

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

SEMIANNUAL REPORT *to* CONGRESS

October 1, 2015

— *to* —

March 31, 2016



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

OAS

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 (CMP).

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. 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.

A MESSAGE FROM THE INSPECTOR GENERAL



*Daniel R. Levinson
Inspector General*

I am pleased to submit this Semiannual Report to Congress that summarizes the activities of the Office of Inspector General (OIG), Department of Health and Human Services (HHS or the Department), for the 6-month period that ended March 31, 2016. OIG advances its core mission of protecting the integrity of HHS programs and the people they serve by working to prevent and detect fraud, waste, and abuse. When misconduct is identified, OIG takes appropriate enforcement action or makes recommendations to improve Department programs and operations.

One of the ways in which OIG helps to prevent fraud, waste, and abuse is by providing guidance that supports the health care industry's compliance efforts. For example, we issue special fraud alerts and bulletins to notify providers of risk areas and problematic conduct. For this reporting period, OIG issued a policy reminder about information blocking and the anti-kickback statute and a policy statement regarding self-administered Medicare drugs dispensed in outpatient settings. Another way that we strive to prevent problems is by making recommendations, that, if implemented, would address vulnerabilities and prevent recurrence of the identified problem. For example, OIG recently recommended that certain States ensure compliance with Federal health and safety requirements for child care providers to help reduce the risk of harm to children.

Through our work, OIG detects and identifies services that are questionable, undocumented, medically unnecessary, or incorrectly coded. We also identify duplicate payments and payments for services that were not provided. In doing so, OIG uncovers potentially systemic payment vulnerabilities. For example, OIG identified that hospices inappropriately billed Medicare over \$250 million for general inpatient care and recommended that the Centers for Medicare and Medicaid Services (CMS) increase its oversight of hospice claims and review Part D payments for drugs for hospice beneficiaries.

OIG leverages technology and forensic audit techniques to identify and address emerging fraud trends and to support efforts to deter misconduct through administrative actions. OIG investigations, including work on Strike Force cases, target emerging patterns of fraud and help to hold wrongdoers accountable. For example, a home health agency owner was sentenced to more than 6 years and ordered to pay \$4.5 million in restitution for billing Medicare for unnecessary home health care and therapy services. OIG uses its administrative tools to complement Department of Justice criminal and civil enforcement efforts and has deployed a team dedicated to pursuing administrative enforcement actions. We pursue enforcement where appropriate, which helps honest providers flourish by weeding out wrongdoers.

During this reporting period, we promoted economy, efficiency, and effectiveness of program management through a comprehensive case study of HealthCare.gov that identified important lessons learned from the CMS's implementation of the website and offered insights that may be used by other programs charged with implementing large, complex, and high-profile initiatives. We expect to apply these lessons in management reviews in the future.

Since its 1976 establishment, OIG has worked diligently with its partners to protect HHS's vital health and human services programs. The achievements of this office would not be possible without the dedication and professionalism of all OIG employees. Once again, I would 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

HHS OIG'S SEMIANNUAL REPORT TO CONGRESS (*Semiannual Report*) describes significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. This edition addresses work completed during the first half of fiscal year (FY) 2016 (October-March) and summarizes key accomplishments during the period.

During the first half of FY 2016, OIG reported expected **recoveries of more than \$2.77 billion** consisting of nearly \$554.7 million in audit receivables and about \$2.22 billion in investigative receivables, which include about \$336.6 million in non HHS investigative receivables resulting from our work in areas such as the States' shares of Medicaid restitution.



OIG reported **428 criminal actions against individuals** or entities that engaged in crimes against HHS programs and **383 civil actions**, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters. **Our CMP recoveries have increased almost five fold over the past 3 years, and OIG is on track to exceed prior recoveries in FY 2016.** We also reported exclusions of 1,662 individuals and entities from participation in Federal health care programs.

Health Care Fraud Strike Force Teams and Other Enforcement Actions

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and the U.S. Department of Justice to strengthen programs and invest in new resources and technologies aimed at preventing and combating health care fraud, waste, and abuse. HEAT has continued to identify and hold accountable those who seek to defraud Medicare and Medicaid. Health Care Fraud Strike Force teams, a key component of HEAT, coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities. The teams have a record of successfully analyzing data to quickly identify, investigate, and prosecute fraud.

The Strike Force model operates in Miami, Florida; Los Angeles, California; Detroit, Michigan; southern Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas. During the first half of FY 2016, Strike Force efforts resulted in the filing of charges against 87 individuals or entities, 100 criminal actions, and \$116.8 million in investigative receivables.

The following is a Strike Force case example:

Home Health Agency Owner Sentenced to More Than 6 Years in Prison for Falsely Billing Medicare

Amer Ehsan, the owner of Advance Home Health Care Services, Inc. (Advance), was sentenced to 6 years and 8 months in prison and ordered to pay \$4.5 million in restitution for his guilty plea to health care fraud conspiracy. Ehsan admitted that he billed Medicare for unnecessary home health care and therapy services, paid physicians to refer Medicare beneficiaries to Advance and sign medical documents falsely certifying that they required home health care, and paid Medicare beneficiaries cash kickbacks in exchange for signing multiple blank physical therapy records. Additionally, Ehsan admitted that he owned Michigan Rehab and Management Services LLC, which he used to sell information about Medicare beneficiaries and corresponding fictitious patient files to other home health care agencies. Ehsan was part of a wide-ranging scheme that involved 12 defendants, all of whom have pleaded guilty.

The following are other investigations case examples:

Medical Equipment Company Enters into \$646 Million Settlement Agreement

Olympus Corporation of the Americas (Olympus) agreed to enter into a \$310 million civil False Claims Act settlement with the United States and a comprehensive 5-year Corporate Integrity Agreement (CIA). The settlement was part of a global criminal and civil resolution under which Olympus agreed to pay a total of \$646 million to resolve kickback allegations. Olympus is the country's largest distributor of endoscopes and related medical equipment. Through the civil settlement agreement, Olympus resolved allegations that, between January 2006 and December 2011, it paid illegal kickbacks to doctors and hospitals to induce them to purchase endoscopes and other medical and surgical equipment. These kickbacks came in the form of consulting agreements, foreign travel, lavish meals, grants, and free endoscopes. As a result, Olympus allegedly caused the submission of false claims to the Medicare, Medicaid, and Tricare programs. The CIA contains several provisions for accountability by Olympus' Board of Directors, extensive audit requirements, and requires Olympus to implement an internal risk assessment and mitigation program.

Pharmacy CEO Sentenced to 10 Years in Prison for Health Care Fraud

Kim Duron Mulder, CEO of Kentwood Pharmacy, was sentenced to 10 years in prison, ordered to pay \$8.8 million in restitution, joint and several, and banned from participation in Federal health care programs for 50 years for his guilty plea to conspiracy to commit health care fraud. According to the investigation, Kentwood Pharmacy billed Medicare and private health insurers for prescription drugs that had been dispensed to patients and subsequently inappropriately returned to pharmacy stock. These fraudulent actions resulted in the cross-contamination of drugs, improper labeling of drugs, the placement of different drug dosages into stock bottles,

and the placement of the wrong drugs into stock bottles. Public and private insurers paid more than \$79 million for adulterated and misbranded drugs that were sent to patients at more than 800 nursing and adult foster care homes.

Inefficient Payments, Policies, and Practices

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

The following are examples of our work:

Average Manufacturer Prices Increased Faster Than Inflation for Many Generic Drugs

Our review found that generic drug price increases exceeded the specified statutory inflation factor applicable to brand-name drugs for 22 percent of the quarterly average manufacturer prices we reviewed. If the provision for brand-name drugs were extended to generic drugs, Medicaid would receive additional rebates. Medicaid would have received \$1.4 billion in additional rebates for the top 200 generic drugs, ranked by Medicaid reimbursement, from 2005 through 2014.

Our findings are consistent with our previous work and support our prior recommendation that CMS consider seeking legislative authority to extend the additional rebate provisions to generic drugs. On November 2, 2015, the Bipartisan Budget Act of 2015 (P.L. No. 114-74) was enacted and included provisions extending the additional rebate to generic drugs. The additional rebate for generic drugs will apply to rebate periods beginning with the first quarter of 2017.

A-06-15-00030 • December 2015



CMS Has Not Performed Required Closeouts of Contracts Worth Billions

CMS relies extensively on contractors to carry out its basic mission and spends billions each year in contracts for a variety of goods and services. Our review focused on CMS's Federal Acquisition Regulation (FAR) contracts that were active as of February 2014, and its FAR contracts pending closeout as of February 2014. We found that CMS had over 6,000 contracts with a combined value of \$25 billion that were not closed out as required under the FAR. CMS continues to have thousands of contracts overdue for closeout, with 15 percent of contracts that were completed before FY 2011 at least 10 years overdue. Because the closeout process is generally the last chance for improper contract payments to be detected and recovered, delays in the closeout process pose a risk to Government funds. Additionally, key pieces of information that CMS could use to manage and oversee contracts, such as project description and contract payments, are not easily accessible through its contract management system.

CMS concurred with all of our recommendations to implement additional strategies to meet required FAR timeframes for closeout, determine the status of contracts for which closeout status could not be determined, improve reports from CMS's contract management system to allow for easier access to contract data that would assist in closeout and funds management, and improve coordination and collaboration across departmental staff with contract closeout responsibilities.

OEI-03-12-00680 • December 2015



Implementation of Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA) required establishment of health insurance marketplaces (also known as health insurance exchanges). ACA also included requirements for insurance affordability and other programs related to the marketplaces. OIG's oversight of the marketplaces focuses on payment, eligibility, management, and IT security issues.

The following are examples of our work:

HealthCare.gov: Case Study of CMS Management of the Federal Marketplace

The objective of this case study was to gain insight into CMS's implementation and management of the Federal Marketplace, focusing primarily on HealthCare.gov. We found that HHS and CMS made many missteps throughout development and implementation that led to the poor launch of HealthCare.gov on October 1, 2013. Most critical was the absence of clear leadership, which caused delays in decision-making and a lack of clarity in

project tasks. Additional missteps included devoting too much time to developing policy, which left too little time for developing the website, and failing to properly manage its key website development contract. CMS's organizational structure and culture also hampered progress, including poor coordination between policy and technical work. CMS continued on a failing path despite signs of trouble, making rushed corrections that proved insufficient.

Following the launch, CMS and contractors pivoted quickly to corrective action, reorganizing the work to improve execution and facilitating health plan enrollment for millions of consumers. Key factors that contributed to recovery of the website included adopting a "badgeless" culture for the project, wherein all CMS staff and contractors worked together as a team, and a practice of "ruthless prioritization" that aligned work efforts with the most important and achievable goals. CMS recovered the website for high consumer use within 2 months and adopted more effective organizational practices. CMS concurred with our recommendation to continue to apply lessons from the HealthCare.gov recovery in its management of the Federal Marketplace and broader organization.

OEI-06-14-00350 • February 2016

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Not All of the State Marketplace's Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

Not all of the internal controls for the marketplaces in Colorado, District of Columbia, Minnesota, Vermont, or Washington were effective in ensuring that individuals were enrolled in qualified health plans (QHPs) according to Federal requirements. Kentucky's internal controls were generally effective. Internal controls were generally not effective in determining or verifying eligibility of applicants, resolving inconsistencies in eligibility data, or maintaining and updating eligibility and enrollment data. In addition, internal controls in Colorado, District of Columbia, and Vermont related to verifying information were not effective, and Colorado's internal controls related to obtaining certain data were ineffective.

As applicable, the marketplaces generally agreed with either our findings or our recommendations that they take action to improve their internal controls related to resolving inconsistencies in eligibility data, to maintaining and updating eligibility and enrollment data, and to verifying applicants' eligibility. Minnesota did not agree with our recommendation that it redetermine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

From October 2015 to March 2016, reports were issued for the following States: Vermont (A-01-14-02507), District of Columbia (A-03-14-03301), Minnesota (A-05-14-00043), Washington (A-09-14-01006), Colorado (A-07-14-03199), and Kentucky (A-04-14-08036).

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CMS Could Not Effectively Ensure That Advance Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums

CMS could not ensure that advance premium tax credit (APTC) payments made to QHP issuers were only for enrollees who had paid their premiums. CMS: (1) relied on each QHP issuer to verify that enrollees paid their monthly premiums and to attest that APTC payment information was accurate; and (2) had sole responsibility for ensuring that APTC payments were made only for enrollees who had paid their premiums and did not share these data for enrollees with the Internal Revenue Service (IRS).

CMS concurred with our recommendation to establish policies and procedures to calculate APTC payments without relying solely on QHP issuers' attestations that enrollees have paid their premiums. CMS did not indicate concurrence or nonconcurrence with our recommendation that once it implements an automated process to maintain individual enrollee data, it consult with the IRS to explore sharing APTC payment data.

A-02-14-02025 • December 2015



Child Care and Development Fund

In 2015 alone, the U.S. Government spent approximately \$5.4 billion to help States, territories, and tribes subsidize childcare for low-income working families. Every month, the Government's Child Care and Development Fund underwrites the care of nearly 1.5 million children from low-income families so their parents can work or attend school. Childcare providers receiving Federal subsidies must offer a safe environment for children. Gaps in oversight and monitoring can place the health and safety of children at risk, as our work has demonstrated.

