

A Message From the Inspector General

THIS SEMIANNUAL REPORT TO CONGRESS, submitted pursuant to the Inspector General Act of 1978, as amended, summarizes the activities of the Office of Inspector General (OIG), U.S. Department of Health & Human Services (HHS), for the 6-month period ending September 30, 2011.



Over the past 6 months, OIG produced significant recommendations to improve HHS programs, investigated fraud and executed enforcement actions, and offered our industry stakeholders new compliance training. OIG realizes that technology has tremendous potential to enhance our program integrity capabilities. OIG is using data mining, predictive analytics, trend evaluation, and modeling to better analyze and target the oversight of HHS programs. Utilizing technologies, OIG is able to improve its strategic, tactical, and operational oversight of HHS programs. The integration of technology provides OIG with an analytical foundation to build upon and improve the enterprise view of activities, trends, patterns, predictive analytics, and prevention opportunities. We also continue to utilize our traditional approaches to conducting reviews and investigations, and combining traditional approaches with the many new tools available through technology, we aim to maximize the investment in our office and produce returns for the taxpayer.

OIG is an excellent investment. Our work results in the recovery of stolen and misspent funds, and our recommendations lead to increased efficiency and effectiveness and fraud prevention. Our results are tangible. For instance, our Medicare Fraud Strike Force activities continue to be successful. During this semiannual reporting period, Strike Force efforts resulted in the filing of charges against 70 individuals or entities, 77 convictions, and \$160.8 million in investigative receivables. Additionally, we have issued reports with respect to payments for prescription drugs that contain recommendations that when implemented could lead to substantial Federal health care program savings.

Our enforcement efforts are coupled with extensive outreach to providers to help them understand program rules and avoid running afoul of applicable statutes and regulations. We conducted provider compliance training around the country and posted the training and additional resources on our Web site. The response to this initiative has been extremely positive.

However, individuals and entities remain that seek to defraud the programs. OIG investigates fraud and works with the Department of Justice to hold accountable its perpetrators. Many of these instances are highlighted in this report. In many cases, OIG enters into corporate integrity agreements with providers as part of the settlement of False Claims Act cases to help ensure future compliance. However, if providers violate the terms of those agreements, OIG holds them accountable, such as by imposing penalties or, for serious breaches, by moving to exclude them from participating in Federal health care programs.

Another priority of our office is reducing improper payments. I testified during this reporting period about OIG's recommendations to the Department to reduce improper payments, including those for Medicaid personal care services, Medicare power wheelchairs, hospice care, and payments to hospitals.

The public health and welfare of HHS beneficiaries continues to be of paramount concern to our office. We issued reports during this reporting period regarding the Food and Drug Administration's monitoring of imported food recalls, oversight of the President's Emergency Plan for AIDS Relief, and access to

dialysis and mental health services at Indian Health Service and tribal facilities. Vulnerable populations and their access to necessary, safe, and high-quality services remain a focus of ongoing and future work.

The pervasiveness of cybersecurity breaches is a major challenge. During this reporting period, our office issued two reports identifying weaknesses in the protection of electronic patient health information. This will continue to be a concern as the provider community increasingly adopts electronic health information technology. OIG has a robust oversight agenda to ensure that sensitive information is protected from nefarious parties.

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

A handwritten signature in black ink that reads "Daniel R. Levinson". The signature is written in a cursive, flowing style.

Daniel R. Levinson
Inspector General

Highlights

The Department of Health & Human Services (HHS) Office of Inspector General (OIG) *Semiannual Reports to Congress* summarize our most significant findings, recommendations, investigative outcomes, and outreach activities in 6-month increments. This edition addresses work completed during the second half of fiscal year (FY) 2011 and provides FY 2011 summary data on key accomplishments. The [Semiannual Report to Congress](#) is one of OIG's three core publications. Our [Work Plan](#) describes work in progress and new projects that we plan to pursue during the fiscal year and beyond. Our [Compendium of Unimplemented Recommendations](#) describes open recommendations from prior periods that when implemented will save tax dollars and improve programs.

