U.S. Department of Health and Human Services

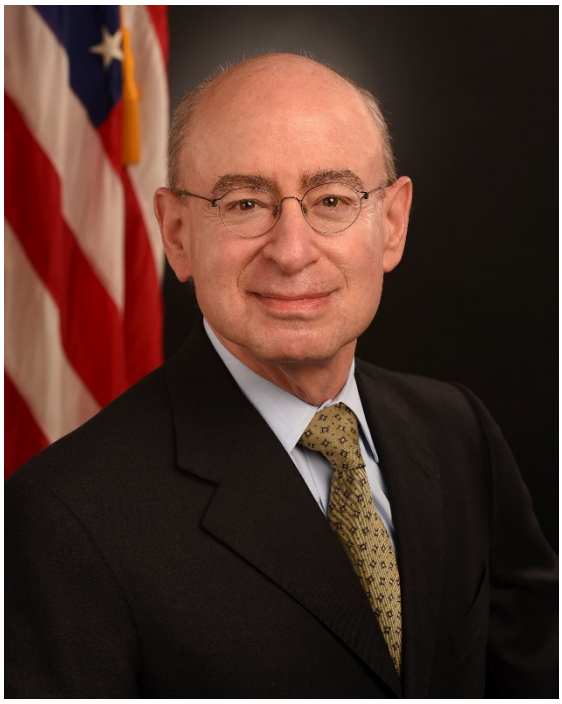
Office of Inspector General

Semiannual Report to Congress

October 1, 2017–March 31, 2018

A MESSAGE FROM THE INSPECTOR GENERAL

I am pleased to present the enclosed *Semiannual Report to Congress* summarizing significant work of the Office of Inspector General (OIG), Department of Health and Human Services (HHS or the Department) for the reporting period covering October 1, 2017, to March 31, 2018. Each day, OIG uses data-driven decision making to combat fraud, waste, and abuse of Federal health care programs and to improve the effectiveness of Department programs. Our multidisciplinary team of auditors, investigators, evaluators, analysts, and attorneys strategically focuses on fraud prevention, detection, and enforcement efforts. Over the 6-month reporting period OIG worked to enhance the integrity of HHS programs and operations, protect vulnerable populations, and drive value in health and human services.



OIG has long been a leader in the Department's fight against prescription drug fraud, including opioids, drug diversion, pill mills, medical identity theft, and other schemes that endanger people and communities. OIG investigates a growing workload of opioid-related fraud cases and provides practical recommendations for programmatic changes to protect patients and programs. In January, OIG testified before the U.S. House of Representatives Committee on Ways and Means about the current opioid landscape and highlighted our related recommendations. OIG works actively with the Department, Congress, and key external stakeholders to reduce inappropriate prescribing and foster effective, efficient addiction treatment.

We are in an information revolution that requires constant vigilance over the security of sensitive data and systems. Cybersecurity incidents and breaches pose a significant risk to the confidentiality, integrity, and availability of sensitive data. Incidents and breaches can impede HHS's ability to deliver essential programs and services, threaten major elements of our country's critical infrastructure, and place at risk the health and safety of patients. OIG is focused on identifying and addressing cybersecurity risks within the Department. During this reporting period, OIG found that security controls across four HHS agencies needed improvement to more effectively detect and prevent cyberattacks. OIG's cybersecurity work helps protect the public from harm and helps the Department secure its data and systems.

HHS programs provide critical health and human services to many vulnerable populations, including adults and children in foster care and individuals receiving care in group home settings. In March, OIG

issued a report that found 20 group care facilities for children in foster care that were surveyed in Washington State did not comply with State health and safety requirements. OIG works to ensure that these individuals have access to and receive high-quality services and are protected from abuse or neglect. During this reporting period, OIG also released a joint report with HHS's Administration for Community Living and Office for Civil Rights that highlighted vulnerabilities in care provided to persons with disabilities in group homes and described model practices States can use to more effectively protect the health and safety of residents living in these group home settings. In conjunction with the report, OIG held a forum with our HHS partners to explore workable, holistic solutions to ensure the safety and quality of care delivery for group home residents.

Looking forward, OIG will continue to leverage our staff expertise to inform Department-wide goals, including combating the opioid crisis, bringing down the high cost of prescription drugs, addressing the cost and availability of health insurance, and transforming our health care system to a value-based system.

Since Congress established HHS-OIG in 1976, we have worked collaboratively with our partners to protect and oversee HHS's vital health and human services programs. OIG appreciates the continued commitment and support of Congress and the Department for the important work of our office.

Daniel R. Levinson
Inspector General

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OIG's Approach to Driving Positive Change

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS or Department), Office of Inspector General (OIG), provides independent and objective oversight that promotes economy, efficiency, and effectiveness in HHS programs and operations. OIG's program integrity and oversight activities are shaped by legislative and budgetary requirements and adhere to professional standards established by the Government Accountability Office (GAO), the U.S. Department of Justice (DOJ), and the Inspector General community. Through a nationwide network of audits, investigations, and evaluations, OIG carries out its mission to protect the integrity of HHS programs and the health and welfare of the people served by those programs. OIG's work is conducted by three operating components—the Office of Audit Services, the Office of Evaluation and Inspections, and the Office of Investigations—with assistance from the Office of Counsel to the Inspector General and Executive Management.

OIG Organization

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 its grantees and contractors in carrying out their respective responsibilities and 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.

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.

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

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

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 coordinating OIG activities and providing mission support, including setting vision and direction for OIG's priorities and strategic planning; ensuring effective management of budget, finance, human resource management, and other operations; and serving as a liaison with HHS, Congress, and other stakeholders. EM plans, conducts, and participates in a variety of cooperative projects within HHS and with other Government agencies. EM provides critical data analytics, data management, and information technology (IT) infrastructure that enables OIG components to conduct their work efficiently and effectively.

OIG Strategic Publications

OIG Strategic Plan

As delineated in OIG's *Strategic Plan for 2014-2018*, OIG's approach to protecting the integrity of HHS programs has four key goals: (1) fight fraud, waste, and abuse; (2) promote quality, safety, and value; (3) secure HHS programs' future; and (4) advance excellence and innovation. These goals drive OIG's work planning for audits and evaluations as well as OIG's approach to enforcement. They also serve as a starting point for OIG's own assessment of its effectiveness.

Top Management and Performance Challenges Facing HHS

To focus the Department's attention on the most pressing issues, each year OIG identifies the Top Management and Performance Challenges facing the Department. These top challenges arise across HHS programs, and they cover critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity.

OIG Work Plan

OIG's *Work Plan* sets forth various projects that OIG plans to undertake during the fiscal year (FY) and beyond. Projects listed in the *Work Plan* span the Department's operating divisions (OPDIV) and staff divisions (STAFFDIV), which include the Centers for Medicare & Medicaid Services (CMS); public health agencies such as the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), and National Institutes of Health (NIH), as well as human services agencies such as the Administration for Children and Families (ACF) and the Administration for Community Living (ACL). The Work Plan also includes oversight of State and local governments' use of Federal funds as well as the administration of the Department. Some of the projects described in the *Work Plan* are statutorily required.

Compendium of Unimplemented Recommendations

OIG drives positive change not only by identifying risks, problems, abuses, and deficiencies, but also by recommending solutions to address them. OIG maintains a list of recommendations it has made to HHS and its OPDIVs to address vulnerabilities detected in its reviews, and it keeps track of whether these recommendations have been implemented. OIG systematically follows up on its recommendations with the relevant HHS OPDIVs. From among the recommendations that have not been implemented, OIG identifies the top recommendations that, if implemented, are likely to garner significant savings and improvements in quality,

efficiency, and effectiveness. OIG compiles these recommendations in the *Compendium of Unimplemented Recommendations*.

OIG Semiannual Report to Congress

OIG's *Semiannual Report(s) to Congress* (Semiannual Reports) describes OIG's work to identify significant problems, abuses, deficiencies, remedies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. In the report below, we present OIG expected recoveries, criminal and civil actions, and other statistics as a result of our work for the first half of FY 2018. We also highlight some of our work completed during this semiannual reporting period covering October 1, 2017, through March 31, 2018.

Highlights of OIG Accomplishments

OIG's Semiannual Report describes OIG's work identifying significant risks, problems, abuses, deficiencies, remedies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period, October 1, 2017, through March 31, 2018.

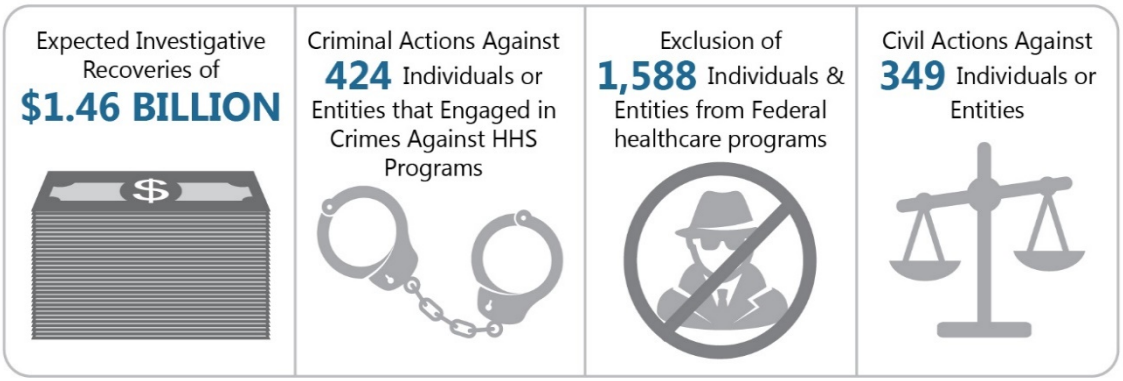
The work of OIG we present here is supported by ongoing investments into data analytics capacity and infrastructure, which we employ in conducting audits, investigations, and evaluations. We also use data analytics to assess relative risks to HHS programs and beneficiaries and help determine where to invest our oversight and enforcement resources.

In the highlights section below, we present OIG expected recoveries, criminal and civil actions, and other statistics as well as highlight some of our most significant work completed during this semiannual reporting period.

Fighting Fraud in HHS Programs—Highlights of Enforcement Accomplishments

OIG remains at the forefront of the Nation's efforts to fight fraud in HHS programs and hold wrongdoers accountable for their actions. Not only does fraud increase HHS costs, it increases risk and potential harm to beneficiaries. During the semiannual reporting period, OIG reported the following:

- Expected investigative recoveries of $1.46 billion
- Criminal actions against 424 individuals or entities that engaged in crimes against HHS programs
- Exclusion of 1,588 individuals and entities from Federal health care programs
- Civil actions against 349 individuals or entities



To combat health care fraud, OIG partners with DOJ, State Medicaid Fraud Control Units (MFCUs or Units), and other Federal, State, and local law enforcement agencies. These partnerships include the Medicare Fraud Strike Force teams, which detect, investigate, and prosecute health care fraud through a coordinated and data-driven approach.

The following examples highlight two of our significant enforcement accomplishments during this semiannual reporting period.

Miami home health agency owner sentenced to more than 6 years, $45 million in restitution for home health fraud scheme. Sila Luis was sentenced to over 6 years in prison and, jointly and severally with her co-defendants, ordered to pay $45 million in restitution following her conviction on conspiracy to commit health care fraud. Luis and her co-defendants were involved in a scheme to improperly recruit patients and bill Medicare for unnecessary home health care services.

Drug manufacturer agreed to pay $210 million and entered into a corporate integrity agreement (CIA) to resolve allegations of paying kickbacks. United Therapeutics Corporation (UT) agreed to pay $210 million to resolve False Claims Acts (FCA) liability associated with allegations that UT violated the FCA by paying kickbacks to Medicare patients through donations it made to Caring Voice Coalition. UT also entered into a 5-year CIA with OIG.

Assessing Mismanagement and Abuse in HHS Programs—Highlights of Accomplishments

OIG oversight of HHS programs ensures integrity, effectiveness, and efficiency. For the first half of FY 2018, OIG reported expected recoveries of $187.5 million and $1.5 billion in potential savings, which includes findings related to Improper Claims for Managed Long-Term Care and Improper Electronic Health Records Incentive Payments.

The following examples highlight two OIG audits that identified significant potential overpayments during this semiannual reporting period.

Services related to the replacement of five recalled and prematurely failed medical devices cost Medicare $7.7 million. OIG found that all 296 payments reviewed for recalled cardiac medical devices with potential overpayments of $4.4 million did not comply with Medicare requirements for reporting manufacturer credits. (See report at A-05-16-00059.)

Many Medicare claims for outpatient physical therapy services did not comply with Medicare requirements. Sixty-one percent of Medicare claims for outpatient physical

therapy services did not comply with Medicare medical necessity, coding, or documentation requirements. (See report at A-05-14-00041.)

Combatting the Opioid Epidemic

Addressing the opioid abuse epidemic is a top priority for OIG. OIG has a longstanding and extensive history of investigative and oversight work focused on the national epidemic of prescription drug abuse, including opioid abuse. We investigate opioid fraud and diversion cases and use advanced data analytics and tools to detect suspected problems for further review. Our work also focuses on strengthening the integrity of HHS prescription drug and addiction treatment programs and protecting at-risk beneficiaries. Significant OIG work during this semiannual reporting period includes the following.

Our partnership with the Attorney General, Federal Bureau of Investigations (FBI), and the Drug Enforcement Administration on the Opioid Fraud and Abuse Detection Unit has led to positive outcomes. The Unit focuses on opioid-related health care fraud using data to identify and prosecute individuals who are contributing to the prescription opioid epidemic. This collaboration led to the selection of 12 judicial districts around the country where OIG has assigned Special Agents to support 12 prosecutors identified by DOJ to focus solely on investigating and prosecuting opioid-related health care fraud cases.

Co-conspirators were convicted of charges resulting from their involvement in an unlawful prescription drug operation. The defendants—physician Dr. Rodney Moret and patient recruiter Kamani Jacobs—conspired to operate a fraudulent medical practice with Advance Care Services. Patient recruiters were found bringing "patients" to the clinic to obtain medically unnecessary prescriptions for controlled substances. Dr. Moret was responsible for illegally distributing over 700,000 dosage units of Hydrocodone, more than 240,000 dosage units of Alprazolam, and more than 2 million milliliters of promethazine with codeine cough syrup, worth more than $15 million in the black market.

A Kentucky pharmacist was convicted on 71 counts and excluded for 50 years from Medicare and Medicaid for illegally dispensing controlled substances. Lonnie Hubbard sold prescription pain pills without a legitimate medical purpose, and sold pseudoephedrine, knowing or having reason to believe that it was being used to manufacture methamphetamine. A jury convicted Hubbard on 71 counts involving the illegal dispensing of oxycodone, hydrocodone, and pseudoephedrine, and sentenced him to 30 years in prison.

Protecting Vulnerable Populations

HHS programs provide critical health and human services to many vulnerable populations, including adults and children in foster care and individuals receiving care in group home settings. OIG helps ensure that these individuals have access to and receive high-quality services and are protected from abuse or neglect. Significant OIG work during this semiannual reporting period includes the following.

Group homes for children in foster care did not always comply with State health and safety requirements. OIG found that in Massachusetts, Ohio, and Washington, the States' monitoring did not ensure that the group homes complied with State requirements related to the health and safety of children in foster care. (See reports on Massachusetts at A-01-16-02500, Ohio at A-05-16-00049, and Washington at A-09-16-01006.)

Minnesota did not comply with Federal requirements in family adult foster care homes. Of the 131 homes in Minnesota where vulnerable adults resided, we selected 20 homes for review. Eighteen of the 20 homes did not comply with 1 or more State licensing requirements. Specifically, we found 64 instances of noncompliance related to health and safety and administrative requirements. (See report at A-05-16-00044.)

OIG and partners produced a portfolio report highlighting vulnerabilities in group home settings. Addressing troubling findings from OIG that found that residents of group homes often experienced serious injuries and medical conditions that resulted in emergency room visits, we gathered together expertise on this issue from across HHS, as well as from the Department of Justice and State stakeholders, to create a joint portfolio report. The report contains workable, holistic solutions that States can use to protect the health and safety of their residents living in group homes. (See report at Joint Report Portfolio.)

Enhancing Program Integrity in Home- and Community-Based Services

Preventing and detecting fraud and abuse in Medicare is vital to safeguarding health care resources and protecting beneficiaries. Home- and community-based services, including home health care and hospice services, can be particularly susceptible to fraud and abuse. OIG, along with our law enforcement partners, focuses specific attention on investigating suspected fraud committed by these providers and in assessing and recommending safeguards to protect taxpayers and beneficiaries. Significant OIG work during this semiannual period includes the following.

The Nation's largest for-profit provider of hospice services entered into a settlement agreement to resolve allegations that it submitted false claims to Medicare. Defendants from VITAS Hospice Services allegedly submitted false claims to Medicare for services provided to patients who were ineligible for hospice benefits, and continuous home care services that were not medically necessary, not provided, or not performed in accordance with Medicare requirements. VITAS Hospice Services agreed to pay $75.5 million to resolve their FCA liability, and entered into a 5-year CIA.

A home- and community-based services agency settled for $6 million and a 5-year CIA to resolve allegations that it knowingly caused false claims to be submitted to Medicare. Catholic Health System, Inc., allegedly submitted, or caused to be submitted, false claims to Medicare for rehabilitation therapy services that were unreasonable, medically unnecessary, and unsupported by the medical records.

Home health agencies might manipulate patient lists to avoid scrutiny from home health surveyors. Home health surveyors rely on lists supplied by home health agencies to select patients for review, which creates a vulnerability because home health agencies could conceal fraudulent activity or health and safety violations by omitting patients from those lists. Some lists we reviewed were indeed missing Medicare beneficiaries. (See report at OEI-05-16-00510.)

Protecting the Integrity of the Medicaid Program

Protecting the integrity of Medicaid is another key focus area in OIG's goal to fight fraud, waste, and abuse. We make recommendations to CMS and States to correct problems and mitigate program risks, and we work closely with State MFCUs to combat Medicaid fraud. Highlights of OIG's work during this reporting period include the following.

California and New York did not correctly determine Medicaid eligibility for newly eligible beneficiaries. OIG estimated that California made Medicaid payments of $738.2 million ($628.8 million Federal share) on behalf of 366,078 ineligible beneficiaries. These deficiencies occurred because California's eligibility determination systems lacked the necessary system functionality and eligibility caseworkers made errors. New York did not always determine Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State requirements. OIG estimated that New York made Federal Medicaid payments of $26.2 million on behalf of 47,271 ineligible beneficiaries. (See reports on California at A-09-16-02023 and New York at A-02-15-01015.)

New Jersey did not follow Federal regulations and CMS guidance when it developed its payment rates for Medicaid school-based services. As a result, the State claimed $300.5 million in unallowable costs. New Jersey claimed an additional $306.2 million in reimbursement using payment rates developed with unsupported costs. (See report at A-02-15-01010.)

Assessing Prescription Drug Payment Policies and Procedures

OIG has a long history of assessing prescription drug payment policies and procedures across HHS programs, including Medicare Parts B and D, Medicaid, and the 340B Drug Discount Program. Our work in this area has identified opportunities for substantial cost savings, risks and instances in which HHS programs have not obtained discounts to which they were entitled by law, and has also resulted in CIAs to resolve fraud allegations. Examples from this reporting period include the following.

Potential misclassifications reported by drug manufacturers may have led to $1 billion in lost Medicaid rebates. OIG found that drug manufacturers may have misclassified 3 percent of drugs in the Medicaid Drug Rebate Program (rebate program). These potential misclassifications may have led to $1.3 billion in lost Medicaid rebates and demonstrate the opportunity for CMS to improve its oversight of classification data in the rebate program. (See report at OEI-03-17-00100.)

OIG identified vulnerabilities in Arkansas' and Arizona's handling of physician-administered drugs and the associated Medicaid rebates. Arkansas did not invoice

manufacturers for rebates associated with $9.9 million (Federal share) in physician-administered drugs. Arkansas improperly claimed Federal reimbursement for single-source drugs and top-20 multiple-source drugs and did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $1.4 million (Federal share). Arizona did not bill for and collect from manufacturers estimated rebates of $36.7 million ($25.6 million Federal share) for physician-administered drugs. Arizona did not always bill for and collect from manufacturers rebates because it did not have a system edit to ensure that National Drug Codes (NDCs) or valid NDCs were submitted for physician-administered drugs before October 1, 2012. (See reports at A-06-16-00018 and at A-09-16-02031.)

Ensuring Food Safety

Among other responsibilities, FDA has the continuing challenge of ensuring the safety and security of most of our Nation's foods. The Centers for Disease Control and Prevention estimates that each year roughly 48 million people get sick from a foodborne illness, 128,000 are hospitalized, and 3,000 die. An effective process for recalling harmful food products is paramount to health and safety. In 2011, Congress granted FDA the authority to require firms to recall certain harmful foods.

FDA's food-recall process did not always ensure the safety of the Nation's food supply. This report reiterated and expanded findings from an August 2016 Early Alert. We found that from 2012 to 2015, FDA could not always ensure that firms initiated recalls promptly. We identified deficiencies in FDA's oversight of recall initiation, monitoring of recalls, and the recall information captured and maintained in FDA's electronic recall data system. (See report at A-01-16-01502.)

Identifying Cybersecurity Risks

Data management, use, and security are essential to the effective and efficient operation of HHS and its programs. As HHS works to leverage the power of data, the Department will maintain and use expanding amounts of sensitive data. So, too, will individuals and entities—such as States, contractors, providers, grant recipients, and beneficiaries—involved in delivering or receiving benefits from the many HHS programs. Cybersecurity incidents and breaches pose a significant risk to the availability of sensitive data. OIG is determined to identify cybersecurity risks within the Department.

Security across four HHS OPDIVs needs improvement to more effectively detect and prevent cyberattacks. We conducted a series of OIG audits at four HHS OPDIVs using network and web application penetration testing to determine how well HHS systems were protected when subject to cyberattacks. Security controls across the four HHS OPDIVs needed improvement to more effectively detect and prevent certain cyberattacks. During testing, we identified configuration management and access control vulnerabilities. (See report A-18-17-08500.)

OIG Participation in Congressional Hearings

10/31/2017
Testimony of James A. Cannatti III, Senior Counselor for Health Information Technology, Office of Inspector General, U.S. Department of Health and Human Services: Senate Committee on Health, Education, Labor, and Pensions: Implementation of the 21st Century Cures Act: Achieving the Promise of Health Information Technology (See testimony here.)

01/17/2018
Testimony of Gary Cantrell, Deputy Inspector General for Investigations, Office of Investigations, Office of Inspector General, Department of Health and Human Services: House Committee on Ways and Means, Subcommittee on Oversight: The Opioid Crisis: The Current Landscape and CMS Actions to Prevent Opioid Misuse (See testimony here.)

01/19/2018
Testimony of Gloria Jarmon, Deputy Inspector General for Audit Services, Department of Health and Human Services: House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations: Safety of the U.S. Food Supply: Continuing Concerns Over the Food and Drug Administration's Food-Recall Process (See testimony here.)

Selected Acronyms and Abbreviations

ACA	Patient Protection and Affordable Care Act
ACF	Administration for Children and Families
ACL	Administration for Community Living
ACO	Accountable Care Organizations
CY	calendar year
CDC	Centers for Disease Control and Prevention
CIA	corporate integrity agreement
CMP	civil monetary penalty
CMS	Centers for Medicare & Medicaid Services
DOJ	Department of Justice
EHR	electronic health records
EMTALA	Emergency Medical Treatment and Labor Act
FCA	False Claims Act
FDA	Food and Drug Administration
FY	fiscal year
GAO	Government Accountability Office
HCBS	home- and community-based services
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IT	information technology
MAC	Medicare Administrative Contractor
MCO	managed care organization
MFCU	Medicaid Fraud Control Unit
NIH	National Institutes of Health
OAS	Office of Audit Services
OCIG	Office of Counsel to the Inspector General
OEI	Office of Evaluation and Inspections
OI	Office of Investigations
OIG	Office of Inspector General
PCS	personal care services
SAMHSA	Substance Abuse and Mental Health Services Administration
SNF	skilled nursing facility

Centers for Medicare & Medicaid Services

Medicare Program Reports and Reviews

Financial Management and Improper Payments

CMS's Policies and Procedures Were Generally Effective in Ensuring That Capitation Payments Were Not Made After Beneficiaries' Dates of Death (A-07-16-05087), October 2017

CMS had policies and procedures in place that were generally effective in ensuring that capitation payments to Medicare Advantage (MA) organizations for Medicare Parts A and B services were not made on behalf of deceased beneficiaries after the individuals' dates of death. During calendar years (CY) 2012 through 2015, CMS received updated beneficiary date-of-death information and then made approximately 1.8 million adjustments to capitation payments, thereby recouping $2.96 billion from MA organizations for Parts A and B capitation payments that had been made on behalf of beneficiaries who had died.

CMS did not, however, identify and recoup all improper capitation payments. As of March 7, 2017, CMS had not recouped $2.4 million associated with 1,817 capitation payments that were made on behalf of 978 beneficiaries. For our audit period, these improper payments represented .0004 percent of the total capitation payments made to MA organizations and .08 percent of the total adjustments that CMS made after receiving information on beneficiaries' dates of death.

CMS concurred with our recommendations that it recoup the $2.4 million in capitation payments made to MA organizations for Medicare Parts A and B services on behalf of deceased beneficiaries and that it implement system enhancements to identify, adjust, and recoup improper capitation payments in the future.

CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program (A-05-14-00049), November 2017

CMS usually selected Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, calculated the sampled DMEPOS single-payment amounts (SPAs), and monitored suppliers in accordance with its established procedures and applicable Federal requirements. We determined that CMS consistently followed its established program procedures and applicable Federal requirements for 192 of the 215 winning suppliers associated with the sampled SPAs reviewed.

While the overall effect on Medicare payments to suppliers was relatively small, we determined that CMS did not consistently follow its established procedures and applicable Federal requirements for selecting suppliers during the bid process for 23 of the 215 winning suppliers. This affected 99 of the 240 sampled SPAs. On the basis of our sample, we estimated that CMS paid suppliers $182,000 less than they would have received without any errors, or less than 0.03 percent of the $553.7 million paid under Round 2 during the last 6 months of 2013.

CMS concurred with our recommendations that it (1) follow its established program procedures and applicable Federal requirements consistently in evaluating the financial documents of all suppliers; (2) ensure that suppliers have the applicable licenses for the specific competitions in which they are submitting a bid by continuing to work with State licensing boards; and (3) monitor supplier licensure requirements by implementing a system to identify and address potential unlicensed suppliers.

CMS Did Not Adequately Address Discrepancies in the Coding Classification for Kwashiorkor (A-03-14-00010), November 2017

Providers incorrectly billed diagnosis code 260 for Kwashiorkor for inpatients who did not have the disease. In separately issued reports, we reviewed the medical records for a total of 2,145 inpatient claims at 25 providers and found that all but 1 claim incorrectly included the diagnosis code for Kwashiorkor, resulting in overpayments in excess of $6 million.

The ICD-9 coding classification contained a discrepancy between the tabular list and the alpha index on the use of diagnosis code 260, which may have resulted in other diseases being assigned this code. CMS did not have adequate policies and procedures in place to address this discrepancy, resulting in a total potential loss of approximately $102 million during CYs 2006 through 2014. Even though CMS was aware of the discrepancy, it did not take any separate action to address it. While our previous reviews successfully returned $5.7 million to the Medicare Trust Fund, we estimate that Medicare could have saved approximately $102 million from CYs 2006 through 2014 if the coding discrepancy had been immediately corrected.

CMS concurred with our recommendations that it (1) review provider Medicare claims to ensure that the diagnosis code for Kwashiorkor is being used correctly by providers and (2) formalize procedures for notifying providers of the correct way to bill diagnosis codes when there is a discrepancy in the coding classification. The 25 hospitals that we reviewed repaid $5.7 million in overpayments. All of the providers stopped incorrectly using diagnosis code 260.

Wisconsin Physicians Service Paid Providers for Hyperbaric Oxygen Therapy Services That Did Not Comply With Medicare Requirements (A-01-15-00515), February 2018

Hyperbaric oxygen (HBO) therapy involves giving a patient high concentrations of oxygen within a pressurized chamber in which the patient intermittently breathes in 100-percent oxygen. Wisconsin Physicians Service (WPS) paid 73 providers for HBO therapy services that did not comply with Medicare requirements. WPS made payments for HBO therapy that did not always comply with Medicare requirements because it had limited policies and procedures in place to ensure that it made correct payments. On the basis of our sample results, we estimate that WPS overpaid providers in Jurisdiction 5 $42.6 million during the audit period for HBO therapy that did not comply with Medicare requirements.

WPS generally agreed with our recommendations that it (1) recover the appropriate portion of the $300,789 in identified Medicare overpayments; (2) notify the providers responsible for the 44,820 nonsampled claims, with potential overpayments estimated at $42.3 million, so that those providers can investigate and return any identified overpayments; (3) identify and recover any improper payments for HBO therapy made after the audit period; and (4) strengthen its policies and procedures for making payments for HBO therapy, which would result in millions in future cost savings.

Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination With Urine Drug Tests (A-09-16-02034), February 2018

Medicare improperly paid 4,480 clinical laboratories and physician offices a total of $66.3 million for specimen validity tests billed in combination with urine drug tests. CMS officials explained that medically necessary tests used to diagnose certain conditions (which include the same tests that can be used to validate urine specimens) that are performed on the same day as a urine drug test for a single beneficiary should be a rare occurrence.

The improper payments occurred because providers did not follow existing Medicare guidance, and CMS's system edits were not adequate to prevent payment for specimen validity tests billed in combination with urine drug tests. Although CMS implemented a system edit designed to identify and prevent these improper payments, we still identified $1.8 million in improper payments from April 1 through December 31, 2016. At this observed rate, these improper payments would total $12.1 million over a 5-year period.

