Department of Health and Human Services

Office of Inspector General

Semiannual Report to Congress

October 1, 2023–March 31, 2024

Contents

Message From the Inspector General

A Message From Christi A. Grimm, Inspector General

I am pleased to submit this Semiannual Report to Congress summarizing the activities of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) for the 6-month period ending on March 31, 2024.

This report demonstrates OIG's ongoing commitment to detecting and preventing fraud, waste, and abuse and to promoting the economy, efficiency, and effectiveness of HHS programs. OIG's multidisciplinary workforce of nearly 1,600 auditors, evaluators, attorneys, investigators, and other professionals provides oversight for more than 100 programs administered by HHS. Using our expertise and authorities, highly developed data analysis techniques, and strong partnerships with other law enforcement and oversight entities, OIG identified $2.76 billion in expected recoveries and issued 195 recommendations, 60 audits, and 18 evaluations in this reporting period.

To hold wrongdoers accountable, OIG doggedly pursues criminals whose schemes put Federal funds at risk and endanger the public. Our enforcement efforts resulted in 712 civil and criminal actions, and we excluded 1,795 bad actors from federally funded programs. These enforcement cases often involved egregious fraud, including false billing, costly kickback schemes, and failures to provide care. In one example, a home health company defrauded Medicare of $93 million by billing for home health care that was never provided. The perpetrators were convicted and sentenced to prison. In a false billing scheme, a nurse practitioner defrauded Medicare by billing for unnecessary genetic tests, unneeded durable medical equipment, and telemedicine visits that never occurred. She was convicted, sentenced to prison, and ordered to pay more than $110 million in restitution. These and other enforcement actions send a strong message that theft and abuse will not be tolerated in HHS programs.

Regular readers of the OIG semiannual report may notice a new approach for this reporting period. The semiannual report has been modernized to respond to statutory amendments for inspector general reporting requirements. We have reorganized the semiannual report around the Top Management and Performance Challenges Facing HHS, which are the areas of greatest vulnerability that OIG identifies for HHS programs each year. Our aim is to enhance transparency and accessibility to our work for Congress and the public. Additional details about work described in this semiannual report are available on our website, including our reports and recommendations tracker.

OIG scrutinizes all corners of the Medicare and Medicaid programs, with a focus on promoting sound financial stewardship, ensuring access to high-quality and safe care, and holding wrongdoers accountable. Oversight of managed care—a rapidly changing sector with significant emerging risks—continues to be a priority. In this

reporting period, OIG identified risks to both funds and enrollees. OIG continued to find that some Medicare Advantage plans are receiving higher payments than they should because they submit data that make plan enrollees appear sicker than they are. In Medicaid, OIG found that States made unallowable payments to Medicaid managed care organizations after enrollees' deaths. Also in Medicaid, as substance use and mental health disorders continue to be major challenges facing enrollees, OIG found that States were not ensuring that Medicaid managed care plans met requirements to provide mental health care to enrollees at parity with other medical benefits. For all these risks, OIG made targeted, impactful recommendations.

OIG's recommendations help ensure the safety and well-being of Americans by driving improvements in HHS programs. As the opioid overdose epidemic continues and overdose deaths in older adults rise, OIG is focusing on access to effective treatments for opioid use disorder. In *The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder in Medicare Part D Appears to Be Low: 2022*, OIG made recommendations to increase access to buprenorphine, an effective treatment for opioid use disorder. Improving access is imperative, as OIG also found that less than 20 percent of Medicare enrollees with opioid use disorder received treatment in *The Consistently Low Percentage of Medicare Enrollees Receiving Medication To Treat Their Opioid Use Disorder Remains a Concern*.

OIG's accomplishments and return on investment illustrate the value of oversight and enforcement. OIG's health care work consistently yields a positive return on investment of around $10 returned to every $1 invested. However, our budget has not kept up with the growth in the size and breadth of HHS programs. OIG oversees more than $2 trillion in HHS expenditures, almost 24 percent of the Federal budget. Additional investment in the Health Care Fraud and Abuse Control Program proposed in the President's Fiscal Year 2024 Budget would provide OIG with critically needed resources to deliver on our mission to safeguard taxpayer dollars and protect HHS programs and the people they serve.

We appreciate the continued support of Congress and HHS for OIG's important work.

Christi A. Grimm
Inspector General

At a Glance: OIG Accomplishments

The Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) oversees more than 100 health and human services programs to ensure that more than $2 trillion in taxpayer funds are responsibly spent and that the more than 150 million Americans who rely on those programs are well served. OIG focuses on the most significant and high-risk issues in health care and human services. OIG also remains at the forefront of the Nation's efforts to fight fraud in HHS programs and hold wrongdoers accountable for their actions.

In our fight against health care fraud, waste, and abuse, our investigative and audit efforts identified $2.76 billion in expected recoveries and receivables. During the semiannual reporting period of October 1, 2023, through March 31, 2024 (reporting period), we issued 60 audits and 18 evaluations to HHS in which we identified systemic weaknesses and opportunities for improvement. See Appendix A for a full list of these audits and evaluations, including the identified questioned costs, funds put to better use, and unsupported costs.

The scope of our work extended beyond identifying concerns; during the reporting period, we issued 195 new recommendations that, if implemented, will foster sustainable program improvements and safeguard taxpayer funds. Our enforcement efforts through our investigative and counsels' offices resulted in more than 712 civil and criminal actions during this reporting period, which includes settlements resulting from using OIG's civil monetary penalty authorities and criminal convictions. Additionally, we identified and excluded 1,795 bad actors from participation in federally funded programs during this reporting period, ensuring that taxpayer funds are not used for fraudulent purposes.

Introduction

The Inspector General Act of 1978 (Public Law 95-452), as amended, requires that the Inspector General report semiannually to the head of the Department and to Congress on the activities of the office. The semiannual reports are intended to keep the Secretary and Congress fully informed of significant current findings and recommendations.

Semiannual Report Restructure

We have restructured this semiannual report based on recent congressional reforms that streamline and modernize reporting requirements and allow inspectors general to focus on the most significant activities and critical issues facing the departments they oversee. This revised semiannual report highlights OIG's oversight work completed during the reporting period focused on the most significant issues facing HHS. OIG identifies these significant issues every year in its Top Management and Performance Challenges Facing HHS (TMCs). OIG identified five TMCs in its 2023 report:

1) Safeguarding Public Health
2) Ensuring the Financial Integrity of HHS Programs
3) Improving Outcomes in Medicare and Medicaid
4) Protecting People Served by HHS Programs
5) Securing Data and Technology

Having identified these TMCs for the Department, OIG makes its own investments, using its suite of oversight and enforcement tools and authorities, to better understand and address these issues. Our mission is to protect the integrity of HHS programs as well as the health and welfare of the people they serve. We do that, in part, by strategically focusing our efforts on the areas of greatest vulnerability. The summaries of OIG's work in this semiannual report identify key findings, information, and recommendations that could help the Department address the TMCs and fulfill its mission to enhance the health and well-being of all Americans.

In addition to highlighting OIG's work related to the TMCs, this report includes a comprehensive overview of all OIG's work completed in this semiannual reporting period. This overview can be found in five appendices that provide detailed information on OIG's oversight, including a full list of OIG audits and evaluations issued to each HHS operating division during the reporting period. Changes to streamline this semiannual report are consistent with statutory amendments for inspector general reporting requirements. Appendix F lists each of the current reporting requirements and the location within this semiannual report where they are met.