Summary of Fiscal Year 2011 Accomplishments

For FY 2011, we reported expected recoveries of about \$5.2 billion consisting of \$627.8 million in audit receivables and \$4.6 billion in investigative receivables (which includes \$952 million in non-HHS investigative receivables resulting from our work in areas such as the States' share of Medicaid restitution). We also identified about \$19.8 billion in savings estimated for FY 2011 as a result of legislative, regulatory, or administrative actions that were supported by our recommendations. Such savings generally reflect third-party estimates (such as by the Congressional Budget Office) of funds made available for better use through reductions in Federal spending.

We reported FY 2011 exclusions of 2,662 individuals and entities from participation in Federal health care programs; 723 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 382 civil actions, which included false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters.

Following are highlights of significant activities, findings, and investigative outcomes that are included in the main body of the Semiannual Report for the second half of FY 2011.



HEAT: Health Care Fraud Prevention and Enforcement Action Team

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was started in 2009 by HHS and the Department of Justice (DOJ) to strengthen programs and invest in new resources and technologies to prevent and combat health care fraud, waste, and abuse.

Medicare Fraud Strike Force Teams Continue To Turn Up the HEAT

Medicare Fraud Strike Force teams coordinate law enforcement operations among Federal, State, and local law enforcement entities. These teams, now a key component of HEAT, have a record of successfully analyzing data to quickly identify and prosecute fraud. The Strike Force began in March 2007 and is operating in several major cities. Recent accomplishments include the following.

- During FY 2011, Strike Force efforts resulted in the filing of charges against 283 individuals or entities, 184 convictions, and \$224.8 million in investigative receivables.
- In late August and early September 2011, Medicare Fraud Strike Force teams in eight cities executed a nationwide operation that resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. In addition to making arrests, agents also executed 18 search warrants in connection with ongoing Strike Force investigations.

The effectiveness of the Strike Force model is enhanced by interagency collaboration. For example, we refer credible allegations of fraud to the Centers for Medicare & Medicaid Services (CMS) so it can suspend payments to the perpetrators. During Strike Force operations, OIG and CMS work to impose payment suspensions that immediately prevent losses from claims submitted by Strike Force targets.

50-year Prison Sentence Longest imposed in a Medicare Fraud Strike Force Case

FLORIDA – Lawrence Duran, one of several owners of American Therapeutic Corporation (ATC), was sentenced to 50 years of incarceration for his role in orchestrating a Medicare fraud scheme in which owners and operators of assisted living facilities, halfway houses, and patient brokers were actively recruited and paid kickbacks in exchange for delivering ineligible patients to ATC. This case was the first Community Mental Health Center investigation under the HEAT initiative to lead to an indictment, and Duran's 50-year prison sentence is the longest imposed in a Medicare Fraud Strike Force case. Marianella Valera, another ATC owner, and Margarita Acevedo, a senior-level ATC manager, were also sentenced to 35 and 7.5 years of incarceration, respectively, for their roles in the scheme. The three individuals and three business entities were ordered to pay more than \$87 million in restitution, jointly and severally. The now-defunct ATC was used to bill Medicare for mental health services that were not necessary or were not provided.

Incarceration and \$11.7 Million in Restitution Ordered for HIV Therapy Scheme

FLORIDA – Dr. Rene De Los Rios was sentenced to 235 months of incarceration and ordered to pay a minimum of \$11.7 million in restitution, jointly and severally with his co-defendants, for conspiracy to commit health care fraud and submission of false claims. De Los Rios was employed by Metro Med of Hialeah Corporation (Metro Med), a clinic that provided injection and infusion therapies to human immunodeficiency virus (HIV)-positive Medicare beneficiaries. Between April 2003 and October 2005, De Los Rios signed medical analysis and diagnosis forms and authorized treatments that were medically unnecessary or were never provided. The owner and operator of Metro Med, Damaris Oliva, and three other co-defendants, Estrella Rodriguez, Jose Diaz, and Lisandra Aguilera, were sentenced to 82 months, 57 months, 54 months, and 70 months of incarceration, respectively, for their roles in the scheme.

