: A-09-01-00084	VISTA DEL MAR NEPHROLOGY GROUP, NOVEMBER 2001, $151,566
CIN: A-05-00-00031	CONTRACTED AUDIT OF UGS--MEDICARE ADMIN. COSTS, NOVEMBER 2000, $138,182
CIN: A-09-99-52846	INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEBRUARY 1999, $136,360
CIN: A-03-01-00219	NATIONAL ASSOCIATION OF PROTECTION & ADVOCACY -NAPAS, SEPTEMBER 2001, $136,181
CIN: A-02-98-01002	PRO CLOSEOUT AUDIT - CPA CONTRACT MONITORING, DECEMBER 1998, $135,492
CIN: A-02-00-01019	HORIZON BC/BS (LEON SNEAD & CO., CPA, SEPTEMBER 2001, $134,584
CIN: A-05-00-00060	MEDICA FOLLOW-UP, REIMB. RATES FOR INSTITUTIONALIZED BENEFICIARIES, JUNE 2001, $133,795
CIN: A-06-00-00014	REV OF INFUSION THERAPY CLAIMS @ DOCTORS HEALTHCARE, JUNE 2000, $132,238
CIN: A-02-01-04000	INTERIM AUDIT OF RUTGER'S CONTRACT NO.SP0103-96-D-, JANUARY 2002, $125,415
CIN: A-05-01-00069	MERITER - MC/MA CREDIT BALANCES, JULY 2002, $122,713
CIN: **A-05-01-00091**	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEPTEMBER 2002, $121,023
CIN: A-02-02-71384	STATE OF NEW YORK, MARCH 2002, $118,773
CIN: A-05-97-00023	KAISER FOUNDATION-HMO INSTITUTIONAL STATUS PROJECT, APRIL 1998, $116,096
CIN: A-02-96-02001	INTERNATIONAL RESCUE COMMITTEE - REFUGEE PROGRAM, JANUARY 1998, $114,631 (Related Table II recommendation of $90,528 is also outstanding.)
CIN: A-03-99-00003	AETNA-US HEALTHCARE/INSTITUTIONAL STATUS/MEDICARE, JULY 1999, $113,993
CIN: A-09-02-71247	WATTSHEALTH FOUNDATION INC., APRIL 2002, $113,000
CIN: A-02-01-01006	IMD-REVIEW OF AGE 21 - 64 IN NEW YORK'S PRIVATE PSYCH HOSPITALS, MAY 2002, $112,925
CIN: A-03-01-00001	EASTERN SHORE AMBULANCE CO., AUGUST 2001, $110,417
CIN: A-02-99-58263	PUERTO RICO OFFICE OF THE GOVERNOR OFFICE OF CHILD, JULY 1999, $101,799
CIN: A-09-01-00080	NEPHROLOGY ASSOCIATES MEDICAL GROUP - RIVERSIDE, NOVEMBER 2001, $100,788
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, $100,692
CIN: A-05-00-65775	STATE OF WISCONSIN, SEPTEMBER 2000, $98,586
CIN: A-07-99-01287	WELLMARK ADMIN COSTS 98, NOVEMBER 1999, $95,990

