DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2015

Office of Inspector General

Justification of Estimates for Appropriations Committees

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

I am pleased to present the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), fiscal year (FY) 2015 Performance Budget Submission. This submission is in accordance with the Inspector General Act, as amended (5 U.S.C. App. 3). It presents OIG's budgetary requirements for meeting its responsibility to protect the integrity of hundreds of HHS programs, as well as the health and welfare of the beneficiaries whom they serve.

The FY 2015 request includes $400 million to further OIG's commitment to protecting the integrity of HHS programs by conducting work that is relevant, innovative, customer focused, and high impact. The request will support OIG's efforts to oversee the administration of HHS's public health and human services program and continue to support and expand the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and related Medicare and Medicaid program integrity efforts.

This budget is presented during a time of significant change in HHS programs. While such change presents opportunities to reduce waste and increase value in health care, it will also require significant oversight to ensure efficient and effective implementation and administration to prevent and take action against fraud and abuse. The request will enable OIG to continue our focus on core risk areas associated with Health Insurance Marketplaces (Marketplaces), such as payment accuracy, eligibility systems, contracting, and data security. The request will also enable OIG to expand its portfolio examining Medicaid, as the program expands to new populations. To ensure the overall integrity of the Medicaid program, the Department must address new and existing concerns regarding eligibility, improper payments, abuse in managed care, and excessive payments to public providers.

Since its establishment in 1976, this office has consistently achieved commendable results and significant returns on investment. OIG continues to protect HHS programs and the well-being of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws.

I am confident that the funding requested will improve programs that benefit all Americans.

Daniel R. Levinson
Inspector General

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Department of Health and Human Services
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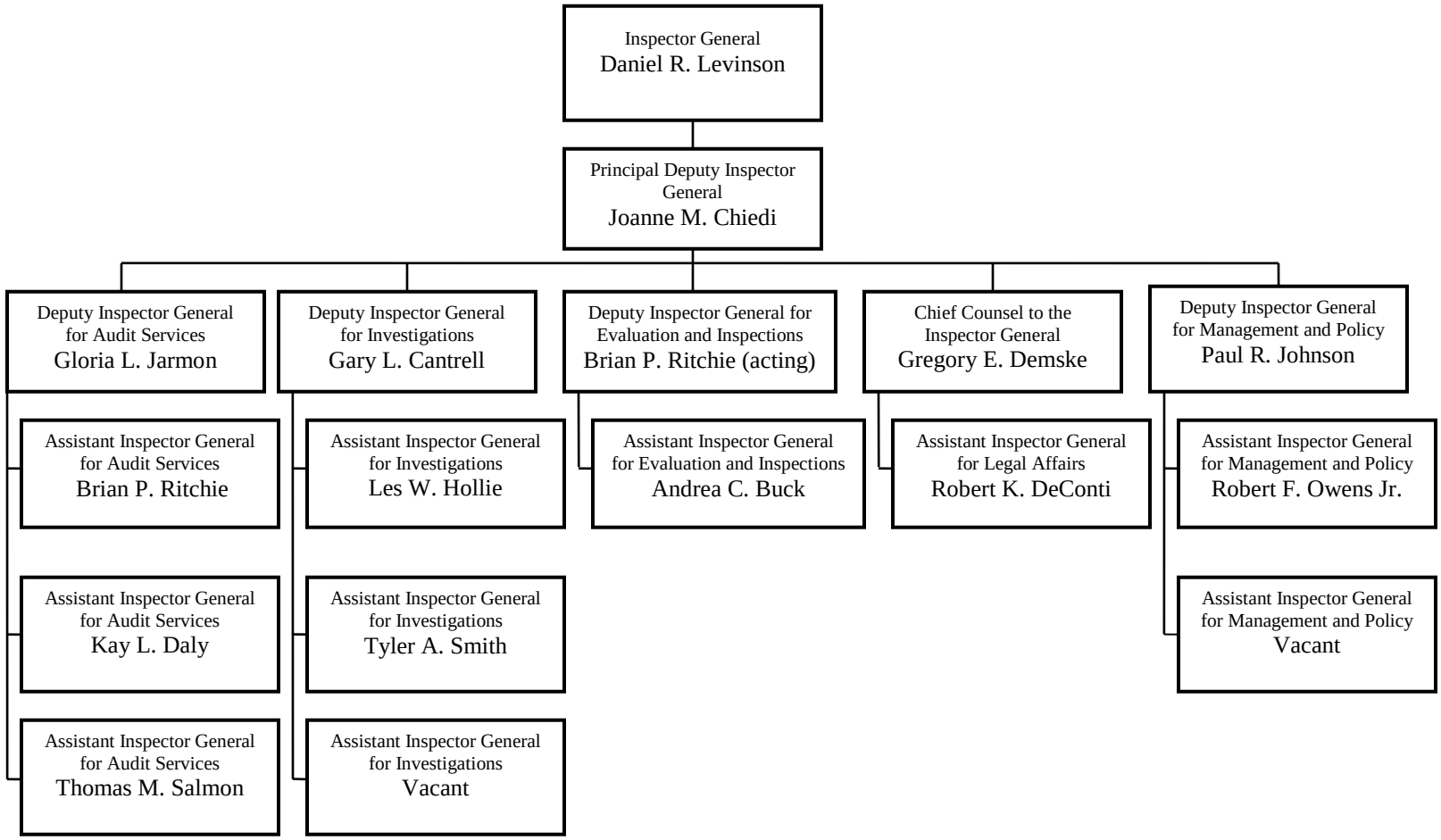
Organizational Chart



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Introduction

The Office of Inspector General (OIG) provides independent and objective oversight that promotes economy, efficiency, and effectiveness in the programs and operations of the U.S. Department of Health and Human Services (HHS or the Department). HHS consists of 11 operating divisions (OPDIVs) and the Office of the Secretary; collectively they seek to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

OIG's program integrity and oversight activities are shaped by legislative and budgetary requirements and adhere to professional standards established by the Government Accountability Office (GAO), the Department of Justice (DOJ), and the Inspector General (IG) community, as well as its core values of relevance, impact, customer-focus, and innovation.

