

U.S. Department of Health & Human Services
Office of Inspector General

SEMIANNUAL REPORT *to* CONGRESS

October 1, 2016 *to*
March 31, 2017



A MESSAGE FROM THE INSPECTOR GENERAL



*Daniel R. Levinson
Inspector General*

I am pleased to submit this Semiannual Report to Congress summarizing 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, 2017. OIG’s mission is to protect the integrity of HHS programs and ensure the health and welfare of the beneficiaries they serve. Our dedicated employees work to fight fraud; enhance safety and quality of care; improve efficiency of program operations; reduce improper payments; foster prudent payment policies; and improve data integrity and information security. OIG’s diverse workforce combines traditional disciplines—auditors, evaluators, investigators, and attorneys—with additional expertise in medicine, technology, data analytics, and economics to prevent fraud and abuse through recommendations to improve program operations; to use data modeling and other techniques to detect problems quickly; and to take appropriate enforcement action when we identify fraudulent and abusive practices.

During this reporting period, we had significant accomplishments overseeing the Department’s more than \$1 trillion portfolio of health and human services. For example, we continued to partner with HHS, the Department of Justice, U.S. Attorneys’ Offices, the Federal Bureau of Investigation, and State and local law enforcement in Health Care Fraud Strike Force teams. During the reporting period, Strike Force efforts resulted in the filing of charges against 49 individuals or entities, 152 criminal actions, and more than \$266.8 million in investigative receivables. Also during this reporting period, we issued noteworthy reviews of many critical Department services and expenditures. One such review examined Federal payments for Medicare Part D catastrophic coverage; these payments exceeded \$33 billion in 2015, more than triple the amount paid in 2010. OIG data analysis revealed 10 high priced drugs that accounted for nearly one-third of this spending, and we determined that CMS will likely need additional tools to secure the future of the Part D program. In two reviews, we closely examined the challenges affecting the ability of Indian Health Service hospitals to provide safe, quality care to patients. Through issuance of new Anti-Kickback Statute safe harbors,

including one that aids beneficiaries in obtaining needed transportation for treatment, we enhanced flexibility for providers to improve efficiency and access to quality care while we continued to protect programs and patients from fraud and abuse.

Looking to the future, OIG is tracking its own performance in priority areas, such as the following: (1) protecting beneficiaries from prescription drug abuse; (2) reducing improper payments for home health services in fraud “hot spots”; (3) improving program integrity for the Child Care and Development Fund grant programs; and (4) maximizing the effectiveness of State Medicaid Fraud Control Units. We will build on our experience and expertise in pursuit of measurable improvements in these and other important areas. We will remain an agile organization focused on the most pressing issues facing Department programs.

OIG remains committed to working collaboratively with our partners to protect beneficiaries and oversee HHS’s programs. The success reflected in this Semiannual Report to Congress derives from the efforts of a dedicated, multidisciplinary workforce in OIG. Once again, I would like to express my appreciation to Congress and to the Department for their sustained commitment to the important work of our office.

Daniel R. Levinson
Inspector General

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 HHS programs and operations. 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 (GAO), the Department of Justice (DOJ), and the Inspector General community. OIG carries out its 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. Our work is conducted by the following operating components.

OAS

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

OEI

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

OI

The Office of Investigations (OI). 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, the District of Columbia, and Puerto Rico, OI coordinates with DOJ and other Federal, State, and local law enforcement authorities. OI also coordinates with OAS and OEI when audits and evaluations uncover potential fraud. OI's investigative efforts often lead to criminal convictions, administrative sanctions, or civil monetary penalties (CMPs).

OCIG

The Office of Counsel to the Inspector General (OCIG). 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, self-disclosure, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements (CIAs). OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry about the anti-kickback statute and other OIG enforcement authorities.

EM

Executive Management (EM). 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 (IT), 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. EM provides critical data analytics, data management, and IT infrastructure that enables OIG components to conduct their work efficiently and effectively.

OIG's Approach to Driving Positive Change

AS DELINEATED IN OIG'S STRATEGIC PLAN, OIG's approach to protecting the integrity of HHS programs has four key goals: (1) fight fraud, waste, and abuse; (2) promote quality, safety, and value; (3) secure HHS programs' future; and (4) advance excellence and innovation. These goals drive OIG's work planning for audits and evaluations as well as OIG's approach to enforcement. OIG focuses on efficient oversight and on achieving outcomes that benefit the Department's programs and the people they serve.

Top Management Challenges Facing HHS

To focus the Department's attention on the most pressing issues, each year OIG identifies the **Top Management and Performance Challenges** facing the Department. These top challenges arise across HHS programs and Operating Divisions, including Medicare, Medicaid, Administration for Children and Families (ACF), the Public Health Service, the Indian Health Service (IHS), and the Food and Drug Administration (FDA). The top challenges cover critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity.

OIG Work Plan

OIG's **Work Plan** sets forth various projects that OIG plans to undertake during the fiscal year (FY) and beyond. Projects listed in the Work Plan span the Department's Operating Divisions, including the Centers for Medicare & Medicaid Services (CMS), public health agencies such as the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH), and human resources agencies such as ACF and the Administration on Aging. The Work Plan also includes oversight of State and local governments' use of Federal funds as well as the administration of the Department. Some of the projects described in the Work Plan are statutorily required.

Compendium of Unimplemented Recommendations

OIG drives positive change not only by identifying problems, abuses, and deficiencies but also by recommending solutions to address them. OIG maintains a list of recommendations to address vulnerabilities detected in its reviews and identifies the top unimplemented recommendations that, if implemented, are likely to garner significant savings and improvements in quality, efficiency, and effectiveness. OIG systematically follows up on its recommendations with responsible Operating Divisions. OIG compiles its top and most significant unimplemented recommendations in our **Compendium of Unimplemented Recommendations**.

OUR SEMIANNUAL REPORT TO CONGRESS (SEMIANNUAL REPORT) describes OIG’s work in identifying significant problems, abuses, deficiencies, remedies, and investigative outcomes relating to the administration of HHS programs and operations. This edition addresses work completed during the reporting period, October 1, 2016, to March 31, 2017.

Enhancing Safety and Quality of Care

Programs operated and administered by HHS touch the lives of nearly all Americans. For example, FDA’s oversight of our food, drugs, and medical devices is critical to the well-being of the American population. Furthermore, the Medicare and Medicaid programs provide essential health care services to more than 120 million people. HHS faces special challenges serving vulnerable populations, including recipients of nursing home care, hospice care, and home- and community-based services (HCBS); IHS beneficiaries; and children.

During this semiannual period, OIG continued its work identifying whether States verify that nursing homes are correcting previously identified deficiencies. In our report, we found that [Arizona](#) did not verify nursing homes’ correction of deficiencies in accordance with Federal requirements for more than half of the deficiencies identified during previous State surveys. We found that Arizona’s practice for less serious deficiencies was to accept the nursing homes’ correction plans as confirmation of substantial compliance without obtaining the required evidence of correction.

During this reporting period, OIG also issued two reports examining issues affecting IHS hospitals’ ability to provide quality care and comply with Medicare standards. These reports described [longstanding challenges](#) in IHS hospitals, including ensuring access to needed care, maintaining clinical competence, recruiting and retaining essential staff, and keeping patients safe despite outdated buildings and equipment. We also found [limitations in IHS’s monitoring](#) of quality of care. IHS has few sources of information on its hospitals’ performance and a limited capacity to provide clinical support; moreover, it lacks the quality assurance infrastructure and monitoring efforts that it urgently needs.

Improving Efficiency of Program Operations

To protect taxpayer dollars, HHS must run its programs efficiently. OIG looks for opportunities for the Department to enhance efficiency in fiscal management, as well as in administrative infrastructure and program execution.

During this semiannual period, OIG continued to engage in management reviews of new program implementation. In December 2016, OIG issued an early implementation review of CMS’s management of the [Quality Payment Program](#) (QPP). OIG found that CMS made significant progress toward implementing the QPP, a set of clinician payment reforms

designed to put increased focus on the quality and value of care. However, OIG identified two vulnerabilities that CMS must address in 2017 because they are critical to the program's success: providing sufficient guidance and technical assistance to ensure that clinicians are ready to participate in the QPP and developing IT systems to support data reporting, scoring, and payment adjustment.

OIG's work on sound financial management includes ensuring that Medicaid programs obtain prescription drug rebates to which they are entitled. **In a series of reports**, OIG is determining whether each State billed and collected from pharmaceutical manufacturers the rebates they owed to States and the Federal Government for outpatient drugs dispensed in the Medicaid program. In this semiannual reporting period, OIG issued reports focusing on claims from three States (**Colorado**, **California**, and **Virginia**) for Federal reimbursement for some Medicaid physician-administered drugs. Consistent with previous findings, OIG found instances in which the audited States did not always invoice and collect all rebates due for drugs administered by physicians.

Efficiency of operations also extends to oversight of HHS's \$100 billion discretionary grant portfolio. During this semiannual period, OIG continued its oversight of grants by focusing on childcare program grant funds. In one report in which we reviewed Head Start funds received by the **Newark Preschool Council**, we identified \$10 million in unallowable funds for costs applicable to under-enrollment, general and administrative expenses, unauthorized purposes, and salary payments. In another report, OIG found that **Puerto Rico** lacked sufficient policies and procedures to properly identify and assign childcare funds to voucher payments in accordance with Federal requirements.

Reducing Improper Payments

Improper payments, as reported in the Department's financial statements, have demonstrated a steady increase over the last several years. In FY 2016, the Department **reported** estimated improper payments of more than \$96 billion.

During this semiannual period, OIG issued several audits that identified improper payments as a result of issues related to eligibility determinations:

- **Express Lane Eligibility.** Under the express lane eligibility option, which allows States to expedite and simplify enrollment in Medicaid and the Children's Health Insurance Program (CHIP) by relying on findings from other agencies' eligibility determinations, we estimated that improper Medicaid payments on behalf of potentially ineligible beneficiaries totaled \$284.1 million. CHIP payments for potentially ineligible beneficiaries totaled \$10.6 million.
- **Payments after death.** Medicare and Medicaid continue to make improper payments on behalf of beneficiaries who are deceased. During this reporting period, we found that Florida did not always stop making capitation payments to Medicaid managed care organizations (MCOs) after a beneficiary's death, resulting in more than \$26 million in overpayments.

- **Incarcerated beneficiaries.** We continued our work reviewing inappropriate payments for incarcerated beneficiaries, recently reporting that CMS has not taken steps to recoup \$34 million in potentially improper payments made on behalf of incarcerated beneficiaries.

OIG also issued several audits identifying payments for medical devices and services that providers should not have billed:

- **Improper Payments for Chiropractic Services.** Based on our sample results, we estimated that \$358.8 million (82 percent) of \$438.1 million paid by Medicare for chiropractic services was unallowable.
- **Room and Board Costs Associated with HCBS Waiver Program Payments.** State Agencies claimed at least \$176 million in unallowable Medicaid reimbursements for services under the HCBS waiver program.
- **Improper Payments for Cochlear Devices.** Medicare spent \$2.7 million inappropriately for cochlear devices (hearing aid devices) that were replaced without cost to the hospital or beneficiary.

In addition to work identifying situations in which providers should not have billed CMS for specific medical devices or services, OIG also has a body of work looking at situations where providers billed for goods and services at higher rates than allowed by program regulations. In this reporting period, OIG looked at how a hospital's reporting of inaccurate **wage data** affected Medicare payments for hospital services.

Fostering Prudent Payment Policies

In an effort to secure HHS programs' future, OIG assesses payment policies and identifies vulnerabilities and misaligned incentives.

During this semiannual reporting period, OIG reported on several vulnerabilities in hospital billing under Medicare's **2-midnight policy** for determining a patient's status as inpatient or outpatient. OIG identified a large number of potentially inappropriate short inpatient stays and an increased number of beneficiaries in outpatient stays facing higher coinsurance costs and more limited access to skilled nursing facility (SNF) services compared to beneficiaries receiving the same care as inpatients. These findings raise concerns about costs to Medicare and beneficiaries.

In another report on payment policies, OIG found that Federal payments for **Part D catastrophic coverage** exceeded \$33 billion in 2015, which is more than triple the amount paid in 2010. Spending for high-price drugs contributed significantly to this growth. Ten high-price drugs accounted for nearly one-third of all drug spending for catastrophic coverage in 2015. The issue of high-price drugs is not exclusive to catastrophic coverage; it affects Federal payments for the entire Part D benefit and can lead to higher premiums and drug costs for patients.

Improving Data Integrity and Information Security

To fulfill its mission, the Department maintains and uses data related to Federal health insurance programs, public health and human services, and the beneficiaries whom the Department serves. With the sheer amount of data and its complexity, however, the Department continues to face challenges in effectively using data to detect and prevent improper payments and to ensure safety and quality of care for program beneficiaries. HHS also faces challenges to protect the privacy and security of the data it collects and maintains.

During this reporting period, OIG continued to work on privacy and security of data, focusing on network and web application penetration testing. The objective of the testing is to determine whether security controls are effective in preventing certain cyber-attacks, the likely level of sophistication an attacker needs to compromise systems or data, and the agencies' ability to detect attacks and respond appropriately.

Fighting Fraud in HHS Programs

OIG remains at the forefront of the Nation's efforts to fight fraud, waste, and abuse in HHS programs and hold wrongdoers accountable for their actions. During the first half of FY 2017, OIG reported expected investigative recoveries of over \$2.04 billion. OIG also reported 468 criminal actions against individuals or entities that engaged in crimes against HHS programs, 461 civil actions, and 1,422 exclusions of individuals and entities from participation in Federal health care programs.

To fulfill our mission, OIG uses state-of-the-art investigative techniques and innovative data analytics. These techniques support our investigations as part of the Medicare Fraud Strike Force – a partnership between OIG, DOJ, and other Federal, State, and local law enforcement agencies to combat health care fraud. Strike Force teams use data analytics to detect and investigate health care fraud through a coordinated and data-driven approach. During this semiannual period, Strike Force efforts led to multiple investigations, including a case in which four defendants involved in a home health care and hospice Medicare fraud scheme were sentenced to a combined 35 years and 2 months in prison and ordered to pay \$33 million in restitution, joint and several.

OIG has formed strong public and private partnerships to amplify our enforcement success. During this reporting period, OIG special agents partnered with Medicaid Fraud Control Units (MFCUs) on 714 criminal investigations. Results from those investigations included a 33-year prison sentence for a former staff physician for the City of Houston who was convicted on 14 counts of health care fraud. OIG continues to participate in the Health Care Fraud Prevention Partnership, a national public-private partnership aimed at fighting and preventing health care fraud through information sharing. We also work with industry groups focused on fraud prevention, such as the National Health Care Anti-Fraud Association and the Health Care Compliance Association.

During the semiannual period, OIG conducted a wide array of enforcement activities. Key areas for enforcement included:

- **Prescription drugs:** OIG is committed to combating drug diversion and pursues numerous cases against providers who knowingly engage in drug diversion. In one recent example, an OIG investigation led to a [physician being sentenced](#) to 30 years for operating a “pill mill” with Pagan’s Motorcycle Club.
- **Care in non-institutional settings:** OIG continues to focus on fraud in non-institutional settings, including in Medicare home health services and HCBS, including personal care services (PCS). For example, during this reporting period, an OIG investigation led to guilty pleas of nine defendants in a \$33 million Detroit [home health and hospice fraud scheme](#). Further, we issued an [Investigative Advisory](#) on Medicaid fraud and patient harm involving PCS.
- **Grant fraud:** A significant and growing portion of OIG’s enforcement efforts target grant fraud. In one grant fraud case during this reporting period, an executive of a health care center received an 18-year prison sentence and was ordered to pay \$13.5 million in restitution for [embezzling \\$17 million](#) in HHS grant funds.

The body of this Semiannual Report provides further details about the examples used in this Executive Summary. The remainder of this report is organized by HHS program area and includes audit and evaluation reports and the results of our investigations for this reporting period. This report also includes appendices that fulfill our reporting requirements under the Inspector General Act of 1978 and Inspector General Empowerment Act of 2016.

