



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**

Office of  
Inspector  
General

Semiannual  
**Report**  
To **Congress**

October 1, 2011 – March 31, 2012

## A Message From the Inspector General

**T**his *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 and Human Services (HHS), for the 6-month period ending March 31, 2012.



Over the past 6 months, OIG has stepped up our focus on data analytics as a critical tool for enhancing our fraud, waste, and abuse activities. We are using advanced data analytics to help us conduct risk assessments; more effectively pinpoint our oversight efforts; and significantly reduce the time and resources required for audits, investigations, evaluations, and other program integrity activities. However, technology is not a silver bullet, and now more than ever, experienced professionals are integral to protecting Medicare and Medicaid. As program integrity efforts become more technology driven, so will health care fraud, and we must adapt to this evolving environment. Additionally, even the best fraud prevention technologies will be of little value if not effectively implemented and appropriately overseen.

OIG's data warehouse is a key component of our strategic use of information technologies. Among other things, the warehouse integrates data from Medicare Parts A, B, and D so we can develop a more comprehensive picture of beneficiaries' histories of medical care and providers' billing patterns. In addition to adding powerful analytic tools, the data warehouse has the potential for dramatically improving the timeliness and impact of our work.

OIG's new hospital compliance initiative illustrates the impact of technology on our ability to identify suspect claims and noncompliant billing practices. OIG has deployed resources toward testing and ensuring acute-care hospital compliance with program requirements. Instead of narrowly focusing our audits on specific risk areas, we are now more quickly and efficiently analyzing a vast array of hospital data to simultaneously identify multiple compliance risks.

As exemplified by the Medicare Fraud Strike Force, sophisticated data analysis, combined with field intelligence and traditional law enforcement techniques, enables us to more quickly identify fraud schemes and trends. The data-driven approach of the Strike Force pinpoints fraud hot spots through the identification of suspicious billing patterns and

targets criminal behavior as it occurs. This *Semiannual Report* highlights many of our Strike Force successes.

We also continue our focus on identifying waste in the operation of HHS programs. Reduction of waste is critical and necessary to achieve savings in Federal health care programs. Waste occurs in many forms, and work included in this report identifies outdated pricing methodologies for pharmaceuticals and durable medical equipment as well as payments for unnecessary and undocumented services. Identifying waste also requires diligent oversight by CMS to ensure that contractors are effectively identifying improper payments made to providers and suppliers. OIG work highlighted in this report provides information regarding our recommendations to CMS in the important area of contractor oversight.

The public health and welfare of HHS beneficiaries continues to be of paramount concern to our office. We completed work during this reporting period regarding adverse events in hospitals and regarding Head Start programs that did not comply with program requirements and therefore jeopardized the health and safety of children.

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.



Daniel R. Levinson  
Inspector General

## Highlights

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) *Semiannual Report(s) to Congress* (Semiannual Report) describe significant problems, abuses, deficiencies, and investigative outcomes relating to the administration of HHS programs and operations that were disclosed during the reporting period. This edition addresses work completed during the first half of fiscal year (FY) 2012 (October – March) and provides summary data on key accomplishments during the period. The [Semiannual Report](#) 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 Accomplishments

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For the first half of FY 2012, we reported expected recoveries of about \$1.2 billion consisting of \$483.1 million in audit receivables and \$748 million in investigative receivables (which includes \$136.6 million in non-HHS investigative receivables resulting from our work in areas such as the States’ shares of Medicaid restitution).

We reported exclusions of 1,264 individuals and entities from participation in Federal health care programs; 388 criminal actions against individuals or entities that engaged in crimes against HHS programs; and 164 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements, and administrative recoveries related to provider self-disclosure matters. Following are highlights of some of the significant problems, abuses, deficiencies, activities, and investigative outcomes that are included in the Semiannual Report for the first half of FY 2012.

## Health Care Fraud Prevention and Enforcement Action Team

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### Medicare Strike Force Teams

Medicare Fraud Strike Force teams coordinate law enforcement operations conducted jointly by 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 nine major cities. 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 that 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.