Additional Resources

OIG's website offers additional resources to understand the full scope of OIG's oversight and enforcement work, including all reports available by issue area and HHS agency; OIG recommendations to improve Department programs and reduce vulnerabilities, including the status of those recommendations; and OIG enforcement actions. Additional information on how OIG's work has a positive financial impact on Medicare and Medicaid can be found in the annual Health Care Fraud and Abuse Control Program Report.

1 | Safeguarding Public Health

Behavioral Health

In 2021, nearly 1 in 4 Americans experienced mental illness, and 1 in 6 Americans had a substance use disorder. Many HHS programs are involved with various aspects of improving behavioral health services, including efforts to respond to the opioid use disorder epidemic. OIG's oversight and enforcement related to behavioral health helps prevent waste, fraud, and abuse; helps ensure access to behavioral health services and treatment for opioid use disorder; and helps prevent drug diversion. Significant OIG work completed during this reporting period related to behavioral health is detailed below.

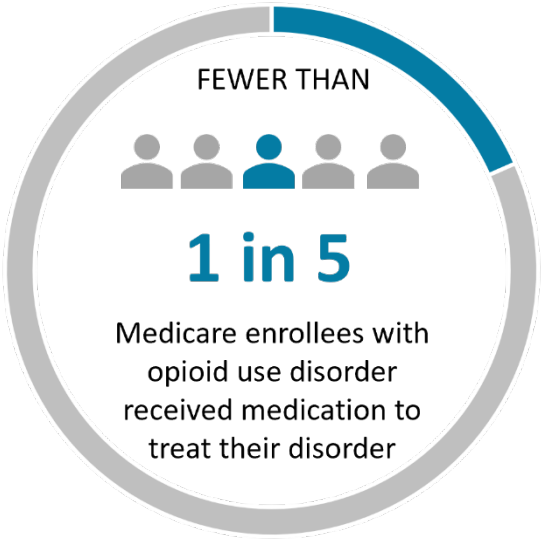
Access to Behavioral Health Services

OIG found that the Centers for Medicare & Medicaid Services (CMS) did not ensure that States complied with requirements that were put in place to make it easier for people with mental health and substance use disorder conditions to access treatment and services. Specifically, for all eight States reviewed, State contracts with Medicaid managed care organizations did not contain required parity provisions, and States may not have ensured that services were delivered in compliance with the requirements (A-02-22-01016).

Further, OIG found that despite unprecedented demand for behavioral health services, treatment rates are low and access to providers is limited. For the 20 counties reviewed, OIG found there were few behavioral health providers who actively served Medicare and Medicaid enrollees, and even fewer providers who could prescribe related medication. Without enough behavioral health providers, these enrollees may experience difficulty accessing providers or delays in care and may even forgo treatment altogether (OEI-02-22-00050).

Access and Treatment for Opioid Use Disorder

OIG found that fewer than 1 in 5 Medicare enrollees with opioid use disorder received medication to treat their disorder. Certain groups of enrollees, such as older enrollees, enrollees without the Part D low-income subsidy, and female enrollees, faced greater challenges accessing treatment than did others (OEI-02-23-00250).



Among Medicare Part D enrollees who did receive buprenorphine to treat opioid use disorder, OIG found that almost all received the recommended amounts and rarely received either very high amounts of buprenorphine or buprenorphine at the same time as they received high amounts of other opioids. Additionally, most enrollees received buprenorphine-naloxone combinations, which are generally recommended to minimize the risk of misuse or diversion. OIG noted that taken together, these findings suggest

that the risk of misuse and diversion of buprenorphine in Medicare Part D continues to be low (OEI-02-24-00130).

Prescription Drug Diversion

OIG excluded multiple bad actors from federally funded health care programs for opioid-related drug diversion. See a case example below.

CASE EXAMPLE

OIG Excluded a Physician and His Wife for 70 Years Each

Mark Murphy, a pain management physician, and his wife Jennifer Murphy conspired to unlawfully dispense and distribute controlled substances, including Fentanyl and Oxycodone, through prescriptions that were not issued for legitimate medical purposes. The Murphys also caused fraudulent claims to be submitted both to Federal health care programs and private insurers for medically unnecessary services and durable medical equipment. As a result of their actions, a court convicted them of conspiracy to distribute controlled substances and health care fraud, sentenced them to 20 years of incarceration, and ordered them to pay approximately $52 million in restitution. Additionally, Tennessee revoked Mark Murphy's medical license. OIG excluded the Murphys from participation in federally funded health care programs for 70 years each.

Public Health

HHS provides public health services in many forms, including product regulation and preventing, preparing for, and responding to public health emergencies (PHEs) such as the COVID-19 pandemic. OIG conducts oversight of HHS's provision of these services and PHE response. Significant OIG work completed during this reporting period related to public health is detailed below.

Tobacco Products

The Food and Drug Administration (FDA) regulates crucial consumer products such as tobacco, which includes e-cigarettes. Use of e-cigarettes by youth remains a public health issue that is affecting children, families, schools, and communities. OIG found that FDA was unable to complete a review of all the submitted premarket applications of electronic nicotine delivery systems (e.g., e-cigarettes) within the 1-year period during which, in accordance with a court order, products with applications filed in a timely manner might remain on the market pending FDA review (A-06-22-01002).

COVID-19 Response and Recovery

PHEs, such as communicable diseases, storms, fires, and human-caused disasters, severely strain public health and medical infrastructure. In its ongoing oversight of HHS's response to the COVID-19 pandemic, OIG has identified lessons learned that can be applied to future PHEs. For example, OIG identified weaknesses in the Centers for Disease Control and Prevention's (CDC's) processes that may have contributed to the failure of the initial COVID-19 test kits. Without effective internal controls, CDC may: (1) experience delays in the development of test kits when responding to future PHEs; (2) not identify problems in a timely manner when developing test kits; and (3) risk damaging public trust, which could undermine its ability to accomplish its mission (A-04-20-02027).

As another example, OIG found that the Indian Health Service (IHS) did not coordinate national or regional supply service center operations to provide for the effective distribution of medical and other supplies before and during the COVID-19 pandemic. OIG also found that IHS did not have policies and procedures to ensure that the national and regional supply service centers' inventory management systems could work together (A-07-22-04131).

Additionally, OIG identified and worked with law enforcement partners to convict bad actors for COVID-19-related charges. See a case example below.

CASE EXAMPLE

Medical Technology Company President Convicted of COVID-19-Related Fraud

Mark Schena, President of the medical technology company Arrayit Corporation, participated in a scheme to defraud investors, commit health care fraud, and pay illegal kickbacks in connection with the submission of more than $77 million in claims. Specifically, Arrayit ran tests on every patient for 120 different allergens regardless of medical necessity and billed Medicare more per patient for these tests than any other laboratory in the United States. Schena orchestrated a deceptive marketing plan that falsely claimed that the company's test was highly accurate and paid kickbacks to marketers in violation of Federal law. Additionally, seeking to capitalize on the 2020 nationwide shortage of COVID-19 tests, Schena falsely announced that the company had a test for COVID-19 and that Government officials required those being tested for COVID-19 to also be tested for allergies. Schena concealed from investors and patients that FDA found the company's COVID-19 test was not accurate enough to receive an emergency use authorization for use in the United States. As a result of OIG and the Department of Justice's (DOJ's) work, Schena was sentenced to serve 8 years in prison and ordered to pay $24 million in restitution.

Read more about OIG's oversight of HHS's emergency preparedness and response, including the COVID-19 response and recovery, here.