OIG Participation in Congressional Hearings



Jan 31, 2017

Vicki L. Robinson, Senior Counselor for Policy, testified before the House Committee on Oversight and Government Reform: Subcommittee on Health Care, Benefits, and Administrative Rules: “Fraud, Waste, and Abuse Under the Affordable Care Act.”



Jan 31, 2017

Ann T. Maxwell, Assistant Inspector General, testified before the House Committee on Energy and Commerce: Subcommittee on Oversight and Investigations: “Existing Problems and Ways to Strengthen the Program.”



March 9, 2017

Daniel R. Levinson, Inspector General, testified before the House Committee on Appropriations: Subcommittee on Labor, Health and Human Services, Education, and Related Agencies: “Management Challenges at the Departments of Labor, Health and Human Services, and Education and the Social Security Administration.”

Selected Acronyms and Abbreviations

ACA	Patient Protection and Affordable Care Act	HCBS	home and community-based services
ACF	Administration for Children and Families	HHS	Department of Health and Human Services
CDC	Centers for Disease Control and Prevention	IHS	Indian Health Service
CIA	corporate integrity agreement	IT	information technology
CHIP	Children's Health Insurance Program	MAC	Medicare Administrative Contractors
CMP	civil monetary penalty	MCO	managed care organization
CMS	Centers for Medicare & Medicaid Services	MFCU	Medicaid Fraud Control Unit
CY	calendar year	NIH	National Institutes of Health
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies	OIG	Office of Inspector General
DOJ	Department of Justice	OMB	Office of Management and Budget
FBI	Federal Bureau of Investigation	PCS	personal care services
FDA	Food and Drug Administration	SAMHSA	Substance Abuse and Mental Health Services Administration
FY	fiscal year	SNF	skilled nursing facility
GAO	Government Accountability Office		

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The Medicare Program

CMS Oversight of Medicare Contractor Performance

CMS relies on contractors to administer the Medicare program and is responsible for overseeing contractors' performance. Medicare contractors are responsible for administering more than half a trillion dollars in benefits each year. Medicare Administrative Contractors (MACs) process Parts A and B claims; Medicare Advantage 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.

Medicare Contractors' Payments to Providers for Hospital Outpatient Dental Services Generally Did Not Comply With Medicare Requirements

In our previous audits of six Medicare contractors, we found that payments made to providers for hospital outpatient dental services generally did not comply with Medicare requirements. Of the 600 dental services in our 6 stratified random samples, 542 did not comply with Medicare requirements. We estimated that the six Medicare contractors in our audits improperly paid providers an estimated \$9.8 million for hospital outpatient dental services that did not comply with Medicare requirements.

CMS disagreed with our recommendation to implement national edits for hospital outpatient dental services but agreed to work with the Medicare contractors to develop or strengthen their local edits to ensure that payments made to providers for dental services comply

with Medicare requirements.

A-06-16-05003 • March 2017

Medicare Payments, Policies, and Practices

Medicare Improperly Paid Providers Millions of Dollars for Incarcerated Beneficiaries Who Received Services During 2013 and 2014

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to establish policies and implement claim edits to ensure that payments are not made for Medicare services rendered to incarcerated beneficiaries. Our audit found that CMS's policies and procedures did not allow CMS to detect and recoup improper payments to beneficiaries who were incarcerated. CMS has not taken steps to determine whether any of the \$34.6 million in potentially improper payments (for claims for incarcerated beneficiaries) made in 2013 and 2014 should have been denied.

We also found that CMS's planned corrective revisions to its policies and procedures do not comply with Medicare requirements. When CMS implements its revised policies and procedures, it will, according to CMS officials, further adjudicate the \$34.6 million in claims. However, because the data that CMS plans to use will be incomplete, these efforts will not identify all improper payments.

CMS did not concur with our recommendation to develop and implement a system that allows CMS to collect the information necessary to fully comply with Medicare requirements and, if necessary, seek the

appropriate legislation and funding. CMS concurred with our recommendations to review the \$34.6 million in claims to determine which portion, if any, was not claimed in accordance with Medicare requirements; direct the Medicare contractors to recoup any ensuing improper payments; and identify improper payments made on behalf of incarcerated beneficiaries after our audit period to ensure that Medicare contractors recoup those payments.

[A-07-15-01158](#) • October 2016

Medicare's Policies and Procedures Identified Almost All Improper Claims Submitted for Deceased Individuals and Recouped Almost All Improper Payments Made for These Claims for January 2013 Through October 2015

OIG found that CMS had policies and procedures in place to ensure that payments were not made for Medicare services ostensibly rendered to deceased individuals. These policies and procedures generally ensured that CMS did not make improper payments when its data systems indicated at the time a claim was processed that the individual had died before the claimed date of service. They also ensured that CMS correctly identified and recouped improper payments for almost all of the cases in which the Enrollment Database (EDB) was updated with date-of-death information after the claims had been processed and paid.

We also found that CMS did not identify and recoup all improper payments. Specifically, for our audit period we identified \$426,000 in improper payments for 427 Medicare claims and \$1.5 million in potentially improper payments for 1,047 Medicare claims with dates of service that were after the individuals' dates of death.

CMS concurred with all of our recommendations to direct Medicare contractors to initiate recoupment for \$415,000 in improper payments associated with the 332 claims whose dates of service were after the individuals' dates of death; confirm that the \$11,000 in improper payments associated with the 95 claims that we identified have been recouped; and review the accuracy of the beneficiary dates of death to determine whether any of the \$1.5 million relating to the 1,047 claims with conflicting date-of-death information were improper payments and, if so, direct Medicare contractors to initiate recoupment for the identified amounts.

[A-07-16-05089](#) • October 2017

Hundreds of Millions in Medicare Payments for Chiropractic Services Did Not Comply With Medicare Requirements

A previous OIG report found that, as chiropractic care for a beneficiary extended beyond 12 treatments in a year, it became increasingly likely that individual services were medically unnecessary. In addition, four OIG reviews of individual chiropractors found that Medicare made improper payments for chiropractic services that were medically unnecessary, incorrectly coded, insufficiently documented, or not documented. Our current report found that most Medicare payments for chiropractic services did not comply with Medicare requirements. Based on our sample results, we estimated that \$358.8 million (82 percent) of the \$438.1 million paid by Medicare for chiropractic services was unallowable. These overpayments occurred because CMS's controls were not effective in preventing payments for medically unnecessary chiropractic services.

The Medicare Program

The Medicaid Program

Centers for Medicare
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We made four recommendations to CMS that could have saved Medicare an estimated \$358.8 million for 2013. CMS concurred with our recommendations to determine a reasonable number of chiropractic services necessary to actively treat spinal subluxation and identify services for review in excess of that number and to improve education of chiropractors on Medicare coverage requirements for chiropractic services. CMS did not concur with our recommendation to determine a reasonable limit for the number of chiropractic services that Medicare will reimburse and implement a system edit to disallow services in excess of that limit. CMS did not comment on our recommendation to identify significant obstacles to developing a more reliable control for identifying maintenance therapy and work to establish such a control.

[A-09-14-02033](#) • October 2016

Wisconsin Physicians Service Insurance Corporation Did Not Properly Settle Indiana Medicare Disproportionate Share Hospital Cost Report Payments

Medicare, like Medicaid, includes provisions under which Medicare-participating hospitals (providers) that serve a disproportionate share of low-income patients may receive disproportionate share hospital (DSH) payments. Because these payments are the result of calculations to which a number of sometimes complex factors and variables (one of which is referred to as “Medicaid patient days”) contribute, they are at risk of overpayment. We found that Wisconsin Physicians Service (WPS) did not properly settle Medicare cost reports submitted by Indiana hospitals for Medicare DSH payments in accordance with Federal requirements, resulting in DSH overpayments totaling

\$6.1 million. These improper claims included both unallowable and unsupported patient days.

WPS concurred with our recommendation to revise the finalized Medicare cost report settlements to recover and refund \$6.1 million in Medicare DSH overpayments. WPS did not concur with our recommendations to revise final cost report settlements that we did not review, recover and refund any additional Medicare DSH overpayments, and identify and obtain any State-level guidance affecting recipient categories that figure into Medicare DSH cost report payments.

[A-07-15-04219](#) • November 2016

Hospitals Did Not Always Comply With Medicare Requirements for Reporting Cochlear Devices Replaced Without Cost

Previous OIG reviews found that hospitals did not always comply with Medicare requirements for reporting credits received from manufacturers for replaced medical devices. Our compliance reviews at specific hospitals nationwide identified approximately \$10 million in Medicare overpayments attributable to hospitals that did not report to CMS device manufacturer credits that they received or that were available under the terms of manufacturer warranties that they did not obtain. During this review, we found that hospitals nationwide did not always comply with Medicare requirements for reporting cochlear devices (hearing aids) replaced without cost to the hospital or beneficiary. For the 116 incorrectly billed claims we identified, hospitals received \$2.7 million in Medicare overpayments.

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CMS concurred with our recommendations that it instruct the Medicare contractors to (1) verify the \$1.4 million in identified overpayments that hospitals stated they refunded to Medicare during our review; (2) recover \$686,000 in identified overpayments for calendar years (CY) 2013 and 2014 that had not been refunded to Medicare; (3) assist hospitals in returning the agreed-upon overpayments of \$553,000 for CY 2012 claims that are outside the Medicare 4-year reopening period; and (4) educate hospitals on how to appropriately bill for and report medical devices replaced without cost to the hospital or beneficiary, including cochlear devices.

[A-01-15-00508](#) • November 2016

Nantucket Cottage Hospital Did Not Accurately Report Certain Wage Data, Resulting in Overpayments to Massachusetts Hospitals

Medicare acute-care hospitals must report wage data annually to CMS. CMS uses the wage data to calculate acute-care hospital wage indexes, which measure geographic area labor market costs relative to a national average. Federal law requires CMS to annually adjust Medicare hospital payments to reflect local labor markets; CMS uses area wage indexes to do this. Previous OIG reviews found that hospitals often reported inaccurate wage data, which resulted in increased Medicare payments in their designated geographic area. Our current review found that Nantucket Cottage Hospital (the Hospital) did not always comply with Medicare requirements for reporting wage data in its FY 2011 Medicare cost report. As a result, the Hospital overstated wages and wage-related costs by \$232,000 (net) and understated hours by 18,060 (net).

Because of the cost reporting errors, we estimated that Medicare overpaid the Hospital \$156,000 for FY 2015 inpatient services and CY 2015 outpatient services. We also estimated that Medicare overpaid 55 other hospitals in Massachusetts a total of \$133.6 million for FY 2015 inpatient services and CY 2015 outpatient services because the Hospital's wage data set the rural floor wage index for Massachusetts.

The Hospital did not concur with our recommendation to ensure that all personnel involved in Medicare cost report preparation follow the requirements in the CMS Provider Reimbursement Manual. The Hospital concurred with our recommendation to strengthen review and reconciliation procedures to ensure that the Medicare wage data it reports to CMS in the future are accurate, allowable, supportable, and in compliance with Medicare requirements.

[A-01-15-00502](#) • March 2017

Vulnerabilities Remain Under Medicare's 2-Midnight Hospital Policy

CMS implemented the 2-midnight rule to address concerns about hospitals' use of short inpatient and long outpatient stays. The rule establishes that inpatient payment is generally appropriate if physicians expect beneficiaries' care to last at least 2 midnights; otherwise, outpatient payment is generally appropriate. During our review, we identified several vulnerabilities in hospital billing under Medicare's 2-midnight policy, including a large number of potentially inappropriate short inpatient stays and an increased number of beneficiaries in outpatient stays paying more and having limited access to skilled nursing facility (SNF) services

compared to inpatients. These findings raise concerns about the cost to Medicare and beneficiaries. We recommended that CMS conduct analyses like those in this evaluation to target their oversight. We also recommended that CMS explore ways to ensure that beneficiaries receiving hospital care in outpatient status have similar cost-sharing protections and access to SNF care as beneficiaries receiving similar hospital care in inpatient status. CMS concurred with all of our recommendations.

[OEI-02-15-00020](#) • December 2016

Early Implementation Review: CMS's Management of the Quality Payment Program

CMS has made significant progress toward implementing the Quality Payment Program (QPP), a set of clinician payment reforms designed to put increased focus on the quality and value of care. As of December 2016, CMS had finalized key policies to implement the QPP, initiated engagement and outreach activities to clinicians, launched a public-facing informational website, and awarded various contracts for technical assistance and training. Although many milestones remain before the QPP payment adjustments begin in 2019, OIG identified two vulnerabilities that are critical for CMS to address in 2017 because of their potential impact on the program's success: providing sufficient guidance and technical assistance to ensure that clinicians are ready to participate in the QPP, and developing IT systems to support data reporting, scoring, and payment adjustment.

CMS officials stated they were committed to continuing to engage with clinicians and provide them with

assistance, and to optimize back-end IT systems support.

[OEI-12-16-00400](#) • December 2016

Drug Pricing and Reimbursement

High-Price Drugs Are Increasing Federal Payments for Medicare Part D Catastrophic Coverage

Federal payments for Part D catastrophic coverage exceeded \$33 billion in 2015, which is more than triple the amount paid in 2010. Spending for high-price drugs contributed significantly to this growth. Moreover, 10 high-price drugs accounted for nearly one-third of all drug spending for catastrophic coverage in 2015. The issue of high-price drugs is not exclusive to catastrophic coverage; it affects the entire Part D benefit and can lead to higher costs for patients. Securing the future of the Part D program while ensuring that patients have access to needed drugs is a complex issue that calls for a multifaceted approach. Recently, CMS has taken steps in response to rising drug prices. Moving forward, CMS will likely need additional tools. Potential tools have been discussed by experts and include restructuring the Part D benefit, creating more transparency, promoting value-based options, and revising the law to allow the Federal Government to negotiate prices for certain drugs. CMS should carefully assess these and other options and, working with Congress, make any needed changes to the Part D program.

[OEI-02-16-00270](#) • January 2017

Oversight of the Medicare Competitive Bidding Program

Medicare Market Shares of Mail Order Diabetes Test Strips From April to June 2016 and Medicare Market Shares of Mail Order Diabetes Test Strips From July Through September 2016

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to phase in a Competitive Bidding Program for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Under this program, suppliers compete to become Medicare contract suppliers for selected DMEPOS items, including diabetes test strips provided via mail order. Additionally, the Medicare Improvements for Patients and Providers Act (MIPPA) requires mail order suppliers to demonstrate in their bids that they can provide at least 50 percent, by volume, of the types of diabetes test strips provided to Medicare beneficiaries.

OIG is conducting three studies to determine the Medicare market shares of diabetes test strips for the periods April through June 2016, July through September 2016, and October through December 2016, respectively. For the first review, we found that from April to June 2016, sampled suppliers provided 30 types of diabetes test strips via mail order. Of these strips, two types accounted for about one-half of the mail order market. Therefore, a supplier's bid would meet the MIPPA 50-percent rule if the bid declared that the supplier intended to provide either (1) both of these 2 types of strips or (2) at least 1 of these 2 types of strips and a combination of certain subsets of the other 28 types of strips sufficient to reach 50 percent. Further, we found that 5 types of diabetes test strips accounted for 81 percent of the Medicare mail order market share, and 10 types accounted for 93 percent. CMS will use

our data to help ensure that contracted suppliers' bids adhere to the 50-percent rule.

For the second review, we found that from July through September 2016, sampled suppliers provided 18 types of diabetes test strips via mail order. The top strip type accounted for 43 percent of the mail order market, and the top 10 strip types accounted for 98 percent. The third report will be published in summer 2017.