- **Strike Force Accomplishments** – During this semiannual period, Strike Force efforts resulted in the filing of charges against 101 individuals or entities, 96 criminal actions, and \$50.9 million in investigative receivables.
- **Arrests in the Northern District of Texas** – A physician and the office manager of his medical practice, along with five owners of home health agencies, were arrested February 28 on charges related to their alleged participation in a nearly \$375 million scheme involving fraudulent claims for home health services. The conduct charged in this indictment represents the single largest fraud amount orchestrated by one doctor in the history of HEAT and our Medicare Fraud Strike Force operations and the largest alleged home health fraud scheme ever committed. As a related matter, CMS announced the suspension of 78 home health agencies (HHA) associated with the physician based on credible allegations of fraud against them.

### Strike Force Investigation Nets Imprisonment, \$6 Million in Restitution in Infusion and Injection Therapy Scheme

**Michigan** – Siblings [Clara Guilarte](#) and [Caridad Guilarte](#), along with previously captured and sentenced co-conspirator [Reynel Betancourt](#), submitted \$9.1 million in false and fraudulent claims. The trio recruited and paid cash and other inducements to Medicare beneficiaries to visit the Dearborn Medical Rehabilitation Center (DMRC), which the Guilartes owned and operated, and sign forms indicating that they received legitimate medical services, including injections and infusions of expensive medications that were not actually provided. The Guilartes then distributed the proceeds through a series of transactions involving shell corporations that served no purpose other than to conceal the nature, source, and location of the funds. After pleading guilty to conspiracy to commit health care fraud and conspiracy to commit money laundering, the Guilartes were each sentenced to serve 14 years in prison. They were also ordered to pay approximately \$6 million in restitution jointly and severally. The Guilartes, who were two of OIG’s Top 10 most wanted fugitives, fled the United States to avoid capture. They were arrested by the Colombian National Police and transferred into the custody of U.S. officials. Sentenced occurred during this reporting period.

### Payments Made to Nonoperational Comprehensive Outpatient Rehabilitation Facilities

Eighteen of the 101 South Florida Comprehensive Outpatient Rehabilitation Facilities (CORF) included in our analysis were not operational. Ten of the 18 CORFs were not at the locations on file with CMS, and 8 were not open during business hours. Medicare allowed \$2.2 million in 2010 for services billed by these nonoperational CORFs. This HEAT initiative review was limited to determining whether the CORFs were operational. In prior reviews at three South Florida CORFs, we estimated that each audited CORF received between \$720,000 and \$1.6 million for services that

did not meet Medicare reimbursement requirements. *South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities*. -OEI-05 10-00090. November 2011. [Web Summary](#). [Full Text](#). See also prior reports: [A-04-05-02009](#), [A-04-05-02010](#), and [A-04-05-02011](#).

## New Provider Compliance Training Videos and Podcasts



OIG’s online training continued to reach the health care community with our compliance message. We have developed comprehensive training materials for HEAT provider compliance training. The FY 2011 materials are available on our Web site.

The materials include [video Webcast modules](#) dividing the presentations by subject area. A series of [new videos](#) and corresponding [audio podcasts](#) are also available.

## Prescription Drug Reviews and Investigations

State Medicaid agencies lack information about pharmacies’ costs to purchase drugs and/or fail to use available information about whether drugs are eligible for payment. As a result, payments to pharmacies often significantly exceed pharmacies’ costs for the drugs and/or are for drugs that are made ineligible for Medicaid reimbursement.

### Multi-Tier Strategy To Avoid Waste in Medicaid Drug Pricing

States may be able to better align Medicaid payments with pharmacies’ invoice prices of drugs by developing separate reimbursement methodologies for major categories of drugs. Numerous OIG reviews have found that the basis that States historically used for Medicaid drug reimbursements did not represent pharmacies’ actual costs to acquire drug ingredients. As a result, States often have overreimbursed pharmacies for those costs.



*Align Medicaid Reimbursements With Pharmacies’ Costs*

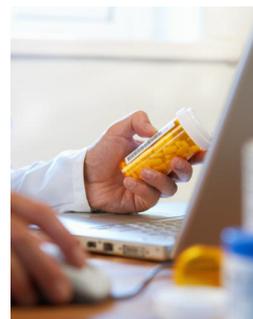
This review evaluated the relationships between three recognized pricing benchmarks and pharmacy invoice prices for Medicaid-reimbursed drugs and found variations depending on whether the drugs were brand-name or generic. *Review of Drug Costs to Medicaid Pharmacies and Their Relation to Benchmark Prices*. A-06-11-00002. October 2011. [Web Summary](#). [Full Text](#).