2 | Ensuring the Financial Integrity of HHS Programs

Improper Payments

In fiscal year (FY) 2023, Medicare and Medicaid improper payments totaled $101.4 billion and accounted for 43 percent of all improper payments across the Federal Government. OIG's oversight promotes good financial stewardship, reduces improper payments, and protects the integrity of the Medicare and Medicaid programs. In addition, OIG recognizes the importance of identifying and holding accountable those who defraud Medicare, Medicaid, enrollees, and taxpayers. Significant OIG work completed during this reporting period related to improper payments is detailed below.

Improper Payments in Medicaid

OIG found that States continue to make unallowable payments to Medicaid managed care organizations after enrollees' deaths. OIG recommended that Delaware refund the more than $3.4 million Federal share of unallowable payments made after enrollees' deaths (A-03-22-00205). OIG also recommended that CMS collect $41 million in outstanding unallowable payments identified in 14 previous audits of State Medicaid payments made after enrollees' deaths (A-04-21-09005).

Prior OIG work identified several challenges State Medicaid agencies have encountered in their efforts to meet third-party liability requirements to help ensure that Medicaid functions as the payer of last resort. In this report, OIG found that States continue to experience challenges in their efforts to meet third-party liability requirements, such as difficulties obtaining timely and reliable coverage information from third parties. OIG recommended that CMS develop an action plan to address these challenges (A-05-21-00013).

OIG found that Pennsylvania improperly claimed $551.4 million in Federal funds through its Medicaid school-based health services program. Pennsylvania did so because the State and its contractor developed complex cost allocation methods that were difficult or impractical to support with documentation or did not follow CMS guidance. OIG recommended that Pennsylvania refund $182.5 million in unallowable funds and support or refund $368.9 million claimed based on an unsupported cost allocation method (A-02-21-01011).

Enforcement Actions

OIG worked with DOJ to prosecute Elizabeth Hernandez, a nurse practitioner, for defrauding Medicare by submitting more than $192 million in claims for unnecessary genetic tests, durable medical equipment that patients did not need, and telemedicine visits that never occurred. Hernandez was convicted and sentenced to 20 years in prison and ordered to pay $111,261,526 in restitution. OIG also worked with DOJ to prosecute Karel Felipe and Tamara Quicutis, faux owners of three home health companies, for their roles in a wide-

ranging conspiracy to defraud Medicare by billing more than $93 million for home health therapy services that were never rendered. Felipe and Quicutis were convicted and sentenced to more than 8 years and more than 5 years in prison, respectively. OIG also excluded the owner of a medical supply company for a minimum of 23 years based on a conviction of conspiracy to commit health care fraud related to a medically unnecessary durable medical equipment scheme. See a case example below.

CASE EXAMPLE

Health Care Network Agrees To Pay $345 Million To Settle Allegations That It Submitted False Claims Based on Illegal Self-Referrals

The Community Health Network, Inc. (Community) allegedly violated the False Claims Act by knowingly submitting claims to Medicare for services that were referred in violation of the Stark law. Specifically, Community knowingly recruited hundreds of local physicians, including cardiovascular specialists, neurosurgeons, and breast surgeons, by paying them salaries that were significantly higher than—sometimes as much as double—what they received in their private practice. Community did so to benefit from the physicians' lucrative downstream referrals. Additionally, Community awarded financial bonuses to physicians who referred a target number of patients to the network. Finally, Community provided false compensation figures to a valuation firm it hired to analyze the proposed compensation and repeatedly ignored that firm's warnings regarding the legal perils of overcompensating its physicians. As a result of OIG and DOJ work, Community agreed to pay the United States $345 million and to enter into a 5-year corporate integrity agreement with OIG.

3 | Improving Outcomes in Medicare and Medicaid

Nursing Home Quality and Safety

According to recent CMS data, approximately 1.2 million people reside in more than 15,000 certified nursing homes. Nursing home residents deserve safe, high-quality care, yet improving nursing homes remains one of the most complex and intransigent challenges facing the American health care system. Improving nursing home quality of care is a top priority for OIG. Significant OIG work completed during this reporting period related to nursing home quality and safety is detailed below.

Nursing Homes' COVID-19 Experience

OIG found that nursing homes were especially impacted by the COVID-19 pandemic (OEI-02-20-00492) and faced challenges with:

- Staffing—including a significant loss of staff and substantial difficulties in hiring, training, and retaining new staff—causing many nursing homes to use outside staffing agencies to fill gaps, which had significant downsides including high costs and lack of familiarity with systems and residents
- Costs, testing protocols, personal protective equipment compliance, and vaccination rates after initial challenges were resolved
- Implementing effective infection control practices

Additionally, OIG found that CDC struggled with the process for nursing homes to report COVID-19 data into the National Healthcare Safety Network (NHSN). While CDC has improved the nursing home reporting process and guidance, some challenges remain (OEI-06-22-00030). CDC's continued efforts to improve NHSN user support and data quality are important for continued reporting on vaccinations and for future public health surveillance.

OIG also found that after attempting counseling or medication changes for residents, nursing homes discharged 72 of the 126 residents reviewed because of behaviors that endangered them or others in a facility (e.g., aggressive or violent behavior). Residents discharged shared some characteristics such as mental health disorders, raising concerns about nursing homes' capacity to care for these residents (OEI-1-18-00252). Additionally, OIG raised concerns about nursing homes' understanding of and compliance with facility-initiated discharge notices and documentation requirements (OEI-01-18-00251).

Nursing Home Patient Abuse and Neglect

OIG and its law enforcement partners, such as Medicaid Fraud Control Units (MFCUs), continued efforts to ensure the safety of nursing home residents. In FY 2023, MFCUs reported 36 criminal convictions and 11 settlements or judgements related to patient abuse or neglect in nursing facilities, totaling nearly $11 million in recoveries (OEI-09-24-00200). See a case example below.

CASE EXAMPLE

OIG Excluded a Registered Nurse for 10 Years

Tina Lavielle, a registered nurse employed by a skilled nursing facility, was convicted of endangerment in connection with the death of a patient. Lavielle, who served as the charge nurse at the facility, was deficient in her duties to care for a resident of the nursing home and did not provide necessary services. As a result, the resident's condition deteriorated. The resident was hospitalized and subsequently died. OIG excluded Lavielle for a minimum of 10 years.

OIG also worked with DOJ and the New York State Office of the Attorney General to ensure the safety of nursing home residents. For example, Chaim Scheinbaum agreed to pay $656,000 to resolve allegations that he violated the False Claims Act by causing the submission of false claims to the Medicaid program when illegally operating a now shuttered skilled nursing facility and overseeing the provision of substandard care to residents. Specifically, despite never obtaining a license to legally operate the facility after the licensed operators relinquished control, Scheinbaum controlled the finances and vendor payment decisions and had the authority to hire and fire high-level employees. Scheinbaum also failed to ensure the health, safety, and welfare of residents by, for example, ensuring that residents were free from significant medication errors, preventable falls, and pressure ulcers, and had access to hot water.

State Oversight of Nursing Home Compliance

OIG found that Louisiana complied with Federal requirements that prohibit the employment of individuals with disqualifying backgrounds. However, although Federal requirements do not specify the methods or types of information that should be considered for a satisfactorily completed background check, OIG identified potential limitations in the nursing homes' background check searches and methods. Specifically, Louisiana only required reviews of background check compliance if concerns had been identified relative to inadequate staffing; issues of abuse, neglect, exploitation, or misappropriation; or both (A-06-21-02000).

