List of Appendixes

Appendix A Reporting Requirements

Appendix B Questioned Costs and Funds To Be Put to Better Use

Appendix C Peer Review Results

Appendix D Summary of Sanction Authorities

Appendix E Acronyms and Abbreviations

Appendix A
Reporting Requirements

The Inspector General Act of 1978

The reporting requirements of the Inspector General Act of 1978, as amended, are listed in the following table along with the location of the required information. Page numbers in the table indicate pages in this report. The word "None" appears where there are no data to report under a particular requirement.

Section	Requirement	Location
Section 4		
(a)(2)	Review of legislation and regulations	Part IV, Other HHS-Related Issues.
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*
(a)(4)	Matters referred to prosecutive authorities	Part III: Legal and Investigative Activities
(a)(5)	Summary of instances in which information was refused	None
(a)(6)	List of audit reports	Submitted to the Secretary under separate cover
(a)(7)	Summary of significant reports	Throughout this report
(a)(8)	Statistical Table 1 – Reports With Questioned Costs	Appendix B
(a)(9)	Statistical Table 2 – Funds Recommended To Be Put to Better Use	Appendix B

Section	Requirement	Location
(a)(10)	Summary of previous audit reports without management decisions	Appendix B
(a)(11)	Description and explanation of revised management decisions	Appendix B
(a)(12)	Management decisions with which the Inspector General disagrees	None
(a)(13)	Information required by the Federal Financial Management Improvement Act of 1996	Reported annually in the spring *Semiannual Report to Congress*, Part IV, Other HHS-Related Issues.
(a)(14)-(16)	Results of peer reviews of HHS-OIG conducted by other OIGs or the date of the last peer review, outstanding recommendations from peer reviews, and peer reviews conducted by HHS OIG of other OIGs.	Appendix C

Other Reporting Requirements

Section	Requirement	Location
§ 845	Significant contract audits required to be reported pursuant to the National Defense Authorization Act for fiscal year 2008 (P.L. No. 110-181), § 845.	Part IV: Other HHS-Related Issues
§205	Pursuant to the Health Insurance Portability and Accountability Act (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 B
Questioned Costs and
Funds To Be Put to Better Use

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

Audit Reports With Questioned Costs

Questioned costs are those questioned by OIG audits because of an alleged violation of a provision of a law, regulation, contract, grant, or other agreement governing the expenditure of funds. Costs are questioned because the expenditure was not supported by adequate documentation or because the expenditure was unnecessary or unreasonable.

OIG includes those questioned costs that HHS program officials, in a management decision, have agreed should not be charged to the Federal Government, commonly referred to as disallowed costs, as part of the expected recoveries in the Accomplishment section at the beginning of the *Semiannual Report*. Superscripts indicate end notes.

In addition to issuing the audit reports noted in Table 1 below, OIG issued an evaluation report during the reporting period with $6,600,000 in questioned costs. (Questionable Billing Patterns of Portable X-Ray Suppliers. OEI-12-10-00190. December 2011.)

Table 1 follows.

Table 1 – Audit Reports With Questioned Costs

	Number of Reports	Dollar Value Questioned	Dollar Value Unsupported
Section 1			
Reports for which no management decision had been made by the beginning of the reporting period[1]	189	$732,134,000	$82,199,000
Reports issued during the reporting period	110	$456,019,000	$2,372,000
Total Section 1	299	$1,188,153,000	$84,571,000
Section 2			
Reports for which a management decision was made during the reporting period[2, 3]			
Disallowed costs	172	$483,145,000*	$32,973,000
Costs not disallowed	2	$211,000	$0
Total Section 2	174	$483,356,000	$32,973,000
Section 3			
Reports for which no management decision had been made by the end of the reporting period (Sec. 1 minus Sec. 2)	125	$704,797,000	$51,598,000
Section 4			
Reports for which no management decision was made within 6 months of issuance[4]	53	$385,319,000	$49,270,000

* Audit receivables (expected recoveries).

