

**OFFICE OF
INSPECTOR GENERAL**

U.S. Department of Health and Human Services

**SEMIANNUAL REPORT
TO CONGRESS**

October 1, 2014 – March 31, 2015

OIG Organization

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) provides independent and objective oversight that promotes economy, efficiency, and effectiveness in the programs and operations of HHS. OIG's program integrity and oversight activities are shaped by legislative and budgetary requirements and adhere to professional standards established by the Government Accountability Office, the Department of Justice (DOJ), and the Inspector General community. OIG carries out our mission to protect the integrity of HHS programs and the health and welfare of the people served by those programs through a nationwide network of audits, investigations, and evaluations conducted by the following operating components with assistance from OIG counsel and management.

OAS
OEI
OI
OCIG
EM

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

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs. OEI reports also present practical recommendations for improving program operations.

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State and the District of Columbia, OI actively coordinates with DOJ and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, or civil monetary penalties (CMPs).

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Executive Management (EM) is composed of the Immediate Office of the Inspector General and the Office of Management and Policy. EM is responsible for overseeing the activities of OIG's components; setting vision and direction, in collaboration with the components, for OIG's priorities and strategic planning; ensuring effective management of budget, finance, information technology, human resources, and other operations; and serving as a liaison with HHS, Congress, and other stakeholders. EM plans, conducts, and participates in a variety of cooperative projects within HHS and with other Government agencies.

A Message From the Inspector General

This Semiannual Report to Congress, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG), Department of Health and Human Services (HHS or the Department), for the 6-month period that ended March 31, 2015.



Daniel R. Levinson
Inspector General

OIG strives to protect the health, safety, and welfare of HHS beneficiaries and those who rely on HHS programs. Robust oversight of quality-of-care issues requires a wide range of oversight tools that go beyond reviewing the accuracy of billing and payments. It also includes examinations of whether beneficiaries have access to care, beneficiaries receive care of a sufficient quality, and their lives are generally enriched by that care.

Several reports released during this reporting cycle served to improve the quality of health care and human services provided to beneficiaries of HHS programs. Of particular note are reports examining issues related to quality in Medicaid, a program for which taxpayers spend almost half-a-trillion dollars each year. One such report evaluated Medicaid beneficiaries' access to physician services by reviewing State standards and testing beneficiaries' ability to obtain appointments with primary care and specialty physicians. We also examined issues surrounding low utilization of preventive screening services intended to help children avoid or minimize childhood illness and, in separate work, identified concerns surrounding the practice of prescribing antipsychotic drugs to children enrolled in Medicaid. These and other reports revealed vulnerabilities in programs and practices and recommended changes to improve the quality of care in Medicaid.

OIG is committed to improving the circumstances and conditions that give rise to substandard quality. We provide education and outreach to help providers better understand and meet their legal obligations. When poor quality care results in violations of fraud and abuse laws, we pursue enforcement actions, including actions to address those who harm beneficiaries or defraud the Government. For example, in the largest settlement of its kind, a nationwide skilled nursing facility (SNF) company recently agreed to pay millions of dollars to resolve allegations that its facilities provided materially substandard or worthless care that resulted in serious patient harm ranging from fractures, to dehydration and malnutrition, to severe pressure ulcers resulting in the loss of a limb.

Our continued partnership with other Federal, State, and local law enforcement entities as part of HEAT Strike Force work continues to yield results and serves to reduce beneficiaries' exposure to fraudulent or otherwise abusive care. In a Strike Force case that is currently scheduled for sentencing, a Detroit-area hematologist-oncologist pleaded guilty to prescribing and administering aggressive chemotherapy and related treatments to patients who did not need these therapies, in order to increase his billing to Medicare and other insurers. These and other law enforcement efforts play a critical role in safeguarding the health and safety of program beneficiaries as well as taxpayer dollars.

OIG continues to monitor the economy, efficiency, and effectiveness of Affordable Care Act programs across HHS. Two reports released in the last 6 months examined the processes used to build Health Insurance Exchanges or Marketplaces. In the first, OIG found that the Centers for Medicare & Medicaid

Services (CMS) did not develop an overarching acquisition strategy for the Federal Marketplace or perform all the acquisition oversight activities required by Federal and HHS regulations. CMS did not plan to assign a lead systems integrator to coordinate all contractors' efforts and missed opportunities to leverage contract planning and oversight tools for a project of this size and importance. In the second, OIG found that the Maryland State Agency did not allocate costs to Medicaid and the grants provided by CMS to establish State-run Marketplaces in accordance with Federal requirements. Upcoming work examines whether CMS's internal controls effectively ensured the accuracy of financial assistance payments made to qualified health plan issuers.

Since its 1976 establishment, OIG has worked diligently with its partners to protect HHS's vital health and human services programs. The achievements of this office would not be possible without the dedication and professionalism of all OIG employees. Once again, I would also like to express my appreciation to Congress and to the Department for their sustained commitment to supporting the important work of our office.

Daniel R. Levinson
Inspector General

Highlights

The Department of Health and Human Services (HHS or the Department) Office of Inspector General (OIG) *Semiannual Report to Congress (Semiannual Report)* describes significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. This edition addresses work completed during the first half of fiscal year (FY) 2015 (October-March) and summarizes key accomplishments during the period.

Accomplishments

During the first half of FY 2015, OIG reported expected recoveries of over \$1.8 billion consisting of nearly \$544.7 million in audit receivables and about \$1.26 billion in investigative receivables, which include about \$142 million in non-HHS investigative receivables resulting from our work in areas such as the States' shares of Medicaid restitution.

OIG reported 486 criminal actions against individuals or entities that engaged in crimes against HHS programs and 326 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties settlements, and administrative recoveries related to provider self-disclosure matters. We also reported exclusions of 1,735 individuals and entities from participation in Federal health care programs.

Strike Force and other fraud accomplishments

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and the Department of Justice to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse. HEAT has continued to identify and hold accountable those who seek to defraud Medicare and Medicaid.

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. The teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force began in March 2007 and is operating in nine major cities. During the first half of FY 2015, Strike Force efforts resulted in the filing of charges against 69 individuals or entities, 124 criminal actions, and \$163 million in investigative receivables. The effectiveness of the Strike Force model is enhanced by interagency collaboration. For example, we refer credible allegations of fraud to the Centers for Medicare & Medicaid Services (CMS) so that it can suspend payments to the suspected perpetrators, thereby immediately preventing losses from claims submitted by Strike Force targets.

Strike Force case example – Beneficiary recruitment and unnecessary services – Louisiana

Roslyn Dogan was sentenced to 7-and-a-half years in prison and ordered to pay \$43.5 million in joint and several restitution after being convicted of conspiracy to commit health care fraud and health care fraud. Dogan co-owned and managed Serenity Center, LLC (Serenity), and served as a manager and marketer for Psychcare of Louisiana, LLC d/b/a Shifa Community Mental Health Center (Shifa). The investigation

revealed that Dogan and co-conspirators recruited Medicare beneficiaries to attend programs at Serenity and Shifa, even though the beneficiaries did not qualify for services, the services were not medically necessary, or the services were not provided. James Hunter and others were paid kickbacks to recruit Medicare beneficiaries to receive partial hospitalization program services at Shifa Community Mental Health Center (CMHC) of Texas, LLC, which were not medically necessary and not provided. Hunter was sentenced to 5 years in prison and ordered to pay \$3.2 million in joint and several restitution.

Fraudulent Part D claims - Florida

Carlos Perez-Gomez and Jesus Fundora were sentenced to a combined 17 years and 1 month in jail and ordered to pay \$6.2 million in joint and several restitution after pleading guilty to conspiracy to commit health care fraud. Perez-Gomez and Fundora operated Kiara Discount Pharmacy, Corp., a Miami based retail pharmacy. The investigation revealed that co-conspirators recruited and paid Medicare beneficiaries to obtain prescriptions for a variety of drugs, including expensive antipsychotic and skin treatment pharmaceutical drugs, that the co-conspirators subsequently furnished to Perez-Gomez and Fundora. Perez-Gomez and Fundora then used the fraudulent prescriptions to bill the Medicare Part D program, falsely representing that the drugs were medically necessary, were prescribed by a doctor, and were provided by Kiara Pharmacy to the beneficiaries.

Inappropriate patient referrals for dialysis treatment – Colorado

In the largest kickback-only settlement to date, DaVita HealthCare Partners, Inc., agreed to pay \$350 million to resolve allegations that the company paid remuneration to nephrologists (physicians who specialize in kidney care) in return for referrals of beneficiaries in need of dialysis treatment. DaVita allegedly provided nephrologists and nephrology practices with exclusive opportunities to buy minority interests in DaVita-owned dialysis clinics at unreasonably favorable rates. In certain paired transactions, the nephrologists or nephrology practices could sell a majority interest in clinics they owned to DaVita at an unreasonably favorable rate. These joint venture opportunities were allegedly given to nephrologists to induce them to refer patients to DaVita's dialysis centers in order to maintain and increase DaVita's market share of dialysis patients.

Inefficient payments, policies, and practices

Medicare and Medicaid policies or practices sometimes result in inefficiencies when unintended loopholes or other inherent problems invite exploitation or hinder consistent payment determinations. Improper payments occur when the programs do not effectively prevent, deter, identify, or address inappropriate and abusive billing by providers and suppliers. Some, but not all, abusive billing is fraudulent.

Hospices' financial incentives to provide care in assisted living facilities

Medicare payments for hospice care provided in assisted living facilities (ALFs) more than doubled in 5 years, totaling \$2.1 billion in 2012. Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Beneficiaries in ALFs often had diagnoses that usually require less complex care. Hospices typically provided fewer than 5 hours of visits and were paid about \$1,100 per week for each beneficiary receiving routine home care in ALFs. This report raises concerns about hospices' targeting beneficiaries in ALFs because they may offer the hospices the greatest financial gain. The findings in this and previous OIG reports show that

payment reform and more accountability are needed to reduce incentives for hospices to focus solely on certain types of diagnoses and settings. [OEI-02-14-00070](#).

Critical access hospitals - Swing bed services payment rates

Swing-bed usage at critical access hospitals (CAHs) significantly increased from calendar years (CYs) 2005 through 2010. Medicare spending for swing-bed services in CAHs steadily increased to, on average, almost four times the costs of similar services at alternative facilities. Medicare could have saved \$4.1 billion over a 6-year period at CAHs if swing-bed services were reimbursed using the skilled nursing facility prospective payment system rate. CAHs ensure that beneficiaries in rural areas have access to a range of hospital services. CAHs provide “swing-bed” services, which are the equivalent of services performed at a skilled nursing facility (SNF). Medicare reimburses CAHs at 101 percent of their reasonable costs for providing services to beneficiaries rather than at rates set by Medicare’s prospective payment system or Medicare’s fee schedules. [A-05-12-00046](#).

Payments made to providers with delinquent debts

CMS made Medicare and Medicaid payments associated with 23 of 82 individual physicians with delinquent debts after CMS had referred their Medicare debts to the U.S. Department of the Treasury (Treasury) for collection. The 23 individual physicians, who collectively owed CMS a total of \$8.8 million, were paid a total of \$10.7 million in direct payments and provided services for an entity that received Federal reimbursement. In addition, 13 of the 23 individual physicians whose debts were referred to Treasury had ownership interest in and/or managing control of 15 Medicare Part B entities that received Medicare reimbursement from CMS after CMS referred the individual physicians’ debts to Treasury. Although these individual physicians are not precluded from indirectly receiving Medicare Part B payments through an entity, CMS finalized a rule in December 2014 that denies an entity’s enrollment due to Medicare debt owed by an owner. CMS is required to seek recovery of all identified overpayments and can recoup or offset overpayments against a provider’s future Medicare and/or Federal share of Medicaid payments irrespective of whether the delinquent debts were transferred to Treasury for collection. [A-02-12-01008](#).

Reconciliation of hospital outlier payments

Medicare contractors Pinnacle Business Solutions, Noridian Healthcare Solutions, and National Government Services (NGS) did not always refer Medicare cost reports whose outlier payments qualified for reconciliation to CMS. In addition, the three contractors did not always reconcile the outlier payments associated with cost reports whose outlier payments qualified for reconciliation. The financial impact to Medicare of the unreconciled outlier payments and cost reports was approximately \$14.4 million (Pinnacle), \$31.8 million (Noridian), and \$19 million (NGS). Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments for unusually high-cost cases. Medicare contractors refer hospitals’ cost reports to CMS for reconciliation of outlier payments. [A-07-11-02773](#), [A-07-10-02774](#), [A-05-14-00046](#).

Developmental Disabilities Waiver Program – New York

New York claimed Federal Medicaid reimbursement for some Office for People With Developmental Disabilities (OPWDD) waiver program services that did not comply with Federal and State requirements. The State agency improperly claimed an estimated \$76.8 million in Federal Medicaid reimbursement for waiver program services during CYs 2006 through 2008. The OPWDD waiver program is intended to

enable adults and children with developmental disabilities to live in the community as an alternative to intermediate care facilities for individuals with intellectual disabilities. This review is part of a series of reviews of New York State's OPWDD Medicaid waiver program. [A-02-10-01044](#).

Nonemergency Medical Transportation - Texas

During FY 2011, Texas claimed at least \$30.4 million for unallowable Medicaid payments for nonemergency medical transportation (NEMT) services. Federal regulations require each State to ensure that Medicaid beneficiaries have necessary transportation to and from medical providers. Prior OIG reviews have found that States' claims for NEMT services were not always in accordance with Federal and State requirements. [A-06-12-00053](#).

Quality of care and beneficiary protection

Gaps in program safeguards intended to ensure medical necessity, patient safety, access to services, and quality of care present significant challenges to the Medicare and Medicaid programs. OIG is committed to continuing its quality-of-care and beneficiary protection oversight across all HHS programs and services.

Substandard and/or worthless skilled nursing services - Wisconsin

In the largest failure-of-care settlement with a nationwide SNF, Extendicare Health Services, Inc., and its subsidiary, Progressive Step Corporation (ProStep), agreed to pay \$38 million to resolve allegations that Extendicare billed Medicare and Medicaid for materially substandard and/or worthless skilled nursing services and billed Medicare for medically unreasonable and unnecessary rehabilitation therapy services. Extendicare allegedly provided inadequate care to residents at some of its SNFs and, as a result, patients suffered fractures, head injuries, malnutrition, dehydration, pressure ulcers, infections, and amputation of limbs.

Provider availability in Medicaid managed care

Slightly more than half of providers reviewed could not offer appointments to enrollees. Notably, 35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but were not participating in the plan. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was 2 weeks. However, over a quarter had wait times of more than 1 month. Finally, primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times. The findings demonstrate significant vulnerabilities in provider availability, which is a key indicator for access to care, and raises serious questions about the abilities of plans, States, and CMS to ensure that access-to-care standards are met. [OEI-02-13-00670](#).

Medicaid children's utilization of preventive screening services

CMS had taken actions toward encouraging participation in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings and toward encouraging the delivery of all components of medical screenings, but it had not fully addressed OIG's recommendations made in 2010. Further, it was found that children's participation in EPSDT medical screenings remained lower than established goals. Although the national participation ratio improved from 56 percent in 2006 to 63 percent in 2013, both ratios are below the Secretary's goal of 80-percent participation. Given that CMS has not yet fully

addressed all OIG recommendations, coupled with evidence that children continue to receive fewer medical screenings than required, CMS must continue to focus on EPSDT screenings. [OEI-05-13-00690](#).

Second-generation antipsychotic drug use among children

In the five States reviewed, medical reviewers identified quality-of-care concerns in the medical records associated with 67 percent of claims for second-generation antipsychotic (SGA) drugs prescribed to children. SGAs are widely used to treat children enrolled in Medicaid who have mental health conditions and can have serious side effects. Quality-of-care concerns identified through medical record reviews corresponded to the following issues: dosage, duration, indications for use, monitoring, polypharmacy (too many drugs), patient age, and side effects. The high percentage of claims for which our reviewers identified quality-of-care concerns indicates that more needs to be done to ensure the quality of care provided to children receiving SGAs paid for by Medicaid. [OEI-07-12-00320](#).

Affordable Care Act implementation

The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, made changes to HHS programs and enacted a range of new programs that affect the Department. Our work related to the Affordable Care Act encompasses the health insurance Marketplaces, Medicaid expansion, use of State establishment grants, and financial assistance payments.

Marketplaces – Inadequacies in contract planning and procurement

CMS relied extensively on contractors to plan and build the Federal Marketplace. However, CMS did not develop an overarching acquisition strategy for the Federal Marketplace contracts as required by Federal and HHS regulations, did not plan to assign a lead systems integrator to coordinate all contractors' efforts, and missed opportunities to leverage contract planning and oversight tools for a project of this size and importance. The complexity of the Federal Marketplace underscored the need for CMS to select the most qualified contractors. However, CMS did not perform thorough reviews of contractor past performance when awarding two key contracts. [OEI-03-14-00230](#).

Marketplaces – Misallocation of costs to establishment grants

The Maryland Department of Health and Mental Hygiene (State agency) did not allocate costs to its establishment grants and Medicaid in accordance with Federal requirements, the terms and conditions of the establishment grants, and its Cost Allocation Plan (CAP). The State agency allocated a total of \$76.6 million to its establishment grants on the basis of a cost allocation methodology that did not prospectively use updated or better data when available and included a material defect. As a result, the State agency misallocated \$28.4 million in costs to the establishment grants instead of the Medicaid program. The State agency misallocated these costs because it did not have adequate internal controls to ensure the proper allocation of costs. [A-01-14-02503](#).

Premium tax credits – Accounting structure review

The report issued jointly with the Treasury Inspector General for Tax Administration (TIGTA) found that the Internal Revenue Service (IRS) and CMS, in coordination with the Department of the Treasury and HHS, took significant steps in planning the shared roles and responsibilities for advanced premium tax credit (APTC) payments. The IRS and CMS, in an effort to ensure that a sound and lawful accounting

structure was selected, identified issues requiring resolution and discussed a variety of accounting approaches. They sought legal opinions from agency counsel and obtained input from the Office of Management and Budget (OMB). By mutual agreement and with OMB concurrence, the IRS and CMS adopted an allocation account structure that they considered a logical and efficient approach. Continuing work by OIG and TIGTA will examine APTC operations. [OEI-06-14-00590](#).