The following is an example of our work:

Some South Carolina, Puerto Rico, and Florida Childcare Providers Did Not Always Comply With Health and Safety Requirements

We found that childcare providers did not comply with health and safety requirements, including physical conditions requirements and record requirements for staff and children. In addition, some of the childcare providers were not available during operating hours to complete our unannounced inspections. South Carolina, Puerto Rico, and Florida generally concurred with our findings and recommendations to ensure compliance with health and safety requirements and documentation requirements.

From October 2015 to March 2016, reports were issued for the following States: South Carolina (A-04-14-08031; A-04-14-08032); Puerto Rico (A-02-14-02001; A-02-14-02016); and Florida (A-04-14-08033; A-04-14-08034).



Health Information Technology

Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. The American health care system is increasingly relying on health IT and the electronic exchange and use of health information, but threats to privacy and security are ever-evolving and the Department must remain vigilant. OIG has identified the meaningful and secure exchange and use of electronic information and health IT as a top management challenge facing the Department.

OIG Policy Reminder: Information Blocking and the Federal Anti-Kickback Statute

As HHS focuses on the flow of information across the care continuum, OIG reminded the public about how information blocking may affect safe harbor protection under the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)). OIG stated that donations of items or services that have limited or restricted interoperability due to action taken by an applicable individual or entity would fail to meet one of the conditions of the safe harbor and would be inconsistent with the intent of the safe harbor to promote the use of technology that is able to communicate with products from other vendors. Failure to meet this condition would mean that the safe harbor would not apply and the arrangement would be subject to case-by-case review under the Federal anti-kickback statute. As OIG stated, such donations would be suspect under the statute.

The following is an example of our work:

High-Risk Security Vulnerabilities Identified During Reviews of Information System General Controls at Three California Managed-Care Organizations Raise Concerns About the Integrity of Systems Used To Process Medicaid Claims

We summarized the high-risk security vulnerabilities that we identified in our previous reviews of information system general controls at three California Medi-Cal managed care organizations (MCOs). We identified 74 high-risk security vulnerabilities, most of which were significant and pervasive, in the information system general controls at the three Medi-Cal MCOs.

Our consolidated findings from the individual reports raise concerns about the integrity of the systems used to process Medicaid managed-care claims. California informed us, in comments on the individual reports, that it was addressing these vulnerabilities. The fact that some of the same vulnerabilities were identified at all three MCOs suggests that other California Medi-Cal managed-care information systems may be similarly vulnerable. This report is intended to provide information to assist California and CMS in strengthening MCOs' system security.

A-09-15-03004 • December 2015



Quality of Care and Beneficiary Access

Quality of care and beneficiaries' access to health care are two areas of accountability that are essential to providing a well-managed health care system. As Americans continue to live longer and with more chronic medical conditions, we must ensure that our Medicare and Medicaid beneficiaries, some of whom are our most vulnerable citizens, receive high-quality health care. We must also ensure that they receive timely access to the health care they need.

The following is an example of our work:

Most Children with Medicaid in Four States Are Not Receiving Required Dental Services

We found that three out of four Medicaid children in California, Indiana, Louisiana, and Maryland did not receive all required dental services, with one in four children failing to see a dentist at all. While these States reported that they employ a variety of strategies to address this problem and CMS has taken some positive steps in this area, we continue to have concerns that children are not receiving required dental services.

CMS fully or partially concurred with the majority of OIG's recommendations including CMS working with States to identify area with limited providers, to analyze the effects of Medicaid payments on access to dental providers, and to educate families about the importance of dental care. CMS did not concur with our recommendation to work with States to track children's use of required dental services.

A-09-15-03004 • December 2015



OIG Participation in Congressional Hearings



March 17, 2016

Erin Bliss, Assistant Inspector General, Office of Evaluation and Inspections, testified before the Senate Finance Committee: [“HealthCare.gov: A Review of Operations and Enrollment”](#)



February 24, 2016

Ann Maxwell, Assistant Inspector General, Office of Evaluation and Inspections, testified before the Senate Special Committee on Aging: [“Opioid Use Among Seniors – Issues and Emerging Trends”](#)



February 10, 2016

John Hagg, Director of Medicaid Audits, Office of Audit Services, testified before the House Committee on Energy and Commerce, Subcommittee on Health: [“Examining Medicaid and CHIP’s Federal Medical Assistance Percentage”](#)



November 5, 2015

Gloria Jarmon, Deputy Inspector General for the Office of Audit Services, testified before the House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations: [“Examining the Costly Failures on ObamaCare’s CO-OP Insurance Loans”](#)



October 7, 2015

Gary Cantrell, Deputy Inspector General for Investigations, testified before the Senate Special Committee on Aging: [“Protecting Seniors from Identity Theft: Is the Federal Government Doing Enough?”](#)

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Selected Acronyms and Abbreviations

ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families
CDC	Centers for Disease Control and Prevention
CIA	corporate integrity agreement
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CY	calendar year
DOJ	Department of Justice
EHR	electronic health record
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration

FY fiscal year

HHS Department of Health and Human Services

HRSA Health Resources and Services Administration

IRS Internal Revenue Service

Marketplaces health insurance exchanges

MFCU Medicaid Fraud Control Unit

NIH National Institutes of Health

OIG Office of Inspector General

OMB Office of Management and Budget

QHP qualified health plan

The Medicare Program

CMS Oversight of Medicare Contractor Performance

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

Medicare Payments, Policies, and Practices

CMS Has Not Performed Required Closeouts of Contracts Worth Billions

CMS relies extensively on contractors to carry out its basic mission and spends billions each year in contracts for a variety of goods and services. Our review focused on CMS's Federal Acquisition Regulation (FAR) contracts that were active as of February 2014, and its FAR contracts pending closeout as of February 2014. We found that CMS had over 6,000 contracts with a combined value of \$25 billion that were not closed out as required under the FAR. CMS continues to have thousands of contracts overdue for closeout, with 15 percent of contracts that were

completed before FY 2011 at least 10 years overdue. Because the closeout process is generally the last chance for improper contract payments to be detected and recovered, delays in the closeout process pose a risk to Government funds. Additionally, key pieces of information that CMS could use to manage and oversee contracts, such as project description and contract payments, are not easily accessible through its contract management system.

CMS concurred with all of our recommendations to implement additional strategies to meet required FAR timeframes for closeout, determine the status of contracts for which closeout status could not be determined, improve reports from CMS's contract management system to allow for easier access to contract data that would assist in closeout and funds management, and improve coordination and collaboration across departmental staff with contract closeout responsibilities.

OEI-03-12-00680 • December 2015

Hoveround Corporation Claimed Millions in Federal Reimbursement for Power Mobility Devices That Did Not Meet Medicare Requirements

Our objective was to determine whether Hoveround Corporation, which received the second largest Medicare reimbursement for power mobility devices (PMDs) in 2010, claimed Federal reimbursement for PMDs in accordance with Medicare requirements. Prior OIG reviews found that Medicare reimbursement for PMDs can have high incidences of fraud and improper payments. For this review, we found that

for 154 of the 200 sampled beneficiaries we reviewed, Hoveround received payments for claims that did not comply with Medicare requirements. For 144 sampled beneficiaries, Hoveround did not support the medical necessity of PMDs, and for 10 sampled beneficiaries, Hoveround provided incomplete documentation to support the PMD claims. We estimated that Medicare paid Hoveround at least \$27 million for PMDs that did not meet Medicare requirements during 2010.

Hoveround disagreed with our recommendations that it refund \$27,027,579 to the Federal Government and implement internal controls to ensure that Medicare requirements are followed to support beneficiaries' medical needs for PMDs and ensure that supporting documentation for PMDs meets Medicare requirements before providing PMDs to beneficiaries.

A-05-12-00057 • December 2015

Medicare Did Not Pay Selected Inpatient Claims for Bone Marrow and Stem Cell Transplant Procedures in Accordance With Medicare Requirements

Our objective was to determine whether Medicare paid selected inpatient claims for stem cell transplants in accordance with Medicare requirements. Recent OIG reviews identified Medicare overpayments to two hospitals that did not always comply with Medicare billing requirements for inpatient claims for stem cell transplants, resulting in overpayments of approximately \$4 million. For this review, we found that 133 of the 143 selected Medicare inpatient claims we reviewed for bone marrow and stem cell transplant procedures did not comply with Medicare

requirements. As a result, Medicare overpaid the hospitals by \$6.3 million.

CMS concurred or partially concurred with our recommendations to: (1) direct Medicare contractors to recover \$4.6 million in overpayments for incorrectly billed claims that are within the 3-year recovery period; (2) work with the Medicare contractors to notify providers of potential overpayments outside of the 3-year recovery period, which we estimate to be as much as \$1.7 million; (3) review the 58 inpatient claims from October 2013 through April 2015 for stem cell transplants with lengths of stays of 1 to 2 days, which could save as much as \$2 million; and (4) strengthen hospital controls and educate them on the appropriate billing of stem cell transplants.

A-09-14-02037 • February 2016

Hospices Inappropriately Billed Medicare Over \$250 Million for General Inpatient Care

Our review found that hospices billed one-third of general inpatient care (GIP) stays inappropriately, costing Medicare \$268 million in 2012. We also found that hospices often did not meet all care planning requirements and sometimes provided poor-quality care. GIP is the second most expensive level of hospice care and is intended to be short-term inpatient care for symptom management and pain control that cannot be handled in other settings. Recent OIG investigations have shown instances in which hospices inappropriately billed Medicare for GIP, including care being billed but not provided and beneficiaries receiving care they did not need.

Our findings make clear the need to address the misuse of GIP and hold hospices accountable when they bill inappropriately or provide poor quality care. CMS concurred with all of our recommendations, which were to increase its oversight of hospice GIP claims and review Part D payments for drugs for hospice beneficiaries; ensure that a physician is involved in the decision to use GIP; conduct prepayment reviews for lengthy GIP stays; increase surveyor efforts to ensure that hospices meet care planning requirements; establish additional enforcement remedies for poor hospice performance; and follow up on inappropriate GIP stays, inappropriate Part D payments, and hospices that provided poor-quality care.

OEI-07-10-00420 • January 2016

Part B Payments for 340B Purchased Drugs

For this review, we determined how much Medicare Part B spent on 340B-purchased drugs in 2013 by identifying paid Medicare claims from covered entities. Under Medicare Part B, certain eligible health care providers—generally those that serve a disproportionate share of needy patients—are allowed to purchase drugs using the 340B Drug Discount Program, thereby receiving sizable statutory discounts. Past OIG work has found that Medicare payments to providers for 340B-purchased drugs substantially exceeded the providers' costs. In the aggregate, Part B payment amounts for drugs purchased in 2013 using the 340B Drug Discount Program were 58 percent more than the statutorily based 340B ceiling prices, which allowed 340B covered entities to retain approximately \$1.3 billion.

As stakeholders debate the nature of 340B discounts and whether statutory changes should be made to enable Medicare and/or Medicaid to share in these savings, this report presents an independent analysis to inform the ongoing discussion and to support congressional and Administration decisionmakers' efforts in striking a balance among the needs of these vital programs. This report contained no recommendations.

OEI-12-14-00030 • November 2015

Quality of Care and Beneficiary Access

National Background Check Program for Long-Term-Care Employees: Interim Report

This interim report describes the overall implementation status and States' results from the first 4 years of the National Background Check Program, and provides CMS with information that may assist its ongoing administration of this program. The ACA provides grants to States to implement background check programs for prospective long-term-care employees and also requires OIG to conduct an evaluation of this grant program. We found that, 4 years into the National Background Check Program, the 25 States that are receiving program grants reported having achieved varying levels of program implementation. For example, only 6 of the 25 States submitted to CMS data sufficient to calculate the percentage of prospective employees who were disqualified. This raises concerns about whether CMS can determine program outcomes and conduct effective oversight of the National Background Check Program.

CMS concurred with both of our recommendations to continue working with participating States to fully implement their background check programs and continue working with participating States to improve required reporting to ensure that CMS can conduct effective oversight of the program.

OEI-07-10-00420 • January 2016
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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 back 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.

Wisconsin Inappropriately Withdrew Federal Medicaid Funds for FYs 2010 Through 2012

Our review of the Wisconsin Department of Health Services' Federal Medicaid withdrawals during FYs 2010 through 2012 determined that these withdrawals did not fully comply with Federal and State regulations. Wisconsin properly withdrew \$13.6 billion of the \$13.7 billion obtained in Federal Medicaid funds, but inappropriately withdrew the difference of \$89.6

million to pay for aggregate annual projected costs. According to the approved State waivers, these costs should have been paid solely with State funds for the first 3 months of each calendar year during FYs 2010 through 2012. Additionally, Wisconsin lacked formal policies and procedures for withdrawing Federal Medicaid funds from the Payment Management System (PMS) account.

Wisconsin disagreed with our recommendations that it refund \$89.6 million to the Federal Government, establish formal policies and procedures for withdrawing Federal funds from PMS for Medicaid, and ensure that all Federal withdrawals from PMS that occurred after our audit period comply with Federal and State requirements.