Audit Reports With Funds Recommended To Be Put to Better Use

Recommendations that funds be put to better use mean that funds could be used more efficiently if management took action to implement an OIG recommendation through reductions in outlays, deobligation of funds, and/or avoidance of unnecessary expenditures. Table 2 reports HHS program officials' decisions to take action on these audit recommendations. Implemented recommendations are reported annually in the fall *Semiannual Report*.

Table 2 – Audit Reports With Funds To Be Put to Better Use

	Number of Reports	Dollar Value
Section 1		
Reports for which no management decision had been made by the beginning of the reporting period[1]	21	$3,553,001,000
Reports issued during the reporting period	7	$225,144,000
Total Section 1	28	$3,778,145,000
Section 2		
Reports for which a management decision was made during the reporting period[2]		
Value of recommendations agreed to by management		
Based on proposed management action	8	$2,756,006,000
Based on proposed legislative action		$0
Value of recommendations not agreed to by management	3	$278,515,000
Total Section 2	11	$3,034,521,000
Section 3		
Reports for which no management decision had been made by the end of the reporting period[4] (Sec. 1 minus Sec. 2)	17	$743,624,000

End Notes

Table 1 End Notes

[1] The opening balance was adjusted upward by $34.4 million because of a reevaluation of previously issued recommendations.

[2] During the period, revisions to previously reported management decisions included:

- A-01-09-91072, *State of New Hampshire*. The Centers for Medicare & Medicaid Services (CMS) reversed its decision to disallow costs associated with this non-Federal audit because it determined that it had already disallowed $35,325,468 in Medicaid disproportionate share hospital (DSH) payments that did not comply with the hospital-specific DSH limits imposed by Federal regulations and the State plan in its

resolution of A-01-05-00001, *Review of New Hampshire's Medicaid Disproportionate Share Hospital Payments During Federal Fiscal Year 2004*.

- A-07-01-02093, *Review of Disproportionate Share Hospital Costs Claimed by the State of Missouri for Fiscal Year Ended June 30, 1999*. The Departmental Appeals Board reduced CMS's disallowance of $36,200,000 to $21,361,339.
- A-01-04-00513, Medicare *Part B Payments for Ambulance Services Rendered to Beneficiaries During Inpatient Stays: 2001 Through 2003*; A-01-07-00522, *Review of Separately Billed Laboratory Tests Paid by National Government Services, Inc., for Medicare Beneficiaries with End-Stage Renal Disease*; and A-02-07-01044, *Review of High-Dollar Payments for Medicare Part B Claims Processed by National Government Services for New Jersey Providers for the Period January 1, 2003, Through December 31, 2005*. CMS determined that it could not recoup its original disallowances totaling $20,345,830 associated with these audits because Federal regulations at 42 CFR 405.980(b) prevented it from reopening claims beyond 4 years after its initial determination.
- A-01-05-00004, *Review of Medicaid Targeted Case Management Services Provided by the Maine Bureau of Child and Family Services During Federal Fiscal Years 2002 and 2003*. CMS reached an agreement with the State to settle targeted case management disallowances. As a result of this settlement, CMS agreed not to pursue recovery of $8,327,896 in costs that it had originally disallowed.
- A-05-07-00019, *Review of Medicaid Outpatient Drug Expenditures in Illinois for the Period October 1, 2003, Through September 30, 2005*. After reviewing additional information from the State that showed that some expenditure were eligible for Medicaid coverage, CMS reduced its original disallowance by $3,227,955.
- A-05-10-12004, *Michigan Department of Human Services*. After reviewing additional information provided by the State, the Administration for Children and Families (ACF) reversed its February 2011 decision to disallow $4,446,704 in costs charged to the Social Services Block Grant.

Not detailed are net reductions to previously reported disallowances totaling $2,076,828.