CIN: A-09-97-00066	WALTER MCDONALD - INDIRECT COST RATE AUDIT, MARCH 1998, $95,733
CIN: A-09-01-00096	AUDIT OF VERMONT SLAUSON ECONOMIC DEVELOPMENT CORP. GRANT AWARD NUMBER 90EE0153, DECEMBER 2001, $95,560
CIN: A-09-98-00065	CSBG DISC. GRANT #90EE004901 - LATINO RESOURCES, JANUARY 1999, $95,102
CIN: A-01-99-00507	NAT-WIDE REF OPNT PSYCH SVC AT ACUTE CARE HOSPITALS, MARCH 2000, $94,716 (Related Table II recommendation of $244,446,692 is also outstanding.)
CIN: A-10-97-00003	BCWAAK-ADM COSTS REMOTE NETWORK ACTIVITIES FYS 93&94, FEBRUARY 1998, $94,643
CIN: A-04-02-02009	MEDICAID IMD'S - PRIVATE FACILITIES IN FLORIDA, SEPTEMBER 2002, $92,726
CIN: A-06-02-72136	STATE OF LOUISIANA, JUNE 2002, $92,044
CIN: A-07-95-01164	MEDICARE ADMIN COSTS - GENERAL AMERICAN, DECEMBER 1995, $89,929 (Related Table II recommendation of $16,632 is also outstanding.)
CIN: A-06-00-00013	REVIEW OF INFUSION THERAPY CLAIMS @ SPRING CREEK N, JUNE 2000, $89,288
CIN: A-01-01-00503	REVIEW OF O/P MEDICAL SUPPLIES AT MERCY HOSPITAL, JULY 2001, $88,904
CIN: A-05-01-00090	PAYMENTS TO AETNA OF FOR INSTITUTIONAL BENEFICIARIES, JULY 2002, $87,516
CIN: A-07-00-00118	REVIEW OF KANSAS RURAL HEALTH CENTER, MAY 2001, $87,493
CIN: A-08-99-56914	RURAL AMERICA INITIATIVES, JULY 1999, $87,468
CIN: A-04-01-01006	BC/BS MEDICARE PART A ADMINISTRATIVE COST AUDIT, NOVEMBER 2001, $87,042
CIN: A-04-02-72118	STATE OF NORTH CAROLINA, MAY 2002, $84,932
CIN: A-05-01-00071	PAYMENTS TO HUMANA-K.C. FOR INSTITUTIONAL BENEFICIARIES, DECEMBER 2001, $84,808
CIN: A-02-01-01014	IMD - NEW YORK - MEDICAL AND ANCILLARY SERVICES, JULY 2002, $84,077
CIN: A-02-01-01026	FY 2001 MEDICARE ERROR RATE - EMPIRE - 3RD QUARTER, JULY 2002, $82,625
CIN: A-03-02-00550	CENTRAL PIEDMONT ACTION COUNCIL - HEAD START, APRIL 2002, $79,777
CIN: A-10-01-67562	KENAITZE INDIAN TRIBE, MARCH 2001, $79,533
CIN: A-04-94-02080	FINALIZATION OF BCBSFL DATA MATCH, JUNE 1995, $79,316
CIN: A-04-01-02003	REVIEW FLORIDA MEDICAID CLAIMS - IMD'S, MARCH 2002, $78,880
CIN: A-04-96-01137	PARTIC. PART OF HCFA SURV.TEAM-DAYTONA NURSG-ORT, DECEMBER 1996, $76,130
CIN: A-01-99-00530	NATIONWIDE REV OF O/P PSYCH SVCS @ PSYCH HOSPITALS, DECEMBER 2000, $75,413 (Related Table II recommendation of $56,936,287 is also outstanding.)
CIN: A-02-02-01016	MEDICARE BAD DEBTS AT ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, SEPTEMBER 2002, $74,412
CIN: A-04-02-72213	STATE OF FLORIDA, JUNE 2002, $73,239
CIN: A-01-00-00503	REVIEW OF MEDICARE OUTLIER PAYMENTS-MASS GENERAL, DECEMBER 2000, $73,019
CIN: A-04-01-02008	ANCILLARY CLAIMS PAID FOR MEDICAID BENEFICIARIES WHILE IN IMDS, JULY 2002, $71,406
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
CIN: A-05-99-00045	KAISER HEALTH PLAN OF OHIO - INSTITUTIONAL STATUS, MAY 2000, $61,177