A-05-13-00045 • October 2015
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New Mexico Received Millions in Unallowable Bonus Payments

Congress appropriated \$3.225 billion for qualifying States to receive performance bonus payments for Federal FYs 2009 through 2013 to offset the costs of increased enrollment of children in Medicaid. We reviewed the bonus payments that New Mexico received for FYs 2009 through 2013 because preliminary analysis indicated inconsistencies between the enrollment of children in Medicaid that New Mexico reported when requesting bonus payments and the enrollment reflected in the Medicaid Statistical Information System, maintained by CMS. New Mexico received more than \$23.8 million in bonus payments for the FYs we reviewed.

We found that most of the data used in New Mexico's bonus payment calculations were in accordance with

Federal requirements, but New Mexico overstated its FYs 2009 through 2013 current enrollment in its bonus requests to CMS because it included individuals who did not qualify. As a result, CMS overpaid New Mexico \$15.9 million in bonus payments. New Mexico disagreed with our recommendation that it refund \$15.9 million to the Federal Government.

A-04-15-08040 • December 2015
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New York State Improperly Claimed Medicaid Reimbursement for Some Adult Day Health Care Services

We reviewed New York State Department of Health's claims for Medicaid reimbursement for adult day health care (ADHC) services provided by New York providers and found that these providers claimed reimbursement for some Medicaid ADHC services that did not comply with certain Federal and State requirements. Of the 100 claims in our random sample, New York claimed reimbursement for services that were unallowable for 40. New York improperly claimed at least \$70 million in Federal Medicaid reimbursement for ADHC services that did not comply with certain Federal and State requirements.

New York disagreed with our recommendation that it refund \$70 million to the Federal Government. New York did not agree or disagree with our recommendation that it improve its monitoring of the ADHC program to ensure that providers comply with Federal and State requirements.

A-02-13-01016 • December 2015
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We Could Not Determine Whether West Virginia's Severance and Business Privilege Tax on Behavioral Health Services Is a Permissible Health-Care-Related Tax

Our objective was to determine whether West Virginia's Severance and Business Privilege Tax is a permissible health-care-related tax under Federal requirements. Revenues from an impermissible health-care-related tax may not be used to finance a State's share of Medicaid expenditures. For this review, we could not determine whether West Virginia's Severance and Business Privilege Tax is a permissible health-care-related tax. CMS agreed with our recommendation that it work with West Virginia to determine whether the Severance Tax is a permissible health-care-related tax. CMS did not concur or nonconcur with our recommendation that it deduct the \$65.7 million used to pay State Medicaid expenditures and recalculate the Federal share, which we estimate was overpaid by \$50.6 million, if the severance tax is impermissible.

CMS made no official decision whether the tax is an impermissible health-care-related tax. CMS stated that, should West Virginia enact a tax structure consistent with CMS's guidance by June 30, 2016, it will not devote further resources to investigate this issue and will not pursue any financial recoveries for periods before June 30, 2016.

A-03-14-00200 • February 2016
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Some of New Jersey's Claims for Medicaid Global Options for Long-Term Care Waiver Services Were Unallowable

Our review of New Jersey's Medicaid reimbursement claims for Global Options for Long-Term Care (GO-LTC) waiver services determined that claims for some of these services did not comply with certain Federal and State requirements. GO-LTC enables Medicaid beneficiaries who are assessed as needing nursing facility level of care and who met financial requirements to remain in the community or return from institutional care to the community. Of the 131 beneficiary months in our sample, New Jersey improperly claimed Medicaid reimbursement for unallowable GO-LTC waiver services during 62 beneficiary months. New Jersey made claims for unallowable services because it lacked clear guidance on claiming and documenting Medicaid services for beneficiaries enrolled in the GO-LTC waiver program. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$47 million in Federal Medicaid reimbursement for unallowable GO-LTC waiver services.

New Jersey generally concurred with our recommendation that it reinforce guidance to the provider community on Federal and State requirements for claiming and documenting Medicaid services for beneficiaries. New Jersey did not concur with our recommendation that it refund \$47.3 million to the Federal Government.

A-02-14-01008 • February 2016



Maryland Claimed Unallowable Costs for Medicaid Communicable Disease Care Services

Our review of Maryland's Department of Health and Mental Hygiene found that it did not always comply with Federal and State requirements when it claimed costs for communicable disease care services. Of the 124 claim lines that we sampled, 49 complied with Federal and State requirements; however, 75 did not. We estimate that the State claimed at least \$16 million (Federal share) in unallowable costs. The State claimed these unallowable costs because it did not have sufficient internal controls to ensure that nursing facilities were correctly claiming communicable disease care services.

The State partially concurred with our findings, which resulted in our recommendation to refund \$16 million to the Federal Government.

A-03-14-00150 • March 2016



State Medicaid Agencies Can Significantly Reduce Medicaid Costs for Durable Medical Equipment and Supplies

During recent Medicaid audits, we determined that selected durable medical equipment and supplies (DME) are available to CMS at a cost well below what is available to State Medicaid agencies. In our audits of four State Medicaid agencies, we found that the States could have saved \$18.1 million on the purchase of selected DME items if they obtained pricing comparable to pricing under Round 1 of Medicare's Competitive Bidding Program. Since issuing those audit reports, we identified \$12 million in additional savings for the selected DME items if the four States

had used pricing comparable to Medicare’s Round 2 Competitive Bidding and National Mail-Order Programs. Medicaid provider reimbursement rates for selected DME items varied significantly among those States. Opportunities exist for these States to lower provider reimbursement rates, resulting in \$30.1 million in potential savings for the States and the Federal Government.

CMS concurred with our recommendations that it seek legislative authority to limit State Medicaid DME reimbursement rates to Medicare program rates and encourage further reduction of Medicaid reimbursement rates through competitive bidding or manufacturer rebates.

A-05-15-00025 • October 2015

States’ Rebates for Some Physician-Administered Drugs

We conducted several reviews 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 the Federal share of these rebates against their expenditures and bill the manufacturers for rebates to reduce the cost of drugs to the program. However, previous OIG reviews found that States did not always bill and collect all rebates due for drugs administered by physicians.

We found that California did not bill for rebates for claims for physician-administered drugs associated

with \$31.7 million. Montana, North Dakota, and South Dakota did not invoice manufacturers for rebates associated with \$16,000 in physician-administered drugs in Montana, \$79,000 in North Dakota, and \$1.2 million in South Dakota.

Montana and North Dakota agreed with our recommendations, and California and South Dakota partially agreed with our recommendations to refund the Federal Government the amounts claimed for physician-administered drugs that were ineligible for Federal reimbursement. California and North Dakota agreed and Montana partially agreed, but South Dakota did not agree with our recommendations to work with CMS to determine the unallowable portion of other claims for physician-administered drugs that were ineligible for Federal reimbursement.

California agreed with our recommendation that it improve oversight of the processes for rebate billing and collection to ensure submission to manufacturers of the drug utilization data for claims for physician-administered drugs. Montana and North Dakota concurred with our recommendations that they strengthen their internal controls to ensure that all physician-administered drugs eligible for rebates are invoiced.

California Claimed Unallowable Federal Medicaid Reimbursement by Not Billing Manufacturers for Rebates for Some Physician-Administered Drugs

A-09-14-02038 • January 2016

Also the following:

Montana Correctly Claimed Federal Reimbursement for Most Medicaid Physician-Administered Drugs

A-07-15-06062 • January 2016

South Dakota Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs

A-07-15-06059 • February 2016

North Dakota Correctly Claimed Federal Reimbursement for Most Medicaid Physician-Administered Drugs

A-07-15-06058 • January 2016

The Medicaid Program Could Have Achieved Savings If New York Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act

The objective of this review was to determine potential Medicaid program savings if the New York State Department of Health required its Medicaid-managed care plans to meet medical loss ratio (MLR) standards similar to those established by the ACA. The ACA set a standard for the amount of premium revenue that certain commercial health insurers and Medicare Advantage plans can spend on costs other than health care-related expenses, which is known as the MLR. Insurers that do not meet these standards must pay rebates. Some States have applied similar standards to their contracts with Medicaid managed care organizations.

While New York had policies limiting the amount plans could charge for administrative costs as a component of their capitated rate, we determined that Medicaid could have saved \$76.9 million (\$38.5 million Federal share) in CY 2012 if New York had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA. New York did not concur

or nonconcur with our recommendation that it incorporate MLR standards into its contracts with Medicaid managed care organizations.

A-02-13-01036 • October 2015

Average Manufacturer Prices Increased Faster Than Inflation for Many Generic Drugs

OIG was requested by Congress to examine recent increases in the prices charged for generic drugs and the effect these prices have had on generic drug spending in the Medicare and Medicaid programs. For this review, we updated a previous review of generic drug price increases under the Medicaid drug rebate program and found that generic drug price increases exceeded the specified statutory inflation factor applicable to brand-name drugs for 22 percent of the quarterly average manufacturer prices we reviewed. If the provision for brand-name drugs were extended to generic drugs, Medicaid would receive additional rebates. Medicaid would have received \$1.4 billion in additional rebates for the top 200 generic drugs, ranked by Medicaid reimbursement, from 2005 through 2014.

Our findings are consistent with our previous work and support our prior recommendation that CMS consider seeking legislative authority to extend the additional rebate provisions to generic drugs. On November 2, 2015, the Bipartisan Budget Act of 2015 (P.L. No. 114-74) was enacted and included provisions extending the additional rebate to generic drugs. The additional rebate for generic drugs will apply to rebate periods

beginning with the first quarter of 2017. Therefore, we are not making any additional recommendations.

A-06-15-00030 • December 2015
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Opportunities for Program Improvements Related to States' Withdrawals of Federal Medicaid Funds

CMS has not issued guidance instructing States on the appropriate handling of Medicaid withdrawals. All three States that we audited withdrew more funds than necessary to meet immediate cash needs: Alabama and Maryland had overdrawn more than \$130 million in Medicaid funds that they had not refunded to the Federal Government. Although Illinois refunded overdrawn Medicaid funds, its withdrawals exceeded its expenditures by an average of \$60 million a quarter.

CMS concurred with our recommendations that it issue guidance that clarifies and further interprets existing requirements concerning the withdrawal of Medicaid funds and publish and enforce formal guidance so that States are aware of the appropriate account from which to withdraw or return funds.

CMS did not indicate concurrence or nonconcurrence with our recommendations that it publish regulations that are consistent with the Treasury provisions and educate States and require States to reconcile total Federal Medicaid funds withdrawn with the Federal share of net expenditures and issue appropriate reconciliation guidelines.

A-06-14-00068 • March 2016
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Quality of Care and Beneficiary Access

Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries

In response to a congressional request, our objective was to determine whether Intermediate Care Facilities (ICFs) in New York with high rates of emergency room visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits, as required, and whether potential neglect or abuse was reported and investigated by the appropriate State agencies. We found that ICFs in New York with high rates of emergency room visits by intellectually disabled Medicaid beneficiaries under their care did report on these visits, as required, and potential neglect or abuse was reported and investigated. We also found that the vast majority of emergency room visits we reviewed resulted from circumstances associated with the Medicaid beneficiaries' underlying medical conditions—not from neglect or abuse. Accordingly, this report contained no recommendations.

A-02-14-01011 • October 2015
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Most Children with Medicaid in Four States Are Not Receiving Required Dental Services

Our objective was to determine whether Medicaid children in California, Indiana, Louisiana, and Maryland were receiving required dental services. We found that three out of four Medicaid children in these States did not receive all required dental services, with one in four children failing to see a dentist at all. While the States reported that they employ a variety of strategies to address this problem and CMS has taken some positive steps in this area, we continue to have concerns that children are not receiving required dental services.

CMS fully or partially concurred with the following recommendations:

- Develop a comprehensive plan to increase the number of children who receive required services.
- Develop benchmarks for dental services and require States to create mandatory action plans to meet them.
- Work with States to identify areas with limited providers and the barriers preventing providers from participating in Medicaid.
- Work with States to analyze the effects of Medicaid payments on access to dental providers.
- Work with States to educate families about the importance of dental care and to encourage ongoing relationships between children and their dentists.
- Identify and share effective strategies with States.

- Ensure that States pay for services in accordance with their periodicity schedules.

CMS did not concur with the remaining recommendation to work with States to track children's use of required dental services.

OEI-02-14-00490 • January 2016

Health Information Technology

Inadequate Security Management Practices Left Utah Department of Health Sensitive Medicaid Data at Risk of Unauthorized Disclosure

Our reviews of the Utah Department of Health's information system general controls found that Utah had not established an effective enterprise security control structure to ensure that adequate information system general controls were implemented in conformance with Federal requirements over the systems used to support Utah Medicaid eligibility determination and claims processing. These inadequate security management practices put Medicaid systems and data at risk. State agencies must 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. Utah previously experienced two serious security breaches in its State Medicaid program.

We identified 39 high-impact, reportable weaknesses during our earlier comprehensive information system general controls audit of the systems used to support

Utah Medicaid eligibility determination and claims processing. Utah concurred with our recommendations that it implement effective security management practices and establish oversight procedures to ensure that adequate information system general controls are implemented that correct the security weaknesses identified and comply with Federal information system security requirements.