[OEI-04-16-00470](#) • November 2016

[OEI-04-16-00471](#) • February 2017

Quality of Care and Beneficiary Access

Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy

Inpatient rehabilitation (rehab) hospitals are freestanding facilities that specialize in providing intensive rehab therapy to patients recovering from illness, injury, or surgery. This intensive therapy requires endurance that some patients receiving post-acute care do not have, potentially causing those patients to be better suited for an alternate setting, such as a SNF. Medicare criteria for admission to post-acute care help ensure that patients receive the most appropriate care for their conditions and needs. We found that Medicare patients who were not suited for intensive rehab therapy had physical limitations, lacked endurance, had unresolved health problems, or had an altered mental status. Most of these patients (32 of 39 stays) remained in inpatient rehab hospitals for extended periods (which we defined as stays lasting longer than 3 days) despite being unable to participate and benefit from intensive

therapy. For 7 of the 39 stays, the medical records indicated that the patients were in exceptionally poor condition and died within a few weeks after being admitted to an inpatient rehab hospital.

We encouraged CMS to consider providing additional technical assistance to ensure that Medicare patients are placed in the most appropriate setting for post-acute care, and that inpatient rehab hospitals do not admit patients who are unable to participate in and benefit from intensive therapy.

[OEI-06-16-00360](#) • December 2016

The Medicaid Program

Payments, Policies, and Practices

To fund their Medicaid programs, States receive Federal grant awards that pay for the Federal share of their Medicaid medical and administrative expenditures. OIG conducts audits on States' withdrawals of Federal Medicaid funds to determine whether a State submitted an improper claim for Federal reimbursement and, therefore, may owe money to the Federal Government. If a State disagrees with our recommendation to refund questioned costs identified in an audit, CMS still has the authority to recoup those costs.

North Carolina Claimed Millions in Unallowable School-Based Medicaid Administrative Costs and Mississippi Claimed Millions in Unallowable School-Based Medicaid Administrative Costs

States can be reimbursed for school-based administrative activities that directly support identifying and enrolling potentially eligible children in Medicaid. School-based Medicaid administrative costs are one

type of public assistance cost that can be reimbursed, if costs claimed comply with Federal requirements. Random moment sampling (RMS) is one acceptable method for allocating salaries and wages among Medicaid and other programs.

In prior reviews of school-based and community-based administrative costs that States allocated to Medicaid using RMS, we identified significant overpayments. As part of our Medicaid risk assessment, we noted that North Carolina and Mississippi used statistically invalid RMS in allocating costs to Medicaid and did not promptly submit to HHS for review their cost allocation plan (CAP) amendments describing their new random moment time study (RMTS) methodology. As a result, North Carolina claimed almost \$107.5 million (almost \$53.8 million Federal financial participation) and Mississippi claimed almost \$42.4 million (almost \$21.2 million Federal financial participation) in unallowable school-based Medicaid administrative costs for Federal FYs 2010 through 2012.

North Carolina and Mississippi did not specifically address our recommendations to refund unallowable costs to the Federal Government; address the statistical validity issues we identified; implement policies and procedures to ensure that their RMTS comply with Federal requirements for statistical validity; maintain adequate support for school-based administrative costs; promptly submit to HHS for review and approval future CAP amendments; and review school-based Medicaid administrative costs claimed after our audit period and refund unallowable amounts.

[A-04-15-00101](#) • October 2016

[A-04-15-00103](#) • March 2017

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State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home- and Community-Based Services Waiver Program

In this review, we described instances from eight previous audits in which States did not always comply with Federal requirements in administering their HCBS waiver programs. Specifically, States did not always exclude unallowable room-and-board costs when determining payment rates under the HCBS waiver program, resulting in unallowable Medicaid reimbursement. States did not have adequate controls to ensure that their HCBS waiver programs complied with applicable Federal requirements regarding the need to exclude unallowable room-and-board costs when determining payment rates and to ensure that certain other costs complied with the requirements associated with their HCBS waiver programs. As a result, the States claimed at least \$176.5 million (Federal share) in unallowable and unsupported Federal Medicaid reimbursement for services under their HCBS waiver programs.

CMS concurred with our recommendations to share the findings of our HCBS waiver program audits with all States to reinforce Medicaid requirements that prohibit the inclusion of unallowable room-and-board costs when determining payment rates, share (at CMS's discretion) the other findings of our HCBS waiver program audits with all States, and encourage all States to review their procedures for calculating and claiming costs under their HCBS waiver programs.

[A-07-16-03212](#) • October 2016

North Carolina Improperly Claimed Federal Reimbursement for Some Medicaid Nonemergency Transportation Services and Louisiana Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program

The objective of these reviews was to determine whether the State agencies claimed Federal Medicaid reimbursement for nonemergency medical transportation (NEMT) services claims submitted by transportation providers in accordance with certain Federal and State requirements. We found that North Carolina and Louisiana claimed Federal Medicaid reimbursement for some NEMT services that did not comply with Federal or State requirements. Based on our sample results, we estimated that North Carolina improperly claimed at least \$18.7 million (\$12 million Federal share) for unallowable NEMT services for the audit period, and Louisiana claimed approximately \$1.1 million. North Carolina also improperly claimed \$20 million in NEMT administrative expenditures, which resulted in excess Federal reimbursement of \$3.1 million. Additionally, none of the 16 counties in our sample fully complied with the State's NEMT policy. Louisiana did not have adequate support for about \$183,000 (Federal share) of costs claimed.

North Carolina generally disagreed with our recommendations to refund \$12 million for unallowable NEMT services identified in our sample, refund \$3.1 million for the additional Federal reimbursement received for NEMT expenditures improperly claimed at the incorrect rate, improve the design of the NEMT program, monitor the results of the counties' reviews of transportation services and vendors, update its

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procedures for claiming Federal reimbursement for NEMT administrative costs, and implement regulations requiring safety and risk management measures as conditions of payment.

Louisiana partly agreed with our recommendations to refund \$1.1 million for improper claims, refund \$183,000 for costs claimed without adequate support, strengthen its policies and procedures to ensure that providers comply with all State and Federal requirements, and strengthen controls over its process for reporting expenditures claimed for NEMT services.

[A-04-15-04037](#) • November 2016

[A-06-15-00019](#) • January 2017

California Improperly Claimed Federal Medicaid Reimbursement for Certain Nonemergency Services

Federal health care benefits are generally allowable when provided to a beneficiary who is a U.S. citizen, U.S. national, or qualified alien. In general, a qualified alien is not permitted to receive Federal benefits until 5 years from the date he or she enters the United States with qualified alien status. States must have a system that verifies whether qualified aliens have met the required waiting period.

We found that California did not correctly identify all non-reimbursable claims for nonemergency services provided to qualified aliens for select quarters in State FYs 2010 through 2014. Specifically, the State agency's Medicaid Management Information System (MMIS) did not identify all claims for its adjustment reports for the audit period for which Federal reimbursement was

unallowable. As a result, the State agency claimed \$9.9 million in unallowable Federal Medicaid reimbursement.

California partially agreed with our recommendation to refund \$9.9 million to the Federal Government. California agreed with our recommendations to identify and refund the Federal share of overpayments for any quarters in State FYs 2015 and 2016 in which claims were approved for payment in one quarter and paid in a subsequent quarter, and to ensure that the MMIS correctly identifies all nonreimbursable claims for nonemergency services provided to qualified aliens.

[A-09-15-02020](#) • January 2017

Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio; Review of South Carolina Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio; and Review of California Medicaid Managed-Care Program Potential Savings With Minimum Medical Loss Ratio

We conducted a series of reviews to determine whether Medicaid could achieve savings if States required Medicaid MCOs to meet a minimum medical loss ratio (MLR) standard and pay remittances if the MLR standard was not met. An MLR is the percentage of premium dollars an insurer spends to provide medical services and health care quality improvement activities for its members compared to the premium dollars it uses to pay for administrative expenses.

The Massachusetts Medicaid program could have saved \$4.7 million (approximately \$3.5 million Federal share) in 2014 if the State agency required its Medicaid managed care plans to meet the minimum MLR

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standard and required remittances when Medicaid managed care plans did not meet the MLR standard. South Carolina’s Medicaid managed care program and nine California Medicaid MCOs would not have saved any Medicaid funds in 2014 if they had required their Medicaid managed care plans to meet the minimum MLR standard and required remittances when Medicaid managed care plans did not meet the MLR standard. Accordingly, we made no recommendations to South Carolina or California.

Massachusetts agreed with our recommendations to incorporate into its contracts with Medicaid MCOs the MLR standards adopted in the CMS final rule and consider implementing into its Medicaid MCO contracts a remittance requirement, if appropriate.

[A-01-15-00505](#) • November 2016

[A-04-16-06191](#) • December 2016

[A-09-15-02025](#) • January 2017

Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary’s Death

The Florida Statewide Medicaid Managed Care Program pays MCOs to provide covered health care services in return for a monthly fixed payment for each eligible beneficiary (capitated payment). In 2014, nearly all of Florida’s Medicaid beneficiaries were moved into managed care. Our audit found that Florida did not always stop making capitation payments after a beneficiary’s death, despite its efforts to identify and recover any overpayments. We estimated that Florida

made overpayments to MCOs totaling \$26.2 million (\$15.4 million Federal share) during our audit period.

Florida did not indicate whether it agreed or disagreed with our recommendations to identify and recover overpayments totaling \$26.2 million from MCOs and refund \$15.4 million (Federal share) to the Federal Government; perform monthly reviews of Florida Medicaid Management Information System (FMMIS) records to ensure that beneficiaries with dates of death (DODs) are removed from the Florida Statewide Medicaid Managed Care Program; implement policies and procedures for identifying and correcting inaccurate death information received through its sources of death data, specifically ensuring that differences in the DODs between the FMMIS and incoming death records are quickly resolved; and improve its collaborative efforts with the Social Security Administration, the Department of Children and Families, and Florida’s Bureau of Vital Statistics to identify and resolve inconsistencies in recipient information. Florida described steps it had taken or planned to take to implement our recommendations.

[A-04-15-06182](#) • November 2016

New Jersey Claimed Medicaid Adult Mental Health Partial Care Services That Were Not in Compliance With Federal and State Requirements

During a prior review of New Jersey’s claims for Medicaid services to adults with mental illness who reside in community residences, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. Based on these

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results, we decided to review clinic services provided to these Medicaid beneficiaries on an outpatient basis. For this review, we estimated that New Jersey improperly claimed at least \$94.8 million in Federal Medicaid reimbursement for partial care services that did not meet Federal and State requirements. The partial care services program provides individualized outpatient clinic services (e.g., group and individual therapy, prevocational services, and medication management) to beneficiaries with mental illness to reduce unnecessary hospitalization. The deficiencies occurred because New Jersey did not adequately monitor the partial care services program to ensure that providers complied with these requirements.

New Jersey disagreed with our recommendation to refund \$94.8 million to the Federal Government and generally agreed with our recommendations to issue guidance to the partial care provider community on Federal and State requirements for claiming these services and improve its monitoring of partial care providers to ensure compliance with Federal and State requirements.

A-02-13-01029 • December 2016

Express Lane Eligibility

Congress authorized States to adopt the Express Lane Eligibility (ELE) option, which allows States to expedite and simplify enrollment in Medicaid and CHIP by relying on findings from other agencies' eligibility determinations. Congress will determine whether to reauthorize the ELE option in 2017. OIG conducted three studies that fulfill a congressional mandate to

assess whether State agencies met Federal requirements in making eligibility determinations using ELE and developing eligibility error rates. See results of those reports below.

State Use of Express Lane Eligibility for Medicaid and CHIP Enrollment

This study examined the benefits and barriers to State use and expansion of ELE. We found that States that used ELE to expedite and simplify enrollment in Medicaid and CHIP adopted variations of three models, with more than half adopting an automated model that requires minimal action from staff and beneficiaries. All 14 States that used ELE reported benefits, including reduced administrative burden and cost savings, and some States reported that they rely heavily on ELE. Eleven States reported that they encountered barriers when they implemented ELE, such as problems sharing information across agencies, but reported that they overcame these barriers through strong partnerships and integrated eligibility systems. Despite largely positive experiences using ELE, 5 of the 14 States that adopted ELE discontinued its use, mainly because of competing priorities, system changes, and short-term agreements with partner agencies. None of the nine States still using ELE plan to expand its use.

We concluded that although State use of ELE is not widespread, ELE appears to meet the intended objective of easing the eligibility and enrollment process. Based on this review of State experiences with ELE, OIG did not identify any significant impediments to continuing to allow voluntary use of ELE once States and CMS have corrected process problems and gaps in oversight identified by OIG audits of ELE enrollments.

Reauthorization of the ELE option would allow States that rely on ELE to continue its use and give other States the opportunity to adopt ELE and likely experience similar benefits.

[OEI-06-15-00410](#) • October 2016

Medicaid Enrollment Using the Express Lane Eligibility Option Did Not Always Meet Federal Requirements

Under the ELE option, a State Medicaid agency can use findings (e.g., income) from eligibility determinations made by a different agency within the State to facilitate enrollment into Medicaid. Based on our sample, we estimated that Federal and State Medicaid payments on behalf of potentially ineligible beneficiaries totaled \$284.1 million. We attribute the enrollment of potentially ineligible beneficiaries to State-specific eligibility determination errors. In addition, States did not develop the mandated error rates specific to the ELE population because CMS did not provide States with an error rate methodology.

CMS concurred with our recommendations to monitor States that use the ELE option for Medicaid eligibility determinations for compliance with Federal requirements; provide technical assistance to States to accurately identify beneficiaries who enroll through the ELE option; issue guidance to States to calculate statutorily required eligibility error rates for those enrolled through the ELE option; and ensure that States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were

enrolled on the basis of eligibility determinations that were not made in compliance with Federal requirements.

[A-04-15-08043](#) • October 2016

Children's Health Insurance Program Enrollment Using the Express Lane Eligibility Option Did Not Always Meet Federal Requirements

We found that States generally determined CHIP eligibility using the ELE option in accordance with Federal requirements. However, on the basis of our sample, we estimated that Federal and State CHIP payments on behalf of potentially ineligible beneficiaries totaled \$10.6 million. We attribute the enrollment of potentially ineligible beneficiaries to State-specific eligibility determination errors. In addition, States did not develop mandated error rates specific to the ELE population because CMS did not provide States with an error rate methodology.

CMS concurred with our recommendations to monitor States that use the ELE option for CHIP eligibility determinations for compliance with Federal requirements; provide technical assistance to States to accurately identify beneficiaries who enroll through the ELE option; issue guidance to States to calculate statutorily required eligibility error rates for those enrolled through the ELE option; and ensure States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were enrolled on the basis of eligibility determinations that

were not made in compliance with Federal requirements.

[A-04-15-08045](#) • October 2016

Rebates for Physician-Administered Drugs Dispensed to Medicaid Enrollees

Colorado Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs

We conducted a review to determine whether States are complying with Federal Medicaid requirements for billing manufacturers for rebates for physician-administered drugs. For a covered outpatient drug to be eligible for Federal reimbursement under Medicaid's drug rebate requirements, manufacturers must pay rebates to the States for the drugs. States generally offset their Federal share of these rebates against their Medicaid expenditures and bill the manufacturers for rebates to reduce the cost of drugs to the program. However, a prior OIG review found that States did not always invoice and collect all rebates due for drugs administered by physicians. We found that Colorado did not invoice manufacturers for rebates associated with \$6.5 million in physician-administered drugs and \$1.6 million that did not have National Drug Codes (NDC) in the utilization data or may have been otherwise ineligible for Federal reimbursement.

Colorado concurred with our recommendations that it strengthen its internal controls to ensure that all physician-administered drugs eligible for rebates are involved, that it work with CMS to determine and refund the unallowable portion of Federal

reimbursement for physician-administered drugs, and that it work with CMS to determine the unallowable portion of \$1.2 million and refund that amount. Colorado did not concur with our recommendations that it refund to the Federal Government \$6.5 million for claims for physician-administered drugs that were ineligible for Federal reimbursement.