CIN: A-05-02-72716	SOKAOGON CHIPPEWA COMMUNITY MOLE LAKE BAND ,SEPTEMBER 2002, $60,378
CIN: A-05-96-00072	MI DEPT. OF COMMUNITY HEALTH/MEDICAID LAB SERVICES, AUGUST 1997, $59,956
CIN: A-06-01-68876	STATE OF LOUISIANA, JUNE 2001, $59,914
CIN: A-01-96-00505	CFO AUDIT OF HCFA'S FINANCIAL STATEMENTS, JULY 1997, $59,327
CIN: A-02-00-62534	CITY OF NEW YORK NEW YORK, JANUARY 2000, $58,309
CIN: A-05-96-00051	ORT ASSIST-ANCILLARY COSTS-ST JOSEPH, JUNE 1997, $58,008
CIN: A-09-97-00059	HEALTH SERVICES ADVISORY GROUP, INC PRO-AZ, MAY 1997, $57,925
CIN: A-08-99-54138	ROSEBUD SIOUX TRIBE, NOVEMBER 1998, $56,223
CIN: A-07-97-01206	PENSION - WASHINGTON/ALASKA - UNFUNDED, MARCH 1997, $4,000
CIN: A-06-00-00053	OIG HCFA NEBULIZER PROJECT - NATIONAL ERROR RATE,OCTOBER 2001, $52,550 (Related Table II recommendation of $133,960,552 is also outstanding.)
CIN: A-08-00-60687	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, NOVEMBER 1999, $52,536
CIN: A-04-00-01223	REV. MGMT FEES - ONCOLOGY CLINIC-PKWY REG'L M'CAL,OCTOBER 2001, $52,000
CIN: A-04-02-68936	STATE OF TENNESSEE, JUNE 2002, $50,717
CIN: A-05-00-00059	TITLE XIX - MEDICAID ESCHEATED WARRANTS, MARCH 2001,$50,162
CIN: A-02-02-70019	SENECA NATION OF INDIANS, DECEMBER 2001, $50,083
CIN: A-09-95-00095	HEALTH SERVICES ADVISORY GROUP, INC (HSAG), DECEMBER 1995, $49,585 (Related Table II recommendation of $1,389,723 is also outstanding.)
CIN: A-03-93-03306	SURVEY RESEARCH ASSOC. CACS NO1-ES-45067, DECEMBER 1993, $48,779
CIN: A-07-02-73024	STATE OF MISSOURI, JULY 2002, $46,902
CIN: A-07-00-00106	PENSION SEGMENTATION AUDIT AT BCBS OF OKLAHOMA, JULY 2001, $45,508
CIN: A-09-99-52845	INTER-TRIBAL COUNCIL OF CALIFORNIA INC., FEBRUARY 1999, $43,315
CIN: A-09-99-57306	PICAYUNE RANCHERIA OF THE CHUKCHANSI INDIAN TRIBE, SEPTEMBER 1999, $43,159
CIN: A-07-01-00121	REV. OF PEN. COSTS FOR MED. REIMB. FOR BC/BS OF OK, JULY 2001, $42,463
CIN: A-01-02-71892	STATE OF VERMONT, APRIL 2002, $42,037
CIN: A-03-99-00017	PSU-HERSHEY/PHY CREDIT BALANCES/MEDICARE, DECEMBER 1999, $41,712
CIN: A-10-02-72331	IDAHO MIGRANT COUNCIL INC., JULY 2002, $40,541
CIN: A-05-00-00017	INDIANA MEDICAID TRANSPORTATION SERVICES, MARCH 2001, $39,735
CIN: A-06-01-00026	JOINT FED/ST AUDIT OF MEDICAID CLINICAL LAB SRVCS IN OK, JULY 2002, $38,690
CIN: A-05-02-72003	STATE OF OHIO, JULY 2002, $37,808
CIN: A-07-98-53295	WINNEBAGO TRIBE OF NEBRASKA, SEPTEMBER 1998, $36,808
CIN: A-10-00-63008	STATE OF IDAHO, MARCH 2000, $36,800
CIN: A-08-00-65136	STATE OF SOUTH DAKOTA, JUNE 2000, $36,380
CIN: A-03-00-00010	PS GEISINGER HMO/INSTITUTIONAL STATUS/MEDICARE, JANUARY 2001, $35,639 (Related recommendation of $306,269 outstanding on Table II.)
CIN: A-06-02-70441	FIVE SANDOVAL INDIAN PUEBLOS INC., JUNE 2002, $35,441
CIN: A-02-00-65502	ABYSSINIAN DEVELOPMENT CORP., AUGUST 2000, $34,737
CIN: A-04-00-60897	STATE OF FLORIDA, MARCH 2000, $33,397
CIN: A-09-01-00050	BALBOA NEPHROLOGY MEDICAL GROUP, APRIL 2001, $32,568
CIN: A-03-99-00008	BLUE CROSS BLUE SHIELD OF DELAWARE - PART A, JANUARY 2000, $32,176
CIN: A-07-97-01199	BC/BS NEW MEXICO UNFUNDED PENSION COST, FEBRUARY 1997, $31,372
CIN: A-05-02-69155	STATE OF WISCONSIN, DECEMBER 2001, $30,900