CMS concurred with our recommendations that it (1) direct the Medicare contractors to recover the $66.3 million in identified improper payments and (2) strengthen its system edits to prevent improper payments for specimen validity tests and instruct the Medicare contractors to educate providers on properly billing for specimen validity and urine drug tests, which could result in savings of an estimated $12.1 million over a 5-year period.

Many Medicare Claims for Outpatient Physical Therapy Services Did Not Comply With Medicare Requirements (A-05-14-00041), March 2018

Sixty-one percent of Medicare claims for outpatient physical therapy services that we reviewed did not comply with Medicare medical necessity, coding, or documentation requirements. Specifically, of the 300 claims in our stratified random sample, therapists claimed $12,741 in Medicare reimbursement on 184 claims that did not comply with Medicare requirements. Therapists properly claimed Medicare reimbursement on the remaining 116 claims.

On the basis of our sample results, we estimated that during the 6-month audit period, Medicare paid $367 million for outpatient physical therapy services that did not comply with Medicare requirements. These overpayments occurred because CMS's controls were not effective in preventing improper payments for outpatient physical therapy services.

CMS partly agreed and partly disagreed with our recommendations that it (1) instruct the Medicare Administrative Contractors to notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, (2) establish mechanisms to better monitor the appropriateness of outpatient physical therapy claims, and (3) educate providers about Medicare requirements for submitting outpatient physical therapy claims for reimbursement.

Hospitals Did Not Comply With Medicare Requirements for Reporting Certain Cardiac Device Credits (A-05-16-00059), March 2018

All 296 payments reviewed for recalled cardiac medical devices did not comply with Medicare requirements for reporting manufacturer credits. Medicare contractors incorrectly paid hospitals $7.7 million for cardiac device replacement claims rather than the $3.3 million they should have been paid, resulting in potential overpayments of $4.4 million. For all payments reviewed, manufacturers issued reportable credits to hospitals for recalled cardiac medical devices, but the hospitals did not adjust the claims with the proper condition codes, value codes, or modifiers to reduce payment as required. The overpayments occurred because Medicare controls were not sufficient to ensure that hospitals properly reported manufacturer credits for cardiac devices.

CMS generally concurred with our recommendations that it instruct its Medicare contractors to notify the 210 hospitals associated with the identified overpayments; educate providers on the requirements for reporting manufacturer credits; and consider studying alternatives to implementing edits in order to eliminate the current Medicare requirements for reporting device credits. CMS did not concur with our recommendation that it instruct its Medicare contractors to implement a postpayment process to follow up with hospitals that submit claims for certain cardiac device replacements.

Excluding Non-Covered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries (OEI-12-17-00260), November 2017

OIG found that CMS and a Federal court interpret the law to require the inclusion of average sales prices (ASPs) for noncovered versions in limited circumstances when setting payment amounts for Part B drugs. As a result, the inclusion of noncovered versions of two drugs caused Medicare and its beneficiaries to pay an extra $366 million from 2014 through 2016.

OIG recommended that CMS seek a legislative change that would provide the agency flexibility to determine when noncovered versions of a drug should be included in Part B payment amount calculations. CMS did not concur with our recommendation.

Quality of Care, Safety, and Access

Followup Review: CMS's Management of the Quality Payment Program (OEI-12-17-00350), December 2017

CMS continued its progress toward implementing the Quality Payment Program (QPP), a set of clinician payment reforms designed to put increased focus on the quality and value of care. During 2017, CMS made significant efforts to address the two vulnerabilities that OIG identified in its 2016 management review—developing IT systems and preparing clinicians to participate in the QPP. CMS appears on track to deploy the IT systems needed for data submission by January 1, 2018. With regard to clinician readiness, CMS has conducted outreach, communicated eligibility information, issued subregulatory guidance, awarded technical assistance contracts, and established a Service Center to respond to questions. Clinician feedback demonstrates widespread awareness of the QPP, but also uncertainty about eligibility, data submission, and other elements of the program. With regard to emerging challenges, we found that CMS has not yet developed a comprehensive program integrity plan. OIG has identified two vulnerabilities that are critical for CMS to address in 2018: (1) if clinicians do not receive sufficient technical assistance, they may struggle to succeed under the QPP or choose not to participate, and (2) if CMS does not develop and implement a comprehensive QPP program integrity plan, the program will be at greater risk of fraud and improper payments.

Program Integrity

CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned: Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Programs (A-09-17-03010), October 2017

The Patient Protection and Affordable Care Act (ACA) established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among providers and suppliers to (1) improve quality of care for Medicare fee-for-service beneficiaries and (2) reduce health care costs. Eligible providers and suppliers may voluntarily participate in the MSSP by creating or joining an accountable care organization (ACO). Beneficiary assignment is the basis for many key MSSP operations, such as determining an ACO's financial performance and reporting quality measures after each performance year. The designated ACO is responsible for the quality and cost of care of its assigned Medicare beneficiaries during a performance year. ACOs may be eligible to receive additional payments (i.e., shared savings payments) if they reduce health care costs and meet certain quality performance standards. ACOs may also be responsible for a portion of any shared losses.

CMS complied with Federal requirements when assigning beneficiaries to ACOs in the MSSP during Performance Years 2013 through 2015 by ensuring that MSSP beneficiaries were assigned to only one ACO and were not assigned to other savings programs. Consequently, this report contained no recommendations.

Medicare Needs Better Controls To Prevent Fraud, Waste, and Abuse Related to Chiropractic Services (A-09-16-02042), February 2018

This portfolio presents an overview of program vulnerabilities identified in prior OIG audits, evaluations, investigations, and legal actions related to chiropractic services in the Medicare Program. It consolidates the findings and issues identified in that work and discusses recommendations from prior reports that have not been implemented or have been implemented ineffectively. In addition, this portfolio provides information to help CMS understand the need for effective controls over chiropractic services.

CMS partly agreed and partly disagreed with our recommendations that it implement the recommendations from prior OIG reports that were not implemented or were ineffectively implemented; work with its contractors to educate chiropractors on the training materials that are available to them; educate beneficiaries on the types of chiropractic services that are covered by Medicare; identify chiropractors with aberrant billing patterns or high service-denial rates, review a sample of their services, review the medical records for the sampled service, estimate the amount overpaid, and request that the chiropractors refund the overpayments; and establish a threshold for the number of chiropractic services beyond which medical review would be required for additional services.

Medicare Advantage Encounter Data Show Promise for Program Oversight, but Improvements Are Needed (OEI-03-15-00060), January 2018

CMS collects detailed information from MA organizations regarding each service provided to beneficiaries in the MA program. This information is known as MA encounter data.

Overall, 28 percent of MA encounter records that we reviewed from the first quarter of 2014 had at least 1 potential error, but CMS reported correcting the majority of these records. With CMS's subsequent correction, only 5 percent of the records in our review would contain a potential error. Some of these errors may raise concerns about the legitimacy of services documented in the data, such as records that lacked a beneficiary last name or a valid identifier for the billing provider. Only a few MA organizations submitted half of the encounter records that had a potential error. CMS does not require MA organizations to submit certain provider identifiers used in program integrity reviews, and these were frequently absent from encounter data. Furthermore, CMS has not tracked how MA organizations responded to edits that reject data, i.e., "reject edits," nor has it established performance measures to monitor MA organizations' submission of records with missing or invalid data.

CMS concurred with our recommendations to (1) take actions as appropriate to address potential errors in the MA encounter data; (2) provide targeted oversight of MA organizations that submitted a higher percentage of encounter records with potential errors; (3) ensure that billing provider identifiers are valid and active on all records in the MA encounter data; and (4) establish and monitor MA encounter data performance thresholds related to MA organizations' submission of records with complete and valid data.

CMS did not concur with our recommendations to (1) require MA organizations to submit ordering and referring provider identifiers for applicable records; (2) ensure that MA organizations submit rendering provider identifiers for applicable records; and (3) track MA organizations' response to reject edits.

Reliance on Unverified Patient Lists Creates a Vulnerability in Home Health Surveys (OEI-05-16-00510), March 2018

In our review, we found that some patient lists supplied by home health agencies (HHAs) were missing Medicare beneficiaries, allowing them to be excluded from surveyor inspections. We also found that surveyors cannot comprehensively verify that HHA-supplied patient lists are complete at the time they conduct their surveys. While our analysis does not demonstrate that these providers were engaged in fraudulent activity, it does illustrate a vulnerability that HHAs could exploit to conceal fraudulent activity or health and safety violations. However, existing data sources may be useful tools for both surveyors and CMS. OIG encourages CMS to explore actions to mitigate this vulnerability.

CMS Ensured Nearly All Part D Drug Records Contained Valid Prescriber Identifiers in 2016 (OEI-03-17-00040), October 2017

Nearly all prescription drug event (PDE) records for Part D drug claims in 2016 contained valid prescriber National Provider Identifiers (NPIs). Prescriber identifiers are a valuable program integrity safeguard as they enable CMS and Part D plan sponsors to determine if legitimate practitioners have prescribed drugs for enrollees. The Medicare Access and the Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 requires that, beginning in 2016, pharmacy claims for covered Part D drugs must contain valid prescriber NPIs. Additionally, the law requires the Secretary of Health and Human Services to establish procedures for determining the validity of these prescriber NPIs and requires OIG to submit to Congress a report on the effectiveness of these procedures no later than January 1, 2018. This evaluation report fulfills OIG's mandate under the CHIP Reauthorization Act. Our report concludes that the system edits that CMS currently has in place to check PDE records are effective in ensuring the validity of the vast majority of Part D prescriber NPIs.

Review of the Department of Health and Human Services (HHS) Cancellation of Marketplace Enrollment Outreach Efforts (OEI-12-17-00290), October 2017

In response to a congressional request, OIG conducted a descriptive, fact-finding review of HHS's cancellation of certain Marketplace enrollment outreach activities (outreach activities) before the January 31st end of the fourth open enrollment period.

OIG determined that HHS canceled and then reinstated certain outreach activities on January 26 and 27, 2017. An official on the HHS Beachhead Team orally instructed HHS officials to cancel Marketplace outreach, and that same official later provided updated instructions about which outreach should remain canceled and which should resume. However, we were unable to determine conclusively whether that individual made the decision to cancel outreach or merely conveyed the decisions made by someone else. In addition, HHS officials conducted a preliminary assessment of costs and savings associated with canceling certain outreach activities, but reported that they did not perform any analyses of the impact that canceling outreach activities would have on Marketplace enrollment.

Medicaid Program Reports and Reviews

Financial Management and Improper Payments

Ohio Received Millions in Unallowable Bonus Payments (A-04-16-08049), November 2017
Kansas Received Millions in Unallowable Bonus Payments (A-04-16-08050), November 2017

Under the CHIP Reauthorization Act of 2009, States receive bonus payments to offset the costs of increased enrollment of children in Medicaid. These two reports are part of a series of reviews that OIG conducted to determine whether these bonus payments were allowable.

Both Ohio and Kansas overstated their current enrollment in their bonus requests to CMS because they included individuals who did not qualify because of their basis-of-eligibility category. As a result of the States' overstated enrollment numbers, CMS overpaid Ohio $29.5 million and Kansas $17.8 million in bonus payments. Ohio and Kansas did not concur with our findings or our recommendations to refund the excess payments.

North Carolina Did Not Comply With Federal and State Requirements When Making Medicaid Cost-Sharing Payments for Professional Medical Services (A-04-16-04054), November 2017

States must make medical assistance available for Medicare deductibles, coinsurance, and copayments (cost-sharing) for certain individuals who are dually eligible to be enrolled in both Medicare and Medicaid. In North Carolina, Medicaid is required to make cost-sharing payments at the lesser of the cost-sharing amount or the Medicaid allowable payment.

North Carolina did not comply with Federal and State requirements when making Medicaid cost-sharing payments for professional medical services. On the basis of our sample results, we estimated that North Carolina made at least $63 million in improper Medicaid cost-sharing payments and claimed Federal

reimbursement of at least $41.2 million for these payments. These improper payments occurred because North Carolina did not program its Medicaid Management Information System (MMIS) to calculate Medicaid cost-sharing payments for professional medical services in accordance with the State's required cost-sharing payment methodology.

North Carolina replaced its MMIS after our audit period. We reviewed a limited number of cost-sharing payments made after our audit period and verified that North Carolina's replacement MMIS calculated payments in compliance with the State's required cost-sharing payment methodology.

North Carolina disagreed with our findings and recommendations that it (1) refund $41.2 million to the Federal Government for cost-sharing payments for professional medical services that did not comply with Federal and State requirements, and (2) ensure that future changes to Medicaid payment methodologies comply with the Medicaid State plan.

New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement (A-02-15-01010), November 2017

New Jersey did not follow Federal regulations and CMS guidance when it developed its payment rates for Medicaid school-based services and, as a result, claimed $300.5 million in unallowable costs. New Jersey claimed an additional $306.2 million in reimbursement using payment rates developed with unsupported costs.

Among our findings, we determined that (1) New Jersey's contractor changed school employees' responses to timestudies to indicate that their activities were directly related to providing Medicaid services when the responses indicated the activities were unrelated; (2) New Jersey improperly incorporated into its payment rates more than $400 million owed to the school employees' pension fund despite not having made scheduled payments to the fund in nearly 20 years; and (3) salaries of some employees who did not provide health-related services were incorporated into the payment rates. In addition, New Jersey did not maintain documentation related to the timestudies, which it used to identify the percentage of time personnel provided particular services.

New Jersey disagreed with our findings and recommendations that it (1) refund $300.5 million in Federal Medicaid reimbursement that it claimed based on payment rates that incorporated unallowable costs; (2) work with CMS to determine the allowable amount of the remaining $306.2 million claimed for Federal Medicaid reimbursement; and (3) revise its payment rates so it complies with Federal requirements.

Texas Did Not Appropriately Spend Some State Balancing Incentive Payments Program Funds (A-06-15-00041), December 2017

Texas appropriately spent $272.4 million of the $284.4 million in Balancing Incentive Payments Program (BIPP) funds it received. Of the remaining $12 million, Texas inappropriately spent $6.3 million for medical service rate increases that did not benefit Medicaid recipients and did not spend $5.7 million in BIPP funds before the end of the funding period. Additionally, Texas did not separately track BIPP funds or follow CMS instructions for extending the funding period.

Texas did not indicate concurrence or nonconcurrence with our recommendations that it refund $12 million in BIPP funds that did not benefit Medicaid recipients or that were not spent before the end of the funding period. Additionally, we recommended that, for future grant programs, Texas separately track funds to ensure (1) the funds are not used in violation of applicable statutory restrictions or prohibitions and (2) all grant procedures and requirements are met, such as following instructions for extending funding periods.

New York Did Not Correctly Determine Medicaid Eligibility for Some Newly Enrolled Beneficiaries (A-02-15-01015), January 2018

New York did not always determine Medicaid eligibility for newly eligible beneficiaries in accordance with Federal and State requirements. In our sample of 130 beneficiaries, New York correctly determined eligibility for 90 beneficiaries. However, it did not determine eligibility for 37 beneficiaries in accordance with Federal and State requirements and did not provide supporting documentation to verify beneficiaries were newly eligible for the remaining 4 potentially ineligible beneficiaries. The total exceeds 130 because 1 beneficiary was found to be ineligible for one determination period and found to be potentially ineligible for another determination period. On the basis of our sample results, we estimated that New York made Federal Medicaid payments of $26.2 million on behalf of 47,271 ineligible beneficiaries.

New York disagreed with our recommendations that it (1) redetermine, as appropriate, the current Medicaid eligibility status of the sample beneficiaries and (2) improve the design of its enrollment system to ensure that it maintains applications, verifies income and citizenship eligibility data, and determines eligibility by using available electronic data sources, as appropriate.

California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements (A-09-16-02023), February 2018

For our sample of 150 beneficiaries who were newly eligible for Medicaid, California made Medicaid payments on behalf of 112. However, for the remaining 38 beneficiaries, California made payments on behalf of ineligible beneficiaries (e.g., a woman who did not meet eligibility requirements for the newly eligible group because she was pregnant) and potentially ineligible beneficiaries (e.g., a beneficiary who may not have met the residency requirement). On the basis of our sample results, we estimated that California made Medicaid payments of $738.2 million ($628.8 million Federal share) on behalf of 366,078 ineligible beneficiaries and $416.5 million ($402.4 million Federal share) on behalf of 79,055 potentially ineligible beneficiaries. These deficiencies occurred because California's eligibility determination systems lacked the necessary system functionality and eligibility caseworkers made errors. We also identified a weakness in California's procedures related to determining eligibility of individuals who may not have intended to apply for Medicaid.

California partly agreed and partly disagreed with our recommendations that it (1) redetermine, if necessary, the current Medicaid eligibility of the sampled beneficiaries; (2) ensure its eligibility determination systems have the functionality to verify eligibility requirements and perform eligibility determinations in accordance with Federal and State requirements; and (3) develop and implement written policies and procedures, as appropriate.

New Jersey Claimed Federal Medicaid Reimbursement for Children's Partial Hospitalization Services That Did Not Meet Federal and State Requirements (A-02-16-01008), March 2018

New Jersey did not comply with Federal and State requirements for all 100 of the claims in our sample, including 94 that contained more than 1 deficiency. For all 100 claims, we found that services provided were not documented or adequately supported. For 81 claims, outpatient hospital services were provided at a facility not licensed by New Jersey's hospital licensing agency. For 48 claims, providers did not meet the minimum staff-to-client ratio requirement for group therapy services. For 16 claims, services were provided by staff members who did not meet qualification requirements. Finally, for 10 claims weekly progress notes were not maintained. As a result, the quality of care provided to the children at these providers might have been inadequate.

The deficiencies occurred because New Jersey did not ensure that children's partial hospitalization services were provided by appropriately licensed hospitals. Also, New Jersey did not adequately monitor the children's partial hospitalization program to ensure that providers complied with Federal and State requirements.

New Jersey disagreed with our recommendations that it refund $54.7 million to the Federal Government and that its Medicaid agency work with the State's hospital licensing agency to ensure that children's partial hospitalization services are provided by appropriately licensed hospitals. We also made other procedural recommendations.

New York Did Not Comply With Federal Grant Requirements for Claiming Marketplace Contract Costs to Medicaid and the Children's Health Insurance Program (A-02-15-01014), March 2018

New York did not always follow Federal requirements for allocating and claiming contract costs to its grants for establishing New York's marketplace customer service center or for claiming contract costs to Medicaid and CHIP. Specifically, for the customer service center, New York may have misallocated costs totaling nearly $19.6 million and claimed unallowable profit fees and other costs totaling nearly $3.8 million. For Medicaid and CHIP, New York claimed unallowable costs totaling as much as $954,521 (as much as $852,992 in unallowable profit fees and $101,529 in unallowable general and administrative costs and related profit fees).

This occurred because New York did not have written policies that explained how to properly allocate costs when it developed its original cost allocation plan. Further, New York did not establish a basis for the profit fee rate with its contractor, Maximus, Inc., at the beginning of the contract; did not require Maximus to always use its final cost rate for general and administrative costs; and did not require Maximus to retroactively adjust the calculation of its profit fee and general and administrative costs by removing project costs that should not have been subject to these charges.

New York disagreed with our recommendations that it (1) refund to CMS $852,992 in unallowable profit fees or work with CMS to determine the appropriate amount that should have been claimed to Medicaid and CHIP and (2) refund to CMS $101,529 in unallowable general and administrative costs and related profit fees.

Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates (OEI-03-17-00100), December 2017

We found that drug manufacturers may have misclassified 3 percent of drugs in the Medicaid Drug Rebate Program (rebate program). These potential misclassifications may have led to $1.3 billion in lost Medicaid

rebates and demonstrate the opportunity for CMS to improve its oversight of classification data in the rebate program.

CMS concurred with all of our recommendations to follow up with manufacturers associated with potentially misclassified drugs identified in this report to determine whether current classifications are correct; improve CMS's Drug Data Reporting for Medicaid system to minimize inconsistent data submissions and track potential classification errors for followup; and pursue a means to compel manufacturers to correct inaccurate classification data reported to the rebate program.

Quality of Care, Safety, and Access

Minnesota Did Not Comply With Federal Waiver and State Requirements for 18 of 20 Family Adult Foster Care Homes Reviewed (A-05-16-00044), October 2017

Minnesota funds home and community-based services for people aged 65 and older who are eligible for medical assistance and require the level of care provided in a nursing home but choose to live in the community, such as at a licensed family adult foster care home (home).

Of the 131 homes in Minnesota where vulnerable adults who receive services through the program resided for the quarter ended March 2016, we reviewed 20 homes. We determined that 18 of the 20 homes did not comply with 1 or more State licensing requirements. Specifically, we found 64 instances of noncompliance related to health and safety and administrative requirements.

County licensor supervisors stated that instances of noncompliance occurred mainly because of low staffing levels and a lack of training opportunities for license holders (providers) and county licensors. Additionally, specific State licensing requirements on the necessity of safeguarding hazardous materials were unclear.

Minnesota partially concurred with our recommendations that it ensure that the 64 instances of noncompliance with health and safety and administrative requirements identified in this report are corrected; work with counties to ensure the health and safety of vulnerable adults by considering staffing standards and caseload thresholds for county agencies; review training opportunities available to providers and county licensors and improve or increase them as needed; and ensure that Minnesota guidance accurately reflects administrative requirements related to hazardous materials.

Drug Pricing and Reimbursement

Arkansas Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs (A-06-16-00018), February 2018

Arkansas did not invoice manufacturers for rebates associated with $9.9 million (Federal share) in physician-administered drugs. Arkansas improperly claimed Federal reimbursement for single-source drugs and top-20 multiple-source drugs and did not submit the utilization data necessary to secure rebates for all other physician-administered drug claims totaling $1.4 million (Federal share).

Arkansas partly agreed with our recommendations that it refund the overpayments and work with CMS to determine the resolution of other drug claims in question.

Arizona Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations (A-09-16-02031), February 2018

Arizona did not bill for and collect from manufacturers estimated rebates of $36.7 million ($25.6 million Federal share) for physician-administered drugs. Arizona did not always bill for and collect rebates from manufacturers because it did not have a system edit to ensure that National Drug Codes (NDCs) or valid NDCs were submitted for physician-administered drugs before October 1, 2012.

Arizona partly agreed with our recommendations that it refund the overpayments and work with CMS to determine the resolution of other drug claims in question. Arizona concurred with our recommendations that it strengthen the NDC edit to ensure that NDCs are captured and valid for all drug utilization data and ensure that all eligible physician-administered drugs are processed for rebates.

Legal and Investigative Activities Related to Medicare and Medicaid

OIG investigates allegations of fraud, waste, and abuse in all HHS programs. Our largest body of work involves investigating matters related to Medicare and Medicaid, such as patient harm; billing for services not rendered, medically unnecessary services, or upcoded services (i.e., services billed for at a level higher than warranted); illegal billing, sale, and diversion of prescription drugs; marketing of off-label uses for 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,
- durable medical equipment, and
- diagnostic radiology and laboratory testing.

OIG also conducts investigations regarding organized criminal activity, including medical identity theft and fraudulent medical schemes established for the sole purpose of stealing Medicare dollars. Investigators are opening an increasing number of cases against health care providers and patients who engage in these health care fraud schemes. Those who participate in the schemes may face heavy fines, jail time, and exclusion from participation in Federal health care programs.

In addition to investigating Medicare and Medicaid fraud, OIG investigates fraud, waste, and abuse in other HHS programs, including ACF, Indian Health Service (IHS), the Health Resources and Services Administration (HRSA), and ACL. OIG investigates potential misuse of grants and contract funds awarded by CDC, NIH, the Substance Abuse and Mental Health Services Administration (SAMHSA), and other HHS agencies. Under certain circumstances, OIG investigates noncustodial parents who fail to pay court-ordered child support. OIG also investigates allegations of employee misconduct, 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 FCA. Depending on the types of fraud or other violations involved, OIG investigations may culminate in criminal or civil court judgments and decisions, administrative sanctions and decisions, and/or negotiated settlement agreements. Investigative outcomes take many forms, including incarceration, restitution, fines, penalties, forfeitures, assessments, and exclusion of individuals or entities from participation in all Federal health care programs. Frequently used exclusion and penalty authorities are described on our website at http://oig.hhs.gov/fraud/enforcement/cmp/.

During this semiannual reporting period, we reported 374 criminal and 346 civil actions against individuals or entities that engaged in offenses related to health care. We also reported more than $1.24 billion in

investigative receivables due to HHS and more than $203.7 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare, Medicaid, and other Federal, State, and private health care programs.

The following are recently completed actions and settlements organized by subject area.

Prescription Drugs

The following are two case examples involving prescription drugs:

- Michigan – Two co-conspirators connected with the health clinic Advance Care Services (ACS), pleaded guilty to charges resulting from their involvement in an unlawful prescription drug operation. In all, they were sentenced to a combined 10 years in prison and ordered to pay $2.5 million in restitution, joint and several. The defendants—ACS physician Dr. Rodney Moret and patient recruiter Kamani Jacobs—conspired to operate a fraudulent medical practice. ACS purported to be a pain management and HIV infusion clinic; however, the actual scheme involved patient recruiters bringing "patients" to the clinic to obtain medically unnecessary prescriptions for controlled substances. Medicare was billed for medical examinations and tests that were not conducted properly or at all. According to statements made at the plea hearing and evidence submitted at sentencing, Dr. Moret often took advantage of the female "patients" who received controlled-substance prescriptions by sexually molesting or harassing them. Dr. Moret was responsible for illegally distributing more than 700,000 dosage units of Hydrocodone, more than 240,000 dosage units of Alprazolam, and more than 2 million milliliters of promethazine with codeine cough syrup, worth more than $15 million on the street market. Three other defendants involved in the scheme were previously sentenced to a combined 6 years and 5 months in prison and ordered to pay $2.5 million in restitution (joint and several).

- Pennsylvania – Dr. Clarence Verdell, Dr. Keyhosrow Parsia, Dr. Alan Summers, and their codefendants conducted a scheme to illegally sell prescriptions for controlled substances. The investigation disclosed that from about February 2012 through August 2016, Verdell and Summers owned substance-abuse clinics in Philadelphia, while Parsia worked at a nearby substance-abuse clinic. Verdell, Parsia, Summers, and other doctors sold prescriptions for Suboxone and Klonopin to drug dealers and drug addicts in exchange for cash payments. Drug dealers openly sold controlled substances inside the clinics and on the street immediately outside. The physicians did not perform medical or mental health examinations of their patients as required by law to legally prescribe these controlled substances. Virtually every customer who visited the clinics received the maximum daily doses of Suboxone and Klonopin regardless of the customer's medical or mental health history. Verdell, Parsia, and Summers all pled guilty to multiple counts regarding controlled substances and health care fraud and were sentenced to a combined 4 years and 1 day in prison; ordered to pay $39,199 in restitution; joint and several; and ordered to forfeit $153,193.

Pharmacy

The following is a case example involving a pharmacy:

- Texas – DaVita Rx, LLC (DaVita Rx), a nationwide pharmacy that specializes in serving patients with severe kidney disease, entered into a settlement agreement to resolve allegations that it billed Federal health care programs for prescription medications that were never shipped, that were shipped but subsequently returned, and that did not comply with requirements for documentation of proof of delivery, refill requests, or patient consent. In addition, the settlement also resolves allegations that DaVita Rx paid financial inducements to Federal health care program beneficiaries in violation of the anti-kickback statute. Specifically, DaVita Rx allegedly accepted manufacturer copayment discount cards in lieu of collecting copayments from Medicare beneficiaries, routinely wrote off unpaid beneficiary debt, and extended discounts to beneficiaries who paid for their medications by credit card. These allegations relating to improper billing and unlawful financial inducements were the subject of self-disclosures by DaVita Rx and a subsequently filed whistleblower lawsuit. DaVita Rx agreed to pay $63.7 million to resolve its FCA liability.

Pharmaceutical Companies

The following is a case example involving a pharmaceutical company:

- Massachusetts – United Therapeutics Corporation (UT) entered into a civil settlement agreement to resolve its FCA liability associated with donations it made to a 501(c)(3) foundation. UT manufactures and sells a number of drugs used to treat pulmonary arterial hypertension. The settlement resolved allegations that from 2010 to 2014 UT violated the FCA by paying kickbacks to Medicare patients through donations it made to Caring Voice Coalition (CVC). CVC, in turn, allegedly used the donations to pay copayments for patients in order to induce the patients to use UT's drugs. The Government alleged that UT routinely obtained data from CVC detailing how much CVC spent for patients who were using UT's drugs and that UT used this data to decide how much money to donate to CVC. Essentially, the Government alleged that UT used CVC as a conduit to pay the copayments of Medicare patients who were using UT's drugs. UT agreed to pay $210 million to resolve its liability and entered a 5-year CIA with OIG.

False EHR Oncology Claims

The following is an oncology-related case example:

- Florida – 21st Century Oncology, Inc., and 21st Century Oncology, LLC (collectively, "21C") and North Carolina Radiation Therapy Management Services, LLC and Radiation Therapy Associates of Western North Carolina, P.A. (collectively, "Radiation Therapy") entered into a settlement agreement to resolve allegations that they submitted false claims to Medicare. 21C is the largest integrated network of cancer treatment centers and affiliated physicians in the world. It is alleged that 21C knowingly submitted, or caused the submission of, false claims under the Medicare Electronic Health Record (EHR) Incentive Program for meaningful use performance years 2012-2014 on behalf of 121 physicians. 21C allegedly submitted false attestations to CMS regarding its compliance with the Medicare EHR Incentive Program and CMS made incentive payments for performance years 2012-2014 to physicians who did not meet the criteria for meaningful use and paid claims for physician services in CYs 2015 and 2016 at a rate that did not reflect the required downward adjustments. This settlement also resolves allegations of violations of the physician self-referral law (commonly referred to as the "Stark law") because of prohibited referrals made by certain physicians with improper compensation arrangements. Between

February 2013 and October 2016, financial relationships with certain 21C physicians allegedly violated the Stark law. Between October 2014 and October 2017, financial relationships with certain Radiation Therapy physicians allegedly violated the Stark law. 21C and Radiation Therapy agreed to pay $26 million to resolve their FCA liability, and 21C entered into a 5-year CIA with OIG.