## State Controls Over Medicaid Drug Expenditures Inadequate

Neither CMS nor the 14 State agencies that we reviewed had adequate controls to ensure that all drug expenditures complied with Federal requirements. The 14 States generally did not use quarterly listings (called quarterly Medicaid drug tapes) that CMS provided to determine whether a drug was eligible for coverage and did not contact CMS to determine whether a drug was eligible for coverage if the drug was not on the tapes. The tapes indicate the drugs’ termination dates, if applicable; specify whether the drugs are less than effective; and include information that the States use to claim rebates from manufacturers. The shortcomings we identified adversely affect the efficiency of the Medicaid outpatient prescription drug program. Cost savings to the Medicaid program can be realized by implementing several corrective actions we outlined in our report. *Multi-State Review of Centers for Medicare & Medicaid Services Medicaid Drug Expenditure Controls*. A-07-10-06003. October 2011. [Web Summary](#). [Full Text](#).

## Pharmacist Sentenced for Health Care Fraud, Money Laundering

**Indiana** – John Love, controlling member and pharmacist for the Terre Haute Prescription Shop, input false prescriptions in the pharmacy's computer system, which bills the Indiana Medicaid Program. Love was sentenced to 4 years and 3 months of incarceration and ordered to pay over \$3.5 million in restitution for his role in the health care fraud and money laundering scheme.



*Computer Billing Misuse*

## Patient Safety and Quality of Care

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As a purchaser of health care, Medicare and Medicaid face challenges in ensuring quality of care for their beneficiaries. Despite increased attention to patient safety, problems persist.

### States and CMS Responded Timely to Allegations of Serious Harm to Hospital Patients, but Missed Opportunities to Improve



State survey and certification agencies’ (State agencies) responses on behalf of Medicare to allegations of serious harm to hospital patients were generally timely and found problems. However, State agencies often missed opportunities to incorporate patient safety principles. CMS often failed to inform the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations) concerning complaints about the hospitals it accredits, thereby impeding the Joint Commission’s oversight.

Safety principles incorporated by State agencies include assessing hospitals’ performance improvement systems and governing bodies, monitoring hospitals for sustained improvements, and maximizing opportunities for hospitals to learn from alleged adverse events. Together, five types of in-hospital adverse events represented half or more of the complaints in our sample: sexual assault, medication error, physical abuse by hospital staff, restraint problems, and suicide. Investigations into these types of events led to most of the citations issued. State agencies conducted the investigations on behalf of Medicare. The hospitals’ corrective actions resulted largely in training, coupled with policy and process changes. *Adverse Events in Hospitals: Medicare’s Responses to Alleged Serious Events*. OEI-01-08-00590. October 2011. [Web Summary](#). [Full Text](#).

## Medicare Improper Payments and Fraudulent Billings



Improper payments are a significant problem across Federal programs, costing billions of dollars annually.

Improper payments in Medicare and Medicaid commonly fall into four categories: unsupported services, medically unnecessary services, incorrect billings, and other noncovered cost or error types. Some of these core payment issues result from fraudulent behavior. Many claims are questioned and disallowed because providers do not maintain required documentation or sufficient documentation to support the services and amounts claimed.



Medical Documentation

### Outpatient Services, Medical Equipment, and Physical Therapy

- **Medicare Overpaid for Outpatient Services.** Payments exceeding charges for outpatient services were prone to errors and overpayments. We continue to review outpatient line items for which Medicare payments significantly exceeded billed charges (the prices that a provider sets for its services). Reports in this period revealed that providers often made errors, including submitting incorrect units of services and incorrect codes, or a combination of those; billing for unallowable services; and submitting inadequate supporting documentation, causing Medicare to overpay for the services. Millions of dollars in overpayments have occurred in part because key Medicare systems (the Fiscal Intermediary Standard System and the Common Working File (CWF)) did not have sufficient edits in place during our audit periods to prevent or detect the overpayments. See Part I (Medicare) of the Semiannual Report for overpayment amounts and links to 13 related reports issued in this semiannual period.
- **Multimillion-Dollar Durable Medical Equipment Fraud Results in Incarceration, Restitution in California.** Christopher Iruke, owner and operator of several fraudulent durable medical

