
Message From the Inspector General



This report, submitted to Congress pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG), Department of Health & Human Services (HHS), for the 6-month period ending September 30, 2010.

As HHS's programs continue to expand in size and complexity, and as we devote significant time and resources toward implementation of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), it is more important than ever to set forth what fundamentally guides OIG as we go about doing the vitally important work of ensuring program integrity.

In this regard, our organization developed a Core Values Statement highlighting the importance of integrity, credibility, and impact in all facets of our work. Our founding statute is now more than 30 years old, and, while our mission to prevent and detect fraud, waste, and abuse and promote economy and efficiency remains our lodestar, we also have witnessed the steady accretion of broader and more complex responsibilities. Below are significant activities in which we have engaged over the past 6 months that reflect our core values at OIG.

Integrity—Acts with independence and objectivity

This value is reflected in our efforts to implement the American Recovery and Reinvestment Act of 2009 (Recovery Act). We have performed internal control assessments of the Department's grant award and monitoring processes and issued 23 recipient capability audits during this reporting period. Through these activities, we have independently and objectively provided HHS with vital information regarding the ability of grantees to manage large grant awards and ensure the integrity of these significant expenditures. Additionally, the new tools afforded to our office under the Affordable Care Act include important new integrity provisions such as enrollment safeguards that will prevent bad actors from obtaining Medicare and Medicaid billing privileges. Once enrolled in the system, OIG now has the authority to suspend payments to those who defraud the system and to impose stiffer penalties for health care fraud.

Credibility—Builds on a tradition of excellence and accountability

Our office works closely with members of Congress and their staff to provide information that is credible and accurately reflects our work regarding the efficiency and effectiveness of the operation of departmental programs. During this reporting period, our office testified before Congress on six occasions. Our testimony provides Congress with recommendations on how to improve program operations and enhance program integrity. Over the past 6 months, we testified on topics regarding cutting fraud, waste, and abuse in Medicare and Medicaid; integrity of Medicare's coverage of durable medical equipment; preventing and recovering Government payment errors; safety of the food supply; and investigative findings regarding operation of the Indian Health Service's Aberdeen Area.

Impact— Yields results that are tangible and relevant

Our partnership with other law enforcement entities as part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) continues to produce significant results as part of its Strike Force activities. During this reporting period, Strike Force efforts have resulted in the filing of charges against 88 individuals or entities, 89 convictions, and \$71.3 million in investigative receivables. This past July, our Special Agents participated in an unprecedented takedown in all seven Strike Force cities that resulted in charges against 94 doctors, health care company owners, executives, and others for more than \$251 million in alleged false billing.

In addition to our enforcement impact, we have made recommendations that contribute directly toward Medicare and Medicaid integrity and improving public health and safety. Work during this reporting period includes recommendations on important issues such as collection activities of Medicare contractors, calculation of the Medicare error rate for payments to certain providers, invalid prescriber identifiers on Medicare Part D claims, deficiencies in Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive screening services, and the ability of the Food and Drug Administration to monitor foreign clinical trials. I am also pleased to report that over the past 6 months, OIG issued reports with about \$171.3 million in questioned costs recommendations and about \$362.7 million in funds recommended to be put to better use. During this reporting period, HHS agencies agreed to recover about \$438.6 million in questioned costs and to put about \$39.2 million to better use. (A portion of the amounts agreed to in this period were from recommendations in audit reports issued in prior periods.)

As we address an expanding mission to protect HHS's vital health and human service programs, I would once again like to express my appreciation to Congress and to the Department for their sustained commitment to supporting the important work of our Office.



Daniel R. Levinson
Inspector General

Highlights

Summary of Accomplishments

For fiscal year (FY) 2010, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) reported expected recoveries and estimated savings of about \$25.9 billion consisting of \$1.1 billion in audit receivables, \$3.8 billion in investigative receivables (which includes \$576.9 million in non-HHS investigative receivables resulting from OIG work, e.g., the States' share of Medicaid restitution) and \$21 billion from legislative and other cost-saving actions that were supported by recommendations in OIG audits and evaluations.