Since the creation of the Health Care Fraud and Abuse Control (HCFAC) Program in 1997, approximately 80 percent of OIG's annual funding and workload has been dedicated exclusively to oversight and enforcement activities with respect to health care fraud and abuse in the Medicare and Medicaid programs.

Mission

OIG's mission is to protect the integrity of HHS programs and operations and the health and welfare of the people they serve.

OIG at a Glance: FY 2013

Oversight

- OIG was responsible for overseeing 26 cents of every Federal dollar spent.
- On average, each OIG full-time equivalent (FTE) was responsible for overseeing over $530 million.
- Eighty-four percent of efforts were dedicated to oversight of Medicare and Medicaid.

Accomplishments

- **Expected Recoveries:** $5.8 billion in total investigative and audit receivables were reported.
- **Program Exclusions:** A total of 3,214 individuals and organizations were excluded from participation in Federal health care programs.
- **Return on Investment (ROI):** Approximately $8 to $1 actual ROI was reported for the HCFAC program, to which OIG is a key partner.
- **Quality and Management Improvement Recommendations:** 232 quality and management improvement recommendations were accepted by HHS program managers.

Staffing

- A total of 1,660 FTE were located in 80 cities.

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Overview of Budget Request

OIG's Fiscal Year (FY) 2015 budget submission includes $400,251,000 and 1,861 FTE, an increase of +$105,014,000 and +284 FTE above the FY 2014 Enacted Level. Program increases include:

- Public Health, Human Services, and Departmentwide (PHHS) Oversight (+$4 million): Ensuring the efficient and effective administration of vital public health and human services programs; targeting key priority areas, including preventing and deterring fraud, waste, and abuse related to the Marketplaces and other Affordable Care Act (ACA) programs; overseeing the management of cross-Departmental operations, such as grants and contracts and information technology (IT) security; addressing significant existing and emerging public safety issues, such as oversight of the regulation of the Nation's domestic and imported food, drugs, biologics, and medical devices; and expanding OIG's capacity to leverage data and to identify fraud trends in the non-CMS program areas.

- Medicare and Medicaid (CMS) Oversight[1] (+$101 million): Supporting and enhancing the Administration's multiagency initiative to prevent health care fraud, while also enforcing current antifraud laws around the country through the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative. Continuing a range of program integrity efforts, including efforts to: leverage technology and data to address emerging trends; increase our efforts to identify questionable billings, address improper payments, and improve patient safety and quality of care; and oversee the growth in Medicaid brought about by the ACA.

Efforts in FY 2015 will continue to be guided by OIG's Strategic Plan and reflected in ongoing work-planning processes. Many areas of potential focus are reflected in OIG's assessment of the top management and performance challenges facing HHS, the most recent of which are found at: https://oig.hhs.gov/reports-and-publications/top-challenges/2013/.

[1] For this report, "CMS Oversight" refers to oversight of the Medicare, Medicaid, and the Children's Health Insurance (CHIP) programs and excludes activities of Center for Consumer Information and Insurance Oversight (CCIIO).

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Overview of Performance

OIG's Strategic Plan, found at: http://oig.hhs.gov/reports-and-publications/strategic-plan/index.asp, outlines the vision and priorities that guide the office in carrying out its mission to protect the integrity of HHS programs and operations and the health and welfare of the people they serve. The Strategic Plan articulates four goals:

- fight fraud, waste, and abuse;
- promote quality, safety, and value;
- secure the future; and
- advance excellence and innovation.

These goals drive OIG's work, such as the planned audits and evaluations in OIG's annual Work Plan. The Strategic Plan also highlights key strategies and indicators for attaining results. It is designed to allow for flexibility to anticipate, assess, and respond to new challenges. OIG's program integrity activities directly support the HHS Strategic Plan.

OIG ensures an efficient and effective use of resources through integrated planning, monitoring, and reporting processes that together set organizational priorities; measure and analyze the impact of our work; and, when necessary, inform strategic and operational change.

Planning: OIG plans its work and allocates its resources using a number of factors. These include the purpose limitations in the agency's various funding sources, authorizing statutes and mandates, stakeholder input, and risk assessments of HHS programs. OIG conducts an annual work-planning process, which results in a published *Work Plan*. As part of this process, OIG engages stakeholders to identify the issues with the greatest potential impact on HHS programs and beneficiaries.

Throughout the year, OIG responds to emerging issues and makes adjustments. Priorities identified in the work-planning process correspond with issues outlined in the HHS *Top Management and Performance Challenges* as well as the goals and objectives expressed in the *OIG Strategic Plan*.

Monitoring: OIG monitors its efforts through qualitative and quantitative metrics, capturing both outputs and outcomes, which are integrated into executive performance plans of OIG's senior leadership.

Reporting: OIG also produces, and is a significant contributor to, several comprehensive annual or semiannual reports that communicate the impact of our programs to Congress and the public. These reports include the OIG *Semiannual Report to Congress*, the HCFAC *Annual Report*, and the *Compendium of Unimplemented OIG Recommendations*.