equipment (DME) companies; his wife and co-conspirator Connie Ikpoh; and co-conspirators Aura Marroquin and others used fraudulent prescriptions and documents to bill Medicare for expensive high-end power wheelchairs and orthotics that were medically unnecessary or were never provided. Iruke and Ikpoh diverted most of the proceeds from their scheme to pay for business and personal expenses, including the leases on their Mercedes vehicles and home-remodeling expenses. Iruke was sentenced to 15 years of incarceration and ordered to pay \$6.7 million in restitution, jointly and severally with co-conspirators, for his role in the multimillion-dollar scheme. Ikpoh, Marroquin, and two other co-conspirators were also convicted for their roles in the scheme.

- **Nursing Services Operator, Others Conspired in Physical Therapy False Billings in Texas.** Umawa Oke Imo, owner and operator of City Nursing Services of Texas Inc. (City Nursing Services), and his co-conspirators fraudulently used City Nursing Services to pay kickbacks to Medicare beneficiaries and recruiters, provide physical therapy services to Medicare beneficiaries even though it did not employ any licensed or qualified physical therapists, and bill Medicare for physical therapy services that were not rendered. To mask this practice, City Nursing Services created false and fraudulent patient files. Imo was sentenced to 27 years and 3 months of incarceration and ordered to pay more than \$30.2 million in restitution, jointly and severally. Co-conspirators Joanne White and Christina Joy Clardy were also sentenced in the scheme, and other conspirators were indicted.

## Oversight of Medicare Program and Benefit Integrity Contractors

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CMS contracts with several entities, including Program Safeguard Contractors (PSC), Medicare Drug Integrity Contractors (MEDIC), Zone Program Integrity Contractors (ZPIC), and Recovery Audit Contractors (RAC), to perform many Medicare integrity functions. OIG work reveals persistent problems with oversight of this area.

### Inadequate Data Limitations, Procedures Obstruct Oversight

CMS’s systems and procedures and those used by its contractors were not sufficient to ensure effective oversight of contractor performance and resolution of known vulnerabilities.

- **Data deficiencies obstructed CMS’s oversight of ZPICs.** The workload data that CMS uses to oversee ZPICs were not accurate or uniform, and inaccuracies and lack of uniformity in the ZPICs’ data prevented us from making a conclusive assessment of ZPICs’ activities. ZPICs are replacing CMS’s PSCs and will perform Medicare Part A and Part B benefit integrity work in seven newly established geographical zones. The inaccuracies and lack of uniformity in ZPICs’ data resulted from system issues in CMS’s Analysis, Reporting, and Tracking System (CMS ARTS); ZPIC reporting errors; ZPICs’ interpretations of workload definitions; and

inconsistencies in requests for information reports. ZPICs' performance evaluations contained few workload statistics, and data access issues affected ZPICs' program integrity activities. The conditions are serious obstacles to CMS's oversight of ZPIC operations and effectiveness. *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*. OEI-03-09-00520. November 2011. [Web Summary](#). [Full Text](#).

- **CMS did not resolve contractor-identified vulnerabilities.** CMS had not resolved, or taken significant action to resolve, 77 percent of vulnerabilities that its Medicare benefit integrity contractors reported in 2009. The estimated impact of vulnerabilities, such as those in claims coding and provider identifiers, which contractors reported inconsistently or not at all, was at least \$1.2 billion. Only two of the vulnerabilities reported in 2009 had been resolved as of January 2011. Although CMS has procedures to consistently track and review vulnerabilities, it lacks procedures to ensure that vulnerabilities are resolved. *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*. OEI-03-10-00500. December 2011. [Web Summary](#). [Full Text](#).

## Medicare's Fee-for-Service Error Rate Calculations Could Be More Accurate

CMS's Comprehensive Error Rate Testing (CERT) program contractors collect and review documents supporting claims for payment, identify improper payments, and calculate a national Medicare fee-for-service error rate. We found issues in current CERT practices.