[A-07-14-06050](#) • January 2017

California Did Not Bill Manufacturers for Rebates for Physician-Administered Drugs Dispensed to Enrollees of Some Medicaid Managed-Care Organizations and Virginia Did Not Bill Manufacturers for Some Rebates for Physician-Administered Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations

We conducted reviews in California and Virginia to determine whether States are complying with Federal Medicaid requirements for billing manufacturers for rebates for physician-administered drugs dispensed to enrollees of MCOs. For a covered outpatient drug to be eligible for Federal reimbursement under Medicaid's drug rebate requirements, manufacturers must pay rebates to the States for the drugs. States generally offset their Federal share of these rebates against their Medicaid expenditures and bill the manufacturers for rebates to reduce the cost of drugs to the program. However, a prior OIG review found that States did not always invoice and collect all rebates due for drugs administered by physicians. We found that California claimed an estimated \$7.3 million in Federal reimbursement that was unallowable and \$35.2 million that may have been unallowable because it did not

comply with Federal Medicaid requirements. Virginia did not bill manufacturers for an estimated \$2.9 million in rebates.

California concurred with our recommendations to work with its MCOs to ensure submission of drug utilization data and to implement a rebate and NDC reporting requirement. California partially concurred with collecting an estimated \$7.3 million in Federal reimbursement that was unallowable and \$35.2 million that may have been unallowable because California did not comply with Federal Medicaid requirements.

Virginia concurred with recommendations that it work with CMS to resolve the drug utilization data without valid NDCs by determining the correct NDCs, to bill for the estimated rebates and refund the Federal share, that it implement Medicaid Management Information System edits to verify that NDCs are valid, and that it ensure that MCOs submit drug utilization data containing NDCs for all physician-administered drugs.

[A-09-15-02035](#) • December 2016

[A-03-15-00201](#) • December 2016

Quality of Care and Beneficiary Access

Arizona Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid

Federal regulations require nursing and skilled nursing facilities (nursing homes) to submit correction plans to

CMS or their respective State survey agency for certain deficiencies identified during surveys, such as nursing homes' failure to provide necessary care and services. State survey agencies must verify the correction of identified deficiencies by obtaining evidence of correction or through onsite reviews. This review of the State survey agency in Arizona is part of an ongoing series of reviews of States' verification of correction of deficiencies.

We found that Arizona did not always verify nursing homes' correction of deficiencies identified during surveys in 2014 in accordance with Federal requirements. We estimated that Arizona did not verify nursing homes' correction of deficiencies in accordance with Federal requirements for 361 (56 percent) of the 650 deficiencies identified during surveys in 2014. Arizona's practice for less serious deficiencies was to accept the nursing homes' correction plans as confirmation of substantial compliance without obtaining the required evidence of correction.

Arizona concurred with our recommendation to improve its practices for verifying nursing homes' correction of identified deficiencies by obtaining nursing homes' evidence of correction for less serious deficiencies.

[A-09-16-02013](#) • October 2016

Legal and Investigative Activities Related to Medicare and Medicaid

OIG INVESTIGATES ALLEGATIONS OF FRAUD, waste, and abuse in all HHS 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 upcoded services; 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 opening an increasing number of cases against health care providers and patients who engage in these health care fraud schemes. Those who participate in the schemes may face heavy fines, jail time, and exclusion from participation in Federal health care programs.

In addition to investigating Medicare and Medicaid fraud, OIG investigates fraud, waste, and abuse in other HHS programs, including ACF, IHS, Health Resources and Services Administration (HRSA), and Administration for Community Living (ACL). OIG investigates potential misuse of grants and contract funds awarded by CDC,

NIH, Substance Abuse and Mental Health Services Administration (SAMHSA), and other HHS agencies. Under certain circumstances, OIG investigates noncustodial parents who fail to pay court-ordered child support. OIG also investigates allegations of employee misconduct, whistle blower 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 on our website at: <http://oig.hhs.gov/fraud/enforcement/cmp/>.

During the first half of FY 2017, we reported 415 criminal and 458 civil actions against individuals or entities that engaged in health-care-related offenses. We also reported over \$1.52 billion in investigative receivables due to HHS and more than \$482.7 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.

The following are recently completed actions and settlements organized by allegation or subject type:

Prescription Drugs

Pennsylvania – William J. O’Brien III was a doctor of osteopathic medicine. According to evidence presented at trial, O’Brien worked with Pagan’s Motorcycle Club, an outlaw gang known for violence and drug dealing, to operate a “pill mill” out of O’Brien’s medical offices. O’Brien wrote fraudulent prescriptions for oxycodone and other drugs, while the Pagans recruited “pseudo-patients” to buy the fraudulent prescriptions. After filling the prescriptions, the Pagans resold the pills on the street. From March 2012 to January 2015, O’Brien distributed more than 700,000 pills containing oxycodone and other Schedule II controlled substances in furtherance of the conspiracy. O’Brien was found guilty of distribution of controlled substances resulting in death and sentenced to 30 years in prison and ordered to pay \$5.3 million in restitution, joint and several. Eight additional defendants involved in the scheme were sentenced to a combined 49 years and 10 months in prison. Five defendants have pleaded guilty and are awaiting sentencing.

Pharmacy

Florida – From July 2012 through March 2016, Niurka Fernandez co-owned and operated several pharmacies in the Miami area, and her son, Roberto Alvarez, was the registered agent of one of the pharmacies. Fernandez admitted to leading a fraud scheme that paid Medicare beneficiaries and patient recruiters for prescriptions that were medically unnecessary.

Fernandez acknowledged that she directed her co-conspirators to make kickback payments and write and cash checks for the purpose of facilitating kickback payments and concealing fraud proceeds. Alvarez admitted that he participated in the conspiracy by writing checks to money launderers to obtain cash to pay the kickbacks to Medicare beneficiaries. Fernandez and Alvarez each pleaded guilty to conspiracy to commit health care fraud and were sentenced to a combined 12 years and 6 months in prison and ordered to pay \$11 million in restitution. Two other defendants involved in the scheme were previously sentenced to a combined 3 years in prison and ordered to pay \$10.9 million in restitution.

Pharmaceutical Companies

Florida – Shire Holdings US AG, Shire Pharmaceuticals, LLC, and Shire Regenerative Medicine LLC (collectively, “Shire”) entered into a settlement agreement to resolve allegations in connection with the sale of a human skin substitute product called Dermagraft® from 2007 to 2014. Specifically, Shire allegedly paid kickbacks to physicians who purchased Dermagraft® and, in turn, billed Medicare, Medicaid, and other federally funded health care programs for the product and related services, and paid kickbacks to physicians employed by the Veterans Administration (VA) who caused the VA to purchase Dermagraft® under a contract with Shire. Shire also marketed Dermagraft® for uses not approved by the FDA to physicians who billed Federal programs. The company made false statements intended to inflate the price of Dermagraft® and to conceal, avoid, or decrease an obligation to pay money to the United States. The company also caused physicians to upcode

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claims to Federal programs for Dermagraft® and related services. Shire agreed to pay \$350 million to resolve their liability under the False Claims Act.

Wisconsin – Forest Laboratories, LLC and Forest Pharmaceuticals, Inc. (collectively “Forest”) entered into a settlement agreement to resolve kickback allegations relating to three Forest products. Specifically, between January 2008 and December 2011, Forest allegedly paid kickbacks to physicians to induce them to prescribe the drugs Bystolic, Savella, and Namenda. The alleged kickbacks took the form of payments and meals provided in connection with speaker programs about the three drugs. Forest agreed to pay \$38 million to resolve its liability under the False Claims Act.

Home Health Care

Michigan – Zafar Mehmood and Badar Ahmadani were owners of 16 home health care agencies in the Detroit area. According to evidence presented at trial, the defendants, from October 2004 through 2011, obtained patients by paying cash kickbacks to recruiters, who in turn paid cash to patients to induce them to sign up for home health care with their agencies. Mehmood and Ahmadani also paid kickbacks to physicians to refer patients to the companies for home health care services that were medically unnecessary and were not provided. The defendants were found guilty and sentenced for health-care-related charges and other charges stemming from this scheme. Mehmood was sentenced to 30 years in prison and ordered to pay \$40.4 million in restitution, joint and several, and Ahmadani was sentenced to 8 years in prison and ordered to pay \$38.1 million in restitution, joint and several. This was a Health Care

Fraud Strike Force case worked jointly with the Federal Bureau of Investigation (FBI).

Louisiana – Elaine Davis was the owner of Christian Home Health Agency (Christian), and Dr. Pramela Ganji was the medical director of the agency. According to evidence presented at trial, Davis and Ganji caused Christian to bill for home health services that were not medically necessary or were not provided, based upon false certifications of medical necessity signed by Ganji. The vast majority of these patients did not require home health care services, and Ganji falsely claimed that beneficiaries she had never examined were qualified to receive these services. The defendants were sentenced for conspiracy to commit health care fraud and health care fraud. Davis was sentenced to 8 years in prison while Ganji was sentenced to 6 years in prison. They were ordered to pay a combined \$9 million in restitution, joint and several. This case was investigated as part of the Southern Louisiana Strike Force.

Transportation Services

Massachusetts – Medstar Ambulance, Inc., Medstar EMS, Inc., MetroWest Emergency Medical Services, Inc., Fitchburg Emergency Medical Services, Inc., Pioneer Valley EMS, Inc., Critical Systems, Inc., Nicolas Melehov, and Gregory Melehov (collectively, “Medstar”) agreed to pay \$12.7 million and enter into a CIA to resolve its liability under the False Claims Act. From January 2011 through October 2014, Medstar allegedly submitted false claims to Medicare for ambulance transportation services in which the services did not qualify for reimbursement because the transports were not medically reasonable and necessary; the transport was

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not to or from a covered destination; claims were submitted without the necessary beneficiary and/or provider signatures and/or complete documentation; and bills were submitted for higher levels of services than were required by patients' conditions.

Durable Medical Equipment

Pennsylvania – Biocompatibles, Inc., entered into a settlement agreement to resolve allegations that the defendant knowingly caused false claims to be submitted to Medicare and Medicaid. Specifically, Biocompatibles allegedly marketed a device known as "LC Bead," which was cleared by the FDA as an embolization device that can be placed in blood vessels to block or reduce blood flow to certain types of tumors and arteriovenous malformations. However, LC Bead was never cleared by FDA as a drug-device combination product or for use as a drug-delivery device. Biocompatibles allegedly loaded the LC Bead with chemotherapy drugs and used it as a drug-delivery device. When LC Bead was combined with prescription drugs for use as a drug-eluting bead, it constituted a new combination drug device product that was not approved by the FDA and not covered by Medicare and Medicaid. The defendant agreed to pay \$25 million to resolve its False Claims Act liability. In addition, as part of the criminal resolution, Biocompatibles was ordered to pay an \$8.75 million criminal fine for the misbranding of LC Bead and a criminal forfeiture of \$2.25 million.

Laboratories

Wisconsin – Gottfried Kellermann, NeuroScience, Inc., and Pharmasan Labs, Inc. (collectively, "Defendants"), entered into a settlement agreement to resolve allegations that they submitted false claims to Medicare and TRICARE for urinary transmitter testing. From January 2008 through January 2014, Pharmasan and Kellermann allegedly violated Clinical Laboratory Improvement Amendments (CLIA) regulations by intentionally subjecting certain Pharmasan as-measured urinary neurotransmitter test results to a "shift factor" that they had not validated pursuant to CLIA regulations. In addition, the United States contended that, during this same period, the Defendants applied unvalidated reference ranges to urinary neurotransmitter test results. The Defendants agreed to pay \$6.1 million to resolve their liability under the False Claims Act.

New Jersey – MedNet, Inc., entered into a settlement agreement to resolve allegations that, from March 2006 through January 2014, it entered into "fee-for-service" or "direct-bill" agreements with certain hospital and physician clinic customers. Under these agreements, MedNet allegedly charged a fee to customers for certain services that they performed in connection with two types of cardiac monitoring. MedNet allowed the customers to bill Medicare directly for these same services and permitted the customers to retain the reimbursements they received from Medicare. However, the Medicare reimbursement exceeded the fee that MedNet charged the customers. The United States contended that these arrangements resulted in a net profit to MedNet's customers who were part of

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these agreements and provided remuneration to these customers to induce referrals from the customers for MedNet’s services. The defendant agreed to pay \$1.3 million to resolve their liability under the False Claims Act.

Radiology

New York – Zwanger & Pesiri Radiology Group, LLP, Zwanger Radiology, P.C., and Dr. Steven Mendelsohn (collectively, “Defendants”) entered into a settlement agreement to resolve allegations that between July 2009 and February 2014 they billed Medicare and Medicaid for radiology testing that was not ordered by a treating physician, and procedures were performed or supervised by physicians or at a practice location that was/were not enrolled in Medicare and/or Medicaid. The Defendants agreed to pay \$8.1 million and enter into a 5-year CIA with OIG to resolve their liability under the False Claims Act. Contemporaneously with the civil settlement, Zwanger-Pesiri pleaded guilty to two counts of health care fraud for illegally performing and billing for procedures that had not been ordered by treating physicians and agreed to forfeit an additional \$2.4 million.

Hospitals

Florida – South Miami Hospital, Inc. (SMH), entered into a settlement agreement to resolve its liability for submitting claims to Medicare, Medicaid, TRICARE, and Federal Employee Health Benefit Programs for medically unnecessary electro physiology studies, echo cardiograms, tilt-table tests, implantable cardiovascular-defibrillators, biventricular pacemakers, atrioventricular

optimizations, and other procedures. SMH is an acute care hospital owned and operated by Baptist Health System of South Florida (Baptist). SMH agreed to pay \$12.5 million and enter into a 5-year CIA with OIG to resolve its liability under the False Claims Act.

Nursing Homes

Tennessee – Life Care Centers of America (LCCA) and LCCA’s owner and sole shareholder, Forrest Preston, entered into a settlement agreement to resolve allegations that, from January 2006 to February 2013, LCCA caused the submission of false claims to Medicare and TRICARE for medically unnecessary rehabilitation therapy services provided to patients at LCCA’s SNFs. LCCA is the Nation’s fourth largest chain of SNFs. The defendants agreed to pay \$145 million plus interest to resolve their liability under the False Claims Act, along with a 5-year comprehensive CIA requiring management certifications from numerous employees at the corporate, divisional, regional, and facility level.

Physicians

Georgia – Dr. Robert E. Windsor owned and operated Georgia Surgical Monitoring, LLC. According to the investigation, from January 2010 through July 2013, Windsor billed for services that he did not perform. Specifically, Windsor billed for intra-operative monitoring, a procedure for reducing the risk of neurological deficits during operations that involve the nervous system. During surgery, a patient is connected electronically to a system that allows a physician to remotely monitor the neurologic system and provide

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guidance to the operating surgeon to prevent neurological damage. This complex monitoring requires specialized skills and experience and is usually provided by a neurologist. Windsor directed a medical assistant to conduct this monitoring on his behalf with no supervision. Windsor was sentenced to 3 years and 2 months in prison and ordered to pay \$1.1 million in restitution after his guilty plea to health care fraud.

New York – Hudson Valley Hematology-Oncology Associates, R.L.L.P. (Hudson), entered into a settlement agreement to resolve Hudson’s liability for improperly submitting claims to Medicare and Medicaid. From June 2010 through June 2015, Hudson allegedly routinely waived co-payments without an individualized determination of financial hardship or exhaustion of reasonable collection efforts and billed Medicare and Medicaid for evaluation and management services, even though Hudson did not provide any significant, separately identifiable services to the beneficiaries. The defendant agreed to pay \$5.5 million and enter into a 5-year CIA with OIG to resolve its liability.

Health Care Fraud Prevention and Enforcement

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

HEAT Provider Compliance Training

OIG provides free training on our website 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: <https://oig.hhs.gov/compliance/compliance-guidance/index.asp>.

Health Care Fraud Strike Force Activities

In 2007, Health Care Fraud Strike Force teams began an effort to combine resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. These partnerships between OIG and HHS, DOJ, U.S. Attorneys’ Offices, FBI, and State and local law enforcement have a common goal: successfully analyze health care fraud data and investigative intelligence to quickly identify fraud and bring prosecutions. Strike Force teams 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.

During the first half of FY 2017, Strike Force efforts resulted in the filing of charges against 49 individuals or entities, 152 criminal actions, and more than \$266.8 million in investigative receivables.