[3] Included are management decisions to disallow $9.95 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 (OMB) Circular A-133. By law, OIG is responsible for ensuring that work performed by these non-Federal auditors complies with Federal audit standards; accordingly, OIG tracks, resolves, and reports on recommendations in these audits.

[4] Because of administrative delays, some of which were beyond management control, resolution of the following 53 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-05-08-00098	REVIEW OF OHIO DEPARTMENT OF JOB AND FAMILY SERVICES CLAIMS FOR COSTS REPORTED BY THE HAMILTON COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES, JAN 2011, $58,987,755
CIN: A-03-07-00560	PA FOSTER CARE MAINTENANCE PAYMENTS – PHILADELPHIA – UNDER $300/DAY, MAY 2008, $56,513,439
CIN: A-09-06-00023	REVIEW OF LOS ANGELES COUNTY APPROVAL PROCESS OF RELATIVE FOSTER FAMILY HOMES, OCT 2009, $45,520,603
CIN: A-01-09-00507	NATIONWIDE REVIEW OF INPATIENT REHABILITATION FACILITIES PATIENT ASSESSMENT INSTRUMENTS, JUN 2010, $39,247,645
CIN: A-01-02-00006	REVIEW OF RATE SETTING METHODOLOGY FOR MEDICAID SCHOOL-BASED HEALTH SERVICES - CT, MAY 2003, $32,780,146
CIN: A-03-08-00554	AUDIT OF PENNSYLVANIA TITLE IV-E FOSTER CARE ALLEGHENY COUNTY, JAN 2011, $28,307,142
CIN: A-04-09-03524	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN GEORGIA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2011, $22,212,932
CIN: A-01-10-00513	NATIONWIDE REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED

	BY PART B CONTRACTORS FOR CY 2008, SEP 2011, $19,270,689
CIN: A-03-06-00564	PA FOSTER CARE MAINTENANCE PAYMENT – PHILADELPHIA - OVER $300/DAY, DEC 2007, $11,693,989
CIN: A-03-05-00550	AUDIT OF PA FOSTER CARE MAINTENANCE PAYMENTS – CASTILLE SAMPLE, SEP 2007, $11,611,822
CIN: A-01-10-00516	NATIONWIDE REVIEW OF PLACE OF SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY PART B CONTRACTORS FOR CY 2009, SEP 2011, $9,501,422
CIN: A-03-09-00019	REVIEW OF MEMBERHEALTH’S 2006 AND 2007 DIRECT AND INDIRECT REMUNERATION REPORTS, OCT 2010, $9,339,013
CIN: A-04-08-03521	AUDIT OF UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS IN TN FOR THE PERIOD OCTOBER 1, 1998 TO DECEMBER 31, 2007, FEB 2009, $5,768,243
CIN: A-01-08-00511	REVIEW OF SEPARATELY BILLED CLINICAL LABORATORY SERVICES PROVIDED TO ESRD BENEFICIARIES BY FRESENIUS MEDICAL CARE NORTH AMERICA’S FACILITIES, MAR 2010, $5,410,712
CIN: A-07-11-00347	REVIEW OF PENSION SEGMENTATION AT A TERMINATED CONTRACTOR, MUTUAL OF OMAHA, APR 2011, $4,564,338
CIN: A-04-08-03523	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN FL FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2009, $4,413,264
CIN: A-01-11-02500	REVIEW OF MASSACHUSETTS’ TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, AUG 2011, $4,242,540
CIN: A-07-11-00359	REVIEW OF POST RETIREMENT HEALTH BENEFITS AT BLUE CROSS BLUE SHIELD OF MISSISSIPPI, MAY 2011, $4,198,848