A-07-15-00455 • January 2016

High-Risk Security Vulnerabilities Identified During Reviews of Information System General Controls at Three California Managed-Care Organizations Raise Concerns About the Integrity of Systems Used To Process Medicaid Claims

We summarized the high-risk security vulnerabilities that we identified in our previous reviews of information system general controls at three California Medi-Cal managed care organizations (MCOs). We identified 74 high-risk security vulnerabilities, most of which were significant and pervasive, in the information system general controls at the three Medi-Cal MCOs we reviewed.

Our consolidated findings from the individual reports raise concerns about the integrity of the systems used to process Medicaid managed-care claims. California informed us, in comments on the individual reports, that it was addressing these vulnerabilities. The fact that some of the same vulnerabilities were identified at all three MCOs suggests that other California Medi-Cal managed-care information systems may

be similarly vulnerable. This report is intended to provide information to assist California and CMS in strengthening MCOs' system security.

A-09-15-03004 • December 2015

OIG Investigations

OIG investigates allegations of fraud, waste, and abuse in all of the Department's programs. Our largest body of work involves investigating matters related to the Medicare and Medicaid programs, such as patient harm; billing for services not rendered, medically unnecessary services, or 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 seeing an increase in individuals, including both health care providers and patients, engaging in these health care fraud schemes. Those who participate in these schemes may face heavy fines, jail time, and exclusion from participating in Federal health care programs.

In addition to investigating Medicare and Medicaid fraud, OIG investigates fraud, waste, and abuse in other HHS programs, including Indian Health Service

(IHS), Administration for Children and Families (ACF), Health Resources and Services Administration (HRSA), and Administration for Community Living (ACL). OIG also investigates potential misuse of grants and contracts funds awarded by National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), 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. Additionally, OIG investigates allegations of employee misconduct, whistleblower reprisals, and wrongdoing by HHS agency officials.

One of the most common types of fraud perpetrated against Medicare, Medicaid, and other Federal health care programs involves filing false claims for reimbursement. False claims may be pursued under Federal and State criminal statutes and, when appropriate, under the False Claims Act (FCA). Depending on the types of fraud or other violations involved, OIG investigations may culminate in criminal or civil court judgments and decisions, administrative sanctions and decisions, and/or negotiated settlement agreements. Investigative outcomes take many forms, including incarceration, restitution, fines, penalties, forfeitures, assessments, and exclusion of individuals or entities from participation in all Federal health care programs. Frequently used exclusion and penalty authorities are described in Appendix C of this *Semiannual Report to Congress* and on our website at: <http://oig.hhs.gov/fraud/enforcement/cmp/>.

For October 1, 2015, to March 31, 2016, we reported 384 criminal and 379 civil actions against individuals or entities that engaged in health-care-related offenses.

We also reported over \$1.86 billion in investigative receivables due to HHS and over \$332.6 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.

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

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

Patient Harm

Michigan – Kim Duron Mulder, CEO of Kentwood Pharmacy, was sentenced to 10 years in prison, ordered to pay \$8.8 million in restitution, joint and several, and banned from participation in Federal health care programs for 50 years for his guilty plea to conspiracy to commit health care fraud. According to the investigation, Kentwood Pharmacy billed Medicare and private health insurers for prescription drugs that had been dispensed to patients and subsequently inappropriately returned to pharmacy stock. These fraudulent actions resulted in the cross-contamination of drugs, improper labeling of drugs, the placement of different drug dosages into stock bottles, and the placement of the wrong drugs into stock bottles. Public and private insurers paid more than \$79 million for adulterated and misbranded drugs that were sent to patients at more than 800 nursing and adult foster care homes. During the course of the investigation, pornographic images were discovered on the computer

of Kentwood Pharmacy’s vice president of sales, Richard Clarke. Clarke was convicted of child pornography as well as health care fraud and sentenced to 14 years in prison and ordered to pay \$8.8 million in restitution, joint and several. Sixteen defendants involved in the scheme were previously sentenced to a combined 22 years in prison and were excluded from participation in Federal health care programs for a combined 145 years. This case was initiated based upon fraud tips provided to the HHS OIG Hotline.

Prescription Drug Fraud

California – Dr. Kenneth Johnson was sentenced to 9 years in prison and ordered to pay \$9.1 million in restitution, joint and several, for his guilty plea to conspiracy to commit health care fraud, conspiracy to possess at least five identification documents and authentication features with intent to use unlawfully, aggravated identity theft, and conspiracy to engage in the misbranding of pharmaceutical drugs. According to the investigation, Johnson was involved in a scheme in which fraudulently prescribed expensive anti-psychotic medications were repeatedly rebilled to the Government. Using prescriptions that were presigned by Johnson, co-defendants generated thousands of prescriptions for identify theft victims, such as elderly beneficiaries of Medicare and Medi-Cal and military veterans, and doctored patient files to make it falsely appear that the drugs were necessary and the patients were legitimately treated. The scheme generated fraudulent billings of more than \$20 million, of which Medi-Cal and Medicare actually paid more than \$9 million. Fifteen defendants involved in the scheme were previously sentenced to a combined 46 years and 3 months in prison.

Kickbacks

New Jersey – Olympus Corporation of the Americas (Olympus) agreed to enter into a \$310 million civil False Claims Act settlement with the United States and a comprehensive 5-year Corporate Integrity Agreement (CIA). The settlement was part of a global criminal and civil resolution under which Olympus agreed to pay a total of \$646 million to resolve kickback allegations. Olympus is the country's largest distributor of endoscopes and related medical equipment. Through the civil settlement agreement, Olympus resolved allegations that, between January 2006 and December 2011, it paid illegal kickbacks to doctors and hospitals to induce them to purchase endoscopes and other medical and surgical equipment. These kickbacks came in the form of consulting agreements, foreign travel, lavish meals, grants, and free endoscopes. As a result, Olympus allegedly caused the submission of false claims to the Medicare, Medicaid, and Tricare programs. The CIA contains several provisions for accountability by Olympus' Board of Directors, extensive audit requirements, and requires Olympus to implement an internal risk assessment and mitigation program.

Florida – Med Match Pharmacy, LLC agreed to pay more than \$4.7 million to resolve its liability under the False Claims Act. The settlement agreement resolves allegations that, from September 2013 through February 2015, Med Match knowingly submitted claims to Federal health care programs for compounded pharmaceuticals that violated the anti-kickback statute, had items and/or services ordered by physicians who failed to have bona fide medical relationships with the beneficiaries for whom

the items and/or services were ordered, and mailed pharmaceuticals to beneficiaries in States in which Med Match failed to have a license to dispense.

Identity Theft

Ohio – Sharon Ward was sentenced to more than 5 years in prison and ordered to pay \$18.1 million in restitution for her guilty plea to health care fraud and aggravated identity theft. Ward was a registered nurse who was excluded in April 2005 after being convicted of Medicaid fraud. She also let her nursing license lapse in 2005. During the entire time she was excluded and unlicensed, Ward owned Heritage Home Health Agency, where she provided nursing services to home-bound clients. Ward used the identity of another nurse with the same name to hide the fact that she was unlicensed. Heritage billed Medicaid exclusively and received more than \$20 million in reimbursement. Sharon's mother, Queen Ward, was part owner and office manager of Heritage. Queen Ward was ordered to pay \$434,747 in restitution for her guilty plea to health care fraud. Queen Ward created false background check reports for Heritage employees who were disqualified from working as home health aides due to their felony criminal convictions.

Home Health Services

Wisconsin – Deaconess Home Health, Inc., and its owner Lazarus Bonilla agreed to pay \$3.7 million to resolve their liability for submitting claims to Medicaid for personal care services that were not provided, were not provided pursuant to appropriate supervision, or were not medically necessary. The agreement also resolves allegations that personal care

services were referred or ordered in violation of the Federal anti-kickback statute. The investigation found that Deaconess paid patient recruiters for referrals of patients for personal care services. OIG negotiated a 15-year voluntary exclusion of both Deaconess and Lazarus Bonilla.

Michigan – Jaweed Mohammed, manager at Advance Home Health Care (Advance), was sentenced to 2 years in prison and ordered to pay \$1.4 million in restitution, joint and several, for his guilty plea to health care fraud conspiracy. Advance, which purported to provide home health care services, paid marketers to recruit Medicare beneficiaries, who were then paid if they agreed to sign up for home health services. Mohammed and his co-conspirators at Advance submitted fraudulent claims to Medicare and concealed the submission of the claims by creating fake patient files. Mohammed also helped sell Advance patient information to other home health care companies once Advance was finished billing the patient to Medicare. Seven defendants involved in the scheme were previously sentenced to a combined 25 years and 4 months in prison and ordered to pay a total of \$13.6 million in restitution.

Physicians

New Jersey – Brett Halper was sentenced to 3 years and 10 months in prison, fined \$100,000, and ordered to forfeit \$325,000 for his guilty plea to accepting bribes. Halper accepted approximately \$6,000 in bribes per month from Biodiagnostic Laboratory Services (BLS) in return for referring patient blood specimens to BLS. David Nicoll, an owner of BLS, pleaded guilty in 2013 to conspiracy to commit bribery

and money laundering and is awaiting sentencing. Eighteen additional defendants have pleaded guilty and are awaiting sentencing in connection with the bribery scheme, which investigators believe involved millions of dollars in bribes and resulted in more than \$100 million in payments to BLS from Medicare and private insurance companies. Twenty defendants were previously sentenced to a combined 41 years in prison and ordered to pay \$487,250 in fines and \$510,695 in forfeiture. To date, OIG has excluded 15 subjects associated with this investigation for a combined total of 111 years.

Personal Care Services

Iowa – Teri Lynn Markle was ordered to pay restitution of \$8,327 for her guilty plea to tampering with records. Markle was also excluded from participation in Federal health care programs. According to the investigation, Markle billed Medicaid for personal care services that she did not actually perform. In most instances, it was determined that Markle was working for her outside, full-time employer while also billing for personal care services that she did not provide.

Pharmacies

New Jersey – Vladimir Kleyman, the owner and pharmacist-in-charge of Prescriptions R Us, was sentenced to 1 year and 8 months in prison and ordered to pay \$476,713 in restitution for his guilty plea to conspiracy to pay kickbacks and to commit health care fraud. Kleyman was also excluded from participation in Federal health care programs for 13 years. According to court documents, Kleyman admitted that he paid kickbacks to a physician in return

for that physician's referral of Medicare and Medicaid patients to Prescriptions R Us for a medically unnecessary compounded pain cream. The physician, James Morales, was paid a kickback for each referral. Kleyman also admitted that he falsely represented the pain cream in order to obtain payment from the insurance carriers as well as making false and misleading representations about the quantity of the pain cream that he dispensed and the frequency with which he dispensed it. Morales pleaded guilty to conspiracy to accept kickbacks and commit health care fraud and is awaiting sentencing.

Hospitals

South Carolina – Tuomey d/b/a Tuomey Regional Medical Center and Tuomey Healthcare System (Tuomey) agreed to pay more than \$72 million and enter into a 5-year CIA with OIG to resolve its liability under the False Claims Act. Tuomey is a 301-bed, nonprofit hospital located in Sumter, South Carolina. The Government alleged that Tuomey, fearing that it could lose lucrative outpatient procedure referrals to a new, freestanding surgery center, entered into contracts with 19 specialist physicians that ran afoul of the physician self-referral law, or Stark law. Specifically, the Government contended that Tuomey required the physicians to refer their outpatient procedures to Tuomey and, in exchange, paid them compensation that far exceeded fair market value and took into account the volume or value of their referrals to the hospital. The CIA includes, among other things, provisions requiring Tuomey to retain a Legal Independent Review Organization to review the hospital's arrangements with physicians and other referral sources.

Psychiatric and Psychological Services

Florida – Dean Augustine Butler, owner, director, and administrator of Greater Miami Behavioral Healthcare Center (GMBC), was sentenced to 16 years in prison and ordered to pay more than \$15.2 million in restitution after pleading guilty to conspiracy to commit health care and wire fraud. Butler and another defendant devised a scheme to pay kickbacks and bribes to patient brokers in return for referring Medicare beneficiaries and falsifying medical records to support claims for services that were never provided. Irina Mora, director of finance for GMBC, was sentenced to 8 years and 1 month in prison after pleading guilty to conspiracy to commit money laundering. Mora and other defendants devised a scheme to conduct financial transactions in order to conceal the payment of kickbacks to patient brokers. Two other defendants involved in the scheme were previously sentenced to a combined 6 years and 4 months in prison and ordered to pay \$848,106 in restitution.

Laboratories

Massachusetts – Millennium Health, LLC (Millennium), agreed to pay \$256 million and enter into a CIA with OIG to resolve its liability under the False Claims Act. The Government alleged that Millennium billed Medicare, Medicaid, and other Federal health care programs for medically unnecessary drug testing and genetic testing, and provided kickbacks to physicians to induce business. Specifically, Millennium allegedly caused physicians to order excessive numbers of urine drug tests, in part through the promotion of "custom profiles." These custom profiles were not customized for individual patients, however. Instead, they were

practice-wide standing orders that caused physicians to order a large number of tests without an individualized assessment of each patient's needs. The CIA made significant changes to its board of directors, including choosing new, independent members. Under the 5-year CIA, OIG will monitor the company's compliance efforts under this new leadership.