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Below are examples of Strike Force cases:

Michigan – Four defendants in a home health care and hospice Medicare fraud scheme pleaded guilty to conspiracy to commit health care fraud and wire fraud. They were sentenced to a combined 35 years and 2 months in prison and ordered to pay \$33 million in restitution, joint and several. Three of the defendants, Shahid Tahir, Manawar Javed, and Muhammad Tariq, owned home health care and hospice companies, while the fourth, Hatem Ataya, was a physician who conspired with the other defendants. From January 2006 through June 2015, Tahir, Javed, and Tariq paid kickbacks, bribes, and other inducements to Ataya and other physicians, as well as to marketers and patient recruiters, for beneficiary referrals to companies they owned. The co-defendants admitted that they then billed Medicare for home health care and hospice services that were often medically unnecessary and/or not provided.

New York – Olga Novogordosky co-owned Cropsey Medical Care. According to the investigation, Novogordosky and her co-conspirators, from November 2009 through October 2012, executed a scheme to defraud Medicare and Medicaid by billing for services not rendered, billing for services that were not medically necessary, and providing cash kickbacks to beneficiaries. Novogordosky also helped to create a fake shell company name for the purpose of money laundering to pay kickbacks to patients. Novogordosky was sentenced to 1 year and 1 day in prison and ordered to pay \$6.5 million in restitution, joint and several, after her guilty plea to conspiracy to commit money laundering and conspiracy to commit health care fraud. Ten defendants involved in the scheme were previously sentenced to a combined 17 years and 1 day in prison and ordered to pay \$13.5 million in restitution, joint and several.

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. These OIG attorneys are detailed full time to DOJ's Criminal Division, Fraud Section, for temporary assignments, including assignments to the Health Care 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.

Below is a related case example:

Texas – Oakey Chikere was the owner and operator of Direct Care medical clinic in the Houston area. According to the investigation, the defendant led a scheme from about March 2011 through February 2013 to bill Medicare for services that were not medically necessary and were not provided. Specifically, Chikere recruited doctors to work for him, representing that they would be paid for certifying and recertifying patients for home health care, regardless of whether the home health services were medically necessary. Chikere marketed to home health agencies that, for a

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fee, his doctors would fraudulently certify Medicare beneficiaries for home health services. Chikere would then refer the patient to a home health agency he had an arrangement with, and he would be paid a kickback. A jury convicted Chikere of conspiracy to commit health care fraud and health care fraud, and he was sentenced to 5 years and 10 months in prison and ordered to pay \$258,738 in restitution.

Most Wanted Fugitives Listed on OIG's Website

The OIG Most Wanted Fugitives website 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 website is continually updated and features a profile 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/>.

One of OIG's Most Wanted Fugitives, Ariel Martinez Ruiz, was captured during this reporting period. Martinez was indicted on charges of health care fraud in June 2016 and fled the United States. Martinez was the owner operator of Magnifique Home Health in Miami, Florida. According to the indictment, from July 2014 through February 2015, Martinez conspired to defraud Medicare by submitting false claims. Specifically, Martinez and others obtained the names and Medicare identification numbers of Medicare beneficiaries, along with the names and provider numbers of physicians, in

order to submit false claims to Medicare. Investigators believe that Martinez, through Magnifique, was paid over \$4.7 million for services Magnifique did not render. Martinez was detained while trying to enter the United States from an inbound flight originating in Cuba. He is currently in custody and will face charges stemming from his indictment.

Because of the success of OIG's Most Wanted Fugitives website, OIG launched its Most Wanted Deadbeat Parents website 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. The Human Services Reviews section of this *Semiannual Report* provides examples.

HHS OIG Hotline

The mission of the HHS OIG Hotline is to support OIG's oversight responsibilities in safeguarding the integrity of all programs and personnel under purview of HHS and protect them from fraud, waste, and abuse. We achieve our mission through our dedication to timely intake and analysis of information received from various sources, such as the "Report Fraud" link on the HHS OIG Internet website. Strategically located within the Office of Investigations, the Hotline is the public-facing division for OIG's intake and evaluation of fraud tips. During this semiannual reporting period, the OIG Hotline reported expected recoveries of \$9.6 million as a direct result of cases originating from Hotline complaints.

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- Contacts to 1-800-HHS-TIPS phone line, including callers seeking information: 66,891
- Total Tips Evaluated : 14,562
- Tips Referred for Action: 9,970
- Closed, no basis provided for further action: 4,222
- Closed, no HHS violation: 370

Source Types of TIPS referred for action:

- Phone: 5,127
- Internet: 3,768
- Letters/Faxes: 1,075

State Medicaid Fraud Control Units

OIG Oversight of State Medicaid Fraud Control Units

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 2016

In FY 2016, combined Federal and State expenditures for the operation of the 50 MFCUs (in 49 States and the District of Columbia) totaled almost \$259 million. The

MFCUs employed 1,965 individuals. Collectively, in FY 2016, MFCUs reported 18,730 investigations, of which 15,509 were related to Medicaid fraud and 3,221 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges or indictments involving 1,721 individuals, including 1,249 for fraud and 472 for patient abuse and neglect. In total, 1,564 convictions were reported in FY 2016, of which 1,160 were related to Medicaid fraud and 404 were related to patient abuse and neglect. Civil judgments and settlements for FY 2016 totaled 998, and monetary recoveries in civil cases totaled over \$1.5 billion. (See Medicaid Fraud Control Units 2016 Expenditures and Statistics contained in an [Interactive Map](#) and [Chart](#)).

OIG Onsite Reviews of MFCUs

In addition to an annual recertification review of each MFCU, OIG conducts periodic in-depth reviews of a sample of MFCUs. OIG evaluates MFCU operations in accordance with 12 [performance standards](#) and assesses compliance with laws, regulations, and OIG policy guidance. OIG issued a report of an onsite review of the following MFCU during the reporting period:

- [Oregon State Medicaid Fraud Control Unit](#): 2016 Onsite Review (OEI-09-16-00200, December 2016).

The following is a case example of joint efforts with MFCUs:

Texas – Jocelyn Pyles Elo was a physician working for Elite P. Medical Clinic in Houston, Texas. According to the investigation, from May 2009 to September 2011, Pyles conspired with others to bill for services she did not provide. In actuality, an unlicensed foreign medical

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graduate saw all the patients at the clinic alone and was instructed not to sign patient progress notes at those visits. Pyles would arrive at the clinic after hours and sign the treatment notes to make it appear as if she saw the patients when in actuality she did not. A jury found Pyles guilty of 14 counts of health care fraud, and she was sentenced to 1 year and 1 day in prison and ordered to pay \$560,718 in restitution.

Advisory Opinions and Other Industry Guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with DOJ, are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. HIPAA, § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. During the first half of FY 2017, OIG received 22 requests for advisory opinions and issued 5 advisory opinions and 1 modification of an advisory opinion.

Sanction Authorities and Other Administrative Actions

Various Federal laws provide authorities the ability 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 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 1,504 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. Exclusion and penalty authorities are described in Appendix D and on our website at <http://oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program Exclusions

During this semiannual reporting period, OIG excluded 1,422 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/>.

The following are examples of program exclusions:

District of Columbia – Florence Bikundi was an owner of Global Healthcare, Inc. According to court documents, Bikundi fraudulently gained approval as a provider in the

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Medicaid program. From August 2009 through February 2014, Bikundi led a scheme to bill Medicaid for services that were not provided, creating phony time sheets, patient files, and employment files. Bikundi was convicted of health care fraud, money laundering, and other charges stemming from this scheme, and was sentenced to 10 years in prison and ordered to pay \$80.6 million in restitution, joint and several. In April of 2000, Bikundi was excluded based on the loss of her license to practice as a licensed practical nurse in the State of Virginia, and this exclusion remains in place. OIG excluded Bikundi for a minimum period of 55 years.

Virginia – Martin Matthews Martin was licensed as a nurse aide. According to court documents, while working as a nurse aide in a nursing home, Martin sexually assaulted an 84-year old patient. The patient was not alert, nonverbal, and suffered from dementia. Martin was sentenced to 22 years in prison based on his conviction for rape. In addition, the Virginia State Board of Nursing revoked his license to practice as a nurse aide. OIG excluded Martin for a minimum period of 30 years.

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, misused grant funds, or are otherwise not presently responsible. Because these are Government-wide 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.

The following are debarment examples:

Florida – Ana Luz Marcano, through her employment at the Children’s Home Society, engaged in a scheme to falsify and expedite applications to the Florida School Readiness Program. According to the investigation, Marcano charged an illegal fee to low-income parents for subsidized daycare benefits that parents were not entitled to receive. The referral forms Marcano completed designated the children as “at-risk” and eligible to receive immediate placement ahead of families already on a waiting list for these services. The defendant was convicted of an organized scheme to defraud and was debarred based on an OIG referral to the Department for a 3-year period.

Nevada – Belinda Thompson was the executive director of Goshen Community Development. Goshen was funded in excess of \$6 million, primarily with SAMHSA grant funds. The funds were intended to fund sub-grantees to perform community services such as drug abuse prevention services and HIV and TB services, law enforcement checkpoints, and community services training. According to the investigation, Thompson knowingly embezzled Goshen’s Federal grant funds. The defendant was convicted of theft of Government

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property, ordered to repay \$399,000, and subsequently debarred based on an OIG referral to the Department for a 3-year period.

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.

The following is a CIA enforcement example:

Kentucky – Kindred Healthcare, Inc., the Nation's largest provider of post-acute care, including hospice and home health services, paid a penalty of more than \$3 million for failing to comply with a CIA. The CIA was the result of allegations involving claims for hospice services that were medically unnecessary and claims for continuous or crisis care services when the patients were not experiencing a crisis. The penalty for violating the CIA resulted from Kindred's failure to correct improper billing practices in the fourth year of the 5-year agreement. OIG made several unannounced site visits to Kindred facilities and found ongoing violations. Specifically, CIA-required audits performed by Kindred's internal auditors in 2013, 2014, and 2015 found that the

company and its predecessors failed to implement policies and procedures required by the CIA, and that poor claims submission practices led to significant error rates and overpayments by Medicare.

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. In addition to administrative penalties and assessments, OIG can also exclude individuals for engaging in conduct prohibited by the CMPL. During this semiannual reporting period, OIG concluded cases involving more than \$26.3 million in CMPs and assessments.

The following is a CMP example:

New Jersey – Roben Brookhim agreed to pay \$1.1 million in assessments and penalties and be excluded from participation in all Federal health care programs for a period of 50 years pursuant to 42 U.S.C. § 1320a-7(b)(7) (fraud, kickbacks, and other prohibited activities). Brookhim is a New Jersey dentist who was previously excluded due to the suspension of his license to practice dentistry in 1999. OIG alleged that Brookhim knowingly presented or caused to be presented to Medicaid claims for items or services he knew or should have known were false or fraudulent or otherwise not provided as claimed; knowingly presented or caused to be presented to Medicaid claims for items or services furnished by an excluded person; and was the owner

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and managing employee of an entity that was participating while he was excluded from participating in Federal health care programs.

Patient Dumping

Some of the CMPL cases that OIG resolved during this semiannual reporting period were pursued under the Emergency Medical Treatment and Labor Act (EMTALA), a statute designed to prevent hospitals from denying emergency care to patients and to ensure patient access to appropriate emergency medical services.

The following are EMTALA case examples:

Missouri – Research Medical Center (RMC) agreed to pay \$360,000 to resolve its potential liability under EMTALA. OIG alleged that RMC failed to provide an adequate medical screening examination and improperly transferred a patient. The patient arrived at RMC’s emergency room (ER) with a psychiatric emergency medical condition. Without providing stabilizing treatment, RMC transferred the patient to a nearby facility by private vehicle. During the transfer, the patient exited the vehicle and was struck by another vehicle. During its investigation, OIG found 17 occasions where RMC failed to provide adequate medical screening examinations and improperly transferred or discharged patients, without providing stabilizing treatment, who arrived at its ER with psychiatric emergency medical conditions. At the time each patient arrived, RMC had the capacity to treat, stabilize, or admit each patient.

Tennessee – Metro Knoxville HMA, LLC agreed to pay \$45,000 to resolve its potential liability under EMTALA. OIG alleged that Metro Knoxville violated EMTALA when it discharged a patient without having provided an adequate medical screening examination or treatment sufficient to stabilize the patient. OIG’s investigation revealed that blood test results indicated the presence of an emergency medical condition; however, Metro Knoxville discharged the patient without confirming that such blood levels had stabilized.

Self-Disclosure Programs

Health care providers, suppliers, or other individuals or entities subject to CMPs can apply for acceptance into the Provider Self-Disclosure Protocol, a program created in 1998, to voluntarily disclose self-discovered evidence of potential fraud. The self-disclosure program may give providers the opportunity to potentially avoid costs or possible disruptions associated with Government-directed investigations and civil or administrative litigation. Application processes for two additional self-disclosure programs were recently added to the OIG website for HHS contractors and grantees. The OIG contractor self-disclosure program enables contractors the opportunity to self-disclose when they have potentially violated the False Claims Act or other Federal criminal laws prohibiting fraud, conflict of interest, bribery, or gratuity. This self-disclosure process is available only to those with a Federal Acquisition Regulation-based contract with HHS. The OIG Grant Self-Disclosure program is available for application by HHS grantees or HHS grant sub-recipients and provides the opportunity for voluntarily disclosure to OIG of

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potential fraud. OIG evaluates the reported results of each internal investigation under the provider self-disclosure protocol to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG website at <https://oig.hhs.gov/compliance/self-disclosure-info/index.asp>. During this semiannual reporting period, self-disclosure cases resulted in more than \$23 million in HHS receivables.

The following are examples of provider self-disclosure settlements:

Texas – Memorial Hermann Health System agreed to pay \$5.6 million to resolve its liability under the CMPL for conduct it disclosed to OIG. Specifically, OIG alleged that, between September 1, 2009, and October 20, 2015, it improperly submitted claims to Medicare, Medicaid, and TRICARE for certain outpatient services by automatically appending modifiers 59 or 91 to Current Procedural Terminology (CPT) codes without regard for clinical appropriateness.

Oklahoma – Muscogee Creek Nation Department of Health, acting on behalf of its subsidiary Creek Nation Hospital and Clinics d/b/a Creek Nation EMS, agreed to pay \$171,767 to resolve its liability under the CMPL for conduct it disclosed to OIG. Specifically, OIG alleged that, from July 4, 2011, through January 24, 2015, Creek Nation EMS improperly billed for ambulance transport services provided by an unlicensed emergency medical technician.

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, HRSA guaranteed commercial loans to students seeking education in health-related fields.¹ 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, nine individuals and related entities were excluded as a result

of PSC referral of their cases to OIG. Individuals who have been excluded because 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.

After being excluded for nonpayment of their HEAL debts, 2,649 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 12 individuals who entered into such settlement agreements or completely repaid their debts during this semiannual reporting period. More than \$210 million is being repaid through settlement agreements or through complete repayment. Of that amount, more than \$984,000 is attributable to this semiannual reporting period.

The following are settlement agreement examples. These practitioners entered into settlement agreements to repay the amounts indicated:

- Florida—Chiropractor- \$132,333
- Iowa – Optometrist- \$72,9835

Indian Health Service

Indian Health Service Hospitals: More Monitoring Needed to Ensure Quality Care

We found that IHS may be missing opportunities to identify and remediate quality problems in its hospitals because it performed limited oversight activities regarding quality care and compliance with the Con-

¹The 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.

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ditions of Participation. IHS relies on its Area Offices to monitor hospitals. However, Area Office staff have few sources of information about hospital quality, and most limit reviews of that information to infrequent meetings of each hospital’s Governing Board. Further, Condition-of-Participation compliance surveys are not conducted by CMS with the frequency needed to make them a useful tool. Staffing shortages in Area Offices also limit the clinical support and guidance that they are able to provide, and the most promising efforts to improve hospital quality lack dedicated funding. Additionally, hospitals struggle to implement data-driven quality improvement methods as a result of limited information technology knowledge, a lack of resources, and difficulties with the electronic health record systems.