CIN: A-04-01-01005	REVIEW DUPLICATE MEDICARE FEE-FOR-SERVICE PAYMENTSAT CAPITAL HEALTH PLAN, NOVEMBER 2001, $30,293
CIN: A-06-02-00018	GRADUATE MEDICAL EDUCATION COST AT METHODIST HOSPITAL IN HOUSTON, JUNE 2002, $30,230
CIN: **A-03-00-00209**	STATE SURVEY AND CERTIFICATION COSTS - VA, AUGUST 2001, $29,298
CIN: A-01-02-71527	STATE OF MASSACHUSETTS , APRIL 2002, $29,260
CIN: A-03-98-03301	AAUAP -- INCURRED COST REVIEW -- HHS 105-95-7011, APRIL 1998, $28,289
CIN: A-03-00-64076	NATIONAL MEDICAL ASSOCIATION, APRIL 2000, $27,106
CIN: A-10-02-69837	NATIVE VILLAGE OF TYONEK , DECEMBER 2001, $26,848
CIN: A-06-00-00020	REV OF INFUSION THERAPY CLAIMS @ VISTA CONTINUING, JUNE 2000, $25,008
CIN: A-03-00-00004	GUTHRIE CLINIC/PHYSICIAN CREDIT BALANCES/MEDICARE, DECEMBER 1999, $23,759
CIN: A-06-02-70732	UNITED STATES-MEXICO BORDER HEALTH ASSOCIATION, JANUARY 2002, $23,483
CIN: A-06-02-71744	SENECA-CAYUGA TRIBE OF OKLAHOMA , MARCH 2002, $21,376
CIN: A-04-00-01206	BC/BS NC - MEDICARE PART A ADMIN COST AUDIT-CARMICHAEL, SEPTEMBER 2000, $21,302
CIN: A-05-01-00078	PAYMENTS TO HEALTH NET-TUCSON, AZ.- FOR INSTITUTIONAL BENEFICIARIES, APRIL 2002, $21,233
CIN: A-05-02-72480	HANSEL NEIGHBORHOOD SERVICE CENTER INC., SEPTEMBER 2002, $20,266
CIN: A-06-02-72610	STATE OF OKLAHOMA, AUGUST 2002, $19,992
CIN: A-05-02-70624	STATE OF OHIO, JANUARY 2002, $19,970
CIN: A-04-01-67441	CATAWBA INDIAN NATION, APRIL 2001, $19,204
CIN: **A-05-01-00100**	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842
CIN: A-04-97-01163	VIMI MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, $18,758
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUNE 2002, $18,645
CIN: A-05-93-21928	WRIGHT STATE UNIV., JULY 1993, $18,308
CIN: A-03-01-00018	WASHINGTON HOSPITAL CENTER GRADUATE MEDICAL EDUCATION COSTS, MAY 2002, $18,000
CIN: A-03-97-00007	NE HEALTH CARE QUALITY FOUNDATION/CCAS/N HAMPSHIRE, MARCH 1997, $17,045
CIN: A-07-00-00117	REV. OF PENSION COSTS FOR MED. REIMB. BC/BS OF ND, JANUARY 2001, $16,863
CIN: A-01-99-55594	STATE OF VERMONT, NOVEMBER 1998, $16,623
CIN: A-01-97-44143	BRANDEIS UNIV., JANUARY 1997, $16,602
CIN: A-06-01-68297	NATIVE AMERICAN CENTER OF RECOVERY INC., MAY 2001, $16,314
CIN: A-01-02-70440	UNIV. OF MASSACHUSETTS , JANUARY 2002, $16,031
CIN: A-10-00-59080	NORTON SOUND HEALTH CORP., DECEMBER 1999, $15,000
CIN: A-05-01-00044	MINNESOTA MEDICAID PERSONAL CARE SERVICES REVIEW, APRIL 2002, $14,844
CIN: A-03-97-00008	NE HEALTH CARE QUALITY FOUNDATION/CCAS/VERMONT, MARCH 1997, $14,596
CIN: A-08-01-67689	FORT BELKNAP INDIAN COMMUNITY, SEPTEMBER 2001, $14,340
CIN: A-09-00-00104	PACIFICARE OF CALIFORNIA - INSTITUTIONAL STATUS, MARCH 2001, $14,278
CIN: A-09-96-00050	CFO - HCFA 1996, NOVEMBER 1997, $13,924
CIN: A-10-02-72976	STATE OF IDAHO, AUGUST 2002, $13,000
CIN: A-03-98-50338	NATIONAL MEDICAL ASSOCIATION, FEBRUARY 1998, $12,968