Significant Accomplishments

In OIG's Fall 2013 *Semiannual Report to Congress*, OIG reported expected recoveries of approximately $5.8 billion for FY 2013. This includes $5.0 billion in investigative receivables (which includes $1.0 billion in non-HHS investigative receivables resulting from OIG's work, such as States' shares of Medicaid restitution) and $0.8 billion in audit receivables. OIG also identified about $19.4 billion in savings estimated[1] for FY 2013 as a result of legislative, regulatory, or administrative actions that were supported by its recommendations.

Additionally, in FY 2013, OIG excluded 3,214 individuals and organizations from participation in Federal health care programs. OIG reported 960 criminal actions against individuals or organizations that engaged in crimes against HHS programs and 472 civil and administrative enforcement actions, including resolutions under the False Claims Act and OIG civil monetary penalties (CMP) law, some of which resulted from self-disclosures. OIG work also prevents fraud and abuse through industry outreach and guidance and recommendations to remedy program vulnerabilities.

For a more complete discussion of OIG's accomplishments and recent performance results, refer to the sections of this document describing OIG's PHHS (beginning on page 33) and CMS (beginning on page 41) oversight work.

[1] Savings estimates are typically from a third party, such as the Congressional Budget Office (CBO) or HHS actuary scoring of policy changes.

All-Purpose Table[1]

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
PHHS Oversight: [2]				
Discretionary Budget Authority (BA)	$47,465	$71,000	$75,000	+$4,000
Subtotal, PHHS Oversight BA	**47,465**	**71,000**	**75,000**	**+4,000**
Disaster Relief Appropriations Act of 2013	4,748	--[3]	--	--
Subtotal, PHHS Oversight Program Level (PL)	**52,213**	**71,000**	**75,000**	**+4,000**
CMS Oversight:				
HCFAC Mandatory BA	186,287	184,979	285,129	+100,150
Current Law (non-add)	*186,287*[4]	*184,979*	*200,333*	*+15,354*
Proposed Law (non-add)	--	--	*84,796*	*+84,796*
HCFAC Discretionary BA	28,122	28,122	28,122	--
Subtotal, CMS Oversight BA[5]	**214,409**	**213,101**	**313,251**	**+100,150**
HCFAC Estimated Collections[6]	9,608	11,136	12,000	+864
Subtotal, CMS Oversight PL	**224,017**	**224,237**	**325,251**	**+101,014**
Total BA	**261,874**	**284,101**	**388,251**	**+104,150**
Total PL	**$276,230**	**$295,237**	**$400,251**	**+$105,014**
FTE	1,660	1,577	1,861	+284

[1] Table excludes non-HCFAC reimbursable funding. In FY 2013, OIG obligated $18 million in non-HCFAC reimbursable funding. The estimate for FYs 2014 and 2015 is $21 million. This estimate includes funds from section 6201 of the ACA for OIG to evaluate a nationwide program for national and State background checks on direct patient access employees of long-term-care facilities and providers. OIG obligated $44,000 for this effort in FY 2013.

[2] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by CCIIO, a component of CMS.

[3] FY 2014 funding level excludes $1.75 million for additional oversight of HHS's disaster relief efforts.

[4] FY 2013 funding level excludes $7.1 million in HCFAC Mandatory funding that was allocated to OIG by HHS.

[5] OIG's HCFAC funding is drawn from the Medicare Hospital Insurance Trust Fund (sec. 1817(k)(3) of the Social Security Act) and is requested and provided through the CMS budget.

[6] In FY 2013, OIG collected $10.1 million under authority of 42 U.S.C. 1320a-7c (section 1128C of the Social Security Act), and the actual amount sequestered is $0.5 million. The table includes estimates for HCFAC collections for FYs 2014 and 2015, and the amounts available will depend on the amounts collected.

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Appropriations Language

Office of Inspector General

For expenses necessary for the Office of Inspector General, including the hire of passenger motor vehicles for investigations, in carrying out the provisions of the Inspector General Act of 1978, [$71,000,000**]***$75,000,000*: Provided, That of such amount, necessary sums shall be available for providing protective services to the Secretary and investigating non-payment of child support cases for which non-payment is a Federal offense under 18 U.S.C. Section 228.

Amounts Available for Obligation [1]

(Dollars in Thousands)

	FY 2013 Actual	FY 2014 Enacted	FY 2015 Pres. Bud.
Discretionary			
General Fund Discretionary Appropriation:			
Appropriation (Labor/HHS)	$50,083	$71,000	$75,000
Rescission/increase (Labor/HHS)	-100	--	--
Subtotal, Appropriation (Labor/HHS)	**49.983**	**71,000**	**75,000**
Amount Sequestered	- 2,518	--	--
Total, Discretionary Appropriation	**47,465**	**71,000**	**75,000**
Transfers			
Transfer of funds from Public Health and Social Services Emergency Fund for Disaster Relief Appropriations Act of 2013	5,000	250	--
Amount Sequestered	-252	--	--
Total, Disaster Relief Appropriations Act	4,748	250	--
Offsetting collections from:			
Trust fund HCFAC Discretionary	29,674	28,122	28,122
Rescission/Increase (Labor/HHS)	-59	--	--
Subtotal, HCFAC Discretionary	**29,615**	**--**	**--**
Amount Sequestered	- 1,493	--	--
Total, Discretionary Offsetting Collections	**28,122**	**28,122**	**28,122**
Offsetting collections from:			
Trust Fund HCFAC Mandatory	196,299	199,331	285,129
Current Law (non-add)	*196,299*	*199,331*	*200,333*
Proposed Law (non-add)	--	--	*84,796*
Trust Fund HCFAC Mandatory Additional Amounts	7,124	--	--
HCFAC Mandatory Recoveries	4,000	--	--
Amount Sequestered	-10,011	-14,352	--
Estimated HCFAC Collections[2]	10,125	12,000	12,000
Amount Sequestered [2]	-516	-864	--
Amounts Previously sequestered, but available	--	516	864
Total, Mandatory Offsetting Collections	**207,020**	**196,631**	**297,993**
Total Discretionary and Mandatory			
Unobligated balance, lapsing	754	--	--
Unobligated balance, start of year	32,838	18,261	13,435
Unobligated balance, end of year	18,261	13,435	31,846
Total, Obligations	**$301,178**	**$300,829**	**$382,704**

[1] Table excludes non-HCFAC reimbursable funding. In FY 2013, OIG obligated $18 million in non-HCFAC reimbursable funding. The estimate for both FYs 2014 and 2015 is $21 million.