Also for this FY, OIG reported exclusions of 3,340 individuals and entities from participation in Federal health care programs; 647 criminal actions against individuals or entities that engaged in crimes against departmental programs; and 378 civil actions, which included False Claims Act (FCA) and unjust enrichment lawsuits filed in Federal district court, Civil Monetary Penalties Law (CMPL) settlements, and administrative recoveries related to provider self-disclosure matters.

The following are highlights of some of OIG's efforts during the semiannual period ending September 30, 2010.

Health Care Fraud Prevention & Enforcement Action Team

Medicare Fraud Strike Force Activities

The interagency Health Care Fraud Prevention & Enforcement Action Team (HEAT), which is comprised of top-level law enforcement and professional staff from HHS, OIG, and the Department of Justice (DOJ), builds on existing partnerships to identify and prevent fraud and enforce current anti-fraud laws around the country. The initiative is enhancing efforts like the Medicare Fraud Strike Force teams that coordinate law enforcement operations with other Federal, State, and local law enforcement entities. Strike Forces began in March 2007 and currently operate in seven major cities—Miami, Florida; Los Angeles, California; Detroit, Michigan; Houston, Texas; Brooklyn, New York; Baton Rouge, Louisiana; and Tampa, Florida. During this semiannual reporting period, Strike Force efforts have resulted in the filing of charges against 88 individuals or entities, 89 convictions, and \$71.3 million in investigative receivables.

In a recent example of a Strike Force outcome, Dr. Jose Castro-Ramirez and Suresh Chand were sentenced to 14 years and 6 years and 9 months in prison, respectively, and ordered to pay \$9,769,113 in joint and several restitution after being convicted of charges related to health care

fraud. Between January 2003 and March 2007, Chand and his co-conspirators paid Medicare beneficiaries cash kickbacks, and provided other inducements such as prescription drugs in exchange for their Medicare numbers and signatures on documents which falsely stated that they received services. The submission of these fraudulent documents resulted in false claims for physical and occupational therapy services that were never provided. Castro signed medical records then billed Medicare for physical therapy, occupational therapy and other services that were either not medically necessary or not rendered.

Medicare Contractors

Collection of Medicare Overpayments Identified by Program Safeguard Contractors

In our reviews of Program Safeguard Contractors (PSC), we examined PSCs' identification and referral of Medicare overpayments to claims processors for collection. In our first study, we found that PSCs referred \$835 million in overpayments to claims processors for collection in 2007. However, 2 of 18 PSCs were responsible for 62 percent of this amount. In our second study, we found that overpayments referred for collection by PSCs in 2007 did not result in significant recoveries for the Medicare program. PSCs referred 4,239 overpayments in 2007, but only 7 percent (\$55 million of \$835 million) had been collected by claims processors as of June 2008. Of the \$55 million collected, 27 percent was for Part A claims; 56 percent was for Part B claims other than durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and 17 percent was for Part B DMEPOS claims. ([OEI-03-08-00030](#); [OEI-03-08-00031](#))

Medicare and Medicaid Prescription Drugs

AstraZeneca Pays \$520 million to Resolve False Claims Violations

AstraZeneca, LP and AstraZeneca Pharmaceuticals, LP (collectively, AstraZeneca) agreed to pay \$520 million plus interest and enter into a 5-year Corporate Integrity Agreement (CIA) to resolve their civil FCA liability in connection with the promotion of the atypical antipsychotic drug Seroquel. AstraZeneca was alleged to have promoted Seroquel between January 2001 and December 2006 for uses that were not approved by the Food and Drug Administration (FDA) as safe and effective. AstraZeneca also was alleged to have violated the Federal anti-kickback statute by offering and paying illegal remuneration to doctors in connection with services rendered by the doctors relating to the unapproved uses of Seroquel.