We recommended that IHS: (1) implement a quality-focused compliance program; (2) establish standards and expectations for Area Office/Governing Board oversight activities; (3) work to identify new – and more meaningful – hospital performance metrics; and (4) continue to invest in training for hospital administration and staff. Additionally, we recommended that CMS assist IHS in its oversight efforts by conducting more frequent surveys of non-accredited hospitals, informing IHS leadership when hospitals are cited with deficiencies, and continuing to provide technical assistance and training.

[OEI-06-14-00010](#) • October 2016

**Indian Health Service Hospitals: Longstanding Challenges
Warrant Focused Attention to Support Quality Care**

IHS hospital administrators reported a range of

interrelated challenges affecting their ability to provide quality care and maintain compliance. IHS hospitals face continual increases in the number of American Indian/Alaskan Natives using their services, yet they provide a small scope of medical services and limited options for specialists and community support (e.g., nursing homes and home health). IHS hospitals particularly struggle to maintain the skills necessary to treat complex inpatient cases. Another significant concern among IHS hospital administrators is the inability to recruit and retain needed staff. The dependence on “acting” personnel and contracted providers to fill vacancies sometimes creates instability in IHS hospitals and weakens the continuity of care provided to patients. Further, hospital administrators reported that limited resources for maintaining old hospital structures and outdated equipment sometimes result in service interruptions and raise concerns about patient safety.

We recommended that the Office of the Secretary of HHS lead an examination of the quality of care delivered in IHS hospitals as part of its newly formed executive council and use the findings to identify and implement innovative strategies to mitigate IHS’s longstanding challenges. We also recommended that IHS conduct a needs assessment and develop an agency-wide strategic plan with actionable initiatives and target dates to build a unified vision of IHS priorities and how to achieve them. The Office of the Secretary, IHS, and CMS provided a joint response to this report and its companion report. Collectively, these HHS agencies concurred with all recommendations in both reports.

[OEI-06-14-00011](#) • October 2016

Administration for Children and Families

Childcare and Head Start Programs

ACF provides Federal grants through several programs, including Head Start and the Child Care and Development Fund (CCDF). CCDF (authorized by the Child Care and Development Block Grant Act and the Social Security Act § 418) assists low-income families receiving temporary public assistance, and families transitioning from public assistance to obtain child care so that they may work or obtain training or education.

Puerto Rico's Controls for Its Child Care and Development Program Claims Were Not Effective

We conducted this review to determine whether Puerto Rico's Department of the Family's controls for provider and client eligibility determinations and for processing CCDF program claims were effective. We found that all of the provider eligibility controls we tested for provider background checks, required provider forms, and provider rate agreements were not effective. Of the client eligibility controls we tested, Puerto Rico's controls for family income and need-for-service eligibility were not effective. Although Puerto Rico's controls for verifying clients' citizenship were effective, Puerto Rico was not implementing Federal law regarding client eligibility. Puerto Rico lacked sufficient written policies and procedures and sufficient staff to effectively oversee licensed providers, and it lacked adequate procedures to monitor non-licensed providers in relation to its CCDF Program.

Puerto Rico concurred with our recommendation to improve its controls for provider and client eligibility determinations and for processing claims to ensure that payments for the CCDF program are made only for eligible clients and to eligible providers. Puerto Rico also concurred with our recommendations to return \$83,000 to the Federal Government for unallowable obligations and establish policies and procedures to ensure that child care funds are identified and assigned to voucher payments in compliance with obligation requirements.

A-02-13-02005 • January 2017

Newark Preschool Council, Inc., Did Not Always Comply With Head Start Requirements

Our review of Newark Preschool Council, Inc. (Newark), which operated throughout Newark, New Jersey, found that Newark did not always comply with Head Start program requirements. As a result, Newark received approximately \$10 million in excess Head Start funds during a 17-month period. In addition, it did not monitor its partner agencies' operations to ensure that children at these facilities received Head Start services.

ACF generally concurred with our recommendations that it ask Newark to refund \$10 million to the Federal Government for unallowable costs applicable to under-enrollment, general and administrative expenses, unauthorized purposes, and salary payments; complete the closeout process for Newark's Head Start grant; if Newark is awarded a Head Start grant in the future, ensure that Newark maintains its funded enrollment level, properly monitor partner agencies, and follow its policies and procedures relating to salary payments and

cash management for any future grant awards; and retain information related to Federal funds used to acquire, construct, or renovate its grantees' properties in accordance with departmental requirements. Newark, which did not provide comments to the report, has filed for bankruptcy.

A-02-14-02024 • February 2017

Child Support Enforcement Activities

OIG Investigations

OIG investigates noncustodial parents who violate 18 U.S.C. § 228 by failing 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. During this semiannual reporting period, OIG investigations of child support enforcement cases nationwide resulted in 13 criminal actions and court-ordered restitution and settlements of \$2 million.

The following is an example of a child support enforcement case:

South Dakota – In January 2001, Cory T. Carter was ordered to pay \$375 per month for the support of his two children. Carter rarely made payments to the custodial parent of his children and had not made a payment in many months. Carter was sentenced to 5

years of probation and ordered to pay restitution of \$101,804 after pleading guilty to felony failure to pay legal child support.

Engaging the Public in Capturing Deadbeat Parents

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

Other HHS-Related Reviews and Investigations

Grants and Contracts

HHS is the largest grant-making organization and one of the largest contracting agencies in the Federal Government. In FY 2016, HHS awarded more than \$463.5 billion in grants and over \$21.1 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 more than 100 public health and human services programs carried out by more than 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.

Grant Fraud Investigations

The following are case examples related to misuse of grant funds:

Alabama – Jonathan Dunning was the CEO of Birmingham Health Center, a federally funded health care center. The investigation disclosed that Dunning engaged in a fraudulent scheme in which approximately \$17 million in Federal grant funds was embezzled from HRSA. The funds were meant to provide quality health care for the homeless and low-income individuals in the Birmingham, Alabama, area. Instead, funds were diverted by fraud to the defendant's multiple corporations for personal use. Dunning was found guilty on 98 counts of conspiracy, wire fraud, bank fraud, and money laundering and was sentenced to 18 years in prison and ordered to pay \$13.5 million in restitution. Three defendants involved in the scheme were

previously sentenced to a combined 17 years and 11 months in prison and ordered to pay \$272,830 in restitution, joint and several.

Kentucky – Jerome Hahn was the owner, chief executive officer, and president of Telehealth Holdings, LLC. Hahn, on behalf of Telehealth, allegedly made false statements and false certifications in applications submitted to NIH to obtain Small Business Innovation Research grants to fund the development of various medical devices, including a sleep apnea monitoring system and an electronic pillbox. The Government alleged that Hahn created phony invoices that grossly overstated expenses and manufactured products in China when all products were supposed to be produced domestically. As a result of these false claims, NIH paid Federal grant funds to Telehealth Holdings, LLC, for which the company was not entitled. Hahn and Telehealth agreed to pay \$1.9 million, joint and several, to resolve their liability under the False Claims Act.

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 with relation to fraud, waste, or abuse in the Small Business Innovative Research/Small Business Technology Transfer (SBIR/STTR) program. OIG must also report on 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 December 2016 report delivered to the three congressional oversight committees, we reported that OIG spent approximately \$151,182 in salaries on

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oversight related to the SBIR/STTR program. HHS referred two new SBIR/STTR cases to OIG in FY 2016.

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 Report to Congress the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. During this reporting period, OIG did not close any investigations.

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 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 issued no 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. During this semiannual period, OIG's National External Audit Review Center reviewed 740 reports covering \$578 billion in audited costs. Federal dollars covered by these audits totaled \$139.3 billion, of which about \$84.8 billion were HHS funds.

Office of Management and Budget (OMB) Circular A-133 and the more recent uniform guidance at 2 CFR § 200, Subpart F establishes audit requirements for State and local governments, colleges and universities, and nonprofit organizations receiving Federal awards. Under this circular and uniform guidance, covered entities must conduct annual organization-wide "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 follow-up. 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

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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, 2016,
through March 31, 2017**

Number of Non-Federal Audits	
Not requiring changes or having minor changes	696
Requiring major changes	39
Having significant technical inadequacies	5
Total	740

The 740 reports included 1,414 recommendations for improving management operations. In addition, these audit reports provided information for 23 OIG special memorandums that identified concerns for increased monitoring by management.

**Other Reporting
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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 *Work Plan* 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 OIG 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.

Implementation of Health Insurance Marketplaces

OIG continues to review programs implemented pursuant to the Patient Protection and Affordable Care Act (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 GAO and other Federal and State oversight agencies.

State-Based Marketplaces

New York Misallocated Costs to Establishment Grants for a Health Insurance Marketplace; The Minnesota Marketplace Misallocated Federal Funds and Claimed Unallowable Costs; Colorado Did Not Correctly Expend Establishment Grant Funds for Establishing a Health Insurance Marketplace; and Kentucky Misallocated Millions to Establishment Grants for a Health Insurance Marketplace

We conducted these audits to determine whether the State agencies allocated costs to their establishment grants for establishing a health insurance marketplace in accordance with Federal requirements. We found that New York, Colorado, Kentucky, and Minnesota did not always follow Federal requirements in implementing a health insurance marketplace. New York misallocated \$148.7 million in establishment costs, Minnesota misallocated or misspent \$1.3 million in establishment

grant funds, Colorado did not expend \$9.7 million of Federal establishment grant funds in accordance with Federal requirements, and Kentucky misallocated \$49.1 million in establishment costs.

We found that New York did not have adequate internal controls to ensure that it properly allocated costs, Minnesota did not have adequate policies and procedures to follow Federal requirements, Colorado lacked adequate stewardship of Federal funds, and Kentucky used an incorrect cost-allocation methodology.

New York disagreed with our recommendations to refund \$148.7 million to the Federal Government for the misallocated funds and improve its allocation procedures. Minnesota generally disagreed with our recommendations to refund \$1.3 million and improve its procedures. Colorado disagreed with our recommendation to refund \$9.7 million but agreed with our recommendation to improve its policies and procedures. Kentucky disagreed with our recommendations to refund \$49.1 million and agreed to improve its allocation procedures and develop a written policy.

[A-02-14-02017](#) • November 2016

[A-05-14-00045](#) • November 2016

[A-07-14-02801](#) • December 2016

[A-04-14-07050](#) • February 2017

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Federal Marketplace

Data Inadequacies Undermine CMS's Oversight of the Inconsistency Resolution Process for the Federal Marketplace

Ensuring that only eligible applicants can enroll in qualified health plans (QHPs) and insurance affordability programs depends on the integrity of the enrollment process. A key part of that process involves resolving inconsistencies between self-attested information submitted by applicants and data received through Federal and other data sources. We found that the Federal marketplace was unable to calculate the total number of applicants with inconsistencies between self-attested information submitted by applicants and data received through Federal or other data sources during the first open enrollment period. Our findings demonstrate that CMS could not readily answer basic questions about inconsistencies, and these data limitations preclude CMS from accurately counting and tracking inconsistencies by applicants seeking to enroll in a qualified health plan.

CMS concurred with our recommendation to improve its management of the inconsistency resolution process to ensure that it can readily identify all applicants with inconsistencies. CMS should refine its data management system so that it can track individuals and readily count the number of each type of inconsistency and whether those inconsistencies are unresolved, resolved, or expired.

[OEI-01-14-00620](#) • March 2017
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Information Security

The University of California at Riverside's Pilot Payroll Certification System Did Not Provide Accountability Over Payroll Charges to Federal Awards

We estimated that the University of California at Riverside (the University) put at risk \$11.7 million in salaries and \$5.9 million in associated facilities and administrative costs claimed against NIH awards. The University's prior effort-reporting system did not always provide the information needed to confirm that payroll costs had been appropriately allocated to Federal awards, and its current payroll certification system pilot (pilot PCS) provided less accountability over payroll charges to Federal awards than its prior effort-reporting system. Effort reporting is a person-based methodology that allocates each employee's reasonable estimate of time worked on all awards and other activities.

Furthermore, the University's IT controls for systems used to support the pilot PCS did not always ensure the security of data used to support labor charges. General IT control weaknesses included unrestricted remote access, inadequate password settings, poor patch management, and expired vendor support.

The University generally disagreed with our procedural recommendations that it increase its accountability over payroll charges to Federal awards and that it strengthen its general IT controls for systems it used to support the pilot PCS.

[A-04-13-01026](#) • February 2017
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State agencies are required to establish appropriate computer system security requirements and conduct biennial reviews of computer system security used in the administration of State plans for Medicaid and other Federal entitlement benefits (45 CFR § 95.621). OIG conducts reviews of States' computer systems used to administer HHS-funded programs.

Public Summary Report: Information Technology Control Weaknesses Found at the Commonwealth of Massachusetts' Medicaid Management Information System

The Massachusetts Medicaid program (MassHealth) did not safeguard Medicaid Management Information System (MMIS) data and supporting systems in accordance with Federal requirements. Specifically, MassHealth had vulnerabilities related to security management, configuration management, system software controls, and website and database vulnerability scans.

Although we did not identify evidence that the vulnerabilities had been exploited, exploitation could result in unauthorized access to, and disclosure of, sensitive information, as well as disruption of operations critical to MassHealth. As a result, the vulnerabilities were collectively and, in some cases, individually significant and could have compromised the confidentiality, integrity, and availability of MassHealth's MMIS. These vulnerabilities existed because MassHealth did not implement sufficient controls over its Medicaid data and information systems.

MassHealth did not indicate concurrence or non-concurrence with our recommendations to address the

findings that we identified related to security management, configuration management, system software controls, and website and database vulnerability scans. However, it described corrective actions that it had taken or planned to take to remediate all the vulnerabilities.

A-06-15-00057 • March 2017
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Public Summary Report: New York Implemented Security Controls Over Its Health Insurance Exchange Website and Database but Could Improve Security Controls

The New York marketplace had implemented security controls, including policies and procedures, to protect personally identifiable information (PII) on its website and database. However, it did not always comply with Federal requirements. As a result, the website had vulnerabilities that, if exploited, could have resulted in the disclosure of participant PII.

Although we did not identify evidence that the vulnerabilities that we identified in the New York marketplace's website had been exploited, exploitation could have resulted in unauthorized access to and disclosure of PII, as well as disruption of critical marketplace operations. As a result, the vulnerabilities were collectively and, in some cases, individually significant and could have compromised the confidentiality, integrity, and availability of the marketplace. In addition, without proper safeguards, systems were not protected from those with malicious intent to obtain access to commit fraud, waste, or abuse or launch attacks against other computer systems and networks.

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The New York marketplace did not indicate concurrence or non-concurrence with our recommendation that it improve the protection of PII on its website.

[A-02-15-03001](#) • November 2016
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**Public Summary Report: The State of Colorado Did Not Meet
Federal Information System Security Requirements for
Safeguarding Its Medicaid Systems and Data**

Colorado had not implemented adequate information system general controls over the Colorado Medicaid eligibility determination and claims processing systems to fully comply with Federal requirements. The vulnerabilities that we identified increased the risk to the confidentiality, integrity, and availability of Colorado’s Medicaid data. In evaluating Colorado’s risk assessment, database security, website security, and universal serial bus (USB) device security for its Medicaid eligibility determination and claim processing information systems, we identified vulnerabilities related to inadequate risk assessment policies and procedures, improper administration of the Medicaid claims database, inadequate security of Medicaid databases, inadequate website security, and improper management of USB ports and devices.

Colorado concurred with our detailed recommendations to address the vulnerabilities that we identified related to its risk assessment policies and procedures, database administration and security, website security, and USB port and device security for its Medicaid eligibility determination and claim processing information systems.

[A-07-15-00463](#) • October 2016
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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 “Executive Summary” section at the beginning of the Semiannual Report. Superscripts indicate end notes that follow the tables below.