[2] The table includes the estimated amounts for FY 2014 and FY 2015.

Summary of Changes
(Dollars in Thousands)

2014	
Total, BA	$71,000
Obligations	71,000
2015	
Total, Estimated BA	75,000
Estimated Obligations	75,000
Net Change in BA	+$4,000

	FY 2015 Estimate FTE	FY 2015 Estimate BA	Change From Base FTE	Change From Base BA
Increases:				
A. Built in:				
1. Provide for salary of FTE	384	$56,669	+13	+$2,461
a. Pay to support additional FTE (non-add)	*13*	*2,191*	*+13*	*+2,191*
b. Increase due to 1- percent pay raise (non-add)	--	*270*	--	*+270*
2. Increased costs related to General Services Administration (GSA) rent	--	170	--	-4
Subtotal, Built-in Increases	**384**	**$56,839**	**+13**	**+$2,457**
B. Program:				
1. Costs related to general operating expenses	--	18,161	--	+1,543
Subtotal, Program Increases	**--**	**18,161**	**--**	**+1,543**
Total, Increases	**--**	**$75,000**	**+13**	**+$4,000**

Note: Table displays OIG's Direct Discretionary funding only. OIG's HCFAC Discretionary BA is appropriated to the CMS HCFAC account.

Budget Authority by Activity

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Bud.
PHHS Oversight			
Discretionary BA	$47,465	$71,000	$75,000
Subtotal, PHHS Oversight BA	**47,465**	**71,000**	**75,000**
[Disaster Relief Appropriations Act of 2013]	[4,748]	[--]	[-]
[Subtotal, PHHS Oversight PL]	**[52,213]**	**[71,000]**	**[75,000]**
CMS Oversight			
HCFAC Mandatory BA	186,287	184,979	285,129
Current Law (non-add)	*186,287*	*184,979*	*200,333*
Proposed Law (non-add)	--		*84,796*
HCFAC Discretionary BA	28,122	28,122	28,122
Subtotal, CMS Oversight BA[1]	**214,409**	**213,101**	**313,251**
[HCFAC Collections[2]]	[9,608]	[11,136]	[12,000]
[Subtotal, CMS Oversight PL]	**[224,017]**	**[224,237]**	**[325,251]**
Total, BA	**261,874**	**284,101**	**388,251**
[Total PL]	**[$276,230]**	**[$295,237]**	**[$400,251]**
FTE	1,660	1,577	1,861

Note: Table excludes non-HCFAC reimbursable funding. In FY 2013, OIG obligated $18 million in non-HCFAC reimbursable funding. The estimate for both FYs 2014 and 2015 is $21 million. This estimate includes funds made available in section 6201 of the ACA for OIG to evaluate a nationwide program for national and State background checks on direct patient access employees of long-term-care facilities and providers. OIG obligated $44,000 for this effort in FY 2013.

Note: Bracketed information is not BA, but rather is PL information. The PL information is included for purposes of comparability.

[1] OIG's HCFAC BA is appropriated to the CMS HCFAC account.

[2] In FY 2013, OIG collected $10.1 million and the actual amount sequestered is $0.5 million. The table includes estimates for HCFAC collections for FYs 2014 and 2015, and the amounts available will depend on the amounts collected.

Authorizing Legislation

(Dollars in Thousands)

	FY 2014 Amount Authorized	FY 2014 Actual	FY 2015 Amount Authorized	FY 2015 Pres. Bud.
OIG:				
Inspector General Act of 1978 (P.L. No. 95-452, as amended)	Indefinite	$71,000	Indefinite	$75,000
Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. No.104-191, as amended), HCFAC Mandatory	$199,331	$184,979	$200,333	$285,129
HIPAA, as amended, HCFAC Discretionary	Indefinite	$28,122	Indefinite	$28,122
HIPAA, as amended, HCFAC Collections	Indefinite	$11,136[1]	Indefinite	$12,000[1]
Unfunded Authorizations				
Supplemental Appropriations Act of 2008 (P.L. No. 110-252, as amended)	$25,000	--	$25,000	--

[1] The table includes estimates for HCFAC collections for FYs 2014 and 2015, and the amounts available will depend on the amounts collected.