Durable Medical Equipment

North Carolina – Ramon Fuerlos was sentenced to 3 years and 6 months in prison and ordered to pay \$2.6 million in restitution for his guilty plea to health care fraud. According to court documents, Fuerlos submitted false claims to Medicare for reimbursement of DME items that were allegedly provided to beneficiaries. As part of the scheme, Fuerlos set up sham DME companies and purchased lists of individually identifiable health information. He used this information to submit false claims without the beneficiary's knowledge. Through this scheme, Fuerlos submitted more than \$7 million in false claims for reimbursement from Medicare.

Hospice Care

Mississippi – Sandra Livingston, owner of Sandanna Hospice, Inc., Milestone Hospice, Inc., and Carol's Hospice & Palliative Services of Shelby, Mississippi, Inc., was sentenced to 3 years in prison and ordered to pay \$1,098,639 in restitution for her guilty plea to conspiracy to commit health care fraud. Livingston admitted to her involvement in a conspiracy to bill Medicare and Medicaid for hospice services for patients who were not terminally ill. Livingston paid recruiters upwards of \$800 per patient and paid cash

kickbacks to the hospice medical director for him to sign hospice orders for patients that he knew were not hospice appropriate. Lara Thompson, a billing clerk at Sandanna and Milestone, was recently sentenced to 1 year and 1 month of incarceration and ordered to pay more than \$1 million in restitution, joint and several, after pleading guilty to conspiracy to commit health care fraud. This case was initiated based on fraud tips provided to the HHS OIG Hotline.

Refugee Resettlement Program

Florida – Leslie Rubero Padilla was sentenced to 1 year and 6 months in prison and ordered to pay \$11,100 in restitution for her guilty plea to wire fraud. Padilla worked as a case manager at a nonprofit social services agency that provides temporary shelter to Unaccompanied Children (UAC). The defendant defrauded more than 10 family members and/or potential sponsors of UAC who were within the custody of the Office of Refugee Resettlement. Padilla was assigned to take care of UAC and attempt to locate their parents or other legal guardians. As part of her duties, once a parent or guardian was located, Padilla made contact with them. She falsely represented to parents and legal guardians of the UAC that if they did not send her the requested amount of money it might take longer to be reunited with their children or their children might be deported to their native countries.

Transportation Services Fraud

Pennsylvania – Serge Sivchuk, owner of Advantage Medical Transport Inc. (Advantage), was sentenced to 2 years in prison and ordered to pay a \$300,000 fine and \$194,378 in restitution, joint and several with

Advantage, for his guilty plea to false statements in health care matters. Advantage was also ordered to pay a \$250,000 fine. According to court documents, employees at Advantage submitted fraudulent claims to Medicare for the transport of beneficiaries to and from dialysis treatment centers. Sivchuk directed Advantage's EMTs to complete their trip sheets in a manner that concealed the fact that the patients were ambulatory and not eligible for Medicare paid ambulance transport.

California – Three executives at ProMed Medical Transportation (ProMed) each pleaded guilty to conspiracy to commit health care fraud and health care fraud. They were sentenced to a combined 14 years of prison and ordered to pay restitution of \$804,755, joint and several. ProMed provided non-emergency services to Medicare beneficiaries, many of whom were dialysis patients. The defendants – Steven Proshak, the owner, operator, and manager of ProMed; Emilia Zverev, the billing manager for ProMed; and Michelle Wallace, the EMT supervisor for ProMed – conspired to bill Medicare for ambulance transportation services for individuals who did not need such services. The defendants also instructed ProMed EMTs to conceal the patients' true medical conditions by altering paperwork and creating fraudulent documents to justify the services. During the course of the conspiracy, ProMed submitted at least \$1.5 million in false claims to Medicare for medically unnecessary transportation services. This case was initiated based on fraud tips provided to the HHS OIG Hotline.

Health Care Fraud Prevention and Enforcement

On May 20, 2009, former HHS Secretary Kathleen Sebelius and former Attorney General Eric Holder announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an interagency effort focused specifically on combating health care fraud. HEAT includes senior officials from 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: <http://oig.hhs.gov/compliance/provider-compliance-training/index.asp>.

Health Care Fraud Strike Force Activities

Health Care Fraud Strike Force teams began in 2007 in an effort to combine the resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. These partnerships between OIG and HHS, DOJ, U.S.

Attorneys' Offices, FBI, and State and local law enforcement have a common goal: to successfully analyze health care fraud data and investigative intelligence to quickly identify fraud and bring prosecutions. Strike Force teams currently operate in nine areas: Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas.

From October 1, 2015, to March 31, 2016, Strike Force efforts resulted in the filing of charges against 87 individuals or entities, 100 criminal actions, and over \$116.8 million in investigative receivables.

Below are examples of Strike Force cases:

Michigan – Amer Ehsan, the owner of Advance Home Health Care Services, Inc. (Advance), was sentenced to 6 years and 8 months in prison and ordered to pay \$4.5 million in restitution for his guilty plea to health care fraud conspiracy. Ehsan admitted that he billed Medicare for unnecessary home health care and therapy services, paid physicians to refer Medicare beneficiaries to Advance and sign medical documents falsely certifying that they required home health care, and paid Medicare beneficiaries cash kickbacks in exchange for signing multiple blank physical therapy records. Additionally, Ehsan admitted that he owned Michigan Rehab and Management Services LLC, which he used to sell information about Medicare beneficiaries and corresponding fictitious patient files to other home health care agencies. Ehsan was part of a wide-ranging scheme that involved 12 defendants, all of whom have pleaded guilty.

Florida – Nine defendants were sentenced to more than 29 years in prison and ordered to pay a combined \$22.1 million in restitution for their roles in a scheme to defraud Medicare. According to court records, five of the defendants were the owners of eight pharmacies that submitted more than \$20 million in fraudulent claims to Medicare. The false claims included prescriptions for drugs that were not properly prescribed or provided to the beneficiaries. The other defendants were involved in schemes in which millions of dollars in fraudulent claims were submitted to Medicare. These conspiracies were accomplished in part by the use of patient recruiters who received kickbacks in return for referring Medicare Part D beneficiaries to the pharmacies.

New York – Office managers Michelle Lee, Gilbert Kim, and Elaine Kim each pleaded guilty to health care fraud conspiracy and were ordered to pay restitution of \$5.9 million, joint and several. Michelle Lee was also excluded from participation in Federal health care programs for 15 years, and Elaine Kim was sentenced to 1 year and 1 day in prison. The defendants artificially increased demand for medical services by providing beneficiaries with free goods and services and submitting false claims to Medicare for medically unnecessary services. Investigators believe the defendants agreed to pay kickbacks for referring beneficiaries for the purpose of billing Medicare. Upon receipt of payment for the false and fraudulent claims, the defendants paid a predetermined percentage of the money from Medicare to Elaine and Gilbert Kim, among others. The defendants created fake medical documents to conceal fraudulent claims submitted to Medicare that were induced by kickback, not medically necessary, and not provided.

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:

North Dakota – Lowie Christie, a Medicare beneficiary, was ordered to pay \$107,497 in restitution for her guilty plea to health care fraud. Christie admitted that, from January 2007 through July 2013, she traveled around the United States to emergency rooms and other medical providers in order to obtain prescriptions for narcotics that she did not have a medical necessity for, and she used her Medicare benefits to pay for them. Christie, or other individuals, would then fill the prescriptions. In order to avoid detection, Christie travelled to hundreds of different providers and

pharmacies across the country, causing approximately 1,830 in claims to be submitted to Medicare for unnecessary medical care.

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>. During this reporting period, four fugitives were captured.

One of OIG's Most Wanted Fugitives is Sandy De La Fe, who was captured during this reporting period. De La Fe was indicted in July 2013 on charges of health care fraud. Investigators believe that De La Fe participated in a prescription drug fraud scheme that bilked Medicare out of millions of dollars. De La Fe was the owner of record for Goldenway Pharmacy Discount, Inc., located in Miami, Florida. According to the indictment, De La Fe's co-conspirators paid Medicare beneficiaries to obtain prescriptions for pharmaceutical drugs. These false prescriptions, some of which were worth more than \$1,000 per prescription, were then billed by Goldenway to Medicare Part D, falsely claiming that these drugs were medically necessary, had been prescribed by a doctor, and had been

provided by Goldenway to Medicare beneficiaries. As a result of these false claims, Medicare paid Goldenway approximately \$2.8 million in reimbursement. De La Fe and his co-conspirators diverted the proceeds from this scheme for their own use and to further the fraud. De La Fe fled to Cuba and remained a fugitive at large until his arrest. 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. Examples are provided in the *Human Services Agencies Reviews* section of this *Semiannual Report*.

HHS OIG Hotline

The mission of the HHS OIG Hotline is to support OIG in oversight responsibilities to safeguard the integrity of all programs and personnel under purview of HHS and protect them from fraud, waste and abuse. We achieve this through our dedication to timely intake and evaluation of information received from various sources, such as the "Report Fraud" website portal on the HHS OIG Internet page and telephone calls to 1-800-HHS-TIPS. Strategically located within the Office of Investigations, the OIG Hotline is the public facing division for the intake of fraud tips. The OIG Hotline is motivated by the constant awareness that our work impacts all Americans, including some of our most

vulnerable citizens, such as the elderly and others who are often unable to help themselves.

OIG Hotline Activity (10/01/15-03/31/16):

- Total HHS TIPS Received via Phone-Evaluated for Action: 59,191
- Total HHS TIPS Received via Phone-Referred: 11,456
- Total HHS TIPS Received via Internet: 4,905
- Total HHS TIPS Received via Letters/Faxes: 2,021
- Total Viable HHS TIPS Evaluated: 15,859
- Total Contacts to the HHS OIG Hotline Calls: 75,050

State Medicaid Fraud Control Units

OIG Oversight of State Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs or Units) 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 2015

In FY 2015, combined Federal and State expenditures for the operation of the 50 MFCUs (in 49 States and the District of Columbia) totaled \$251 million. The

MFCUs employed 1,944 individuals. Collectively, in FY 2015, MFCUs reported 17,665 investigations, of which 14,441 were related to Medicaid fraud and 3,224 were related to patient abuse and neglect, including misappropriation of patients' private funds. The cases resulted in criminal charges or indictments involving 1,892 individuals, including 1,387 for fraud and 505 for patient abuse and neglect, including patient funds cases. In total, 1,553 criminal actions were reported in FY 2015, of which 1,097 were related to Medicaid fraud and 456 were related to patient abuse and neglect, including patient funds cases. Civil judgments and settlements for FY 2015 totaled 795, and monetary recoveries in civil cases totaled over \$397 million. (See Medicaid Fraud Control Units 2015 Expenditures and Statistics contained in a [MapChart](#).)

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 Units. OIG evaluates MFCU operations in accordance with 12 [performance standards](#) and assesses compliance with laws, regulations, and OIG policy guidance. OIG issued reports of onsite reviews of the following MFCUs during the reporting period:

California State Medicaid Fraud Control Unit: 2015 Onsite Review.

OEI-09-15-00070 • 2016 February.

Delaware State Medicaid Fraud Control Unit: 2015 Onsite Review.

OEI-07-15-00240 • 2016 February.

Arizona State Medicaid Fraud Control Unit: 2015 Onsite Review.

OEI-07-15-00280 • 2015 December.

The following are case examples of joint efforts with MFCUs:

Texas – Huey P. Williams, Jr., was sentenced to 5 years and 3 months in prison and ordered to pay \$1.96 million in restitution after a jury found him guilty of healthcare fraud. Williams owned and operated the DME companies Hermann Medical Supplies Inc. and Hermann Medical Supplies II (collectively Hermann Medical). Through these companies, Williams submitted approximately \$3.4 million in fraudulent DME claims to Medicare. Specifically, Williams caused Hermann Medical to bill Medicare for components of an “arthritis kit,” which included expensive, rigid braces and orthotics with adjustable joints that required fitting and adjustment. However, in actuality, Williams never purchased any of the expensive braces and instead purchased and provided to beneficiaries inexpensive, flimsy neoprene braces and equipment, to the extent that he provided any equipment at all. Medicare paid Hermann Medical \$1.96 million on these claims. This was a joint investigation with the FBI and the Texas MFCU.

Florida – Edys Illanes was sentenced to 1 year and 6 months in prison and ordered to pay \$2.4 million in restitution, joint and several, for her role in a Medicare Part C and Medicaid fraud scheme. Evidence showed that, from June 2013 to April 2014, Illanes was a licensed insurance agent employed by a Medicare Advantage Organization (an HMO) to market and sell their plans. Under the scheme, Illanes recruited Medicare

beneficiaries living in Nicaragua to enroll in a Medicare Advantage plan. She submitted fraudulent enrollment requests to Medicare, falsely representing that the beneficiaries actually resided in Florida. This was a joint investigation with the FBI and the Florida MFCU.

Advisory Opinions and Other Industry Guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with DOJ, are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPPA), § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. From October 1, 2015, to March 31, 2016, OIG received 23 requests for advisory opinions, issued 8 new opinions, modified 9 opinions, and terminated 3 opinions.