Home Health

The following are two case examples involving home health:

- Florida – Sila Luis, the co-owner and operator of two home health agencies, engaged in an elaborate health care fraud scheme. According to court documents, from January 2006 through June 2012, Luis and her co-defendants enlisted and paid patient recruiters kickbacks and bribes in exchange for the referral of Medicare beneficiaries to the two home health agencies to receive home health and physical therapy services that were not medically necessary, not provided, or both. Luis pleaded guilty to conspiracy to commit health care fraud and was sentenced to 6 years and 8 months in prison and ordered to pay restitution of $45 million, joint and several. Two additional defendants involved in the scheme were previously sentenced to a combined 11 years and 8 months in prison and ordered to pay a portion of the $45 million in restitution, as well as an additional $27 million in restitution.

- Texas – Eric Ugorji, a registered nurse who owned and operated two home health agencies, engaged in a scheme to defraud Medicare. According to the investigation, from approximately August 2009 through April 2016, Ugorji and his co-defendants were involved in a scheme to recruit patients to receive home health services that were not medically necessary, not provided, or both. Ugorji also paid kickbacks to physicians who would falsely certify in a plan of care that the Medicare beneficiaries were under their care and confined to the home when they were not. Ugorji pleaded guilty to conspiracy to commit health care fraud and was sentenced to 10 years in prison and ordered to pay $17.1 million in restitution.

Transportation

The following is a transportation-related case example:

- Florida – AmeriCare Ambulance Service, Inc., and its sister company, AmeriCare ALS, Inc. (collectively, AmeriCare), entered into a settlement agreement to resolve allegations that they defrauded Medicare by billing for medically unnecessary ambulance transportation services. From January 2008 through December 2016, AmeriCare allegedly submitted fraudulent claims to Medicare and TRICARE for Basic Life Support (BLS), nonemergency ambulance transports that were not medically justified. AmeriCare had created thousands of false reports and other documentation during this time period in a failed effort to support this illicit practice. AmeriCare agreed to pay $5.49 million to resolve its liability under the FCA, and entered into a 5-year CIA.

Durable Medical Equipment

The following is a case example involving durable medical equipment:

- Louisiana – Geoffrey Ricketts and Samuel Kim directed a $38 million Medicare fraud scheme. The defendants operated Care Concepts, LLC and Choice Home Medical Equipment and Supplies. According

to court documents, the defendants paid kickbacks to workers at call centers from which operators would cold-call Medicare recipients to convince them to accept talking glucose meters and related supplies. From 2007 through 2015, the defendants caused thousands of claims to be submitted to Medicare, virtually all of which were fraudulent. Ricketts and Kim both pleaded guilty to conspiracy to commit health care fraud. Ricketts was sentenced to 3 years and 10 months in prison and ordered to pay $1.3 million in restitution, while Kim was sentenced to 2 years and 1 month in prison and ordered to pay $988,593 in restitution. Two defendants involved in the scheme were previously sentenced to a combined 1 year and 1 day in prison and ordered to pay $133,807 in restitution.

Laboratories

The following is a case example involving laboratories:

- Texas – Primex Clinical Laboratories, LLC (Primex) and Mitch Edland, the CEO and owner of DNA Stat, LLC (DNA Stat), entered into settlement agreements to resolve allegations that they paid kickbacks in exchange for laboratory referrals for patient pharmacogenetic testing. Primex is a licensed clinical laboratory providing clinical diagnostic testing services, including pharmacogenetic testing. DNA Stat was a laboratory management company that employed sales representatives and licensed pharmacists. Primex and DNA Stat entered into a services agreement related to pharmacogenetic testing services. From June 2013 through March 2016, Primex and DNA Stat allegedly were involved in several kickback schemes, including a scheme where the defendants created the appearance of paying physicians to provide clinical study data for a Primex-sponsored study related to pharmacogenetic testing when, in fact, the physicians were being paid for referring patients for the testing. Primex and DNA Stat also allegedly provided physicians with in-office medical technicians to do work related to the Primex-sponsored study in an effort to induce those physicians to order pharmacogenetic tests from Primex. Primex agreed to pay $3.5 million and enter into a 5-year CIA. Edland agreed to pay $270,000 and to be excluded for a period of 5 years.

Radiology

The following is a radiology-related case example:

- Delaware – Orthopaedic and Neuro Imaging LLC (ONI) and its owner, Richard Pfarr, engaged in a scheme to defraud Medicare. The investigation disclosed that ONI and Pfarr knowingly submitted false claims to Medicare by administering contrast dye during MRI scans on patients without proper supervision by a physician. Contrast dye is a chemical that is injected intravenously into the body in order to make certain tissues more clearly visible on an MRI. ONI was ordered to pay $16.2 million in damages, and Pfarr was ordered to pay $6.1 million in damages, joint and several.

Nursing Homes

The following case example pertains to a nursing home:

- New York – Catholic Health System, Inc., Home & Community Based Care (Catholic Health) entered into a settlement agreement to resolve allegations that it knowingly caused false claims to be submitted to Medicare. Catholic Health operated and provided long- and short-term skilled nursing care and postacute care to seniors at Father Baker Manor, the McAuley Residence, and St. Frances Williamsville

(collectively described herein as the "Subject Facilities"). The agreement resolves allegations that between January 1, 2007, and December 31, 2014, Catholic Health submitted, or caused to be submitted, false claims to Medicare for rehabilitation therapy services at the Ultra High Resource Utilization Group level it administered to beneficiaries that were unreasonable, not medically necessary, and unsupported by the medical records at its Subject Facilities. Catholic Health agreed to pay $6 million and enter into a 5-year CIA with OIG to resolve this liability.

Mental Health

The following is a case example related to mental health:

- Mississippi – Region 8 Mental Health Services (Region 8) agreed to pay a lump sum of $6.9 million, plus approximately $1.7 million based on the anticipated value of six properties, to resolve allegations that it violated the FCA by submitting false claims to Medicaid. Region 8 provides a variety of mental health services to children and adults located in five counties in Mississippi. The settlement resolves allegations that, from October 2004 through December 2010, Region 8 submitted false claims for services to Medicaid beneficiaries enrolled in its preschool Day Treatment program that it did not provide or that were not provided by qualified individuals. Medicaid defines Day Treatment as "a behavioral intervention program, provided in the context of a therapeutic milieu, which provides children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community."

Identity Theft

The following is a case example involving identity theft:

- Florida – Miguel De Paula Arias was engaged in a sophisticated scheme to defraud Medicare by committing identity theft. According to the investigation, Arias stole the identities of five retired and semi-retired physicians along with their Medicare provider numbers used to submit claims for services provided to patients. Arias utilized fake passports, driver's licenses, and other identification documents to establish bank accounts, mailing addresses, and phone answering services in the names of the victim physicians to give the appearance that the physicians were in practice and providing medical care to deceased beneficiaries in different locations around the country. From June 2011 through December 2016, Arias submitted fraudulent claims to Medicare for purportedly providing medical services. Arias had the money paid by Medicare deposited into the bank accounts he controlled in the victim doctors' names. The doctors, as a result of Arias' crimes, received bills from the IRS for unpaid taxes and from Medicare for repayment of the apparently fraudulent claims. Arias pleaded guilty to health care fraud, false statements regarding health care fraud, and aggravated identity theft. He was sentenced to 13 years and 5 months in prison and ordered to pay $1.6 million in restitution.

Hospitals

The following is a case example involving a hospital:

- Georgia – Meadows Regional Medical Center, Inc. (MRMC), a 57-bed not-for-profit safety net hospital located in rural southeast Georgia, entered into two settlement agreements to resolve its FCA liability. Three physician groups (Dublin Internal Medicine, Middle Georgia Urology, and Downtown Dublin

Wound Center) were also parties to one of the settlement agreements. The investigation revealed that from 2012 to 2015, MRMC allegedly violated the Stark law (and, with some arrangements, also the anti-kickback statute) by paying physicians substantially more than the fair-market value of their services in exchange for patient referrals from the physicians to MRMC. The focus of the investigation and the settlements was MRMC's relationships with 12 physicians and their respective groups. Two of the physicians were independent contractors of MRMC, operated wound care centers, and were paid under medical director agreements. The remaining 10 physicians were employees of MRMC. MRMC entered into one settlement agreement to resolve its FCA liability related to the physician groups for $3.6 million, but it could increase up to $11.1 million contingent upon MRMC's meeting certain financial thresholds, and a second agreement to resolve its liability related to two individual physicians for $1.7 million. MRMC also entered into a 5-year CIA with an arrangements review.

Hospice

The following is an example of a hospice case:

- Missouri – Chemed Corporation and various wholly-owned subsidiaries, including VITAS Hospice Services, LLC and Vitas Healthcare Corporation entered into a settlement agreement to resolve allegations that they submitted false claims to Medicare. VITAS is the Nation's largest for-profit provider of hospice services. The defendants allegedly submitted false claims to Medicare for (1) services provided to patients who were ineligible for hospice benefits and (2) continuous home care services that were not medically necessary, not provided, or not performed in accordance with Medicare requirements. VITAS agreed to pay $75.5 million to resolve their FCA liability, and entered into a 5-year CIA.

Health Care Fraud Prevention and Enforcement

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

HEAT Provider Compliance Training

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

Medicare Fraud Strike Force Activities

In 2007, Medicare Fraud Strike Force teams began an effort to combine resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse. These partnerships among 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 operate in nine areas: Miami and

Tampa, Florida; Dallas and Houston, Texas; Los Angeles, California; Detroit, Michigan; Brooklyn, New York; Southern Louisiana; and Chicago, Illinois.

During this semiannual reporting period, Strike Force efforts resulted in the filing of charges against 77 individuals or entities, 107 criminal actions, and more than $100.3 million in investigative receivables.

The following are two examples of Strike Force cases:

- Michigan – Dr. Johnny Trotter, II and Elaine Lovett, owners of a medical billing company, were involved in a $26 million scheme to fraudulently bill Medicare for nerve block injections that were never provided. According to the evidence presented at trial, from May 2008 until May 2014, Trotter and Lovett knowingly submitted fraudulent claims for services that they knew had not been provided, mainly nerve block injections. Additionally, after Medicare imposed a requirement in 2009 that required Trotter's claims to undergo a medical review prior to payment, Trotter and Lovett conspired to circumvent Medicare's fraud investigation of Trotter by creating sham medical practices. To continue to receive payment for services that were not provided, Trotter and Lovett concealed their involvement in these practices from Medicare, and instead recruited their family members and employees to serve as straw owners of the companies. Trotter and Lovett were both found guilty of conspiracy and health care fraud. Trotter was sentenced to 15 years in prison, Lovett was sentenced to 10 years in prison, and they were both ordered to pay nearly $9.2 million in restitution, joint and several.

- Florida – Five co-conspirators were convicted of charges resulting from their involvement in a scheme to defraud Medicare. In all, they were sentenced to a combined 13 years and 7 months in prison, and ordered to pay $27.5 million in restitution, joint and several. The defendants—Antonio E. Alfonso-Ramos, Dayan Vina Guerra, Jose Ruiz-Dean, Jose Carlos Gonzalez, and Rosa Marbella Patino-Gonzalez—conspired to operate multiple fraudulent home health care agencies and a rehab facility. According to court documents, from about January 2010 through about May 2015, the defendants were involved in a scheme to recruit patients to receive unnecessary home health visits. Specifically, the defendants paid kickbacks and bribes to patient recruiters in exchange for the referrals of Medicare beneficiaries to serve as patients at the home health care agencies, which then billed Medicare for services that were not medically necessary, not provided, or both. The defendants also paid kickbacks and bribes for home health prescriptions and plans of care, which falsely represented that Medicare beneficiaries qualified for home health services when, in fact, they did not. Three defendants involved in the scheme were previously sentenced to a combined 13 years and 9 months in prison and ordered to pay $34.2 million in restitution, joint and several. One additional defendant is a fugitive in Cuba.

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 the Fraud section of DOJ's Criminal Division 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.

The following case is an example of Medicare fraud:

- Texas – Patricia Ann Thomas owned and operated group homes in the Houston, Texas area. Thomas engaged in a scheme to defraud Medicare by receiving kickbacks in exchange for referring her group home residents for home health services. Thomas pleaded guilty to making false statements to Federal agents and was sentenced to 6 months in prison.

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/.

The following is a case example involving a captured fugitive:

- One of OIG's Most Wanted Deadbeat Parents, Joseph Stroup, was captured during this reporting period. Joseph Stroup had been a fugitive for nearly 20 years—he owes more than $560,000 in child support. He was recently located in Calgary, Canada, based on a tip from a Canadian national who identified the fugitive on the OIG Child Support Enforcement website. Stroup, who had been living in Canada under an assumed identity, was detained by the Canadian Border Services Agency and transported to the United States on February 15, 2018. He is currently in U.S. custody and will stand trial for his child support violation. In August 1989, Stroup was ordered to pay child support for his four children in the amount of $100 per month. However, as a result of telling the court he was unemployed and medically disabled, his support was reduced to $14 per month. In 1996, the court learned that Stroup was operating a successful Internet business, which he ultimately sold for more than $2 million. The child support order was subsequently modified to account for the unreported income. From June 1996 to present, Stroup failed to pay any further child support. An arrest warrant was issued in July 1998.

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 whose failure to pay court-ordered child support for their children places unnecessary strain on the custodial parents and the children as well as on agencies that enforce these matters. The Human Services Reviews section of this Semiannual Report provides examples.

OIG Hotline

Part of OIG's Office of Investigations, the hotline is the public-facing division for OIG's intake and evaluation of fraud tips. The mission of the OIG Hotline is to support OIG's oversight responsibilities in safeguarding the integrity of all programs and personnel under HHS's purview and protecting them from fraud, waste, and abuse. The hotline achieves its mission through its staff's dedication to timely intake and analysis of information received from various sources, such as the "Report Fraud" link on the OIG website. During this semiannual reporting period, the OIG Hotline reported expected HHS recoveries of more than $2 million as a direct result of cases originating from hotline complaints.

OIG Hotline Activity (10/01/17–03/31/18)

Contacts to 1-800-HHS-TIPS phone line, including callers seeking information	53,969
Total tips evaluated	13,551
Closed; no basis provided for further action	178
Tips referred for action	6,979

Sources of Tips Referred for Action

Phone	2,830
OIG website	3,327
Letters/faxes	801
Other	21

State MFCUs

OIG Oversight of State MFCUs

MFCUs are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. OIG has oversight responsibility for MFCUs and administers grants that provide Federal funding for Unit operations. The Federal Government reimburses 75 percent of the costs of operating all existing Units, which are in 49 States and the District of Columbia. MFCUs investigate and prosecute Medicaid provider fraud and patient abuse and neglect in health care facilities or board and care facilities.

Medicaid Fraud Control Units Fiscal Year 2017 Annual Report (OEI-09-18-00180), March 2018

This annual report highlights statistics on the accomplishments of the 50 MFCUs during FY 2017. OIG found that the number of convictions in FY 2017 remained similar to those in recent years. Just over 45 percent of the 1,157 MFCU fraud convictions involved personal care services attendants. Fraud cases accounted for 76 percent of the MFCU convictions, while 24 percent involved patient abuse or neglect. MFCUs reported 961 civil settlements and judgments, 44 percent of which involved pharmaceutical manufacturers. MFCUs reported over $1.8 billion in criminal and civil recoveries.

In an appendix to the report, OIG summarizes beneficial practices by the MFCUs that were identified in onsite review reports published during FYs 2012–2017.

OIG Onsite Reviews of MFCUs

In addition to an annual recertification review of each MFCU, OIG conducts periodic reviews of a sample of MFCUs. OIG evaluates MFCU operations based on 12 performance standards and assesses compliance with laws, regulations, and OIG policy guidance. OIG may also make observations of Unit operations and practices, including identifying effective practices that may be useful to other Units. In addition, OIG provides training and technical assistance to Units while onsite and on an ongoing basis.

Medicaid Fraud Control Units: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services (OEI-12-17-00500), December 2017

MFCUs investigate and prosecute Medicaid provider fraud and patient abuse or neglect under State law. We conducted this study to provide data on MFCU investigations, indictments, and convictions involving fraud and patient abuse in Medicaid personal care services (PCS). We found that during the review period, PCS fraud cases were a substantial and growing percentage of MFCU cases and outcomes. In FY 2015, fraud cases involving PCS providers or attendants constituted 12 percent of total investigations. From FY 2012 through FY 2015, fraud cases involving PCS providers or attendants constituted 38 percent of indictments and 34 percent of convictions. We also found that during this time, indictments increased 56 percent and convictions increased 33 percent. We found that MFCUs have made recommendations to States for strengthening PCS oversight. Finally, we found that, in MFCUs' efforts to protect beneficiaries receiving PCS services, they are constrained by their ineligibility to receive Federal funding to investigate and prosecute complaints of beneficiary abuse or neglect in nonfacility settings (such as beneficiaries' homes). The findings suggest that PCS remain vulnerable to fraud and support the need for greater oversight of Medicaid PCS. CMS has made efforts in this area, but MFCUs report that States have generally not implemented the specific recommendations that MFCUs made to them for strengthening program integrity. The recommendations that MFCUs made to States align with recommendations that OIG has made previously to CMS and which OIG continues to support. In addition, to protect beneficiaries from abuse and neglect, it is key that Federal funding authority be expanded so that MFCUs can investigate and prosecute cases of patient abuse and neglect in nonfacility settings.

The following case is an example of OIG's joint efforts with MFCUs:

- North Carolina – Justin Daniel, pharmacist and owner of Old Main Pharmacy, directed a scheme to defraud Medicare and Medicaid. The investigation disclosed that from 2011 through 2015, Daniel

instructed his staff to make a compound pain cream using bulk Ketoprofen powder, which was not reimbursable, while he billed insurance programs as if the more expensive extended-release capsules, which are reimbursable, were used. Daniel requested and received payment for the fraudulent claims from Medicare and Medicaid. Daniel pleaded guilty to conspiracy to commit health care fraud and was sentenced to 12 months and 1 day in prison and ordered to pay $2.4 million in restitution.

Advisory Opinions and Other Industry Guidance

As part of OIG's continuing efforts to promote the highest level of ethical and lawful conduct by the health care industry, we issue advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. Advisory opinions, which are developed in consultation with DOJ, are issued to requesting parties regarding the interpretation and applicability of certain statutes relating to Federal health care programs. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), § 205, allows OIG to provide case-specific formal guidance on the application of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. During this semiannual reporting period, OIG received 27 requests for advisory opinions and issued 5 advisory opinions and no modifications of advisory opinions. OIG also issued one rescission of an advisory opinion.

Sanction Authorities and Other Administrative Actions

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

During this semiannual reporting period, OIG imposed 1,678 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries.

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

Program Exclusions

During this semiannual reporting period, OIG excluded 1,588 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, 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:

- Illinois – Gwen Hilsabeck was an administrator at Passages Hospice, LLC. According to court documents, from August 2009 to September 2009, Hilsabeck altered patient files to make visits that were at the routine level appear to have been general inpatient services. General inpatient services, which are reimbursed at a higher rate than routine care services, were not medically necessary and were not provided. Hilsabeck pleaded guilty to conspiracy to commit an offense against the United States and was sentenced to 2 years and 4 months in prison and ordered to pay $9.0 million in restitution, joint and several among other defendants. OIG excluded Hilsabeck for a minimum period of 30 years.

- Kentucky – Lonnie Hubbard was a pharmacist who owned RX Discount Pharmacy. According to evidence presented at trial, from January 2010 through December 2015, Hubbard sold prescription pain pills without a legitimate medical purpose and sold pseudoephedrine, knowing or having reason to believe that it was being used to manufacture methamphetamine. Many of Hubbard's customers visited pain clinics in other states to obtain illegitimate prescriptions from irreputable clinics. Hubbard would charge $600 to $1,000 to fill the prescriptions, which included excessive amounts of oxycodone. According to trial testimony, Hubbard also sold multiple boxes of pseudoephedrine at a time, for excessively high prices, to drug addicts and traffickers. A jury convicted Hubbard on 71 counts involving the illegal dispensing of oxycodone, hydrocodone, and pseudoephedrine, and sentenced him to 30 years in prison. OIG excluded Hubbard for a minimum period of 50 years.

Civil Monetary Penalties Law (CMPL)

The CMPL authorizes OIG to impose administrative penalties, assessments, and exclusions 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. The exclusions statute also authorizes OIG to exclude a person who violates the CMPL. During this semiannual reporting period, OIG concluded cases involving more than $35.5 million in CMPs and assessments.

Affirmative Litigation

The CMPL authorizes OIG to use its administrative remedies to affirmatively pursue cases. OIG may also exclude under the exclusions statute for engaging in conduct that violates the CMPL. When OIG excludes under the exclusions statute for engaging in conduct that violates the CMPL, it is known as an affirmative exclusion.

The following is an example of an affirmative litigation case under the CMPL:

- Virginia – Nathan Guerette, M.D. (Guerette) and his medical practice, The Female Pelvic Medicine Institute of Virginia, P.C. (FPMI), agreed to pay more than $1.4 million and enter into a 3-year CIA to resolve their potential liability under the CMPL for submitting claims to Federal health care programs for items or services that FPMI knew or should have known were not provided as claimed or were false or fraudulent. Specifically, OIG alleged that Guerette and FPMI submitted claims for pelvic floor therapy services that were provided by unqualified individuals; diagnostic

electromyography services under CPT Code 51784 that had not been performed pursuant to the indicated code's requirements; unbundled biofeedback procedures; and "incident to" services that lacked the required physician supervision level. OIG also alleged that Guerette and FPMI submitted claims for electromyography services under CPT Code 51784 and anorectal manometry services under CPT Codes 91120 and 91122 that were not supported by the medical record. This resolution resulted from OIG's collaboration with the Consolidated Data Analytics Center.

Patient Dumping

Some of the CMPL cases that OIG resolved during this semiannual reporting period were pursued under 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 case examples relate to the EMTALA statute:

- Massachusetts – Cambridge Health Alliance (CHA) agreed to pay $90,000 to resolve its potential liability under EMTALA. OIG alleged that CHA violated EMTALA when it failed to screen a patient after she presented on hospital property in medical distress. Specifically, OIG alleged that a patient who was experiencing a severe asthma attack presented to CHA's Somerville Hospital Campus, but was unable to gain entry to the ambulance bay doors. The patient called 911, which notified the hospital's responding nurse. OIG alleged that CHA was negligent in its search for the patient, looking only briefly outside without leaving the ambulance bay door or searching the sidewalk located just steps from the doors. The patient had collapsed on a bench adjacent to the ambulance doors. Ultimately, the 911 dispatchers sent emergency responders to the hospital who found the patient in full cardiac arrest and no longer breathing. The patient was brought inside the hospital in grave condition, and 6 days later died of hypoxic brain injury.

- Georgia – Piedmont Newton Hospital (PNH) agreed to pay $52,414 to resolve its potential liability under EMTALA. OIG alleged that PNH violated EMTALA when it failed to provide an appropriate medical screening exam and stabilizing treatment to a patient (TMK) and inappropriately transferred TMK to another hospital. Specifically, OIG alleged that TMK arrived at PNH complaining of left-sided pleuritic chest pain and abdominal pain. PNH's emergency department (ED) physician observed that her abdomen was diffusely firm with hypoactive bowel sounds, and ordered blood tests, which revealed that TMK's lactic acid and bleeding and clotting time were elevated beyond normal limits. The ED physician learned that TMK had undergone dilation and curettage two days earlier. The ED physician ordered an acute abdominal series with chest x-ray for TMK, which showed a large amount of intraperitoneal air under her right diaphragm, suggesting bowel perforation. The ED physician consulted with the on-call surgeon, who recommended transferring TMK to the other hospital where she previously underwent the dilation and curettage procedure. The other hospital agreed to accept the transfer and asked that TMK be airlifted to their facility. The ED physician's notes revealed that TMK had a perforated bowel and her condition was critical at the time of transfer. Upon her arrival at the other hospital, TMK was in septic shock and appeared on the verge of a respiratory collapse. She was immediately intubated and taken to the operating room for a resection and

colostomy. TMK's condition worsened and she died later that day due to septic shock with multi-organ failure.

Self-Disclosure Programs

Health care providers, suppliers, or other individuals or entities subject to CMPs can apply for acceptance into the Provider Self-Disclosure Protocol, a program created in 1998 for voluntary disclosure of self-discovered evidence of potential fraud. The self-disclosure program may give providers the opportunity to avoid costs or disruptions associated with Government-directed investigations and civil or administrative litigation.

Application processes for two additional self-disclosure programs were recently added to the OIG website for HHS contractors and grantees. The OIG contractor self-disclosure program provides contractors the opportunity to self-disclose when they have potentially violated the FCA or other Federal criminal laws prohibiting fraud, conflict of interest, bribery, or gratuity. This self-disclosure process is available only to those with a Federal Acquisition Regulation-based contract with HHS. The OIG Grant Self-Disclosure program is available for application by HHS grantees or HHS grant subrecipients and provides the opportunity for voluntary disclosure to OIG of potential fraud. OIG evaluates the reported results of each internal investigation under the provider self-disclosure protocol to determine the appropriate course of action. The self-disclosure guidelines are available on the OIG website at https://oig.hhs.gov/compliance/self-disclosure-info/index.asp. During this semiannual reporting period, provider self-disclosure cases resulted in more than $34.1 million in HHS receivables.

The following examples pertain to provider self-disclosure settlements:

- Florida – After self-disclosing conduct to OIG, Shands Jacksonville Medical Center, Inc. d/b/a UF Health Jacksonville and University of Florida Jacksonville Physicians, Inc. (collectively, Respondents), agreed to pay more than $4.4 million to resolve its liability under the CMPL. Specifically, OIG alleged that Respondents presented false claims to Medicare and Medicaid for hospital and professional services associated with surgical procedures performed by ophthalmologist Kakarla Venkata Chalam, M.D., Ph.D., at UF Health Jacksonville, from April 8, 2010, through April 7, 2016, when the record did not support medical necessity for the procedures performed.

- Maryland – After self-disclosing conduct to OIG, St. Agnes Healthcare, Inc. (St. Agnes), agreed to pay more than $2.2 million to resolve its liability under the CMPL. Specifically, OIG alleged that, from February 1, 2011, through July 1, 2017, St. Agnes paid a physician excessive compensation in the forms of an inflated salary and improper incentive and administrative payments to induce his referrals of Federal health care program patients.

CIAs

Many health care providers elect to settle their cases before litigation. As part of the settlements, providers often agree to enter into CIAs with OIG to avoid exclusions from Medicare, Medicaid, and other Federal health care programs. Under a CIA, a provider commits to establishing a program and taking other specified steps to ensure future compliance with Medicare and Medicaid rules. The compliance programs are designed, in part, to prevent future fraud. OIG monitors providers'

compliance with these agreements and may impose penalties on entities that fail to comply with the requirements of their CIAs.

The following is a CIA enforcement example:

- California – Chatsworth Park Health Care Center (Chatsworth), Palm Terrace Care Center (Palm Terrace), and Park Ridge Care Center (Park Ridge)—skilled nursing facilities (SNFs) affiliated with North American Health Care, Inc. (NAHC)—paid a total of $843,106.04 to resolve their CMPL liability for employing or contracting with individuals who were excluded from participation in Federal health care programs to provide items or services for which payment may be made under such programs. Specifically, the settlement agreements resolve allegations that (1) Chatsworth employed an excluded individual from May 1, 2014, through December 19, 2016; (2) Palm Terrace employed an excluded individual from January 24, 2006, through January 31, 2017; and (3) Park Ridge contracted with an excluded individual from May 20, 2012, through November 20, 2016. NAHC disclosed this conduct to OIG pursuant to its obligations under its CIA with OIG. NAHC entered into the CIA in 2016 in connection with its settlement of FCA liability based on the alleged provision of medically unnecessary rehabilitation therapy services provided to patients at SNFs that had service agreements with NAHC.

Suspension 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, have misused grant funds, or are otherwise not presently responsible. Because these are Government-wide sanctions, an individual or entity that has been suspended or debarred by HHS or any other agency is ineligible to participate in any future funding opportunities across the Federal Government for a specified period.

OIG refers individuals and entities that have potentially engaged in grant or contract fraud or misconduct to the HHS official 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 examples concern debarment of daycare providers:

- Florida – Jacqueline Johnson, through her employment at the Children's Home Society, engaged in a scheme to falsify and expedite applications to the Florida School Readiness Program. According to the investigation, Johnson helped family and friends receive subsidized daycare benefits they were not entitled to receive. The referral forms Johnson completed designated the children as "at-risk" and eligible to receive immediate placement ahead of families already on a waiting list for these services. Johnson entered into a plea agreement on five felony charges of uttering forged instruments and was subsequently debarred for a 3-year period based on an OIG referral to the Department.

- Illinois – Bishop Herman Jackson was the owner and pastor of the Ark of Safety Apostolic Faith Temple. He and his wife Jannette Faria operated three daycare centers from 2002 to 2011 and received childcare subsidies from ACF block grants. The investigation found that Jackson and Faria enrolled children who did not financially qualify to receive subsidized daycare services. Jackson and Faria also falsely represented the names and number of children attending the daycare centers, the number of days the children attended, and whether the children attended full- or part-time to obtain subsidy payments they were not entitled to receive. Jackson and Faria were found guilty of mail fraud, wire fraud, and making false statements and were debarred for a 3-year period based on an OIG referral to the Department.