Oversight of HHS grants

HHS is the largest grantmaking organization in the Federal Government, and its funding of health and human services programs touches the lives of almost all Americans. The size and scope of Departmental awards make the operating effectiveness of these grants crucial to the success of programs designed to improve the health and well-being of the public. Yet OIG has noted weaknesses in the oversight of grantees year after year.

Debarment of Soundview Healthcare Network

Following a lengthy investigation by the Federal Bureau of Investigation (FBI) and the United States Attorney's Office, Pedro Espada, Jr., was found guilty of stealing Federal funds from Soundview Healthcare Network (Soundview). Pedro Espada, Jr., was sentenced to 5 years in prison. His son, Pedro G. Espada, was sentenced to 6 months in jail and 6 months' home confinement. After the conviction of the Espadas, OIG began suspension and debarment proceedings against the Espadas and Soundview to ensure that they could not obtain future Federal funds. Effective February 5, 2015, HHS debarred the Espadas and Soundview, along with two other affiliated organizations (Soundview Management Enterprises and Community Expansion Development Corporation) for a period of 3 years. During this time, they are not eligible to receive Federal grant funds or participate in contracts with the Federal Government.

Child Care and Development Fund – Provider compliance with health and safety requirements

The family childcare home providers reviewed in two States did not always comply with applicable State licensing requirements to ensure the health and safety of children (19 out of 20 providers reviewed in Minnesota and 20 out of 20 providers reviewed in Arizona). In addition, the childcare center providers in Minnesota did not always comply with applicable State licensing requirements to ensure the health and safety of children (three out of three providers reviewed). We found several types of errors, but not all errors appeared in each State. Health and safety standards must cover three areas: prevention and control of infectious disease, building and physical premises safety, and health and safety training. [A-05-14-00021](#), [A-05-14-00022](#), [A-09-13-01004](#).

OIG participation in congressional hearings

03/24/2015 Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections, testified before the House Committee on Energy and Commerce, Subcommittee on Health: “Examining the 340B Drug Pricing Program.” [Testimony](#).



Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections

03/24/2015 Gary Cantrell, Deputy Inspector General for Investigations, testified before the House Committee on Ways and Means, Subcommittee on Oversight: “Fraud in Medicare.” [Testimony](#).



Gary Cantrell, Deputy Inspector General for Investigations

<http://oig.hhs.gov>

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Selected acronyms

ACA	Patient Protection and Affordable Care Act of 2010, P.L. No. 111-148 (as amended by the Health Care Education and Reconciliation Act of 2010)
ACF	Administration for Children and Families
ALF	assisted living facility
AMP	average manufacturer price
APTC	advanced premium tax credit
CAH	critical access hospital
CAP	cost allocation plan
CDC	Centers for Disease Control and Prevention
CIA	corporate integrity agreement
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CMHC	community mental health center
CMP	civil monetary penalty
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CY	calendar year
DME	durable medical equipment
DOJ	Department of Justice
EHR	electronic health record
EMTALA	Emergency Medical Treatment and Labor Act, § 9121 of the Consolidated Omnibus Reconciliation Act of 1985, P.L. No. 99-272
FBI	Federal Bureau of Investigation
FCA	False Claims Act (31 U.S.C. §§ 3729–3733)
FDA	Food and Drug Administration
FISMA	Federal Financial Management Improvement Act of 1996
FY	fiscal year
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HEAL	Health Education Assistance Loan
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IRS	Internal Revenue Service
Marketplaces	health insurance exchanges
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MFCU	Medicaid Fraud Control Unit
NEMT	nonemergency medical transportation
NIH	National Institutes of Health
OIG	Office of Inspector General
OMB	Office of Management and Budget
PEPFAR	President’s Emergency Plan for AIDS Relief
PMD	power mobility device
QIO	quality improvement organization
SBIR	Small Business Innovative Research (Program)

SBIR/STTR	Small Business Innovation Research /Small Business Technology Transfer (Program)
SGA	second-generation antipsychotic
SNF	skilled nursing facility
TIGTA	Treasury Inspector General for Tax Administration
VAT	value-added tax

Centers for Medicare & Medicaid Services

CMS oversight of Medicare contractor performance

The Centers for Medicare & Medicaid Services (CMS) relies on contractors to administer the Medicare program and is responsible for overseeing the contractors' performance. Medicare contractors are responsible for administering more than a half-trillion dollars in benefits each year. Medicare Administrative Contractors (MACs) process Parts A and B claims; Medicare Advantage (MA) plans provide managed care services under Part C; Part D plans provide prescription drug coverage under Part D; and various benefit integrity contractors serve to protect Medicare from fraud, waste, and abuse.

Contractor postretirement benefit assets and excess plan costs

- *Highmark Medicare Services, Inc., Overstated Its Allocable Medicare Postretirement Benefit Plan Costs for Calendar Years 2008 Through 2011. A-07-14-00439. 2014 November.*

Highmark Medicare Services, Inc., a CMS contractor, overstated its allocable postretirement benefit (PRB) plan costs by \$11.2 million for calendar years (CYs) 2008 through 2011. Although Highmark did not directly address our recommendations, it suggested that it did not concur and OIG continues to recommend that Highmark:

- decrease the allocable PRB costs used to calculate the indirect cost rates by \$11.2 million for CYs 2008 through 2011 and
- work with CMS to determine the allowable PRB cost related to the MAC contract.

- *Blue Cross Blue Shield of South Carolina Overstated Its Allocable Medicare Excess Plan Costs for Calendar Years 2006 Through 2011. A-07-14-00445. 2014 December.*

Blue Cross Blue Shield of South Carolina, which through its subsidiaries administered Medicare functions for CMS, overstated its allocable Medicare Excess Plan costs by approximately \$17.6 million for CYs 2006 through 2011. Although Blue Cross Blue Shield of South Carolina did not concur, OIG continues to recommend that Blue Cross Blue Shield of South Carolina:

- decrease the allocable Excess Plan costs by \$17.6 million for CYs 2006 through 2011.

<http://oig.hhs.gov>

Medicare payments, policies, and quality

Medicare improper claims and payments

Deceased beneficiaries – HIV drugs

- *Medicare Paid for HIV Drugs for Deceased Beneficiaries. OEI-02-11-00172. 2014 October.*

Medicare paid for HIV drugs for over 150 deceased beneficiaries in 2012. CMS's current practices allowed most of these payments to occur. Specifically, CMS has edits (i.e., systems processes) in place that reject prescription drug event records for drugs with dates of service more than 32 days after death. This practice allows payment for drugs for deceased beneficiaries. These drugs are clearly not medically indicated, which is a requirement for Part D coverage. A change in CMS's practice would affect all Part D drugs, not just HIV drugs. Considering the enormous number of Part D drugs, a change in practice could result in significant cost savings for the program and for taxpayers. CMS concurred with the following recommendation:

- change its practice of paying for drugs that have a date of service within 32 days after the beneficiary's death.

Ophthalmology services

- *Medicare Paid \$22 Million in 2012 for Potentially Inappropriate Ophthalmology Claims. OEI-04-12-00281. 2014 December.*

Medicare paid \$22 million for ophthalmology claims in 2012 that were potentially inappropriate, according to national and local coverage requirements. The finding demonstrates vulnerabilities in Medicare's oversight and enforcement of its national and local coverage requirements. CMS concurred with the following recommendations:

- implement additional claims processing edits or improve existing edits to ensure claims are paid appropriately and
- determine the appropriateness of ophthalmology claims identified in this report and take appropriate action.

Hospitals – Referral of cost reports and reconciliation of outlier payments

- *Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments. A-07-11-02773. 2014 October.*
- *Noridian Healthcare Solutions, LLC, Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments. A-07-10-02774. 2014 December.*

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- *National Government Services, Inc., Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdiction 8. A-05-14-00046. 2015 March.*

Medicare contractors Pinnacle Business Solutions, Noridian Healthcare Solutions, and National Government Services (NGS) did not always refer Medicare cost reports whose outlier payments qualified for reconciliation to CMS. In addition, the three contractors did not always reconcile the outlier payments associated with cost reports whose outlier payments qualified for reconciliation. The financial impact to Medicare of the unreconciled outlier payments and cost reports was approximately \$14.4 million (Pinnacle), \$31.8 million (Noridian), and \$19 million (NGS). Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments for unusually high-cost cases. Medicare contractors refer hospitals' cost reports to CMS for reconciliation of outlier payments. Novitas (which assumed Pinnacle's responsibilities), Noridian, and Wisconsin Physicians Service Insurance Corporation (which assumed NGS's responsibilities) concurred with the following recommendations:

- review the cost reports that qualified for referral and, if applicable, determine whether the cost reports may be reopened, reconcile the associated outlier payments, and refund the amounts due to Medicare and due to providers;
- reconcile the outlier payments associated with the cost reports that were referred and, if applicable, determine whether these cost reports may be reopened, work with CMS to reconcile the associated outlier payments, finalize these cost reports, and ensure the return of funds to Medicare and to the providers;
- work with CMS to resolve the \$185,000 (Pinnacle) and \$236,099 (NGS) in outlier payments that we could not recalculate;
- ensure that control procedures are in place so that all cost reports with qualifying outlier payments are referred and reconciled; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

Power mobility devices – Face-to-face examination documentation requirements

- *Medicare Paid Suppliers for Power Mobility Device Claims That Did Not Meet Federal Requirements for Physicians' Face-to-Face Examinations of Beneficiaries. A-09-12-02068. 2015 January.*

Medicare paid an estimated \$35.2 million in 2010 for suppliers' power mobility device (PMD) claims that did not meet Federal requirements because physicians had not conducted the required face-to-face examinations of beneficiaries or the physicians' medical records did not meet the minimum documentation requirements for face-to-face examinations. In 2005, CMS introduced the optional Healthcare Common Procedure Coding System code G0372 for a physician to establish and document the need for a PMD. We refer to a physician claim with the G0372 code as a "G-code claim." For PMD claims with corresponding G-code claims, Medicare paid the PMD claims in accordance with Federal requirements for face-to-face examinations of beneficiaries. For PMD claims without corresponding G-code claims, Medicare did not always pay the PMD claims in accordance with Federal requirements for

face-to-face examinations of beneficiaries. Of the 100 sample claims, 53 claims met the requirements, but 47 did not. On the basis of our sample results, we estimated that, of the \$87.4 million of high-risk claims reviewed, Medicare paid approximately \$35.2 million in 2010 for PMD claims that did not meet Federal requirements. CMS partially concurred with the following recommendations:

- adjust the 47 sample claims representing overpayments of \$115,000 to the extent allowed under the law and
- after implementing the second and third recommendations (listed below), require DME Medicare contractors to match suppliers' PMD claims to physicians' G code claims, which would help these contractors to identify and review suppliers with a large number of high-risk PMD claims and could have saved an estimated \$35.2 million for the 1-year period we reviewed.

Although CMS did not concur, OIG continues to recommend that CMS:

- require physicians to use the G0372 code when prescribing PMDs and
- require Part B Medicare contractors to educate physicians on the use of the G0372 code and the documentation requirements for face-to-face examinations.

Medicare payments, policies, and practices

Critical Access Hospitals – Payment policies

- *Medicare Could Have Saved Billions at Critical Access Hospitals If Swing-Bed Services Were Reimbursed Using the Skilled Nursing Facility Prospective Payment System Rates. A-05-12-00046. 2015 March.*

Swing-bed usage at critical access hospitals (CAHs) significantly increased from CYs 2005 through 2010. Medicare spending for swing-bed services at CAHs steadily increased to, on average, almost four times the cost of similar services at alternative facilities. Medicare could have saved \$4.1 billion over a 6-year period at CAHs if swing-bed services were reimbursed using the skilled nursing facility prospective payment system rate (SNF PPS). CAHs ensure that beneficiaries in rural areas have access to a range of hospital services. CAHs provide “swing-bed” services, which are the equivalent of services performed at a SNF. Medicare reimburses CAHs at 101 percent of their reasonable costs for providing services to beneficiaries rather than at rates set by Medicare’s PPS or Medicare’s fee schedules. Although CMS did not concur, OIG continues to recommend that CMS:

- seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities.

- *Medicare Beneficiaries Paid Nearly Half of the Costs for Outpatient Services at Critical Access Hospitals. OEI-05-12-00085. 2014 October.*

Beneficiaries typically pay more in coinsurance for outpatient services received at CAHs than for outpatient services received at other acute care hospitals. For example, for 10 frequently provided outpatient services at CAHs, beneficiaries paid between two and six times the amount in coinsurance that they would have for the same services at acute-care hospitals. Without a change in how

coinsurance for CAH outpatient services is calculated, beneficiaries will continue to pay more for these services. CMS neither concurred nor nonconcurred with the following recommendation:

- seek legislative authority to modify how coinsurance is calculated for outpatient services received at CAHs.

Hospices

- *Medicare Hospices Have Financial Incentives To Provide Care in Assisted Living Facilities. OEI-02-14-00070. 2015 January.*

Medicare payments for hospice care provided in assisted living facilities (ALFs) more than doubled in 5 years, totaling \$2.1 billion in 2012. Hospices provided care much longer and received much higher Medicare payments for beneficiaries in ALFs than for beneficiaries in other settings. Beneficiaries in ALFs often had diagnoses that usually require less complex care. Hospices typically provided fewer than 5 hours of visits and were paid about \$1,100 per week for each beneficiary receiving routine home care in ALFs. This report raises concerns about hospices' targeting beneficiaries in ALFs because they may offer the hospices the greatest financial gain. CMS concurred with the following recommendations:

- reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays,
- target certain hospices for review,
- develop and adopt claims-based measures of quality,
- make hospice data publicly available for beneficiaries, and
- provide additional information to hospices to educate them about how they compare to their peers.

Provider debt referrals

- *CMS Made Payments Associated With Providers After Referring Individual Providers' Debts to the Department of the Treasury for Collection. A-02-12-01008. 2015 February.*

CMS made Medicare and Medicaid payments associated with 23 of 82 individual physicians with delinquent debts after CMS had referred their Medicare debts to the U.S. Department of the Treasury (Treasury) for collection. The 23 individual physicians, who collectively owed CMS a total of \$8.8 million, were paid a total of \$10.7 million in direct payments and provided services for an entity that received Federal reimbursement. In addition, 13 of the 23 individual physicians whose debts were referred to Treasury had ownership interest in and/or managing control of 15 Medicare Part B entities that received Medicare reimbursement from CMS after CMS referred the individual physicians' debts to Treasury. Although these individual physicians are not precluded from indirectly receiving Medicare Part B payments through an entity, CMS finalized a rule in December 2014 that denies an entity's enrollment due to Medicare debt owed by an owner. CMS is required to seek recovery of all identified overpayments and can recoup or offset overpayments against a provider's future Medicare and/or Federal share of Medicaid payments irrespective of whether the delinquent debts were transferred to Treasury for collection. CMS concurred with the following recommendations:

- ensure that it does not pay individual physicians with delinquent debts after referring their Medicare debts to Treasury for collection, which could have resulted in savings to the Federal Government of \$317,000;
- consider authorizing Treasury to use its administrative wage garnishment authority to collect delinquent debts, totaling \$8.8 million, associated with 21 individual physicians;
- consider the results of our review when developing and evaluating policies that prevent payments to entities claiming reimbursement for services provided by individual physicians who have delinquent debts, which could have resulted in savings to the Federal Government of \$10.4 million; and
- consider promulgating Federal regulations to prevent entities for which individual physicians with delinquent debts that have any ownership interest and/or managing control from enrolling in Medicare.

Part B drugs – Price substitution

- *Comparing Average Sales Prices and Average Manufacturing Prices for Medicare Part B Drugs: An Overview of 2013. OEI-03-14-00520. 2015 February.*

On the basis of mandated pricing comparisons performed by OIG for the year 2013, CMS reduced reimbursement amounts for 15 Medicare Part B drugs, saving Medicare and its beneficiaries an estimated \$13 million over 1 year. According to our estimates, CMS could have saved an additional \$6 million by expanding its price substitution criteria to include Part B drugs with complete average manufacturer price (AMP) data in a single quarter or certain drugs with partial AMP data. Although CMS did not state whether it concurred and stated that more experience with the current price reduction criteria is needed before they can be expanded, OIG continues to recommend that CMS:

- consider pursuing rulemaking to expand the criteria for price reductions.

Medicare quality of care and beneficiary access

National Mail Order Program – Diabetes test strips

- *Medicare Market Shares of Mail Order Diabetes Test Strips 3–6 Months After the Start of the National Mail Order Program. OEI-04-13-00682. 2014 November.*

Suppliers submitted claims for at least 41 types of mail order diabetes test strips for the 3-month period of October to December 2013. Two types of diabetes test strips accounted for 44 percent of the Medicare mail order market share. Three types of diabetes test strips accounted for 58 percent of the Medicare mail order market share, and 10 types accounted for 91 percent. CMS may consider this information to evaluate the effect of the National Mail Order Program on the types of diabetes test strips available to beneficiaries. CMS may also find this information useful in assessing whether bidders have met the Medicare Improvements for Patients and Providers Act requirement for suppliers to demonstrate that their bids cover at least 50 percent, by volume, of all types of mail order diabetes test strips. This report did not contain recommendations.

Compounded drugs

- *Medicare's Oversight of Compounded Pharmaceuticals Used in Hospitals. OEI-01-13-00400. 2015 January.*

Medicare oversight entities (i.e., State survey agencies or CMS-approved hospital accreditors) address most recommended practices related to sterile compounded drugs at least some of the time, but oversight entities may lack the human capital required to thoroughly review hospitals' preparation and use of these drugs. These findings raise concerns whether hospital surveyors are properly equipped to assess this highly technical aspect of hospital operations. CMS concurred with the following recommendations:

- ensure that hospital surveyors receive training on standards from nationally recognized organizations related to safe compounding practices and
- amend the interpretive guidelines to address hospitals' contracts with standalone compounding pharmacies.

Drug compendia – Anticancer drug therapies

- *Drug Compendia Publishers Maintain Transparent Processes for Evaluating Anticancer Drug Therapies and Identifying Potential Conflicts. OEI-07-13-00220. 2014 October.*

Each of the publishers of the four authorized drug compendia complied with Federal laws for maintaining a transparent process for evaluating anticancer drug therapies and identifying potential conflicts of interest. Also, the number and nature of disclosures related to potential conflicts of interest varied across publishers. Insufficient evaluation criteria and conflicts of interest among compendia staff could lead to anticancer drugs' being inappropriately recommended for inclusion in a compendium. This report did not contain recommendations.