Health Information Technology

OIG Policy Reminder: Information Blocking and the Federal Anti-Kickback Statute

As HHS focuses on the flow of information across the care continuum, OIG reminded the public about how information blocking may affect safe harbor protection

under the Federal anti-kickback statute (42 U.S.C. § 1320a-7b(b)). OIG stated that donations of items or services that have limited or restricted interoperability due to action taken by an applicable individual or entity would fail to meet one of the conditions of the safe harbor and would be inconsistent with the intent of the safe harbor to promote the use of technology that is able to communicate with products from other vendors. Failure to meet this condition would mean that the safe harbor would not apply and the arrangement would be subject to case-by-case review under the Federal anti-kickback statute. As OIG stated, such donations would be suspect under the statute.

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 civil monetary penalties (CMPs) for submitting false and fraudulent claims to a Federal health care program or for violating the anti-kickback statute; the Stark law; or the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient dumping statute.

During this semiannual reporting period, OIG imposed 1,774 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries. Exclusion

and penalty authorities are described in Appendix C and on our website at <http://oig.hhs.gov/fraud/enforcement/cmp/index.asp>.

Program Exclusions

During this semiannual reporting period, OIG excluded 1,662 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:

Texas – Dennis Barson, Jr., a doctor of osteopathy, was excluded for a minimum period of 25 years based on his conviction of conspiracy to commit health care fraud and health care fraud, aiding and abetting. Beginning around April 2009 and continuing to about February 2010, Barson conspired with others to defraud the Medicare program. As part of the conspiracy, Barson billed Medicare for procedures and services that were never performed. As a result of this activity, the court sentenced Barton to pay \$1,188,993 in restitution and serve 10 years in prison. The Texas State Board of Medicine revoked his license to practice and the Virginia State Board of Medicine suspended his license.

Colorado – Paul Bugaric, a certified nurse assistant, was excluded for a minimum period of 25 years based on his convictions for sexual assault. Bugaric performed sexual acts on a person who had a traumatic brain injury that rendered her unable to give consent to the acts. Bugaric was sentenced to 15 years of incarceration. In addition, his license to practice as a certified nurse assistant was revoked by the Colorado State Board of Nursing.

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 Governmentwide sanctions, an individual or entity that has been suspended or debarred by HHS or any other agency is ineligible from participating in any future funding opportunities across the Federal Government for a specified period of time.

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

The following are debarment examples:

California – Vivian Benn, chief executive officer of Family Hope Foster Family Agency, was debarred for a 3-year period based on her criminal embezzlement convictions. Family Hope Foster Family Agency was an indirect recipient of Federal grant funds from ACF. According to the investigation, Benn used her position of trust to embezzle \$450,000 for her personal use. Benn was sentenced to 3 years and 4 months of incarceration and ordered to pay \$450,000 in restitution.

Montana – Wilford Harlan “Huck” Sunchild, acting director of the Wellness Center, a department under the Rocky Boy Health Board Clinic for the Chippewa Cree Tribe of the Rocky Boy’s Reservation, was debarred for a 3-year period based on his criminal theft convictions. The Wellness Center is an indirect recipient of Federal self-governance compact funds, which are provided by IHS. While acting as director, Sunchild secured an agreement with a program of Nike, Inc., Nike Native Air N7, which was to provide Nike N7 shoes and apparel to members of the Chippewa Cree Tribe at a reduced rate to promote wellness within the tribe. Sunchild used his position to set up a bank account for the Nike Native Air N7 program, but in reality Sunchild diverted Wellness Center contributions into this account for his own personal use. Sunchild was sentenced to 1 year and 1 day of incarceration and ordered to pay \$19,735 in restitution. In addition, Sunchild was excluded from Federal health care programs for 5 years.

Corporate Integrity Agreements

Many health care providers elect to settle their cases

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

Civil Monetary Penalties Law

The Civil Monetary Penalties Law (CMPL) authorizes OIG to impose administrative penalties on and assessments against a person who, among other things, submits, or causes to be submitted, claims to a Federal health care program that the person knows, or should know, are false or fraudulent. During this semiannual reporting period, OIG concluded cases involving more than \$43.8 million in CMPs and assessments.

The following are CMP examples:

New Jersey – Ascend Laboratories, LLC (Ascend) agreed to pay \$1,287,000 to settle allegations that it failed to submit drug pricing data to CMS. The Medicaid Drug Rebate Program requires pharmaceutical companies to enter into and have in effect a national rebate agreement with the Secretary of HHS in order for Medicaid payments to be available for the

pharmaceutical company's covered drugs. Companies with such rebate agreements are required to submit certain drug pricing information to CMS, including quarterly and monthly average manufacturer's price (AMP) data. OIG can seek penalties against manufacturers that misrepresent, or fail to timely report, drug pricing information. OIG alleged that Ascend failed to submit timely monthly and quarterly AMP data for several months in 2013 and 2014 and for three quarters in 2013.

Texas – Gustavo Grieco, M.D.; Sohail Siddiqui, M.D.; and Marco Vargas, D.P.M.; agreed to pay \$208,000, \$75,000, and \$65,000, respectively, to settle allegations that they received improper remuneration in exchange for the referral of patients to an independent diagnostic testing center, OneStep Diagnostic, Inc. (OneStep), in the Houston area. Specifically, OIG alleged that from January 1, 2008, through June 30, 2012, Grieco, Siddiqui, and Vargas each received improper remuneration from OneStep in the form of compensation from a Medical Directorship agreement and that took into account the value and volume of referrals made to OneStep. In October 2014, OneStep agreed to pay \$1.2 million and adhere to a 5-year CIA to resolve their related liability.

Patient Dumping

Some of the CMPL cases that OIG resolved between October 1, 2015, and March 31, 2016, were pursued under the EMTALA, a statute designed to prevent hospitals from denying emergency care to patients and to ensure patient access to appropriate emergency medical services.

The following are EMTALA case examples:

South Carolina – St. Francis Hospital agreed to pay two maximum penalties of \$50,000 each to resolve its potential liability under EMTALA. OIG alleged that St. Francis failed to treat two gunshot victims who arrived at its emergency department. OIG contended that a 32-year-old male arrived at St. Francis's emergency department with a gunshot wound to his leg. The patient required a CT angiogram of his leg to assess possible vascular injuries and treatment by a surgeon. While these services were available at St. Francis, they were not provided. Instead, the patient was transferred to another hospital. OIG also contended that a 29-year-old male arrived at St. Francis's emergency department with a gunshot wound to the abdomen. Although St. Francis had both the capacity and capability to further treat the patient, St. Francis instead transferred the patient to another hospital without providing stabilizing care. In addition to the above two instances, CMS found that St. Francis failed to ensure that their emergency department EMTALA policies and procedures, Medical Staff By-Laws, or Medical Staff Rules and Regulations defined the responsibilities of on-call physicians under EMTALA.

Mississippi – University of Mississippi Medical Center (UMMC) agreed to pay a maximum penalty of \$50,000 to resolve its potential liability under EMTALA. OIG alleged that a 64-year-old woman arrived at a hospital in Mississippi with abnormal vital signs and lab results. A chest x-ray revealed a large right pleural effusion, and the patient was diagnosed with atrial fibrillation, pleural effusion, urinary tract infection, and congestive heart failure. She was given numerous medicines, but was determined to need a higher level of care than

was available at that hospital. An emergency department physician called UMMC and requested a transfer of the patient to UMMC. OIG contended that when UMMC discovered the patient was from Louisiana, it refused to accept the transfer of the patient due to UMMC's new policy of not accepting patients from Louisiana.

Provider Self-Disclosure Protocol

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

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

the OIG website at <https://oig.hhs.gov/compliance/self-disclosure-info/index.asp>.

During this reporting period, self-disclosure cases resulted in more than \$48.1 million in HHS receivables.

The following are examples of provider self-disclosure settlements:

Ohio – The Kroger Company agreed to pay \$21,523,047 to resolve its liability under the CMPL for conduct disclosed to OIG. Kroger is an Ohio for-profit corporation that operates more than 2,109 pharmacies and 2,640 supermarkets and multi-department stores in 34 states. OIG alleged that Kroger employed 14 individuals who were excluded from participation in Federal health care programs. Kroger also filled prescriptions, for which payment was made under a Federal health care program, that were written by 84 excluded prescribers.

Alabama – Community Health United Home Care, LLC (CHUHC) agreed to pay \$9,800,707 to resolve its liability under the CMPL for conduct it disclosed to OIG. Specifically, OIG alleged that, from January 1, 2008, through February 29, 2012, CHUHC submitted claims for hospice services at Center Home Care Corporation and Fallbrook Home Care Services without certifications of terminal illness, face-to-face encounters, and/or physician narratives, as required by hospice regulations.

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

After being excluded for nonpayment of their HEAL debts, 2,617 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 21 individuals who entered into such settlement agreements or completely repaid their debts during this semiannual reporting period. More than \$207 million is being repaid through settlement agreements or through complete repayment. Of that amount, \$1.9 million is attributable to this semiannual reporting period.

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

- Massachusetts – Dentist – \$206,570
- California – Medical Doctor – \$126,133
- California – Chiropractor – \$51,277
- Michigan – Osteopath – \$14,957

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

Administration for Children and Families

Hurricane Sandy — Response Preparedness

The Response to Superstorm Sandy Highlights the Importance of Recovery Planning for Childcare Nationwide

We reviewed New Jersey and New York’s emergency preparedness for, response to, and recovery from Superstorm Sandy as related to childcare. We found that, before Superstorm Sandy, New Jersey and New York’s emergency planning did not include the development of strategies for restoring or rebuilding childcare facilities and infrastructure after a disaster, as recommended by ACF. However, these States established post-disaster task forces that assisted childcare providers with the recovery and rebuilding process. Since Superstorm Sandy, ACF has taken steps to improve nationwide emergency preparedness, response, and recovery for childcare. However, fewer than half of all States reported including or planning to include the restoration or rebuilding of childcare facilities and infrastructure after a disaster in their emergency preparedness and response plans. Because of legislation enacted in November 2014, States are required to have statewide childcare disaster plans; however, the requirements do not explicitly specify that these plans must include planning for the restoration or rebuilding of childcare facilities and infrastructure after a disaster.

ACF concurred with our recommendation to require States to include planning for the restoration or rebuilding of childcare facilities and infrastructure after a disaster in their statewide childcare disaster plans.

OEI-04-14-00410 • December 2015



Childcare Health and Safety Requirements

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, families receiving temporary public assistance, and families transitioning from public assistance to obtain childcare so that they may work or obtain training or education. The objective of the reviews below were to determine whether State’s were ensuring that providers receiving CCDF funds complied with State requirements related to the health and safety of children.

Some South Carolina Childcare Centers Did Not Always Comply With State Health and Safety Licensing Requirements

A-04-14-08032 • November 2015

Also, Some South Carolina Family Childcare Homes Did Not Always Comply With State Health and Safety Requirements

We found that four childcare providers that we reviewed did not comply with the childcare center physical condition requirements, which had previously been cited by South Carolina, or with caregiver documentation requirements; one provider did not comply with children’s immunization record requirements. Of the 20 childcare homes we reviewed, 16 did not comply with 1 or more of the guidelines for physical conditions, 9 did not comply with guidelines for child records, 4 did not comply with training requirements, and 4 were not available during operating hours to complete our unannounced inspection.

South Carolina generally concurred with our recommendations in both reports that it ensure compliance with Federal health and safety requirements for CCDF providers; ensure that CCDF homes complete and submit training documentation and impose penalties for failures to comply; and ensure that required documentation is included in the children’s records. South Carolina also generally concurred with our recommendations in the family childcare homes report that it inspect registered family childcare homes annually.

A-04-14-08031 • November 2015

Puerto Rico Child Daycare Centers Did Not Always Comply With Commonwealth Health and Safety Requirements

A-02-14-02001 • October 2015

Also, Puerto Rico Childcare Home Providers Did Not Always Comply With Commonwealth Health and Safety Requirements

We found that Puerto Rico did not ensure that providers receiving funding from CCDF complied with requirements related to the health and safety of children. Potentially hazardous conditions existed at the three daycare center providers we reviewed. Potentially hazardous conditions also existed at 19 of the 20 childcare home providers we reviewed.

Puerto Rico concurred with our findings in both reports that resulted in our recommendations to establish binding health and safety requirements for all CCDF providers in Puerto Rico; have procedures in place to ensure that providers receive adequate training on health and safety requirements; develop a

single comprehensive and specific checklist to aid in its monitoring of providers for compliance with health and safety requirements; correct the specific health and safety issues noted in the reports; and ensure that providers employ only individuals with proper background certification.

Puerto Rico also concurred with our findings in the childcare home provider report that resulted in our recommendations to update its CCDF State Plan to more accurately describe childcare home types and requirements; establish policies and procedures to ensure that onsite inspections are performed at all providers at least annually; and establish requirements for all household members to obtain a certification that they are not in Puerto Rico’s registry of persons convicted of sex crimes and child abuse.

A-02-14-02016 • October 2015

Puerto Rico Improperly Claimed Some Childcare and Development Targeted Funds

We reviewed \$18.9 million in CCDF targeted fund expenditures and found that Puerto Rico did not comply with Federal requirements for the use of \$12.5 million. Puerto Rico used \$10.9 million for nontargeted fund activities and \$1.6 million in targeted funds for contractor activities not specified as “targeted.” Puerto Rico did not indicate concurrence or nonconcurrence with our recommendations to refund to the Federal Government \$12.5 million for expenditures that were not used for targeted fund activities, ensure that targeted funds are expended in accordance with funding allocations established by ACF, and develop

procedures for reconciling accounting records to reports submitted by contractors and monitor these reports to ensure that contractors are using targeted funds for targeted activities.