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	175	\$438,171,000	\$18,200,000
Reports issued during the reporting period	54	\$471,830,000	\$50,000
Total Section 1	229	\$910,001,000	\$18,250,000
Section 2			
Reports for which management decisions were made during the reporting period ^{2, 3}			
Disallowed costs	134	*\$357,870,000	\$0
Costs not disallowed	3	\$4,146,000	\$55,000
Total Section 2	137	\$362,016,000	\$55,000
*Audit receivables (expected recoveries).			

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	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)	92	\$547,985,000	\$18,195,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance ⁴	47	\$174,772,000	\$18,145,000

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 Values
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period ¹	6	\$15,051,289,000
Reports issued during the reporting period	4	\$366,487,000
Total Section 1	10	\$15,417,776,000
Section 2		
Reports for which management decisions were made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	1	\$12,776,000
Based on proposed legislative action		\$0

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	Reports	Dollar Values
Value of recommendations not agreed to by management	0	\$0
Total Section 2	1	\$12,776,000
Section 3		
Reports for which no management decisions had been made by the end of the reporting period ² (Sec. 1 minus Sec. 2)	9	\$15,405,000,000

End Notes

Table 1 End Notes

¹The opening balance was adjusted upward by \$75.4 million because of a reevaluation of previously issued recommendations.

² Revisions to previously reported management decisions:

- A-01-11-02500 *Review of Massachusetts’ Title IV-E Adoption Assistance Costs for Federal Fiscal Years 2006 thru 2008*. Subsequent review by ACF determined that additional costs totaling \$1,695,066 was unallowable and issued a disallowance letter to recover cost.
- A-06-15-00014 *Medicare Contractor Payments to Providers for Hospital Outpatient Dental Services in Jurisdiction H Generally Did Not Comply With Medicare Requirements* Subsequent review of claims by CMS determined that the final amount of over payment for the questioned period was \$10,582,929, resulting in additional overpayment totaling \$8,815,823.
- A--10-14-22271 *State of Washington*
In consideration of additional supporting documentation provided by the State of Washington, ACF reduced the disallowance in this finding by \$17,950,349.
- A-06-12-00053 *Texas Did Not Always Comply With Federal and State Requirements for Claims Submitted for the Nonemergency Medical Transportation Program*. Based on revised appraisal of the statistical sample, it was determined that some claims were allowable. Disallowed cost for \$30,385,925 was reduced by \$5,877,059.
- Not detailed are net reductions to previously disallowed management decisions totaling \$3,609,297.

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³ Included are management decisions to disallow \$85 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 currently 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 47 audits were 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-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY MEDICAID SCHOOL-BASED CHILD HEALTH PROGRAM COSTS CLAIMED BY THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES JULY 1997 THROUGH JUNE 2001, MAY 2003, \$32,780,146
CIN: A-01-14-02503	MARYLAND MISALLOCATED MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE, MAR 2015, \$28,400,000
CIN: A-07-13-01125	MEDICARE IMPROPERLY PAID MEDICARE ADVANTAGE ORGANIZATIONS MILLIONS OF DOLLARS FOR UNLAWFULLY PRESENT BENEFICIARIES FOR 2010 THROUGH 2012, APR 2014, \$26,150,043
CIN: A-02-12-02016	PUERTO RICO IMPROPERLY CLAIMED SOME CHILD CARE AND DEVELOPMENT TARGETED FUNDS, JAN 2016, \$12,471,385
CIN: A-01-15-02500	VERMONT DID NOT PROPERLY ALLOCATE MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE, SEP 2016, \$11,243,006
CIN: A-07-15-01159	MEDICARE IMPROPERLY PAID MILLIONS OF DOLLARS FOR UNLAWFULLY PRESENT BENEFICIARIES FOR 2013 AND 2014, SEP 2016, \$9,267,392
CIN: A-01-13-00518	MEDICARE COMPLIANCE REVIEW OF HOME HEALTH VNA FOR 2011 AND 2012, AUG 2016, \$6,348,971
CIN: A-03-12-00004	REVIEW OF HORIZON'S 2009 AND 2010 BONA FIDE SERVICE FEES, MAR 2013, \$4,344,417
CIN: A-02-12-02012	NEW YORK IMPROPERLY CLAIMED SOME CHILD CARE AND DEVELOPMENT TARGETED FUNDS, JUL 2015, \$3,827,836

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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-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-09-14-02041	MEDICARE IMPROPERLY PAID HOSPITALS FOR BENEFICIARIES WHO HAD NOT RECEIVED 96 OR MORE CONSECUTIVE HOURS OF MECHANICAL VENTILATION, JUN 2016, \$1,488,165
CIN: A-07-11-06013	THE UNIVERSITY OF COLORADO DENVER DID NOT ALWAYS CLAIM SELECTED COSTS CHARGED DIRECTLY TO DEPARTMENT OF HEALTH AND HUMAN SERVICES AWARDS IN ACCORDANCE WITH FEDERAL REGULATIONS, JUN 2013, \$1,419,524
CIN: A-03-12-00008	REVIEW OF XL HEALTH DIR, JAN 2013, \$1,410,342
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

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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-09-14-01007	NEVADA MISALLOCATED COSTS FOR ESTABLISHING A HEALTH INSURANCE MARKETPLACE TO ITS ESTABLISHMENT GRANTS, FEB 2016, \$893,464
CIN: A-04-15-04040	MEDICAL ACCESS UGANDA LIMITED GENERALLY MANAGED THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS IN ACCORDANCE WITH AWARD REQUIREMENTS, JUN 2016, \$751,399
CIN: A-09-11-01007	HAWAII CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS FOR HONOLULU COMMUNITY ACTION PROGRAM, INC.'S EXPENDITURES UNDER THE RECOVERY ACT, FEB 2013, \$513,649
CIN: A-04-13-01024	THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL DID NOT ALWAYS CLAIM SELECTED COSTS CHARGED DIRECTLY TO DEPARTMENT OF HEALTH AND HUMAN SERVICES AWARDS IN ACCORDANCE WITH FEDERAL REQUIREMENTS, JUN 2014, \$352,843
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, \$293,870
CIN: A-02-11-02015	PUERTO RICO CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT RECOVERY ACT COSTS FOR INSTITUTO SOCIO-ECONÓMICO, INC., 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-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-05-12-00012	ROCKFORD HUMAN SERVICES DID NOT ALWAYS CHARGE ALLOWABLE COSTS TO THE COMMUNITY SERVICES BLOCK GRANT- RECOVERY ACT PROGRAM, JUL 2013, \$205,296
CIN: A-06-09-00012	RISK ADJUSTMENT DATA VALIDATION OF PAYMENTS MADE TO PACIFICARE OF TEXAS FOR CALENDAR YEAR 2007 (CONTRACT NUMBER H4590), MAY 2012, \$183,247

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CIN: A-04-11-01004	NORTHEAST FLORIDA COMMUNITY ACTION AGENCY, INC., DID NOT ALWAYS CHARGE ALLOWABLE COSTS TO THE COMMUNITY SERVICES BLOCK GRANT- RECOVERY ACT PROGRAM, SEP 2012, \$165,795
CIN: A-04-11-01008	CENTRAL FLORIDA COMMUNITY ACTION AGENCY, INC., DID NOT ALWAYS CHARGE ALLOWABLE COSTS TO THE COMMUNITY SERVICES BLOCK GRANT- RECOVERY ACT PROGRAM, APR 2013, \$160,404
CIN: A-05-14-00017	OHIO DID NOT ALWAYS MAKE CORRECT MEDICAID CLAIM ADJUSTMENTS, SEP 2016, \$151,313
CIN: A-07-11-02766	NOT ALL COMMUNITY SERVICES BLOCK GRANT COSTS CLAIMED ON BEHALF OF THE CARBON COUNTY COMMUNITY ACTION COMMITTEE FOR THE PERIOD OCTOBER 1, 2008, THROUGH SEPTEMBER 30, 2010, WERE ALLOWABLE, AUG 2013, \$143,588
CIN: A-09-11-01013	OREGON CLAIMED SOME POTENTIALLY UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS FOR MULTNOMAH COUNTY'S EXPENDITURES UNDER THE RECOVERY ACT, APR 2013, \$115,911
CIN: A-06-11-00058	CROWLEY'S RIDGE DEVELOPMENT COUNCIL, INC., CLAIMED UNALLOWABLE COSTS UNDER A RECOVERY ACT GRANT, AUG 2012, \$115,420
CIN: A-07-12-02779	NOT ALL COMMUNITY SERVICES BLOCK GRANT RECOVERY ACT COSTS CLAIMED ON BEHALF OF THE COMMUNITY ACTION PARTNERSHIP OF NATRONA COUNTY FOR THE PERIOD JULY 1, 2009, THROUGH SEPTEMBER 30, 2010, WERE ALLOWABLE, JUN 2013, \$104,971
CIN: A-02-11-02000	REVIEW OF SELECT EXPENDITURES CLAIMED BY THE RESEARCH FOUNDATION OF THE STATE UNIVERSITY OF NEW YORK, STATE UNIVERSITY OF NEW YORK AT ALBANY, OCT 2011, \$27,384
CIN: A-09-11-01014	HAWAII CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS FOR HAWAII COUNTY ECONOMIC OPPORTUNITY COUNCIL'S EXPENDITURES UNDER THE RECOVERY ACT, JUL 2012, \$22,602
CIN: A-05-11-00053	THE COLUMBUS URBAN LEAGUE CLAIMED SOME UNALLOWABLE COSTS TO HEAD START, SEP 2012, \$13,102
TOTAL CINS:	47
TOTAL AMOUNT:	\$174,772,000

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Table 2 End Notes

¹The opening balance had no prior period adjustments of previously issued recommendations.

² Because of administrative delays, some of which were beyond management control, 6 of the 9 audits open at end of the period were not resolved within 6 months of issuance of 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	MEDICARE AND BENEFICIARIES COULD SAVE BILLIONS IF CMS REDUCES HOSPITAL OUTPATIENT DEPARTMENT PAYMENT RATES FOR AMBULATORY SURGICAL CENTER-APPROVED PROCEDURES TO AMBULATORY SURGICAL CENTER PAYMENT RATES, APR 2014, \$15,000,000,000
CIN: A-09-14-02041	MEDICARE IMPROPERLY PAID HOSPITALS FOR BENEFICIARIES WHO HAD NOT RECEIVED 96 OR MORE CONSECUTIVE HOURS OF MECHANICAL VENTILATION, JUN 2016, \$19,562,498
CIN: A-07-13-02795	PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR DID NOT ALWAYS REFER MEDICARE COST REPORTS AND RECONCILE OUTLIER PAYMENTS IN JURISDICTION 1, JUL 2015, \$15,792,301
CIN: A-09-14-02037	MEDICARE DID NOT PAY SELECTED INPATIENT CLAIMS FOR BONE MARROW AND STEM CELL TRANSPLANT PROCEDURES IN ACCORDANCE WITH MEDICARE REQUIREMENTS, FEB 2016, \$2,054,306
CIN: A-04-14-04028	NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES DID NOT ALWAYS CLAIM COSTS UNDER CDC PREVENTION AND PUBLIC HEALTH FUND AWARDS IN ACCORDANCE WITH FEDERAL REQUIREMENTS, JAN 2016, \$493,401
CIN: A-03-14-00406	WEST VIRGINIA MADE INCORRECT MEDICAID ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS TO HOSPITALS, AUG 2016, \$208,117

TOTAL CINs: 6

TOTAL AMOUNT: \$15,038,111,000

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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). Recently CIGIE approved a new peer-review process for Inspection and Evaluation units within OIGs across the Federal Government, including at HHS OIG, the implementation of which will begin in 2018.

Office of Audit Services

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
	May 2015	Department of Transportation	HHS OIG, OAS

The system of quality control for the audit organization of HHS OIG in effect for the year ending September 30, 2014, 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
	December 2015	HHS OIG, OAS	U.S. Department of Agriculture (USDA)

The system of quality control for the audit organization of USDA OIG in effect for the year ending March 31, 2015, has been suitably designed and complied with to provide USDA 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. USDA OIG received a peer-review rating of pass.

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Office of Investigations

During this semiannual reporting period, no peer reviews involving Office of Investigations (OI) were completed. Listed below is information concerning OI’s peer-review activities during prior reporting periods.

OI	Date	Reviewing Office	Office Reviewed
	August 2015	DOL-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, 2015, were in full compliance with the quality standards established by CIGIE and the Attorney General’s guidelines.

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.

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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 list of authorities provided under other statutes 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 \$15,270 for each item or service falsely or fraudulently

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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 \$55,262 for each false statement, as well as activities relating to fraudulent marketing by MCOs, their employees, or their agents.

The 21st Century Cures Act (enacted on December 13, 2016) added more grounds for imposing CMPs, assessments, and exclusion from Federal health care programs for fraudulent conduct in an HHS grant, contract, or other agreement. OIG may assess CMPs of up to \$10,000 per claim and assessments of up to 3 times the amount claimed for knowingly presenting a false or fraudulent claim. In addition, OIG may impose a penalty of up to \$50,000 and assessments of up to 3 times the amount of funds at issue (1) for each instance of knowingly making a false statement in a document required to be submitted in order to receive funds under an HHS contract, grant, or other agreement; (2) for knowingly making or using a false record or statement that is material to a false or fraudulent claim; and (3) for knowingly making or using a false record or statement material to an obligation to pay or transmit funds or property owed to HHS. OIG may impose a penalty of up to \$10,000 per day and assessments of up to 3 times the amount at issue for knowingly concealing, or knowingly and improperly avoiding or decreasing, an obligation owed to HHS with respect to an HHS grant, contract, or other agreement. Finally, HS OIG may impose a penalty of up to \$15,000 per day for failing to grant timely access to OIG upon reasonable request for audits or to carry out other statutory functions in matters involving an HHS grant, contract, or other agreement.

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

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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 \$52,414 against small hospitals (fewer than 100 beds) and up to \$104,826 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 \$104,826 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 (FCA), 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 \$10,957 and \$21,916 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 whistle blower, provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistle blower 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.

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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 Reviews and Investigations” section
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout this report
(a)(3)	Prior significant recommendations on which corrective action has not been completed	<i>OIG Compendium of Unimplemented Recommendations</i>
(a)(4)	Matters referred to prosecutive authorities	“Legal and Investigative Activities” section
(a)(5)	Summary of instances in which information requested by OIG was refused	None for this reporting period
(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, in which no establishment comment was returned within 60 days, and in which there are any outstanding unimplemented recommendations	Appendix A
(a)(11)	Description and explanation of revised management decisions	Appendix A
(a)(12)	Management decisions with which the Inspector General disagrees	None for this reporting period
(a)(13)	Information required by the FISMA	Reported annually in the spring <i>Semiannual Report to Congress</i> , “Other HHS-Related Reviews and Investigations” section

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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 B
(a)(17)	Investigative statistical tables	Appendix E
(a)(18)	Metrics description for statistical tables	Appendix E
(a)(19)	Investigations on Senior Government Employees	Appendix E
(a)(20)	Description of whistle blower retaliation instances	Appendix E
(a)(21)	Description of attempts to interfere with OIG independence	Appendix E
(a)(22)	Description of closed and non-disclosed reports and investigations regarding Senior Government Employees	Appendix E
Other reporting requirements		
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 Reviews and Investigations" 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 Semiannual Report, 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

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Reporting Requirements in the Inspector General Empowerment Act of 2016

The Inspector General Empowerment Act of 2016 (IGEA) establishes new reporting requirements for the Semiannual Reports to Congress. These requirements amend portions of § 5 of the IG Act. The requirements are below in italics, followed by OIG’s responses.