CIN: A-15-01-20002	CONGRESS HEIGHTS TRAINING CENTER, INC. -- FINANCIAL AUDIT N OMH GRANT AWARD, SEPTEMBER 2001, $11,300
CIN: A-05-01-00070	PAYMENTS TO GHP MCO/ST LOUIS FOR INSTITUTIONAL BENEFICIARIES, JANUARY 2002, $11,089 (Related Table II recommendation of $98,698 is also outstanding.)
CIN: A-03-01-00513	IRSA - KOSOVO ASSISTANCE GRANT 90-ZK-0002/01, DECEMBER 2001, $10,913
CIN: A-03-02-71608	SUPPORTIVE CHILD ADULT NETWORK INC., APRIL 2002, $10,561
CIN: A-09-02-71757	PYRAMID LAKE PAIUTE TRIBE, MAY 2002, $9,857
CIN: A-10-97-00002	GROUP HEALTH INSTITUTIONALIZED, NOVEMBER 1997, $9,769
CIN: A-02-01-02003	FORDHAM UNIVERSITY - DISCRETIONARY GRANT REVIEW, MAY 2002, $9,451
CIN: A-02-01-66887	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES , FEBRUARY 2001, $9,000
CIN: A-05-01-67360	MICHIGAN FAMILY INDEPENDENCE AGENCY , FEBRUARY 2001, $8,708
CIN: A-07-97-01231	PROWEST-DOSHI WASHINGTON, JUNE 1997, $8,027 (Related Table II recommendation of $163,552 is also outstanding.)
CIN: A-03-02-72715	DISTRICT OF COLUMBIA DEPT. OF HEALTH, JULY 2002, $7,851
CIN: A-05-01-68270	LAKE COUNTY COMMUNITY ACTION PROJECT, MAY 2001, $7,614
CIN: A-05-02-72464	ST. MARYS DULUTH CLINIC HEALTH SYSTEM, SEPTEMBER 2002, $7,412
CIN: A-03-98-00045	TEMPLE UNIV/PHYSICIAN CREDIT BALANCES/MEDICARE, JULY 1999, $7,280
CIN: A-01-97-49174	BRANDEIS UNIV., AUGUST 1997, $7,068
CIN: A-07-95-01167	PENSION COSTS CLAIMED NEBRASKA BC/BS, JANUARY 1996, $6,075
CIN: A-01-02-00502	REVIEW FO INTERNAL CONTROL PROCEDURES A RENEX DIALYSIS CLINICS OF NORTH ANDOVER AND AMESBURY FOR THE ADMINISTRATION OF EPOGEN FOR CALENDAR YEAR 1999, SEPTEMBER 2002, $6,016
CIN: A-06-97-48062	SER-JOBS FOR PROGRESS NATIONAL INC., MAY 1997, $5,924
CIN: A-01-02-72476	UNIV. OF MASSACHUSETTS, SEPTEMBER 2002, $5,012
CIN: A-01-00-60299	INDIAN TOWNSHIP TRIBAL GOVERNMENT PASSAMAQUODDY TR, JANUARY 2000, $4,597
CIN: A-04-01-68839	STATE OF FLORIDA, JUNE 2001, $4,169
CIN: A-03-02-73128	MAGEE-WOMENS HEALTH CORP. & SUBSIDIARY, AUGUST 2002, $4,155
CIN: A-04-97-01162	HMSA MEDICARE PRO CONTRACT AUDIT, SEPTEMBER 1997, $3,871
CIN: A-01-01-00510	REASONABLENESS & RCVRY OF EPO AT FMC, AUGUST 2002, $3,585
CIN: A-09-01-00067	EAST BAY NEPHROLOGY MEDICAL GROUP, AUGUST 2001, $3,418
CIN: A-03-01-03303	JOHNS HOPKINS UNIVERSITY/KPMG/NIDA/N01DA-3-7301, FEBRUARY 2001, $3,347
CIN: A-02-01-01038	EMPIRE BLUE CROSS AND BLUE SHIELD - PARTS A & B (CONRAD & ASSOCIATES), FEBRUARY 2002, $3,250
CIN: A-05-02-69215	ONEIDA TRIBE OF INDIANS OF WISCONSIN, OCTOBER 2001, $3,109
CIN: A-02-01-66889	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES, FEBRUARY 2001, $3,103
CIN: A-03-95-03318	TRANS-MANAGEMENT SYSTEMS 105-92-1527 (CCO), MAY 1996,$3,016
CIN: A-02-01-66888	PUERTO RICO ADMINISTRATION OF CHILDREN & FAMILIES , FEBRUARY 2001, $2,883
CIN: A-06-01-00086	DISCRETIONARY GRANT-HUCKLEBERRY HOUSE BASIC CENTER IN CA, JANUARY 2002, $2,783
CIN: A-07-98-02502	CT. BC/BS PENSION COSTS CLAIMED, MARCH 1998, $2,725
CIN: A-03-98-51505	ALLIED SIGNAL TECHNICAL SERVICES CORP., APRIL 1998, $2,722
CIN: A-01-97-45487	ABT ASSOCIATES INC., JANUARY 1997, $2,596
CIN: A-03-97-43996	ACTUARIAL RESEARCH CORP., OCTOBER 1996, $2,561