Public Health Agencies

Public Health Agencies Reports and Reviews

CDC

Entities' Experiences and Perceptions of Reporting the Theft, Loss, or Release of Select Agents or Toxins to CDC (OEI-04-15-00432), February 2018

Congress and the media have devoted attention to several events at laboratories involving theft, loss, or release (TLR) events of select agents and toxins that have the potential to pose severe threats to public health, such as anthrax or smallpox. Entities that work with select agents and toxins must report TLR events to the Federal Select Agent Program (FSAP), which is jointly managed by CDC's Division of Select Agents and Toxins and the U.S. Department of Agriculture's Animal and Plant Health Inspection Service.

We found that all 21 entities in our review had been registered with FSAP for at least 6 years, and two-thirds of them had reported at least 1 TLR event to FSAP. The remaining one-third had never reported a TLR event; however, we found no evidence that any of the 21 entities were underreporting TLR events. In addition, we found that although entities are required to report TLR events to FSAP and they identified benefits to reporting TLR events, one-half of the entities in our review reported that obstacles to TLR events include a fear of negative consequences and a burdensome, restrictive reporting process. CDC may be able to better encourage reporting TLR events by addressing these obstacles, improving entities' training and guidance, and further fostering a culture of safety within FSAP that encourages such reporting.

The findings identify potential actions that the CDC could take to encourage the reporting of TLR events and to increase entities' compliance with FSAP. This report contains no recommendations but offers suggestions that CDC could consider in its ongoing efforts to improve oversight of FSAP. This is the second of three OIG reports on FSAP.

The Association for Public Health Laboratories Managed Global Health Security Agenda Funds in Accordance With Federal Requirements (A-04-17-02004), February 2018

The Association for Public Health Laboratories managed Global Health Security Agenda funds during the budget period July 1, 2015, through June 30, 2016, in accordance with Federal requirements. Accordingly, this report contained no recommendations.

President's Emergency Plan for AIDS Relief

The President's Emergency Plan for AIDS Relief (PEPFAR) was authorized to receive $48 billion in funding for the 5-year period beginning October 1, 2008, to assist foreign countries in combating HIV/AIDS, tuberculosis, and malaria. CDC awards PEPFAR funds to and works with ministries of health and other partners in 60 countries to combat HIV/AIDS globally. Additional funds were authorized to be appropriated through 2018.

During the semiannual reporting period, OIG issued one report related to PEPFAR funding:

Aurum Institute Generally Managed and Expended the President's Emergency Plan for AIDS Relief Funds in Accordance With Award Requirements (A-04-17-01003), March 2018

On the basis of our sample results, we concluded that Aurum Institute (Aurum) managed and expended PEPFAR funds in accordance with the award requirements. However, it did not always maintain segregation of duties among different personnel within the organization. Additionally, Aurum used a procurement-management system that did not allow it to record an invoice with multiple items as a single transaction to the general ledger. Finally, Aurum implemented corrective actions for all five recommendations from our previous audit.

The deficiencies we identified occurred because Aurum did not have the necessary financial staff to manage the extra duties and responsibilities that arose from its accelerated growth and because its procurement-management system had limited compatibility with its accounting system.

Aurum agreed with our recommendation that it continue to (1) implement segregation of duties among different key personnel and (2) upgrade its procurement and accounting systems to effectively track procurements.

FDA

Drug Supply Chain Security: Dispensers Received Most Tracing Information (OEI-05-16-00550), March 2018

Drug diversion, counterfeiting, and the importation of unapproved drugs may result in potentially dangerous drugs entering the drug supply chain, posing a threat to public health and safety. To enhance the security of this supply chain, the Drug Supply Chain Security Act (DSCSA) requires trading partners in the drug supply chain to create a record of each drug product transaction. The FDA can then use such records to investigate suspect and illegitimate drug products and potential diversion.

This study is the second in a series of examinations of drug supply chain security, each following the implementation of various DSCSA provisions. We found that all 40 selected dispensers received at least some drug product tracing information from their trading partners, and 26 of these dispensers received all required elements of this information. The remaining 14 dispensers were missing a few of the required elements. Two of these dispensers were unaware of DSCSA and requirements for drug product tracing. DSCSA requires that dispensers receive complete tracing information before accepting ownership of a drug product. Although dispensers are generally implementing these requirements, missing information and a lack of awareness of DSCSA requirements raise concerns that a complete tracing record for a drug product may not always be available to support investigations of suspect and illegitimate drug products in the supply chain.

To facilitate dispensers' compliance with DSCSA, we recommended that FDA offer educational outreach to dispensers where appropriate. Specifically, we recommended that FDA provide education to ensure

dispensers understand their responsibilities to receive complete drug product tracing information from trading partners before taking ownership. FDA concurred with our recommendation.

NIH

The National Institutes of Health Did Not Always Administer Superfund Appropriations During Fiscal Year 2015 in Accordance With Federal Requirements (A-04-16-04046), February 2018

During FY 2015, NIH did not always administer Superfund appropriations in accordance with applicable Federal requirements. NIH generally obligated and disbursed Superfund appropriations. However, NIH did not (1) always ensure that Superfund grantees complied with grant terms and conditions, (2) properly record Superfund grant disbursements in NIH's accounting system, and (3) always resolve audit findings contained in grantee audit reports.

NIH concurred with our recommendations that it formalize procedures for identifying and resolving improper account balances in NIH's accounting system and that it update guidance to require reconciliations between NIH's database for tracking audit reports and audit report information that the National External Audit Review Center generates. NIH did not concur with our recommendations that it issue new or updated guidance related to grant monitoring or that it provide additional training to grants management personnel.

Legal Actions and Investigations Related to Public Health Agencies

Health Education Assistance Loan Program

OIG excludes from Federal health care programs individuals who have defaulted on Health Education Assistance Loan (HEAL) loans. Under the HEAL program, which stopped making loans in 1998, HRSA guaranteed commercial loans to students seeking education in health-related fields. The students can 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 debt. After the PSC has exhausted efforts to secure repayment of a debt, it declares an individual in default. The Social Security Act prevents individuals in default on their HEAL loans from receiving reimbursement under Medicare, Medicaid, and all other Federal health care programs.

HEAL Exclusions

During this semiannual reporting period, 28 individuals and related entities were excluded because of a PSC referral of their cases to OIG. Individuals who have been excluded because of default may enter into settlement agreements whereby the exclusions are stayed while they pay specified amounts each month to satisfy their debts. If they default on these settlement agreements, they may be excluded until the entire debt is repaid, and they may not appeal the exclusions.

After being excluded for nonpayment of their HEAL debts, 2,728 individuals chose to enter into settlement agreements or completely repay their debts. That figure includes 46 individuals who entered into such settlement agreements or completely repaid their debts during this semiannual reporting period. More than $215 million is being repaid through settlement agreements or through

complete repayment. Of that amount, more than $3.7 million is attributable to this semiannual reporting period.

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

- New York –Richard Maretzo, Jr., dentist - $412,929
- Florida – Ana Maria Rodriguez, dentist - $205,468

Human Services Agencies Reviews and Enforcement Activities

ACF

The Administration for Children and Families Region II Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements (A-02-16-02009), February 2018,
The Administration for Children and Families Region X Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements (A-09-16-01004), December 2017
The Administration for Children and Families Did Not Always Resolve American Indian and Alaska Native Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements (A-06-17-07003), December 2017

Head Start grantees are required to have single audits conducted in accordance with Office of Management and Budget Circular A-133 (also known as A-133 audits) for fiscal years beginning before December 26, 2014. For Region II, Region X, and American Indian and Alaska Native Head Start grantees that submitted audit reports to the Federal Audit Clearinghouse, ACF did not always resolve recurring audit findings in accordance with Federal requirements and ACF policies and procedures. ACF did not issue letters transmitting management decisions within 6 months after receiving the reports, did not establish specific dates for grantees to correct deficiencies noted in the audit reports, or did not always follow up with grantees to ensure that they took corrective actions to resolve audit findings.

ACF partly agreed and partly disagreed with our recommendations to (1) review its staffing levels to ensure that the audit resolution process is conducted in accordance with Federal requirements, including the requirement to issue management decisions to grantees within 6 months; (2) provide training to Head Start grantees on implementing corrective action plans; (3) include in the letters sent to Head Start grantees specific dates for correcting deficiencies; and (4) monitor Head Start grantees to ensure they actually implement corrective actions.

BCFS Health and Human Services Did Not Always Comply With Federal Requirements Related to Less-Than-Arm's-Length Leases (A-06-16-07007), January 2018

While BCFS Health and Human Services (BCFS HHS) generally claimed only allowable expenditures, it did not comply with Federal regulations related to less-than-arm's-length leases. A less-than-arms-length lease is one under which one party to the lease agreement can control or substantially influence the actions of the other. Of the 140 randomly selected transactions we reviewed, we determined that

138 were allowable, but 2 rental cost transactions for 1 less-than-arm's-length lease were unallowable. We also identified additional rental costs on two less-than-arm's-length leases that exceeded the amount allowable for such leases. These unallowable rental costs on three less-than-arm's-length leases totaled $658,248. According to BCFS HHS officials, they were unaware of the limitations on rental costs related to less-than-arm's-length lease agreements.

BCFS HHS did not concur with our recommendation that it refund $658,248 to the ACF Office of Refugee Resettlement (ORR) for unallowable rental costs incurred under the less-than-arm's-length lease agreements and limit future rental costs to the amount that would be allowed under 45 CFR part 75.465(c).

Office of Refugee Resettlement Unaccompanied Alien Children Grantee Review—His House (A-04-16-03566), December 2017

His House Children's Home, Inc. (His House), an Unaccompanied Alien Children (UAC) grantee responsible for caring for children in ORR custody, met safety standards for the care and release of children in its custody. However, some UAC case files were missing evidence of sponsor background checks and other required documentation. While His House claimed only allowable expenditures, we identified areas in which His House lacked an efficient and effective system of internal controls when administering UAC program funds.

As a result, His House (1) might not have followed ORR policies for 652 children regarding sponsor background checks, prompt medical care, provision of appropriate clothing, sponsor placement decisions, postrelease services, or the notification of the Department of Homeland Security of the child's release to a sponsor; and (2) might have placed Federal funds totaling $9 million at risk of mismanagement or misappropriation.

His House did not agree with our findings; however, it concurred with our recommendations that it (1) develop a policy for maintaining UAC case file documentation that would ensure ORR policies and procedures were followed when releasing a child to a sponsor; (2) increase oversight of its reviewing process for UAC case files to ensure that all required documentation is maintained in the file; and (3) implement a financial management system that requires adequate identification of the source and application of Federal funds and effective accountability of property and other assets. We also made procedural recommendations aimed at addressing internal control deficiencies we identified, with which His House also concurred.

Pine Bluff Jefferson County Economic Opportunities Commission Did Not Always Operate Its Head Start Program in Accordance With Federal Requirements (A-06-16-00013), December 2017

Pine Bluff Jefferson County Economic Opportunities Commission (Pine Bluff) did not always claim Head Start grant costs that were allowable and allocable in accordance with Federal regulations. Specifically, Pine Bluff claimed $392,094 of unsupported non-Federal share, $214,372 in costs that did not meet procurement-related requirements, and $123,158 in costs that either did not or may not have benefited

the Head Start program. In addition, Pine Bluff did not always manage the Head Start program in accordance with Federal requirements.

Pine Bluff partly agreed with our findings and associated recommendations that it work with ACF's Office of Head Start to determine and refund the amount of grant funds for which Pine Bluff would not have been eligible because of the $392,094 of unsupported non-Federal share; refund $214,372 for procurement-related costs that that did not meet requirements; and refund costs that did not benefit the Head Start program and work with the Office of Head Start to determine what portion of costs allocated to the Head Start program should be allocated to its other programs. We also made policy and procedural recommendations for Pine Bluff to account for and manage Federal funds and to operate its Head Start program in accordance with Federal regulations. For the findings and recommendations with which Pine Bluff did concur, it provided information on corrective actions it has taken our plans to address them.

Not All of Missouri's Child Care Subsidy Program Payments Complied With Federal and State Requirements (A-07-15-04226), November 2017

Missouri did not always comply with Federal and State requirements when making payments under its Child Care subsidy program for State FYs 2014 and 2015. Client attendance records were not adequately documented, and Missouri did not exercise sufficient oversight over its Child Care Subsidy program. On the basis of our sample results, we estimated that at least $19.1 million (Federal share) of the Child Care Subsidy program payments that Missouri made did not comply with Federal and State requirements.

Missouri partly agreed and partly disagreed with our recommendations that it refund the estimated $19.1 million (Federal share) of Child Care Subsidy program payments to the Federal Government, strengthen its controls and oversight activities to ensure that providers maintain required attendance documentation to support the childcare payment amounts that they claim for reimbursement, and develop policies and procedures to ensure that it obtains attendance records from providers that are no longer in business.

Southeast Arkansas Community Action Corporation Did Not Always Operate Its Head Start Program in Accordance With Federal Regulations (A-06-16-00015), October 2017

Southeast Arkansas Community Action Corporation (Southeast) did not always operate its Head Start program in accordance with Federal regulations and did not always manage and account for Federal funds. Specifically, Southeast (1) had ineffective controls and accountability over its assets, (2) used questionable methods to allocate shared costs, (3) did not have required fiscal or legal expertise on its governing board, and (4) claimed some unallowable costs.

Southeast generally concurred with our recommendations that it (1) conduct a full physical inventory to ensure inventory asset records are accurate and complete, follow its existing purchasing policy to submit a purchase requisition one week in advance, and expand its purchasing policies to include review procedures for credit card purchases and consequences for unauthorized purchases; (2) work with the Office of Head Start to ensure shared costs claimed during our audit period are allocated

correctly; (3) elect members to the board of directors who have legal and financial expertise or hire a consultant or another individual with relevant expertise; and (4) refund $4,784 in unallowable costs. We also made other procedural recommendations.

Safety of Children in Foster Care

Some Massachusetts Group Homes for Children in Foster Care Did Not Always Comply With State Health and Safety Requirements (A-01-16-02500), December 2017

Some Ohio Group Homes Did Not Always Comply With Foster Care Health and Safety Requirements (A-05-16-00049), February 2018

Some Washington State Group-Care Facilities for Children in Foster Care Did Not Always Comply With State Health and Safety Requirements (A-09-16-01006), March 2018

Although Massachusetts and Ohio conducted the required inspections at all 30 of the group homes we reviewed in each State, and Washington performed required onsite monitoring at all 20 of the group homes we reviewed, this monitoring did not ensure that the group homes that received funds under Title IV-E of the Act complied with State requirements related to the health and safety of children in foster care. In Massachusetts, 27 group homes did not comply with 1 or more State requirements; in Ohio, 19 of the 30 homes we reviewed did not comply with 1 or more requirements; and in Washington, none of the 20 homes we reviewed complied with 1 or more requirements.

Ohio "was in accordance" with our recommendations that it (1) ensure that all instances of noncompliance are documented and corrected; (2) ensure that the group homes adhere to all requirements for the health and safety of children by continuing onsite visits; and (3) ensure that group homes obtain the required criminal record checks for all employees who provide direct care to children. It concurred with our fourth recommendation – to consider additional outreach programs for the group homes, such as training and technical assistance in the areas identified as noncompliant.

Massachusetts concurred with our recommendations that it (1) work with the State licensing agency to correct all instances of noncompliance; (2) increase the frequency of announced visits and consider including unannounced visits as part of its monitoring system; and (3) work with the State licensing agency to ensure that all group home employees who have the potential for unsupervised contact with children receive all of the required background record checks within a specific and reasonable timeframe. It said it would take under consideration our recommendation to consider adding a requirement in future contracts that the group homes conduct repairs and general upkeep within a specified timeframe.

Washington concurred with our recommendations that it (1) ensure that all instances of noncompliance that we identified are documented and corrected; (2) conduct unannounced visits for health and safety reviews of group care facilities; (3) ensure that regional licensors perform and document a site inspection during each health and safety visit at a group care facility; (4) ensure that regional licensors and group care facilities have adequate training and guidance on the best practices for administering

medications and maintaining related documentation; (5) provide regional licensors and group care facilities with adequate guidance and supervision regarding background check requirements; (6) ensure that the handbook *Minimum Licensing Requirements for Group Care Facilities* is updated with the latest background check requirements; and (7) consider requiring FBI fingerprint-based background checks for all group care facility employees, seeking additional legislative authority as needed.

Oklahoma Did Not Always Comply With Requirements for Providing Health Care Services to Children in Foster Care (A-06-16-07006), February 2018

Oklahoma did not always ensure that there was documentation in the case files of Title IV-E eligible children supporting that they had received required health care services designed to protect their health and safety. We found that 17 of the 70 case files we reviewed did not contain evidence to support that required health care services were provided. For 7 of the 17 children whose case files lacked documentation, there were Medicaid claims in the MMIS to support that all required health services had been provided. However, for 10 of these children, there was no Medicaid claim to support that dental care was provided during the year.

Oklahoma did not follow its policies and procedures to ensure there was evidence in Title IV-E case files to support that all required health care services were provided to Title IV-E children in foster care. Nor were there Medicaid claims in the State's MMIS to support that all children whose case files lacked documentation received the required services. These documentation failures demonstrate that Title IV-E eligible children in foster care may not be receiving required health care services.

Oklahoma agreed with our recommendation that it follow its policies and procedures to ensure that Title IV-E eligible children in foster care receive required health care services and that the visits are documented in the children's case files.

HRSA

Henry J. Austin Health Center, Inc., a Health Resources and Services Administration Grantee, Did Not Comply With Federal Grant Requirements (A-02-17-02002), February 2018

HRSA awarded Henry J. Austin Health Center, Inc. (HJAHC), a not-for-profit organization, $8.3 million in grant funds through several Community Health Center Program grants to provide comprehensive primary care services in the Trenton, New Jersey, area.

HJAHC did not comply with Federal requirements related to its Community Health Center Program grants. Specifically, HJAHC did not track and account for grant expenditures separately from other Federal and non-Federal operating expenses, did not reconcile actual grant expenditures to its approved budgeted amounts used to draw down Federal funds, and did not maintain documentation that supported grant expenditures for certain activities. As a result, we could not determine whether $8 million in costs claimed by HJAHC for certain Community Health Center Program grants were allowable. In addition, HJAHC claimed costs totaling $243,000 for certain activities that were unallowable.

HRSA concurred with our recommendations that it (1) require HJAHC to refund $8 million to the Federal Government or work with HJAHC to determine what portion of these costs claimed to the Community Health Center Program grants were allowable; and (2) require HJAHC to refund $243,000 to the Federal Government for unallowable costs. We also made procedural recommendations.

HRSA Complied With Federal and HHS Grant Policies When Awarding Zika Response and Preparedness Appropriations Act Funds During Fiscal Year 2017 (A-04-17-02003), October 2017

We reviewed all 30 grants that HRSA awarded from October 1, 2016, through March 15, 2017, for Zika response activities. For these 30 grants, HRSA awarded Zika Act funds in compliance with applicable Federal and HHS grant policies. Accordingly, this briefing report contained no recommendations.

Child Support Enforcement Activities

OIG Investigations

OIG investigates noncustodial parents who violate 18 U.S.C. § 228 by failing to pay court-ordered child support. OIG works with ACF's Office of Child Support Enforcement; DOJ; U.S. Attorneys' offices; the U.S. Marshals Service; and Federal, State, and local partners to address egregious child support enforcement cases with appropriate law enforcement and prosecutorial action. During this semiannual reporting period, OIG investigations of child support enforcement cases nation-wide resulted in 10 criminal actions and court-ordered restitution and settlements of $595,294.

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

- North Dakota – In August 2001, Jay Harding was ordered to pay $385 per month for the support of his two children. This amount of ordered support was later raised to $822 in 2005. Harding only occasionally made payments to the custodial parent of his children, and last made a payment in 2013. Harding was sentenced to 1 year of probation and ordered to pay restitution of $195,311.02 after pleading guilty to failure to pay child support.

Engaging the Public in Capturing Deadbeat Parents

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

Other HHS-Related Reviews and Investigations

Grants and Contracts

HHS is the largest grant-making organization and one of the largest contracting agencies in the Federal Government. In FY 2017, HHS awarded more than $481 billion in grants and over $24 billion in contracts across all program areas. OIG's direct annual discretionary appropriation funding is used to conduct program integrity and enforcement activities for the more than 100 public health and human services programs carried out by more than 70,000 employees around the world. The size and scope of departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public.

Reviews

The following is a case example related to misuse of grant funds:

- Montana – Former Rocky Boy Health Board (RBHB) interim Chief Financial Officer (CFO) Kathy Sutherland devised a scheme to defraud the RBHB clinic, a health care benefit program that provides a variety of medical services to residents of the Chippewa Cree Tribal community. The RBHB receives Federal funding to operate the clinic, including IHS self-governance compact funds. In her roles as cash and grants manager and interim CFO, Sutherland was responsible for administering RBHB's employee loan program. From approximately November 2005 until May 2015, Sutherland fraudulently disbursed over $111,902 in loans from the RBHB to herself without the necessary approvals. Sutherland pleaded guilty to wire fraud and was sentenced to a prison term of 12 months and 1 day and ordered to pay restitution of $111,902.

The following is a case example related to misuse of contract funds:

- Georgia – Juan Carlos Bazantes and Cesar Arbelaez Tabares owned and operated IWES Contractors, Inc., a drywall labor supply company in Norcross, Georgia. The investigation disclosed that from January 2012 through April 2013, Bazantes and Tabares conspired to mislead Government construction project managers at the CDC by submitting false payroll certifications. Bazantes and Tabares falsely certified to the CDC that they were collecting Federal employment taxes from their workers when in fact no such taxes were being collected. To carry out their scheme, Bazantes and Tabares kept two sets of books. One set falsely certified to the Government that taxes were being withheld from the workers' pay, and another accurately reflected that the workers' pay was not being taxed. This scheme left the workers responsible for the entire tax liability. A jury found Bazantes and Tabares guilty of making false statements and conspiracy to defraud the United States. Bazantes and Tabares were each sentenced to 8 years in prison and ordered to pay $75,000 in fines.

Small Business Innovation Research Program

The National Defense Authorization Act for Fiscal Year 2012, § 5143, requires OIG to report annually on the number of cases referred to OIG to fraud, waste, or abuse in the Small Business Innovation 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 November 2017 report delivered to the three congressional oversight committees, we reported that OIG spent approximately $446,016 in salaries on oversight related to the SBIR/STTR program. In FY 2017, six new SBIR/STTR cases were referred to OIG.

Recovery Act Retaliation Complaint Investigations

The Recovery Act, § 1553, prohibits non-Federal employers that have received Recovery Act funding from retaliating against employees who disclose evidence of mismanagement of Recovery Act funds or any violation of law related to Recovery Act funds. OIGs are required to include in their Semiannual Report the retaliation complaint investigations that they decided not to conduct or continue during the reporting period. During this semiannual reporting period, OIG closed one investigation, in which no instances of whistleblower retaliation were identified.

Contract Audits

Pursuant to the National Defense Authorization Act for FY 2008, § 845, OIGs appointed under the Inspector General Act of 1978 (IG Act) are required to submit, as part of their semiannual report, pursuant to section 5 of the IG Act, information on final "completed contract audit reports issued to the contracting activity during the period." This information must contain significant audit findings. OIG issued no final reports meeting § 845 criteria during this semiannual period.

OIG Reviews of Non-Federal Audits

OIG reviews audits conducted by non-Federal auditors of entities receiving Federal awards. During this semiannual reporting period, OIG's National External Audit Review Center reviewed 882 reports covering $658.6 billion in audited costs. Federal dollars covered by these audits totaled $121.4 billion, of which about $66.2 billion were HHS funds.

The regulation at 45 CFR, subpart F, establishes audit requirements for certain State and local governments, colleges and universities, and nonprofit organizations receiving HHS awards. Entities subject to part 75's single-audit requirements must conduct annual organization-wide single audits. 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.

The following table categorizes OIG's reports on non-Federal audits reviewed during this reporting period:

Non-Federal Audits, October 1, 2017, through March 31, 2018

Number of Non-Federal Audits	
Not requiring changes or having minor changes	830
Requiring major changes	51
Having significant technical inadequacies	1
Total	882

The 882 reports included 1,657 recommendations for improving management operations. In addition, these audit reports provided information for 26 OIG special memorandums that identified concerns for increased monitoring by management.

Other Reporting Requirements and Reviews

Legislative and Regulatory Reviews

Pursuant to the IG 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 Unimplemented Recommendations* describes priority findings and recommendations from past periods that remain to be implemented.
- Our *Work Plan* provides citations to laws and regulations that are the subject of ongoing or future reviews.

We also review proposed legislation and regulations related to HHS programs and operations. HHS routinely involves OIG and HHS OPDIVs and other STAFFDIVs 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.

Health Insurance Marketplaces

Key focus areas for our oversight of the health insurance marketplaces include payment accuracy, eligibility, management and administration, and security. In developing our work plan, we coordinate with GAO and other Federal and State oversight agencies.

New York Did Not Comply With Federal Grant Requirements for Allocating and Claiming Marketplace Contract Costs (A-02-15-02008), December 2017

New York did not always follow Federal requirements for allocating and claiming contract costs to its grants for establishing New York's marketplace customer service center. Specifically, New York may have misallocated costs totaling nearly $19.6 million and claimed unallowable profit fees and other costs totaling nearly $3.8 million.

This occurred because New York did not have written policies that explained how to properly allocate costs when it developed its original cost allocation plan. Further, New York did not establish a basis for the profit fee rate with its contractor, Maximus, Inc., at the beginning of the contract; did not require Maximus to always use its final cost rate for general and administrative costs; and did not require Maximus to retroactively adjust the calculation of its profit fee and general and administrative costs by removing project costs that should not have been subject to these charges.

New York generally disagreed with our recommendations that it (1) refund to CMS $19.6 million that may have been misallocated to the establishment grants or work with CMS to determine the appropriate allocation to the grants; (2) refund to CMS $797,096 in unallowable profit fees or work with CMS to determine the appropriate amount that should have been claimed to the grants; (3) refund to CMS $32,083 in unallowable general and administrative costs and related profit fees; and (4) work with CMS to ensure that Maximus contract costs claimed after our audit period are properly allocated.

Review of The Department of Health and Human Services (HHS) Cancellation of Marketplace Enrollment Outreach Efforts (OEI-12-17-00290), October 2017

In response to a congressional request, the OIG conducted a descriptive, fact-finding review of HHS's cancellation of certain Marketplace enrollment outreach activities (outreach activities) before the January 31st end of the fourth open enrollment period.

OIG determined that HHS canceled and then reinstated certain outreach activities on January 26 and 27, 2017. An official on the HHS Beachhead team orally instructed HHS officials to cancel Marketplace outreach, and that same official later provided updated instructions about which outreach should remain canceled and which should resume. However, we were unable to determine conclusively whether that individual made the decision to cancel outreach or merely conveyed the decisions made by someone else. In addition, HHS officials conducted a preliminary assessment of costs and savings associated with canceling certain outreach activities, but reported that they did not perform any analyses of the impact that canceling outreach activities would have on Marketplace enrollment.

Information Security

These summaries do not include details of the vulnerabilities that we identified because of the sensitive nature of the information.

Summary Report for Fiscal Year 2016 OIG Penetration Testing of Four HHS Operating Division Networks (A-18-17-08500), December 2017

We conducted a series of OIG audits at four HHS OPDIVs using network and web application penetration testing to determine how well HHS systems were protected when subject to cyberattacks.

Security controls across the four HHS OPDIVs needed improvement to more effectively detect and prevent certain cyberattacks. During testing, we identified configuration management and access control vulnerabilities.

We shared with senior-level information technology personnel the common root causes for the vulnerabilities we identified across the OPDIVs we tested. We provided actionable information regarding HHS's cybersecurity posture, information on common vulnerabilities, recommendations and strategies to mitigate exploited weaknesses, key indicators to better identify signs of attack or compromise, and lessons learned during testing.

The four HHS OPDIVs that were part of the penetration testing generally concurred with our summary findings and conveyed that the vulnerabilities identified were corrected or were in the process of being corrected.

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 IG 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

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

Table 1

			Dollar Value Unsupported
Section 1			
Reports for which no management decisions had been made by the beginning of the reporting period[1]	156	$547,757,000	18,792,000
Reports issued during the reporting period	39	$680,031,000	20,007,000
Total Section 1	**195**	**$1,227,788,000**	**$38,799,000**
Section 2			
Reports for which management decisions were made during the reporting period[2, 3]			
Disallowed Cost*	108	$187,519,000	$0
Costs not disallowed	22	$57,524,000	$14,000
Total Section 2	**130**	**$245,043,000**	**$14,000**
*Audit receivables (expected recoveries)			
Section 3			
Reports for which no management decisions had been made by the end of the reporting period[2] (*Section 1 minus Section 2*)	65	$982,745,000	$38,785,000
Section 4			
Reports for which no management decisions were made within 6 months of issuance[4]	37	$361,725,000	$18,778,000

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 acted 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 act on these audit recommendations.

Table 2

	Reports	Dollar Value
Section 1		
Reports for which no management decisions had been made by the beginning of the reporting period[1]	9	$17,760,976,000
Reports issued during the reporting period	3	$156,476,000
Total Section 1	**12**	**$17,917,452,000**
Section 2		
Reports for which management decisions were made during the reporting period		
Value of recommendations agreed to by management		
Based on proposed management action	4	$1,456,581,000
Based on proposed legislative action	0	0
Value of recommendations not agreed to by management	0	0
Total Section 2	**4**	**$1,456,581,000**
Section 3		
Reports for which no management decisions had been made by the end of the reporting period[2] (*Section 1 minus Section 2*)	8	$16,460,871,000

Notes to Table 1

[1] The opening balance was adjusted upward by $36.2 million because of a reevaluation of previously issued recommendations.