Other Part A and Part B Highlights

Inpatient Rehabilitation Facilities' Compliance With Medicare's Transfer Regulation

Based on our sample results for FYs 2004 through 2007, we estimated that inpatient rehabilitation facilities (IRF) were overpaid \$34 million for claims that were improperly coded as discharges to home rather than transfers to other facilities. Under Medicare's transfer regulation, Medicare pays the full prospective payment to an IRF that discharges a beneficiary to home and pays a lesser amount for a transfer case. Whether Medicare pays for a discharge or a transfer depends on the patient status code indicated on the IRF's claim. Even though a new edit in the Centers for Medicare & Medicaid Services' (CMS) Common Working File (CWF) detected the miscoded claims, fiscal intermediaries (FI) did not adjust the claims to prevent overpayments. We recommended, among other things, that CMS recover \$1.2 million in overpayments identified in our sample, instruct its contractors to review the unsampled claims and identify and recover additional overpayments estimated at \$32.8 million, and instruct its contractors to take appropriate action in response to future CFW edit alerts. CMS agreed with our recommendations. ([A-04-09-00059](#))

Inpatient Rehabilitation Facilities' Transmission of Patient Assessment Instruments

For 2006 and 2007, IRFs did not always receive reduced payments for claims with patient assessment instruments that were transmitted to CMS more than 27 days after the beneficiaries' discharges. Such claims should have been reduced by 25 percent. Based on our sample results, we estimated that IRFs were overpaid \$20.2 million for claims with late patient assessment instruments. IRFs may have received an additional \$19 million in overpayments by initially transmitting the instruments within the deadline but subsequently retransmitting them after the deadline to correct errors. CMS guidance does not address the applicability of the 25-percent penalty in these situations. We recommended that CMS take several actions, including (1) adjusting the sampled claims for overpayments of \$424,000, (2) reviewing the nonsampled claims (which have overpayments estimated at \$19.8 million and set-aside payments estimated at \$18.7 million) and recovering any overpayments, and (3) establishing written policies on whether modified patient assessment instruments that are transmitted after the deadline are subject to the 25-percent payment penalty. CMS concurred. ([A-01-09-00507](#))

Analysis of Errors Identified in the Fiscal Year 2009 Comprehensive Error Rate Testing Program

This analysis found that six types of Medicare health care providers accounted for \$4.4 million, or 94 percent, of the \$4.7 million in improper payments identified by CMS's Comprehensive Error Rate Testing (CERT) contractor for FY 2009. The provider types were inpatient hospitals, durable medical equipment (DME) suppliers, hospital outpatient departments, physicians, skilled nursing facilities, and home health agencies. Our analysis of the erroneous claims identified by the CERT contractor found that insufficient documentation, miscoded claims, and

medically unnecessary services and supplies accounted for about 98 percent of the improper payments attributable to the six types of providers. CMS concurred with our recommendation to use the results of our analysis in identifying (1) the types of payment errors indicative of programmatic weaknesses and (2) any additional corrective actions needed to strengthen the CERT program. ([A-01-10-01000](#))

Medicare Part D

Invalid Prescriber Identifiers on Medicare Part D Drug Claims

We found that Medicare drug plans and enrollees paid pharmacies \$1.2 billion in 2007 for more than 18 million prescription drug claims that contained 527,749 different invalid prescriber identifiers. These invalid identifiers either (1) were not listed as valid identifiers in the National Provider Identifier (NPI), Drug Enforcement Administration (DEA) number, or Unique Physician Identification Number (UPIN) registry databases or (2) had been deactivated or retired before January 1, 2006. For 17 percent of the drug claims that contained invalid prescriber identifiers, the identifiers did not conform to length or format requirements. Our review also revealed that only 10 identifiers accounted for 17 percent of all drug claims with invalid prescriber identifiers in 2007. These drug claims represented \$237 million in payments by Medicare drug plans and enrollees. One of the top ten invalid prescriber identifiers was recorded on almost 1.8 million PDE records for more than 150,000 beneficiaries enrolled with 248 different Medicare drug plan sponsors. These plan sponsors and enrollees paid pharmacies almost \$105 million for drug claims with this single invalid identifier. In addition, 5 of the top 10 invalid identifiers appeared on individual claims for very expensive drugs, with payment amounts totaling more than \$10,000 per claim. ([OEI-03-09-00140](#))