CIN: A-09-01-00068 ROLLUP REPORT CALIFORNIA INPATIENT HEMODIALYSIS SERVICES, MARCH 2002, $1,858
CIN: A-07-97-01232 PROWEST - DOSHI ALASKA, JUNE 1997, $1,473 (Related Table II recommendation of $21,218 is also outstanding.)
CIN: A-07-00-02082 REVIEW OF A COST HMO - IOWA, FEBRUARY 2002, $1,006
CIN: A-07-01-00134 REVIEW OF THE CALCULATION OF DISPROPORTIONATE SHARE PAYMENTS ATR MUTUAL OF OMAHA, JULY 2002, ($2,345)

B. One report is under appeals and resolution is expected before the end of the next semiannual reporting period:

CIN: A-05-94-00047 NATIONWIDE INS., MEDICARE PART B ADMIN. COSTS, SEPTEMBER 1995, $1,049,309

Notes to Table 2

Table II

[1.] The opening balance was adjusted upward by $61 million.

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

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

CIN: A-03-00-00203 PA/INTERGOVERNMENTAL TRANSFERS/MEDICAID, FEBRUARY 2001, $3,700,000,000
CIN: A-05-00-00056 MEDICAID INTERGOVERNMENTAL TRANSFERS - IDPA, MARCH 2001, $1,870,000,000
CIN: A-06-00-00023 MEDICAID PHARMACY/PHYSICIAN ACTUAL ACQUISITION COS, AUGUST 2001, $1,080,000,000
CIN: A-10-00-00011 MEDICAID INTERGOVERNMENTAL TRANSFERS - WA STATE, MARCH 2001, $475,000,000
CIN: A-06-01-00069 EVALUATION OF LEGISLATION TO INCREASE MEDICAID HOSP-SPEC DSH PAYMENT LIMITS, DECEMBER 2001, $380,000,000
CIN: A-04-00-02165 REVIEW OF AL MEDICAID INTERGOVERNMENTAL TRANSFERS, MARCH 2001, $147,500,000
CIN: A-04-00-02169 ALABAMA MEDICAID INTERGOVERNMENTAL TRANSFERS-HOSPITAL ENHANCE, MAY 2001, $63,000,000
CIN: A-07-98-02534 EMPIRE BC/BS PENSION PLAN TERMINATION, MARCH 2000, $38,626,351
CIN: A-04-97-00109 EMERGENCY ASSISTANCE CLAIMS - NC, JULY 1998, $13,000,000
CIN: A-01-99-00506 FOLLOW-UP REVIEW OF SEPARATELY BILLABLE ESRD LAB TESTS, JANUARY 2001, $12,200,000
CIN: A-06-99-00060 REVIEW OF HMO UNDERPAYMENT CLAIM OF $21 MILLION, JUNE 2001, $12,191,579
CIN: A-01-00-00502 REV OF EXORBITANT MEDICARE PMTS FOR OUTPATIENT SERVICES, MAY 2001, $12,100,000
CIN: A-07-96-01177 MEDICARE POST RETIREMENT CLAIM BC MICH, NOVEMBER 1996, $8,978,998
CIN: A-06-99-00045 MEDICARE LEFT AGAINST MEDICAL ADVICE DISCHARGES, MARCH 2002, $6,800,000