[2] Revisions to previously reported management decisions:

- *Hoveround Corporation Claimed Millions in Federal Reimbursement for Power Mobility Devices that Did Not Meet Medicare Requirements* (A-05-12-00057), December 2015. A settlement agreement between CMS and Hoveround reduced overpayment cost of $14,731,534 to $2,000,000. As a result, disallowed cost was reduced by $12,731,554.
- *Review of Practitioner Compliance with the Requirements of the Hurricane Katrina Health-Care-Related Professional Workforce Supply Grant for the Greater New Orleans Area* (A-06-09-00051), July 2011. Subsequent review by CMS and the State determined that $8,317,791 of $13,629,287 in questioned cost, would be returned to the Federal Government. Disallowed cost was reduced by $5,311,496.
- *Florida Did Not Suspend Medicaid Payments to Some Providers that had Credible Fraud Allegation Cases in Accordance With the Social Security Act* (A-04-14-07046), April 2017. CMS and DOJ's subsequent review of supporting documentation resulted in a settlement agreement with the State, reducing disallowed cost from $8,056,973 to $2,783,523. Resulted in the reduction of disallowed cost by $5,273,450.
- *Florida Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Death* (A-04-15-06182), November 2016. State identified additional overpayment in subsequent review and refunded $4,984,642 to the Federal Government.
- Not detailed are reductions to previously disallowed management decisions totaling $8.9 million.

[3] Included are management decisions to disallow $20.3 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 Office of Management and Budget Circular A-133. OIG is currently ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

[4] Because of administrative delays, some of which were beyond management control, resolution of the following 37 audits was not completed within 6 months of issuance of the reports; however, agency management has informed us that the agency is working to resolve the outstanding recommendations before the end of the next semiannual reporting period:

CIN: A-02-14-02017	NEW YORK MISALLOCATED COSTS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE, NOV 2016, $149,654,512
CIN: A-09-16-02026	MEDICARE INAPPROPRIATELY PAID ACUTE-CARE HOSPITALS FOR OUTPATIENT SERVICES THEY PROVIDED TO BENEFICIARIES WHO WERE INPATIENTS OF OTHER FACILITIES, SEP 2017, $51,640,728
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY MEDICAID SCHOOL-BASED CHILD HEALTH PROGRAM COSTS CLAIMED BY THE CONNECTICUT DEPARTMENT OF SOCIAL SERVICES, JULY 1997 THROUGH JUNE 2001, MAY 2003, $32,780,146
CIN: A-01-14-02503	MARYLAND MISALLOCATED MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE, MAR 2015, $28,400,000

CIN: A-07-13-01125	MEDICARE IMPROPERLY PAID MEDICARE ADVANTAGE ORGANIZATIONS MILLIONS OF DOLLARS FOR UNLAWFULLY PRESENT BENEFICIARIES FOR 2010 THROUGH 2012, APR 2014, $26,150,043
CIN: A-04-14-07050	KENTUCKY MISALLOCATED MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE, FEB 2017, $25,530,429
CIN: A-01-15-02500	VERMONT DID NOT PROPERLY ALLOCATE MILLIONS TO ESTABLISHMENT GRANTS FOR A HEALTH INSURANCE MARKETPLACE, SEP 2016, $11,243,006
CIN: A-02-14-02024	NEWARK PRESCHOOL COUNCIL, INC., DID NOT ALWAYS COMPLY WITH HEAD START REQUIREMENTS, FEB 2017, $9,950,556
CIN: A-02-12-02012	NEW YORK IMPROPERLY CLAIMED SOME CHILD CARE AND DEVELOPMENT TARGETED FUNDS, JUL 2015, $3,827,836
CIN: A-02-14-02012	VISITING NURSE SERVICE OF NEW YORK BUDGETED COSTS THAT WERE NOT APPROPRIATE AND CLAIMED SOME UNALLOWABLE HURRICANE SANDY DISASTER RELIEF ACT FUNDS, NOV 2016, $3,771,672
CIN: A-05-13-00014	OHIO EXCEEDED THE 5-PERCENT LIMIT FOR CLAIMING CHILD CARE DEVELOPMENT FUND ADMINISTRATIVE EXPENDITURES, NOV 2013, $3,164,630
CIN: A-05-14-00047	MEDICARE PAID HUNDREDS OF MILLIONS IN ELECTRONIC HEALTH RECORD INCENTIVE PAYMENTS THAT DID NOT COMPLY WITH FEDERAL REQUIREMENTS, JUN 2017, $2,635,902
CIN: A-05-15-00026	MINNESOTA DID NOT ALWAYS COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR CLAIMS SUBMITTED FOR THE NONEMERGENCY MEDICAL TRANSPORTATION PROGRAM, SEP 2017, $1,871,457
CIN: A-07-11-06013	THE UNIVERSITY OF COLORADO DENVER DID NOT ALWAYS CLAIM SELECTED COSTS CHARGED DIRECTLY TO DEPARTMENT OF HEALTH AND HUMAN SERVICES AWARDS IN ACCORDANCE WITH FEDERAL REGULATIONS, JUN 2013, $1,419,524
CIN: A-05-14-00045	THE MINNESOTA MARKETPLACE MISALLOCATED FEDERAL FUNDS AND CLAIMED UNALLOWABLE COSTS, NOV 2016, $1,279,677
CIN: A-07-16-04230	THE THREE AFFILIATED TRIBES IMPROPERLY ADMINISTERED LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM FUNDS FOR FYS 2010 THROUGH 2014, JUL 2017, $1,221,425
CIN: A-05-12-00089	THE COUNCIL ON RURAL SERVICE PROGRAMS, INC., CLAIMED UNALLOWABLE HEAD START COSTS, NOV 2013, $1,074,352

CIN: A-09-14-01007	NEVADA MISALLOCATED COSTS FOR ESTABLISHING A HEALTH INSURANCE MARKETPLACE TO ITS ESTABLISHMENT GRANTS, FEB 2016, $893,464
CIN: A-04-15-04040	MEDICAL ACCESS UGANDA LIMITED GENERALLY MANAGED THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS IN ACCORDANCE WITH AWARD REQUIREMENTS, JUN 2016, $751,399
CIN: A-02-15-02009	ECONOMIC OPPORTUNITY COMMISSION OF NASSAU COUNTY, INC., CLAIMED SOME UNALLOWABLE HURRICANE SANDY DISASTER RELIEF ACT FUNDS, APR 2017, $614,278
CIN: A-07-16-04233	THE TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS IMPROPERLY ADMINISTERED SOME LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM FUNDS FOR FISCAL YEARS 2010 THROUGH 2013, SEP 2017, $587,248
CIN: A-09-11-01007	HAWAII CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS FOR HONOLULU COMMUNITY ACTION PROGRAM, INC.'S EXPENDITURES UNDER THE RECOVERY ACT, FEB 2013, $513,649
CIN: A-04-16-04044	THE MINISTRY OF HEALTH AND SOCIAL WELFARE NATIONAL AIDS CONTROL PROGRAM DID NOT ALWAYS MANAGE AND EXPEND PEPFAR FUNDS IN ACCORDANCE WITH AWARD REQUIREMENTS, AUG 2017, $495,379
CIN: A-04-13-01024	THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL DID NOT ALWAYS CLAIM SELECTED COSTS CHARGED DIRECTLY TO DEPARTMENT OF HEALTH AND HUMAN SERVICES AWARDS IN ACCORDANCE WITH FEDERAL REQUIREMENTS, JUN 2014, $352,843
CIN: A-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-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW OF CTE, INC., MAY 2011, $239,975
CIN: A-04-15-04039	MILDMAY UGANDA DID NOT ALWAYS MANAGE THE PRESIDENT’S EMERGENCY PLAN FOR AIDS RELIEF FUNDS IN ACCORDANCE WITH AWARD REQUIREMENTS, MAR 2017, $209,480
CIN: A-05-12-00012	ROCKFORD HUMAN SERVICES DID NOT ALWAYS CHARGE ALLOWABLE COSTS TO THE COMMUNITY SERVICES BLOCK GRANT – RECOVERY ACT PROGRAM, JUL 2013, $205,296

CIN: A-04-16-04045	MANAGEMENT AND DEVELOPMENT FOR HEALTH DID NOT ALWAYS MANAGE THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF FUNDS IN ACCORDANCE WITH AWARD REQUIREMENTS, JUN 2017, $180,820
CIN: A-04-11-01004	NORTHEAST FLORIDA COMMUNITY ACTION AGENCY, INC., DID NOT ALWAYS CHARGE ALLOWABLE COSTS TO THE COMMUNITY SERVICES BLOCK GRANT – RECOVERY ACT PROGRAM, SEP 2012, $165,795
CIN: A-04-11-01008	CENTRAL FLORIDA COMMUNITY ACTION AGENCY, INC., DID NOT ALWAYS CHARGE ALLOWABLE COSTS TO THE COMMUNITY SERVICES BLOCK GRANT – RECOVERY ACT PROGRAM, APR 2013, $160,404
CIN: A-07-11-02766	NOT ALL COMMUNITY SERVICES BLOCK GRANT COSTS CLAIMED ON BEHALF OF THE CARBON COUNTY COMMUNITY ACTION COMMITTEE FOR THE PERIOD OCTOBER 1, 2008, THROUGH SEPTEMBER 30, 2010, WERE ALLOWABLE, AUG 2013, $143,588
CIN: A-09-11-01013	OREGON CLAIMED SOME POTENTIALLY UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS FOR MULTNOMAH COUNTY'S EXPENDITURES UNDER THE RECOVERY ACT, APR 2013, $115,911
CIN: A-06-11-00058	CROWLEY'S RIDGE DEVELOPMENT COUNCIL, INC., CLAIMED UNALLOWABLE COSTS UNDER A RECOVERY ACT GRANT, AUG 2012, $115,420
CIN: A-02-13-02005	PUERTO RICO'S CONTROLS FOR ITS CHILD CARE AND DEVELOPMENT PROGRAM CLAIMS WERE NOT EFFECTIVE, JAN 2017, $82,544
CIN: A-09-11-01014	HAWAII CLAIMED UNALLOWABLE COMMUNITY SERVICES BLOCK GRANT COSTS FOR HAWAII COUNTY ECONOMIC OPPORTUNITY COUNCIL'S EXPENDITURES UNDER THE RECOVERY ACT, JUL 2012, $22,602
CIN: A-05-11-00053	THE COLUMBUS URBAN LEAGUE CLAIMED SOME UNALLOWABLE COSTS TO HEAD START, SEP 2012, $13,102
TOTAL CINS:	37
TOTAL AMOUNT:	$361,725,000

Notes to Table 2

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

[2] Because of administrative delays, some of which were beyond management control, 5 of the 8 audits open at the end of the period were not resolved within 6 months of issuance of reports. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-05-12-00020	MEDICARE AND BENEFICIARIES COULD SAVE BILLIONS IF CMS REDUCES HOSPITAL OUTPATIENT DEPARTMENT PAYMENT RATES FOR AMBULATORY SURGICAL CENTER-APPROVED PROCEDURES TO AMBULATORY SURGICAL CENTER PAYMENT RATES, APR 2014, $15,000,000,000
CIN: A-03-16-00200	OHIO'S AND MICHIGAN'S SALES AND USE TAXES ON MEDICAID MANAGED CARE ORGANIZATION SERVICES DID NOT MEET THE BROAD-BASED REQUIREMENT BUT NOW ARE IN COMPLIANCE, APR 2017, $797,000,000
CIN: A-09-14-02033	HUNDREDS OF MILLIONS IN MEDICARE PAYMENTS FOR CHIROPRACTIC SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS, OCT 2016, $358,800,549
CIN: A-09-16-02026	MEDICARE INAPPROPRIATELY PAID ACUTE-CARE HOSPITALS FOR OUTPATIENT SERVICES THEY PROVIDED TO BENEFICIARIES WHO WERE INPATIENTS OF OTHER FACILITIES, SEP 2017, $99,149,320
CIN: A-03-13-03002	HHS DID NOT IDENTIFY AND REPORT ANTIDEFICIENCY ACT VIOLATIONS, MAY 2017, $49,445,025
TOTAL CINS:	5
TOTAL AMOUNT:	$16,304,395,000

Appendix B: Peer-Review Results

Peer-Review Results

The IG Act, 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 an OIG of other OIGs in the semiannual period. Peer reviews are conducted by member organizations of the Council of the Inspectors General on Integrity and Efficiency (CIGIE). Recently CIGIE has approved a new peer-review process for Inspection and Evaluations units within OIGs across the Federal Government, including at HHS OIG, the implementation of which will begin in 2018.

Office of Audit Services

During this semiannual reporting period, one peer review involving OAS was completed.

OAS	Date	Reviewing Office	Office Reviewed
	March 2018	United States Postal Service OIG	HHS OIG, OAS

The system of quality control for the audit organization of HHS OIG in effect for the year ending September 30, 2017, 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) OIG

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 review involving the Office of Investigations (OI) was completed. Listed below is information concerning OI's peer-review activities during prior reporting periods.

OI	Date	Reviewing Office	Office Reviewed
	August 2017	HHS OIG, OI	U.S. Postal Service OIG

The system of internal safeguards and management procedures for the investigative function of USPS OIG in effect for the year ending September 30, 2015, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

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 through June 2014, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Office of Evaluation and Inspections

During this semiannual reporting period, OEI conducted a peer review of certain Department of Defense (DoD) OIG Inspection and Evaluations (I&E) units at the request of DoD OIG. Results of this peer review will be reported in May 2018.

OEI	Date	Reviewing Office	Office Reviewed

September 2017	HHS OIG	DoD OIG, I&E units

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 (permissive exclusion) to exclude individuals and entities on several other grounds, including misdemeanors for other health care fraud (other than Medicare or Medicaid); 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.

CMPL

The CMPL of the Social Security Act, 1128A (42 U.S.C. § 1320a-7a), imposes penalties, assessments, and exclusion from participation in Federal health care programs for engaging in certain activities. For example, a person who submits, or causes to be submitted, to a Federal health care program a claim for items and services that the person knows, or should know, is false or fraudulent is subject to a penalty of up to $15,270 for each item or service falsely or fraudulently claimed, an assessment of up to three times the amount falsely or fraudulently claimed, and exclusion.

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

The ACA added more grounds for imposing CMPs. These include, among other types of conduct, knowingly making, or causing to be made, any false statements or omissions in any application, bid, or contract to participate as a provider in a Federal health care program (including Medicare and Medicaid managed care

programs and Medicare Part D); the ACA authorizes a penalty of up to $55,262 for each false statement, as well as activities relating to fraudulent marketing by managed care organizations, their employees, or their agents.

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

Patient Dumping

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

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

OIG is authorized to collect CMPs of up to $52,414 against small hospitals (fewer than 100 beds) and up to $104,826 against larger hospitals (100 beds or more) for each instance in which the hospital negligently violated any of the section 1867 requirements. In addition, OIG may collect a penalty of up to $104,826 from a responsible physician for each negligent violation of any of the section 1867 requirements and, in some circumstances, may exclude a responsible physician.

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

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)).

False Claims Act (FCA)—Under the FCA, as amended by the False Claims Amendments Act of 1986 (31 U.S.C. §§ 3729–3733), a person or an entity is liable for up to treble damages and a penalty between $11,181 and $22,363 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 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. 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 FCA, no specific intent to defraud is required. Further, 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. 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 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 following table lists the reporting requirements of the IG Act, as amended, along with the location of the required information.

Section	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	"Other HHS-Related Reviews and Investigations" section
Section 5		
(a)(1)	Significant problems, abuses, and deficiencies	Throughout this report
(a)(2)	Recommendations with respect to significant problems, abuses, and deficiencies	Throughout this report
(a)(3)	Prior significant recommendations on which corrective action has not been completed	OIG *Compendium of Unimplemented Recommendations* (Compendium)
(a)(4)	Matters referred to prosecutive authorities	"Legal and Investigative Activities Related to the Medicare and Medicaid Programs" section
(a)(5)	Summary of instances in which information requested by OIG was refused	None for this reporting period
(a)(6)	List of audit reports	Submitted to the Secretary of Health and Human Services under separate cover
(a)(7)	Summary of significant reports	Throughout this report
(a)(8)	Statistical Table 1—Reports with Questioned Costs	Appendix A
(a)(9)	Statistical Table 2—Funds Recommended To Be Put to Better Use	Appendix A
(a)(10)	Summary of previous audit reports without management decisions, in which no establishment	Appendix A

Section	Requirement	Location
	comment was returned within 60 days, and in which there are any outstanding unimplemented recommendations	
(a)(11)	Description and explanation of revised management decisions	Appendix A
(a)(12)	Management decisions with which the Inspector General disagrees	None for this reporting period
(a)(13)	Information required by the Federal Information Security Management Act.	Reported annually in the spring Semiannual Report, "Other HHS-Related Reviews and Investigations" 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
(a)(17)	Investigative statistical tables	Appendix F
(a)(18)	Metrics description for statistical tables	Appendix F
(a)(19)	Investigations on senior Government employees	Appendix F
(a)(20)	Description of whistleblower retaliation instances	Appendix F
(a)(21)	Description of attempts to interfere with OIG independence	Appendix F
(a)(22)	Description of closed and nondisclosed reports and investigations regarding senior Government employees	Appendix F

Other Reporting Requirements

Section	Requirement	Location
845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for FY 2008 (P.L. No. 110-181), § 845.	"Other HHS-Related Reviews and Investigations" section
205	Pursuant to HIPAA (P.L. No. 104-191), § 205, the Inspector General is required to solicit proposals annually via a Federal Register notice for developing new and modifying existing safe harbors to the anti-kickback statute of the Social Security Act, § 1128(b), and for developing special fraud alerts. The Inspector General is also required to report annually to Congress on the status of the proposals received related to new or modified safe harbors.	Reported annually in the fall Semiannual Report, Appendix G
1553	Pursuant to the American Recovery and Reinvestment Act of 2009, P.L. No. 111-5, § 1553, OIG reports to Congress the retaliation complaint investigations it decided not to conduct or continue during the period.	"Other HHS-Related Reviews and Investigations" section

Appendix E: Reporting Requirements in the Inspector General Empowerment Act of 2016

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

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

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

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

For audit, inspection, and evaluation reports issued from FY 2011 through FY 2018, OIG had 122 reports with overdue final management decisions.[1]

OIG is unable to provide reasons and timetables for each of these overdue management decisions due to the volume and that OIG did not historically track this information.

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

For draft reports that include recommendations, OIG typically requests establishment comments within 30 days. In some instances, OIG grants extensions when requested and appropriate. When OIG does not receive establishment comments or a request for extension within the 30-day timeframe, OIG typically issues the report and notes the lack of establishment comments.

For this semiannual reporting period, OIG had no reports with comments exceeding 60 days.

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

OIG is actively tracking 1,240 unimplemented open recommendations made in reports issued since FY 2011. Given the volume of recommendations OIG makes each year, the table below reflects summary data by fiscal year:

[1] OIG is able to track the status of management decisions for all reports back to FY 2011. OIG can track the status of management decisions for audit reports back to FY 1990. We have identified 10 additional audit reports with overdue management decisions from FY 1990 through FY 2010.

FY (2011–2018)	Number of Reports with Unimplemented Recommendations	Number of Unimplemented Recommendations	Dollar Value of Aggregate Potential Cost Savings
2011	17	30	$435,349,613
2012	34	43	$342,029,256
2013	45	88	$267,498,939
2014	48	98	$15,158,930,599
2015	54	113	$529,509,088
2016	79	215	$309,327,014
2017	105	417	$2,116,342,503
2018	67	236	$715,220,191
Total	449	1,240	$19,874,207,203

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

(17) Statistical tables showing-

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

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

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

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

Total number of investigative reports issued during the reporting period, including Management Implication Reports and Investigative Advisories	0

Total number of persons referred[2] to Federal prosecuting authorities for criminal prosecution during the reporting period[3]	1,185
Total number of persons referred to State and local prosecuting authorities for criminal prosecutions during the reporting period	160
Total number of Federal indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities	340
Total number of State and local indictments and criminal informations during the reporting period that resulted from any prior referral to prosecuting authorities	96

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

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

Regarding (17)(B) and (C), OIG defines this measure as the term "presentations" to both Federal and State/local prosecuting jurisdictions as the representation of the work we do. For example, when OIG opens an investigation, it evaluates the complaint and decides whether to "present" the matter for prosecution. Generally, if the case has prosecutorial merit, and is accepted for Federal prosecution, OIG works with DOJ as the primary investigative agency, as opposed to referring the matter to DOJ without further involvement on OIG's part. OIG works with State and local prosecutorial authorities in addition to working with DOJ.

Regarding (17)(D), the table above provides the number of indictments/criminal informations during the semiannual reporting period, including sealed indictments/criminal informations. However, the information cannot be limited to only those that occurred as a result of a presentation in a previous period. In certain situations, the presentation and charging dates are in the same reporting period.

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

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

[2] A referral includes OIG presentations to DOJ and/or State/local prosecutorial authorities.
[3] OIG counts "persons" as both individuals and entities.

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

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

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

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

However, we request from the agency a copy of an SF-50 documenting a personnel action, if one is taken. To the extent that we have information regarding subsequent administrative action, OIG can provide that information. However, because there are sometimes settlement agreements that may impact the final action, OIG may not have a complete record of the disposition of the investigation. Accordingly, such information might be more efficiently and effectively provided directly by the employing agency.

For this section, OIG describes investigations, both criminal and administrative, conducted during this reporting period, involving senior Government employees for whom allegations of misconduct were substantiated. The descriptions below include a level of detail appropriate for each investigation, depending on whether the case details were available in public documents. During this reporting period, OIG did not investigate any senior Government employees for misconduct.

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

For departmental agencies, OIG conducts investigations and gathers facts related to whistleblower complaints. Before 2015, OIG made no determinations as to whether retaliatory action had been taken. However, to better facilitate the report review process, OIG changed its process in 2015 to include findings in its reports as to whether it was more likely than not that whistleblower retaliation had occurred. While OIG now includes these findings in its reports, it does not make recommendations as to what, if any, corrective action(s) should be taken.

During the time period from October 1, 2017, through March 31, 2018, OIG did not issue any reports that included findings of retaliation.

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

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

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

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

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

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

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

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

Nonpublic Reports by Category, October 1, 2017, to March 31, 2018

Category/Description	Number of Reports
IT security reviews (involve IT systems, e.g., penetration test audits)	2
Reimbursable audits performed for other Federal agencies (primarily contract audits)	1
Other	2
Total	**5**

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

In section 5(a)(19), we detail investigations of senior Government employees in which allegations were substantiated. Those investigations are all closed and none have been disclosed to the public. OIG interprets section 5(a)(22)(B) as requiring reporting on investigations with either substantiated or unsubstantiated allegations. As such, we refer to our section 5(a)(19) response to address investigations of senior Government employees in which allegations were substantiated that were closed and not disclosed to the public. Our section 5(a)(22)(B) response describes investigations, both criminal and administrative, conducted during this reporting period involving a senior Government employee in which OIG did not substantiate allegations of misconduct.

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

investigations are below.

Description of Investigation	Status	Disposition	DOJ Referral	DOJ Referral Date	DOJ Declination	DOJ Declination Date
A senior Government employee was alleged to have been involved in misconduct.	Closed	No evidence to support allegations.	No	N/A	N/A	N/A
A former senior Government employee was alleged to have engaged in unethical post-employment activities.	Closed	No evidence to support allegations.	No	N/A	N/A	N/A

APPENDIX F: Anti-Kickback Statute – Safe Harbors

Anti-Kickback Statute – Safe Harbors

Pursuant to HIPAA, § 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, section 1128B(b) of the Social Security Act, 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.

In crafting safe harbors for a criminal statute, it is incumbent upon the OIG to engage in a complete and careful review of the range of factual circumstances that may fall within the proposed safe harbor subject area to uncover all potential opportunities for fraud and abuse by unscrupulous providers. Having done so, OIG must then determine, in consultation with DOJ, whether it can develop effective regulatory limitations and controls—not only to foster beneficial or innocuous arrangements but also to protect Federal health care programs and their beneficiaries from abusive practices.

Public Proposals for New and Modified Safe Harbors

In response to the 2016 annual solicitation, OIG received the following proposals related to safe harbors.

Proposal	OIG Response
A new safe harbor that would protect value-based payment arrangements that bundle products and related services and allow for price adjustments if a measurable clinical and/or cost outcome is not achieved.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
A new safe harbor that would protect value-based warranties offered by manufacturers or suppliers of products that provide certain assurances about clinical and/or cost outcomes and appropriate remedies where such outcomes are not achieved.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.

A new safe harbor that would protect value-based payment arrangements generally.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
A new safe harbor that would protect arrangements that support patient adherence to a treatment regimen that has been recommended by the patient's health care provider.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
A new safe harbor that would protect arrangements that pay for, or provide, data analytics.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
The modification of the personal services and management contracts safe harbor, 42 C.F.R. § 1001.952(d), to protect personal services arrangements involving part-time or periodic services that lack an exact schedule of services or precise length of intervals.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
The modification of the discounts safe harbor, 42 C.F.R. § 1001.952(h), to include exceptions for value-based arrangements within the existing definition of discount; to protect certain discounts offered in connection with value-based arrangements; and to define "value-based arrangement" to capture appropriate and beneficial arrangements while excluding arrangements that are abusive or result in inappropriate financial incentives.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
The modification of the discounts safe harbor, 42 C.F.R. § 1001.952(h), to expand upon the subcategories of buyers potentially protected by the safe harbor; to specify under what circumstances a discount or rebate arrangement may involve the performance of services or activities; and to clarify the disclosure obligations that arise under the safe harbor.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
The modification of the warranties safe harbor, 42 C.F.R. § 1001.952(g), to protect	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions

remuneration paid to cover certain services and items that are related to the item that is the subject of the warranty in the context of value-based arrangements.	about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
The modification of the warranties safe harbor, 42 C.F.R. § 1001.952(g), to protect manufacturer-issued refunds in circumstances in which the manufacturer's products do not work as specified for individual patients or patient populations, particularly in outcomes or value-based arrangements.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.
The modification of the price reductions offered to health plans, price reductions offered to eligible managed care organizations, and price reductions offered by contractors with substantial financial risk to managed care organizations safe harbors, 42 C.F.R. § 1001.952(m), (t), and (u), to clarify the circumstances under which drug manufacturer rebate agreements with managed care organizations or pharmacy benefit managers would be protected.	OIG is not adopting this suggestion at this time, as it requires further study. In the meantime, questions about the application of the anti-kickback statute to such arrangements should be addressed on a case-by-case basis, such as under the advisory opinion process.