Less-Than-Effective Medicare Part D Drugs

We found that for calendar years (CY) 2006 and 2007, a CMS system edit appropriately identified and rejected the vast majority of Medicare Part D sponsors' prescription drug event (PDE) data associated with less-than-effective drugs. However, the edit accepted PDE data totaling \$43.3 million associated with less-than-effective drugs because the Part D program used an incomplete list of these drugs as the basis for the edit. Less-than-effective drugs are drugs that the FDA approved before 1962 and that FDA subsequently found to be less than effective. There is no definitive list of these drugs. CMS agreed with our recommendation to determine whether it can impose financial adjustments on sponsors that were paid for furnishing less-than-effective drugs. CMS partially agreed with our recommendation to help ensure that Part D drugs comply with Federal requirements by collaborating with FDA on a list of less-than-effective drugs, disseminating the list to all sponsors, and using the list to reject such PDE data. CMS stated that FDA should be responsible for maintaining and disseminating the list of less-than-effective drugs. ([A-07-09-04138](#))

Medicaid

Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services

Most children in nine selected States are not fully benefitting from Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) comprehensive screening services. In our review, we found that 76 percent of children in these States, or 2.7 million children, did not receive all of the required number of medical, vision, and hearing screenings. Fifty-five percent of children in the nine States received a medical screening during the study period. Of these children, 59 percent lacked at least one component of a complete medical screening. These factors taken together indicate that very few children received the correct number of complete screenings required by law. ([OEI-05-08-00520](#))

Other Health Care Investigations

Nine Health Care Employees Sentenced After Death of At-Risk Child

Nine employees at MultiEthnic Behavioral Health Services, Inc., (MEBH) were sentenced to prison terms ranging from 15 months to 17½ years and were ordered to pay joint and several restitution ranging from \$316,000 to \$1,216,000 based on charges related to health care fraud and the death of an at-risk child who was under MEBH's care. Federal and local investigators found that MEBH employees did not provide any services to the at-risk child with cerebral palsy, even though she was under their care. The child suffered severe bed sores and extreme weight loss as she slowly starved to death. MEBH employees then attempted to conceal the incident by destroying old records and creating new false records of the child's care. The defendants' fraudulent activity also included creating false documentation for visits that did not occur, forging guardian signatures, destroying records, and fabricating other medical documents.

Businesses Agree to Pay \$7.3 Million to Settle Stark Law Violations

Physician-owned United Shockwave Services, Ltd; United Urology Centers, LLC; and United Prostate Centers, LLC (collectively, United) agreed to pay \$7,359,500 and, along with United Therapies, LLC, enter into a 5-year CIA to resolve their CMPL liability. The settlement resolves allegations that United violated the anti-kickback statute by soliciting remuneration from hospitals in exchange for patient referrals. Specifically, it was alleged that United threatened hospitals that it would refer patients to competing hospitals if they did not agree to a contract with United, or promised additional referrals to hospitals that did contract with United.