- **Impact of Appeals** – A CERT contractor's error rate calculations did not account for pending appeals. If the CERT statistical contractor had included overturned CERT claim payment denials in its error rate calculations, it would have decreased the estimated value of reported errors for FYs 2009 and 2010 by approximately \$2 billion each year. CMS could improve the accuracy of the reported estimate of improper payment error rates by including an adjustment for overturned CERT claim payment denials. *Review of CERT Errors Overturned Through the Appeal Process for FYs 2009 and 2010*. A-01-11-00504. March 2012. [Web Summary](#). [Full Text](#).
- **Impact of Documentation** – A CERT contractor did not initially obtain all necessary documentation. Additional documentation to overturn the claim payment denials used in the FY 2010 error rate calculation would have reduced the estimate of improper payments for FY 2010 by almost \$1 billion. *Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 CERT Program Audit*. A-01-11-00502. February 2012. [Web Summary](#). [Full Text](#).

## Medicaid Reimbursements and Program Integrity



The Federal Government and States jointly administer, fund the cost of, and oversee the integrity of the Medicaid medical assistance program. At the

Federal level, CMS administers the program. At the State level, State agencies administer their Medicaid programs in accordance with broad Federal CMS-approved State plans.

### States Improperly Claimed Federal Reimbursement for Unallowable Services

States have considerable flexibility in designing and operating their Medicaid programs; however, to receive a Federal share of Medicaid costs, applicable State and Federal requirements must be met.

- **New Jersey** – Personal Care Services (PCS) Claims. New Jersey improperly claimed an estimated \$145.4 million in Federal Medicaid reimbursement for PCS. The mixed deficiencies found in the claims we reviewed included no prior authorizations, no in-service education for personal care assistants, no nursing supervision, no documentation of services, no nursing assessments, and no certification of personal care assistants by the New Jersey Board of Nursing. New Jersey did not effectively monitor the PCS program for compliance with Federal and State requirements. *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey. A-02-09-01002. December 2011. [Web Summary](#). [Full Text](#).* For a quick view of OIG’s PCS work, see the [Spotlight](#) article on PCS on our Web site.
- **New York State** – Continuing Day Treatment (CDT) Claims. More than half of the claims for CDT services that we reviewed did not comply with one or more of New York State’s own requirements for payment. The deficiencies resulted in an estimated \$84.3 million in unallowable CTD claims. Providers did not properly document the type of CDT services billed, recipients’ clinical progress, and/or recipients’ contact with outpatient program staff. Although the State conducts periodic onsite monitoring, its monitoring program did not ensure that providers complied with all State requirements. *Review of Medicaid Claims Submitted by Continuing Day Treatment Providers in New York State Audit. A-02-09-01023. October 2011. [Web Summary](#). [Full Text](#).*

### Concerns Found With Medicaid Integrity Contractors and Managed Care Oversight

- **Impact of Poor Data** – Medicaid Integrity Contractors’ (MIC) performance was hindered by poor data. For the MICs that we reviewed, analytical assignments under the task orders did not result in recommendations of specific audit leads or identification of potential fraud leads. MICs identified problems with CMS’s Information Technology Infrastructure data that limited their ability to accurately complete data analysis assignments. Because data were missing or inaccurate data, the MICs inaccurately identified potential overpayments and may have overlooked some potential overpayments. States invalidated more than one-third of the

potential overpayments in samples the MICs provided. CMS says that it has several initiatives underway to improve the data the MICs use. *Early Assessment of Review Medicaid Integrity Contractors*. OEI-05-10-00200. February 2012. [Web Summary](#). [Full Text](#).

- **Fraud Concerns Continue** – Medicaid managed care entities (MCE) reportedly took steps to oversee fraud and abuse safeguards but they remain concerned about the prevalence of fraud. CMS, States, and Medicaid MCEs expressed that services billed but not rendered are their primary concern with respect to fraud and abuse in Medicaid managed care. Other concerns include rendering services that are not medically necessary, upcoding by providers, questionable beneficiary eligibility, and prescription drug abuse by beneficiaries. All MCEs in our sample reported taking steps to meet Federal program integrity requirements. *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*. OEI-01-09-00550. December 2011. [Web Summary](#). [Full Text](#).

## Public Health and Human Services Reviews and Enforcement

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Our public health and human services work reflects some of HHS's top management challenges related to administration of contracts and grants management, including grantee performance issues and fraud. OIG also plays a significant role in child support enforcement activities.