CIN: A-10-96-00001	REVIEW OF GROUP HEALTH COOPERATIVE OF PUGET SOUND REPORTING OF ESRD, APR 1997, $2,763,498
CIN: A-07-10-02752	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN TENNESSEE FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, APR 2011, $2,078,774
CIN: A-03-10-00011	REVIEW OF CAPITAL BLUE CROSS 2008 DIR, OCT 2010, $1,818,249
CIN: A-07-09-03121	MO TITLE IV-E TRAINING COSTS FOR RESIDENTIAL TREATMENT CENTERS AND FOSTER CARE PARENTING, SEP 2009, $569,663
CIN: A-09-10-02017	REVIEW OF OREGON'S MEDICAID MANAGEMENT INFORMATION SYSTEM EXPENDITURES CLAIMED FOR THE 24-MONTH PERIOD ENDED SEPTEMBER 30, 2009, AUG 2011, $565,727
CIN: A-05-09-00047	HEAD START MATCHING COSTS – COMMUNITY ACTION COMMITTEE OF LANCASTER FAIRFIELD COUNTY, JAN 2010, $547,019
CIN: A-06-06-00072	REVIEW OF COST FOR TEXAS MEDICAL FOUNDATION AUDITEE, MAY 2008, $403,581
CIN: A-05-01-00096	PAYMENTS TO INTER VALLEY FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $319,355
CIN: A-07-05-01013	PAYMENTS FOR M+C ORGANIZATION FOR INSTITUTIONAL BENEFICIARIES, OCT 2005, $293,885
CIN: A-01-10-02505	RESULTS OF LIMITED SCOPE REVIEW AT CTE, INC., MAY 2011, $293,870
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MI, AUG 2006, $257,859
CIN: A-05-01-00094	PAYMENTS TO KAISER OF OAKLAND FOR INSTITUTIONAL BENEFICIARIES, OCT 2002, $229,656
CIN: A-07-06-01035	AUDIT OF QUALITY IMPROVEMENT ORGANIZATION - IOWA, OCT 2007, $208,974
CIN: A-09-05-00077	REVIEW OF PACIFICARE'S USE OF ADDITIONAL CAPITATION UNDER THE MMA OF 2003, MAR 2006, $135,000

CIN: A-09-09-01007	REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JUL 2009, $124,046
CIN: A-05-01-00091	PAYMENTS TO UNITED HC OF FLA FOR INSTITUTIONAL BENEFICIARIES, SEP 2002, $121,023
CIN: A-04-07-01045	COSTS CLAIMED FOR ESRD NETWORK 6 OPERATIONS, AUG 2009, $116,728
CIN: A-05-97-00017	FHP, INC. - HMO INSTITUTIONAL STATUS PROJECT, JUN 1998, $109,114
CIN: A-05-01-00079	PAYMENTS TO BLUE CARE MID-MI FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $100,692
CIN: A-01-10-02503	RESULTS OF LIMITED SCOPE REVIEW AT THE COMMUNITY ACTION COMMITTEE OF DANBURY, INC., APR 2011, $98,806
CIN: A-05-01-00090	PAYMENTS TO AETNA U.S. HEALTHCARE PA FOR INSTITUTIONAL BENEFICIARIES, JUL 2002, $87,516
CIN: A-03-08-00011	REVIEW OF DUPLICATE PAYMENTS TO PHARMACIES FOR MEDICARE PART D DRUGS (PDE-DEMO): BARON DRUGS, SEP 2009, $79,489
CIN: A-02-06-01023	REVIEW OF QUALITY IMPROVEMENT ORGANIZATION IN NEW YORK STATE, MAR 2008, $77,358
CIN: A-09-06-00039	MEDICARE INTEGRITY – AUDIT OF QUALITY IMPROVEMENT ORGANIZATION – WASHINGTON STATE, FEB 2008, $73,636
CIN: A-05-01-00086	PAYMENTS TO HMO OF NE PA FOR INSTITUTIONAL BENEFICIARIES, MAY 2002, $62,432
CIN: A-04-06-00023	REVIEW OF QUALITY IMPROVEMENT ORGANIZATIONS- TENNESSEE, JUL 2008, $30,654
CIN: A-08-03-73541	SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE, JAN 2003, $28,573
CIN: A-07-02-00150	PAYMENTS TO COVENTRY-PITTSBURG FOR INSTITUTIONAL BENEFICIARIES, JUN 2003, $26,000