Quality Improvement Organizations

- *Quality Improvement Organizations Provide Support to More Than Half of Hospitals but Overlap With Other Programs. OEI-01-12-00650. 2015 January.*

In 2013, over half of hospitals participated with quality improvement organizations (QIOs) on quality improvement projects, but 8 out of 10 participating hospitals also worked with other federally funded entities on the same topics as QIOs. Because CMS is funding these quality improvement efforts at about \$1 billion to work on the same topics, it is crucial to evaluate the relative effectiveness of these efforts and ensure that quality improvement efforts are well-coordinated and nonduplicative. CMS concurred with the following recommendations:

- take additional steps to coordinate, and reduce overlap between, the QIO program and CMS's other quality improvement efforts and
- determine the relative contribution of its quality improvement efforts.

Medicaid payments, policies, and quality

Improper State claims for Federal reimbursement

Questionable billing – Dental services – Indiana

- *Questionable Billing for Medicaid Pediatric Dental Services in Indiana. OEI-02-14-00250. 2014 November.*

Ninety-four general dentists and one oral surgeon in Indiana were identified as having questionable billing. These providers were extreme outliers when compared to their peers, and Medicaid paid these providers \$30.5 million for pediatric dental services in 2012. These findings raise concerns that certain providers may be billing for services that are not medically necessary or were never provided. They also raise concerns about the quality of care provided to children with Medicaid. Prior OIG reports have also found vulnerabilities in the oversight of Medicaid dental providers. The Indiana Family & Social Services Administration concurred with the following recommendations:

- enhance its monitoring of dental providers to identify patterns of questionable billing,
- closely monitor billing by providers in dental chains,
- ensure that dental providers appropriately bill for behavior management and educate providers on the use of behavior management, and
- take appropriate action on the dental providers identified as having questionable billing.

Nonemergency medical transportation program – Texas

- *Texas Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program. A-06-12-00053. 2014 October.*

During FY 2011, Texas claimed at least \$30.4 million for unallowable Medicaid payments for nonemergency medical transportation services (NEMT). Federal regulations require each State to ensure that Medicaid beneficiaries have necessary transportation to and from medical providers. Prior OIG reviews have found that States' claims for NEMT services were not always in accordance with Federal and State requirements. Texas generally concurred with the findings and described actions that it has taken or will take to address the following recommendations:

- refund \$30.4 million to the Federal Government and
- strengthen its policies and procedures to ensure that providers comply with Federal and State requirements.

Targeted Case Management services – Missouri

- *Missouri Claimed Unallowable Medicaid Payments for Targeted Case Management Services Provided to Individuals With Developmental Disabilities. A-07-13-03193. 2014 October.*

Missouri claimed \$11.5 million of unallowable Medicaid payments for Targeted Case Management (TCM) services provided to individuals with developmental disabilities during State FYs 2011 through 2013. Missouri did not specifically address the following recommendations:

- refund \$11.5 million to the Federal Government,
- adjust future payment rates for TCM services and work with CMS to determine the unallowable Medicaid payments, and
- follow the State plan requirements for the calculation of rebased payment rates for TCM services.

Developmental Disabilities Waiver Program – New York

- *New York Claimed Some Unallowable Costs for Services by New York State Providers Under the State's Developmental Disabilities Waiver Program. A-02-10-01044. 2015 January.*

New York claimed Federal Medicaid reimbursement for some Office for People With Developmental Disabilities (OPWDD) waiver program services that did not comply with Federal and State requirements. The State agency improperly claimed an estimated \$76.8 million in Federal Medicaid reimbursement for waiver program services during CYs 2006 through 2008. The OPWDD waiver program is intended to enable adults and children with developmental disabilities to live in the community as an alternative to intermediate care facilities for individuals with intellectual disabilities. This review is part of a series of reviews of New York State's OPWDD Medicaid waiver program. New York generally concurred with the following recommendations:

- refund \$79,000 to the Federal Government,
- work with CMS to determine the additional amount of overpayments for claims in the sampling frame, and
- work with OPWDD to strengthen the agencies' policies and procedures.

Personal care services – New York

- *New York State Improperly Claimed Medicaid Reimbursement for Continuous 24-Hour Personal Care Claims. A-02-12-01004. 2015 March.*
- *New York State Improperly Claimed Medicaid Reimbursement for Continuous 24-Hour Personal Care Claims in Ulster County. A-02-14-01003. 2015 February.*

New York claimed at least \$12 million in Federal Medicaid reimbursement over 5 years for continuous 24-hour personal care services claims that were unallowable for beneficiaries residing outside New York City and Ulster County. New York claimed \$6.3 million over 4 years for unallowable continuous 24-hour

personal care services provided to beneficiaries in Ulster County. New York generally concurred with the following recommendations:

- issue guidance to the local districts related to the requirements for continuous 24-hour personal care services and
- improve its monitoring of local districts and personal care providers to ensure their compliance with Federal and State requirements related to continuous 24-hour personal care services.

Although New York did not indicate concurrence or nonconcurrence with the financial disallowance recommendations, OIG continues to recommend that New York:

- refund \$18.3 million (\$12 million and \$6.3 million, respectively) to the Federal Government.

Disproportionate Share Hospital payments – New Jersey

- *New Jersey Claimed Excessive Medicaid Disproportionate Share Hospital Payments for Five County-Operated Psychiatric Facilities. A-02-13-01035. 2014 November.*

New Jersey claimed Federal Medicaid reimbursement for Disproportionate Share Hospital (DSH) payments totaling almost \$12 million for five county-operated psychiatric facilities that exceeded the facilities' hospital-specific DSH limits. The State agency claimed DSH payments totaling \$23.7 million (\$11.9 million Federal share) that exceeded five county-operated psychiatric facilities' hospital-specific limits. The remaining DSH payments totaling \$247.4 million (\$123.7 million Federal share) were equal to or less than the hospital-specific limits. The overpayments occurred because the State agency had not established procedures for reconciling and adjusting the facilities' expenditures to ensure that DSH payments did not exceed hospital-specific limits. New Jersey explained how it was addressing the following recommendation:

- establish procedures for reconciling and adjusting the county-operated psychiatric facilities' expenditures to ensure that the facilities' DSH payments do not exceed hospital-specific limits.

Although New Jersey did not concur, OIG continues to recommend that New Jersey:

- refund \$11.9 million to the Federal Government.

Medicaid payments, policies, and practices

Supplemental Medicaid rebates

- *Medicaid States' Collection of Offset and Supplemental Medicaid Rebates. OEI-03-12-00520. 2014 December.*

Forty-eight States reported \$2 billion in offset rebates for 2011 and 2012, and 44 States reported collecting \$1.7 billion in supplemental Medicaid rebates. The Affordable Care Act (ACA) increased Federal Medicaid rebates – by an amount referred to as the "offset rebate" – in a way that may affect States' ability to negotiate for supplemental Medicaid rebates from drug manufacturers. The ACA changes to the Federal Medicaid rebate program increased total rebates to the Federal Government, but

the method that most States used to calculate supplemental rebates caused supplemental rebates to decrease with the introduction of offset rebates. Specifically, for 41 States, the supplemental rebates are inverse to the Federal rebate amount: if the Federal rebate increases, the supplemental rebate decreases by an equal amount. CMS concurred with the following recommendations:

- ensure that all States appropriately report offset rebate amounts,
- consider further whether to encourage all States to establish supplemental rebate programs, and
- encourage States to explore alternate methods for calculating supplemental rebates.

Durable medical equipment – Payment policies

- *The New York Medicaid Program Could Significantly Lower Payment Rates for Selected Durable Medical Equipment and Supplies. A-02-13-01042. 2015 February.*

The New York Medicaid program could have saved an estimated \$8.9 million on selected durable medical equipment (DME) items for 2011 and 2012 by obtaining pricing similar to pricing under Medicare's Competitive Bidding Program. Although New York disagreed, OIG continues to recommend that New York:

- establish a competitive bidding program that functions similarly to Medicare's Competitive Bidding Program for the reimbursement of 54 selected DME items, which could have resulted in cost savings of approximately \$8.9 million for the 2-year audit period.

Medicaid quality of care and beneficiary access

Medicaid Managed Care – Access to care

- *Access to Care: Provider Availability in Medicaid Managed Care. OEI-02-13-00670. 2014 December.*

Slightly more than half of providers reviewed could not offer appointments to enrollees. Notably, 35 percent could not be found at the location listed by the plan, and another 8 percent were at the location but were not participating in the plan. An additional 8 percent were not accepting new patients. Among the providers who offered appointments, the median wait time was 2 weeks. However, over a quarter had wait times of more than 1 month. Finally, primary care providers were less likely to offer an appointment than specialists; however, specialists tended to have longer wait times. CMS concurred with the following recommendations to work with States:

- to assess the number of providers offering appointments and improve the accuracy of plan information,
- ensure that plans' networks are adequate and meet the needs of their Medicaid managed care enrollees, and
- ensure that plans are complying with existing State standards and assess whether additional standards are needed.

Children's preventative medical screening services

- *CMS Needs To Do More To Improve Medicaid Children's Utilization of Preventive Screening Services. OEI-05-13-00690. 2014 November.*

CMS has taken actions toward encouraging participation in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings and toward encouraging the delivery of all components of medical screenings, but it had not fully addressed OIG's recommendation made in 2010. Further, children's participation in EPSDT medical screenings remained lower than established goals. Although the national participation ratio improved from 56 percent in 2006 to 63 percent in 2013, both ratios are below the Secretary's goal of 80-percent participation. Given that CMS has not yet fully addressed all OIG recommendations, coupled with evidence that children continue to receive fewer medical screenings than required, CMS must continue to focus on EPSDT screenings. OIG did not issue new recommendations, but considers all four of the recommendations from its previous report open:

- require States to report vision and hearing screenings,
- collaborate with States and providers to develop effective strategies to encourage beneficiary participation in EPSDT screenings,
- collaborate with States and providers to disseminate education and incentives for providers to encourage complete medical screenings, and
- identify and disseminate promising State practices for increasing children's participation in EPSDT screenings and increasing providers' delivery of complete medical screenings.

Antipsychotic drugs – Use among Medicaid-enrolled children

- *Second-Generation Antipsychotic Drug Use Among Medicaid-Enrolled Children: Quality-of-Care Concerns. OEI-07-12-00320. 2015 March.*

In the five States reviewed, medical reviewers identified quality-of-care concerns in the medical records associated with 67 percent of claims for second-generation antipsychotic (SGA) drugs prescribed to children. SGAs are widely used to treat children enrolled in Medicaid who have mental health conditions and can have serious side effects. Quality-of-care concerns identified through medical record reviews corresponded to the following issues: dosage, duration, indications for use, monitoring, polypharmacy (too many drugs), patient age, and side effects. The high percentage of claims for which our reviewers identified quality-of-care concerns indicates that more needs to be done to ensure the quality of care provided to children receiving SGAs paid for by Medicaid. CMS concurred with the following recommendations:

- perform utilization reviews of antipsychotic drugs prescribed to children,
- conduct periodic reviews of medical records associated with claims for antipsychotic drugs prescribed to children, and
- work with States to consider other methods of enhanced oversight of antipsychotic drugs prescribed to children.

<http://oig.hhs.gov>

Legal and investigative activities related to Medicare and Medicaid

For October 1, 2014, to March 31, 2015, we reported 422 criminal and 320 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported over \$1.1 billion in investigative receivables due to the U.S. Department of Health and Human Services (HHS or the Department) and over \$133 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare; Medicaid; and other Federal, State, and private health care programs.

OIG investigates allegations of fraud, waste, and abuse in all of the Department's programs. Our largest body of work involves investigating matters related to the Medicare and Medicaid programs, such as patient harm; billing for services not rendered, medically unnecessary services, or services more extensive than those actually provided; illegal billing, sale, diversion, and off-label marketing of prescription drugs; and solicitation and receipt of kickbacks, including illegal payments to patients for involvement in fraud schemes and illegal referral arrangements between physicians and medical companies.

Specific case types include fraud schemes related to:

- controlled and noncontrolled prescription drugs,
- home health agencies and personal care services,
- ambulance transportation,
- DME, and
- diagnostic radiology and laboratory testing.

OIG also conducts investigations involving organized criminal activity, including medical identity theft and fraudulent medical schemes established for the sole purpose of stealing Medicare dollars. Investigators are seeing an increase in individuals, including both health care providers and patients, engaging in these health care fraud schemes. Those who participate in these schemes may face heavy fines, jail time, and exclusion from participating in Federal health care programs.

In addition to investigating Medicare and Medicaid fraud, OIG investigates fraud, waste, and abuse in other HHS programs, including the Indian Health Service, the Administration for Children and Families (ACF), the Health Resources and Services Administration (HRSA), and the Administration for Community Living. OIG also investigates potential misuse of grants and contracts funds awarded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration, and other HHS agencies. Under certain circumstances, OIG investigates noncustodial parents who fail to pay court-ordered child support. Additionally, OIG investigates allegations of employee misconduct, whistleblower reprisals, and wrongdoing by HHS agency officials.

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, when appropriate, under the False Claims Act (FCA). Depending

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

For all OIG investigations, the charges contained in an indictment or other charging document are merely accusations and a defendant is presumed innocent unless and until proven guilty.

Health care fraud prevention and enforcement

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

HEAT provider compliance training

OIG provides free training on our Web site for health care providers, compliance professionals, and attorneys. OIG's Provider Compliance Training was an initiative developed as part of HEAT in 2011 that continues to reach the health care community with OIG's message of compliance and prevention via free, downloadable, comprehensive training materials and podcasts. OIG's provider compliance training resources can be accessed at http://oig.hhs.gov/newsroom/video/2011/heat_modules.asp.

Medicare Fraud Strike Force activities

Medicare Fraud Strike Force teams began in 2007 in an effort to combine the resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. These teams are partnerships between OIG and HHS, DOJ, U.S. Attorneys' Offices, the Federal Bureau of Investigation (FBI), and State and local law enforcement with a common goal: to successfully analyze health care fraud data and investigative intelligence to quickly identify fraud and bring prosecutions. Strike Force teams currently operate in nine areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas.

From October 1, 2014, to March 31, 2015, Strike Force efforts resulted in the filing of charges against 69 individuals or entities, 124 criminal actions, and over \$163 million in investigative receivables.

Strike Force examples

Miami Strike Force – Eleven defendants were charged with conspiracy to commit health care fraud and wire fraud, health care fraud, conspiracy to defraud the United States and make false statements related to health care matters, and making false statements related to health care matters. According to the indictment, the defendants allegedly were part of a scheme to recruit individuals residing in Nicaragua

and the Dominican Republic to enroll in Medicare Advantage plans and Florida Medicaid, even though they were not entitled to Medicare or Medicaid coverage. To perpetrate this fraud, the defendants allegedly submitted enrollment applications to Medicare Advantage plans and Medicaid, using nonresidential addresses, addresses belonging to the relatives and friends of these foreign residents, and addresses associated with the defendants, to falsely represent that the foreign residents lived in Florida. As a result of the fraudulent enrollment applications, the defendants received approximately \$25 million from Medicare and Medicaid on behalf of the purported beneficiaries, who were not eligible to enroll and did not reside in the service plan area. Nine defendants are currently in custody and are awaiting trial, while two defendants remain at large.

Southern Louisiana Strike Force – Roslyn Dogan was sentenced to 7½ years in prison and ordered to pay \$43.5 million in joint and several restitution after being convicted by a jury on charges of conspiracy to commit health care fraud and health care fraud. James Hunter was sentenced to 5 years in prison and ordered to pay \$3.2 million in joint and several restitution after being convicted by a jury of conspiracy to commit health care fraud and conspiracy to pay and receive health care kickbacks. Dogan co-owned and managed Serenity Center, LLC (Serenity), and served as a manager and marketer for Psychcare of Louisiana, LLC, d/b/a Shifa Community Mental Health Center (Shifa). The investigation revealed that Dogan and co-conspirators recruited Medicare beneficiaries to attend programs at Serenity and Shifa, even though the beneficiaries did not qualify for services, the services were not medically necessary, or the services were not provided. Hunter and others were paid cash kickbacks to recruit Medicare beneficiaries to receive partial hospitalization program services at Shifa Community Mental Health Center (CMHC) of Texas, LLC. However, these services were not medically necessary and were not provided. Co-conspirators also falsified notes for patients, making it appear as if they either evaluated patients for admission or provided educational psychotherapy and/or recreational psychotherapy to patients when, in fact, the patients were already receiving inpatient treatment at various hospitals. The three CMHCs billed Medicare more than \$258 million for these fraudulent services. In addition to Dogan and Hunter, 15 defendants have been convicted in connection with this scheme.

Miami Strike Force – Julio Armando Brunet was sentenced to 10 years and 1 month in prison and ordered to pay \$18.6 million in restitution after pleading guilty to conspiracy to commit health care fraud and payment of kickbacks in connection with a Federal health care program. Brunet was the director of Nightingale Home Health Care of Miami, and he controlled Visual Care and Supplies, Inc., two Miami-based businesses that purportedly provided home health services to Medicare beneficiaries. The investigation found that Brunet paid co-conspirators thousands of dollars in kickbacks in exchange for referring Medicare beneficiaries to be placed at Visual Care and Nightingale. Brunet also paid kickbacks to the owner of a medical clinic in exchange for home health services prescriptions. Brunet and his co-conspirators then billed Medicare millions of dollars for home health services that were not medically necessary.

Dallas Strike Force – Nicolas Padron was sentenced to 7 years and 3 months of incarceration and ordered to forfeit his house, cars, boat, and funds from several bank accounts after pleading guilty to conspiracy to unlawfully distribute controlled substances. Padron operated Padron Wellness Clinic, a family practice and weight loss management clinic based in Dallas, Texas. The investigation revealed that Padron Wellness Clinic operated as a pill mill, where “dealers” recruited and drove “patients” in groups to the clinic to obtain prescriptions for hydrocodone and Xanax. Padron prescribed these medically unnecessary drugs with little or no medical examination and generally charged a cash fee of \$250 for a new patient and \$185 for an established patient. The dealers then drove the patients to a local pharmacy to fill the prescriptions. Once the prescriptions were filled, the patients gave the drugs to the

dealers, who sold them on the street for a profit. Office manager Jose Martinez and dealers Joesephis Austin, Patricia Bryant, and Dennis Wade were also sentenced during this reporting period to more than 18 years in prison, combined. In a separate, unrelated health care fraud case, Padron was sentenced for his role as the medical director of A Medical House Calls, a physician house-call company that falsely billed Medicare for care plan oversight that was not provided.