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

OFFICE OF AUDIT SERVICES

FINAL AUDIT REPORTS ISSUED FOR SEMIANNUAL PERIOD

HEALTH FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-01-15-00515	Wisconsin Physicians Service Paid Providers for Hyperbaric Oxygen Therapy Services That Did Not Comply With Medicare Requirements	$300,789		$42,329,336	2
A-01-16-01502	The Food and Drug Administration's Food-Recall Process Did Not Always Ensure The Safety Of The Nation's Food Supply				14
A-01-18-31475	HEALTH REINSURANCE ASSOCIATION (CONNECTICUT)				1
A-01-18-31913	GBAPP, INC.				0
A-01-18-31975	AIDS CARE OCEAN STATE INC.				2
A-01-18-31977	NORTH SHORE COMMUNITY HEALTH INC.				3
A-01-18-32011	CENTER FOR HEALTH POLICY DEVELOPMENT NATIONAL ACAD				2
A-01-18-32105	CARE NEW ENGLAND HEALTH SYSTEM & AFFILIATES				1
A-01-18-32148	MITRE CORP.				0
A-01-18-32222	COMMUNITY HEALTH CENTER ASSOCIATION OF CONNECTICUT				0
A-01-18-32230	CENTER FOR SOCIAL INNOVATION, LLC				0
A-01-18-32287	HOULTON BAND OF MALISEET INDIANS				0
A-01-18-32288	PENOBSCOT INDIAN NATION				0
A-01-18-32330	INDIAN STREAM HEALTH CENTER INC.				3
A-01-18-32377	KATAHDIN VALLEY HEALTH CENTER				1
A-01-18-32539	HEALTH ACCESS NETWORK INC.				3
A-01-18-32593	TETRAGENETICS, INC.				2
A-01-18-32623	HIGHLAND INSTRUMENTS, INC.				0
A-01-18-32638	ETIOMETRY INC.				3
A-01-18-32639	SYMBIOTIX BIOTHERAPIES, INC.				1
A-01-18-32685	SAVE THE CHILDREN FEDERATION, INC. & RELATED ENTIT				1
A-01-18-32686	NARRAGANSETT INDIAN TRIBE				8
A-01-18-32728	NETWORK FOR REGIONAL HEALTHCARE IMPROVEMENT				2
A-01-18-32747	INDIAN TOWNSHIP TRIBAL GOVERNMENT				7
A-01-18-32771	MINUTEMAN HEALTH INC.				1
A-01-18-32793	THAMES VALLEY COUNCIL FOR COMMUNITY ACTION INC & S				1
A-01-18-32794	PLEASANT POINT PASSAMAQUODDY TRIBAL COUNCIL				2
A-01-18-32914	BROAD INSTITUTE, INC.				0
A-01-18-32915	YALE UNIV.				0
A-01-18-32927	DIMAGI INC. & SUBSIDIARIES				0
A-01-18-32940	PATHFINDER INTERNATIONAL & SUBSIDIARIES				1
A-01-18-32951	GOODWIN COMMUNITY HEALTH & SUBSIDIARY				1
A-01-18-32969	PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, INC. &				1
A-01-18-33008	MANCHESTER COMMUNITY HEALTH CENTER				3
A-01-18-33025	FOUNDATION OF MASSACHUSETTS EYE & EAR INFIRMARY IN				1
A-01-18-33026	ST. JOSEPHS COLLEGE				0
A-01-18-33078	ACTION FOR BOSTON COMMUNITY DEVELOPMENT INC.				0
A-01-18-33079	DARTMOUTH COLLEGE				0
A-01-18-33122	COMMUNITY HEALTH CENTER INC.				1
A-01-18-33174	GREATER LAWRENCE FAMILY HEALTH CENTER INC.				1
A-01-18-33175	SOUTH END COMMUNITY HEALTH CENTER, INC.				1
A-01-18-33282	MOHEGAN TRIBE OF INDIANS OF CONNECTICUT SPECIAL RE				0
A-02-15-01010	New Jersey Claimed Hundreds of Millions in Unallowable or Unsupported Medicaid School-Based Reimbursement	$300,452,930			1
A-02-15-01014	New York Did Not Comply with Federal Grant Requirements for Claiming Marketplace Contract Costs to Medicaid and the Childrens Health Insurance Program	$954,521			0
A-02-15-01015	New York's Medicaid Eligibility Determinations for Newly Eligible Beneficiaries Did Not Always Meet Federal and State Requirements				2
A-02-15-01024	New York Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid				1
A-02-15-02008	New York Did Not Comply with Federal Grant Requirements for Allocating and Claiming Marketplace Contract Costs	$20,415,344			1
A-02-16-01008	New Jersey Claimed Federal Medicaid Reimbursement for Children's Partial Hospitalization Services That Did Not Meet Federal and State Requirements	$54,732,002			5

OFFICE OF AUDIT SERVICES

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HEALTH FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-02-17-02002	Henry J. Austin Health Center, Inc., a Health Resources and Services Administration Grantee, Did Not Comply With Federal Grant Requirements	$8,243,519			1
A-02-18-31487	JEWISH RENAISSANCE MEDICAL CENTER INC.				5
A-02-18-31661	MOROVIS COMMUNITY HEALTH CENTER, INC.				0
A-02-18-31752	HEALTH REPUBLIC INSURANCE OF NEW YORK, CORP.				2
A-02-18-31847	MUNICIPALITY OF PONCE PUERTO RICO				4
A-02-18-31849	MUNICIPALITY OF SAN JUAN PUERTO RICO				3
A-02-18-31850	CONCILIO DE SALUD INTEGRAL DE LOIZA INC.				4
A-02-18-31866	MERCY COLLEGE				0
A-02-18-31867	COLLEGE OF NEW ROCHELLE				2
A-02-18-31868	CATHOLIC CHARITIES NEIGHBORHOOD SERVICES INC.				4
A-02-18-31873	SISTEMA UNIVERSITARIO ANA G. MENDEZ, INC.				0
A-02-18-31889	FAIRLEIGH DICKINSON UNIV.				0
A-02-18-31968	NORTHWEST BUFFALO COMMUNITY HEALTH CARE CENTER INC				2
A-02-18-32018	HARLEM UNITED COMMUNITY AIDS CENTER INC. & AFFILIA				5
A-02-18-32203	GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STA				25
A-02-18-32355	CHAUTAUQUA CENTER INC.				4
A-02-18-32358	NATIONAL DEVELOPMENT & RESEARCH INSTITUTES INC.				2
A-02-18-32387	CENTER FOR COMMUNITY ALTERNATIVES				3
A-02-18-32389	MT. VERNON NEIGHBORHOOD HEALTH CENTER INC.				0
A-02-18-32401	REPRIXYS PHARMACEUTICALS CORP.				0
A-02-18-32416	BROOME COUNTY NEW YORK				0
A-02-18-32474	DELAWARE COUNTY NEW YORK				0
A-02-18-32476	COLD SPRING HARBOR LABORATORY				0
A-02-18-32521	SCHENECTADY FAMILY HEALTH SERVICES INC. & AFFILIAT				1
A-02-18-32538	JEWISH RENAISSANCE MEDICAL CENTER INC.				6
A-02-18-32645	NANOMETICS, LLC				1
A-02-18-32679	CHILDREN'S FUTURES, INC. & CHILDREN'S FUTURES SUPP				1
A-02-18-32683	SCHC COMPANIES INC. & AFFILIATES				1
A-02-18-32684	BETANCES HEALTH CENTER				5
A-02-18-32740	NEWARK COMMUNITY HEALTH CENTERS, INC.				1
A-02-18-32744	MIDDLETOWN COMMUNITY HEALTH CENTER INC.				1
A-02-18-32745	NASSAU COUNTY NEW YORK				1
A-02-18-32746	BROOKLYN PLAZA MEDICAL CENTER INC.				1
A-02-18-32769	ALBERT EINSTEIN COLLEGE OF MEDICINE, INC.				0
A-02-18-32777	RESEARCH FOUNDATION FOR MENTAL HYGIENE INC.				0
A-02-18-32778	ICAHN SCHOOL OF MEDICINE AT MT. SINAI				0
A-02-18-32779	PUBLIC HEALTH SOLUTIONS				0
A-02-18-32780	MEMORIAL SLOAN KETTERING CANCER CENTER & AFFILIATE				0
A-02-18-32808	COLLEGE OF NEW ROCHELLE				0
A-02-18-32893	AHRC HEALTH CARE, INC. (D/B/A ACCESS COMMUNITY HEA				4
A-02-18-32894	MT. VERNON NEIGHBORHOOD HEALTH CENTER INC.				3
A-02-18-32946	HUDSON COUNTY NEW JERSEY				0
A-02-18-32971	BEACON CHRISTIAN COMMUNITY HEALTH CENTERS, INC.				5
A-02-18-32987	TRI-COUNTY COMMUNITY ACTION AGENCY INC.				0
A-02-18-33022	AMERICAN INDIAN COMMUNITY HOUSE, INC.				6
A-02-18-33023	STATE OF NEW YORK				19
A-02-18-33031	CALADRIUS BIOSCIENCES				2
A-02-18-33057	HOUSING WORKS INC. & AFFILIATES				2
A-02-18-33206	RESEARCH FOUNDATION FOR THE STATE UNIV. OF NEW YOR				0
A-02-18-33281	ONEIDA INDIAN NATION				0
A-03-14-00010	CMS Did Not Adequately Address Discrepancies in the Coding Guidelines for Kwashiorkor			$102,000,000	1
A-03-16-00201	The District of Columbia Claimed Some Day Treatment Program Services That Were Not in Compliance With Federal or District Requirements	$4,588,756			0

OFFICE OF AUDIT SERVICES

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HEALTH FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-03-18-00352	Independent Attestation Review: National Institutes of Health Fiscal Year 2017 Detailed Accounting Submissions and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions				0
A-03-18-00353	Independent Attestation Review: Substance Abuse and Mental Health Services Administration Fiscal Year 2017 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions				0
A-03-18-00354	Independent Attestation Review: Health Resources and Services Administration Fiscal Year 2017 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions				0
A-03-18-00355	Independent Attestation Review: Centers for Disease Control and Prevention Fiscal Year 2017 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions				0
A-03-18-31482	CITY OF NORFOLK VIRGINIA				0
A-03-18-31496	TRI-AREA COMMUNITY HEALTH				0
A-03-18-31524	TRI-AREA COMMUNITY HEALTH				1
A-03-18-31635	CITY OF PHILADELPHIA				1
A-03-18-31674	SALUS UNIV. & ITS FOUNDATION				0
A-03-18-31759	NORTHSIDE CHRISTIAN HEALTH CENTER				3
A-03-18-31760	HEALTHY START INC.				2
A-03-18-31855	HOWARD UNIV.				4
A-03-18-31864	GAUDENZIA INC. & GAUDENZIA FOUNDATION INC.				8
A-03-18-31865	NEIGHBORHOOD HEALTH CENTERS OF THE LEHIGH VALLEY				3
A-03-18-31880	CATHOLIC RELIEF SERVICES - UNITED STATES CONFERENC				1
A-03-18-31883	LEHIGH VALLEY HEALTH NETWORK INC.				0
A-03-18-31903	CROZER-KEYSTONE HEALTH SYSTEM				1
A-03-18-31923	AMERICAN IMMUNIZATION REGISTRY ASSOCIATION				1
A-03-18-31971	ELAINE ELLIS CENTER OF HEALTH INC.				2
A-03-18-32014	AFRICARE				3
A-03-18-32021	CITY OF BALTIMORE MARYLAND				7
A-03-18-32032	COVENANT HOUSE INC.				1
A-03-18-32051	INSTITUTE FOR CLINICAL RESEARCH INC.				2
A-03-18-32058	AMERICAN ASSOCIATION OF POISON CONTROL CENTERS				1
A-03-18-32095	AMMFT RESEARCH & EDUCATION FOUNDAITON				1
A-03-18-32104	SCRANTON PRIMARY HEALTH CARE CENTER INC.				1
A-03-18-32152	ASSOCIATION OF STATE & TERRITORIAL HEALTH OFFICIAL				1
A-03-18-32156	HENRY M. JACKSON FOUNDATION FOR THE ADV. OF MILITA				2
A-03-18-32205	AMERICAN INTERNATIONAL HEALTH ALLIANCE, INC.				8
A-03-18-32307	DISTRICT OF COLUMBIA PRIMARY CARE ASSOCIATION				3
A-03-18-32348	POPULATION SERVICES INTERNATIONAL				2
A-03-18-32376	PRIMARY CARE HEALTH SERVICES, INC.				3
A-03-18-32382	NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRE				2
A-03-18-32408	AMERICAN ASSOCIATION OF BLOOD BANKS				2
A-03-18-32505	STO-ROX NEIGHBORHOOD HEALTH COUNCIL INC.				6
A-03-18-32535	WILLIAMSON HEALTH & WELLNESS CENTER, INC.				1
A-03-18-32537	MISSION WEST VIRGINIA, INC.				1
A-03-18-32559	CIRCULOMICS INC.				1
A-03-18-32566	KEYSTONE NANO, INC.				1
A-03-18-32585	PROTEIN POTENTIAL, LLC				1
A-03-18-32633	AZEVAN PHARMACEUTICALS, INC.				1
A-03-18-32673	FAMILY & MEDICAL COUNSELING SERVICE INC.				1
A-03-18-32681	WELSH MOUNTAIN MEDICAL & DENTAL CENTER INC.				3
A-03-18-32708	CITY OF BALTIMORE MARYLAND				6
A-03-18-32709	AMERICAN COLLEGE OF MEDICAL GENETICS & GENOMICS				2
A-03-18-32719	HEMOSONICS, LLC				1
A-03-18-32738	GEISINGER HEALTH SYSTEM				1
A-03-18-32739	HAMILTON HEALTH CENTER INC. & SUBSIDIARY				1

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A-03-18-32762	NATIONAL INDIAN HEALTH BOARD				2
A-03-18-32764	SOUTHBRIDGE MEDICAL ADVISORY COUNCIL, INC.				1
A-03-18-32770	HIGHMARK HEALTH				1
A-03-18-32776	HEALTH INTEGRITY, LLC				0
A-03-18-32878	PENNSYLVANIA MOUNTAINS HEALTHCARE RESOURCE DEVELOP				2
A-03-18-32885	KENNEDY KRIEGER INSTITUTE INC. & AFFILIATES				1
A-03-18-32912	WEST VIRGINIA UNIV. RESEARCH CORP.				0
A-03-18-32918	DEVELOPMENT SERVICES GROUP INC.				1
A-03-18-32942	FAMILY HEALTH CENTERS OF BALTIMORE INC.				2
A-03-18-32968	SUSQUEHANNA COMMUNITY HEALTH & DENTAL CLINIC, INC.				3
A-03-18-33015	CITY OF RICHMOND VIRGINIA				0
A-03-18-33076	UPMC				0
A-03-18-33077	CHILDREN'S HOSPITAL OF PHILADELPHIA FOUNDATION & C				0
A-03-18-33144	BOARD OF EDUCATION OF PRINCE GEORGE'S COUNTY				3
A-03-18-33155	ST. CHARLES HEALTH COUNCIL INC.				2
A-03-18-33166	BALTIMORE HEALTHY START, INC.				1
A-03-18-33261	THOMAS JEFFERSON UNIV. & CONTROLLED AFFILIATES				2
A-03-18-33304	STATE OF WEST VIRGINIA				11
A-04-15-06190	Tennessee Managed Care Organizations Received Medicaid Capitation Payments After Beneficiry's Death	$1,814,761			3
A-04-16-04046	The National Institutes of Health Did Not Always Administer Superfund Appropriations During Fiscal Year 2015 in Accordance With Federal Requirements				4
A-04-16-04049	Medicare Compliance Review of Carolinas Medical Center for Claims Paid From January 1, 2014, Through December 31, 2015	$1,659,619			2
A-04-16-04054	North Carolina Did Not Comply With Federal and State Requirements When Making Medicaid Cost-Sharing Payments for Professional Medical Services	$41,188,318			1
A-04-16-07061	Managed Care Payments for Benes with Multiple Medicaid IDs in GA	$667,472			1
A-04-16-08049	Ohio Received Millions in Unallowable Bonus Payments	$29,524,741			0
A-04-16-08050	Kansas Received Millions in Unallowable Bonus Payments	$17,796,598			0
A-04-17-01003	Aurum Institute Generally Managed and Expended the President's Emergency Plan for AIDS Relief Funds in Accordance With Award Requirements				2
A-04-17-02003	HRSA Complied With Federal and HHS Grant Policies When Awarding Zika Response and Preparedness Appropriations Act Funds During Fiscal Year 2017				0
A-04-17-02004	CDC Domestic Recipients Receiving Global Health Security Agenda (GHSA) Funds				0
A-04-17-02500	North Carolina Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid				2
A-04-17-08055	Compliance Review of Selected Medicare Claims at Memorial University Medical Center for CY 2015 and 2016	$1,455,892			2
A-04-17-08056	Idaho Received Millions in Unallowable Bonus Payments	$3,103,167			0
A-04-18-31427	OCRACOKE HEALTH CENTER				0
A-04-18-31670	CLAIBORNE COUNTY FAMILY HEALTH CENTER INC.				2
A-04-18-31671	BAKERSVILLE COMMUNITY MEDICAL CLINIC, INC.				1
A-04-18-31746	CENTER FOR BLACK WOMEN'S WELLNESS, INC.				1
A-04-18-31854	SHAW UNIV. INC.				0
A-04-18-31874	TRIAD ADULT & PEDIATRIC MEDICINE, INC.				0
A-04-18-31875	TRIAD ADULT & PEDIATRIC MEDICINE, INC.				2
A-04-18-31952	MONTGOMERY COUNTY NORTH CAROLINA				1
A-04-18-31963	ACCESS FAMILY HEALTH SERVICES INC.				1
A-04-18-31970	FAMILY HEALTH CENTERS, INC.				1
A-04-18-31972	FOOTHILLS COMMUNITY HEALTH CARE INC.				3
A-04-18-32009	G.A. CARMICHAEL FAMILY HEALTH CENTER, INC.				2
A-04-18-32048	BAPTIST HEALTHCARE SYSTEM, INC. & AFFILIATES				2
A-04-18-32059	UNITED HEALTH CENTERS				2
A-04-18-32097	PARK DUVALLE COMMUNITY HEALTH CENTER, INC.				1
A-04-18-32102	FOOTHILLS COMMUNITY HEALTH CARE INC.				0

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A-04-18-32111	UNIV. OF ALABAMA				1
A-04-18-32113	PINELLAS COUNTY FLORIDA				1
A-04-18-32114	CENTRAL FLORIDA FAMILY HEALTH CENTER, INC.				1
A-04-18-32172	TOMBIGBEE HEALTHCARE AUTHORITY				2
A-04-18-32273	MICCOSUKEE CORP.				0
A-04-18-32290	UNIV. OF ALABAMA AT BIRMINGHAM				0
A-04-18-32304	MISSISSIPPI FAMILIES AS ALLIES FOR CHILDRENS MENTA				0
A-04-18-32305	BAKERSVILLE COMMUNITY MEDICAL CLINIC, INC.				1
A-04-18-32306	CHARLOTTE-MECKLENBURG HOSPITAL AUTHORITY				1
A-04-18-32354	CAHABA MEDICAL CARE FOUNDATION				1
A-04-18-32371	POARCH BAND OF CREEK INDIANS				2
A-04-18-32384	METROPOLITAN COMMUNITY HEALTH SERVICES INC.				7
A-04-18-32406	AMITE COUNTY MEDICAL SERVICES INC.				1
A-04-18-32407	EAST CENTRAL MISSISSIPPI HEALTH CARE, INC.				1
A-04-18-32432	FLORIDA ASSOCIATION OF COMMUNITY HEALTH CENTERS, I				1
A-04-18-32433	CATAWBA INDIAN NATION				3
A-04-18-32458	HIGH COUNTRY COMMUNITY HEALTH, INC.				1
A-04-18-32464	HEALTH SERVICES INC.				4
A-04-18-32465	GOSHEN MEDICAL CENTER INC.				1
A-04-18-32520	CHRIST COMMUNITY HEALTH SERVICES AUGUSTA INC.				2
A-04-18-32525	EPICYPHER, INC.				3
A-04-18-32534	SOUTHEAST ALABAMA RURAL HEALTH ASSOCIATION				1
A-04-18-32670	COLUMBUS DEPT. OF PUBLIC HEALTH				1
A-04-18-32703	HEALTH SERVICES CENTER INC.				4
A-04-18-32705	SOUTHERN RESEARCH INSTITUTE				1
A-04-18-32706	FULTON COUNTY GEORGIA				2
A-04-18-32707	FURMAN UNIV.				1
A-04-18-32715	AGILE SCIENCES INC.				1
A-04-18-32736	SHAWNEE CHRISTIAN HEALTHCARE CENTER				2
A-04-18-32750	SOUTH CAROLINA PRIMARY HEALTH CARE ASSOCIATION				1
A-04-18-32759	MORE THAN CONQUERORS, INC.				1
A-04-18-32768	BROWARD REGIONAL HEALTH PLANNING COUNCIL INC.				0
A-04-18-32785	CARE NET OF LANCASTER				6
A-04-18-32791	RURAL HEALTH SERVICES INC. D/B/A MARGARET J. WESTO				1
A-04-18-32805	NEIGHBORHOOD MEDICAL CENTER INC.				4
A-04-18-32859	ST. JUDE CHILDREN'S RESEARCH HOSPITAL, INC. & SUBS				0
A-04-18-32865	NEW HORIZON FAMILY HEALTH SERVICES INC.				4
A-04-18-32866	ANSON REGIONAL MEDICAL SERVICES INC.				1
A-04-18-32883	CENTRAL NORTH ALABAMA HEALTH SERVICES INC.				1
A-04-18-32938	CATAWBA INDIAN NATION				1
A-04-18-32939	WAKE HEALTH SERVICES INC.				2
A-04-18-32978	CATAWBA COUNTY NORTH CAROLINA				0
A-04-18-32981	WAKE FOREST UNIV.				0
A-04-18-33000	RURAL HEALTH MEDICAL PROGRAM INC.				1
A-04-18-33013	FAMILY HEALTH CENTERS OF GEORGIA INC.				1
A-04-18-33020	VANDERBILT UNIV. MEDICAL CENTER				1
A-04-18-33050	CHEROKEE HEALTH SYSTEMS				2
A-04-18-33051	BOND COMMUNITY HEALTH CENTER INC.				3
A-04-18-33052	TRIAD ADULT & PEDIATRIC MEDICINE, INC.				1
A-04-18-33068	CALDWELL COUNTY				0
A-04-18-33086	FAMILY & CHILDRENS SERVICE TENNESSEE				1
A-04-18-33113	EMPOWER 'U', INC.				3
A-04-18-33141	SOUTHEAST CLINICAL ONCOLOGY RESEARCH CONSORTIUM IN				1
A-04-18-33142	MOREHOUSE SCHOOL OF MEDICINE INC. & AFFILIATE				1
A-04-18-33189	SHELBY COUNTY TENNESSEE				0
A-04-18-33190	POLK COUNTY DISTRICT SCHOOL BOARD				0
A-04-18-33193	MEDICAL UNIV. OF SOUTH CAROLINA				0
A-04-18-33196	ROCKINGHAM COUNTY				0

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A-04-18-33223	MOUNTAIN PROJECTS INC.				0
A-04-18-33256	EASTERN BAND OF CHEROKEE INDIANS				9
A-04-18-33291	MEHARRY MEDICAL COLLEGE				0
A-04-18-33294	LUTHERAN SERVICES FLORIDA INC. & SUBSIDIARIES				0
A-05-14-00041	Physical Therapists Nationwide Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services				3
A-05-14-00049	CMS Generally Met Requirements in Round 2 of the DMEPOS Competitive Bidding Program				3
A-05-16-00013	Ohio Claimed Unallowable Federal Reimbursement for Some Medicaid Physician-Administered Drugs	$2,325,552	$20,007,447		2
A-05-16-00044	Review of Health and Safety Standards for Family Adult Foster Homes in Minnesota				4
A-05-16-00056	Indiana Did Not Always Comply With Maternal, Infant, and Early Childhood Home Visiting Program Requirements				4
A-05-16-00059	Hospitals Did Not Always Comply With Medicare Requirements for Reporting Cardiac Device Credits	$4,410,568			3
A-05-16-00062	Medicare Compliance Review of Rush University Medical Center	$10,158,611			2
A-05-16-00064	Medicare Compliance Review of the University of Michigan Health System for 2014 and 2015	$6,162,201			2
A-05-18-31756	YOUTH NETWORK COUNCIL D/B/A ILLINOIS COLLABORATION				2
A-05-18-31861	FAMILY CHRISTIAN HEALTH CENTER				4
A-05-18-31862	TCA HEALTH INC.				4
A-05-18-31901	COMMUNITY HEALTH SYSTEMS, INC.				8
A-05-18-31908	FAMILY HEALTH CENTER INC.				1
A-05-18-31914	FOND DU LAC BAND OF LAKE SUPERIOR CHIPPEWA				0
A-05-18-31973	AUNT MARTHA'S YOUTH SERVICE CENTER INC. & SUBSIDIA				1
A-05-18-31974	CIRCLE HEALTH SERVICES				1
A-05-18-31976	SOUTHERN ILLINOIS HEALTHCARE FOUNDATION INC.				3
A-05-18-32012	IIT RESEARCH INSTITUTE				2
A-05-18-32017	UNITED FAMILY PRACTICE HEALTH CENTER & SUBSIDIARIE				3
A-05-18-32030	FAMILY HEALTH CENTER OF MARSHFIELD INC.				2
A-05-18-32052	CITY OF DETROIT				2
A-05-18-32053	KNOX COUNTY, ILLINOIS				3
A-05-18-32116	OPEN DOOR HEALTH CENTER				2
A-05-18-32118	WESTERN WAYNE FAMILY HEALTH CENTERS				1
A-05-18-32146	LAKES COMMUNITY HEALTH CENTER, INC.				2
A-05-18-32151	BATTELLE MEMORIAL INSTITUTE & SUBSIDIARIES				1
A-05-18-32159	SAGINAW COUNTY COMMUNITY MENTAL HEALTH AUTHORITY				3
A-05-18-32176	NATIONAL AHEC ORGANIZATION, INC.				3
A-05-18-32277	WHITE EARTH RESERVATION				0
A-05-18-32278	LOWER SIOUX INDIAN COMMUNITY SERVICES DEPT.				2
A-05-18-32279	GRAND PORTAGE RESERVATION TRIBAL COUNCIL				0
A-05-18-32280	BOIS FORTE BAND OF CHIPPEWA				1
A-05-18-32281	FOREST COUNTY POTAWATOMI COMMUNITY				0
A-05-18-32282	GRAND TRAVERSE BAND OF OTTAWA & CHIPPEWA INDIANS				1
A-05-18-32283	KEWEENAW BAY INDIAN COMMUNITY				0
A-05-18-32285	SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS				1
A-05-18-32351	NEIGHBORHOOD HEALTHSOURCE				2
A-05-18-32352	LAC COURTE OREILLES BAND OF LAKE SUPERIOR CHIPPEWA				8
A-05-18-32353	AXESSPOINTE COMMUNITY HEALTH CENTER INC.				2
A-05-18-32374	MILWAUKEE HEALTH SERVICES INC.				4
A-05-18-32375	HEART OF OHIO FAMILY HEALTH CENTERS				2
A-05-18-32385	DETROIT HEALTH CARE FOR THE HOMELESS				0
A-05-18-32386	CITY OF CHICAGO	$11,931			1
A-05-18-32415	LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS				0
A-05-18-32436	HENDERSON COUNTY RURAL HEALTH CENTER INC.				4
A-05-18-32448	NDI MEDICAL, LLC				2
A-05-18-32490	DELPHINUS MEDICAL TECHNOLOGIES, INC.				1
A-05-18-32517	DETROIT COMMUNITY HEALTH CONNECTION, INC.				1
A-05-18-32567	TSRL, INC.				1

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A-05-18-32582	CARECHOICE COOPERATIVE HEALTH CARE INNOVATION AWAR				4
A-05-18-32622	NAVIDEA BIOPHARMACEUTICALS INC.				1
A-05-18-32678	ERIE COUNTY GENERAL HEALTH DISTRICT				2
A-05-18-32699	OAKLAND PRIMARY HEALTH SERVICES, INC.				0
A-05-18-32731	CEDAR RIVERSIDE PEOPLE'S CENTER				1
A-05-18-32732	WELLNESS PLAN MEDICAL CENTERS				2
A-05-18-32734	NORTHEAST OHIO NEIGHBORHOOD HEALTH SERVICES INC.				2
A-05-18-32742	PARTNERSHIP COMMUNITY HEALTH CENTER, INC.				1
A-05-18-32752	BAY MILLS INDIAN COMMUNITY				1
A-05-18-32753	OPEN DOOR CLINIC OF GREATER ELGIN				2
A-05-18-32754	SOUTHSIDE COMMUNITY HEALTH SERVICES INC.				4
A-05-18-32772	RED LAKE BAND OF CHIPPEWA INDIANS				0
A-05-18-32790	DETROIT HEALTH CARE FOR THE HOMELESS				10
A-05-18-32803	MIDWESTERN UNIV.				1
A-05-18-32847	LAC VIEUX DESERT BAND OF LAKE SUPERIOR CHIPPEWA IN				0
A-05-18-32848	LITTLE RIVER BAND OF OTTAWA INDIANS				0
A-05-18-32890	COMMUNITY HEALTH SYSTEMS, INC.				6
A-05-18-32891	OUTREACH COMMUNITY HEALTH CENTERS, INC.				7
A-05-18-32892	DECATUR COUNTY INDIANA				5
A-05-18-32913	MEDICAL COLLEGE OF WISCONSIN, INC.				0
A-05-18-32944	SCHOOL DISTRICT OF WESTFIELD				2
A-05-18-32965	MARIAN UNIV. INC.				0
A-05-18-32966	INSTITUTE FOR POPULATION HEALTH INC.				11
A-05-18-33004	NEAR NORTH HEALTH SERVICE CORP.				1
A-05-18-33019	BERLIN AREA SCHOOL DISTRICT				1
A-05-18-33074	COMMON GROUND HEALTHCARE COOPERATIVE				2
A-05-18-33075	HEARTLAND ALLIANCE FOR HUMAN NEEDS & HUMAN RIGHTS				0
A-05-18-33118	CHICAGO FAMILY HEALTH CENTER, INC. & SUBSIDIARIES				1
A-05-18-33150	M.G.H. FAMILY HEALTH CENTER DBA: MUSKEGON FAMILY C				1
A-05-18-33151	COMMUNITY HEALTH & EMERGENCY SERVICES INC.				6
A-05-18-33169	CITY OF DETROIT				1
A-05-18-33170	HAMILTON COMMUNITY HEALTH NETWORK, INC.				2
A-05-18-33171	NORTHWEST INDIANA HEALTH DEPT. COOPERATIVE				4
A-05-18-33173	CEDARVILLE UNIVERSITY				0
A-05-18-33181	ONEIDA NATION				1
A-05-18-33280	MATCH-E-BE-NASH-SHE-WISH BAND OF POTTAWATOMI INDIA				0
A-06-12-00043	REVIEW OF PHYSICIAN SUPPLEMENTAL PAYMENTS AT TEXAS TECH UNIVERSITY	$9,911,321			0
A-06-15-00041	Texas Did Not Appropriately Spend Some State Balancing Incentive Payments Program Funds	$11,982,826			2
A-06-16-00004	Texas Did Not Bill Some Manufacturers for Rebates for Pharmacy Drugs Dispensed to Enrollees of Medicaid Managed-Care Organizations	$4,438,368			1
A-06-16-00018	Review of Physician Administered Drug Rebates in Arkansas	$9,892,356			2
A-06-16-05004	Texas Managed Care Organizations Received Medicaid Capitation Payments After Beneficiary's Deaths	$1,038,875			3
A-06-16-08004	Oklahoma May Be Paying for Provider-Preventable Conditions on Some Inpatient Hospital Claims				1
A-06-16-08012	Oklahoma Did Not Correctly Process Adjustments to Medicare Crossover Claims				1
A-06-18-31412	SOONERVERSE, INC.				0
A-06-18-31610	COMANCHE NATION GOVERNMENTAL PROGRAMS DEPT.				0
A-06-18-31902	LA CASA DE BUENA SALUD INC.				3
A-06-18-32008	PREVENTATIVE CARE HEALTH SERVICES, INC.				4
A-06-18-32056	LONE STAR COMMUNITY HEALTH CENTER INC.				1
A-06-18-32060	EAST TEXAS BORDER HEALTH CLINIC D/B/A GENESIS PRIM				1
A-06-18-32092	PRESBYTERIAN MEDICAL SERVICES				1
A-06-18-32110	TARRANT COUNTY TEXAS				1
A-06-18-32145	COUNCIL FOR ADVANCEMENT OF SOCIAL SERVICES & EDUCA				3
A-06-18-32170	ELLIS COUNTY COALITION FOR HEALTH OPTIONS, INC. (H				3