OIG Trains Health Care Providers To Prevent Fraud and Improve Compliance

OIG's HEAT Provider Compliance Training initiative (HEAT PCT) provided free compliance training for providers, compliance professionals, and attorneys in Strike Force cities and elsewhere. HEAT PCT, which included presenters from OIG, CMS Regional Offices, CMS Program Integrity, United States Attorneys' Offices, and State Medicaid Fraud Control Units, held sessions in Houston, Tampa, Kansas City, Baton Rouge, Denver, and Washington, D.C., training a total of 737 in-person attendees. The final HEAT PCT session in Washington, D.C., was Webcast live to 2,335 participants. Pictured above are OIG attorneys Amanda Walker and Meredith Williams. HHS/OIG developed comprehensive training materials to accompany HEAT PCT, and those materials are now available online, together with [16 video modules](#) dividing the Webcast by subject area. The online training will continue reaching the health care community with our compliance message.



Prescription Drug Investigations and Reviews

Pharmaceutical Company Resolves False Claims Act Liability

MARYLAND – Serono Laboratories, Inc.; EMD Serono, Inc.; Merck Serono S.A.; and Ares Trading S.A. (collectively Serono), agreed to pay \$44.3 million plus interest and enter into a False Claims Act (FCA) settlement to resolve allegations that between January 2002 and December 2009, Serono paid illegal remuneration to health care professionals (for activities such as promotional speaking engagements, speakers' training, and charitable contributions) to induce them to prescribe their multiple sclerosis prescription drug called Rebif and, thereby, caused the submission of false claims to Medicare and other Federal health care programs. As part of a 2005 civil and criminal settlement relating to Serono's promotion of the drug Serostim, Serono entered into a corporate integrity agreement (CIA) with OIG. As part of the 2011 settlement, Serono entered into a 3-year addendum to the existing CIA.

OIG Raises Concerns About Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents

FOR THE PERIOD JANUARY 1 THROUGH JUNE 30, 2007, 51 PERCENT OF MEDICARE CLAIMS FOR ATYPICAL ANTIPSYCHOTIC DRUGS DID NOT COMPLY WITH MEDICARE REIMBURSEMENT CRITERIA, AMOUNTING TO \$116 MILLION IN ERRONEOUS PAYMENTS. Atypical antipsychotic drugs are approved by the Food and Drug Administration (FDA) for treatment of schizophrenia and/or bipolar disorder. Fourteen percent of 2.1 million elderly (age 65 and older) nursing home residents had at least 1 claim for such drugs. Eighty-three percent of the claims were associated with off-label conditions (conditions other than schizophrenia and/or bipolar disorder), and 88 percent were associated with dementia (the condition specified in the FDA boxed warning). Twenty-two percent of claims were for drugs that were not administered in accordance with CMS standards for drug therapy in nursing homes. Our recommendations to CMS included that it facilitate Medicare's access to information necessary to ensure accurate coverage and reimbursement determinations and take appropriate action regarding the claims associated with the erroneous payments identified in our sample.

Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents. OEI-07-08-00150. [Web Summary](#). [Full Text](#). Inspector General's [CNN Article](#). [CBS News Video](#).

Cost of Alternative Drug Treatments for Age-Related Macular Degeneration

IF PHYSICIANS HAD TREATED ALL MEDICARE BENEFICIARIES WITH WET AGE-RELATED MACULAR DEGENERATION (WET AMD) WITH AVASTIN DURING CALENDAR YEARS (CY) 2008 AND 2009, MEDICARE PART B WOULD HAVE SAVED APPROXIMATELY \$1.1 BILLION. Conversely, if the same beneficiaries had been treated with Lucentis, Medicare Part B would have increased spending by approximately \$1.5 billion. Avastin and Lucentis (both manufactured by Genentech) are the most commonly administered Part B biologicals used to treat wet AMD, which is the leading cause of severe vision loss in people over age 65 in the United States. Given the significant difference in Medicare Part B reimbursements for the products, we questioned the sufficiency of CMS's authorities to limit Part B drug and biological expenditures effectively. Our recommendations included that CMS evaluate coverage and reimbursement policies and seek such additional authorities as are necessary.