OIG found 1,973 deficiencies among 98 nursing homes in its audits of 5 States' oversight of nursing home compliance with Federal requirements for life safety (e.g., fire detection systems), emergency preparedness (e.g., evacuation plans), and infection control (e.g., procedures for ensuring immunizations) (A-03-22-00206, A-09-22-02006, A-05-22-00019, A-06-22-09007, A-07-22-07009).

Read more about OIG's nursing home oversight here.

4 | Protecting People Served by HHS Programs

Health and Safety of Children

HHS provides or funds services to children through programs such as the Unaccompanied Children (UC) Program, which provides services to children who arrive in the United States unaccompanied by a parent or legal guardian; foster care; and programs that serve larger groups including children. OIG oversees these programs to ensure that children receive appropriate services in safe environments, free from potential harm. Significant OIG work completed during this reporting period related to the health and safety of children is detailed below.

Unaccompanied Children

OIG found that gaps in the Administration for Children and Families' (ACF's) implementation of sponsor screening and followup calls create vulnerabilities that could impact the safety of unaccompanied children who are released to sponsors (OEI-07-21-00250). For example, OIG found that in 16 percent of children's case files, one or more required sponsor safety checks lacked any documentation indicating that the checks were conducted. Additionally, in 22 percent of cases, the Office of Refugee Resettlement did not conduct timely safety and well-being followup calls, and in 18 percent of cases, the calls were not documented in children's case files. OIG also found ACF failed to conduct mandatory home studies in two cases, and four other cases raise concerns about whether guidance on discretionary home studies should offer more specificity. Read more about OIG's oversight of the UC Program here.

American Indian Children

Thoroughly vetting providers and staff by using background checks helps prevent potential abuse and neglect of children served by HHS programs. OIG found that two Tribes and their health programs varied in their level of compliance with Federal and Tribal requirements for performing background investigations. The Choctaw Nation did not conduct required FBI fingerprint background investigations on any individuals and sometimes did not make inquiries about an applicant's criminal history to State and Tribal law enforcement for the previous 5 years of residency. The Cherokee Nation sometimes did not conduct required FBI fingerprint investigations, primarily for volunteers. As a result, Indian children faced an increased risk of harm (A-01-20-01505).

Children in Foster Care Programs

OIG found that Kentucky did not always comply with State and Federal requirements related to background checks and caseworker visits to foster homes during the COVID-19 pandemic, even when those requirements had been modified to provide flexibility. Lack of compliance with these requirements could jeopardize the safety and well-being of children in those foster care homes (A-06-22-07001). Additionally, OIG found that California did not always comply with State requirements related to psychotropic and opioid medications prescribed for children in foster care (A-05-22-00007).

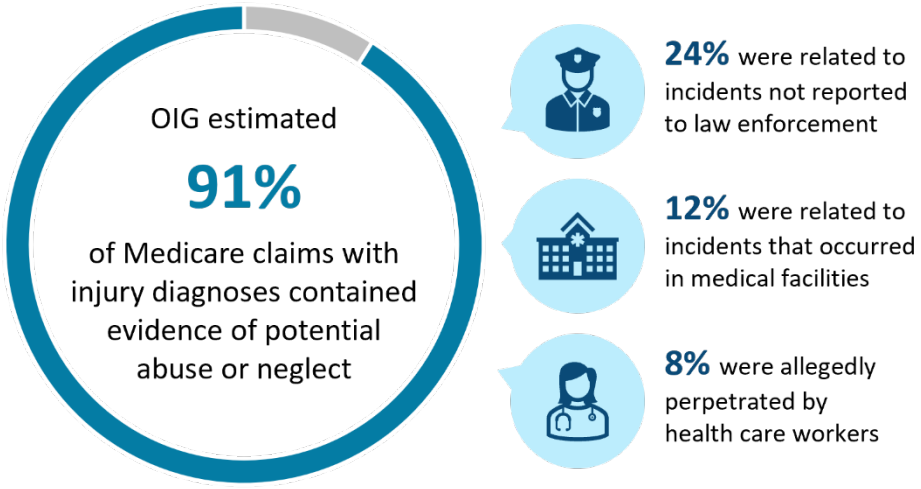
Enforcement Actions

OIG identified and worked with law enforcement partners to convict bad actors for charges related to the health and safety of children. For example, OIG worked with DOJ to sentence Douglas Kelley, a former nurse, to more than 10 years in prison and 5 years of supervised release for knowingly conspiring to acquire fentanyl by means of misrepresentation, fraud, deception, and subterfuge and for possessing child pornography, which was discovered during the investigation when law enforcement executed a search warrant on his cell phone.

Medicare Enrollee Abuse and Neglect

OIG works to ensure that people served by HHS programs receive appropriate services that meet standards for quality, are free from abuse or neglect, and do not experience preventable harm. OIG also works to hold accountable those who harm others. Significant OIG work completed during this reporting period related to Medicare enrollee abuse and neglect is detailed below.

OIG found that 30,258 Medicare claims for services provided in 2019 and 2020 contained diagnosis codes that indicated the treatment of injuries potentially caused by abuse or neglect of Medicare enrollees (A-01-22-00501). Read more in the graphic on the right.



OIG excluded a physician due to the permanent revocation of her State medical license, which she lost because she: (1) failed to meet the appropriate standard of care and demonstrated incompetence and negligence, creating an unreasonable risk that patients may be harmed, in connection with her prescription of controlled substances to three patients; (2) solicited and received a loan from one of the patients; and (3) demonstrated acts of repeated dishonesty by modifying patient records for years after treating the patients.

OIG also excluded a direct care worker employed by a residential facility that provided inpatient care to individuals with severe physical, intellectual, and emotional disabilities for a minimum of 65 years based on a conviction for causing bodily injuries to at least 13 residents. Finally, OIG excluded a nurse who worked at a women's prison for a minimum of 60 years based on a conviction that he committed various forms of sexual assault on inmates when they sought medical treatment or worked as orderlies in the prison medical unit.

5 | Securing Data and Technology

HHS faces persistent cybersecurity threats that exacerbate the challenges associated with data and technologies used to carry out the Department's vital health and human services missions. OIG oversees HHS's cybersecurity, including ensuring that systems that store critical and potentially sensitive data, such as genetic data, data about children, and data about Medicaid enrollees, are safe from cyberattacks and related vulnerabilities. Significant OIG work completed during this reporting period related to securing data and technology is detailed below.

Genetic Sequencing Data

The National Institutes of Health's (NIH's) Sequence Read Archive (SRA) is the largest publicly available repository of raw, unassembled genetic sequencing data. The SRA holds diverse genomic data, including early COVID-19 sequencing, used for genomic research. OIG's audit of internal controls for SRA's data integrity identified control weaknesses. For example, NIH did not conduct a system-level risk assessment to identify threats and vulnerabilities, which means NIH may not have identified threats to the SRA. As a result, NIH may not have implemented the appropriate cybersecurity controls to mitigate the threats, potentially leading to SRA data integrity issues (A-18-22-03300).

Unaccompanied Children Data

ACF's UC Portal is a web application used to collect, organize, and report sensitive data related to children who are in ACF's care. The UC Portal is a key data source for reunification efforts for separated children and contains data on both children and potential sponsors. OIG recently found that ACF did not completely address OIG's recommendation in a prior audit that it consistently perform user account reviews, potentially allowing malicious actors to gain unauthorized access to children's sensitive data (A-18-22-03200).