### National Institutes of Health's Compliance With Appropriation Laws

We found time and amount issues in four contracts that potentially violated the Antideficiency Act and/or the bona fide needs rule. The Antideficiency Act prohibits an agency from obligating or expending funds in advance of or in excess of an appropriation unless specifically authorized by law. Federal statutes specify that a fiscal year appropriation may be obligated only to meet a legitimate (bona fide) need arising in or continuing to exist in the appropriation's period of availability. 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 assessed compliance with the purpose, time, and amounts requirements specified in appropriations statutes. We recommended making monetary adjustments and reporting Antideficiency Act violations as appropriate. (See the Public Health section in the body of this publication for report titles and numbers.)

### Early Head Start Grantees' Management Deficiencies Affected Their Funding.

Of 83 Early Head Start program grant applicants that OIG assessed, 75 had problems with financial stability, inadequate systems to manage and account for Federal funds, inadequate organizational structures, inadequate procurement and property management procedures, and inadequate personnel policies and procedures. Using our findings, the Administration for Children and Families (ACF) awarded \$15 million in Recovery Act funds to the 8 applicants that had no

deficiencies; did not award \$31 million requested by 15 of the 75 deficient applicants; and awarded \$126 million to 60 of the 75 deficient applicants on the condition that they receive increased ACF oversight, training, and technical assistance. *Review of 83 Early Head Start Applicants Under the American Recovery and Reinvestment Act.* A-01-10-02501. November 2011. [Web Summary](#). [Full Text](#).

## Head Start Grantees Found To Have Health and Safety Violations



*Rake and machete on broken steps*

Of the 24 Head Start grantees that we reviewed, none fully complied with Federal Head Start or State requirements to protect children from unsafe materials and equipment. Twenty-one of the grantees did not fully comply with Federal Head Start or State requirements to conduct criminal records checks, recurring background checks, checks of childcare exclusion lists, or checks of child abuse and neglect registries. The grantees also failed to properly document criminal records checks.

*Review of 24 Head Start Grantees' Compliance With Health and Safety Requirements.* A-01-11-02503.

December 2011. [Web Summary](#). [Full Text](#).

See also OIG's [Spotlight](#) on Head Start Health and Safety available on our Web site.

## ACF Grantee Sentenced to Incarceration for Failure To Meet Grant Requirements

Florida – Jimmy D. Howard, Jr., executive director of Dream Builders of Tallahassee, Inc. (DBT), pleaded guilty to the charge of wire fraud related to an ACF grant. Howard was unable to find the non-Federal matching funds required by the grant award, and after approximately 2 years of failing to meet this requirement, he began submitting false statements to HHS indicating that his company had the requisite amount of matching non-Federal funds. Howard also allegedly used a portion of the grant money for personal expenses. DBT is a nonprofit organization established to help low-income individuals save money by providing funds to match monies that the participants proved they had saved. As part of the grant requirements, DBT was required to have an equal amount of non-Federal funds to match the money saved by the individuals. Howard was sentenced to 51 months of incarceration and ordered to pay \$307,075 in restitution.

## OIG Launched Child Support Enforcement Web Page, Introduced “Most Wanted” List of Deadbeat Parents

OIG launched a new Child Support Enforcement Web page that enlists the public's help in continuing Federal efforts to bring fugitive deadbeat parents to justice. See <http://oig.hhs.gov/fraud/child-support-enforcement/>.

## OIG Participation in Congressional Hearings

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During this semiannual period, OIG witnesses testified at two hearings conducted by committees of Congress on aspects of waste, fraud, and abuse in Medicare and Medicaid. The full text of OIG’s testimony before congressional committees is available on our Web site at:

<http://www.oig.hhs.gov/testimony.asp>.

**12-07-2011**

Gary Cantrell, Deputy Inspector General for Investigations, testified before the United States House of Representatives Committee on Oversight and Government Reform, Subcommittee on Government Organization, Efficiency and Financial Management, and Subcommittee on Health Care, District of Columbia, Census and the National Archives. Mr. Cantrell summarized OIG’s efforts to combat Medicaid fraud. [Testimony](#)



*Gary Cantrell, Deputy Inspector General for Investigations*

**11-30-2011**

Daniel R. Levinson, Inspector General, testified before the United States Senate Special Committee on Aging. Mr. Levinson described OIG’s work relating to the use of antipsychotic drugs in nursing homes. [Testimony](#)



*Daniel R. Levinson, Inspector General*