CIN: A-05-01-00078	PAYMENTS TO HEALTH NET-TUCSON, AZ. FOR INSTITUTIONAL BENEFICIARIES, APR 2002, $21,233
CIN: A-08-04-76779	COLORADO FOUNDATION FOR MEDICAL CARE, DEC 2003, $18,925
CIN: A-05-01-00100	PAYMENTS TO FALLON HEALTH FOR INSTITUTIONALIZED BENEFICIARIES, MAY 2002, $18,842
CIN: A-05-01-00095	PAYMENTS TO HUMANA OF ARIZONA FOR INSTITUTIONAL BENEFICIARIES, JUN 2002, $18,645
CIN: A-07-04-01011	PAYMENTS FOR UNITED HEALTHCARE FOR INSTITUTIONAL BENEFICIARIES, MAR 2005, $13,128
CIN: A-05-06-00043	REVIEW OF OHIO KEPRO, FEB 2008, $11,874

CIN: A-05-01-00070	PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS - MISSOURI GROUP HEALTH PLAN, JAN 2002, $11,089

TOTAL NUMBER OF REPORTS: 53
TOTAL AMOUNT: $385,319,455

Table 2 End Notes

[1] The opening balance was adjusted downward by $400.9 million resulting primarily from a series of contract reviews to determine whether an HHS agency was in compliance with the purpose, time, and amount requirements specified in appropriations statutes.

[2] Because of administrative delays, some of which were beyond management control, resolution of the following eight audits was not completed within 6 months of issuance of the report. OIG is working with management to reach resolution on these recommendations before the end of the next semiannual reporting period:

CIN: A-02-07-02000	OPEN AND INACTIVE GRANTS ON THE PAYMENT MANAGEMENT SYSTEM – ACF, FEB 2009, $472,155,156
CIN: A-03-10-03117	CONTRACT NO 1 –A-3-0052, SEP 2011, $31,300,000
CIN: A-07-10-02752	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN TENNESSEE FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, APR 2011, $7,502,017
CIN: A-05-05-00033	UNDISTRIBUTED CHILD SUPPORT COLLECTIONS - MI, AUG 2006, $4,397,133
CIN: A-04-09-03524	REVIEW OF TITLE IV-E ADOPTION ASSISTANCE MAINTENANCE PAYMENTS IN GEORGIA FOR THE PERIOD OCTOBER 1, 2004 THROUGH SEPTEMBER 30, 2007, MAY 2011, $2,842,653
CIN: A-05-01-00070	PAYMENTS FOR BENEFICIARIES WITH INSTITUTIONAL STATUS - MISSOURI GROUP HEALTH PLAN, JAN 2002, $98,689
CIN: A-05-06-00023	UNDISTRIBUTABLE CHILD SUPPORT COLLECTIONS - MN, SEP 2006, $28,240

CIN: A-09-09-01007 REVIEW OF IDAHO'S TITLE IV-E ADOPTION ASSISTANCE COSTS FOR FEDERAL FISCAL YEARS 2006 THRU 2008, JULY 2009, $17,764

TOTAL NUMBER OF REPORTS: 8

TOTAL AMOUNT: $518,341,652

Appendix C
Peer Review Results

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

Office of Audit Services Peer Review Results

During this semiannual reporting period, two peer reviews involving the Office of Audit Services (OAS) were started and were still in progress as of March 31, 2012. The table below lists the reviews in progress and describes OAS's peer review activities during prior reporting periods.