Each Inspector General shall, not later than April 30 and October 31 of each year, prepare semiannual reports summarizing the activities of the Office during the immediately preceding six-month periods ending March 31 and September 30. Such reports shall include, but need not be limited to-

(10) a summary of each audit report, inspection reports, and evaluation reports issued before the commencement of the reporting period-

(a) for which no management decision has been made by the end of the reporting period (including the date and title of each such report), an explanation of the reasons such management decision has not been made, and a statement concerning the desired timetable for achieving a management decision on each such report;

For audit, inspection, and evaluation reports issued before the commencement of the reporting period, OIG had 204 reports for which no management decision has been made.*

*This includes information compiled from OIG’s Office of Audit Services (OAS) and Office of Evaluation and Inspections (OEI) databases. The OAS database began tracking management decisions in FY 1990. The OEI database began tracking management decisions in FY 2011. These 204 reports reflect situations in which the agency failed to provide a management decision for at least one of the recommendations we made in a given report. Due to the volume of reports with recommendations for which no management decision has been made, OIG is working to reconfigure its databases to provide information in this section in a table format, similar to 10c, in future Semiannual Reports.

(b) for which no establishment comment was returned within 60 days of providing the report to the establishment; and

Currently, OIG tracks this measure on a 30-day time frame. In connection with draft reports that include recommendations, OIG typically requests establishment comments within 30 days. In some instances, OIG grants extensions when requested and appropriate. When OIG does not receive establishment comments or a request for extension within the 30-day time frame, OIG issues the report and typically notes the lack of establishment comments.

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For the period October 1, 2016, through March 31, 2017, we received establishment comments during our 30-day time frame for all OIG reports. We are exploring ways to modify our reporting inputs to capture this new 60-day requirement.

(c) for which there are any outstanding unimplemented recommendations, including the aggregate potential cost savings of those recommendations.

OIG is actively tracking 1,223 unimplemented or open recommendations made in reports issued since FY 2011. Given the volume of recommendations OIG makes on an annual basis, the table below reflects only the data that are immediately accessible within OIG’s automated tracking system:

Fiscal Year (2011-2017)	Number of Reports with Unimplemented Recommendations	Number of Unimplemented Recommendations	Dollar Value of Aggregate Potential Cost Savings
2011	28	66	\$475,140,370
2012	46	78	\$416,404,187
2013	59	139	\$1,004,149,575
2014	67	140	\$15,288,185,803
2015	64	155	\$640,366,375
2016	134	383	\$516,922,675
2017 (partial year)	73	262	\$831,782,190
Totals	471	1,223	\$19,172,951,175

OIG annually produces a Compendium of Unimplemented Recommendations ([Compendium](#)), which constitutes OIG’s response to a specific requirement of the IG Act, as amended (§ 5(a)(3)). It identifies significant recommendations with respect to problems, abuses, or deficiencies for which corrective actions have not been completed. The Compendium’s Appendix includes a list of OIG’s significant unimplemented recommendations. These recommendations represent opportunities to achieve expected impact through cost savings, improvements in program effectiveness and efficiency, and increasing quality of care and safety of beneficiaries. In OIG’s view, these recommendations would most positively impact HHS programs in terms of cost savings and/or quality improvements and should therefore be prioritized for implementation.

(17) statistical tables showing-

(A) the total number of investigative reports issued during the reporting period;

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(B) the total number of persons referred to the Department of Justice for criminal prosecution during the reporting period;

(C) the total number of persons referred to State and local prosecuting authorities for criminal prosecution during the reporting period; and

(D) the total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities;

Total number of investigative reports issued during the reporting period	1
Total number of persons referred to DOJ/State and local prosecuting authorities for criminal prosecution during the reporting period ²	1,086
Total number of indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities	327

(18) a description of the metrics used for developing the data for the statistical tables under paragraph (17);

Regarding (17)(A), OIG considers Investigative Reports as Management Implication Reports (MIR) and Investigative Advisories. A MIR is a document that identifies systemic weaknesses or vulnerabilities within HHS programs, which are generally identified during the course of an OIG investigation and could lead to fraud, waste, or abuse. It provides recommendations to correct or minimize the problem. Corrective actions may require administrative, procedural, policy, regulatory, or legislative change. When a MIR is issued to an HHS Operating or Staff division, it is generally signed by the Inspector General. Investigative Advisories are similar documents, emphasizing an identified HHS issue, which are generally signed by the Deputy Inspector General for Investigations.

Regarding (17)(B) and (C), OIG is reporting on referrals to both Federal and State/local prosecuting jurisdictions. When OIG opens an investigation, it evaluates the complaint and makes a decision whether to refer the matter for prosecution. Generally, if the case has prosecutorial merit, and is accepted for Federal prosecution, OIG works with DOJ as the primary investigative agency. In addition to DOJ, OIG works with State and local prosecutorial authorities.

Presently, OIG’s case management system does not have the capability to distinguish between a Federal and State referral. Consequently, the information provided in the table represents combined totals of Federal and State/local referrals. OIG is currently addressing these database programming challenges.

Regarding (17)(D), the table provides the number of indictments/criminal informations during the semiannual reporting

²OIG counts “persons” as both individuals and entities.

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period, including sealed indictments/criminal informations.³ However, the information cannot be limited to only those that occurred as a result of a referral in a previous period. In certain situations, the referral and charging dates are in the same reporting period. OIG’s case management system is currently unable to separate Federal from State/local indictments/criminal informations.

(19) a report on each investigation conducted by the Office involving a senior Government employee where allegations of misconduct were substantiated, including a detailed description of-

(A) the facts and circumstances of the investigation; and

(B) the status and disposition of the matter, including-

(i) if the matter was referred to the Department of Justice, the date of the referral; and

(ii) if the Department of Justice declined the referral, the date of the declination;

To respond fully to this subparagraph, OIG would need to make a finding of misconduct. However, OIG does not make findings with regard to its investigations relating to substantiated allegations of Departmental employee misconduct. Our reports relay the facts obtained during the investigations (e.g., parties involved, dates of events) related to any substantiated allegations. At the conclusion of an OIG investigation related to substantiated allegations concerning possible employee misconduct, OIG provides a report to management in the employing agency. The agency management makes determinations of employee misconduct. The disposition of the matter and any resulting administrative actions are taken by the agency.

However, we request from the agency a copy of an SF-50 documenting a personnel action, if one is taken. To the extent that we have information regarding subsequent administrative action, OIG is able to provide that information. However, after taking an administrative action as a result of an OIG investigation, the Department may enter into a settlement agreement with the employee in order to resolve any potential litigation risk as a result of the administrative action. Such agreements sometimes change the nature of the administrative action (e.g., a termination might be replaced by a voluntary resignation). If this were to happen, OIG may not have a complete record of the disposition of the investigation. Accordingly, such information might be more efficiently and effectively provided directly from the employing agency.

For this section, OIG describes investigations during this reporting period, both criminal and administrative, involving senior Government employees where allegations of misconduct were substantiated. The descriptions below include a level of detail appropriate for each investigation, depending on whether the case details were available in public documents. During this reporting period, OIG investigated five senior Government employees for misconduct, and OIG determined the allegations to be substantiated, but no prosecution resulted. Descriptions of the investigations follow:

³An “information” is a formal criminal charge that begins a criminal proceeding in the courts.

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Description of Investigation	Status	Disposition	DOJ Referral	DOJ Referral Date	DOJ Declination
A senior Government employee was alleged to have improperly shared information regarding an HHS Quality Data Online Program.	Closed	Admonishment/Reminder of Policy (Oral/Written)	No	N/A	No
A senior Government employee was alleged to have been involved in a policy violation involving the use of an HHS purchase card while purchasing official/approved property for Government use.	Closed	Admonishment/Reminder of Policy (Oral/Written)	No	N/A	No
HHS employees, including a senior HHS official, inappropriately participated in a private consortium, giving the appearance of a conflict of interest.	Closed	Agency Policy Change Issued	No	N/A	No
HHS senior Government employees were accused of Standard of Conduct/Behavior Unbecoming.	Closed	Admonishment/Reminder of Policy (Oral/Written)	No	N/A	No
A senior HHS Government employee was accused of sharing information in advance of public release.	Closed	Employee Suspended and Transferred	No	N/A	No

(20) a detailed description of any instance of whistle blower retaliation, including information about the official found to have engaged in retaliation and what, if any, consequences the establishment imposed to hold that official accountable;

For departmental agencies, OIG conducts investigations and gathers facts related to whistleblower complaints. In the past, OIG has not made determinations as to whether retaliatory action had been taken. However, to better facilitate the report review process, OIG changed its process in 2015 to include findings in its reports as to whether it was more likely than not that whistle blower retaliation had occurred. While OIG now includes these findings in its reports, it does not make recommendations as to what, if any, corrective action(s) should be taken.

Under this system, OIG submitted two reports that included findings of retaliation to the HHS Secretary’s Office prior to October 1, 2016 (both prior to the semiannual reporting period). The Department issued findings and recommendations with respect to both of the OIG reports at issue.

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When determining the level of detail to provide for a description of any instance of whistleblower retaliation, OIG is always mindful of balancing the risk that a detailed description of the allegation could inadvertently reveal the whistleblower's identity, thus having a chilling effect on future whistleblowers. The following information is provided with this in mind.

The first report: The whistleblower in this matter filed numerous "incident reports" with IHS management at an IHS medical facility raising concerns about quality of care, confidentiality of patient and staff information, property incidents, and mismanagement. The whistleblower also raised allegations that he/she suffered reprisal and that management was creating a hostile work environment.

OIG found that it was more likely than not that the whistleblower was subjected to reprisal for whistle blowing activities in this matter for the following reasons. First, the whistleblower made numerous protected communications. Second, management was aware of those communications (because many of the communications were sent to management). Third, multiple adverse personnel actions were taken against the whistleblower during the relevant time period. Fourth, a causal connection existed between the protected communications and the adverse personnel actions because the personnel actions referenced the fact that the whistleblower went outside of the chain of command to raise his/her concerns and instructed the whistleblower not to do so in the future.

By memo dated January 12, 2017, the Deputy Secretary agreed with the proposed "findings and recommendations" and found that the whistleblower had been subjected to reprisal for his/her protected communications and agreed with the following proposed corrective action: 1) supervisors were to be sent to training on employee supervision, performance management, and dispute resolution; 2) the whistleblower along with supervisors were to be sent to training on communication and email etiquette; 3) the whistleblower was to be returned to a duty status in a position equivalent to the one the whistleblower was removed from; 4) the letters of reprimand were to be removed from the whistleblower's personnel file; and 5) supervisors were to be sent to training concerning quality of care improvements.

The second report: The whistleblower in this matter alleged that a senior government official attempted to intimidate the whistleblower into accepting responsibility for the failure of a project for which the whistleblower was not responsible. The whistleblower made this disclosure to the Department's Labor and Employee Relations (LER) Division, to the Department's Equal Employment Opportunity Compliance and Operations (EEOCO) Division, and to OIG. The whistleblower alleged that he/she suffered reprisal for the disclosures when his/her security clearance was suspended and later revoked.

OIG found that it was more likely than not that the whistleblower was subjected to reprisal for whistleblowing activities in this matter for the following reasons. First, the whistleblower made several protected communications. Second, the whistleblower's management was aware of those communications. Third, the whistleblower's security clearance was suspended and then revoked. Fourth, we found that the whistleblower's protected disclosures were a contributing factor in the decision to suspend and revoke his/her eligibility for access to classified information for several reasons, including:

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the close proximity in time between the protected disclosures and the decision to suspend and revoke the whistleblower’s clearance; the lack of evidence to support the stated basis for the revocation of the clearance; and the fact that the manager responsible for revoking the whistleblower’s clearance had expressed animus towards the whistleblower as a result of his/her disclosures. Fifth, OIG concluded that there was no “clear and convincing” evidence that the same action would have been taken against the whistleblower in the absence of the protected disclosures because similarly situated employees who engaged in conduct similar to that of the whistleblower did not have their clearances revoked.

By way of an undated memo from the Acting Deputy Secretary to the whistleblower, the Department issued its “findings and recommendations” with respect to this matter. The Department concurred in the OIG’s finding that the whistleblower was subjected to retaliation in this matter and ordered the following corrective action: 1) senior government official was ordered to take training on whistleblowers’ rights, employee supervision, performance management and conduct, dispute resolution and communication; 2) all employees in the relevant Office were ordered to take training on whistleblowers’ rights; 3) the Department said it would review the record to determine whether other remedies were necessary related to restoration of the whistleblower’s security clearance; and 4) the Department noted that it was conducting a further review of the management of the Office at issue and would determine if disciplinary or other corrective action was necessary at the conclusion of that review.

Subsequently, the Department entered into a settlement agreement with the senior government official accused of whistleblower reprisal in this matter. The senior government official no longer works for the Department. OIG has not received a copy of the settlement agreement entered into by the Department and the senior government official; therefore, OIG does not know what corrective action the Department ultimately took in this matter.

(21) a detailed description of any attempt by the establishment to interfere with the independence of the Office, including-

(A) with budget constraints designed to limit the capabilities of the Office; and

(B) incidents where the establishment has resisted or objected to oversight activities of the Office or restricted or significantly delayed access to information, including the justification of the establishment for such action; and

Although there have been instances in which HHS agencies have questioned OIG oversight activities or have not provided all information in the precise content, format, and timeline as requested, OIG has not identified any instances in which the Department interfered with the independence of OIG during this reporting period. OIG would immediately notify Congress if it were unable to resolve these issues within the Department.

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(22) detailed descriptions of the particular circumstances of each-

(A) inspection, evaluation, and audit conducted by the Office that is closed and was not disclosed to the public; and

The table below lists evaluation and audit reports for this semiannual reporting period that did not result in public reports. However, in some circumstances, a public summary of these nonpublic reports was published.

Nonpublic Reports by Category, October 1, 2016, to March 31, 2017

Category/Description	Number of Reports
Information technology security reviews (involve information technology systems, e.g., Federal Information Security Management Act audits)	5
Homeland security issues (involve particularly sensitive topics, e.g., bioterrorism, emergency preparedness, and classified or potentially classified information)	0
Recipient Capability Audits (primarily in Head Start/Early Head Start programs)	0
Reimbursable audits performed for other Federal agencies (primarily contract audits)	5
Confidential or proprietary information (e.g., Medicare Part B drug claims/imaging services, Medicare investment income)	2
Medicare Adverse Event Reviews (required by law not to disclose)	0
Medicare Prescription Drug Event Reviews	0
Other	1
Departmental technical assistance reports ⁴	1
Finance-related attestation reviews	2
Total	16

(B) investigation conducted by the Office involving a senior Government employee that is closed and was not disclosed to the public.

In section 5(a)(19), we detail senior Government employee investigations where allegations were substantiated. Those investigations are all closed and none have been disclosed to the public. OIG interprets Section 5(a)(22)(B) as requiring reporting on investigations with either substantiated or unsubstantiated allegations. As such, we refer to our section 5(a)

⁴OIG routinely provides technical assistance to the Department. Generally, that technical assistance is not part of a formal report and is not formally tracked. However, in some limited circumstances, OIG does provide technical assistance in a formal report, and only this category of technical assistance is reflected in this table.

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(19) response to address senior Government employee investigations with substantiated allegations that were closed and not disclosed to the public. Our section 5(a)(22)(B) response describes investigations during this reporting period, both criminal and administrative, involving a senior Government employee where allegations of misconduct were unsubstantiated by OIG.

When determining the level of detail to provide for the investigations described above, OIG is mindful of balancing the risk that a detailed description of the investigation could inadvertently reveal the subject’s identity. During this reporting period, OIG investigated five senior Government employees for misconduct, but OIG determined the allegations to be unsubstantiated. Descriptions of the investigations are below.

Description of Investigation	Status	Disposition	DOJ Referral	DOJ Referral Date	DOJ Declination
A senior Government employee was alleged to have submitted false claims and misused his/her position.	Closed	No evidence to support allegations.	No	N/A	No
A senior Government employee was alleged to have accessed an HHS network for an unauthorized purpose.	Closed	No evidence to support allegations.	No	N/A	No
A senior Government employee was alleged to have accessed an HHS network for an unauthorized purpose.	Closed	No evidence to support allegations.	No	N/A	No
A senior Government employee was alleged to have accessed an HHS network for an unauthorized purpose.	Closed	No evidence to support allegations.	No	N/A	No
A senior Government employee was alleged to have accessed inappropriate material.	Closed	No evidence to support allegations.	No	N/A	No



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