Miami Strike Force – Yanira Sotolongo was sentenced to 4 years in prison and ordered to pay \$6.4 million in restitution after pleading guilty to conspiracy to pay health care kickbacks and payment of kickbacks in connection with a Federal health care program. Sotolongo was a registered agent for both RR Healthcare and Associates, LLC, and Interim Healthcare of South Florida, Inc., two businesses that purportedly provided skilled nursing services, physical therapy, occupational therapy, and home health aide services to Medicare beneficiaries. According to the investigation, Sotolongo paid thousands of dollars in cash and checks to co-conspirator patient recruiters in return for referring Medicare beneficiaries to her businesses, as well as another home health agency, Viva Healthcare, Inc. Sotolongo and her co-conspirators then used the beneficiary information as a basis to submit false claims to Medicare for home health services purportedly provided to the recruited beneficiaries.

Other criminal and civil enforcement activities

Special Assistant U.S. Attorney Program

During this reporting period, DOJ and OIG continued their participation in a program in which OIG attorneys, some of whom are Special Agents, serve as Special Assistant U.S. Attorneys. OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, including assignments to the Medicare Fraud Strike Force. Other attorneys prosecute matters on a case-by-case basis. Both arrangements offer excellent litigation training for OIG attorneys and enhance collaboration between the Departments in their efforts to fight fraud. Under this program, OIG attorneys have successfully litigated important criminal cases relating to the fraudulent billing of medical equipment and supplies, infusion therapy, and physical therapy, as well as other types of Medicare and Medicaid fraud. Related case examples follow.

California – Gabriel Ejizu pleaded guilty to conspiracy to commit health care fraud and is awaiting sentencing. He faces up to 10 years in jail, up to a \$250,000 fine, and payment of restitution. The investigation revealed that Ejizu created South Bay Medical Supply, a DME company that purportedly provided power wheelchairs and other equipment to Medicare beneficiaries. Ejizu and his co-conspirators recruited Medicare beneficiaries to receive power mobility devices, hospital beds, or reclining chairs in exchange for their Medicare numbers. The beneficiaries often did not see a physician, but rather Ejizu and his co-conspirators fabricated documents and obtained false prescriptions in order to bill Medicare for DME, even though the DME was not always provided to the beneficiaries and was not medically necessary. South Bay also billed for power wheelchairs when, in actuality, they provided beneficiaries with reclining chairs, a type of DME for which Medicare does not reimburse. This case was prosecuted by a Special Assistant U.S. Attorney in the District of North Dakota under a collaborative program by OIG and DOJ that brings cases from multiple jurisdictions to a dedicated health care fraud prosecutor, who is located in the same district as one of the MACs.

Most wanted fugitives listed on OIG's Web site

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

In November 2014, OIG Most Wanted Fugitive Luis Marin was captured in Florida by Miami-Dade Police. Marin was indicted in August 2014 on charges of conspiracy to commit health care fraud and wire fraud, health care fraud, conspiracy to commit money laundering, and money laundering. Marin was president of DD Quality Services Corp. in Sunny Isles, Florida, a company that purportedly provided physical therapy to Medicare beneficiaries. According to court records, Marin was allegedly involved in a scheme in which patient recruiters were paid kickbacks in exchange for referring Medicare beneficiaries to two purported home health companies in Florida: Sacred Health, Inc., and Marcial HealthCare Corp. Marin and his co-conspirators allegedly falsified records to document the purported receipt of home health services from home health companies that, in reality, were not provided and were not medically necessary. The false documents were then used to bill Medicare more than \$16 million.

Because of the success of OIG's Most Wanted Fugitives Web site, OIG launched its Most Wanted Deadbeat Parents Web site at: <https://oig.hhs.gov/fraud/child-support-enforcement/index.asp>. The site identifies parents who fail to pay court-ordered child support for their children; as a result, an unnecessary strain is placed on the custodial parents and the children, as well as on agencies that enforce these matters. Examples are provided in the "Human Services Reviews" section of this Semiannual Report.

OIG Hotline Operations

The mission of OIG Hotline Operations is to assist OIG in protecting the integrity of all HHS programs and agencies. Strategically placed within the Office of Investigations (OI), OIG Hotline Operations serves as the "public face" of OIG through analysis and processing of complaints and information received through various available hotlines and numbers, including, but not limited to: OIG's Fraud, Waste and Abuse Hotline; OIG's Fugitive Hotline; and the CDC's Select Agent and Import Permit Hotlines. Constantly working to improve outcomes and results, OIG Hotline Operations uses state-of-the-art approaches and current technology to best address all matters received.

OIG Hotline Activity

Contacts Received: FY 2015

Total Calls Received: 67,014

(Total Operator Assisted Calls: 12,339)

Total Non-Call Matters Received: 6,904

<i>Total Contacts</i> ¹ :	74,018
Total Complaints Evaluated:	13,495

Recently completed actions and settlements

Prescription drug diversion

Maryland – Duvine Price was sentenced to 8 years and 4 months of incarceration after pleading guilty to conspiracy to distribute and possession with intent to distribute oxycodone. The investigation revealed that Price obtained fraudulent prescriptions for oxycodone from a secretary who was stealing prescriptions from the doctor’s office where she worked. The prescriptions were filled out in the names of Medicare beneficiaries and other defendants, including Price. Price then either filled the prescriptions himself and billed Medicare or had them filled by other individuals and sold the oxycodone pills for around \$10 per pill on the street. At least 487,000 milligrams of oxycodone were distributed during this scheme. In addition to receiving a sentence, Price was ordered to forfeit two cars and currency. Eight other defendants previously pleaded guilty to charges in connection with this scheme and were sentenced to a combined 29½ years in jail.

Florida – Carlos Perez-Gomez and Jesus Fundora were sentenced to a combined 17 years and 1 month in jail and ordered to pay \$6.2 million in joint and several restitution after pleading guilty to conspiracy to commit health care fraud. Perez-Gomez and Fundora operated Kiara Discount Pharmacy Corp., a Miami-based retail pharmacy. The investigation revealed that co-conspirators recruited and paid Medicare beneficiaries to obtain prescriptions, including prescriptions for expensive antipsychotic and skin treatment pharmaceutical drugs, that the co-conspirators subsequently furnished to Perez-Gomez and Fundora. Perez-Gomez and Fundora then used the fraudulent prescriptions to bill the Medicare Part D program, falsely representing that the drugs were medically necessary, were prescribed by a doctor, and were provided by Kiara Pharmacy to the beneficiaries. As a result of this scheme, Perez-Gomez and Fundora received approximately \$6.2 million in Medicare payments to which they were not entitled.

Kentucky – Smbat Muradyan was sentenced to 2 years and 3 months in jail and ordered to pay \$75,837 in restitution after pleading guilty to health care fraud. The investigation revealed that Muradyan was involved in a scheme to submit false claims for prescription drugs purportedly provided to Medicare beneficiaries. The prescriptions were for expensive, noncontrolled medications for asthma, stroke, and other ailments. Muradyan and his co-conspirators forged the underlying prescriptions using the names and unique electronic identification numbers of California physicians who had not authorized the prescriptions. The patients whose names were used to fill the prescriptions also were unaware of these transactions.

Patient harm

Wisconsin – In the largest failure-of-care settlement with a nationwide SNF, Extendicare Health Services, Inc., and its subsidiary, Progressive Step Corporation (ProStep), agreed to pay \$38 million to resolve

¹ A contact is the total number of instances when a person contacts OIG Hotline Operations, regardless of the nature of the contact, and receives service through automated or manual means.

allegations that Extendicare billed Medicare and Medicaid for materially substandard and/or worthless skilled nursing services and billed Medicare for medically unreasonable and unnecessary rehabilitation therapy services. Extendicare operates 146 SNFs in 11 States and, through ProStep, provides physical, occupational, and speech therapy to Medicare and Medicaid beneficiaries. Extendicare allegedly provided inadequate care to residents at 33 of its SNFs, including having an insufficient number and skill level of nursing staff to properly care for residents, failing to provide adequate catheter care to some residents, failing to follow appropriate pressure ulcer and falls protocols, failing to appropriately provide for some residents' activities of daily living, and failing to appropriately administer medications to some residents. As a result of the inadequate care, the United States alleged that patients suffered fractures, head injuries, malnutrition, dehydration, pressure ulcers, infections, and amputation of limbs. In addition to being required to pay the settlement amount, Extendicare agreed to enter into a 5-year quality-of-care corporate integrity agreement (CIA) with OIG that includes, among other things, enhanced provisions to ensure the quality, quantity, and composition of nursing staff necessary to meet resident needs at all Extendicare facilities.

New York – Cardiologist Rohan Wijetilaka was sentenced to 3 years in prison and ordered to pay \$2 million in restitution and forfeiture after pleading guilty to a charge of health care fraud. Wijetilaka maintained a cardiology practice in Westchester County, New York. According to the investigation, Wijetilaka lured new patients and maintained existing patients by offering them narcotics prescriptions in exchange for those patients' undergoing unnecessary diagnostic tests and other medical procedures. Wijetilaka then billed Medicare, Medicaid, and private insurance carriers millions of dollars for these fraudulent claims. Investigators believe that Wijetilaka performed cardiac procedures that served no legitimate medical purpose, billed for office visits that did not occur, and falsified patients' symptoms to justify costly and unnecessary diagnostic tests.

Quality of care

Pennsylvania – Tianna Edwards was sentenced to 5 years and 3 months in jail and ordered to pay \$1.4 million in restitution after pleading guilty to charges of wire fraud. Edwards controlled and operated two daycare facilities in Pennsylvania called Tianna's Terrific Tots, despite the fact that she had a criminal record that should have precluded her from obtaining a license to operate a daycare facility in Pennsylvania. Some of the children who were enrolled in Tianna's Terrific Tots were eligible for Medicaid benefits. Pennsylvania's Department of Public Welfare (DPW), which administers the Medicaid program, provides childcare subsidy payments for operators of privately owned and operated child daycare centers to provide child daycare services on behalf of eligible parents. To circumvent the DPW's criminal history clearance requirements for a license, Edwards submitted applications, renewal applications, and other falsified records containing the forged signatures of another individual. As a result of this scheme, Edwards billed and received more than \$1.4 million in fraudulent payments from DPW. Records showed that Edwards spent hundreds of hours at a casino, where she gambled more than \$1.5 million. In April 2012, DPW closed one of Edwards's facilities because of conditions constituting "gross incompetence, negligence and misconduct in operating a facility" and "likely to constitute immediate and serious danger to the life and health of children in care." In June 2012, a child enrolled in one of Edwards's facilities drowned in a crowded and dirty backyard pool at the home of Edwards's mother. Edwards was not onsite at the time of the drowning. Shortly thereafter, DPW closed the second facility. In addition to being sentenced on wire fraud charges, Edwards pleaded guilty to involuntary manslaughter charges related to the child's death and is scheduled to be sentenced in the spring of 2015.

Detroit – Oncologist Farid Fata pleaded guilty to charges of health care fraud, conspiracy to pay or receive kickbacks, and money laundering. He faces a statutory maximum of 175 years in prison. Dr. Fata owned and operated the cancer treatment clinic Michigan Hematology Oncology, P.C., which had several locations in Michigan. Fata admitted that he prescribed and administered aggressive chemotherapy, cancer treatments, intravenous iron, and other infusion therapies to patients who did not need these therapies, in order to increase his billings to Medicare and other insurance companies. He then submitted fraudulent claims to Medicare and other insurers for these unnecessary treatments. In total, approximately \$225 million in claims was submitted by Fata, of which he received more than \$91 million in reimbursement. In addition, Fata also admitted to soliciting kickbacks from Guardian Angel Hospice and Guardian Angel Home Health Care in exchange for his referral of patients to those facilities.

Home health care

Florida – Elsa Ruiz was sentenced to 6 years and 8 months of incarceration and ordered to pay \$45 million in restitution after pleading guilty to conspiracy to commit health care fraud. Ruiz was an administrator at LTC Professional Consultants, Inc. (LTC), and an owner and operator of Professional Home Care Solutions, Inc. (PHCS). Both businesses purportedly provided home health care and physical therapy services to Medicare beneficiaries. The investigation revealed that Ruiz and her co-conspirators paid kickbacks to patient recruiters for the referral of patients and for the provision of prescriptions, plans of care, and certifications for therapy and home health services. These services either were not medically necessary or were not actually provided. LTC and PHCS submitted approximately \$74 million in fraudulent claims for home health services to Medicare and were paid approximately \$45 million on those claims. Myriam Acevedo, an administrator at LTC who was involved in the scheme, was previously sentenced to 5 years in prison and ordered to pay \$27 million in restitution.

Electronic health records

Texas – Joe White pleaded guilty to making a false statement and is awaiting sentencing. He could face up to 5 years in prison, up to a \$250,000 fine, and payment of restitution. White was the Chief Financial Officer at Shelby Regional Medical Center, where he was responsible for overseeing the implementation of electronic health records (EHRs) for the hospital and attesting that the hospital's EHR platform met meaningful use requirements in order to qualify for incentive payments under Medicare's EHR Incentive Program. The investigation revealed that, during FY 2012, Shelby Regional did not meaningfully use the EHR platform. Instead, with White's knowledge, the hospital staff only minimally used the EHR platform and continued using paper records and charts as well as older, uncertified technology. In an effort to meet the required thresholds for meaningful use and obtain EHR incentive payments from CMS, White directed others to manually input data from paper records and other sources into Shelby Regional's EHR system, oftentimes many months after the patients were discharged from the hospital. White also created a user ID for a hospital representative, without the representative's knowledge or approval, and used that ID to falsely attest to CMS that the information provided about its EHR usage was true, accurate, and complete. White falsely certified to CMS that Shelby Regional met the meaningful use requirements, even though he was fully aware that Shelby Regional used the EHR system sparingly and did not meet the criteria for incentives. As a result of White's conduct, Shelby Regional received a \$785,655 EHR incentive payment from CMS in FY 2012. Dr. Tariq Mahmood, who owned and controlled six Texas hospitals, including Shelby Regional, was sentenced to 11 years and 3 months in prison after being convicted on charges of conspiracy to commit health care fraud, health care fraud, and aggravated identity theft. The investigation revealed that Dr. Mahmood and his co-conspirators instructed hospital

personnel to improperly assign principal diagnostic codes that were not accurate representations of the actual diagnoses and conditions of the patients, none of which he ever saw. He and his co-conspirators then caused false claims to be submitted to Medicare and Medicaid by representing that certain principal diagnoses were accurate and were more severe than they actually were.

Pharmaceutical companies

Massachusetts – Pharmaceutical company Daiichi Sankyo, Inc., agreed to pay \$39 million to resolve allegations that it violated the FCA. Daiichi allegedly caused the submission of false claims for its prescription drugs, including Azor, Benicar, Tribenzor, and Welchol, by paying kickbacks to physicians in order to induce them to prescribe the drugs. The Government alleged that the kickbacks took the form of honoraria payments, lavish meals, and other remuneration to physicians who participated, or supposedly participated, in Physician Opinion & Discussion programs and other speaker programs. Daiichi allegedly made payments to physicians even when the physician participants took turns “speaking” on duplicative topics over Daiichi-paid dinners or when they spoke only to members of their own staffs in their own offices. As part of the settlement, Daiichi agreed to enter into a 5-year CIA with OIG that includes undertaking substantial internal compliance reforms, in particular concerning the company’s arrangements with physicians.

Clinics

Colorado – In the largest kickback-only settlement to date, DaVita HealthCare Partners, Inc., agreed to pay \$350 million to resolve allegations that the company paid remuneration to nephrologists (physicians who specialize in kidney care) in return for referrals of beneficiaries in need of dialysis treatment. DaVita operates or provides administrative services to more than 2,000 outpatient dialysis centers in 44 States and the District of Columbia, serving approximately 163,000 patients. DaVita allegedly provided nephrologists and nephrology practices with exclusive opportunities to buy minority interests in DaVita-owned dialysis clinics at unreasonably favorable rates. In certain paired transactions, the nephrologists or nephrology practices could sell to DaVita a majority interest in clinics they owned, again at an unreasonably favorable rate. These joint venture opportunities were allegedly given to nephrologists to induce them to refer patients to DaVita’s dialysis centers, in order to maintain and increase DaVita’s market share of dialysis patients. In addition to agreeing to pay the settlement amount, DaVita entered into a 5-year CIA with OIG, which includes hiring an independent monitor chosen by OIG to oversee DaVita’s unwinding of the joint ventures that formed the basis for the covered conduct and prospectively review future arrangements between DaVita and nephrologists and other health care providers.

Personal care services

Alaska – Good Faith Services, LLC, pleaded guilty to a charge of medical assistance fraud and, as part of its plea agreement, will pay \$1.2 million in restitution and a \$300,000 fine. Good Faith purportedly provided personal care services, including transportation to and from medical appointments, to Medicaid beneficiaries. Since July 2013, the State of Alaska has filed criminal charges against 53 defendants associated with Good Faith, including 10 employees who billed Medicaid nearly \$400,000 for services they claimed to be providing to beneficiaries while they were actually working in the office. The investigation further revealed that Good Faith billed Medicaid more than \$1 million for services provided by personal care attendants who, at the time, had not received valid background checks, in violation of State regulations. As part of its plea agreement, Good Faith agreed to be permanently dissolved and will

no longer provide services to Medicaid recipients. To date, 35 defendants have pleaded guilty to charges related to this scheme and have been sentenced to a combined 10 years and 9 months of incarceration and 87 years and 8 months of home detention. The defendants were ordered to pay a combined \$435,442 in restitution and fines. This was a joint investigation with the Alaska Medicaid Fraud Control Unit (MFCU or Unit), the Alaska Department of Health and Human Services, the FBI, and U.S. Immigration and Customs Enforcement.