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A-06-18-32201	TEXAS BIOMEDICAL RESEARCH INSTITUTE				1
A-06-18-32263	PUEBLO OF POJOAQUE				3
A-06-18-32264	MESCALERO APACHE TRIBE				0
A-06-18-32268	CHICKASAW NATION				0
A-06-18-32269	WICHITA & AFFILIATED TRIBES				1
A-06-18-32270	MODOC TRIBE OF OKLAHOMA				0
A-06-18-32271	SEMINOLE NATION OF OKLAHOMA				5
A-06-18-32272	SAC & FOX NATION OF OKLAHOMA				0
A-06-18-32311	KICKAPOO TRIBE OF OKLAHOMA				0
A-06-18-32332	PUEBLO DE SAN FELIPE				0
A-06-18-32346	SOUTH CENTRAL HOUSTON ACTION COUNCIL, INC. D/B/A C				11
A-06-18-32347	CITY OF BATON ROUGE & PARISH OF EAST BATON ROUGE				1
A-06-18-32362	MIAMI TRIBE OF OKLAHOMA				0
A-06-18-32363	ABSENTEE SHAWNEE TRIBE OF INDIANS OF OKLAHOMA				0
A-06-18-32370	COUSHATTA TRIBE OF LOUISIANA				3
A-06-18-32405	HEALTH SERVICES OF NORTH TEXAS, INC.				1
A-06-18-32412	PICURIS PUEBLO				0
A-06-18-32413	CHOCTAW NATION OF OKLAHOMA				1
A-06-18-32418	VALLEY AIDS COUNCIL, INC.				0
A-06-18-32482	RAMAH NAVAJO SCHOOL BOARD, INC.				2
A-06-18-32491	VISIONQUEST BIOMEDICAL, LLC				1
A-06-18-32499	HIDALGO MEDICAL SERVICES				3
A-06-18-32514	SANTO DOMINGO TRIBE TRIBAL PROGRAMS OFFICE				7
A-06-18-32530	WINDMILL CARDIOVASCULAR SYSTEMS, INC.				4
A-06-18-32548	PEORIA TRIBE OF INDIANS OF OKLAHOMA				0
A-06-18-32640	VULINTUS, INC.				1
A-06-18-32659	PUEBLO OF TESUQUE				3
A-06-18-32660	JICARILLA APACHE NATION				3
A-06-18-32661	PUEBLO OF ISLETA				3
A-06-18-32662	PUEBLO OF ZUNI				2
A-06-18-32664	LONGVIEW WELLNESS CENTER INC.				1
A-06-18-32665	SPECIAL HEALTH RESOURCES OF EAST TEXAS INC.				1
A-06-18-32667	PAWNEE NATION OF OKLAHOMA				1
A-06-18-32668	CHEYENNE & ARAPAHO TRIBES OF OKLAHOMA				8
A-06-18-32695	PUEBLO DE COCHITI GOVERNMENTAL SERVICES DEPARTMENT				4
A-06-18-32696	PREVENTATIVE CARE HEALTH SERVICES, INC.				2
A-06-18-32700	KAW NATION				1
A-06-18-32701	OTOE-MISSOURIA TRIBE OF INDIANS				4
A-06-18-32722	YSLETA DEL SUR PUEBLO				0
A-06-18-32729	MT. ENTERPRISE COMMUNITY HEALTH CLINIC				2
A-06-18-32758	ST. GABRIEL HEALTH CLINIC INC.				0
A-06-18-32796	MID-DELTA HEALTH SYSTEMS INC.				1
A-06-18-32831	OHKAY OWINGEH				0
A-06-18-32832	PUEBLO OF SANDIA				2
A-06-18-32833	TAOS PUEBLO CENTRAL MANAGEMENT SYSTEM				0
A-06-18-32834	SANTA CLARA INDIAN PUEBLO ADMINISTRATIVE UNIT				0
A-06-18-32835	PUEBLO OF ACOMA				1
A-06-18-32839	ALABAMA-COUSHATTA TRIBE OF TEXAS				0
A-06-18-32840	FORT SILL APACHE TRIBE OF OKLAHOMA				0
A-06-18-32841	IOWA TRIBE OF OKLAHOMA				2
A-06-18-32856	INDIAN HEALTH CARE RESOURCE CENTER OF TULSA INC.				0
A-06-18-32858	BAYLOR COLLEGE OF MEDICINE				0
A-06-18-32871	AMERICAN HEART ASSOCATIONS, INC.				1
A-06-18-32879	HOUSTON AREA COMMUNITY SERVICES, INC.				4
A-06-18-32880	UNIV. OF OKLAHOMA HEALTH SCIENCES CENTER				1
A-06-18-32881	UNIV. OF OKLAHOMA NORMAN CAMPUS				2
A-06-18-32882	UNIV. OF ARKANSAS FOR MEDICAL SCIENCES				0
A-06-18-32898	PUEBLO OF LAGUNA				3

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A-06-18-32899	TEXAS HEART INSTITUTE & SUBSIDIARIES				3
A-06-18-32901	EXCELTH, INC.				1
A-06-18-32932	LANGSTON UNIV.				1
A-06-18-32936	ST. GABRIEL HEALTH CLINIC INC.				3
A-06-18-32995	NEW MEXICO OFFICE OF THE SUPERINTENDENT OF INSURAN				11
A-06-18-32998	TEXAS A&M RESEARCH FOUNDATION				2
A-06-18-33006	NEW MEXICO CONSORTIUM & SUBSIDIARY				1
A-06-18-33010	EIGHT NORTHERN INDIAN PUEBLOS COUNCIL, INC.				6
A-06-18-33046	LA FAMILIA MEDICAL CENTER				5
A-06-18-33081	PUEBLO DE SAN ILDEFONSO				0
A-06-18-33082	EASTERN SHAWNEE TRIBE OF OKLAHOMA				0
A-06-18-33083	TUNICA-BILOXI TRIBE OF LOUISIANA				7
A-06-18-33138	NEW MEXICO HUMAN SERVICES DEPT.				8
A-06-18-33140	COUNCIL FOR ADVANCEMENT OF SOCIAL SERVICES & EDUCA				2
A-06-18-33229	NEW MEXICO DEPT. OF HEALTH				2
A-06-18-33230	DISABILITY RIGHTS ARKANSAS INC.				1
A-06-18-33275	FIRST NATIONS COMMUNITY HEALTHSOURCE INC.				0
A-06-18-33276	PUEBLO OF NAMBE				0
A-06-18-33278	COMANCHE NATION GOVERNMENTAL PROGRAMS DEPT.				0
A-07-13-06046	Physician Administered Drug Rebates for Managed Care Claims in Nebraska	$1,065,264			2
A-07-16-00486	Review of North Carolina Medicaid General Controls over the NC Fast Eligibiility Determination System				9
A-07-16-00493	First Coast Service Options, Inc., Understated Its Allocable Pension Costs				2
A-07-16-00494	First Coast Service Options, Inc., Understated Its Medicare Segment Pension Assets	$1,033,833			1
A-07-16-00495	First Coast Service Options, Inc., Generally Claimed Allowable Medicare Pension Costs	$33,619			0
A-07-16-05087	Review of Medicare Part C Payment on Behalf of Deceased Beneficiaries	$2,420,761			1
A-07-17-00506	Palmetto Government Benefits Administrator, LLC Claimed Some Unallowable Pension Costs Through Its Incurred Costs Proposals	$95,038			0
A-07-17-00513	CGS Administrators, LLC, Did Not Claim Some Allowable Pension Costs Through Its Incurred Cost Proposals				1
A-07-17-00516	Wisconsin Physician Service Insurance Corporation Understated Its Medicare Segment Pension Assets for Its Employees' Pension Plan	$241,574			1
A-07-17-00517	Wisconsin Physicians Service Insurance Corporation Overstated Its Medicare Segment Penion Assets for Its Managerial Retirement Program for Selected Locations	$33,463			1
A-07-17-00518	Wisconsin Physician Service Insurance Corporation Understated Its Medicare Segment Pension Assets for Its Managerial Pension Plan	$3,214,152			1
A-07-17-00519	Wisconsin Physicians Service Insurance Corporation Did Not Claim Some Allowable Medicare Pension Costs				1
A-07-17-00520	Wisconsin Physicians Service Insurance Corporation Understated Its Allocable Pension Costs				2
A-07-18-31672	COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA INC.				3
A-07-18-31673	PARAQUAD, INC. & PARAQUAD 5240, INC.				2
A-07-18-31758	ASCENSION HEALTH ALLIANCE				1
A-07-18-31857	CITY OF ST. LOUIS				2
A-07-18-31922	HUNTER HEALTH CLINIC INC.				4
A-07-18-31965	IOWA HEALTH SYSTEM & SUBSIDIARIES				0
A-07-18-32098	CHARLES DREW HEALTH CENTER INC. & FOUNDATION				1
A-07-18-32207	OMAHA TRIBE OF NEBRASKA				12
A-07-18-32274	PONCA TRIBE OF NEBRASKA				0
A-07-18-32275	WINNEBAGO TRIBE OF NEBRASKA				4
A-07-18-32308	COMMUNITY HEALTH CENTERS OF SOUTHERN IOWA INC.				1
A-07-18-32328	HEARTLAND HEALTH CENTER INC.				4
A-07-18-32356	GRACE HILL SETTLEMENT HOUSE				4
A-07-18-32438	ATCHISON COMMUNITY HEALTH CLINIC INC.				5
A-07-18-32466	EAST CENTRAL MISSOURI BEHAVIORAL HEALTH SERVICES,				4
A-07-18-32467	SAC & FOX TRIBE OF THE MISSISSIPPI IN IOWA				10

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A-07-18-32503	KANSAS CITY CARE CLINIC				5
A-07-18-32536	DES MOINES UNIV. - OSTEOPATHIC MEDICAL CENTER				0
A-07-18-32641	APT THERAPEUTICS, INC.				2
A-07-18-32674	PRAIRIE BAND POTAWATOMI NATION				1
A-07-18-32711	DOUGLAS COUNTY, KANSAS				3
A-07-18-32724	KICKAPOO TRIBE IN KANSAS				5
A-07-18-32725	NATIONAL RURAL ACCOUNTABLE CARE CONSORTIUM				3
A-07-18-32726	FATHER FLANAGAN'S BOYS' HOME DBA BOYS TOWN				1
A-07-18-32789	SOUTHWEST BAPTIST UNIV.				0
A-07-18-32845	IOWA TRIBE OF KANSAS & NEBRASKA				0
A-07-18-32860	UNIV. OF KANSAS MEDICAL CENTER RESEARCH INSTITUTE,				1
A-07-18-32861	UNIV. OF KANSAS CENTER FOR RESEARCH INC.				0
A-07-18-32888	METROPOLITAN COMMUNITY COLLEGE				0
A-07-18-32889	MARYVILLE UNIV.				0
A-07-18-32943	COMMUNITY ACTION PARTNERSHIP OF WESTERN NEBRASKA I				3
A-07-18-32963	OZARK TRI-COUNTY HEALTH CARE CONSORTIUM, INC.				2
A-07-18-32967	ASCENSION HEALTH ALLIANCE				1
A-07-18-33002	PLANNED PARENTHOOD OF THE HEARTLAND INC.				1
A-07-18-33003	MT. MERCY UNIV.				0
A-07-18-33018	BIG SPRINGS MEDICAL ASSOCIATION, INC.				2
A-07-18-33027	CITY OF ST. LOUIS MENTAL HEALTH				1
A-07-18-33139	GREAT MINES HEALTH CENTER INC.				1
A-07-18-33168	EAST CENTRAL MISSOURI BEHAVIORAL HEALTH SERVICES I				2
A-08-18-31856	TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS				7
A-08-18-31967	SUMMIT COMMUNITY CARE CLINIC, INC.				2
A-08-18-32043	ACTION FOR EASTERN MONTANA				1
A-08-18-32054	PREVENT CHILD ABUSE NORTH DAKOTA				6
A-08-18-32057	UTAH PARTNERS FOR HEALTH				2
A-08-18-32093	ARAPAHOE HOUSE, INC.				3
A-08-18-32108	MARILLAC CLINIC INC.				6
A-08-18-32177	BLACKFEET TRIBE OF THE BLACKFEET INDIAN RESERVATIO				3
A-08-18-32210	THREE AFFILIATED TRIBES				9
A-08-18-32211	TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS				7
A-08-18-32237	BOULDER COUNTY COLORADO				2
A-08-18-32266	ROCKY BOY HEALTH BOARD				0
A-08-18-32267	ASSINIBOINE & SIOUX TRIBES OF THE FORT PECK INDIAN				1
A-08-18-32276	SISSETON-WAHPETON OYATE				0
A-08-18-32300	WASATCH HOMELESS HEALTH CARE INC.				4
A-08-18-32345	LA CLINICA TEPEYAC				1
A-08-18-32383	COMMUNITY ACTION OF LARAMIE COUNTY, INC.				6
A-08-18-32404	UNCOMPAHGRE COMBINED CLINICS				1
A-08-18-32428	PLAN DE SALUD DEL VALLE INC.				1
A-08-18-32456	CUSTER COUNTY COMMUNITY HEALTH CENTER, INC.				2
A-08-18-32457	NORTHLAND HEALTH PARTNERS COMMUNITY HEALTH CENTER				3
A-08-18-32500	MOUNTAIN FAMILY HEALTH CENTERS				1
A-08-18-32606	SITEONE THERAPEUTICS INC.				1
A-08-18-32648	CARTERRA, INC.				1
A-08-18-32657	PAIUTE INDIAN TRIBE OF UTAH				4
A-08-18-32675	COMMUNITY HEALTH CENTER OF THE BLACK HILLS, INC. &				4
A-08-18-32697	COMMUNITY HEALTH CENTER OF CENTRAL WYOMING INC.				4
A-08-18-32761	BIGHORN VALLEY HEALTH CENTER INC.				1
A-08-18-32774	SISTERS OF CHARITY OF LEAVENWORTH HEALTH SYSTEM IN				0
A-08-18-32787	LOWER BRULE SIOUX TRIBE				8
A-08-18-32788	NEUROPSYCHIATRIC RESEARCH INSTITUTE & NRI MEDICAL				1
A-08-18-32836	NORTHWESTERN BAND OF THE SHOSHONE NATION				0
A-08-18-32837	NORTHERN ARAPAHO TRIBE OF INDIANS				0
A-08-18-32846	OGLALA SIOUX TRIBE				0
A-08-18-32875	EASTERN SHOSHONE TRIBE				8

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A-08-18-32903	AVERA HEALTH				5
A-08-18-33001	CANKDESKA CIKANA COMMUNITY COLLEGE				2
A-08-18-33009	CARBON MEDICAL SERVICE ASSOCIATION INC.				2
A-08-18-33047	SOUTHERN UTE INDIAN TRIBE				1
A-08-18-33085	NATRONA COUNTY WYOMING				4
A-08-18-33097	BLACKROCK MICROSYSTEMS, LLC				1
A-08-18-33098	BLACKROCK MICROSYSTEMS, LLC				1
A-08-18-33110	UTAH NAVAJO HEALTH SYSTEM, INC.				2
A-08-18-33117	CHEYENNE RIVER SIOUX TRIBE				8
A-08-18-33137	STATE OF UTAH				6
A-08-18-33152	PREVENT CHILD ABUSE NORTH DAKOTA				4
A-08-18-33156	GREEN RIVER MEDICAL CENTER				1
A-08-18-33290	COMMUNITY DEVELOPMENT INSTITUTE HEAD START				0
A-09-16-02023	California Made Medicaid Payments on Behalf of Newly Eligible Beneficiaries Who Did Not Meet Federal and State Requirements				7
A-09-16-02031	Arizona Did Not Bill Manufacturers for Some Rebates for Drugs Dispensed to Enrollees of Medicaid Managed Care Organizations	$18,326,775			2
A-09-16-02034	Medicare Improperly Paid Providers for Specimen Validity Tests Billed in Combination With Urine Drug Tests	$66,309,751		$12,146,760	0
A-09-16-02037	Lincare Pharmacy Services Inc. Generally Complied with Medicare Requirements When Billing for Inhalation Drugs				1
A-09-16-02042	Medicare Needs Better Controls to Prevent Fraud, Waste, and Abuse Related to Chiropractic Services: An OIG Portfolio				4
A-09-17-03010	CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned: Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Program				0
A-09-18-31667	SOUTHERN TRINITY HEALTH SERVICES INC.				0
A-09-18-31839	WILMINGTON COMMUNITY CLINIC				1
A-09-18-31843	CHILDREN'S HOSPITAL & RESEARCH CENTER AT OAKLAND				4
A-09-18-31863	ANTELOPE VALLEY COMMUNITY CLINIC				1
A-09-18-31871	COALITION FOR A DRUG-FREE HAWAII INC. DBA DRUG-FRE				3
A-09-18-31906	COMMONWEALTH HEALTHCARE CORP.				45
A-09-18-31916	CENTRAL CITY COMMUNITY HEALTH CENTER				3
A-09-18-32015	GUAM DEPT. OF EDUCATION				0
A-09-18-32025	COMMUNITY MEDICAL CENTERS, INC.				4
A-09-18-32026	STANFORD UNIV.				2
A-09-18-32027	HEAD START OF NORTHEASTERN NEVADA				2
A-09-18-32045	SUSTAINABLE SCIENCES INSTITUTE				0
A-09-18-32047	COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS PUBLI				2
A-09-18-32088	GOVERNMENT OF GUAM				5
A-09-18-32103	NORTHEAST VALLEY HEALTH CORP.				1
A-09-18-32160	SUN LIFE FAMILY HEALTH CENTER INC.				2
A-09-18-32166	REPUBLIC OF THE MARSHALL ISLANDS				0
A-09-18-32167	INTER-TRIBAL COUNCIL OF NEVADA INC.				3
A-09-18-32192	HAWAII YOUTH SERVICES NETWORK				2
A-09-18-32193	FEDERATED STATES OF MICRONESIA				0
A-09-18-32196	SAN CARLOS APACHE TRIBE				3
A-09-18-32197	NAVAJO NATION				3
A-09-18-32241	HOOPA VALLEY TRIBE				2
A-09-18-32258	ELKO BAND COUNCIL				0
A-09-18-32259	FORT MCDOWELL YAVAPAI NATION				0
A-09-18-32260	FORT DEFIANCE INDIAN HOSPITAL BOARD, INC.				0
A-09-18-32261	HAVASUPAI TRIBE				0
A-09-18-32262	GILA RIVER INDIAN COMMUNITY				0
A-09-18-32289	GILA RIVER HEALTH CARE CORP.				1
A-09-18-32299	SRI INTERNATIONAL				1
A-09-18-32302	YAVAPAI-PRESCOTT INDIAN TRIBE				2
A-09-18-32324	ADELANTE HEALTHCARE, INC.				2
A-09-18-32333	COLUSA INDIAN COMMUNITY COUNCIL OF THE CACHIL DEHE				0

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A-09-18-32364	REDDING RANCHERIA				0
A-09-18-32390	NATIVE AMERICANS FOR COMMUNITY ACTION INC.				0
A-09-18-32409	INDIAN HEALTH COUNCIL INC.				0
A-09-18-32410	SONOMA COUNTY INDIAN HEALTH PROJECT INC.				0
A-09-18-32411	FALLON PAIUTE-SHOSHONE TRIBE				0
A-09-18-32429	TRANSLATIONAL GENOMICS RESEARCH INSTITUTE & AFFILI				1
A-09-18-32461	QUECHAN INDIAN TRIBE				6
A-09-18-32484	SONOMOTION INC.				1
A-09-18-32516	SCINTILLON INSTITUTE				1
A-09-18-32528	INTRINSIC LIFESCIENCES LLC				2
A-09-18-32543	INVENIO IMAGING INC.				2
A-09-18-32551	SHERWOOD VALLEY BAND OF POMO INDIANS				0
A-09-18-32552	RENO-SPARKS INDIAN COLONY				0
A-09-18-32555	AK-CHIN INDIAN COMMUNITY				0
A-09-18-32557	SANTA YNEZ TRIBAL HEALTH CLINIC OF THE SANTA YNEZ				1
A-09-18-32570	OSEL, INC. & SUBSIDIARY				0
A-09-18-32587	PROGNOSYS BIOSCIENCES, INC.				3
A-09-18-32594	SIGRAY INC.				4
A-09-18-32614	RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH INC.				0
A-09-18-32642	EYENUK, INC.				3
A-09-18-32656	PYRAMID LAKE PAIUTE TRIBE				4
A-09-18-32658	TONTO-APACHE TRIBE				5
A-09-18-32663	TUOLUMNE BAND OF ME-WUK INDIANS				4
A-09-18-32669	QUARTZ VALLEY INDIAN RESERVATION				2
A-09-18-32687	PALA BAND OF MISSION INDIANS				0
A-09-18-32688	ROUND VALLEY INDIAN TRIBES OF THE ROUND VALLEY RES				2
A-09-18-32693	WALKER RIVER PAIUTE TRIBE				2
A-09-18-32694	COCOPAH INDIAN TRIBE				1
A-09-18-32702	SCOTTS VALLEY BAND OF POMO INDIANS				7
A-09-18-32712	ELY SHOSHONE TRIBE				0
A-09-18-32713	PAXVAX GLOBAL, INC.				1
A-09-18-32735	BARTZ-ALTADONNA COMMUNITY HEALTH CENTER				2
A-09-18-32749	WINTERS HEALTHCARE FOUNDATION, INC.				1
A-09-18-32751	BIOMEDICAL RESEARCH INSTITUTE OF SOUTHER CALIFORNI				1
A-09-18-32756	AMERICAN COLLEGE OF MEDICAL TOXICOLOGY, INC. & IT'				1
A-09-18-32765	SAN DIEGO STATE UNIV. RESEARCH FOUNDATION				0
A-09-18-32766	KAISER FOUNDATION HEALTH PLAN INC. & SUBSIDIARIES				0
A-09-18-32775	CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.				0
A-09-18-32795	CENTRAL CITY COMMUNITY HEALTH CENTER				3
A-09-18-32809	IIPAY NATION OF SANTA YSABEL				0
A-09-18-32810	HOPLAND BAND OF POMO INDIANS				0
A-09-18-32811	ELY SHOSHONE TRIBE				1
A-09-18-32812	COYOTE VALLEY BAND OF POMO INDIANS				0
A-09-18-32815	SUSANVILLE INDIAN RANCHERIA				1
A-09-18-32827	WASHOE TRIBE OF NEVADA & CALIFORNIA				1
A-09-18-32828	CHEMEHUEVI INDIAN TRIBE				0
A-09-18-32829	YAVAPAI-APACHE NATION				1
A-09-18-32830	HUALAPAI NATION				0
A-09-18-32842	SHINGLE SPRINGS BAND OF MIWOK INDIANS				0
A-09-18-32843	GREENVILLE RANCHERIA				0
A-09-18-32844	PINOLEVILLE POMO NATION				0
A-09-18-32852	SORRENTO THERAPEUTICS, INC. & SUBSIDIARY				4
A-09-18-32855	SAN DIEGO AMERICAN INDIAN HEALTH CENTER				0
A-09-18-32872	UNIV. OF SAN DIEGO				0
A-09-18-32873	BUCK INSTITUTE FOR AGE RESEARCH				1
A-09-18-32877	AMERICAN INDIAN HEALTH & SERVICES				5
A-09-18-32897	HORIZON HEALTH & WELLNESS, INC.				2
A-09-18-32926	EPIGEN BIOSCIENCES, INC.				1

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A-09-18-32928	WHITTIER COLLEGE				1
A-09-18-32929	DAVIS STREET COMMUNITY CENTER INC.				2
A-09-18-32933	CITY OF HENDERSON, NEVADA				0
A-09-18-32934	NEVADA SYSTEM OF HIGHER EDUCATION				0
A-09-18-32953	CHARLES DREW UNIV. OF MEDICINE & SCIENCE				0
A-09-18-32982	SANFORD BURNHAM PREBYS MEDICAL DISCOVERY INSTITUTE				0
A-09-18-32991	DOMINICAN UNIV. OF CALIFORNIA				2
A-09-18-32993	WASHOE COUNTY, NEVADA				0
A-09-18-33011	SANTA BARBARA NEIGHBORHOOD CLINICS				1
A-09-18-33021	CIRCLE THE CITY & SUBSIDIARIES				1
A-09-18-33044	COMMUNITY MEDICAL CENTERS, INC.				4
A-09-18-33062	CITY OF HOPE & AFFILIATES				0
A-09-18-33063	CEDARS-SINAI MEDICAL CENTER				0
A-09-18-33080	PIT RIVER HEALTH SERVICE INC.				0
A-09-18-33103	COUNTY OF SAN LUIS OBISPO CALIFORNIA				0
A-09-18-33109	SIERRA COUNTY CALIFORNIA				0
A-09-18-33120	PACIFIC ISLANDS PRIMARY CARE ASSOCIATION				1
A-09-18-33133	MISSION CITY COMMUNITY NETWORK, INC.				1
A-09-18-33136	SOUTHERN NEVADA HEALTH DISTRICT				2
A-09-18-33159	HOPI TRIBE				13
A-09-18-33161	WHITE MOUNTAIN APACHE TRIBE				18
A-09-18-33182	VOLUNTEERS OF AMERICA OF LOS ANGELES				0
A-09-18-33184	SANTA CRUZ COUNTY				0
A-09-18-33185	BUTTE COUNTY CALIFORNIA				3
A-09-18-33204	SCRIPPS RESEARCH INSTITUTE				0
A-09-18-33228	LAS VEGAS PAIUTE TRIBE				4
A-09-18-33265	LAKE COUNTY TRIBAL HEALTH CONSORTIUM INC.				0
A-09-18-33285	ALAMEDA COUNTY CALIFORNIA				0
A-09-18-33286	SAN FRANCISCO UNIFIED SCHOOL DISTRICT				0
A-10-18-31684	LA PINE COMMUNITY HEALTH CENTER				2
A-10-18-32001	ALASKA ISLAND COMMUNITY SERVICES				1
A-10-18-32150	SPRINGSTAR, INC.				4
A-10-18-32248	JAMESTOWN S' KLALLAM TRIBE OF INDIANS				0
A-10-18-32255	SPOKANE TRIBE OF INDIANS				0
A-10-18-32256	CONFEDERATED TRIBES & BANDS OF THE YAKAMA NATION				0
A-10-18-32257	CONFEDERATED TRIBES OF THE COLVILLE RESERVATION				0
A-10-18-32265	NEZ PERCE TRIBE				2
A-10-18-32321	WATERFALL CLINIC, INC.				5
A-10-18-32322	INSTITUTE FOR SYSTEMS BIOLOGY				3
A-10-18-32323	HARBORVIEW MEDICAL CENTER				1
A-10-18-32360	CONFEDERATED TRIBES OF THE UMATILLA INDIAN RESERVA				0
A-10-18-32379	COQUILLE INDIAN TRIBE				0
A-10-18-32426	OREGON PRIMARY CARE ASSOCIATION				1
A-10-18-32479	CONFEDERATED TRIBES OF THE GRAND RONDE COMMUNITY O				0
A-10-18-32480	YAKUTAT TLINGIT TRIBE				0
A-10-18-32481	UPPER SKAGIT INDIAN TRIBE				0
A-10-18-32498	MOSES LAKE COMMUNITY HEALTH CENTER & SUBSIDIARY				2
A-10-18-32533	RINEHART CLINIC				4
A-10-18-32549	CONFEDERATED TRIBES OF SILETZ INDIANS OF OREGON				0
A-10-18-32553	SWINOMISH INDIAN TRIBAL COMMUNITY				0
A-10-18-32605	PAI LIFE SCIENCES, INC.				3
A-10-18-32632	NOVUSON SURGICAL, INC.				2
A-10-18-32650	KING COUNTY WASHINGTON				1
A-10-18-32651	COWLITZ INDIAN TRIBE				1
A-10-18-32653	TULALIP TRIBES OF WASHINGTON				0
A-10-18-32680	SAGE BIONETWORKS				1
A-10-18-32690	NOOKSACK INDIAN TRIBE				1
A-10-18-32691	SAUK-SUIATTLE INDIAN TRIBE				3

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A-10-18-32692	CONFEDERATED TRIBES OF THE CHEHALIS RESERVATION				1
A-10-18-32698	PROVIDENCE ST. JOSEPH HEALTH				2
A-10-18-32767	PIERCE COUNTY WASHINGTON				0
A-10-18-32784	COAST COMMUNITY HEALTH CENTER				1
A-10-18-32817	CONFEDERATED TRIBES OF COOS LOWER UMPQUA & SIUSLAW				0
A-10-18-32818	CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATIO				0
A-10-18-32819	KETCHIKAN INDIAN CORP.				1
A-10-18-32820	LUMMI INDIAN BUSINESS COUNCIL				0
A-10-18-32821	PORT GAMBLE S'KLALLAM TRIBE				0
A-10-18-32822	NISQUALLY INDIAN TRIBE				1
A-10-18-32823	MUCKLESHOOT INDIAN TRIBE				0
A-10-18-32824	MAKAH TRIBAL COUNCIL				0
A-10-18-32862	ANCHORAGE NEIGHBORHOOD HEALTH CENTER INC.				1
A-10-18-32876	BOISE STATE UNIV.				1
A-10-18-32908	OREGON HEALTH & SCIENCE UNIV.				0
A-10-18-32930	WATERFALL CLINIC, INC.				6
A-10-18-32931	CROSS ROAD HEALTH MINISTRIES INC.				3
A-10-18-32972	NATIVE VILLAGE OF TYONEK				3
A-10-18-32985	FRED HUTCHINSON CANCER RESEARCH CENTER				0
A-10-18-32992	ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS				18
A-10-18-33030	SEDIA BIOSCIENCES CORP.				1
A-10-18-33045	DECISION SCIENCE RESEARCH INSTITUTE INC. DBA DECIS				1
A-10-18-33084	BENTON COUNTY				2
A-10-18-33135	SEATTLE CHILDREN'S HOSPITAL				1
A-10-18-33146	ALTIUS INSTITUTE FOR BIOMEDICAL SCIENCES				6
A-10-18-33163	BOISE STATE UNIV.				2
A-10-18-33177	SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM				0
A-10-18-33246	YUKON-KUSKOKWIM HEALTH CORP.				1
A-10-18-33267	EASTERN ALEUTIAN TRIBES INC.				1
A-10-18-33268	NATIVE VILLAGE OF EKLUTNA				0
A-10-18-33270	BRISTOL BAY AREA HEALTH CORP.				2
A-10-18-33271	NORTON SOUND HEALTH CORP.				0
A-10-18-33272	MANIILAQ ASSOCIATION				1
A-10-18-33273	FAIRBANKS NATIVE ASSOCIATION				0
A-10-18-33274	SHOALWATER BAY INDIAN TRIBE				0
A-10-18-33288	MULTNOMAH COUNTY OREGON				0
A-17-17-02016	FY 2017 CFO Financial Statement Audit of CMS				0
A-18-16-30810	IT Audit - SAMHSA Penetration Test				8
A-18-17-11200	Review of the DHHS' Compliance with the FISMA of 2014 for FY 2017				6
A-18-17-11300	Review of Medicare Administrative Contractor Information Security Program Evaluations for FY 2016				0
	Totals :	**$640,005,268**	**$20,007,447**	**$156,476,096**	