Review of Medicare Part B Avastin and Lucentis Treatments for Age-Related Macular Degeneration.
A-01-10-00514. [Web Summary](#). [Full Text](#).

Higher Manufacturer Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D

ALTHOUGH PHARMACY REIMBURSEMENT AMOUNTS UNDER MEDICAID AND MEDICARE PART D WERE SIMILAR FOR MOST SELECTED BRAND-NAME DRUGS IN 2009, MEDICAID'S NET UNIT DRUG COSTS WERE MUCH LOWER THAN PART D'S BECAUSE MEDICAID HAS SUBSTANTIALLY HIGHER REBATES FOR BRAND-NAME DRUGS. Manufacturer rebates for generic drugs under both programs were negligible. We also found that State Medicaid agencies and Part D sponsors paid pharmacies roughly the same amount for brand-name drugs. However, after accounting for rebates, Medicaid's net costs for selected brand-name drugs were much lower than Part D's net costs. Medicaid recouped 45 percent of its drug spending on selected brand-name drugs in manufacturer rebates while Part D sponsors recouped 19 percent. We concluded that given the potential impact on beneficiary and Government expenditures, differences in how rebates are collected across Medicaid and Part D should be continually examined by CMS.

Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D.
OEI-03-10-00320. [Web Summary](#). [Full Text](#).

Medicare Part A and Part B Reviews and Enforcement Actions

Medicare Hospices That Focus on Nursing Facility Residents

MEDICARE SPENDING ON HOSPICE CARE FOR NURSING FACILITY RESIDENTS HAS GROWN NEARLY 70 PERCENT SINCE 2005. WE FOUND THAT HUNDREDS OF HOSPICES—MOST OF WHICH WERE FOR-PROFIT—HAD MORE THAN TWO-THIRDS OF THEIR BENEFICIARIES IN NURSING FACILITIES IN 2009. Hospices with a high percentage of their beneficiaries in nursing homes received more Medicare payments per beneficiary than other hospices and had beneficiaries who spent more time in care. The high-percentage hospices typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities. We recommended that CMS monitor hospices that depend heavily on nursing facility residents and modify the payment system for hospice care in nursing facilities. The current payment structure provides incentives for hospices to seek out nursing facility beneficiaries who often receive longer but less complex care. Medicare pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private



homes. However, unlike private homes, nursing facilities (which are often paid by third-party payers or Medicaid) are already staffed with professional caregivers and are required to provide personal care services (PCS) that are similar to hospice aide services.

Medicare Hospices That Focus on Nursing Facility Residents. OEI-02-10-00070. [Web summary](#). [Full Text](#). See also OIG's [Spotlight](#) and [Podcast](#) on Hospice Care; OIG's March 2011 [Compendium](#),¹ Part I, pp. 19 and 20; and report number [OEI-02-06-00221](#), all available on our Web site.

Changes in Skilled Nursing Facilities Billing

ALTHOUGH CHANGES MADE TO THE SKILLED NURSING FACILITY (SNF) PAYMENT SYSTEM EFFECTIVE FY 2011 WERE INTENDED BE TO BE BUDGET NEUTRAL, UNANTICIPATED BILLING PATTERNS CONTRIBUTED TO A \$2.1 BILLION (16-PERCENT) INCREASE IN MEDICARE PAYMENTS. The increase occurred from the last half of FY 2010 to the first half of FY 2011. At the same time, several of the changes reduced billing for certain higher-paying groups. The data indicate that Medicare should adjust payment rates to address the significant increases in payments to SNFs. The data also show that Medicare should make changes to how SNFs account for group therapy. Further, the data highlight the need for changes to make Medicare payments more consistent with beneficiaries' care and resource needs. On the basis of this report, CMS has proposed a number of changes to the SNF payment system and will issue a final rule for FY 2012.

Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011. OEI-02-09-00204. [Web Summary](#). [Full Text](#).