Vermont – Magen Hill was sentenced to 18 to 36 months in jail, all suspended, and placed on 1½ years of probation after being convicted on charges of false pretenses. She was also ordered to pay \$4,485 in restitution and a \$423 fine. Hill was hired to care for a beneficiary under the Developmental Disability Services program, which is part of the Vermont Medicaid program. However, the investigation revealed that Hill did not provide any hands-on personal care, did not work the total hours stated on her timesheets, and was not present at the beneficiary’s residence during the times stated on her timesheets. Despite the fact that she did not provide adequate care for the beneficiary and did not work the hours stated, Hill falsified more than a dozen timesheets as a personal care services worker and used them to obtain reimbursement from the Vermont Medicaid program. Hill admitted to investigators that she often split her Medicaid reimbursement checks with the beneficiary’s wife.

Illinois – Marlene Liss was sentenced to 5 years of probation, 6 months to be served in home confinement, and ordered to pay \$32,790 in restitution and a \$100 assessment after pleading guilty to health care fraud. According to the investigation, Liss served as a personal assistant to a beneficiary who was also one of her relatives. In that capacity, Liss purportedly assisted in such tasks as shopping, personal care, incidental health care, and monitoring to ensure the health and safety of the beneficiary. Liss submitted timesheets to the Illinois Department of Human Services falsely certifying that she had worked 5 hours per day, 7 days per week as a personal assistant. However, during this time, she was already employed full-time at the Illinois Office of the Secretary of State.

Hospice care

Mississippi – Regina Swims-King was sentenced to 5 years and 10 months of incarceration and ordered to pay \$7.9 million in restitution after pleading guilty to conspiracy to commit health care fraud. Swims-King owned and operated Angelic Hospice and Palliative Care Services (Angelic), located in Greenwood, Mississippi. The investigation revealed that, from around March 2010 to February 2013, Swims-King and her co-conspirators used Angelic to submit millions of dollars in fraudulent claims to Medicare, for which they were reimbursed more than \$12.5 million. These false billings included claims for patients who were not eligible for hospice benefits because they were not terminally ill and claims based on medical records containing forged signatures of the beneficiaries, the hospice medical director, and/or the beneficiaries’ attending physician. The investigation also revealed that Swims-King, through Angelic, submitted claims to Medicare based on patient referrals from physicians who, in actuality, had never referred patients to Angelic. Many of the patient names were obtained from a medical records clerk, who has been separately charged for accepting over \$240,000 in kickbacks from Swims-King. Swims-King used the funds obtained from Medicare to purchase more than \$1.4 million in vehicles and property.

Laboratories

Georgia – Rahsaan Jackson Garth was sentenced to 3 years and 10 months of incarceration and ordered to pay \$246,536 in restitution after pleading guilty to health care fraud. Garth owned and operated Polaris Allergy Labs, Inc., a laboratory that purportedly administered allergy skin tests (also known as “scratch” tests) and blood tests when ordered by a patient’s doctor. The investigation revealed that, from approximately September 2012 through February 2014, Garth falsely billed Medicare, Medicaid, TRICARE, and private insurers for blood sample allergy testing that Polaris had not actually performed. Garth directed his laboratory technician not to test some of the blood samples for allergens, in an effort to save money by not using the allergen reagents necessary for testing. Instead, Garth instructed the laboratory technician to create blank test result report templates, which Garth filled in with false allergy test result numbers and then discarded the patient’s blood without ever testing it. Garth then sent the false results to the allergy patients’ physicians and billed Federal and private health care programs for the testing that had never occurred. In addition to submitting false negatives to the patients’ physicians and in an effort to further conceal the fraud, Garth also created results indicating that patients had a positive allergic reaction to a substance, even though the blood samples had never been tested.

Durable medical equipment

New Jersey – OtisMed Corp. was ordered to pay \$34.4 million in fines and \$5.1 million in forfeiture after pleading guilty to distributing, with the intent to defraud and mislead, adulterated medical devices into interstate commerce in violation of the Food, Drug, and Cosmetic Act. Between 2006 and 2009, Charlie Chi was the Chief Executive Officer of OtisMed, a biotechnology company that manufactured, marketed, and sold a total knee replacement device known as the OtisKnee. OtisMed submitted a premarket notification to the Food and Drug Administration (FDA) seeking clearance to market the OtisKnee in October 2008. Prior to that time, the company had not sought FDA’s clearance or approval and had been falsely representing to physicians and other potential purchasers that the OtisKnee was exempt from such premarket requirements. In September 2009, FDA sent OtisMed a notice that its submission was denied, stating that the company failed to demonstrate that the OtisKnee was as safe and effective as other legally marketed devices. Despite his awareness of the letter and advice from legal counsel that it would be unlawful to continue distributing the OtisKnee, Chi ordered employees at OtisMed to distribute more than 200 OtisKnee devices to surgeons throughout the United States. Chi and others at OtisMed then took steps to conceal the shipments from FDA, and neither Chi nor any other OtisMed employee informed the surgeons that commercial distribution of the OtisKnee device was prohibited. Chi pleaded guilty to introducing adulterated medical devices in interstate commerce. He is scheduled to be sentenced in the spring of 2015 and could face up to 3 years in prison. Apart from making the criminal plea, OtisMed agreed to pay a \$41.2 million settlement to resolve its civil FCA liability arising from the marketing and distribution of the OtisKnee and to be excluded from participation in Medicare, Medicaid, and all other Federal health care programs for 20 years.

California – Maritza Velazquez was sentenced to 1 year and 3 months in prison and ordered to pay \$3.4 million in restitution after pleading guilty to conspiracy to commit health care fraud. Velazquez was an office manager at Lutemi Medical Supply, Inc., a DME company in Carson, California. While working at Lutemi, Velazquez also operated Betty’s Billing Service, a medical billing business. The investigation revealed that Velazquez and her co-conspirators paid cash and checks to marketers to recruit Medicare beneficiaries who purportedly needed power wheelchairs and other DME. However, these products were medically unnecessary. Velazquez and her co-conspirators also paid kickbacks to physicians and

medical clinics in exchange for writing false prescriptions and documents for the power wheelchairs and other DME. The fraudulent information was then used to bill millions to Medicare for DME that was medically unnecessary.

Community mental health centers

Florida – Rodolfo Santaya was sentenced to 12½ years in prison and ordered to pay \$18.2 million in joint and several restitution after being convicted by a jury on charges of conspiracy to commit health care fraud and wire fraud, conspiracy to pay and receive bribes and kickbacks in connection with a Federal health care benefit program, and receipt of bribes and kickbacks in connection with a Federal health care benefit program. American Therapeutic Corporation (ATC) operated several purported partial hospitalization programs (PHPs) throughout Florida. Evidence at trial demonstrated that Santaya, who was a certified nursing assistant, received thousands of dollars a month in cash kickbacks in exchange for referring Medicare patients to ATC. The evidence also demonstrated that the beneficiaries Santaya sent to ATC did not need, qualify for, or receive PHP treatment. Nevertheless, ATC submitted false claims to Medicare for PHP services purportedly provided to each of these patients. To justify ATC's fraudulent billings, physicians and other medical professionals fabricated and signed fraudulent medical documentation and patient files. To date, 30 defendants, including the owners of ATC, have previously pleaded guilty or been convicted at trial on charges related to the ATC scheme, which resulted in more than \$200 million in fraudulent Medicare billings.

Texas – Physicians Mansour Sanjar and Cyrus Sajadi were sentenced to a combined 22 years and 4 months in prison and ordered to pay a combined \$8 million in restitution after being convicted by a jury on charges of conspiracy to commit health care fraud and conspiracy to pay and receive kickbacks, as well as related counts of health care fraud and paying illegal kickbacks. Sanjar and Sajadi owned Spectrum Care P.A., a community mental health clinic that purportedly provided PHP services to Medicare beneficiaries. Evidence at trial showed that Sanjar and Sajadi paid kickbacks to group care home operators and patient recruiters in exchange for bringing ineligible Medicare beneficiaries to Spectrum. Sanjar and Sajadi then signed admission documents and progress notes certifying that the beneficiaries qualified for PHP services when, in fact, they did not qualify for or need these services and/or the actual services were not performed. Specifically, Sanjar and Sajadi billed for PHP services when the beneficiaries were actually watching movies, coloring, or playing games. Spectrum billed Medicare approximately \$97 million for these fraudulent services. One of the group home owners, Chandra Nunn, was sentenced to 4½ years in prison and ordered to pay \$1.8 million in restitution.

Pharmacies

California – Rite Aid Corporation agreed to pay \$2.9 million to resolve allegations that it violated the FCA and the anti-kickback statute. Rite Aid is a drug store chain with over 4,500 stores in 31 States and the District of Columbia. The Government alleged that, between May 2008 and October 2010, Rite Aid offered and provided improper inducements to beneficiaries of Government programs in order to encourage them to transfer their prescriptions to Rite Aid pharmacies. These inducements took the form of gift cards, gift checks, and similar promotions.

Transportation fraud

Pennsylvania – Feda Kuran was sentenced to 5 years and 4 months of incarceration and was ordered to pay more than \$2 million in restitution after pleading guilty to health care fraud and anti-kickback statute charges. Kuran co-owned Brotherly Love Ambulance, Inc., which operated four different ambulances and a minivan. The investigation revealed that, from July 2010 to October 2011, Kuran and her co-conspirators transported by ambulance patients who could walk; transported patients in personally owned vehicles, but billed as if the patients were transported by ambulance; used patient information to bill as if the patients had been transported by ambulance when, in fact, the patients had actually transported themselves; and paid patients to be transported by Brotherly Love. The majority of Brotherly Love’s clients were dialysis patients who attended dialysis treatments 3 times per week, thereby enabling Brotherly Love to bill extensively for these patients. Kuran and employees at Brotherly Love submitted and caused the submission of more than \$2 million in false claims to Medicare for medically unnecessary ambulance services, services that were not provided, or services that were not permitted because they were induced by illegal remuneration.

Hospitals

California – Dignity Health, formerly known as Catholic Healthcare West, agreed to pay \$36.7 million to resolve allegations under the FCA. Dignity Health is a nonprofit health system representing the largest hospital provider in California and the fifth largest health system in the country. The settlement agreement resolves allegations that Dignity Health knowingly submitted, or caused to be submitted, false claims for reimbursement of: (1) inpatient admissions following certain interventional cardiovascular procedures billed to Medicare and TRICARE that should have been performed on an outpatient basis, (2) inpatient admissions related to certain medical diagnoses and procedures billed to Medicare and TRICARE that should have been billed as outpatient or observation services, and (3) inpatient admissions for kyphoplasty procedures billed to Medicare that should have been billed as outpatient services. Dignity Health also entered into a 5-year CIA with OIG that requires the provider to, among other things, retain an independent review organization to review paid claims annually, as determined by OIG in its sole discretion, and review inpatient admissions for medical necessity and appropriateness.

Alabama – Infirmary Health System, Inc. (IHS), and Diagnostic Physicians Group, P.C. (DPG), agreed to pay \$24.5 million to resolve allegations that they violated the FCA by paying or receiving financial inducements in connection with claims to the Medicare program. The Government alleged that two IHS-affiliated clinics entered into agreements with DPG to pay the group a percentage of Medicare payments for tests and procedures referred by DPG physicians, in violation of the Physician Self-Referral Law and the Anti-Kickback Statute. In addition to entering into the settlement agreement, IHS entered into a 5-year CIA with OIG that requires retaining a legal independent review organization to review its arrangements with physicians and other referral sources.

Employee misconduct

Nebraska – Timothy DeFoggi was sentenced to 25 years in prison, followed by lifetime supervision, and ordered to register as a sex offender for the remainder of his life after being convicted on charges of child exploitation enterprise and access with intent to view child pornography. DeFoggi was the acting director of cyber security at HHS. The investigation revealed that DeFoggi was a registered member of a

Tor, an anonymous network-based child pornography Website. Through the site, DeFoggi accessed child pornography; solicited child pornography from other members; and exchanged private messages with other members, including messages expressing an interest in the violent rape and murder of children. The site has been taken down by the FBI. Four other members of the site, along with the site's administrator, Aaron McGrath, have been sentenced to a combined 83 years in prison. The cases were investigated as part of Project Safe Childhood, a nationwide initiative to combat the growing epidemic of child sexual exploitation and abuse.

State Medicaid Fraud Control Units

OIG oversight of State MFCUs

MFCUs are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. OIG has oversight responsibility for MFCUs and administers grants that provide Federal funding for Unit operations. The Federal Government reimburses 75 percent of the costs of operating a Unit; the States contribute the remaining 25 percent. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities or board and care facilities.

MFCU funding and accomplishments in FY 2014

In FY 2014, combined Federal and State expenditures for the operation of 50 MFCUs (including 1 in Washington, DC), totaled about \$235 million. The MFCUs employed 1,958 individuals. Collectively, in FY 2014, MFCUs reported 16,464 investigations, of which 13,192 were related to Medicaid fraud and 3,272 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges against or indictments of 1,659 individuals, including 1,185 for fraud and 474 for patient abuse and neglect, including patient funds cases. In total, 1,318 criminal actions were reported in FY 2014, of which 956 were related to Medicaid fraud and 362 were related to patient abuse and neglect, including patient funds cases. Civil judgments and settlements for FY 2014 totaled 874, and monetary recoveries in civil cases totaled over \$1.7 billion. (Medicaid Fraud Control Units FY 2014 Annual Report. OEI-06-15-00010. Appendix C. 2015 APR.) See also Medicaid Fraud Control Units 2014 Statistics [Interactive Map](#) and [Chart](#) on our Web site.

OIG onsite reviews of MFCUs

OIG has developed 12 performance standards for use in assessing the operations of MFCUs. A copy of the MFCU performance standards, most recently revised in June 2012, may be found on the OIG Web site. Periodically—approximately every 5 years—OIG conducts an indepth onsite review of each Unit's operations as related to the 12 performance standards and to assess compliance with laws, regulations, and OIG policy guidance. OIG issued reports of onsite reviews of the following MFCUs during the reporting period. The full reports are available on our Web site.

- *New Mexico State Medicaid Fraud Control Unit: 2014 Onsite Review. OEI-09-14-00240. 2015 February.*
- *Iowa State Medicaid Fraud Control Unit: 2014 Onsite Review. OEI-06-14-00190. 2014 November.*

Joint investigations with MFCUs

Tennessee – CareAll Management LLC and its affiliated entities (collectively, CareAll) agreed to pay \$25 million to resolve allegations that it violated the FCA by submitting claims to Medicare and Medicaid for upcoded and noncovered home health services. Between April 2006 and December 2012, CareAll allegedly upcoded the conditions of some of its home health care patients and billed Medicare and Medicaid for home health services in which the patients were not homebound and the services were not medically necessary. Between August 2012 and August 2013, CareAll also allegedly billed for home health and physical therapy services that were not covered by Medicare, were not supported by the proper documentation, were not medically necessary, or were provided to patients who were not homebound. As part of the settlement, CareAll entered into a 5-year CIA with OIG. This investigation was conducted jointly with the Tennessee MFCU.

Advisory opinions and other industry guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with DOJ, are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. From October 1, 2014, to March 31, 2015, OIG received 21 requests for advisory opinions and issued 7 opinions.

Sanction authorities and other administrative actions

Various Federal laws provide authorities to impose administrative sanctions for fraud and abuse, as well as other activities that pose a risk to Federal health care programs and their beneficiaries. Sanctions include the exclusion of individuals and entities from Federal health care programs and the imposition of civil monetary penalties (CMPs) for submitting false and fraudulent claims to a Federal health care program or for violating the anti-kickback statute; the Stark Law; or the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient dumping statute.

During this semiannual reporting period, OIG imposed 1,814 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. Exclusion and penalty authorities are described in Appendix C and on our Web site at <http://oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program exclusions

During this semiannual reporting period, OIG excluded 1,735 individuals and entities from Medicare, Medicaid, and other Federal health care programs. Most of the exclusions resulted from convictions for crimes relating to Medicare or Medicaid, for patient abuse or neglect, or as a result of license revocation. OIG is also responsible for reinstating providers who apply and have met the requirements of their

exclusions. For a list of excluded individuals and entities, see: <https://exclusions.oig.hhs.gov/>. Case examples follow.

New York – Physician Peter Lesniewski was excluded for a minimum period of 50 years on the basis of his conviction of conspiracy to commit mail fraud, wire fraud, and health care fraud; conspiracy to defraud the United States Railroad Retirement Board (RRB); health care fraud; and mail fraud. From approximately 1998 through 2008, Lesniewski assisted employees from the Long Island Railroad (LIRR) in applying for disability benefits from the RRB, even though he knew they were not disabled. The LIRR employees generally paid Lesniewski \$800 to \$1200, often in cash, to prepare medical assessments and/or illness narratives for submission to the RRB. Lesniewski prescribed and billed patients' insurers for unnecessary medical tests, including x-rays, scans, and nerve conduction tests, and he ordered physical therapy and medical treatments in an effort to pad their medical files to make it appear as if they were disabled. Lesniewski's fabricated and fraudulent assessments enabled 242 LIRR employees to supplement their pensions with a collective \$70 million in RRB disability benefit payments to which they were not entitled. Lesniewski was sentenced to 8 years in prison and ordered to pay \$70.6 million in restitution. The New York State Board for Professional Medical Conduct revoked his medical license, and the New York State Office of the Medicaid Inspector General excluded him from participation in the Medicaid program.

Pennsylvania – Vadim Fleshler was excluded for a minimum of 40 years on the basis of his conviction of conspiracy to commit health care fraud and false statements in health care matters. Fleshler worked for Superior EMS Ambulance Company, which was owned by his wife. From about September 2010 to August 2013, Fleshler participated in a scheme in which he transported, either by ambulance or his own personal vehicle, Medicare beneficiaries who had no medical necessity for ambulance transportation. The investigation determined that the beneficiaries, some of whom were taken 3 days a week to their dialysis appointments, could walk or be safely transported by other means. Fleshler falsified "trip sheets" to reflect that the beneficiaries needed to be transported by stretcher and needed continuous medical monitoring during transport when, in fact, patients often walked to the ambulance and no medical monitoring was provided during the trip. Fleshler, who was illegally in possession of a firearm at the time of his arrest, was sentenced to 13½ years in prison and ordered to pay \$1.9 million in restitution.