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FINAL AUDIT REPORTS ISSUED FOR SEMIANNUAL PERIOD
HUMAN DEVELOPMENT FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-01-16-02500	MA Foster Care Health and Safety - Group Home Inspections				4
A-01-18-32312	SELF HELP, INC.				0
A-01-18-32359	AREA COOPERATIVE EDUCATIONAL SERVICES				5
A-01-18-32905	ANDROSCOGGIN HEAD START & CHILD CARE				1
A-01-18-32970	FRANKLIN COUNTY DIAL SELF INC.				1
A-01-18-32989	COMMUNITY DAY CARE CENTER OF LAWRENCE INC.				0
A-01-18-32990	COMMUNITY TEAMWORK, INC.				0
A-01-18-33132	CONNECTICUT COALITION AGAINST DOMESTIC VIOLENCE IN				0
A-02-15-02014	New York Did Not Always Comply with State Requirements for Recording and Investigating Allegations of Abuse and Neglect for Title IV-E Foster Care Children				1
A-02-16-02009	The Administration for Children and Families Region II Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements				4
A-02-18-31869	CHILD CENTER OF NEW YORK, INC.				1
A-02-18-32019	PUERTO RICO DEPT. OF THE FAMILY				19
A-02-18-32101	QUALITY CARE RESOURCE & REFERRAL SERIVCES, INC.				1
A-02-18-32366	MDRC				0
A-02-18-32388	JOINT COUNCIL FOR ECONOMIC OPPORTUNITY OF CLINTON				1
A-02-18-32392	COMMUNITY ACTION OF ORLEANS & GENESEE, INC.				0
A-02-18-32440	LEWIS COUNTY HEAD START INC.				1
A-02-18-32473	MONMOUTH COUNTY NEW JERSEY				0
A-02-18-32741	OCEAN COMMUNITY ECONOMIC ACTION NOW INC.				7
A-02-18-32806	SULLIVAN COUNTY HEAD START INC.				1
A-02-18-32948	BURLINGTON COUNTY COMMUNITY ACTION PROGRAM				2
A-02-18-32949	REGIONAL ECONOMIC COMMUNITY ACTION PROGRAM INC.				1
A-02-18-33121	COMMUNITY ACTION ORGANIZATION OF ERIE COUNTY INC.				1
A-03-18-31917	NATIONAL DISABILITY RIGHTS NETWORK, INC.				1
A-03-18-32220	NORTHERN TIER COMMUNITY ACTION CORP.				2
A-03-18-32327	RESNA				2
A-03-18-32373	INDEPENDENCE NOW, INC.				1
A-03-18-32380	SCHOOL DISTRICT OF PITTSBURGH PENNSYLVANIA				0
A-03-18-32459	KIDSPEACE CORP. & SUBSIDIARIES				1
A-03-18-32506	POLARIS PROJECT, INC.				1
A-03-18-32671	TRANSCEN INC.				5
A-03-18-32672	COMMUNITY ACTION PARTNERSHIP				3
A-03-18-32676	MILE HIGH KIDS & COMMUNITY DEVELOPMENT, INC.				1
A-03-18-32884	MONTICELLO AREA COMMUNITY ACTION AGENCY INC.				2
A-03-18-32941	CENTER FOR URBAN FAMILIES INC.				2
A-03-18-33007	FAMILY & COMMUNITY CHRISTIAN ASSOCIATION				4
A-03-18-33055	TABLELAND SERVICES INC.				1
A-03-18-33088	KANAWHA INSTITUTE FOR SOCIAL RESEARCH & ACTION INC				2
A-03-18-33165	STEPS, INC				1
A-04-16-03566	Unaccompanied Alien Children Program Grantee Review - His House Children's Home				6
A-04-18-31796	FAMILY SERVICES INC.				1
A-04-18-31897	FIVE COUNTY CHILD DEVELOPMENT PROGRAM INC.				3
A-04-18-31898	PARTNERSHIP FOR COMMUNITY ACTION, INC.				1
A-04-18-31899	COMMUNITY ACTION FOR IMPROVEMENT, INC.				6
A-04-18-32016	MOBILE COMMUNITY ACTION, INC.				6
A-04-18-32029	SALISBURY-ROWAN COMMUNITY ACTION AGENCY, INC.				0
A-04-18-32049	COASTAL COMMUNITY ACTION INC.				1
A-04-18-32050	LUMBEE REGIONAL DEVELOPMENT ASSOCIATION, INC.				4
A-04-18-32204	KCEOC COMMUNITY ACTION PARTNERSHIP, INC. & AFFILIA				1
A-04-18-32221	BEAUFORT-JASPER ECONOMIC OPPORTUNITY COMMISSION, I				0
A-04-18-32310	ORGANIZED COMMUNITY ACTION PROGRAM INC.				0
A-04-18-32372	SALISBURY-ROWAN COMMUNITY ACTION AGENCY, INC.				4
A-04-18-32502	WATEREE COMMUNITY ACTIONS, INC.				7
A-04-18-32704	MOBILE COMMUNITY ACTION, INC.				5

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CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-04-18-32799	WATEREE COMMUNITY ACTIONS, INC.				6
A-04-18-32863	CENTRAL MISSISSIPPI INC.				3
A-04-18-32902	CATHOLIC SOCIAL SERVICES OF THE GREATER MOBILE ARE				2
A-04-18-32937	MONTGOMERY COMMUNITY ACTION COMMITTEE & CDC, INC.				1
A-04-18-32975	BREVARD COUNTY DISTRICT SCHOOL BOARD FLORIDA				0
A-04-18-33067	DISTRICT SCHOOL BOARD OF COLLIER COUNTY				0
A-04-18-33087	GREENE LAMP INC.				1
A-04-18-33114	COMMUNITY ACTION OPPORTUNITIES				2
A-04-18-33188	EARLY LEARNING COALITION OF MIAMI-DADE/MONROE, INC				0
A-04-18-33192	ECKERD YOUTH ALTERNATIVES INC. DBA ECKERD CONNECT				0
A-05-18-31860	METROPOLITAN CHILDREN & YOUTH, INC. UNITED				1
A-05-18-31915	BLUE WATER COMMUNITY ACTION				0
A-05-18-32031	WEST CENTRAL ILLINOIS AREA AGENCY ON AGING				4
A-05-18-32122	MAHUBE-OTWA COMMUNITY ACTION PARTNERSHIP, INC.				2
A-05-18-32234	DUBOIS-PIKE-WARRICK ECONOMIC OPPORTUNITY COMMITTEE				0
A-05-18-32391	KNO-HO-CO-ASHLAND COMMUNITY ACTION COMMISSION & SU				0
A-05-18-32435	LAKES & PRAIRIES COMMUNITY ACTION PARTNERSHIP INC.				3
A-05-18-32468	MATRIX HUMAN SERVICES				9
A-05-18-32504	CHILD CARE CONSORTIUM, INC.				11
A-05-18-32518	HEARTLAND HEAD START INC.				5
A-05-18-32579	NORTHWESTERN ILLINOIS COMMUNITY ACTION AGENCY INC.				2
A-05-18-32733	COMMUNITY ACTION PARTNERSHIP OF LAKE COUNTY				1
A-05-18-32773	MACOMB COUNTY MICHIGAN				2
A-05-18-32804	COUNCIL FOR ECONOMIC OPPORTUNITIES IN GREATER CLEV				1
A-05-18-32904	TWO RIVERS REGIONAL COUNCIL OF PUBLIC OFFICIALS				1
A-05-18-33005	ECONOMIC & COMMUNITY DEVELOPMENT INSTITUTE				3
A-05-18-33148	BATTERED WOMENS JUSTICE PROJECT				2
A-05-18-33153	OUNCE OF PREVENTION FUND ILLINOIS				1
A-05-18-33154	FREMONT COMMUNITY SCHOOLS				3
A-05-18-33212	ROCK ISLAND-MILAN SCHOOL DISTRICT NO. 41				0
A-06-16-00013	Pine Bluff Jefferson County Economic Opportunities Commission Did Not Always Operate Its Head Start Program In Accordance With Federal Requirements	$279,543			11
A-06-16-00015	Southeast Arkansas Community Action Corporation Did Not Always Operate Its Head Start Program In Accordance With Federal Regulations	$4,784			8
A-06-16-07006	Oklahoma Did Not Always Comply With Requirements for Providing Health Care Services to Children in Foster Care				1
A-06-16-07007	BCFS Health and Human Services Did Not Always Comply with Federal Requirements Related to Less-Than-Arm's Length Leases	$658,248			0
A-06-17-07003	The Administration for Children and Families Did Not Always Resolve American Indian and Alaska Native Head Start Grantees' Single Audit Findings in Accordance with Federal Requirements.				4
A-06-18-31905	ST. JAMES PARISH SCHOOL BOARD				2
A-06-18-32013	ARKANSAS EARLY LEARNING, INC.				2
A-06-18-32094	NATIONAL DOMESTIC VIOLENCE HOTLINE				3
A-06-18-32171	CHILDCAREGROUP				1
A-06-18-32303	COMMUNITY ACTION PROGRAM FOR CENTRAL ARKANSAS INC.				4
A-06-18-32367	DELTA COMMUNITY ACTION FOUNDATION INC.				0
A-06-18-32430	OUACHITA MULTI-PURPOSE COMMUNITY ACTION PROGRAM IN				3
A-06-18-32431	SOUTHEAST ARKANSAS COMMUNITY ACTION CORP.				2
A-06-18-32453	MOREHOUSE COMMUNITY IMPROVEMENT ORGANIZATION INC.				2
A-06-18-32462	WILLIAMSON-BURNET COUNTY OPPORTUNITIES, INC.				4
A-06-18-32463	CENTRAL TRIBES OF THE SHAWNEE AREA INC.				4
A-06-18-32472	HIDALGO COUNTY				0
A-06-18-32501	CHILDREN'S CENTER, INC.				10
A-06-18-32519	AMBASSADORS FOR CHRIST YOUTH MINISTRIES				0
A-06-18-32526	WEBSTER PARISH OFFICE OF COMMUNITY SERVICES				1
A-06-18-32558	CHILD CARE ASSOCIATES				0
A-06-18-32666	SCURRY COMMUNITY SERVICES INC.				4

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FINAL AUDIT REPORTS ISSUED FOR SEMIANNUAL PERIOD
HUMAN DEVELOPMENT FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-06-18-32682	CENTER FOR NEW COMMUNITIES				1
A-06-18-32757	GALVESTON COUNTY COMMUNITY ACTION COUNCIL INC.				4
A-06-18-32792	AMBASSADORS FOR CHRIST YOUTH MINISTRIES				1
A-06-18-32857	TEXAS MIGRANT COUNCIL D/B/A TMC-TEACHING & MENTORI				1
A-06-18-32900	BRAZORIA COUNTY HEAD START EARLY LEARNING SCHOOLS,				1
A-06-18-32917	SHILOH TREATMENT CENTER, INC.				0
A-06-18-32958	CHILD INC.				3
A-06-18-33048	NORTHEAST OKLAHOMA COMMUNITY ACTION AGENCY, INC. &				2
A-06-18-33049	COMMUNITY ACTION PROGRAM FOR CENTRAL ARKANSAS INC.				3
A-06-18-33065	BCFS HEALTH & HUMAN SERVICES				0
A-06-18-33111	AVANCE, INC.				2
A-06-18-33164	WEST FELICIANA PARISH SCHOOL BOARD				2
A-06-18-33186	SOUTHWEST KEY PROGRAMS, INC. & AFFILIATES				0
A-07-15-04226	Not All of Missouri's Child Care Subsidy Program Payments Complied with Federal and State Requirements	$19,076,167			2
A-07-18-31882	OZARKS AREA COMMUNITY ACTION CORP.				0
A-07-18-31885	SALVATION ARMY OMAHA AREA				0
A-07-18-31891	WEST CENTRAL MISSOURI COMMUNITY ACTION AGENCY				2
A-07-18-32100	CONNECTIONS TO SUCCESS				7
A-07-18-32223	YOUTH IN NEED				0
A-07-18-32730	CONNECTIONS TO SUCCESS				7
A-07-18-32886	CENTRAL COMMUNITY COLLEGE AREA				2
A-07-18-32983	DOUGLAS COUNTY SCHOOL DISTRICT #0001				0
A-07-18-33147	CENTRAL NEBRASKA COMMUNITY SERVICES, INC.				1
A-08-18-32439	CENTER FOR CHILDREN & FAMILIES, INC.				4
A-08-18-32515	ANACONDA - DEER LODGE COUNTY				3
A-08-18-32763	NORTHWEST MONTANA HEAD START INC.				1
A-08-18-32786	RED CLOUD INDIAN SCHOOL, INC.				1
A-08-18-32887	LUTHERAN SOCIAL SERVICES OF SOUTH DAKOTA, INC. & C				5
A-08-18-32961	BISMARCK PUBLIC SCHOOL DISTRICT NO. 1				2
A-08-18-32994	SALT LAKE COMMUNITY ACTION PROGRAM				5
A-08-18-33054	FIRST NATIONS DEVELOPMENT INSTITUTE & SUBSIDIARY				1
A-08-18-33157	CENTRO DE LA FAMILIA DE UTAH				2
A-09-16-01004	The Administration for Children and Families Region X Did Not Always Resolve Head Start Grantees' Single Audit Findings in Accordance With Federal Requirements				1
A-09-16-01006	Some Washington State Group-Care Facilities for Children in Foster Care Did Not Always Comply With State Health and Safety Requirements				7
A-09-18-31757	SAN DIEGO WORKFORCE PARTNERSHIP, INC.				1
A-09-18-32028	CHILD START, INC.				3
A-09-18-32424	KEIKI O KA 'AINA PRESCHOOL, INC.				1
A-09-18-32874	INTER-TRIBAL COUNCIL OF CALIFORNIA, INC.				13
A-09-18-32907	COMMUNITY ACTION PARTNERSHIP OF KERN				0
A-09-18-32957	ABILITY360 & SUBSIDIARY				3
A-09-18-32973	LONG BEACH UNIFIED SCHOOL DISTRICT				0
A-09-18-32974	NEIGHBORHOOD HOUSE ASSOCIATION				0
A-09-18-33059	LOS ANGELES COUNTY OFFICE OF EDUCATION				0
A-09-18-33060	CRYSTAL STAIRS INC.				0
A-09-18-33061	CHILD CARE RESOURCE CENTER, INC.				0
A-09-18-33064	SACRAMENTO EMPLOYMENT & TRAINING AGENCY				0
A-09-18-33160	ARIZONA'S CHILDREN ASSOCIATION & ARIZONA'S CHILDRE				1
A-09-18-33183	STANISLAUS COUNTY OFFICE OF EDUCATION				0
A-09-18-33203	RIVERSIDE COUNTY OFFICE OF EDUCATION				0
A-10-18-32091	FAMILY SERVICES OF GRANT COUNTY				1
A-10-18-32194	ORGANIZED VILLAGE OF KWETHLUK KWETHLUK IRA COUNCIL				2
A-10-18-32455	MID-COLUMBIA CHILDREN'S COUNCIL INC.				1
A-10-18-32469	COOK INLET NATIVE HEAD START				1
A-10-18-32652	OKANOGAN COUNTY CHILD DEVELOPMENT ASSOCIATION				2

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A-10-18-32654	DIOCESE OF OLYMPIA					1
A-10-18-32689	KIDS & COMPANY OF LINN COUNTY					4
A-10-18-32755	BRIGHT BEGINNINGS FOR KITTITAS COUNTY					2
A-10-18-32954	ROGUE COMMUNITY COLLEGE DISTRICT					1
A-10-18-33227	NEIGHBORHOOD ECONOMIC DEVELOPMENT CORP. & SUBSIDIA					1
		Totals :	**$20,018,742**	**$0**	**$0**	

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GENERAL GOVERNMENT FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-03-18-00351	Independent Attestation Review: Indian Health Service Fiscal Year 2017 Detailed Accounting Submission and Performance Summary Report for National Drug Control Activities and Accompanying Required Assertions				0
A-03-18-32802	NATIVE AMERICAN LIFELINES INC.				4
A-03-18-33205	ALLEGHENY VALLEY SCHOOL				0
A-04-18-32800	EDGECOMBE COUNTY NORTH CAROLINA				0
A-04-18-32910	UNION COUNTY				0
A-04-18-32911	DURHAM COUNTY NORTH CAROLINA				0
A-04-18-32976	SOUTH FLORIDA BEHAVIORAL HEALTH NETWORK INC.				0
A-04-18-32977	FLORIDA HEALTHY KIDS CORP.				0
A-04-18-33069	HAYWOOD COUNTY				0
A-04-18-33070	RUTHERFORD COUNTY NORTH CAROLINA				0
A-04-18-33072	BUNCOMBE COUNTY NORTH CAROLINA				0
A-04-18-33073	ALAMANCE COUNTY NORTH CAROLINA				0
A-04-18-33107	JONES COUNTY NORTH CAROLINA				0
A-04-18-33115	TRANSYLVANIA COUNTY NORTH CAROLINA				0
A-04-18-33187	CHILDNET, INC. & AFFILIATE				0
A-04-18-33197	SURRY COUNTY NORTH CAROLINA				0
A-04-18-33198	SAMPSON COUNTY NORTH CAROLINA				0
A-04-18-33199	JOHNSTON COUNTY NORTH CAROLINA				0
A-04-18-33200	BLADEN COUNTY NORTH CAROLINA				0
A-04-18-33201	CHILD CARE RESOURCES INC. NORTH CAROLINA				0
A-05-17-32033	SUSTAINABLE RESOURCES CENTER INC. & SUBSIDIARY				0
A-05-18-33102	HUBBARD COUNTY				0
A-06-18-32284	KEWA PUEBLO HEALTH CORP.				0
A-06-18-32556	JENA BAND OF CHOCTAW INDIANS				0
A-06-18-33066	JEFFERSON PARISH PUBLIC SCHOOL SYSTEM				0
A-06-18-33179	NORTHEASTERN TRIBAL HEALTH SYSTEM				0
A-08-18-32507	CONFEDERATED TRIBES OF THE GOSHUTE RESERVATION				0
A-08-18-32508	CONFEDERATED TRIBES OF THE GOSHUTE RESERVATION				0
A-08-18-32509	CONFEDERATED TRIBES OF THE GOSHUTE RESERVATION				0
A-08-18-32727	BLACK HILLS CENTER FOR AMERICAN INDIAN HEALTH				2
A-08-18-32935	URBAN INDIAN CENTER OF SALT LAKE				3
A-09-18-31925	SAN JOAQUIN COUNTY CALIFORNIA				0
A-09-18-32109	WINSLOW INDIAN HEALTH CARE CENTER INC.				1
A-09-18-32286	LOVELOCK PAIUTE TRIBE				0
A-09-18-32331	SIERRA TRIBAL CONSORTIUM INC.				0
A-09-18-32334	BAKERSFIELD AMERICAN INDIAN HEALTH PROJECT INC.				0
A-09-18-32335	SYCUAN BAND OF THE KUMEYAAY NATION				0
A-09-18-32378	STRONG FAMILY HEALTH CENTER				0
A-09-18-32403	NEVADA URBAN INDIANS INC.				1
A-09-18-32414	GUIDIVILLE BAND OF POMO INDIANS				0
A-09-18-32427	YOMBA SHOSHONE TRIBE				6
A-09-18-32460	APACHE BEHAVIORAL HEALTH SERVICES, INC.				1
A-09-18-32477	CONSOLIDATED TRIBAL HEALTH PROJECT INC.				0
A-09-18-32478	NORTHERN VALLEY INDIAN HEALTH INC.				0
A-09-18-32554	KAIBAB BAND OF PAIUTE INDIANS				0
A-09-18-32655	YOMBA SHOSHONE TRIBE				4
A-09-18-32813	KASHIA BAND OF POMO INDIANS OF THE STEWARTS POINT				0
A-09-18-32814	MARIPOSA, AMADOR, CALAVERAS, TUOLUMNE HEALTH BOARD				0
A-09-18-32825	FORT MCDERMITT PAIUTE-SHOSHONE TRIBE				0
A-09-18-32826	DUCKWATER SHOSHONE TRIBE				3
A-09-18-32838	TABLE MOUNTAIN RANCHERIA				0
A-09-18-32849	WILTON RANCHERIA				3
A-09-18-33176	CABAZON BAND OF MISSION INDIANS				0
A-09-18-33180	FEATHER RIVER TRIBAL HEALTH INC.				0
A-09-18-33266	CHAPA-DE INDIAN HEALTH PROGRAM INC.				0
A-09-18-33284	SAN BERNARDINO COUNTY SUPERINTENDENT OF SCHOOLS				0

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GENERAL GOVERNMENT FROM 10/01/2017 TO 03/31/2018

CIN	Audit Title	Costs Questioned	Unsupported Cost	Funds Put To Better Use	PM Recs
A-10-18-32361	SAMISH INDIAN NATION				0
A-10-18-32816	KLAMATH TRIBAL HEALTH & FAMILY SERVICES				0
A-10-18-32896	BURNS PAIUTE TRIBE				7
A-10-18-33101	CHITINA TRADITIONAL INDIAN VILLAGE COUNCIL				4
A-10-18-33269	NATIVE VILLAGE OF KARLUK				1
A-10-18-33277	KOOTENAI TRIBE OF IDAHO				0
A-17-17-00001	FY 2017 HHS Consolidated Financial Statement Audit				0
A-17-17-02018	DATA Act Audit				0
A-18-16-30540	Two Indian Health Service Hospitals Had System Security and Physical Controls for Prescription Drug and Opioid Despensing but Could Still Improve Controls				8
	Totals :	**$0**	**$0**	**$0**	

OEI Final Reports Issued

Issue Date Between 10/01/2017 and 03/31/2018

Inspection Number	Funding Source	Inspection Title	Report	Issued
OEI-03-17-00040	Medicare	CMS Ensured Nearly All Part D Drug Records Contained Valid Prescriber Identifiers in 2016	FINALS	10/31/2017
*OEI-03-17-00550	Medicare	Comparison of Average Sales Prices and Average Manufacturer Prices: Results for Second Quarter 2017	FINALS	11/14/2017
OEI-03-17-00100	Medicaid	Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates	FINALS	12/15/2017
*OEI-03-15-00060	Medicare	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	FINALS	01/11/2018
*OEI-03-18-00150	Medicare	Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Third Quarter of 2017	FINALS	02/15/2018
*OEI-04-15-00432	Discretionary	Entities' Experiences and Perceptions of Reporting the Theft, Loss, and Release of Select Agents or Toxins to CDC	FINALS	02/27/2018
OEI-05-16-00510	Medicare	Reliance on Unverified Patient Lists Creates a Vulnerability in Home Health Surveys	FINALS	03/05/2018
OEI-05-16-00550	Discretionary	Drug Supply Chain Security: Dispensers Received Most Tracing Information	FINALS	03/26/2018
*OEI-09-18-00180	Medicaid	Medicaid Fraud Control Units Fiscal Year 2017 Annual Report	FINALS	03/30/2018
OEI-12-17-00290	Medicare	Review of The Department of Health and Human Services (HHS) Cancellation of Marketplace Enrollment Outreach Efforts	FINALS	10/25/2017
OEI-12-17-00260	Medicare	Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries	FINALS	11/21/2017
*OEI-12-16-00500	Medicaid	Medicaid Fraud Control Units: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services	FINALS	12/06/2017
OEI-12-17-00350	Medicare	Followup Review: CMS's Management of the Quality Payment Program	FINALS	12/12/2017

Total Records Returned: 13

OEI-12-17-00290	Medicare	Review of The Department of Health and Human Services (HHS) Cancellation of Marketplace Enrollment Outreach Efforts	FINALS	10/25/2017
OEI-03-17-00040	Medicare	CMS Ensured Nearly All Part D Drug Records Contained Valid Prescriber Identifiers in 2016	FINALS	10/31/2017

* - No IG Signature

Issue Date Between 10/01/2017 and 03/31/2018

Inspection Number	Funding Source	Inspection Title	Report	Issued
*OEI-12-16-00500	Medicaid	Medicaid Fraud Control Units: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services	FINALS	12/06/2017
OEI-12-17-00350	Medicare	Followup Review: CMS's Management of the Quality Payment Program	FINALS	12/12/2017
OEI-03-17-00100	Medicaid	Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates	FINALS	12/15/2017
*OEI-03-15-00060	Medicare	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	FINALS	01/11/2018
OEI-05-16-00550	Discretionary	Drug Supply Chain Security: Dispensers Received Most Tracing Information	FINALS	03/26/2018
*OEI-09-18-00180	Medicaid	Medicaid Fraud Control Units Fiscal Year 2017 Annual Report	FINALS	03/30/2018
*OEI-03-17-00550	Medicare	Comparison of Average Sales Prices and Average Manufacturer Prices: Results for Second Quarter 2017	FINALS	11/14/2017
OEI-12-17-00260	Medicare	Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries	FINALS	11/21/2017
*OEI-03-18-00150	Medicare	Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Third Quarter of 2017	FINALS	02/15/2018
*OEI-04-15-00432	Discretionary	Entities' Experiences and Perceptions of Reporting the Theft, Loss, and Release of Select Agents or Toxins to CDC	FINALS	02/27/2018
OEI-05-16-00510	Medicare	Reliance on Unverified Patient Lists Creates a Vulnerability in Home Health Surveys	FINALS	03/05/2018

Total Records Returned: 13

Philadelphia

Blue Cover Report

OEI-03-17-00040	Medicare	CMS Ensured Nearly All Part D Drug Records Contained Valid Prescriber Identifiers in 2016	FINALS	10/31/2017
OEI-03-17-00100	Medicaid	Potential Misclassifications Reported by Drug Manufacturers May Have Led to $1 Billion in Lost Medicaid Rebates	FINALS	12/15/2017
*OEI-03-15-00060	Medicare	Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed	FINALS	01/11/2018

Product Type Records: 3

Issue Date Between 10/01/2017 and 03/31/2018

Inspection Number	Funding Source	Inspection Title	Report	Issued
Philadelphia				
Memo				
*OEI-03-17-00550	Medicare	Comparison of Average Sales Prices and Average Manufacturer Prices: Results for Second Quarter 2017	FINALS	11/14/2017
*OEI-03-18-00150	Medicare	Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Third Quarter of 2017	FINALS	02/15/2018
Product Type Records:	2			
Regional Records Returned:	5			
Atlanta				
Memo				
*OEI-04-15-00432	Discretionary	Entities' Experiences and Perceptions of Reporting the Theft, Loss, and Release of Select Agents or Toxins to CDC	FINALS	02/27/2018
Product Type Records:	1			
Regional Records Returned:	1			
Chicago				
Blue Cover Report				
OEI-05-16-00550	Discretionary	Drug Supply Chain Security: Dispensers Received Most Tracing Information	FINALS	03/26/2018
Product Type Records:	1			
Other				
OEI-05-16-00510	Medicare	Reliance on Unverified Patient Lists Creates a Vulnerability in Home Health Surveys	FINALS	03/05/2018
Product Type Records:	1			
Regional Records Returned:	2			
San Francisco				
Blue Cover Report				

Issue Date Between 10/01/2017 and 03/31/2018

Inspection Number	Funding Source	Inspection Title	Report	Issued
San Francisco				
*OEI-09-18-00180	Medicaid	Medicaid Fraud Control Units Fiscal Year 2017 Annual Report	FINALS	03/30/2018
Product Type Records:	1			
Regional Records Returned:	1			
Headquarters				
Blue Cover Report				
OEI-12-17-00290	Medicare	Review of The Department of Health and Human Services (HHS) Cancellation of Marketplace Enrollment Outreach Efforts	FINALS	10/25/2017
*OEI-12-16-00500	Medicaid	Medicaid Fraud Control Units: Investigation and Prosecution of Fraud and Beneficiary Abuse in Medicaid Personal Care Services	FINALS	12/06/2017
OEI-12-17-00350	Medicare	Followup Review: CMS's Management of the Quality Payment Program	FINALS	12/12/2017
Product Type Records:	3			
Memo				
OEI-12-17-00260	Medicare	Excluding Noncovered Versions When Setting Payment for Two Part B Drugs Would Have Resulted in Lower Drug Costs for Medicare and its Beneficiaries	FINALS	11/21/2017
Product Type Records:	1			
Regional Records Returned:	4			
Total Records Returned:	13			