Medicaid Enrollee Data

OIG performed four audits of State systems for Medicaid eligibility determinations and claims processing and information retrieval, which store protected health information and other sensitive information. These audits found that, although the States' security controls were either adequate or partially effective, all States' security controls could be improved (A-18-21-09004, A-18-22-09005, A-18-21-09001, A-18-22-09010).

Cloud-Based Data

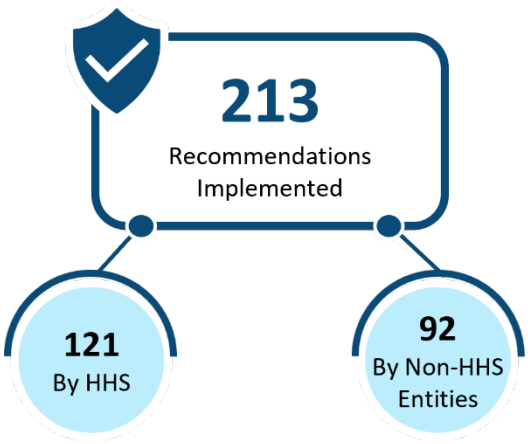
OIG found that because ACF had not established policies and procedures to inventory and monitor cloud information, it was not able to accurately identify and inventory all of its cloud computing assets. OIG also found that ACF did not effectively implement some security controls, potentially making ACF data stored in certain cloud information systems at high risk of compromise (A-18-22-08020).

Additional OIG Activities

Recommendations

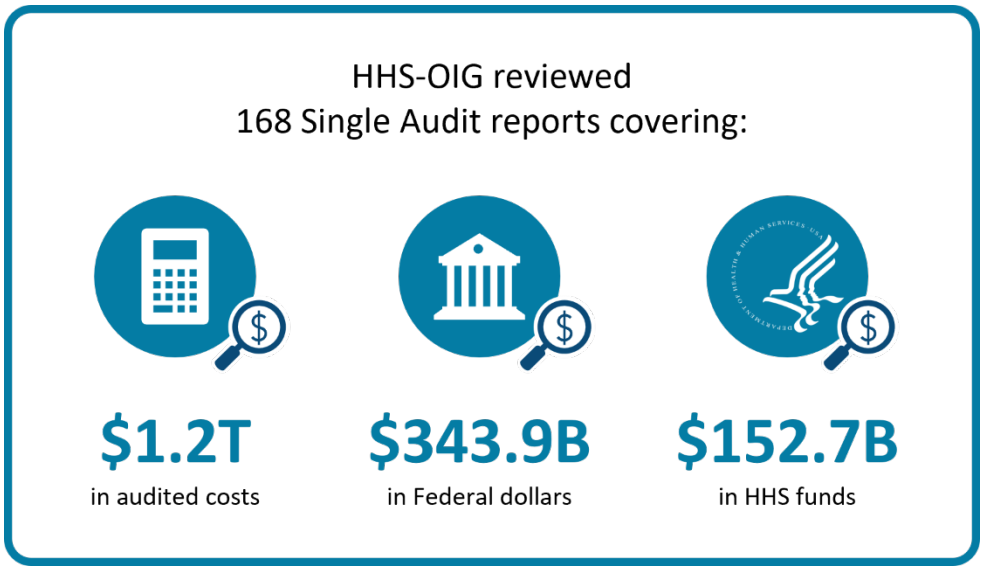
During the reporting period, OIG issued 195 recommendations to HHS and non-HHS entities (e.g., States) to address problems identified in OIG audits and evaluations. Additionally, HHS and non-HHS entities implemented 213 previously issued OIG recommendations.

For more information, see OIG's Recommendations Tracker, which lists all OIG recommendations, including those made before the reporting period. The Recommendations Tracker also notes whether final management decisions have been made and if corrective actions have been completed and includes information for each recommendation, such as associated potential costs savings.



Single Audit Oversight

OIG conducts oversight of Single Audits—organizationwide audits of non-Federal entities' financial statements and expenditures of Federal awards—to monitor how recipients are using Federal funds for HHS programs. By working to improve the quality of Single Audits, HHS-OIG provides assurance to the public that taxpayer dollars are being safeguarded and spent for their intended purposes, resulting in millions of Americans receiving improved health care and human services. See below for the number of Single Audits OIG reviewed during the reporting period, as well as the amounts those Single Audits covered. Read more on OIG's Single Audits website.



Whistleblower Retaliation

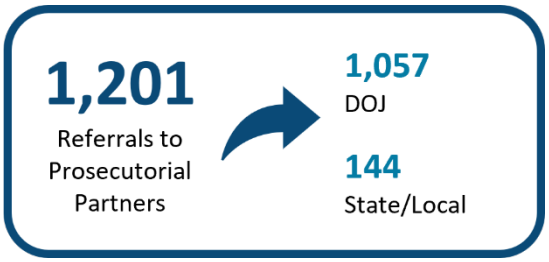
OIG investigated and substantiated one complaint from a whistleblower who reported wrongdoing at HHS, its agencies, or non-Federal employers and was retaliated against because of it. Read more about the complaint here and more about OIG's Whistleblower Protection Coordinator role here.

Safe Harbors

OIG annually solicits proposals for developing new and modifying existing safe harbors to the Federal anti-kickback statute, section 1128B(b) of the Social Security Act, and for developing special fraud alerts. In December 2023, OIG published its annual solicitation in the *Federal Register*. OIG received 14 proposals during our reporting period, all of which are still under review as of the end of the reporting period. For information about the proposals received in response to the 2022 annual solicitation and OIG's response to those proposals, see Appendix F in OIG's Fall 2023 Semiannual Report to Congress.

Referrals to Prosecutorial Partners

OIG made 1,201 referrals to our prosecutorial partners, including 1,057 to DOJ and 144 to our State and local partners. Referrals are presentations of OIG subjects to Federal, State, or local prosecuting jurisdictions for prosecutorial consideration. OIG referrals to these prosecuting authorities, made prior to and during the reporting period, resulted in 312 indictments and criminal informations.



Medicaid Fraud Control Units

OIG also works with MFCU grantees as State-based law enforcement partners. During FY 2023, MFCUs were responsible for 1,143 convictions, 436 civil settlements and judgements, and $1.2 billion in recoveries. For information about MFCU accomplishments, see our FY 2023 MFCU Annual Report.

Appendix A: Audits and Evaluations

The following table summarizes OIG's audit and evaluation reports issued during the reporting period, including, if applicable, the associated questioned costs, funds put to better use, unsupported costs, and whether a management decision was made during the reporting period. (OIG has not yet received management decisions for most reports listed below because those decisions are not due to OIG until 6 months following the issuance of a report.) OIG did not issue nonpublic audits or evaluations during this reporting period. See Appendices D and E for more detail about reports with questioned costs and funds put to better use.