Manufacturer Resolves Noncompliance With Orthotic Shoe Insert Specifications

WISCONSIN – Rikco International, LLC, d/b/a Dr. Comfort (Dr. Comfort), agreed to pay \$27 million plus interest and enter into a 5-year CIA to resolve its liability under the FCA in connection with the alleged sale of durable medical equipment (DME) reimbursed by Medicare. Between June 2004 and March 2006, Dr. Comfort allegedly shipped diabetic orthotic shoe inserts to DME suppliers under the false pretense that the inserts were approved by Medicare for reimbursement and that the inserts met specifications established by CMS when, in fact, they did not meet the specifications.

Physician Settles Radiation Oncology Services-Related Billing Issues

NEVADA – Rakesh Nathu, M.D., and Nathu Compassionate Cancer Care, Chartered (collectively Nathu), agreed to pay \$5.7 million plus interest to settle allegations under the FCA for the false billing of radiation oncology services, including intensity modulated radiation therapy. Intensity modulated radiation therapy is a treatment for specific types of cancer where extreme precision is required to spare surrounding organs or healthy tissue. Between 2007 and 2009, Nathu allegedly submitted improper claims to Medicare, TRICARE, and the Federal Employees Health Benefits Plan by double-billing for procedures affiliated with radiation treatment plans. Nathu also allegedly billed for services that were medically unnecessary and billed higher reimbursement radiation services when a different, less expensive service should have been billed. This was a joint investigation with the Federal Bureau of Investigation.

¹ OIG's *Compendium of Unimplemented Recommendations* (Compendium) describes recommendations that when implemented will save tax dollars and improve programs and operations.

Medicaid Reviews



States Urged To Refund Over \$61 Million in Federal Share of Improper Medicaid Payments for Personal Care Services

THREE STATES IMPROPERLY CLAIMED ABOUT \$61.3 MILLION OF FEDERAL MATCHING FUNDS FOR PCS THAT DID NOT MEET FEDERAL AND/OR STATE REQUIREMENTS. We set aside an additional \$34.8 million for further analysis and resolution by the States and CMS. We recommended that the States refund the Federal share and work with CMS to

resolve the amounts set aside. We also recommended improvements in guidance, controls, and monitoring. PCS, which are nonmedical services provided to assist with activities of daily living, such as bathing, dressing, and meal preparation, are generally furnished to individuals residing in their homes and not residing in institutional care settings, such as hospitals or nursing facilities. The three reviews completed in this semiannual period are part of OIG's larger body of work on PCS.

- NEBRASKA – A-07-10-03152. (Refund \$169,000; resolve \$4.5 million set aside.) [Web Summary](#). [Full Text](#).
- NORTH CAROLINA – A-04-10-04003. (Refund \$41.7 million.) [Web Summary](#). [Full Text](#).
- WASHINGTON STATE – A-09-09-00030. (Refund \$19.4 million; resolve \$30.3 million set aside.) [Web Summary](#). [Full Text](#).

See also OIG's [Spotlight on Personal Care Services](#) and a related matter in our March 2011 [Compendium, Part III](#), pp. 15 and 16, available on our Web site.

Illinois' Payments for One State-Owned Psychiatric Hospital

ILLINOIS IMPROPERLY CLAIMED AN \$82.9 MILLION FEDERAL SHARE OF PAYMENTS IT MADE TO A STATE-OWNED PSYCHIATRIC HOSPITAL THAT FAILED TO DEMONSTRATE COMPLIANCE WITH FEDERAL REQUIREMENTS. During the audit period, the hospital did not demonstrate compliance with special Medicare Conditions of Participation (CoP) because the State agency did not believe that such demonstration was necessary. We recommended that Illinois refund the \$82.9 million; work with CMS to evaluate an additional \$12.6 million that we set aside for further analysis and resolution; identify and refund the Federal share of any other payments associated with the same type of noncompliance; and ensure that with regard to psychiatric hospitals, it claims Federal matching funds only for those hospitals that can demonstrate compliance with the special Medicare CoP.