A-02-14-02016 • February 2016

Some Florida Childcare Centers Did Not Always Comply With State Health and Safety Licensing Requirements

A-04-14-08033 • March 2016

Also, Some Florida Family Childcare Homes Did Not Always Comply With State Health and Safety Requirements

We reviewed four childcare providers and found that all four providers did not comply with the physical conditions requirements, two providers did not comply with staff record requirements, and two providers did not comply with child record requirements. Of the 20 childcare home providers we reviewed, 15 did not comply with 1 or more of the physical conditions requirements; 11 did not comply with child record requirements; 4 did not comply with staff documentation requirements; and 4 were not available during operating hours to complete our unannounced inspection, which prevented us from assessing the physical conditions and children's records.

Florida concurred with our recommendations in both reports to ensure that required documentation is complete, current, and included in the children's files. Florida also concurred with our recommendation in the family childcare centers report that providers meet training requirements. Florida did not concur or nonconcur with our recommendations in the family childcare homes report that the specific health and

safety issues noted in the report are corrected, the program complies with Federal health and safety requirements for CCDF providers, the timing of provider inspections is less predictable and conducted in accordance with the new CCDF Block Grant Act requirements, and licensed providers comply with background screening or rescreening requirements and staffing requirements.

A-04-14-08034 • March 2016

Child Support Enforcement Activities

OIG Investigations

OIG investigates noncustodial parents who fail to pay court-ordered child support. OIG works with ACF's Office of Child Support Enforcement; DOJ; U.S. Attorneys' Offices; the U.S. Marshals Service; and Federal, State, and local partners to address egregious child support enforcement cases with appropriate law enforcement and prosecutorial action. During this reporting period, OIG investigations of child support enforcement cases nationwide resulted in 22 criminal actions and court-ordered restitution and settlements of \$924,128.

The following are examples of child support enforcement cases:

Maine – Glen Caristinos was sentenced to 5 years of probation and ordered to pay \$117,601 in restitution after pleading guilty to failure to pay child support. In October 2001, Caristinos was ordered to pay \$248.16 per week for the support of his son. However, from 2001 to 2005, Caristinos made inconsistent payments to the custodial parent of his child before moving to Florida and virtually ceasing to make further payments.

South Dakota – Michael Paul Marsh was sentenced to 3 years of probation and ordered to pay \$103,190 in restitution after pleading guilty to failure to pay child support. In 2005, Marsh was ordered to pay child support for his three children, and since is more than \$100,000 in arrears. Marsh admitted that he was aware that a support order was issued, and that he was physically capable of working and could have paid more than he did.

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 is at <https://oig.hhs.gov/fraud/child-support-enforcement/index.asp>.

Grants and Contracts

New York University School of Medicine Budgeted Costs That Were Appropriate and Claimed Allowable Hurricane Sandy Disaster Relief Act Funds

Our objectives were to determine whether New York University (NYU) School of Medicine’s Disaster Relief Act budgeted costs were appropriate and its claimed costs were allowable in accordance with Federal requirements. On July 1, 2013, nearly 9 months after Hurricane Sandy, NIH began awarding Disaster Relief Act funds to NYU School of Medicine for the restoration of its medical scientific research activities, which were damaged by Hurricane Sandy. From July 1, 2013, through September 30, 2015, NIH awarded \$127.8 million for Grantee Research Programs to NYU School of Medicine. NYU School of Medicine planned to use the funds to restore experiments and reestablish research programs affected by the loss of biospecimens, animals, data, and time. We found that NYU School of Medicine appropriately budgeted and claimed allowable Hurricane Sandy Disaster Relief Act funding. Accordingly, this report contained no recommendation.

A-02-14-02011 • December 2015
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Hidalgo Medical Services Did Not Comply With All Federal Requirements Related to Its Capital Development Grant

As part of our ACA oversight activities, OIG is conducting a series of reviews of certain ACA-funded capital development grants, funded by HRSA, because of the potential risks associated with expansion and

construction projects, such as a change of scope, scheduling delays, and cost overruns. Our review of Hidalgo Medical Services (HMS), in Lordsburg, New Mexico, determined that HMS did not comply with applicable Federal requirements and grant terms related to its ACA-funded capital development grant. HMS also did not provide the community health services described in the application because of changes in management after submission of the grant application and a lack of awareness of Federal grant policies and procedures. HMS, a not-for-profit health center in New Mexico, received \$8,715,094 in HRSA funds to construct a new community health center in Silver City, New Mexico, and to construct a senior wellness center in Lordsburg, New Mexico.

HMS did not concur with our recommendations, but HRSA did concur with our recommendations that it either require HMS to refund \$898,000 to the Federal Government for the unallowable grant expenses or provide HMS with disposition instructions for the wellness center at issue and, upon disposition, require HMS to refund to the Federal Government either the wellness center’s fair market value or \$898,000 of the wellness center’s cost, whichever is lower, and work with HMS to strengthen its financial, property management, and procurement controls over grant funds.

A-06-14-00056 • January 2016
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Grant Fraud

HHS is the largest grant-making organization and one of the largest contracting agencies in the Federal Government. In FY 2015, HHS awarded more than \$412 billion in grants and over \$20 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 over 70,000 employees around the world. The size and scope of departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public. Recent appropriations increased OIG's discretionary funding for public health and human services oversight.

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

Florida – The University of Florida entered into a \$19.875 million settlement agreement with OIG and seven HHS operating divisions that awarded grants to the University. The University of Florida receives millions of dollars in grant funding from HHS on hundreds of grants each year. The settlement resolves allegations that the University overcharged hundreds of grants for the salary costs of its employees, charged some of these grants for administrative costs for equipment and supplies when those items should not have been directly charged to the grants under Federal regulations, and inflated costs charged to HHS grants awarded at its Jacksonville campus for services

performed by an affiliated entity, Jacksonville Healthcare, Inc.

Montana – Timothy Rosette, the acting chief executive officer of the Rocky Boy Health Board (RBHB) clinic for the Chippewa Cree Tribe of the Rocky Boy's Indian Reservation, was sentenced to more than 3 years in prison and ordered to pay \$600,000 in restitution for his guilty plea to bribery and theft from an Indian tribal organization. Investigators believe that Rosette accepted bribes from multiple businesses, including TMP Services (a contractor used after the clinic incurred damage from a flood), in exchange for the award of tribal contracts. After the clinic experienced damage from a flood, all the property salvaged from the clinic building was stored using FEMA funds with the idea that the property would be used in the new clinic building, but it was never used. Investigators believe that Rosette was a secret partner in TMP Services and that bogus claims were generated to reimburse Rosette for the bribes. Eight defendants involved in the scheme were previously sentenced to a combined 15 years and 2 months in prison and ordered to pay more than \$1.2 million in restitution.

New York – Dorothy Ogundu was sentenced to between 1 and 3 years of incarceration after a jury found her guilty on 29 counts, including grand larceny. According to court documents, Ogundu owned Angeldocs, a not-for-profit medical clinic. From approximately April 2006 through September 2013, Ogundu stole a portion of each of the 12 Government grants that she received, totaling approximately \$300,000. Two of the 12 grants in question were congressional earmarks sponsored by a U.S. Congressman

and administered by the U.S. Department of Housing and Urban Development and the CDC. Ogundu used the money that she stole to pay the mortgage and utilities on a commercial property she owned, make improvements to the property to increase its value, purchase and ship vehicles to Nigeria, and make other purchases for her personal benefit and for the benefit of her not-for-profit business.

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 2015 report delivered to the three Congressional oversight committees, we reported that OIG spent approximately \$236,239 in salaries on oversight related to the SBIR/STTR program. HHS referred two new SBIR/STTR cases to OIG in FY 2015.

Recovery Act Retaliation Complaint Investigations

The American Recovery and Reinvestment Act (Recovery Act), § 1553, prohibits non-Federal employers that have received Recovery Act funding from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds.

OIGs are required to include in their Semiannual Reports to Congress the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. During this reporting period, OIG closed two 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 Reports to Congress* pursuant to section 5 of such Act, information on final completed contract audit reports issued during the period to the contracting activity containing significant audit findings. OIG did not issue final reports meeting § 845 criteria during this semiannual period.

OIG Reviews of Non-Federal Audits

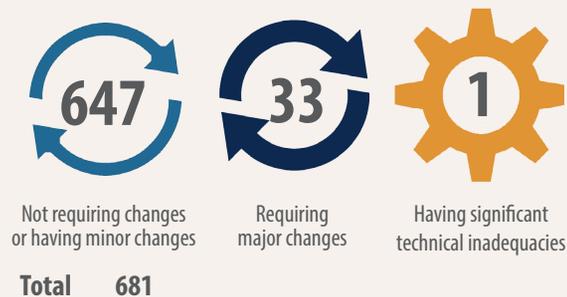
OIG reviews audits conducted by non-Federal auditors of entities receiving Federal awards. In this semiannual period, OIG's National External Audit Review Center reviewed 681 reports covering \$110.5 billion in audited costs. Federal dollars covered by these audits totaled \$62.4 billion, of which about \$523.5 million were HHS funds.

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

and State auditors. OIG reviews the quality of these audits and assesses the adequacy of the entities' management of Federal funds.

OIG's oversight of non-Federal audit activity informs Federal managers about the soundness of management of Federal programs and identifies any significant areas of internal control weakness, noncompliance, and questioned costs for resolution or 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 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.

**Number of Non-Federal Audits:
October 1, 2015 through March 31, 2016**



The 681 reports included 1,524 recommendations for improving management operations. In addition, these audit reports provided information for 21 OIG special memorandums that identified concerns for increased monitoring by management.

Other Reporting Requirements and Reviews

Legislative and Regulatory Reviews

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

- Our [Semiannual Report to Congress](#) describes findings and recommendations from recently completed reviews, many of which focus on existing laws and regulations.

- Our [Compendium of Priority Recommendations](#) describes priority findings and recommendations from past periods that remain to be implemented.
- Our annual [Work Plan and Mid-Year Update](#) provides citations to laws and regulations that are the subject of ongoing or future reviews.

We also review proposed legislation and regulations related to HHS programs and operations. HHS routinely involves us and its operating and other staff divisions in the review and development of HHS regulations through a well-established HHS process. Our audits, evaluations, and investigations are sometimes cited in regulatory preambles as influencing HHS regulations. In addition, we provide independent, objective technical assistance on a bipartisan, bicameral basis to congressional committees and members who request it.

Implementation of Health Insurance Marketplaces

OIG continues to review programs implemented pursuant to the ACA. OIG's ACA oversight strategy focuses on the health insurance marketplaces, reforms in the Medicare and Medicaid programs, and public health programs. Key focus areas for our marketplace oversight include payment accuracy, eligibility, management and administration, and security. In developing our work plan, we coordinate with the Government Accountability Office and other Federal and State oversight agencies.

Federal Marketplace

HealthCare.gov: Case Study of CMS Management of the Federal Marketplace

The objective of this case study was to gain insight into CMS's implementation and management of the Federal Marketplace, focusing primarily on HealthCare.gov. We found that HHS and CMS made many missteps throughout development and implementation that led to the poor launch of HealthCare.gov on October 1, 2013. Most critical was the absence of clear leadership, which caused delays in decision-making and a lack of clarity in project tasks. Additional missteps included devoting too much time to developing policy, which left too little time for developing the website, and failing to properly manage its key website development contract. CMS's organizational structure and culture also hampered progress, including poor coordination between policy and technical work. CMS continued on a failing path despite signs of trouble, making rushed corrections that proved insufficient.

Following the launch, CMS and contractors pivoted quickly to make corrective actions, reorganizing the work to improve execution and facilitating health plan enrollment for millions of consumers. Key factors that contributed to recovery of the website included adopting a "badgeless" culture for the project, wherein all CMS staff and contractors worked together as a team, and a practice of "ruthless prioritization" that aligned work efforts with the most important and achievable goals. CMS recovered the website for high consumer use within 2 months and adopted more effective organizational practices. CMS concurred with

our recommendation to continue to apply lessons from the HealthCare.gov recovery in its management of the Federal Marketplace and broader organization.

OEI-06-14-00350 • February 2016

State-Based Marketplaces

The ACA requires the establishment of a health insurance exchange (marketplace) in each State and District of Columbia. A marketplace is designed to serve as a “one-stop shop” at which individuals get information about their health insurance options; are evaluated for eligibility for a QHP and, when applicable, eligibility for insurance affordability programs; and enroll in the QHP of their choice. A previous OIG review found that not all internal controls implemented by the Federally facilitated marketplace and the State marketplaces in California and Connecticut were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. The reviews below are part of an ongoing series that looks at seven State marketplaces across the Nation and determines whether their marketplace’s internal controls were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements.