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)				
Kentucky Experienced Challenges in Meeting Federal and State Foster Care Program Requirements During the COVID-19 Pandemic (A-06-22-07001), November 2023	-	-	-	Yes
California Did Not Comply With Requirements for Documenting Psychotropic and Opioid Medications Prescribed for Children in Foster Care (A-05-22-00007), December 2023	-	-	-	-
Gaps in Sponsor Screening and Followup Raise Safety Concerns for Unaccompanied Children (OEI-07-21-00250), February 2024	-	-	-	-
Administration for Children and Families Data Hosted in Certain Cloud Information Systems May Be at a High Risk of Compromise (A-18-22-08020), March 2024	-	-	-	-
ACF Has Enhanced Some Cybersecurity Controls Over the Unaccompanied Children Portal and Data but Improvements Are Needed (A-18-22-03200), March 2024	-	-	-	-
Issue Brief: Insights From OIG's Work on the Office of Refugee Resettlement's Efforts To Care for Unaccompanied Children (OEI-09-23-00440), March 2024	-	-	-	-
ADMINISTRATION FOR STRATEGIC PREPAREDNESS AND RESPONSE (ASPR)				
The Strategic National Stockpile Was Not Positioned To Respond Effectively to the COVID-19 Pandemic (A-04-20-02028), October 2023	-	-	-	-
CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)				
CDC's Internal Control Weaknesses Led to Its Initial COVID-19 Test Kit Failure, but CDC Ultimately Created a Working Test Kit (A-04-20-02027), October 2023	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
New York City Department of Health and Mental Hygiene Charged Some Unallowable Costs to Its CDC COVID-19 Award (A-04-22-02035), October 2023	$15,671,958	-	-	-
CDC Has Improved the Nursing Home Reporting Process for COVID-19 Data in NHSN, but Challenges Remain (OEI-06-22-00030), January 2024	-	-	-	-
The Thailand Ministry of Public Health Managed PEPFAR Funds According to Federal Regulations but Internal Controls Could Be Improved (A-04-21-01021), March 2024	-	-	-	-
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)				
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Aetna, Inc. (Contract H5521) Submitted to CMS (A-01-18-00504), October 2023	$632,070	-	-	Yes
Medicare Could Save Millions if It Implements an Expanded Hospital Transfer Payment Policy for Early Discharges to Post Acute Care (A-01-21-00504), October 2023	-	$694,000,000	-	-
Mississippi Did Not Always Invoice Rebates to Manufacturers for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations (A-07-21-06103), October 2023	$13,707,201	-	-	Yes
South Dakota MMIS and E&E System Security Controls Were Partially Effective and Improvements Are Needed (A-18-21-09004), October 2023	-	-	-	Yes
States Face Ongoing Challenges in Meeting Third-Party Liability Requirements for Ensuring That Medicaid Functions as the Payer of Last Resort (A-05-21-00013), October 2023	$1,245,924	-	-	-
Medicare Advantage Compliance Audit of Diagnosis Codes That CarePlus Health Plans, Inc. (Contract H1019) Submitted to CMS (A-04-19-07082), October 2023	$641,467	-	-	Yes
Congressional Mandate: Part B Payment Amounts for Two Drugs Included Noncovered Self-Administered Versions in 2022 (OEI-BL-22-00380), November 2023	-	-	-	-
Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Second Quarter of 2023 (OEI-03-24-00040), November 2023	-	-	-	-
The Risk of Misuse and Diversion of Buprenorphine for Opioid Use Disorder in Medicare Part D Continues to Appear Low: 2022 (OEI-02-24-00130), November 2023	-	-	-	-
Early Alert: Part B Payment Amount for Tezspire Included a Noncovered Self-Administered Version in 2023 (OEI-BL-24-00030), November 2023	-	-	-	-
Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers (A-06-22-05000), November 2023	-	-	-	Yes
CMS Can Do More To Leverage Medicare Claims Data To Identify Unreported Incidents of Potential Abuse or Neglect (A-01-22-00501), November 2023	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2023 (A-17-23-53000), November 2023	-	-	-	-
Pennsylvania Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (A-03-22-00206), November 2023	-	-	-	Yes
Review of Medicare Administrative Contractor Information Security Program Evaluations for Fiscal Year 2022 (A-18-23-11300), November 2023	-	-	-	-
Multiple States Made Medicaid Capitation Payments to Managed Care Organizations After Enrollees' Deaths (A-04-21-09005), November 2023	-	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That SelectCare of Texas, Inc. (Contract H4506) Submitted to CMS (A-06-19-05002), November 2023	$482,601	-	-	Yes
Louisiana Should Improve Its Oversight of Nursing Homes' Compliance With Requirements That Prohibit Employment of Individuals With Disqualifying Background Checks (A-06-21-02000), November 2023	-	-	-	-
Pennsylvania Implemented Our Prior Audit Recommendations for Critical Incidents Involving Medicaid Enrollees With Developmental Disabilities but Should Continue To Take Action To Reduce Unreported Incidents (A-03-22-00202), November 2023	-	-	-	-
The Consistently Low Percentage of Medicare Enrollees Receiving Medication To Treat Their Opioid Use Disorder Remains a Concern (OEI-02-23-00250), December 2023	-	-	-	-
Data Snapshot: Medicare Part B Spending on Clinical Diagnostic Laboratory Tests in 2022 (OEI-09-23-00350), December 2023	-	-	-	-
Connecticut Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents (A-01-21-00001), December 2023	-	-	-	-
Washington State Did Not Ensure That Selected Nursing Homes Complied With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (A-09-22-02006), December 2023	-	-	-	-
Medicare Generally Paid Acute-Care Hospitals for Inpatient Stays for Medicare Enrollees Diagnosed With COVID-19 in Accordance With Federal Requirements (A-09-21-03009), December 2023	-	-	-	-
Ohio Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (A-05-22-00019), December 2023	-	-	-	Yes
Oklahoma Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety,	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Emergency Preparedness, and Infection Control (A-06-22-09007), January 2024				
Cahaba Government Benefits Administrators, LLC, Properly Updated the Medicare Segment Pension Assets and Overstated Medicare's Share of the Medicare Segment Excess Pension Liabilities as of December 31, 2018 (A-07-22-00627), January 2024	-	-	-	-
Cahaba Safeguard Administrators, LLC, Overstated Its Medicare Segment Pension Assets as of January 1, 2020 (A-07-23-00631), January 2024	-	-	-	-
Cahaba Government Benefits Administrators, LLC, Did Not Claim Some Allowable Medicare Pension Costs Through Its Incurred Cost Proposals (A-07-23-00634), January 2024	-	-	-	-
Cahaba Safeguard Administrators, LLC, Claimed Some Unallowable Medicare Pension Costs Through Its Incurred Cost Proposals (A-07-23-00635), January 2024	$146,658	-	-	-
Cahaba Government Benefits Administrators, LLC, Claimed Some Unallowable Medicare Postretirement Benefit Costs Through Its Incurred Cost Proposals (A-07-23-00636), January 2024	$1,085,470	-	-	-
Cahaba Safeguard Administrators, LLC, Claimed Some Unallowable Medicare Postretirement Benefit Costs Through Its Incurred Cost Proposals (A-07-23-00637), January 2024	$9,806	-	-	-
Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Third Quarter of 2023 (OEI-03-24-00050), February 2024	-	-	-	-
Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes (OEI-02-20-00492), February 2024	-	-	-	-
Data Snapshot: Biosimilar Cost and Use Trends in Medicare Part B (OEI-05-22-00141), February 2024	-	-	-	-
Colorado Could Better Ensure That Nursing Homes Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control (A-07-22-07009), February 2024	-	-	-	-
Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements (A-01-21-00501), February 2024	-	-	-	-
Report to Congress on the Reported Impact of Discarded Drug Refunds on Biosimilar Biological Products (A-06-23-04003), February 2024	-	-	-	-
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MediGold (Contract H3668) Submitted to CMS (A-07-20-01198), February 2024	$2,183,514	-	-	-
Medicaid Fraud Control Units Fiscal Year 2023 Annual Report (OEI-09-24-00200), March 2024	-			