Review of Select Medicaid Inpatient Psychiatric Hospital Service Requirements for One Illinois State-Owned Psychiatric Hospital During the Period January 1, 2000, Through December 31, 2009.
A-05-10-00046. [Web Summary](#). [Full Text](#).

Corporate Integrity Agreement Enforcement Activities

Two Firms Pay Penalties of \$272,500 for Violating Corporate Integrity Agreements

Many health care providers that enter into agreements with the Federal Government to settle potential liabilities under the FCA also agree to adhere to a separate CIA with OIG. In a CIA, a provider

typically commits to establishing a program or taking other specified steps to ensure future compliance with Medicare and Medicaid rules. The compliance programs are designed, in part, to prevent a recurrence of the underlying fraudulent conduct. OIG monitors providers' compliance with these agreements.

During this reporting period, OIG imposed stipulated penalties totaling \$272,500 on two companies, Church Street Health Management (Church Street, formerly known as FORBA Holdings, LLC) and The SCOOTER Store, Inc., because they did not comply with requirements of their CIAs with OIG. A penalty of \$230,000 was imposed on Church Street because it failed to implement training, develop and distribute policies and procedures, submit an Independent Review Organization (IRO) report, and provide notice of Government investigations. Church Street also made false certifications. A penalty of \$42,500 was imposed on The SCOOTER Store, Inc., because it did not submit a timely IRO report, as required under its CIA.

Public Health Reviews

FDA's Monitoring of Imported Food Recalls Warrants Improvement

BECAUSE FDA'S FOOD RECALL GUIDANCE IS NONBINDING ON THE INDUSTRY, FDA CANNOT COMPEL FIRMS TO FOLLOW IT. THEREFORE, FDA CANNOT ENSURE THE SAFETY OF THE NATION'S FOOD SUPPLY. We reviewed 17 of 40 Class I recalls of imported food products conducted from July 1, 2007, through June 30, 2008. We found that firms did not promptly initiate recalls, their recall strategies were not submitted to FDA or were incomplete, they did not issue accurate and complete recall communications to their consignees, and they did not submit timely and complete recall status reports. FDA did not always follow its own procedures. It did not always conduct inspections of firms, obtain complete information on the contaminated products, conduct timely or complete audit checks of consignees, review recall strategies, promptly issue notification letters to firms conveying the review results and other essential instructions, witness the disposal of the products, or obtain the required disposal documentation. We recommended that FDA consider the results of this review in implementing the recently enacted FDA Food Safety Modernization Act and follow its procedures for monitoring recalls.

Review of the Food and Drug Administration's Monitoring of Imported Food Recalls.
A-01-09-01500. [Web Summary.](#) [Full Text.](#)

CDC's Monitoring of AIDS-Relief Funds Is Insufficient

RECIPIENTS' USES OF PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR) FUNDS WERE NOT ALWAYS MONITORED IN ACCORDANCE WITH DEPARTMENTAL AND OTHER FEDERAL REQUIREMENTS. Although the Centers for Disease Control and Prevention (CDC) performed some monitoring, most of the award files we reviewed did not include all required documents or evidence to demonstrate that all cooperative agreements were monitored to the extent required. Of the 30 cooperative agreements in our sample, only 1 file contained all required documents. To ensure proper stewardship over PEPFAR funds, we recommended that CDC follow departmental and other Federal requirements in monitoring recipients' use of such funds. PEPFAR strengthens health systems and builds sustainable HIV and acquired immunodeficiency syndrome (AIDS) programs in more than 75 countries in Africa, Asia, Central and South America, and the Caribbean. HHS receives PEPFAR funds from the Department of State through a memorandum of agreement.