CIN: A-01-97-02506	REVIEW OF THE AVAILABILITY OF MEDICAL COVERAGE/CSE SUPPORT, JUNE 1998, $5,704,585
CIN: A-06-00-00073	REV OF MGR CARE ADDTL BENEFITS FOR CY 00 OF NYLCAR, MARCH 2002, $4,000,000
CIN: A-04-98-01188	REVIEW ADMIN. COSTS @ MEDICARE MANAGED RISK PLAN, AUGUST 1999, $2,559,357
CIN: **A-05-00-00083**	REVIEW OF MEDICAID DME CLAIMS - MICHIGAN, OCTOBER 2001, $2,500,000
CIN: A-05-02-00066	REVIEW OF RFP CMS-02-001/ELH1, MAY 2002, $1,885,793
CIN: A-05-01-00031	WI MEDICAID - DME, OCTOBER 2001, $1,250,000
CIN: A-05-02-00082	BID PROPOSAL FOR 1-800 MEDICARE HOTLINE ADMINISTRATION, AUGUST 2002, $609,950
CIN: A-05-00-00057	REVIEW OF MEDICAID MUTUALLY EXCLUSIVE CODES - OH, NOVEMBER 2001, $450,000
CIN: A-03-02-72239	STATE OF DELAWARE, JULY 2002, $336,316
CIN: A-05-01-00074	REVIEW OF BID PROPOSAL RFP HCFA-01-0003, JUNE 2001, $282,049
CIN: A-07-97-01230	OFMQ - DOSHI OKLAHOMA, JUNE 1997, $203,510
CIN: A-03-01-00022	UNITED HOSPITAL CENTER BAD DEBT REVIEW, JULY 2002, $42,328
CIN: A-01-97-00526	PSYCHIATRIC OUTPATIENT SERVICES, MARCH 1998, $7,245
CIN: A-01-98-00506	PSYCHIATRIC OUTPATIENT AT NEWTON-WELLESLEY HOSPITAL, MARCH 1998, $1,120

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

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

Section of the Act	*Requirement*	*Page*
Section 4(a)(2)	Review of legislation and regulations	56
Section 5		
(a)(1)	Significant problems, abuses and deficiencies	Throughout
(a)(2)	Recommendations with respect to significant problems, abuses and deficiencies	Throughout
(a)(3)	Prior significant recommendations on which corrective action has not been completed	Appendices B & C
(a)(4)	Matters referred to prosecutive authorities	59
(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	54
(a)(9)	Statistical Table 2—Funds Recommended to Be Put to Better Use	55
(a)(10)	Summary of previous audit reports without management decisions	Appendix D
(a)(11)	Description and explanation of revised management decisions	Appendix D
(a)(12)	Management decisions with which the Inspector General is in disagreement	None

Appendix F
Summary of Sanction Authorities

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

Program Exclusions

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

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

Patient Dumping

Section 1867 of the Social Security Act (42 U.S.C. § 1395dd) provides that when an individual presents to the emergency room of a Medicare-participating hospital, the hospital must provide an appropriate medical screening examination to determine whether that individual has an emergency medical condition. If an individual has such a condition, the hospital must provide either: 1) treatment to stabilize the condition; or 2) 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.

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

Civil Monetary Penalties Law

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

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

Anti-Kickback Statute

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

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

False Claims Act

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

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

Appendix G
Performance Measure Reports

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

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

Centers for Medicare and Medicaid Services:

FY 2002 Financial Statement Audit
FY 2002 Medicare Error Rate
Nurse Aide Training
Nursing Home Quality Assurance Committees

Public Health Agencies:

State and Local Bioterrorism Preparedness
Financial Statement Audits

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

Head Start Program Enrollment
Financial Statement Audit

General Oversight:

Audit of the Department's Financial Statements
Departmental Service Organizations

Office of Inspector General Components

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

Office of Investigations (OI)—conducts criminal, civil and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. Investigative efforts lead to criminal convictions, administrative sanctions or civil monetary penalties. The OI serves as liaison to the Department of Justice on all matters relating to investigations of HHS programs and personnel. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

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

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

Office of Management and Policy (OMP)—provides mission support services to the IG and other components. The 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. The OMP also conducts and coordinates reviews of existing and proposed legislation and regulations to assess implications and economic consequences for HHS programs and operations.