Public Health

Challenges to FDA's Ability To Monitor and Inspect Foreign Clinical Trials

We found that in FY 2008, sponsors relied heavily on data from foreign clinical trials to support their marketing applications for drugs and biologics. The Food, Drug, and Cosmetic Act (FDCA) requires all new investigational drugs and biologics to undergo clinical trials on human subjects to demonstrate the safety and efficacy of these products prior to approval for sale in the United States. Sponsors may submit data from foreign and domestic clinical trials to support marketing applications. We found that 80 percent of approved marketing applications for drugs and biologics contained data from foreign clinical trials. Further, over half of clinical trial subjects and sites were located outside the United States. We found that the FDA inspected less than 1 percent of foreign clinical trial sites. Challenges in conducting foreign inspections and data limitations inhibit FDA's ability to monitor foreign clinical trials. ([OEI-01-08-00510](#))

FDA Inspections of Domestic Food Facilities

We identified significant weaknesses in FDA's inspections of food facilities. FDA inspects food facilities to ensure food safety and compliance with regulations. FDA should take some type of regulatory action when an inspection identifies violations that are significant enough to warrant an "official action indicated" (OAI) classification. This regulatory action could include issuing a warning letter; holding a regulatory meeting; or initiating an enforcement action, such as a seizure or an injunction. We found that FDA inspects less than a quarter of food facilities each year. In addition, more than half of all food facilities have gone 5 or more years without an FDA inspection. Moreover, for 36 percent of the facilities that received OAI classifications, FDA took no additional steps to ensure that the violations were corrected. ([OEI-02-08-00080](#))

Background on Recommendations

At all levels, OIG works in close cooperation with HHS and its operating and staff divisions, DOJ, other agencies in the executive branch, Congress, and States to bring about successful prosecutions, negotiated settlements, recovery of funds, and systemic improvements, which often include greater beneficiary protections, improved program oversight, or funds put to better use. Systemic results are usually achieved through modifications to administrative policies, processes, or procedures; changes to existing regulations and law; or improvements in information technology.

OIG relies on HHS management and other governmental policymakers to decide which program recommendations are implemented. Although many OIG recommendations are directly implemented by organizations within HHS, some are acted on by States, which collaborate with HHS to administer, operate, and/or oversee designated programs, such as Medicaid. HHS and the States sometimes do not immediately implement OIG's

recommendations for various reasons, including administrative complexities, the current policy environment, or a lack of statutory authority. In such cases, Congress may step in to weave OIG's recommendations into legislative actions, many of which result in substantial funds being made available for better use or in program improvements.

The body of this *Semiannual Report* describes the results of selected reviews and other efforts finalized during the period. Information about the estimated current or potential monetary impact of our recommendations is found in the appendixes. Some current outcomes relate to reports issued and corresponding actions taken in prior periods. Specifically, Appendix B includes data on management decisions that were made during the period to disallow questioned costs, thus creating audit receivables. Some of the questioned costs disallowed were identified as findings in reports that were issued in prior semiannual periods.

In addition to publishing the semiannual reports to Congress, OIG annually publishes the [*Compendium of Unimplemented Recommendations*](#), which consolidates significant unimplemented monetary and nonmonetary recommendations that have been addressed previously to HHS and its pertinent operating and staff divisions. The *Compendium* provides information about outstanding recommendations that, if implemented, have the potential to result in cost savings and improvements to program efficiency and effectiveness. These recommendations, which are selected from audits and evaluations, require one or more of three types of actions: administrative, regulatory, or legislative. OIG performs routine followup with the Department to determine the status of actions being taken in response to our recommendations.

Legislative and Regulatory Review

Pursuant to the Inspector General Act of 1978 (IG Act), § 4(a)(2), OIG reviews existing and proposed legislation and regulations relating to HHS's programs and operations and makes recommendations concerning their impact on economy and efficiency or the prevention and detection of fraud and abuse. Most audits and other reviews that OIG conducts are designed to test compliance with and/or assess the administration and oversight of existing laws and regulations. OIG's reports of such reviews describe our findings, which include questioned costs, inefficiencies, vulnerabilities to fraud, inconsistencies, errors in application, or weaknesses in oversight or supporting systems. OIG's corresponding recommendations advise HHS and the pertinent operating or staff divisions of the type of actions we believe are needed to effectively respond to the findings. Recommendations may be administrative, regulatory, legislative, or a combination.