Review of the Centers for Disease Control and Prevention's Oversight of the President's Emergency Plan for AIDS Relief Funds for Fiscal Years 2007 Through 2009. A-04-10-04006. [Web Summary.](#) [Full Text.](#)

National Institutes of Health Showed Mixed Compliance With Appropriations Laws

WE FOUND TIME AND AMOUNT ISSUES IN FOUR CONTRACTS THAT POTENTIALLY VIOLATED THE ANTIDEFICIENCY ACT (ADA). The ADA prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by law. From November 2008 through February 2009, an HHS internal review group assessed 176 HHS contracts, including 21 National Institutes of Health (NIH) contracts. Our reviews of the NIH contracts assess compliance with the purpose, time, and amounts requirements specified in appropriations statutes. For four of the contracts we completed in this semiannual period, NIH had a bona fide need for the items and appropriately funded the contracts and their modifications from the pertinent appropriations years. We found time and amount issues in four other contracts in which NIH's National Institute of Allergy and Infectious Diseases (NIAID) potentially violated the ADA. For the four reviews with time and amount issues, we recommended making monetary adjustments and reporting ADA violations as appropriate. (See Part IV, page 4 for report names and numbers.)

Challenges to Receiving Mental Health and Kidney Dialysis Services at Indian Health Service and Tribal Facilities

SHORTAGES OF HIGHLY SKILLED PROVIDERS, REMOTE LOCATIONS, LACK OF RESOURCES, AND SMALL PATIENT POPULATIONS CONTRIBUTE TO THE LIMITED MENTAL HEALTH AND DIALYSIS SERVICES FOUND AT SOME INDIAN HEALTH SERVICE (IHS) AND TRIBAL FACILITIES. American Indians and Alaska Natives (AI/AN) rank first among ethnic groups as likely to suffer mental health disorders that can lead to suicide, such as anxiety and depression, and AI/ANs' rate of end stage renal disease (ESRD) is the second highest among all racial/ethnic groups. Two reviews in this period address these services and offer recommendations. View OIG's [Spotlight on the Indian Health Service](#), available on our Web site.

- **MENTAL HEALTH SERVICES** – Although 82 percent of facilities provide some type of mental health service and 39 percent of the facilities reported that they provide crisis intervention 24 hours a day, we found that shortages of highly skilled providers limit access to mental health services at those facilities. To help address shortages of licensed providers, 17 percent of IHS and tribal facilities use telemedicine for mental health services. *Access to Mental Health Services at Indian Health Service and Tribal Facilities*. OEI-09-08-00580. September, 2011. [Web Summary](#). [Full Text](#).
- **KIDNEY DIALYSIS SERVICES** – Only 20 of 506 IHS and tribal facilities reported that dialysis services are provided at their facilities. Most AI/AN receive dialysis services at non-IHS/nontribal dialysis facilities. Many tribal facilities assist tribal members in accessing dialysis services by providing transportation and expanding access to specialists. *Access to Kidney Dialysis Services at Indian Health Service and Tribal Facilities*. OEI-09-08-00581. September, 2011. [Web Summary](#). [Full Text](#).

Other HHS-Related Issues

Professional Athlete Ordered To Pay Almost \$1 Million in Child Support

ILLINOIS – Tyrone Lamont Nesby, a former NBA player, was sentenced to 5 years of probation and ordered to pay \$977,402 in restitution for unpaid child support obligations. Between 1999 and 2010, Nesby unlawfully failed to pay child support in three districts for his minor children. The districts included the District of Nevada, the Northern District of Indiana, and the Southern District of Illinois. Nesby pleaded guilty to the charges and agreed to pay restitution for unpaid child support in all three districts. At sentencing, the court strenuously recommended that Nesby speak to underprivileged

children in schools about the importance of family and the lessons he has learned from his experiences.

Grants Fraud Prevention and Investigations

In a July 2011 Grants.gov quarterly Webcast, Special Agents Brandon Trice (HHS OIG) and Ken Dieffenbach (DOJ OIG), pictured at right with Grants.gov Acting Program Manager, Boris DeSouza, gave a special presentation on grant fraud prevention that highlights three areas of interest: conflicts of interest, misuse of funds, and embezzlement. The [session](#), which runs about 1 hour, includes discussion and audience questions and can be viewed on the OIG Web site. A [CBS News video](#) about fraudulent Federal grants can also be viewed on our Web site. In addition to grant fraud prevention activities, our office actively pursues those who abuse Federal grant dollars as summarized below.