Texas – Pharmacist Lisa Hollier was excluded for a minimum period of 10 years on the basis of her conviction for conspiracy to unlawfully distribute controlled substances. Hollier owned and operated Urban Independent Pharmacy (UIP). The investigation revealed that Hollier participated in a scheme whereby "dealers" recruited "patients" to obtain unlawful prescriptions for controlled substances and drove the patients to UIP, where Hollier filled their prescriptions. Hollier typically had large amounts of hydrocodone and other controlled substances in prefilled bottles ready each day to handle the large groups of dealers and their patients. After Hollier filled the prescriptions, the patients provided the pills to the dealers, who then sold them on the street for a profit. Hollier was sentenced to 5 years in prison.

Iowa – Pediatrician Dennis Jones was excluded for a minimum of 30 years on the basis of his conviction of possession of child pornography. The investigation revealed that Jones used a hidden camera to take pictures and videos of his minor patients without the advice or knowledge of the patients, their parents, or guardians. The images and videos were taken during what were purported to be necessary medical exams. Investigators searched Jones's computers and found files that included child pornography along with videos and images of the minor patients. Jones was sentenced to 10 years and 1 month in prison. The Iowa Board of Medicine also accepted the surrender of his license to practice as a medical doctor.

Suspensions and debarments

Suspensions and debarments are administrative tools used by HHS and other Federal agencies to protect the Government from individuals and entities that have engaged in contract fraud, that have misused grant funds, or that are otherwise not presently responsible. Because these are Governmentwide sanctions, an individual or entity that has been suspended or debarred by HHS or any other agency is ineligible from participating in any future funding opportunities across the Federal Government for a specified period of time.

OIG refers individuals and entities that have potentially engaged in grant or contract fraud or misconduct to the HHS Suspension and Debarment Official, who is responsible for determining whether to impose a suspension or debarment. OIG continues to develop a robust Suspension and Debarment program and uses this tool to protect Government programs against fraud, waste, poor performance, and noncompliance with contract provisions or applicable law.

Below are two debarment examples:

Republic of the Marshall Islands – Four defendants who participated in a scheme to embezzle money from Federal grants awarded to different ministries with the Republic of the Marshall Islands were debarred from participation in Government programs for 3 years. The debarment was based on criminal convictions on charges of cheating, forgery, conspiracy, and misconduct in public office, among others. The investigation revealed that the defendants had prepared and submitted false purchase requisitions, vendors' invoices, purchase orders, and other documents that suggested a vendor had supplied certain goods to the Government when, in fact, the vendor had not supplied the goods. The proceeds from the fraud were shared among the defendants.

New York – Following a lengthy investigation by the FBI and the United States Attorney's Office, Pedro Espada, Jr., was found guilty of stealing Federal funds from Soundview Healthcare Network (Soundview). Pedro Espada, Jr., was sentenced to 5 years in prison. His son, Pedro G. Espada was sentenced to 6 months in jail and 6 months' home confinement. After the conviction of the Espadas, OIG began suspension and debarment proceedings against the Espadas and Soundview to ensure that they could not obtain future Federal funds. Effective February 5, 2015, HHS debarred the Espadas and Soundview, along with two other affiliated organizations (Soundview Management Enterprises and Community Expansion Development Corporation) for a period of 3 years. During this time, they are not eligible to receive Federal grant funds or participate in contracts with the Federal Government.

Corporate integrity agreements

Many health care providers elect to settle their cases before litigation. As part of the settlements, providers often agree to enter into CIAs with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Under a CIA, a provider commits to establishing a program and taking other specified steps to ensure future compliance with Medicare and Medicaid rules. The compliance programs are designed, in part, to prevent future fraud. OIG monitors providers' compliance with these agreements and may impose penalties on entities that fail to comply with the requirements of their CIAs. Many civil settlements include CIAs with OIG. Examples of these CIAs are included in the case narrative section.

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties on and assessments against a person who, among other things, submits, or causes to be submitted, claims to a Federal health care program that the person knows, or should know, are false or fraudulent. During this semiannual reporting period, OIG concluded cases involving more than \$34.9 million in CMPs and assessments. The following are case examples.

Texas – Three Houston-area physicians collectively agreed to pay \$200,266 for allegedly violating the CMPL provisions applicable to kickbacks. OIG alleged that family practitioner Jimmy Dung Doan, orthopedic surgeon Dan Kelly Eidman, and orthopedic surgeon Robert L. Burke received illegal remuneration from physician Jack Baker and Baker’s practice, Fairmont Diagnostic Center and Open MRI, Inc. This improper remuneration took the form of Baker’s paying the salary of one of Doan’s employees to serve as a “referral coordinator” and hiring Eidman and Burke as medical directors. OIG alleged that these arrangements took into account the volume or value of referrals made to Baker by each of the three physicians. To date, 11 physicians have agreed to pay a collective total of \$1,415,137 to resolve their CMPL liability for allegedly receiving kickbacks from Baker. Another physician, Scott Houson Hung, agreed to be excluded from participation in Federal health care programs for 3 years.

New York – Jennan Comprehensive Medical, P.C. (Jennan), and its owner, physician Henry Chen, entered into a \$694,887 settlement agreement with OIG. The settlement resolved allegations that, from May 2008 to December 2013, Jennan and Chen knowingly submitted, or caused to be submitted, fraudulent claims to Medicare for physical therapy services. Specifically, OIG alleged that these claims were fraudulent for one or more of the following reasons: (1) physical therapy services were not provided or supervised by the rendering provider, (2) group services were billed as one-on-one provider-patient physical therapy services, (3) services were performed by unqualified individuals, and (4) claims for time-based physical therapy services did not accurately reflect the actual time spent performing the services.

California – Hyundai Drugs and its owner Sang Kim agreed to pay \$1,342,295 to resolve allegations under the CMPL. From January 1, 2009, through April 12, 2014, Hyundai allegedly submitted claims to Medicare Part D for prescription drugs that it knew, or should have known, were not provided as claimed and were false or fraudulent. The case was investigated as part of Operation Pharm Fury, a joint effort between OIG’s Office of Investigations, Office of Evaluation and Inspections, and Office of Counsel to the Inspector General. Operation Pharm Fury has exposed pharmacies across the country that have shown a pattern of questionably high billing practices when submitting claims to Medicare for prescription drugs.

Patient Dumping

Some of the CMPL cases that OIG resolved between October 1, 2014, and March 31, 2015, were pursued under the EMTALA, a statute designed to prevent hospitals from denying emergency care to patients and to ensure patient access to appropriate emergency medical services. Examples follow.

Alabama – Atmore Community Hospital agreed to pay a maximum penalty of \$25,000 to resolve its EMTALA liability. OIG alleged that Atmore failed to provide stabilizing treatment to a patient who had been shot in the upper arm and taken to Atmore by ambulance to meet an air ambulance that would transport the patient to a trauma center. As the ambulance approached Atmore, the paramedic received a call that foggy weather prevented the air ambulance from landing and that the patient should be taken by ground transportation to a hospital 1 hour away. The patient insisted that he first go to Atmore’s

emergency department to get relief for his pain, which he rated 10 out of 10. As the patient was being unloaded from the ambulance, Atmore's emergency department physician and a nurse came out. However, despite multiple requests from the paramedic and the patient, the physician and nurse refused to let the patient enter to obtain pain medication because the hospital did not have a trauma surgeon. The physician and nurse returned to the emergency department with locked doors closing behind them.

Tennessee – Tristar Summit Medical Center (Summit) agreed to pay \$40,000 to resolve its liability under EMTALA. OIG alleged that Summit violated EMTALA by transferring a patient on the basis of the patient's insurance status, when the patient was not stabilized for transfer. Specifically, OIG contended that the patient came to Summit's emergency department after attempting suicide by consuming a bottle of antifreeze, and emergency room personnel determined that the patient would need to be admitted to an Intensive Care Unit (ICU). Although Summit had capacity in its own ICU, Summit transferred the patient to another hospital, allegedly because the patient was outside of her TennCare HMO insurance network.

Florida – Palms West Hospital (Palms) agreed to pay a maximum penalty of \$50,000 to resolve its liability under EMTALA. OIG alleged that Palms refused an appropriate transfer of a toddler brought by her mother to another hospital's emergency department after ingesting an unknown quantity of Drano. Poison control recommended that the patient be seen by a pediatric gastroenterologist, which the first hospital did not have. When contacted to confirm that pediatric gastroenterology services were available, the emergency department physician at Palms initially accepted transfer of the patient. The physician subsequently rescinded the acceptance, however, erroneously believing that she had made a mistake about on-call coverage. As a result, the patient was transferred to a third hospital, despite the fact that Palms had a pediatric gastroenterologist available.

Provider self-disclosure protocol

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

The protocol guides providers and suppliers through the process of structuring a disclosure to OIG about matters that constitute potential violations of Federal laws. After making an initial disclosure, the provider or supplier is expected to thoroughly investigate the nature and cause of the matters uncovered and make a reliable assessment of their economic impact. OIG evaluates the reported results of each internal investigation to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG Web site at <https://oig.hhs.gov/compliance/self-disclosure-info/index.asp>.

During this reporting period, self-disclosure cases resulted in over \$19.5 million in HHS receivables. The following are examples of provider self-disclosure settlements.

Arizona – Abode Healthcare, Inc., self-disclosed to OIG that two of its subsidiaries, Premier Hospice and Palliative Care, LLC, and Premier Hospice & Palliative Care – Indiana, LLC (the Premier Entities), had

submitted claims to Medicare for hospice services when the underlying documentation did not support hospice eligibility. Abode disclosed that, from October 1, 2009, through April 30, 2013, the Premier Entities billed for hospice services that failed to comply with Medicare's brief physician narrative and face-to-face attestation obligations for purposes of certifying terminal illness. Abode and the Premier Entities' prior owners, Jeff L. Smith and SP Management, Inc., agreed to pay \$2,674,895 to resolve their liability under the CMPL.

California – Physicians Immunodiagnostic Laboratory, Inc. (PIL), self-disclosed that, from May 20, 2008, through November 9, 2012, it improperly billed Medicare, Medicaid, and TRICARE for services provided by excluded individual Mayra Perry. PIL employed Perry as a client account representative who was responsible for consulting with physicians sending samples to PIL for testing, helping to manage the laboratory, and performing other administrative services. PIL agreed to pay \$1,386,816 plus interest to resolve its CMPL liability for employment of an excluded individual.

Maryland – St. Agnes Healthcare, Inc., d/b/a St. Agnes Hospital (St. Agnes), self-disclosed that its entry into and operation under a lease agreement with MidAtlantic Cardiovascular Associates, PA (MACA), potentially violated the Anti-Kickback Statute and the Stark Law. Between December 1, 2001, and September 30, 2009, St. Agnes and MACA had an arrangement in which MACA purchased from St. Agnes on an as-needed or "per use" basis equipment, supplies, staff, and space needed to provide certain nuclear diagnostic cardiology testing services to MACA's patients. MACA paid \$339 per use, which was determined to be up to \$129 below fair market value. St. Agnes agreed to pay \$1,414,248 for allegedly violating the CMPL provisions applicable to kickbacks and physician self-referrals.

California – Arrowhead Cardiology Medical Group, Inc., a practice owned in part by physicians Steven Fitzmorris and Sunil Nowrangi, self-disclosed that it had submitted improper claims to Medicare for telemetry services. Arrowhead contracted with a local hospital to provide telemetry services, and on a daily basis, its physicians read and evaluated the telemetry strips sent from the hospital and billed under a code that should be used only once per patient per day unless there is a documented change in the patient's condition to warrant an additional service. From December 6, 2006, through July 9, 2013, Arrowhead billed Medicare using that particular code in excess of once per patient per day without any documented change in the patient's condition. Arrowhead, Fitzmorris, and Nowrangi agreed to pay \$485,217 plus interest for allegedly violating the CMPL.

Public health agencies and enforcement activities

Centers for Disease Control and Prevention

President's Emergency Plan for AIDS Relief

- *The Centers for Disease Control and Prevention Generally Achieved Its Main Goals Related to Certain HIV/AIDS Prevention, Treatment, and Care Activities Under the Partnership Framework in Ethiopia. A-04-13-04011. 2014 October.*
- *The Ethiopian Public Health Association Generally Managed the President's Emergency Plan for AIDS Relief Funds but Did Not Always Meet Program Goals in Accordance With Award Requirements. A-04-13-04016. 2014 October.*
- *The Ethiopian Public Health Institute Did Not Always Manage the President's Emergency Plan for AIDS Relief Funds or Meet Program Goals in Accordance With Award Requirements. A-04-13-04017. 2015 January.*

OIG, among others, provides oversight of programs, including the President's Emergency Plan for AIDS Relief (PEPFAR), to assist foreign countries in combating HIV/AIDS, tuberculosis, and malaria. OIG conducted a series of audits of CDC offices and organizations receiving PEPFAR funds from CDC. In Ethiopia, CDC generally achieved its main goals related to certain HIV/AIDS prevention, treatment, and care activities under the Partnership Framework and collaborated with the United States Agency for International Development (USAID) to reduce PEPFAR redundancies. The Ethiopian Public Health Association (EPHA) generally managed PEPFAR funds but did not always meet program goals in accordance with award requirements. The Ethiopian Public Health Institute (the Institute) generally did not always manage PEPFAR funds or meet program goals in accordance with award requirements. CDC concurred with the following recommendations:

- implement a system to recognize incremental progress toward laboratory accreditation,
- work with Office of the Global AIDS Coordinator (OGAC) to improve target setting for performance measures,
- work with the grantees to overcome obstacles to meeting the conditions of participation's performance measures, and
- work with OGAC to allow for updates and corrections to the Foreign Assistance Coordination and Tracking System.

EPHA officials concurred with the following recommendations:

- work with CDC to resolve whether the value-added tax (VAT) was an allowable expenditure under the cooperative agreement and to seek reimbursement from the Ethiopian Government for the \$68,000 of VAT paid and

- develop and implement policies and procedures for recording expenditures, maintaining adequate supporting documentation, preparing and submitting an annual progress report, and submitting its annual financial audit report in a timely manner.

Institute officials concurred with the following recommendations:

- refund to CDC \$4,300 of unallowable expenditures,
- work with CDC to resolve whether VAT was an allowable expenditure under the cooperative agreement to seek reimbursement from the Ethiopian Government for the \$163,000 of VAT paid,
- require regional facilities to submit quarterly expenditure reports and reconcile the outstanding cash advances, and
- develop and implement adequate policies and procedures.

Public-Health-Related Legal Actions and Investigations

Health Education Assistance Loan Program

OIG excludes individuals who have defaulted on Health Education Assistance Loan (HEAL) loans from participation in Federal health care programs. Under the HEAL program, which stopped making loans in 1998, the Health Resources and Services Administration (HRSA) guaranteed commercial loans to students seeking education in health-related fields.² The students are allowed to defer repayment of the loans until after they graduate and begin to earn income. Although HHS's Program Support Center (PSC) takes steps to ensure repayment, some loan recipients do not resolve their indebtedness. After PSC has exhausted efforts to secure repayment of a debt, it declares an individual in default. The Social Security Act permits exclusion thereafter of such individuals from Medicare, Medicaid, and all other Federal health care programs for nonpayment of the loans.

Exclusion means that the individual may not receive reimbursement under these programs for professional services rendered, nor may any other provider receive reimbursement for services ordered or prescribed by the excluded individual. OIG is responsible for excluding individuals who have defaulted on HEAL loans from participation in Federal health care programs.

HEAL Exclusions

During this semiannual reporting period, 12 individuals and related entities were excluded as a result of PSC referral of their cases to OIG. Individuals who have been excluded as a result of default may enter into settlement agreements, whereby the exclusions are stayed while they pay specified amounts each month to satisfy their debts. If they default on these settlement agreements, they may be excluded until the entire debt is repaid and they may not appeal the exclusions.

² The HEAL Program, noted in previous *Semiannual Reports*, was permanently transferred from HHS to the U.S. Department of Education as required by the Consolidated Appropriations Act, 2014 (Pub. L. 113-76). The transfer was completed on July 1, 2014.

After being excluded for nonpayment of their HEAL debts, 2,570 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 16 individuals who entered into such settlement agreements or completely repaid their debts during this semiannual reporting period. More than \$201 million is being repaid through settlement agreements or through complete repayment. Of that amount, \$1.4 million is attributable to this semiannual reporting period.

Practitioners in five States entered into settlement agreements to repay the amounts indicated:

- Michigan – Osteopath - \$191,520
- Maryland – Optometrist - \$47,086
- Texas – Optometrist - \$39,278
- Texas – Chiropractor - \$26,560
- Mississippi – Medical Doctor - \$11,160

<http://oig.hhs.gov>

Human services agencies and enforcement activities

Administration for Children and Families

Child Care and Development Fund

- *Some Minnesota Childcare Home Providers Did Not Always Comply With State Health and Safety Licensing Requirements. A-05-14-00021. 2015 March.*
- *Some Arizona Family Childcare Home Providers Did Not Always Comply With State Health and Safety Certification Requirements. A-09-13-01004. 2015 February.*
- *Some Minnesota Childcare Centers Did Not Always Comply With State Health and Safety Licensing Requirements. A-05-14-00022. 2015 March.*

The family childcare home providers reviewed in two States did not always comply with applicable State licensing requirements to ensure the health and safety of children (19 out of 20 providers reviewed in Minnesota and 20 out of 20 providers reviewed in Arizona). In addition, the childcare center providers in Minnesota did not always comply with applicable State licensing requirements to ensure the health and safety of children (3 out of 3 providers reviewed). We found several types of errors, but not all errors appeared in each State. Health and safety standards must cover three areas: prevention and control of infectious disease, building and physical premises safety, and health and safety training. In the family childcare home provider reports, Minnesota and Arizona concurred with the following recommendation:

- ensure through more frequent onsite monitoring that providers comply with health and safety regulations.

Arizona concurred with the following recommendation:

- strengthen its existing policies and procedures to effectively identify when fingerprint clearance cards have been suspended or revoked.

Minnesota and Arizona partially concurred with the following recommendation:

- develop a mandatory training program to improve provider compliance with health and safety regulations.

Minnesota partially concurred with the following recommendation:

- ensure adequate oversight by reducing licensing inspectors' caseloads.