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2006				
Discretionary Direct	$39,813,000	$39,813,000	$39,813,000	$39,813,000
Rescission	--	--	--	-398,000
HCFAC Mandatory	160,000,000	160,000,000	160,000,000	160,000,000
Medicaid Oversight[1]	25,000,000	--	--	25,000,000
FY 2007				
Discretionary Direct	43,760,000	41,415,000	43,760,000	39,808,000
HCFAC Discretionary Allocation Adjustment	11,336,000	--	--	--
HCFAC Mandatory	160,000,000	160,000,000	160,000,000	165,920,000
Medicaid Oversight[1]	25,000,000	--	--	25,000,000
Never Events[2]	--	--	--	3,000,000
FY 2008				
Discretionary Direct	44,687,000	44,687,000	45,687,000	44,000,000
Rescission	--	--	--	-769,000
HCFAC Discretionary Allocation Adjustment	17,530,000	36,690,000	36,690,000	--
HCFAC Mandatory	169,238,000	--	--	169,736,000
Medicaid Oversight[1]	25,000,000	--	--	25,000,000
FY 2009				
Discretionary Direct	46,058,000	44,500,000	46,058,000	45,279,000
HCFAC Discretionary Allocation Adjustment	18,967,000	18,967,000	18,967,000	18,967,000
HCFAC Mandatory	174,998,000	--	--	177,205,000
Medicaid Oversight[1]	25,000,000	--	--	25,000,000
Medicaid Oversight[3] (Supplemental)	--	--	--	25,000,000
Recovery Act: Medicaid Oversight	--	--	--	31,250,000
Recovery Act: General Oversight	--	--	--	17,000,000
FY 2010				
Discretionary Direct	50,279,000	50,279,000	50,279,000	50,279,000
HCFAC Discretionary Allocation Adjustment	29,790,000	29,790,000	29,790,000	29,790,000
HCFAC Mandatory[4]	177,205,000	--	--	177,205,000
Medicaid Oversight	$25,000,000	--	--	$25,000,000

[1] Funds appropriated for Medicaid Oversight in the Deficit Reduction Act of 2005 (DRA) (P.L. No. 109-171).

[2] The Tax Relief and Health Care Act of 2006 (P.L. No. 109-432) included $3 million for OIG to study Medicare "never events."

[3] Funds appropriated for Medicaid Oversight in the Supplemental Appropriations Act of 2008 (P.L. No. 110-252).

[4] HCFAC Mandatory amount for FY 2010 does not include $1.5 million allocated to OIG by HHS.

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2011				
Discretionary Direct	$51,754,000	--	$54,754,000	$50,278,000
Rescission	--	--	--	-100,000
HCFAC Discretionary Allocation	94,830,000	--	94,830,000	29,730,000
Adjustment				
Rescission	--	--	--	-59,000
HCFAC Mandatory	177,205,000	--	--	197,998,000
FY 2012				
Discretionary Direct	53,329,000	--	50,178,000	50,178,000
Rescission	--	--	--	-95,000
Public Health Services Evaluation Set-Aside	10,000,000	--	--	--
HCFAC Discretionary Allocation	97,556,000	--	97,556,000	29,730,000
Adjustment				
Rescission	--	--	--	-56,000
HCFAC Mandatory	193,387,000	--	--	196,090,000
FY 2013				
Discretionary Direct	58,579,000	--	55,483,000	50,083,000
Rescission	--	--	--	-100,000
Sequestration	--	--	--	-2,518,000
HCFAC Discretionary Allocation	102,500,000	--	102,500,000	29,855,000
Adjustment				
Rescission	--	--	--	-59,348
Sequestration	--	--	--	-1,492,771
HCFAC Mandatory[1]	196,669,000	--	--	196,299,000
Sequestration	--	--	--	-10,011,228
Disaster Relief Appropriations Act of 2013	--	--	--	5,000,000
Sequestration	--	--	--	-251,849
FY 2014				
Discretionary Direct	68,879,000	--	59,879,000	71,000,000
HCFAC Discretionary Allocation	29,790,000	--	107,541,000	28,122,000
Adjustment				
HCFAC Mandatory	278,030,000	--	200,279,000	199,331,000
Sequestration	--	--	--	-14,351,831
FY 2015				
Discretionary Direct	75,000,000	--	--	--
HCFAC Discretionary Allocation	28,122,000	--	--	--
Adjustment				
HCFAC Mandatory	$285,129,000	--	--	--

[1] The HCFAC Mandatory amount for FY 2013 does not include $7.1 million that was allocated to OIG by HHS.

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OIG Summary of Request

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
PHHS Oversight[1]	$52,213	$71,000	$75,000	+$4,000
CMS Oversight[2]	224,017	224,237	325,251	+101,014
Total Request	**$276,230**	**$295,237**	**$400,251**	**+105,014**
FTE	1,660	1,577	1,861	+284

Authorizing Legislation ..... Inspector General Act of 1978, as amended
FY 2015 Authorization ..... Indefinite
Allocation Method .....Direct Federal

Program Description

For over 30 years, OIG has safeguarded HHS expenditures, program administration, and beneficiary well-being by promoting the economy, efficiency, and effectiveness of HHS programs and combating fraud, waste, and abuse in those programs and operations. Legislative and budgetary requirements shape OIG activities. These activities comply with professional standards established by GAO, DOJ, and the IG community.

OIG's areas of oversight fall into two broad categories: (1) PHHS and (2) CMS. In a given year, the amount of work conducted in each category reflects purpose limitations of the funding that OIG is appropriated. By law a significant portion of OIG's efforts and resources are directed toward safeguarding the integrity of the Medicare and Medicaid programs and the health and welfare of beneficiaries (approximately 84 percent in 2013). The remaining share of OIG's efforts and resources focused on HHS's other programs and management processes, including critical issues, such as food and drug safety; child support enforcement; the integrity of departmental contracts and grants management processes and transactions; and oversight of the ACA-established Marketplaces, also referred to as "insurance exchanges."

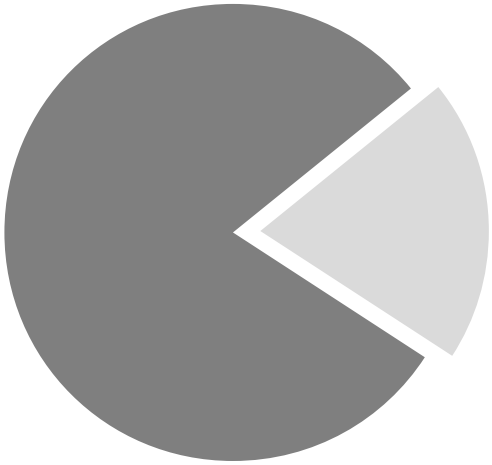
[1] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by CCIIO, a component of CMS.