Table 1 – Office of Audit Services

Date	Reviewing Office	Office Reviewed
2012 In Progress	HHS-OIG	Environmental Protection Agency (EPA) OIG

OAS is reviewing the Environmental Protection Agency for the 3 years ending Sept. 30, 2011. The review was in progress at March, 31, 2012.

Date	Reviewing Office	Office Reviewed
2012 In Progress	Department of Homeland Security (DHS) OIG	HHS-OIG

OAS is being reviewed by the Department of Homeland Security for the 3years ending Sept. 30, 2011. The review was in progress at March 31, 2012.

Table 1 – Office of Audit Services (continued)

Date	Reviewing Office	Office Reviewed
2009 December	HHS-OIG, OAS	Department of Defense (DoD) OIG

The system of quality control for the audit organization of DoD-OIG in effect for the year ending March 31, 2009, has been suitably designed and complied with to provide DoD-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. DoD-OIG received a peer review rating of pass.

HHS OIG recommended that DoD-OIG continue to improve its system of quality control, including audit supervision, audit documentation, and report content, by ensuring compliance with audit standards and its policies and procedures. DoD-OIG indicated that it has completed the corrective actions to improve its quality control system that were underway during December 2009.

Date	Reviewing Office	Office Reviewed
2009 June	U.S. 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, 2008, 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.

Office of Investigations Peer Review Results

During this semiannual reporting period, no peer reviews were conducted by another OIG organization of HHS OIG's Office of Investigations (OI). OI did not conduct a peer review of another OIG. Listed below is information concerning OI's peer review activities during prior reporting periods.

Table 2 – Office of Investigations

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

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

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

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

Date	Reviewing Office	Office Reviewed
2010 January	HHS-OIG, OI	Department of Justice (DOJ) OIG

The system of internal safeguards and management procedures for the investigative function of DOJ-OIG in effect for the year ending September 30, 2009, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Table 2 – Office of Investigations (continued)

Date	Reviewing Office	Office Reviewed
2009 March	Department of Labor OIG	HHS-OIG, OI

The system of internal safeguards and management procedures for the investigative function of HHS-OIG in effect for the year ending September 30, 2008, was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines.

Appendix D
Summary of Sanction Authorities

The Inspector General Act of 1978, as amended, sets forth specific 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.

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

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) added another basis for the imposition of 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 Department of Health and Human Services (HHS) Departmental Appeals Board and Federal district and appellate courts regarding the basis for the exclusion and the length of the exclusion.

Civil Monetary Penalties Law

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

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

The Affordable Care Act added more grounds for imposing CMPs. These include, among other 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) for which the Affordable Care Act authorizes a penalty of up to $50,000 for each false statement, as well as activities relating to fraudulent marketing by managed care organizations, their employees, or their agents.

Patient Dumping

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

If a transfer is ordered, the transferring hospital must provide stabilizing treatment to minimize the risks of transfer and must ensure that the

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

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

Anti-Kickback Statute and Civil False Claims Act Enforcement Authorities

The Anti-Kickback Statute – The anti-kickback statute authorizes penalties against anyone who knowingly and willfully solicits, receives, offers, or pays remuneration, in cash or in kind, to induce or in return for (1) referring an individual to a person or an entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Federal health care programs or (2) purchasing; leasing; 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 of the 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 Amendments Act of 1986 – Under the Federal False Claims Amendments Act of 1986 (FCA) (31 U.S.C. §§ 3729–3733), a person or an entity is liable for up to treble damages and a penalty between $5,500 and $11,000 for each false claim it knowingly submits, or causes to be submitted, to a Federal program. Similarly, a person or an entity is liable under the FCA

if it knowingly makes or uses, or causes to be made or used, a false record or statement to have a false claim paid.

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

Appendix E
Acronyms and Abbreviations

Following are selected acronyms and abbreviations commonly used in the *Semiannual Report(s) to Congress*. Public laws are listed at the end of the appendix.