GEORGIA – Bernard Walker was sentenced to 33 months of incarceration after pleading guilty to theft or embezzlement from a program receiving Federal grant funding and money laundering. He fraudulently obtained and laundered checks from a federally funded not-for-profit program meant to feed low-income children. Walker used his position as a nutrition specialist for a Head Start program to obtain kickbacks from various vendors and submitted fraudulent invoices from nonexistent vendors to obtain payment. He also ordered food through the Head Start program for his personal catering company. In addition to Walker's sentencing, the district court ordered the forfeiture of Walker's Audi A6 Quattro and BMW 528i vehicles, which were purchased with the proceeds of his theft.

OIG Identifies Weaknesses in the Department's Oversight of Electronic Protected Health Information

Two OIG reviews raised significant concerns about the security of electronic protected health information (ePHI).

- OVERSIGHT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT SECURITY RULE.** The Department's oversight and enforcement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule were not sufficient to ensure that covered entities, such as hospitals, effectively implemented the rule. Our audits of 7 hospitals throughout the Nation identified 151 vulnerabilities in the systems and controls intended to protect ePHI, of which 124 were categorized as high impact. These vulnerabilities placed the confidentiality, integrity, and availability of ePHI at risk. *Nationwide Rollup Review of the Centers for Medicare & Medicaid Services Health Insurance Portability and Accountability Act of 1996 Oversight.* A-04-08-05069. [Web Summary.](#) [Full Text.](#)
- SECURITY CONTROLS IN HHS'S HEALTH INFORMATION TECHNOLOGY STANDARDS.** Among the health information technology standards promulgated by HHS's Office of the National Coordinator (ONC), we found no standards that included general security controls. General security controls include encrypting data stored on mobile devices, such as compact disks and thumb drives; requiring two-factor authentication when remotely accessing a system; and updating the operating systems of computers that process and store electronic records. A lack of any of these or other security controls can expose systems to a host of problems. Our recommendations included that ONC broaden its focus to include well-developed general security controls for

supporting systems, networks, and infrastructures as well as emphasizing the importance of system security to medical practitioners. *Audit of Information Technology Security Included in Health Information Technology Standards.*

A-18-09-30160. [Web Summary](#). [Full Text](#)

Congressional Testimony and Intergovernmental Leadership

During this semiannual period, we testified at three hearings conducted by committees of Congress on aspects of waste, fraud, and abuse in Medicare and Medicaid. The full text of the testimony is available on our Web site at <http://www.oig.hhs.gov/testimony.asp>.



- 07-28-2011** – House of Representatives Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency, and Financial Management. Daniel R. Levinson, Inspector General (above), testified about the scope of improper payments in Medicare; OIG's oversight of the Department's measurement of Medicare improper payments; and OIG's role in preventing, detecting, and reducing improper payments. [Testimony](#).
- 07-12-2011** – Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security. Lewis Morris, Chief Counsel to the Inspector General (second from left), testified on harnessing technology and innovation to cut waste and curb fraud in Federal health programs. [Testimony](#).
- 04-05-2011** – House of Representatives Committee on Oversight & Government Reform, Subcommittee on Health Care, District of Columbia, Census and the National Archives. Gerald Roy, Deputy Inspector General for Investigations, presented his personal perspective on fraud, waste, and abuse within the Medicare and Medicaid Programs. [Testimony](#). [Video](#).



Inspector General Levinson Appointed to Government Accountability and Transparency Board

On July 28, 2011, HHS Inspector General Daniel R. Levinson was appointed by the President to the Government Accountability and Transparency Board. This Board is tasked with developing plans to enhance transparency in Federal spending and root out and stop waste, fraud, and abuse in Federal programs. ([View the White House announcement.](#)) Inspector General Levinson also serves on the Recovery Accountability and Transparency Board (RATB), which coordinates and conducts oversight of American Recovery and Reinvestment Act of 2009 (Recovery Act) funds to prevent fraud, waste, and abuse and to foster transparency by providing the public with accurate, user-friendly information. (View the [RATB Web site.](#))