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
Concerns Remain About Safeguards To Protect Residents During Facility-Initiated Discharges From Nursing Homes (OEI-01-18-00251), March 2024	-	-	-	-
Nursing Home Residents With Endangering Behaviors and Mental Health Disorders May Be Vulnerable to Facility-Initiated Discharges (OEI-01-18-00252), March 2024	-	-	-	-
A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care (OEI-02-22-00050), March 2024	-	-	-	-
Pennsylvania Improperly Claimed $551 Million in Medicaid Funds for Its School-Based Program (A-02-21-01011), March 2024	$551,436,272	-	$368,870,827	-
Kansas's Medicaid Estate Recovery Program Was Cost Effective, but Kansas Did Not Always Follow Its Procedures, Which Could Have Resulted in Reduced Recoveries (A-07-22-03254), March 2024	-	-	-	-
Utah MMIS and E&E System Had Adequate Security Controls in Place, but Improvements Are Needed (A-18-21-09001), March 2024	-	-	-	-
South Carolina MMIS and E&E System Security Controls Were Adequate, but Some Improvements Are Needed (A-18-22-09005), March 2024	-	-	-	-
CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements (A-02-22-01016), March 2024	-	-	-	-
Delaware Made Capitation Payments to Medicaid Managed Care Organizations After Enrollees' Deaths (A-03-22-00205), March 2024	$7,731,663	-	$7,731,663	-
New Jersey Significantly Improved Its Oversight of Medicaid Adult Partial Care Services Except for Those Provided Using Telehealth During the COVID-19 Public Health Emergency (A-02-22-01007), March 2024	$18,826,714	-	-	-
Alabama MMIS and E&E System Security Controls Were Adequate, but Some Improvements Are Needed (A-18-22-09010), March 2024	-	-	-	-
FOOD AND DRUG ADMINISTRATION (FDA)				
The Food and Drug Administration Needs To Improve the Premarket Tobacco Application Review Process for Electronic Nicotine Delivery Systems To Protect Public Health (A-06-22-01002), November 2023	-	-	-	-
HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)				
HHS's Oversight of Automatic Provider Relief Fund Payments Was Generally Effective but Improvements Could Be Made (A-02-20-01025), October 2023	$352,192,979	-	-	-
The Provider Relief Fund Helped Select Nursing Homes Maintain Services During the COVID-19 Pandemic, but Some Found Guidance Difficult To Use (OEI-06-22-00040), December 2023	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
HRSA Made Some Potential Overpayments to Providers Under the Phase 2 General Distribution of the Provider Relief Fund Program (A-09-22-06001), March 2024	$18,371,939	$159,379,359	-	-
INDIAN HEALTH SERVICE (IHS)				
Independent Attestation Review: Indian Health Service Fiscal Year 2023 Detailed Accounting Report and Budget Formulation Compliance Report for National Drug Control Activities, and Accompanying Required Assertions (A-03-24-00351), January 2024	-	-	-	-
Two Tribes in Oklahoma and Their Health Programs Did Not Meet All Federal and Tribal Requirements for Background Investigations on Individuals in Contact With Indian Children (A-01-20-01505), January 2024	-	-	-	-
IHS Did Not Coordinate Supply Service Center Operations Before and During the COVID-19 Pandemic and Should Consider Upgrading Supply Centers' Inventory Management Systems and Implementing Policies and Procedures To Enhance Coordination and Alignment (A-07-22-04131), March 2024	-	-	-	-
NATIONAL INSTITUTES OF HEALTH (NIH)				
The National Institutes of Health Administered Superfund Appropriations During Fiscal Year 2022 in Accordance With Federal Requirements (A-04-23-03586), December 2023	-	-	-	-
The National Institutes of Health Did Not Receive 81 of 109 Required Audit Reports for Foreign Grant Recipients (A-05-21-00019), December 2023	-	-	-	-
NIH Did Not Consistently Meet Federal Single Audit Requirements for Extramural Grants (OEI-04-21-00160), December 2023	-	-	-	-
NIH Generally Implemented System Controls Over the Sequence Read Archive but Some Improvements Needed (A-18-22-03300), February 2024	-	-	-	-
OFFICE OF THE SECRETARY (OS)				
Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2023 (A-17-23-00001), November 2023	-	-	-	-
HHS Did Not Ensure Foundational Cybersecurity Controls Were in Place Prior to Implementation of HHS Protect and Use of a Contractor's Cloud Service (A-18-20-06800R), December 2023	-	-	-	-
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)				
Some of California's Substance Abuse Prevention and Treatment Block Grant Expenditures for Los Angeles County Did Not Comply With Federal and State Requirements (A-09-21-01001), November 2023	-	$3,502,188	-	-
Independent Attestation Review: Substance Abuse and Mental Health Services Administration Fiscal Year 2023 Detailed Accounting Report and Budget Formulation Compliance Report for National Drug Control Activities,	-	-	-	-

Report	Questioned Costs	Funds Put to Better Use	Unsupported Costs	Management Decision Made
and Accompanying Required Assertions (A-03-24-00352), January 2024				
New Jersey Complied With Federal Regulations When Implementing Programs Under SAMHSA's Opioid Response Grants, but Did Not Meet Its Program Services Goals (A-02-22-02002), March 2024	-	-	-	-
TOTAL REPORTS: 78	**$984,366,236**	**$856,881,547**	**$376,602,490**	

OIG issued no investigative reports, which are reports that identify or bring renewed attention to systemic weaknesses or vulnerabilities within HHS programs and recommend administrative, procedural, policy, regulatory, or legislative change to correct or minimize the problems.

Appendix B: Peer Reviews

Peer reviews are conducted by member organizations of the Council of the Inspectors General on Integrity and Efficiency (CIGIE). The CIGIE peer review program provides OIGs and their stakeholders with an assessment of the OIG's compliance with relevant quality standards and its quality control systems (e.g., policies and procedures).

Office of Audit Services

During the reporting period, the Department of Housing and Urban Development (HUD) OIG conducted a peer review of OIG's Office of Audit Services (OAS), the final report of which was issued in March 2024. In that review, OIG received a "pass" rating and HUD-OIG issued no recommendations. OAS has no outstanding peer review recommendations. OAS did not conduct a peer review during the reporting period. The most recent peer review OAS conducted was of the Department of Labor OIG in September 2022.

Office of Evaluation and Inspections

During the reporting period, OIG's Office of Evaluation and Inspections (OEI) did not receive a peer review. The most recent peer review OEI received was conducted by the Department of Energy (DOE) OIG, the final report of which was issued in February 2023. In that review, DOE-OIG determined that OEI's policies and procedures and the four reports reviewed generally were consistent and complied with the CIGIE Blue Book standards. OEI has no outstanding peer review recommendations. OEI did not conduct a peer review during the reporting period. The most recent per review OEI conducted was of the Special Inspector General for Afghanistan Reconstruction OIG, the final report of which was issued in March 2023.

Office of Investigations

During the reporting period, OIG's Office of Investigations (OI) did not receive a peer review. The most recent peer review OI received was conducted by the Social Security Administration (SSA) OIG, the final report of which was issued in February 2019. In that review, SSA-OIG determined that OI was in conformity with the CIGIE Quality Standards for Investigations, the Quality Assessment Review Guidelines, and the Attorney General's Guidelines for Office of Inspectors General with Statutory Law Enforcement Authority. OI has no outstanding peer review recommendations. OI did not conduct a peer review during the reporting period. The most recent per review OI conducted was of the Department of Defense OIG, the final report of which was issued in February 2023.