The narratives in this *Semiannual Report to Congress* describe findings and recommendations from recently completed OIG reviews, many of which focus on existing laws and regulations. In our *Compendium of Unimplemented Office of Inspector General Recommendations*, which is published annually, we describe priority findings and recommendations from past periods that remain to be implemented, along with pertinent citations of existing laws and regulations. In

our annual *Work Plan*, which is published at the start of each fiscal year, we provide citations to laws and regulations that are the subject of ongoing or future reviews.

OIG also reviews proposed legislation and regulations related to HHS programs and operations. HHS routinely involves its operating and staff divisions, including OIG, in the review and development of HHS regulations through a well-established HHS process. Moreover, OIG's audits, evaluations, and investigations are sometimes cited in regulatory preambles as influencing HHS regulations. OIG participates in a longstanding HHS process for developing and reviewing HHS's legislative proposals. In addition, OIG provides independent, objective technical assistance on a bipartisan, bicameral basis to congressional committees and members who request it.

Congressional Testimony

During this semiannual period, OIG witnesses testified six times at hearings conducted by committees of Congress. Excerpts follow.

May 6, 2010: Safety of the Nation's Food Supply

Jodi Nudelman, OIG Regional Inspector General for Evaluation and Inspections, testified before the Subcommittee on Oversight and Investigations of the U.S. House of Representatives, Committee on Energy and Commerce on the safety of the Nation's food supply. The following is an excerpt.

Our recent report [*FDA Inspections of Domestic Food Facilities*] is a part of a larger body of OIG work that demonstrates that more needs to be done to ensure the safety of the Nation's food supply. In a report on food traceability, we found that only 5 of 40 selected products could be traced through each stage of the food supply chain. In addition, more than half of the facilities that handled these food products failed to meet FDA recordkeeping requirements. In another report, we found that 5 percent of selected facilities failed to register their facilities with FDA as required. Of those facilities that did register, almost half failed to provide accurate information in FDA's registry. Finally, we completed a report that found that FDA did not always follow its procedures when overseeing certain pet food recalls and noted that FDA does not have the statutory authority to mandate [pet food] recalls. [Full text.](#)

June 15, 2010: Reducing Fraud, Waste, and Abuse in Medicare

Lewis Morris, Chief Counsel to the Inspector General, testified before the Subcommittees on Health and Oversight of the U.S. House of Representatives, Ways and Means Committee, on reducing fraud, waste and abuse in Medicare. The following is an excerpt.

Fraud, waste, and abuse cost taxpayers billions of dollars each year and put beneficiaries' health and welfare at risk. The impact of these losses and risks is

exacerbated by the growing number of people served by these programs and the increased strain on Federal and State budgets. With new and expanded programs under the Affordable Care Act, it is critical that we strengthen oversight of these essential health care programs. [Full text.](#)

July 15, 2010: Preventing and Recovering Government Payment Errors

Robert A. Vito, Acting Assistant Inspector General, CMS Audits, testified before the U.S. Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, on Preventing and Recovering Government Payment Errors. The following is an excerpt.

Recent OIG work illustrates that because of ... vulnerabilities, Medicare has paid for substantial numbers of questionable claims for prescription drugs under Part D. OIG's June 2010 report, *Invalid Prescriber Identifiers on Medicare Part D Drug Claims*, reveals that CMS and its plan sponsors have not adequately performed one of the most basic oversight checks in Medicare Part D—ensuring that a drug was prescribed by a physician. As a result, Part D sponsors and beneficiaries paid pharmacies \$1.2 billion in 2007 for claims in which the prescriber identifiers listed on the claims did not correspond to practicing physicians. Because prescriber identifiers are a key indicator on Part D claims that link prescribing physicians, dispensing pharmacies, and Medicare beneficiaries, they play a critical role in program integrity efforts. Without a valid prescriber identifier, CMS and its contractors cannot determine whether a physician even prescribed a drug, much less verify that the physician was appropriately licensed or had not been excluded from the Medicare program. Furthermore, invalid prescriber identifiers inhibit OIG investigations by making it more difficult to identify questionable prescribing patterns and the parties responsible for potential fraud. [Full text.](#)

September 15, 2010: Medicare's Coverage of Durable Medical Equipment

Daniel R. Levinson, Inspector General, testified before the Subcommittee on Health of the U.S. House of Representatives Committee on Energy and Commerce on the integrity of Medicare's coverage of DMEPOS. The following is an excerpt.