Not All of the Colorado Marketplace’s Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

A-07-14-03199 • December 2015

Also the following:

Not All of the District of Columbia Marketplace’s Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

A-03-14-03301 • February 2016

The Kentucky Marketplace’s Internal Controls Were Generally Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

A-04-14-08036 • October 2015

Not All of the Minnesota Marketplace’s Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

A-05-14-00043 • February 2016

The Vermont Marketplace’s Internal Controls Were Not Always Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

A-01-14-02507 • March 2016

Not All of the Washington Marketplace’s Internal Controls Were Effective in Ensuring That Individuals Were Enrolled in Qualified Health Plans According to Federal Requirements

A-09-14-01006 • January 2016

We found that not all of the internal controls for the marketplaces in Colorado, District of Columbia,

Minnesota, Vermont, or Washington were effective in ensuring that individuals were enrolled in QHPs according to Federal requirements. Kentucky's internal controls were generally effective. Internal controls were not effective in determining or verifying eligibility of applicants, resolving inconsistencies in eligibility data, or maintaining and updating eligibility and enrollment data. In addition, internal controls in Colorado, District of Columbia, and Vermont related to verifying information were not effective, and Colorado's internal controls related to obtaining certain data were ineffective.

As applicable, the marketplaces generally agreed with either our findings or our recommendations that they take action to improve their internal controls related to resolving inconsistencies in eligibility data, to maintaining and updating eligibility and enrollment data, and to verifying applicants' eligibility. Minnesota did not agree with our recommendation that it redetermine, if necessary, the eligibility of the sample applicants for whom we determined that verifications were not performed according to Federal requirements.

Payments and Policies

CMS Could Not Effectively Ensure That Advance Premium Tax Credit Payments Made Under the Affordable Care Act Were Only for Enrollees Who Paid Their Premiums

The objectives of our review were to determine whether: (1) CMS had a process in place to ensure that advance premium tax credit (APTC) payments were made only for enrollees who paid their monthly premiums, and (2) CMS shared APTC payment data for

enrollees with the IRS when making these payments. We found that CMS could not ensure that APTC payments made to QHP issuers were only for enrollees who had paid their premiums. CMS: (1) relied on each QHP issuer to verify that enrollees paid their monthly premiums and to attest that APTC payment information was accurate, and (2) had sole responsibility for ensuring that APTC payments were made only for enrollees who had paid their premiums and did not share these data for enrollees with the IRS.

CMS concurred with our recommendation to establish policies and procedures to calculate APTC payments without relying solely on QHP issuers' attestations that enrollees have paid their premiums. CMS did not indicate concurrence or nonconcurrence with our recommendation that once it implements an automated process to maintain individual enrollee data it consult with the IRS to explore sharing APTC payment data.

A-02-14-02025 • January 2016

Information Security

Public Summary Report: Connect for Health Colorado Generally Protected Personally Identifiable Information on Its Health Insurance Exchange Websites and Databases but Could Continue To Improve Information Security Controls

This public summary report provides an overview of the results of our audit of the information security controls at Colorado's health insurance exchange, Connect for Health Colorado (C4HCO). We found that C4HCO implemented security controls over its websites and databases, but improvements are still needed to

fully comply with Federal requirements and to increase protection of personally identifiable information. As of November 2014, C4HCO had not updated the system security plan's supporting policies or ensured that vulnerabilities identified during prior scans were mitigated in a timely manner. We also identified numerous weaknesses regarding user access administration and inadequate security settings during our database security scans. Moreover, C4HCO had not performed incident response testing.

C4HCO concurred with our detailed recommendations and described corrective actions that it had taken or planned to take. Based on the evidence C4HCO provided, we determined that it has successfully remediated the issues related to the system security plan and incident response testing and has partially remediated the issues related to the application production databases and vulnerability mitigation.

A-07-15-00454 • February 2016

Health Reform Oversight Plan

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

expansion and services, Medicare payment and delivery reform, and Medicare and Medicaid program integrity.

Health Reform Oversight Plan Fiscal Year 2015 •
2015 February

Appendix A: Questioned Costs and Funds To Be Put to Better Use

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

Audit Reports With Questioned Costs

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

Table 1 – Audit Reports with Questioned Costs

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period ¹	171	\$732,926,000	\$46,825,000
Reports issued during the reporting period	58	\$353,261,000	\$1,155,000
Total Section 1	229	\$1,086,187,000	\$47,980,000
Section 2			
Reports for which management decisions were made during the reporting period ^{2,3}			
Disallowed costs	136	*\$598,018,000	\$27,226,000
Costs not disallowed	3	\$54,590,000	\$1,454,000
Total Section 2	139	\$652,608,000	\$28,680,000
*Audit receivables (expected recoveries).			

	Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 3			
Reports for which no management decisions had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	90	\$433,579,000	\$19,300,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance ⁴	46	\$165,962,000	\$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 Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period ¹	9	\$15,094,517,000
Reports issued during the reporting period	4	\$46,000,000
Total Section 1	13	\$15,140,517,000

	Reports	Dollar Value
Section 2		
Reports for which management decisions were made during the reporting period ^{2,3}		
Value of recommendations agreed to by management		
Based on proposed management action	7	\$114,849,000
Based on proposed legislative action		\$0
Value of recommendations agreed to by management	1	\$5,533,000
Total Section 2	8	\$120,382,000
Section 3		
Reports for which no management decisions had been made by the end of the reporting period ² (Sec. 1 minus Sec. 2)	5	\$15,020,135,000

End Notes

Table 1 End Notes

¹ The opening balance was adjusted upward by \$213.5 million because of a reevaluation of previously issued recommendations.

² Revisions to previously reported management decisions:

- A-02-09-01023 *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State*. The Department of Appeals Board (DAB) ruling further reduced the disallowed cost to \$53,446,805. CMS adjusted grant awards accordingly by \$30,920,124.
- A-07-10-02775 *Palmetto Government Benefits Administrator Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments in Jurisdictions 11*. Subsequent review by CMS determined that the 3-year deadline for reopening the cost report had passed and there were no indications of fraud. Costs totaling \$1,641,927 were allowable.

- A-04-13-00093 *Medicare Compliance Review of Methodist Healthcare for the Period January 1, 2011, Through June 30, 2012*. Subsequent review by CMS and OIG determined that the overpayment amount of \$5,893,302 should have been \$4,948,753. As a result, \$944,549 was determined to be allowable cost.
- A-04-07-00033 *Review of CIGNA Government Services Durable Medical Equipment Regional Carrier Medicare Termination Cost Vouchers for the Period October 1, 2006, Through October 31, 2007*. CMS subsequent review of supporting document provided by CIGNA reduced disallowed cost by \$922,108.
- Not detailed are net reductions to previously disallowed management decisions totaling \$3.1 million.

³ Included are management decisions to disallow \$69.6 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 responsible for ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

⁴ Because of administrative delays, some of which were beyond management control, resolution of the following 46 audits was not completed within 6 months of issuance of the reports; however, 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 FOR MEDICAID SCHOOL BASED HEALTH SERVICES—CT, MAY 2003, \$32,780,146
CIN: A-01-14-02503	REVIEW OF MD STATE AGENCY PROCESSES FOR DESIGN & IMPLEMENTATION OF THE STATE’S HEALTH INSURANCE EXCHANGE, MAR 2015, \$28,400,000
CIN: A-07-13-01125	MEDICARE PART C UNLAWFULLY PRESENT ENROLLEES, APR 2014, \$26,150,043
CIN: A-01-12-02507	REVIEW OF CONNECTICUT’S TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS, NOV 2013, \$17,499,083
CIN: A-06-13-00038	CHILDCARE DEVELOPMENT FUND: TARGETED FUNDS REVIEW IN TEXAS, AUG 2014, \$14,967,129
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 CHILDCARE 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 CHILDCARE 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-07-11-06013	INDIRECT COSTS CLAIMED AS DIRECT COSTS—UNIVERSITY OF COLORADO DENVER, JUN 2013, \$1,419,524
CIN: A-03-12-00008	REVIEW OF XL HEALTH DIR, JAN 2013, \$1,410,342
CIN: A-03-13-00021	REVIEW OF FALLON COMMUNITY HEALTH PLAN'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,079,578
CIN: A-05-12-00089	THE COUNCIL ON RURAL SERVICE PROGRAMS, INC., CLAIMED UNALLOWABLE HEAD START COSTS, NOV 2013, \$1,074,352

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CIN: A-03-13-00022	REVIEW OF MD CARE, INC.'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$1,040,501
CIN: A-03-13-00023	REVIEW OF NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION'S 2009, 2010, AND 2011 BONA FIDE SERVICE FEES, JAN 2014, \$957,921
CIN: A-02-11-02020	REVIEW OF ACTION FOR A BETTER COMMUNITY, INC. CSBG ARRA COSTS CLAIMED BY NEW YORK STATE, SEP 2013, \$795,608
CIN: A-09-11-01007	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR HCAP, FEB 2013, \$513,649
CIN: A-04-13-01024	ALLOWABILITY OF SELECTED COSTS CHARGED TO FEDERAL GRANTS AND CONTRACTS UNC, JUN 2014, \$352,843
CIN: A-01-11-02510	REVIEW OF CT CSBG RECOVERY ACT COSTS CLAIMED, APR 2013, \$314,605
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, \$293,870
CIN: A-02-11-02015	REVIEW OF INSEC, INC. CSBG ARRA COSTS CLAIMED BY THE COMMONWEALTH OF PUERTO RICO, APR 2013, \$285,412
CIN: A-02-11-02017	NEW JERSEY CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS INCURRED BY CHECK-MATE INC., UNDER THE RECOVERY ACT, AUG 2014, \$246,359
CIN: A-09-09-00045	RISK ADJUSTMENT DATA VALIDATION OF PAYMENTS MADE TO PACIFICARE OF CALIFORNIA FOR CALENDAR YEAR 2007 (CONTRACT H0543), NOV 2012, \$224,388
CIN: A-06-12-00057	CHILDCARE DEVELOPMENT FUND: TARGETED FUNDS REVIEW IN LOUISIANA, SEP 2013, \$221,578
CIN: A-05-12-00012	REVIEW OF IL CSBG RECOVERY ACT COSTS CLAIMED—ROCKFORD, JUL 2013, \$205,296
CIN: A-06-09-00012	RISK ADJUSTMENT DATA VALIDATION—PACIFICARE H4590, MAY 2012, \$183,247
CIN: A-04-11-01004	NORTHEAST FLORIDA COMMUNITY ACTION AGENCY, INC.'S CSBG FUNDS AWARDED UNDER THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009, SEP 2012, \$165,795
CIN: A-04-11-01008	FLORIDA'S ADMINISTRATION OF CSBG RECOVERY ACT PROGRAM AND COSTS CLAIMED BY CENTRAL FLORIDA COMMUNITY ACTION AGENCY, INC., APR 2013, \$160,404

APPENDIXES

CIN: A-07-11-02766	REVIEW OF WY CSBG RECOVERY ACT COSTS CLAIMED—CARBON COUNTY, AUG 2013, \$143,588
CIN: A-09-11-01013	REVIEW OF OREGON’S HOUSING AND COMMUNITY SERVICES DEPARTMENT, APR 2013, \$115,911
CIN: A-06-11-00058	REVIEW OF CSBG ARRA COSTS CLAIMED BY CROWLEY’S RIDGE DEVELOPMENT COUNCIL, AUG 2012, \$115,420
CIN: A-07-12-02779	REVIEW OF NATRONA COUNTY CSBG RECOVERY ACT COSTS CLAIMED, JUN 2013, \$104,971
CIN: A-02-11-02000	DIRECT COST REVIEW—SUNY ALBANY, OCT 2011, \$27,384
CIN: A-09-11-01014	REVIEW OF CSBG RECOVERY ACT COSTS CLAIMED BY HI FOR THE HAWAII COUNTY ECONOMIC OPPORTUNITY COUNCIL, JUL 2012, \$22,602
CIN: A-05-11-00053	THE COLUMBUS URBAN LEAGUE CLAIMED SOME UNALLOWABLE COSTS TO HEAD START, SEP 2012, \$13,102
CIN: A-07-13-03194	REVIEW OF CCDF TARGETED FUND IN COLORADO, DEC 2014, \$4,543
CIN: A-03-12-00250	AUDIT OF LANCASTER COUNTY COMMUNITY ACTION PROGRAM, NOV 2013, \$2,813
TOTAL CINS:	46
TOTAL AMOUNT:	\$165,962,000

Table 2 End Notes

¹The opening balance was adjusted upward by \$49.2 million because of reevaluation of previously issued recommendations.

² Because of administrative delays, some of which were beyond management control, 3 of the 5 audits open at the end of the period were not resolved within 6 months of issuance of the reports. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-05-12-00020	COMPARISON OF SURGICAL SERVICES PROVIDED IN THE ASC SETTING TO OTHER OUTPATIENT SETTINGS, APRIL 2014, \$15,000,000,000
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APPENDIXES

CIN: A-07-13-02795	REVIEW OF PALMETTO MEDICARE OUTLIER PROCESSING TIMELINESS FOR J1, JULY 2015, \$15,792,301
CIN: A-05-06-00023	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS—MN, SEP 2006, \$28,240
TOTAL CINS:	3
TOTAL AMOUNT:	\$15,015,821,000

Appendix B: Peer Review Results

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

Office of Audit Services

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.

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.

Appendix C: Summary of Sanction Authorities

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

Program Exclusions

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

.....

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

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

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

Civil Monetary Penalties Law

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

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

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

Patient Dumping

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

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

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

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

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

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

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

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

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

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

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

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



U.S. Department of Health & Human Services

Office of Inspector General

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