Appendix C: Investigations of Senior Government Employees

OIG conducted 12 investigations of 13 senior Government employees and substantiated 4 allegations, which resulted in nonpublic reports.

OIG substantiated and referred the following allegations:

1. OIG investigated an employee (GS-15) for allegedly forging an adult child's signature on a diplomatic passport application after being told that the child's own signature would be required. When interviewed about the forgery, the employee knowingly lied, claiming no knowledge of this requirement, despite significate email chains showing differently. During an interview, the employee also claimed not to know that a diplomatic passport was for official use only. This investigation was referred to the appropriate HHS operational division for evaluation and administrative action.
2. OIG investigated an employee (GS-15) for alleged illegal hiring, prohibited personnel practices, merit systems principal preselections, veteran preferences violations, compensation violations, appointed authorities, violations of titles 42 and 38, abuse of authority, fraud, and waste of funds. This investigation was referred to the appropriate HHS operational division for evaluation and administrative action.
3. OIG investigated an employee (SES) for allegedly pressing to increase Government stocks of the smallpox vaccine. The Government ultimately made an agreement to buy up to $2.8 billion of the vaccine from a company that once paid the employee as a consultant. However, this connection was not disclosed on a Senate questionnaire when the employee was nominated. Under the agreement, the Government paid more than double the price per dose it had previously paid for the drug. This investigation was referred to the Office of Special Counsel.
4. OIG investigated an employee (GS-15) for allegedly working a full-time job as a contract manager. This investigation was referred to the appropriate HHS operational division for evaluation and administrative action.

OIG did not find any evidence to support the following allegations:

5. OIG investigated an employee (GS-15) for allegedly working full time as a faculty member at a university.
6. OIG investigated an employee (GS-15) for allegedly sending sensitive information to an outside source from the employee's Government account.
7. OIG investigated an employee (SES) for allegedly misusing their position by engaging in a conflict-of-interest activity for potential financial gain.
8. OIG investigated an employee (GS-15) for allegedly not reporting to work and committing time and attendance fraud.
9. OIG investigated an employee (GS-15) for allegedly forming an LLC and purchasing a condominium with someone who worked on a contract the employee oversaw.
10. OIG investigated an employee (GS-15) for allegedly providing a signed HHS joint research agreement to a university in China.
11. OIG investigated two employees (SES) for allegedly approving the timecards for another employee who had been detailed for more than 2 years without the proper paperwork or knowing where the employee was detailed. It is also alleged that neither of the senior employees have followed up on the other employee and are unsure if the employee is even still working on the detail. It is further alleged that the employee has information on mismanagement; therefore, the senior employees have left the other employee alone and continue to approve the employee's timecards knowing that the employee has not been there in more than 2 years.
12. OIG investigated an employee (SES) for allegedly possessing and trading stocks that conflicted with official duties and for using nonpublic information to further the employee's private interests.

Appendix D: Audit Reports With Questioned Costs

As defined by the Inspector General Act, the term "questioned cost" means a cost that is questioned by OIG because of: (1) an alleged violation of a provision of law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a cost that is not supported by adequate documentation at the time of the audit; or (3) the expenditure of funds for the intended purpose is unnecessary or unreasonable. Questioned costs that HHS program officials have, in a management decision, sustained or agreed should not be charged to the Government are disallowed costs.

Description	No. of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period*	66	$2,616,754,000	$38,692,000
Issued during the reporting period	15	$984,366,000	$376,602,000
Total Section 1	**81**	**$3,601,120,000**	**$415,294,000**
Section 2			
Reports for which management decisions were made during the reporting period			
Disallowed costs	29	$194,358,000**	$0
Costs not disallowed	28	$2,152,922,000	$38,599,000
Total Section 2	**57**	**$2,347,280,000**	**$38,599,000**
Section 3			
Reports for which no management decisions had been made by the end of the reporting period (Section 1 – Section 2)	**24**	**$1,253,840,000**	**$376,695,000**
Section 4			
Reports for which no management decisions were made within 6 months of issuance	**13**	**$284,937,000**	**$93,000**

* The opening balance was adjusted upward by $784,567,000 because of re-evaluations of previously issued recommendations.

** Audit receivables (expected recoveries)

Appendix E: Audit Reports With Funds Put to Better Use

The phrase "recommendations that funds be put to better use" means that funds could be used more efficiently if management took action to implement an OIG recommendation through reductions in outlays, de-obligation of funds, and/or avoidance of unnecessary expenditures.

Description	No. of Reports	Dollar Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period	8	$15,686,722,000
Reports issued during the reporting period	3	$856,882,000
Total Section 1	**11**	**$16,543,604,000**
Section 2		
Reports for which management decisions were made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	1	$8,845,000
Based on proposed legislative action	-	-
Value of recommendations not agreed to by management	3	$45,061,000
Total Section 2	**4**	**$53,906,000**
Section 3		
Reports for which no management decisions had been made by the end of the reporting period (Section 1 – Section 2)	**7**	**$16,489,698,000**

Appendix F: Reporting Requirements

The National Defense Authorization Act (NDAA) of FY 2023, section 5273, amended the Inspector General Act of 1978 and the Inspector General Empowerment Act of 2016 to streamline semiannual reporting requirements for offices of inspectors general, which now appear in the note of 5 U.S.C. § 405. The following table presents the new NDAA requirements and other remaining requirements, along with the location of the information in this report.

Section	Requirement	Location
U.S.C. § 405		
5(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
5(a)(2)	Recommendations for which corrective action has not been completed	Additional OIG Activities
5(a)(3)	Significant investigations closed during the reporting period	Throughout this report
5(a)(4)	Total number of convictions during the reporting period resulting from investigations*	At a Glance: OIG Accomplishments
5(a)(5)	Information regarding reports issued during the reporting period	Appendix A: Audits and Evaluations
5(a)(6)	Information regarding any management decision made during the reporting period with respect to any report issued during a previous reporting period	Additional OIG Activities
5(a)(7)	Information required by the Federal Financial Management Improvement Act of 1996	None this reporting period
5(a)(8)	Results of peer reviews of HHS-OIG conducted by other OIGs	Appendix B: Peer Reviews
5(a)(9)	Outstanding recommendations from peer reviews of HHS-OIG conducted by other OIGs	Appendix B: Peer Reviews
5(a)(10)	Peer reviews of other OIGs conducted by HHS-OIG	Appendix B: Peer Reviews
5(a)(11)	Investigative statistical tables	Additional OIG Activities Appendix A: Audits and Evaluations
5(a)(12)	Metrics description for investigative statistical tables	Additional OIG Activities Appendix A: Audits and Evaluations
5(a)(13)	Investigations of senior Government employees	Appendix C: Investigations of Senior Government Employees
5(a)(14)	Description of whistleblower retaliation instances	Additional OIG Activities
5(a)(15)	Description of attempts to interfere with OIG independence	None this reporting period
5(a)(16)	Description of closed and nondisclosed reports and investigations regarding senior Government employees	Appendix C: Investigations of Senior Government Employees
Other Requirements		
NDAA 2008 section 845	Significant contract audits	None this reporting period
Health Insurance Portability and Accountability Act	Public proposals for new and modified safe harbors	Additional OIG Activities
American Recovery and Reinvestment Act section 1553	Retaliation complaint investigations OIG decided not to conduct or continue during the period	None this reporting period

*Convictions are included among criminal actions.

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Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does it Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.