Arizona partially concurred with the following recommendation:

- perform criminal records and child abuse registry checks in compliance with requirements.

In the childcare report, Minnesota concurred with the following recommendations:

- to ensure, through more frequent onsite monitoring, that providers comply with health and safety regulations and
- ensure that providers' employees who provide direct services to children have completed background studies.

Minnesota partially concurred with the following recommendation:

- ensure adequate oversight by reducing licensing inspectors' caseloads.

Foster Care

- *Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings. OEI-07-13-00460. 2015 March.*

We found that nearly a third of children in foster care who were enrolled in Medicaid in four States did not receive at least one health screening as required by their respective States' plans for health services oversight and coordination and that 28 percent of children in foster care received required screenings late. These findings raise concerns because missing or late screenings may prevent children's mental health needs, physical health needs, and developmental needs from being identified and treated. ACF stated that it would consider the following recommendation:

- expand its Child & Family Services Reviews to determine whether children in foster care receive required health screenings according to the timeframes specified in States' plans.

ACF concurred with the following recommendation:

- identify and disseminate State strategies to ensure that all children in foster care receive required health screenings.

Child support enforcement activities

OIG investigations

OIG investigates noncustodial parents who fail to pay court-ordered child support. OIG works with ACF's Office of Child Support Enforcement; DOJ; U.S. Attorneys' Offices; the U.S. Marshals Service; and Federal, State, and local partners to address egregious child support enforcement cases with appropriate law enforcement and prosecutorial action. OIG investigations of child support enforcement cases nationwide resulted in 32 criminal actions and court-ordered restitution and settlements of \$1.32 million during this semiannual reporting period. The following are examples of child support enforcement cases:

North Carolina – Child Support Enforcement Most Wanted Fugitive Edward Morrill was sentenced to serve up to 180 days in a halfway house and ordered to pay \$46,200 in restitution after pleading guilty to failure to pay legal child support obligations. In 1989, Morrill was ordered by the court to pay child support, provide medical insurance, and help pay medical bills for his two children. However, the investigation revealed that, as of August 2004, he was nearly \$60,000 in arrears. Morrill was arrested in March 2014, during his attempt to enter the United States at the Mexico and El Paso, Texas, border.

Morrill, a fugitive from the law for nearly 10 years, remained in jail until sentencing and his placement in a halfway house.

Maine – Jay Dandreo was sentenced to a 1½ years in jail and ordered to pay \$71,988 in restitution after being convicted following a trial on charges of willfully failing to pay child support and possession with the intent to manufacture or distribute marijuana. In May 2004, the Maine Department of Health & Human Services ordered Dandreo to pay for the support of his four minor children. Between May 2004 and November 2013, Dandreo knowingly and intentionally failed to make any child support payments, resulting in an unpaid obligation of approximately \$70,000. In August 2012, Maine Drug Enforcement Agency investigators searched a property located in Limerick, Maine, that was owned by Dandreo's father, and they seized 183 marijuana plants growing at several locations on the property, as well as drug distribution paraphernalia and several firearms.

Pennsylvania – William Albright was sentenced to 1 year and 1 day in prison and ordered to pay \$50,915 in restitution after pleading guilty to failure to pay child support obligations. In 2000, Albright was ordered by the Pennsylvania Court of Common Pleas to pay \$378 a month toward his court-ordered child support. However, investigators determined that he had not made a child support payment since 2009.

Engaging the public in capturing deadbeat parents

Because of the success of OIG's Most Wanted Fugitives Web site, OIG launched its Most Wanted Deadbeat Parents Web site. The site identifies parents who fail to pay court-ordered child support for their children and thereby put an unnecessary strain on the custodial parents and the children, as well as on agencies that enforce these matters. The site, which is updated frequently, includes information on OIG's role in pursuing parents who fail to pay court-ordered child support and has a reporting button to turn in deadbeat parents. OIG's Most Wanted Deadbeat Parents Web site is at: <https://oig.hhs.gov/fraud/child-support-enforcement/index.asp>.

<http://oig.hhs.gov>

Other HHS-related reviews

Grants and Contracts

Payroll Certification System Pilot

- *The University of California at Irvine's Pilot Payroll Certification System Could Not Be Assessed. A-04-13-01027. 2014 December.*

We could not determine whether the University of California—Irvine's (the University's) pilot payroll certification system provided data that supported labor charges that it made to its Federal awards because it could not reconcile its accounting records to its Federal financial reports (FFRs). As a result, we cannot determine whether the University certified, reported, or claimed labor costs and associated fringe benefits that accurately reflected the actual effort its personnel had devoted to Federal awards. Although the University did not concur, OIG continues to recommend that the University:

- reconcile the \$491.3 million it had reported on its FFRs to its accounting records and
- modify its financial management system to ensure that amounts it reports on its FFRs can be supported by amounts recorded in its accounting records.

Grant fraud

HHS is the largest grantmaking organization and one of the largest contracting agencies in the Federal Government. In FY 2014, HHS awarded over \$381 billion in grants and over \$21 billion in contracts across all program areas. OIG's direct annual discretionary appropriation funding is used to conduct program integrity and enforcement activities with regard to the over 100 public health and human services programs carried out by over 70,000 employees around the world. The size and scope of departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public. Recent appropriations increased OIG's discretionary funding for public health and human services oversight.

Misuse of Grant Funds Examples:

Maryland – Jason Dietz was sentenced to 1½ years in prison and ordered to pay \$683,705 in restitution after pleading guilty to theft from programs receiving Federal funds. Dietz worked for Matthews Media Group (MMG), which was contracted by the National Institute for Drug Abuse (NIDA) to recruit, screen, and compensate participants for clinical research studies involving drug addiction and treatment. Dietz was also responsible for keeping a spreadsheet of participants' compensation with supporting documentation. The investigation revealed that Dietz embezzled funds from MMG in several ways, including paying study participants and obtaining a signed receipt from them, then logging a higher amount on his spreadsheet and pocketing the difference. Dietz also created fictitious receipt numbers and amounts, which he placed on his spreadsheet, and then kept all the cash from these fictitious payments. In addition, Dietz documented on his spreadsheet higher amounts than were actually paid to

employees at one of the NIDA clinics and pocketed the difference. The investigation determined that Dietz embezzled, stole, and converted to his own use funds in excess of \$570,000.

Illinois – Charles Bennett entered into a \$475,000 settlement agreement to resolve allegations under the FCA. Bennett was a former employee and researcher at Northwestern University's (Northwestern's) Robert H. Lurie Comprehensive Cancer Center, a grantee of NIH. The Government alleged that Bennett submitted, or caused the submission of, false claims to NIH for unallowable grant expenditures incurred in connection with research projects for which he served as the principal investigator. Specifically, between January 2003 and August 2010, Bennett allegedly misspent grant funds on professional and consulting services, including those performed by unqualified family members. Bennett also allegedly misspent NIH grant funds on airfare and other transportation, conference registration fees, meals, hotel stays, and other items that were for his personal benefit or were for the personal benefit of friends and family. The grants at issue involved research on adverse drug events, multiple myeloma drugs, a rare blood disorder, and quality of care for cancer patients.

New York – The Trustees of Columbia University in the City of New York and ICAP, f/k/a International Center for AIDS Care and Treatment Programs (collectively, Columbia), agreed to pay \$9 million to resolve allegations under the FCA. The United States contended that Columbia submitted false claims in connection with Federal grants obtained to fund ICAP's AIDS- and HIV-related work. As the grant administrator on behalf of ICAP, Columbia received millions of dollars in Federal grants and, pursuant to the rules applicable to such grants, was required to verify that ICAP's nearly 200 employees located in New York City had actually performed the work charged to a particular grant. The United States alleged that Columbia was aware that employee work was not being verified and that Columbia continued to falsely charge Federal grants for work that was not devoted to the projects being funded by CDC, HRSA, NIH, and other HHS granting agencies.

Small Business Innovative Research Program

The National Defense Authorization Act for Fiscal Year 2012, § 5143, requires OIG to annually report on the number of cases that were referred to it related to fraud, waste, or abuse in the Small Business Innovative Research/Small Business Technology Transfer (SBIR/STTR) program; the actions taken in each case; justification for not taking action on a case; and an accounting of funds used to address waste, fraud, and abuse in this program. In our November 2014 report delivered to the three Congressional oversight committees, we reported that OIG spent approximately \$236,860 in salaries on oversight related to the SBIR/STTR program. HHS referred 13 new SBIR/STTR cases to OIG in FY 2014.

Recovery Act retaliation complaint investigations

The American Recovery and Reinvestment Act (Recovery Act), § 1553, prohibits non-Federal employers that have received Recovery Act funding from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds. OIGs are required to include in their *Semiannual Reports* to Congress the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. During this reporting period, OIG closed three investigations.

Peer review results

During this semiannual reporting period, OI did not conduct a peer review of another OIG. A peer review of OI by another OIG was not conducted during this reporting period.

Contract Audits

Pursuant to the National Defense Authorization Act for FY 2008, § 845, OIGs appointed under the Inspector General Act of 1978 are required to submit, as part of their *Semiannual Report(s)* to Congress pursuant to section 5 of such Act, information on final completed contract audit reports issued during the period to the contracting activity containing significant audit findings. OIG did not issue final reports meeting § 845 criteria during this semiannual period.

OIG reviews of non-Federal audits

OIG reviews audits conducted by non-Federal auditors of entities receiving Federal awards. In this semiannual period, OIG's National External Audit Review Center reviewed 1,986 reports covering \$834.2 billion in audited costs. Federal dollars covered by these audits totaled \$143.7 billion, of which about \$70.7 billion were HHS funds.

Office of Management and Budget (OMB) Circular A-133 establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular, covered entities must conduct annual organizationwide "single audits" of all Federal money they receive. These audits are conducted by non-Federal auditors, such as public accounting firms and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entities' management of Federal funds.

OIG's oversight of non-Federal audit activity informs Federal managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs for resolution or followup. We identify entities for high-risk monitoring, alert program officials to any trends that could indicate problems in HHS programs, and profile non-Federal audit findings of a particular program or activity over time to identify systemic problems. We also provide training and technical assistance to grantees and members of the auditing profession. OIG maintains a process to assess the quality of the non-Federal reports received and the audit work that supports the selected reports. OIG's reports on non-Federal audits reviewed during this reporting period are categorized in the following table.

Non-Federal Audits, October 1, 2014, through March 31, 2015

Number of Non-Federal Audits:	
■ <i>Not requiring changes or having minor changes</i>	1,185
■ <i>Requiring major changes</i>	93
■ <i>Having significant technical inadequacies</i>	8

Total	1,986
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The 1,986 reports included 1,979 recommendations for improving management operations. In addition, these audit reports provided information for 29 OIG special memorandums that identified concerns for increased monitoring by management.

Other reporting requirements and reviews

Government Charge Card Abuse Prevention Act

- *Letter to Office of Management and Budget Director To Meet Requirements of Government Charge Card Abuse Prevention Act of 2012 Regarding Agency Progress Implementing Recommendations on Charge-Card-Related Findings. [A-04-14-06175](#). 2015 January.*

This letter report describes the progress that HHS has made in implementing previous purchase and travel card audit recommendations and the status of OIG's annual risk assessment. The letter was issued to meet the requirements of the Government Charge Card Abuse Prevention Act of 2012 (P.L. No. 112-194) (Charge Card Act) to report to the OMB Director on agency progress in the implementation of recommendations on charge-card-related findings. In addition, while not required for this report, we also explain how we intend to conduct required annual risk assessments of agency purchase cards.

Legislative and regulatory reviews

Pursuant to the Inspector General Act, § 4(a)(2), OIG is required to review existing and proposed legislation and regulations relating to HHS's programs and operations and make recommendations concerning their impact on economy and efficiency or the prevention and detection of fraud and abuse. Most audits and other reviews that we conduct are designed to test compliance with and/or assess the administration and oversight of existing laws and regulations. Our reports of such reviews describe findings, which include questioned costs, inefficiencies, vulnerabilities to fraud, inconsistencies, errors in application, or weaknesses in oversight or supporting systems. Our corresponding recommendations tell HHS and its operating or staff divisions what administrative, regulatory, or legislative actions we believe are needed to effectively respond to the findings. Our regularly published core publications reflect the relationship between our work and laws and regulations.

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

We also review proposed legislation and regulations related to HHS programs and operations. HHS routinely involves us and its operating and other staff divisions in the review and development of HHS

regulations through a well-established HHS process. Our audits, evaluations, and investigations are sometimes cited in regulatory preambles as influencing HHS regulations. In addition, we provide independent, objective technical assistance on a bipartisan, bicameral basis to congressional committees and members who request it.

Affordable Care Act implementation

OIG continues to review programs implemented pursuant to the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 (ACA). OIG's ACA oversight strategy focuses on the health insurance Marketplaces, reforms in the Medicare and Medicaid programs, and public health programs. Key focus areas for our Marketplace oversight include payment accuracy, eligibility, management and administration, and security. In developing our work plan, we coordinate with the Government Accountability Office and other Federal and State oversight agencies.

Health Reform Oversight Plan

- *Health Reform Oversight Plan Fiscal Year 2015. 2015 February.*

This FY 2015 Health Reform Oversight Plan (the Plan) describes OIG's current and planned efforts to oversee the implementation and management of HHS's programs under the ACA. The Plan outlines OIG's key tactical considerations, key focus areas, and target timeframes for issuing reports on reviews related to the Marketplaces. Key focus areas for ongoing and potential work include the Marketplaces, Medicaid expansion and services, Medicare payment and delivery reform, and Medicare and Medicaid program integrity.

Following are examples of recent ACA reviews.

Marketplaces – Contract planning and procurement

- *Federal Marketplace: Inadequacies in Contract Planning and Procurement. OEI-03-14-00230. 2015 JAN.*

CMS relied extensively on contractors to plan and build the Federal Marketplace. However, CMS did not develop an overarching acquisition strategy for the Federal Marketplace contracts as required by Federal and HHS regulations, did not plan to assign a lead systems integrator to coordinate all contractors' efforts, and missed opportunities to leverage contract planning and oversight tools for a project of this size and importance. The complexity of the Federal Marketplace underscored the need for CMS to select the most qualified contractors. However, CMS did not perform thorough reviews of contractor past performance when awarding two key contracts. HHS and CMS concurred with the following recommendations:

- ensure that acquisition strategies are completed as required by regulation,
- assess whether to assign a lead systems integrator for complex IT projects,
- ensure contract actions are properly documented,
- ensure that all contracts subject to oversight review requirements undergo those reviews,

- limit or eliminate regulatory exceptions to acquisition planning requirements, and
- revise acquisition guidance to include specific standards for conducting past performance reviews.

Marketplaces – Establishment grants

- *Maryland Misallocated Millions to Establishment Grants for a Health Insurance Marketplace, A-01-14-02503. 2015 March.*

Maryland did not allocate costs to its establishment grants and Medicaid in accordance with Federal requirements, the terms and conditions of the establishment grants, and its Cost Allocation Plan (CAP). As a result, the State agency misallocated \$28.4 million in costs to the establishment grants instead of Medicaid because its cost allocation methodology did not prospectively use updated or better data when available and included a material defect. Maryland concurred with the following recommendations and described actions that it has taken or will take to address the recommendations:

- develop a written policy that explains how to calculate cost allocations and that emphasizes the necessity to use updated and actual data and
- oversee operations to ensure the identification and correction of enrollment projection errors, the use of better or updated enrollment data, and the application of these data to allocate costs.

Although Maryland did not concur, we continue to recommend that Maryland:

- refund \$15.9 million to CMS that was misallocated to the cooperative agreements because it did not prospectively use updated actual enrollment data,
- refund \$12.5 million to CMS that was misallocated to the establishment grants using a methodology that included a material defect, and
- immediately amend the CAP and the Advance Planning Document for July 1 through December 31, 2014, so that allocated costs correspond to the relative benefits received.

Financial Assistance Payments

- *Review of the Accounting Structure Used for the Administration of Premium Tax Credits. OEI-06-14-00590. 2015 March.*

The report issued jointly with the Treasury Inspector General for Tax Administration (TIGTA) found that the Internal Revenue Service (IRS) and CMS, in coordination with the Department of the Treasury and HHS, took significant steps in planning the shared roles and responsibilities for advanced premium tax credit (APTC) payments. The IRS and CMS, in an effort to ensure that a sound and lawful accounting structure was selected, identified issues requiring resolution and discussed a variety of accounting approaches. They sought legal opinions from agency counsel and obtained input from OMB. By mutual agreement and with OMB concurrence, the IRS and CMS adopted an allocation account structure, that they considered a logical and efficient approach. Continuing work by OIG and TIGTA will examine these operations. There were no recommendations in this report.

Appendixes

- A Questioned Costs and Funds To Be Put to Better Use
- B Peer Review Results
- C Summary of Sanction Authorities
- D Reporting Requirements in the Inspector General Act of 1978

Appendix A: Questioned costs and funds put to better use

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

Audit Reports With Questioned Costs

Questioned costs are those questioned by OIG audits because of an alleged violation of a provision of a law, regulation, contract, grant, or other agreement governing the expenditure of funds. Costs are questioned because the expenditure was not supported by adequate documentation or because the expenditure was unnecessary or unreasonable. OIG includes those questioned costs that HHS program officials, in management decisions, have agreed should not be charged to the Federal Government, commonly referred to as disallowed costs, as part of the expected recoveries in the “Accomplishments” section at the beginning of the *Semiannual Report*. Superscripts indicate end notes.

Table 1 – Audit Reports with Questioned Costs

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period ¹	225	\$917,154,000	\$25,138,000
Reports issued during the reporting period	62	\$182,514,000	\$96,000
Total Section 1	287	\$1,099,668,000	\$25,234,000
Section 2			
Reports for which management decisions were made during the reporting period ^{2, 3}			
Disallowed costs	172	\$544,702,000*	\$108,000
Costs not disallowed	3	\$84,876,000	\$1,381,000
Total Section 2	175	\$629,578,000	\$1,489,000

*Audit receivables (expected recoveries).

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 3			
Reports for which no management decisions had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	112	\$470,090,000	\$23,745,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance ⁴	67	\$338,339,000	\$23,649,000

Audit Reports With Funds Recommended To Be 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, deobligation of funds, and/or avoidance of unnecessary expenditures. Table 2 reports HHS program officials’ decisions to take action on these audit recommendations.

