OIG NEWS

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OIG Reports More Than $1 Billion in Recoveries From Fighting Fraud, Waste, and Abuse

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) Semiannual Report to Congress announced expected recoveries of $1.02 billion for the first half of fiscal year (FY) 2006 from efforts to reduce fraud, waste, and abuse in HHS programs.

Specifically, OIG's $1.02 billion in expected recoveries encompasses $288 million in audit-related recoveries, and $732.4 million in investigative-related recoveries. Additional savings from implemented recommendations are calculated annually and will be reported in the fall.

"These recoveries reflect our dedicated efforts to reduce fraud, waste, and abuse in HHS programs," said Inspector General Daniel R. Levinson. "It is through a combination of vigilant oversight, outreach to the health care community, and partnership with government agencies at all levels that we are able to accomplish this mission."

Also for this period, OIG reported exclusions of 1,540 individuals and organizations for fraud or abuse of Federal health care programs and/or their beneficiaries; 226 criminal actions against individuals or organizations that engaged in crimes against HHS programs; and 119 civil actions, which include False Claims Act and unjust enrichment suits filed in district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters.

Enforcement actions for the period included the Serono settlement of $704 million plus interest paid to the U.S. Government and a 5-year corporate integrity agreement with OIG. The settlement resolved allegations that Swiss pharmaceutical manufacturer Serono, S.A., and its

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American subsidiaries, engaged in the illegal promotion of its AIDS-related drug Serostim, paid kickbacks to physicians for the prescription of Serositim, and used an unapproved medical device to diagnose AIDS-wasting syndrome as a marketing tool for Serostim.

OIG's accomplishments also included oversight focused on Medicaid integrity, Medicare Part D implementation, and the response to Hurricanes Katrina and Rita. For example, audits of the calculation of upper payment limits for payments to hospitals and nursing facilities by Alabama, Indiana, Mississippi, and New York were part of OIG's increasing attention to Medicaid program integrity. The audits found potential Federal overpayments of $243.2 million resulting from the States' use of upper payment limit calculations that did not follow Federal regulations and/or State Medicaid plans. Federal overpayments included $25.7 million in Alabama, $3.2 million in Indiana, $43.3 million in New York, and potentially $171 million in Mississippi.

OIG also conducted an early implementation review that examined whether Medicare Part D prescription drug plans' (PDP) formularies included drugs most commonly used by "dual eligibles"—beneficiaries of both Medicare and Medicaid. This evaluation found that most of the drugs reviewed are included on PDP formularies. However, dual eligibles may need targeted assistance to transition from Medicaid to Medicare drug coverage, given the variation among PDP formularies and the medical and resource challenges faced by this population.

In response to Hurricanes Katrina and Rita, OIG launched a coordinated oversight effort to ensure that HHS recovery funds are spent appropriately and fraud is investigated and prosecuted. This oversight includes audits, evaluations, and investigations of issues ranging from duplicate Medicaid payments to quality of care.

Protecting the integrity of HHS programs is at the core of OIG's mission. OIG continues to be a strong force within HHS to improve the efficiency and effectiveness of the Department and to sanction those who defraud its programs. The Semiannual Report describes OIG investigations and evaluation and audit reports finalized during the reporting period. To read more about OIG activities go to: http://oig.hhs.gov/publications/semiannual.html

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