It has been too easy for fraudulent DMEPOS suppliers to obtain Medicare billing privileges. The enrollment standards that I have described are intended to ensure that only legitimate and qualified businesses are enrolled as Medicare suppliers. Unfortunately, we have found that all too often, unscrupulous suppliers are able to gain entry to the system and defraud Medicare.... Thus far in fiscal year 2010, OIG investigations of DMEPOS fraud have resulted in more than 80 convictions with ordered recoveries of more than \$90 million.... Since 1997, OIG has issued several reports that have assessed supplier compliance with standards by conducting unannounced site visits. We have consistently found that Medicare enrollment standards and oversight are not sufficient to prevent noncompliant and sham suppliers

from obtaining Medicare provider numbers and billing privileges. Some Medicare-enrolled suppliers fail to maintain even the most basic Medicare standards—for example, maintaining a physical facility or being open during reasonable business hours. [Full text.](#)

September 22, 2010: Cutting Waste, Fraud, and Abuse in Medicare and Medicaid

Daniel R. Levinson, Inspector General, testified before the Subcommittee on Health of the House Committee on Energy and Commerce on cutting waste, fraud, and abuse in Medicare and Medicaid. The following is an excerpt.

Waste of funds and abuse of the health care programs ... cost taxpayers billions of dollars. In FY 2009, [CMS] estimated that overall, 7.8 percent of the Medicare fee-for-service claims it paid (\$24.1 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid.... OIG's work has ... demonstrated that Medicare and Medicaid pay too much for certain services and products and that aligning payments with market costs could produce substantial savings. For example, in 2007, OIG reported that Medicare reimbursed suppliers for pumps used to treat pressure ulcers and wounds based on a purchase price of more than \$17,000, but that suppliers paid, on average, approximately \$3,600 for new models of these pumps. Similarly, we found that in 2007, Medicare allowed, on average, about \$4,000 for standard power wheelchairs that cost suppliers, on average, about \$1,000 to acquire. These pricing disparities also affect beneficiaries, who are responsible for 20 percent copayments on items and services covered under Medicare Part B. [Full text.](#)

September 28, 2010: Indian Health Service's Aberdeen Area

Testimony of Gerald Roy, Deputy Inspector General for Investigations, before the U.S. Senate Committee on Indian Affairs on investigative oversight of the Indian Health Service's (IHS) Aberdeen Area. The following is an excerpt from that testimony.

Over the last 10 years, my office opened nearly 300 investigations related to, or affecting IHS. Many of these cases also involved allegations of Medicare or Medicaid fraud. In the course of these investigations, OIG has identified three general areas of vulnerability that threaten IHS. These areas are: (1) mismanagement, (2) employee misconduct, and (3) drug diversion. [Full text.](#)

Outline of Major Parts and Appendixes

| | |
|-------------|---|
| Part I: | Medicare Reviews |
| Part II: | Medicaid Reviews |
| Part III: | Legal and Investigative Activities Related to Medicare and Medicaid |
| Part IV: | Public Health, Human Services, and Departmentwide Issues |
| Appendix A: | Savings Achieved Through Implementation of Recommendations |
| Appendix B: | Recommendations for Questioned Costs and Funds To Be Put to Better Use |
| Appendix C: | Reporting Requirements of the Inspector General Act of 1978, as Amended |
| Appendix D: | Public Proposals for New and Modified Safe Harbors |
| Appendix E: | Summary of Sanction Authorities |
| Appendix F: | Peer Review Results |