Terms, Titles, and Organizations

ACF	Administration for Children and Families
AHRQ	Administration for Healthcare Research and Quality
AIDS	acquired immunodeficiency syndrome
AMP	average manufacturer price
ASP	average sales price
CBSA	Core Based Statistical Area
CDC	Centers for Disease Control and Prevention
CDT	continuing day treatment
CERT	Comprehensive Error Rate Testing (program)
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIA	corporate integrity agreement
CIGIE	Council of the Inspectors General on Integrity and Efficiency
CLASS	Community Living Assistance Services and Supports Program
CMPL	Civil Monetary Penalties Law
CMS	Centers for Medicare & Medicaid Services
CoP	conditions of participation
CORF	Comprehensive Outpatient Rehabilitation Facility
CTSA	Clinical and Translational Science Awards (program)
CWF	Common Working File
CY	calendar year
DME	durable medical equipment
DoD	Department of Defense
DOJ	Department of Justice
DSH	disproportionate share hospital
ESRD	end stage renal disease
FACP	final administrative cost proposal
FDA	Food and Drug Administration
FFP	Federal financial participation

Form CMS-64	Medicaid Statement of Expenditures for the Medical Assistance Program
FTE	full-time equivalent
FY	fiscal year
GME	graduate medical education
HEAL	Health Education Assistance Loan
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHA	home health agency
HHS	Department of Health & Human Services
HIV	human immunodeficiency virus
HRSA	Health Resources and Services Administration
HUD	Department of Housing and Urban Development
IDTF	independent diagnostic testing facility
IRIS	Intern and Resident Information System
IRS	Internal Revenue Service
LTC	long-term care
MA	Medicare Advantage (Part C)
MAC	Medicare administrative contractor
MED	Medicare Exclusion Database
MCE	managed care entity
MCO	Managed Care Organization
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
NEMT	nonemergency medical transportation
NIH	National Institutes of Health
NPRM	notice of proposed rulemaking
NSC	National Supplier Clearinghouse
OAI	official action indicated
OASIS	Outcome and Assessment Information Set
OCSE	Office of Child Support Enforcement
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPPS	Outpatient Prospective Payment System
PCS	personal care services
PDE	prescription drug event
PDP	prescription drug plan
PIHP	prepaid inpatient hospital plan
P.L.	Public Law

PPI	Producer Price Index
RAC	Recovery Audit Contractor
RMTS	random moment time study
RN	radiological and nuclear
SNF	skilled nursing facility
TANF	Temporary Assistance for Needy Families
U.S.C.	United States Code
WAMP	widely available market price
ZPIC	Zone Program Integrity Contractor

Public Laws

ACA	See Affordable Care Act
Affordable Care Act	Patient Protection and Affordable Care Act of 2010, P.L. No. 11-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-52
CFO Act	Chief Financial Officer Act of 1990, P.L. No. 101-576
DRA	Deficit Reduction Act of 2005, P.L. No. 109-171
EMTALA	Emergency Medical Treatment and Labor Act of 1986, P.L. No. 99-272
FCA	False Claims Act Amendments of 1986, P.L. No. 99-562 (Updated in P.L. No. 111-203)
FDCA	Federal Food, Drug, and Cosmetic Act of 1938, P.L. No. 75-717
FFMIA	Federal Financial Management Improvement Act of 1996, P.L. No. 110-181
HIPAA	Health Insurance Portability and Accountability Act of 1996, P.L. No. 104-191
IG Act	Inspector General Act of 1978, as amended by P.L. No. 111-25, 5 U.S.C. App.
IPERA	Improper Payments Elimination Act of 2010, P.L. 111-204
IPIA	Improper Payments Information Act of 2002, P.L. 107-300
MIPPA	Medicare Improvements for Patients and Providers Act, P.L. No. 110-275
MMA	P.L. No. 108-173
PHS Act	Public Health Service Act of 1944
Recovery Act	American Recovery and Reinvestment Act of 2009, P.L. No. 111-5