Table 2 – Audit Reports with Funds to Be Put to Better Use

	Reports	Dollar Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period ¹	14	\$15,861,878,000
Reports issued during the reporting period	10	\$161,194,000
Total Section 1	24	\$16,023,072,000
Section 2		
Reports for which management decisions were made during the reporting period ²		
Value of recommendations agreed to by management		
Based on proposed management action	7	\$127,739,000
Based on proposed legislative action		0
Value of recommendations not agreed to by management		
	1	\$168,000
Total Section 2	8	\$127,907,000

	Reports	Dollar Value
Section 3		
Reports for which no management decisions had been made by the end of the reporting period ³ (Sec. 1 minus Sec. 2)	16	\$15,895,165,000

End Notes

Table 1 End Notes

¹ The opening balance was adjusted upward by \$79.6 million because of a reevaluation of previously issued recommendations.

² Revisions to previously reported management decisions:

- A-04-11-08008 *Alabama Improperly Claimed Federal Funds for Children's Health Insurance Program Enrollees Who Had Medicaid or Other Health Insurance Coverage*. Disallowed cost was reduced by \$1,430,756.
- A-05-10-13555 *State of Indiana*. The State provided documentation to support the amount claimed on the CMS-64 report. The \$2,443,635 questioned costs were determined to be allowable.
- A-06-11-00050 *The Emergency Medical Services Authority of Oklahoma City Billed and Was Paid for Advanced Life Support Transports That Were Not Medically Necessary*. A decision in response to an appeal by Novitas determined that questioned costs totaling \$365,889 were allowable.
- A-09-07-88410 *State of California*. Subsequent review by CMS determined that refundable costs totaling \$3,331,446 should be \$2,907,056. As a result, the disallowed costs were adjusted by \$404,390.
- Not detailed are net reductions to previously disallowed management decisions totaling \$383,019.

³ Included are management decisions to disallow \$77.1 million in questioned costs that were identified by non-Federal auditors in audits of State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards conducted in accordance with OMB Circular A-133. OIG is responsible currently for ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

⁴ Because of administrative delays, some of which were beyond management control, resolution of the following 67 audits was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations before the end of the next semiannual reporting period:

CIN: A-07-12-01116 MEDICARE IMPROPERLY PAID PROVIDERS MILLIONS OF DOLLARS FOR UNLAWFULLY PRESENT BENEFICIARIES WHO RECEIVED SERVICES DURING 2009 THROUGH 2011, JAN 2013, \$91,620,548

CIN: A-07-12-01113	MEDICARE IMPROPERLY PAID PROVIDERS MILLIONS OF DOLLARS FOR INCARCERATED BENEFICIARIES WHO RECEIVED SERVICES DURING 2009- THROUGH 2011, JAN 2013, \$33,587,634
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL BASED HEALTH SERVICES - CT, MAY 2003, \$32,780,146
CIN: A-07-12-06038	REVIEW OF MEDICARE PART D PAYMENTS FOR UNLAWFULLY PRESENT BENEFICIARIES, OCT 2013, \$28,990,718
CIN: A-07-13-01125	MEDICARE PART C UNLAWFULLY PRESENT ENROLLEES, APR 2014, \$26,150,043
CIN: A-07-13-01127	MEDICARE A & B PAYMENTS FOR BENEFICIARIES WITH TERMINATED ENTITLEMENT, APR 2014, \$18,374,440
CIN: A-01-12-02507	REVIEW OF CONNECTICUT'S TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS, NOV 2013, \$17,499,083
CIN: A-06-13-00038	CHILD CARE DEVELOPMENT FUND: TARGETED FUNDS REVIEW IN TEXAS, AUG 2014, \$14,967,129
CIN: A-04-12-00085	ACCURACY OF MEDICAID COLLECTIONS REPORTED BY THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH, APR 2014, \$10,915,180
CIN: A-04-12-01016	AUDIT OF COSTS NORMALLY TREATED AS ADMINISTRATIVE AND CLERICAL COSTS BUT CHARGED DIRECTLY TO HHS AWARDS AT THE UNIVERSITY OF SOUTH FLORIDA, APR 2014, \$6,467,290
CIN: A-03-12-00004	REVIEW OF HORIZON'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$4,344,417
CIN: A-01-11-02500	REVIEW OF MASSACHUSETTS' TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, AUG 2011, \$4,242,540
CIN: A-05-13-00014	OHIO EXCEEDED THE 5-PERCENT LIMIT FOR CLAIMING CHILD CARE DEVELOPMENT FUND ADMINISTRATIVE EXPENDITURES, NOV 2013, \$3,164,630
CIN: A-07-12-03175	REVIEW OF CCDF TARGETED FUNDS IN NEBRASKA, APR 2013, \$2,965,913
CIN: A-03-13-00024	REVIEW OF NEW ORLEANS REGIONAL PHYSICIAN HOSPITAL ORGANIZATION, INC.'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, APR 2014, \$2,880,698
CIN: A-03-13-00025	REVIEW OF UAB HEALTH SYSTEM'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$2,812,109
CIN: A-03-13-00026	REVIEW OF USABLE MUTUAL'S (ARKANSAS BLUE CROSS BLUE SHIELD) 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$2,763,821
CIN: A-03-11-00002	REVIEW OF NEW ENGLAND JOINT ENTERPRISE 2009 DIR REPORTS, APR 2012, \$2,710,732
CIN: A-03-12-00006	REVIEW OF TAHMO'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$2,355,532
CIN: A-03-13-00020	REVIEW OF CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$2,070,605
CIN: A-03-12-00007	REVIEW OF ARCADIAN'S 2009 AND 2010 BONA FIDE SERVICE FEES, FEB 2013, \$2,048,967
CIN: A-03-12-00005	REVIEW OF WINDSOR'S 2009 AND 2010 BONA FIDE SERVICE FEES, JAN 2013, \$1,948,737
CIN: A-03-13-00018	REVIEW OF AMERIGROUP CORPORATION'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,943,251
CIN: A-03-13-00019	REVIEW OF BLUECROSS BLUESHIELD OF SOUTH CAROLINA'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, DEC 2013, \$1,799,096

CIN: A-05-12-00021	REVIEW OF CDC'S OVERSIGHT OF PEPFAR FUNDS PROVIDED TO AURUM IN SOUTH AFRICA FOR 2009-10, AUG 2013, \$1,690,605
CIN: A-07-11-06013	INDIRECT COSTS CLAIMED AS DIRECT COSTS - UNIVERSITY OF COLORADO DENVER, JUN 2013, \$1,419,524
CIN: A-03-12-00008	REVIEW OF XL HEALTH DIR, JAN 2013, \$1,410,342
CIN: A-01-12-02500	REVIEW OF CONNECTICUT'S TITLE IV-E ADMINISTRATIVE/TRAINING COSTS AND MAINTENANCE PAYMENTS, DEC 2012, \$1,316,684
CIN: A-01-12-01501	REVIEW OF SAMHSA COSTS CLAIMED AT LATIN AMERICAN HEALTH INSTITUTE, BOSTON, MA, APR 2013, \$1,261,328
CIN: A-03-13-00021	REVIEW OF FALLON COMMUNITY HEALTH PLAN'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,079,578
CIN: A-05-12-00089	THE COUNCIL ON RURAL SERVICE PROGRAMS, INC., CLAIMED UNALLOWABLE HEAD START COSTS, NOV 2013, \$1,074,352
CIN: A-03-13-00022	REVIEW OF MD CARE, INC.'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,040,501
CIN: A-03-13-00023	REVIEW OF NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$957,921
CIN: A-02-12-02003	ECONOMIC OPPORTUNITY COMMISSION OF NASSAU CO., INC. CLAIMED SOME UNALLOWABLE HEAD START COSTS, SEP 2013, \$879,876
CIN: A-02-11-02020	REVIEW OF ACTION FOR A BETTER COMMUNITY, INC. CSBG ARRA COSTS CLAIMED BY NEW YORK STATE, SEP 2013, \$795,608
CIN: A-02-11-02005	LIMITED HEAD START REVIEW OF INCLUDED EDUCATIONAL SERVICES, JUL 2012, \$588,830
CIN: A-09-11-01007	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR HCAP, FEB 2013, \$513,649
CIN: A-04-13-01024	ALLOWABILITY OF SELECTED COSTS CHARGED TO FEDERAL GRANTS AND CONTRACTS UNC, JUN 2014, \$352,843
CIN: A-07-12-06035	REVIEW OF MEDICARE PART D PAYMENTS FOR INCARCERATED BENEFICIARIES, JAN 2014, \$325,903
CIN: A-01-11-02510	NORWALK ECONOMIC OPPORTUNITY NOW, INC., DID NOT ALWAYS CHARGE ALLOWABLE COST TO COMMUNITY SERVICES BLOCK GRANT – RECOVERY ACT PROGRAMS, APRIL 2013 \$314,605
CIN: A-04-13-04015	REVIEW OF THE ETHIOPIA MINISTRY OF HEALTH FY 11 COOPERATIVE AGREEMENT 5U2GPS002087-02, SEP 2014, \$294,654
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, \$293,870
CIN: A-04-13-04004	REVIEW OF ZAMBIA'S MINISTRY OF HEALTH COOPERATIVE AGREEMENT 5U2GPS001792-2, JUN 2014, \$290,575
CIN: A-02-11-02015	REVIEW OF INSEC, INC. CSBG ARRA COSTS CLAIMED BY THE COMMONWEALTH OF PUERTO RICO, APR 2013, \$285,412
CIN: A-02-11-02017	NEW JERSEY CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS INCURRED BY CHECK-MATE INC., UNDER THE RECOVERY ACT, AUG 2014, \$246,359
CIN: A-05-12-00023	REVIEW OF CDC'S OVERSIGHT OF PEPFAR FUNDS PROVIDED TO SOUTHERN AFRICAN CATHOLIC BISHOPS' CONFERENCE FOR JUNE 1, 2009 TO MAY 31, 2010, JUL 2013, \$235,130

CIN: A-09-09-00045	RISK ADJUSTMENT DATA VALIDATION OF PAYMENTS MADE TO PACIFICARE OF CALIFORNIA FOR CALENDAR YEAR 2007 (CONTRACT H0543), NOV 2012, \$224,388
CIN: A-06-12-00057	CHILD CARE DEVELOPMENT FUND: TARGETED FUNDS REVIEW IN LOUISIANA, SEP 2013, \$221,578
CIN: A-05-12-00012	REVIEW OF IL CSBG RECOVERY ACT COSTS CLAIMED - ROCKFORD, JUL 2013, \$205,296
CIN: A-05-12-00024	NATIONAL HEALTH LABORATORY SERVICE DID NOT ALWAYS MANAGE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS OR MEET PROGRAM GOALS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2013, \$185,768
CIN: A-06-09-00012	RISK ADJUSTMENT DATA VALIDATION - PACIFICARE H4590, MAY 2012, \$183,247
CIN: A-04-11-01004	NORTHEAST FLORIDA COMMUNITY ACTION AGENCY, INC.'S CSBG FUNDS AWARDED UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, SEP 2012, \$165,795
CIN: A-04-11-01008	FLORIDA'S ADMINISTRATION OF CSBG RECOVERY ACT PROGRAM AND COSTS CLAIMED BY CENTRAL FLORIDA COMMUNITY ACTION AGENCY, INC., APR 2013, \$160,404
CIN: A-04-11-03538	HEAD START HIGH RISK GRANTEE - MOBILE COMMUNITY ACTION AGENCY, INC., DEC 2011, \$147,587
CIN: A-07-11-02766	REVIEW OF WY CSBG RECOVERY ACT COSTS CLAIMED - CARBON COUNTY, AUG 2013, \$143,588
CIN: A-09-11-01013	REVIEW OF OREGON'S HOUSING AND COMMUNITY SERVICES DEPARTMENT, APR 2013, \$115,911
CIN: A-06-11-00058	REVIEW OF CSBG ARRA COSTS CLAIMED BY CROWLEY'S RIDGE DEVELOPMENT COUNCIL, AUG 2012, \$115,420
CIN: A-07-12-02779	REVIEW OF NATRONA COUNTY CSBG RECOVERY ACT COSTS CLAIMED, JUN 2013, \$104,971
CIN: A-05-12-00022	THE SOUTH AFRICAN NATIONAL DEPARTMENT OF HEALTH DID NOT ALWAYS MANAGE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS OR MEET PROGRAM GOALS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2013, \$77,790
CIN: A-04-13-04010	REVIEW OF UNIVERSITY OF ZAMBIA FY 2010 COOPERATIVE AGREEMENT 5U2GPS000749, APR 2014, \$76,638
CIN: A-06-11-00057	THE VIETNAM ADMINISTRATION PEPFAR REVIEWS, JUNE 2013, \$47,708
CIN: A-02-11-02000	DIRECT COST REVIEW - SUNY ALBANY, OCT 2011, \$27,384
CIN: A-09-11-01014	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR THE HAWAII COUNTY ECONOMIC OPPORTUNITY COUNCIL, JULY 2012, \$22,602
CIN: A-04-13-04005	REVIEW OF UNIVERSITY TEACHING HOSPITAL-ZAMBIA COOPERATIVE AGREEMENT 5U2GPS001932-2, MAR 2014, \$13,554
CIN: A-05-11-00053	THE COLUMBUS URBAN LEAGUE CLAIMED SOME UNALLOWABLE COSTS TO HEAD START, SEP 2012, \$13,102
CIN: A-09-13-02024	MEDICARE COMPLIANCE REVIEW AT SUTTER MEDICAL CENTER, SACRAMENTO, APR 2014, \$11,668
CIN: A-03-12-00250	AUDIT OF LANCASTER COUNTY COMMUNITY ACTION PROGRAM, NOV 2013, \$2,813
Total CINs :	67
Total Amount:	\$338,339,000

Table 2 End Notes

¹The opening balance was adjusted upward by \$12.2 million because of reevaluation of previously issued recommendations.

² Revisions to previously reported management decisions:

- A-07-11-03169 *Nursing Facilities in Missouri Did Not Reconcile Invoice Records With Credit Balances and Report the Associated Medicaid Overpayments to the State Agency*. Subsequent review by Health Management Systems, LLC (HMS), identified additional cost savings totaling \$1,926,165.

³ Because of administrative delays, some of which were beyond management control, 6 of the 16 audits open at the end of the period were not resolved within 6 months of issuance of the reports. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-05-12-00020	COMPARISON OF SURGICAL SERVICES PROVIDED IN THE ASC SETTING TO OTHER OUTPATIENT SETTINGS, APR 2014, \$15,000,000,000
CIN: A-01-12-00507	ACUTE-CARE INPATIENT HOSPITAL TRANSFERS TO INPATIENT HOSPICE CARE, MAY 2013, \$602,519,187
CIN: A-07-11-05017	NATIONWIDE REVIEW OF PART D INVESTMENT INCOME, APR 2013, \$111,244,413
CIN: A-07-13-06041	REVIEW OF MEDICARE PART D PAYMENTS FOR BENEFICIARIES INCARCERATED IN MENTAL HEALTH INSTITUTIONS, JUL 2014, \$12,641,770
CIN: A-04-12-06154	REVIEW OF HOSPITAL OUTPATIENT PAYMENTS FOR ESTABLISHED PATIENTS, MAR 2014, \$7,536,964
CIN: A-05-06-00023	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS - MN, SEP 2006, \$28,240
Total CINs:	6
Total Amount:	\$15,733,976,000

Appendix B: Peer review results

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

Office of Audit Services peer review results

During this semiannual reporting period, no peer reviews involving the Office of Audit Services (OAS) were completed. Listed below is information concerning OAS's peer review activities during prior reporting periods.

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

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

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

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

(Peer Review Results continued on next page)

Office of Investigations peer review results

During this semiannual reporting period, no peer reviews involving OI were completed. Listed below is information concerning OI's peer review activities during prior reporting periods.

OI	Date	Reviewing Office	Office Reviewed
	June 2014	HHS-OIG, OI	TIGTA

The system of internal safeguards and management procedures for the investigative function of TIGTA, in effect through June 2014, were in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

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

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

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

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

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

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

Appendix C: Summary of Sanction authorities

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

Program Exclusions

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

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

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

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

Civil Monetary Penalties Law

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

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

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

Patient Dumping

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

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

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

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

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

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

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

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

Appendix D: Reporting requirements in the Inspector General Act of 1978

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

Section	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	"Other HHS-Related Issues" section
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout this report
(a)(3)	Prior significant recommendations on which corrective action has not been completed	OIG <i>Compendium of Unimplemented Recommendations</i>
(a)(4)	Matters referred to prosecutive authorities	"Legal and Investigative Activities" section
(a)(5)	Summary of instances in which information requested by OIG was refused	None
(a)(6)	List of audit reports	Submitted to the Secretary under separate cover
(a)(7)	Summary of significant reports	Throughout this report
(a)(8)	Statistical Table 1 – Reports With Questioned Costs	Appendix A
(a)(9)	Statistical Table 2 – Funds Recommended To Be Put to Better Use	Appendix A
(a)(10)	Summary of previous audit reports without management decisions	Appendix A
(a)(11)	Description and explanation of revised management decisions	Appendix A
(a)(12)	Management decisions with which the Inspector General disagrees	None
(a)(13)	Information required by the FISMA	Reported annually in the spring <i>Semiannual Report to Congress</i> , "Other HHS-Related Issues" section

Section	Requirement	Location
(a)(14)-(16)	Results of peer reviews of HHS-OIG conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by HHS-OIG of other OIGs	Appendix C

Other reporting requirements

Section	Requirement	Location
845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for FY 2008 (P.L. No. 110-181), § 845.	"Other HHS-Related Issues" section
205	Pursuant to HIPAA (P.L. No. 104-191), § 205, the Inspector General is required to solicit proposals annually via a Federal Register notice for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b) and for developing special fraud alerts. The Inspector General is also required to report annually to Congress on the status of the proposals received related to new or modified safe harbors.	Reported annually in the fall <i>Semiannual Report</i> . Appendix F
1553	Pursuant to the American Recovery and Reinvestment Act of 2009, § 1553, OIG reports to Congress the retaliation complaint investigations it decided not to conduct or continue during the period.	"Other HHS-Related Issues" section