[2] The request for CMS oversight includes HCFAC funding, which is drawn from the Medicare Hospital Insurance Trust Fund (sec. 1817(k)(3) of the Social Security Act) and is requested and provided through the CMS budget. Additionally, this total includes an estimate for HCFAC collections.

OIG's Areas of Oversight

Medicare & Medicaid Oversight Areas Include:

- Medicare Part A
- Medicare Part B
- Medicare Parts C and D
- Medicaid



PHHS Oversight Areas Include:

- Food and drug safety
- Child support enforcement
- Conflict-of-interest and financial disclosure policies
- Grants and contracts management
- Marketplaces-related programs
- Emergency preparedness and response
- Vaccine safety and supplies

OIG accomplishes its mission through the complementary efforts of five components, which are:

- Office of Audit Services (OAS): OAS provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

- Office of Investigations (OI): OI conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. OI actively coordinates with DOJ and other Federal, State, and local law enforcement authorities. OI's investigations often lead to criminal convictions, administrative sanctions, exclusions from participation in Federal health care programs, and/or civil monetary penalties.

- Office of Evaluation and Inspections (OEI): OEI conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

- Office of Counsel to the Inspector General (OCIG): OCIG provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and

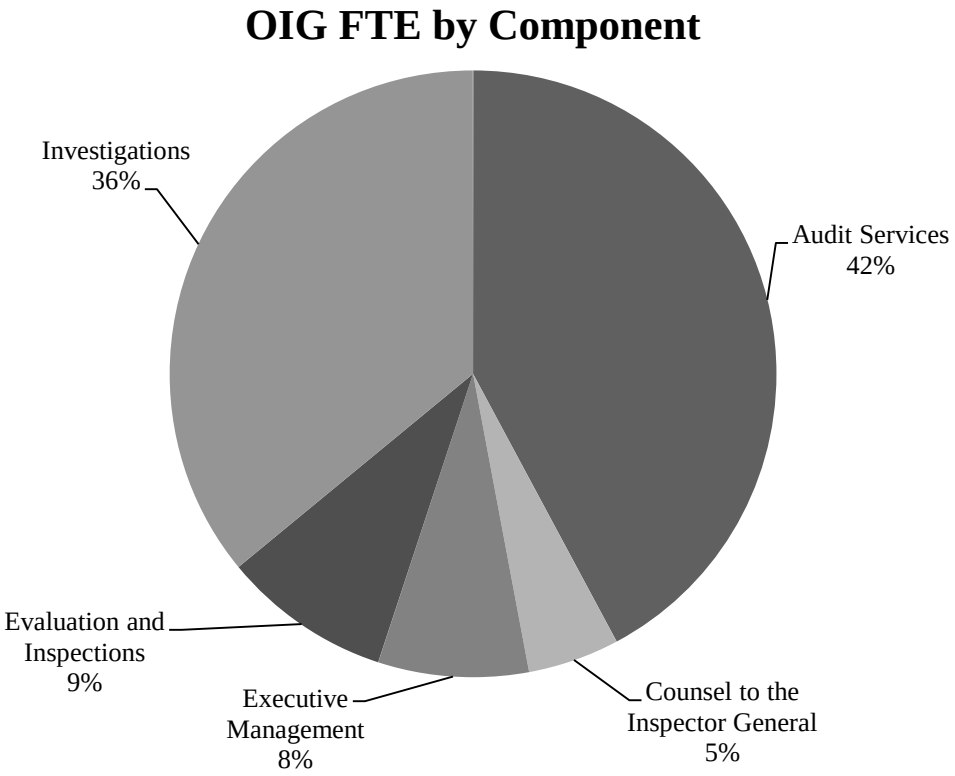
providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements (CIAs). OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

- Executive Management (EM): EM is composed of the Immediate Office of the Inspector General and the Office of Management and Policy. EM is responsible for generally supervising and coordinating the activities of OIG's components; setting vision and direction, in collaboration with the components, for OIG's priorities and strategic planning; ensuring effective management of budget, finance, IT, human resource management, and other operations; and serving as a liaison with HHS, Congress, and other stakeholders. EM plans, conducts, and participates in a variety of cooperative projects within HHS and with other Government agencies.

The specialties and technical skills of the varied professional disciplines represented by each of these components enable OIG to implement a multifaceted program integrity approach that simultaneously assesses broad trends in HHS public policy implementation while focusing significant effort on promoting economy, efficiency, and effectiveness and addressing instances of possible fraud, waste, and abuse.

OIG maintains a Washington, DC, office and a nationwide network of regional and field offices; over 70 percent of employees work outside the Washington, DC, metropolitan area. At all levels, OIG staff work closely with HHS and its OPDIVs and staff divisions (STAFFDIVs); DOJ, other IG offices, and other Federal agencies in the executive branch; Congress; and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds to protect the integrity of HHS programs and expenditures and the well-being of beneficiaries.

In FY 2013, the OIG staff was composed of 1,660 FTE, who were distributed among the 5 components as follows:

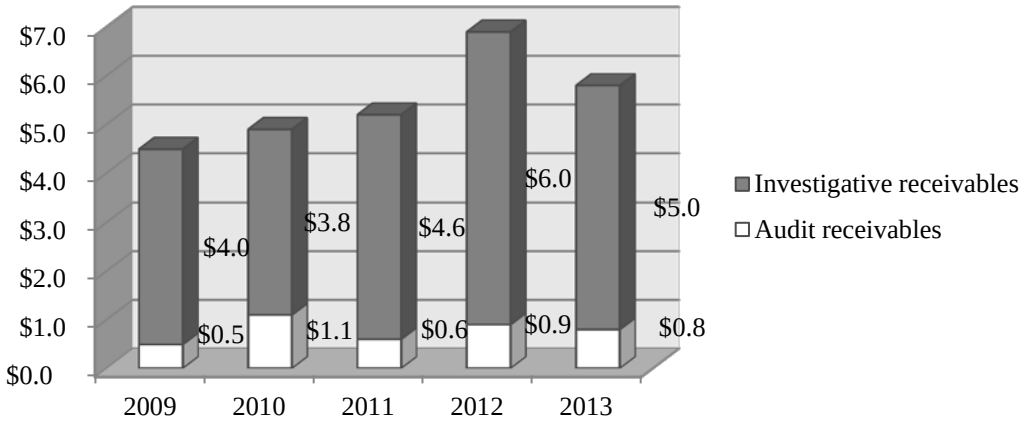


Accomplishments

In OIG's Fall 2013 *Semiannual Report to Congress*, OIG reported expected recoveries of approximately $5.8 billion for FY 2013. This includes $5.0 billion in investigative receivables (which includes $1.0 billion in non-HHS investigative receivables resulting from OIG's work, such as States' shares of Medicaid restitution) and $0.8 billion in audit receivables. OIG also identified about $19.4 billion in savings estimated for FY 2013 as a result of legislative, regulatory, or administrative actions that were supported by its recommendations.

- Expected Recoveries: As reflected in the following graph, OIG's expected recoveries trend upward and have increased over 24 percent since FY 2009. This success is attributable, in part, to the availability and better use of data and higher dollar settlements and judgments, as well as continued efforts to work with HHS OPDIVs to implement OIG recommendations.

OIG Expected Recoveries, FYs 2009 - 2013
(Dollars in Billions)



- Cost savings: OIG identified approximately $19.4 billion in savings estimated for FY 2013. This estimate reflects prior-period legislative, regulatory, or administrative actions that were supported with OIG recommendations. Such estimates generally reflect third-party projections (such as those by CBO or HHS actuaries) made at the time the action was taken. Actual savings may be higher or lower.

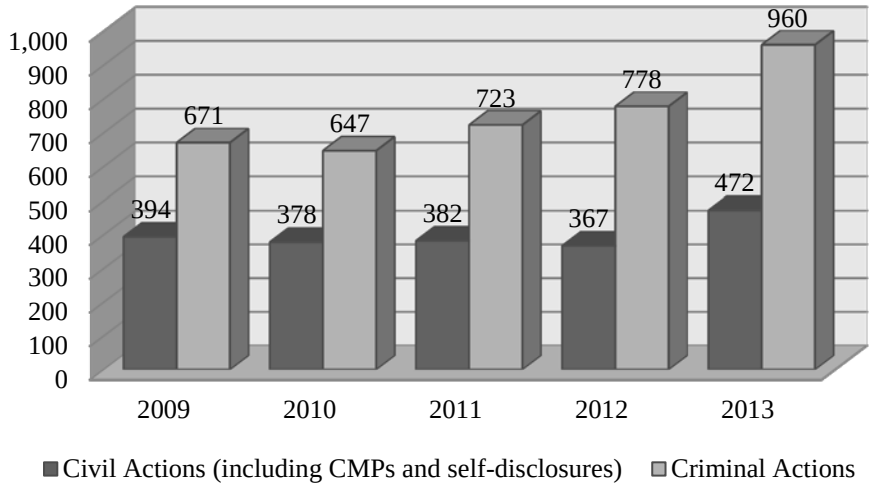
  Savings of this kind generally reflect not only OIG work, but the contributions of others, such as HHS OPDIVs and STAFFDIVs, the Congress, and GAO. At all levels, OIG works closely with its Federal partners to bring about successful systemic improvements through modifications to administrative policies, processes, or procedures; changes to existing regulations and law; or improvements in IT.

- Criminal and Civil Actions[1] and Program Exclusions: In FY 2013, OIG reported 960 criminal actions against individuals or organizations that engaged in crimes against HHS programs. These crimes included various health care fraud violations. Additionally, OIG reported 472 civil and administrative actions. Among other things, civil and administrative actions include False Claims Act suits filed in Federal district court and CMP cases, some of which resolve matters self-disclosed by a provider. The number of criminal, civil, and administrative actions has increased approximately

[1] OIG defines "criminal action" as a conviction or pretrial or precharging diversion agreement. A "civil action" is a civil settlement or judgment or a CMP law action.

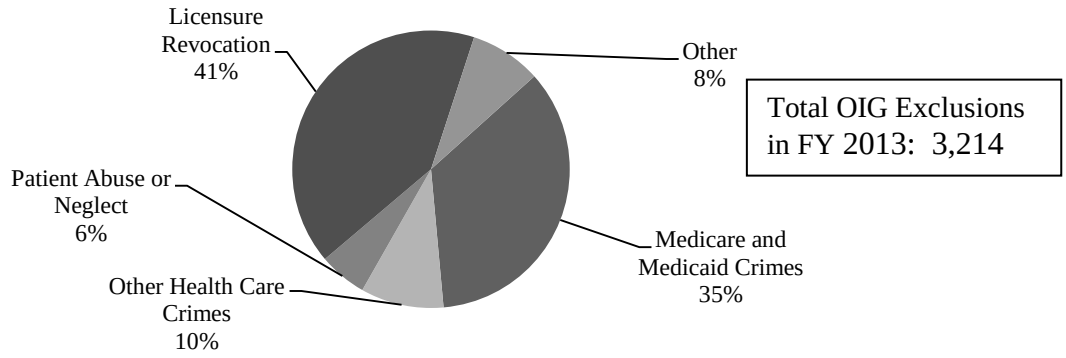
34 percent since FY 2009. During FY 2013, OIG concluded CMP settlements involving more than $18 million in penalties and assessments.

Civil and Criminal Actions
FYs 2009 - 2013



Also in FY 2013, OIG excluded 3,214 individuals and organizations from participating in Federal health care programs. Included in the FY 2013 exclusions were those based on convictions for crimes related to Medicare and Medicaid (1,132) or to other health-care-related matters (311), patient abuse or neglect (180), or licensure revocations (1,324). Approximately 46 percent were permissive exclusions, for which OIG had discretion to exclude certain individuals or entities on any of a number of grounds. The remaining 54 percent of OIG's FY 2013 exclusions were mandatory exclusions—OIG was required by law to exclude individuals and entities from participating in all Federal health care programs. Additional information may be found at http://oig.hhs.gov/fraud/exclusions.asp.

OIG Exclusions, by Type
2013



- CIAs: OIG often negotiates compliance obligations with entities (i.e., individuals, companies, etc.) as part of the settlement of allegations arising under civil and administrative false claims and fraud statutes. An entity consents to these obligations as part of the civil settlement and in exchange for OIG's agreement not to seek the entity's exclusion from participation in Federal health care programs. CIAs typically last for 5 years. OIG monitors entities' compliance with CIAs and holds accountable those who violate them. CIAs generally include penalties for failure to meet certain terms, and OIG may exclude an entity that has breached its CIA. During FY 2013, OIG entered into 39 new CIAs and, at the close of the year, was monitoring compliance with 201 CIAs.

- Advisory Opinions, Education, and Other Guidance: As authorized in statute and as part of continuing efforts to promote the highest level of health care industry ethics and lawful conduct, OIG issues advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. This enables OIG to help industry navigate the complexities of the anti-kickback statute, other OIG health care fraud and abuse sanctions, and safe harbor provisions. During FY 2013, OIG received 56 advisory opinion requests and, in consultation with DOJ, issued 23 advisory opinions, including 2 modifications.[1] A total of 299 advisory opinions have been issued during the 17 years of the HCFAC program.

  OIG also develops outreach materials and conducts training about the Federal laws designed to protect Medicare and Medicaid and beneficiaries from fraud, waste, and abuse. For example, as part of the HEAT Compliance Training Initiative, training materials, including podcasts and video, are available on OIG's Web site.

  "We believe these efforts to educate provider communities will help foster a culture of compliance and protect Federal health care programs and beneficiaries."

  –Daniel R. Levinson
  Inspector General

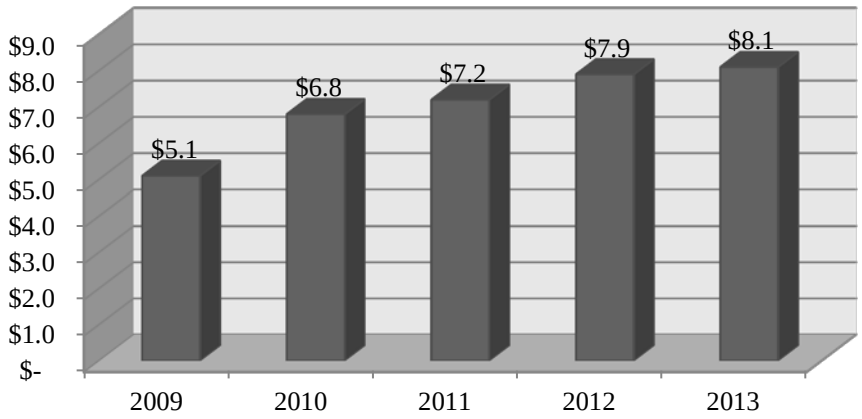
  Additionally, OIG continues to look for ways to improve the effectiveness of its publications and expand on its work in key areas. In November 2012, OIG published an OIG Portfolio titled *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement,* which synthesizes OIG's body of work in the personal care services area and offers new and comprehensive recommendations to address vulnerabilities. The Portfolio identifies trends in payment, compliance, oversight, or fraud vulnerabilities requiring priority attention and action to protect the integrity of HHS programs and the beneficiaries they serve.

- HCFAC Program ROI: Under the joint direction of the Attorney General and the Secretary of HHS acting through the IG, the HCFAC Program coordinates Federal, State, and local law enforcement activities with respect to health care fraud and abuse. The

[1] OIG closes many advisory opinion requests without issuing opinions, frequently because the requests are withdrawn. In FY 2013, OIG closed 38 advisory opinion requests without issuing opinions.

most recent ROI for the HCFAC program is approximately $8 to $1. This is a ratio of actual monetary returns to the Government to total HCFAC program appropriations. From its inception in 1997 through 2013, HCFAC Program activities have returned more than $25.9 billion to the Medicare Trust Funds. HCFAC's continued success confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud, and to protect program beneficiaries. The chart below shows the ROIs reported each year from FY 2009 through 2013.

HCFAC Program Return on Investment
FYs 2009 - 2013



Budget Request

The FY 2015 request for OIG includes $400,251,000 and 1,861 FTE, an increase of +$105,014,000 and +284 FTE above the FY 2014 Enacted Level. With these resources, OIG is charged with overseeing approximately $900 billion in HHS spending, which represents approximately a quarter of every Federal dollar spent. Consistent with its funding, OIG's spending falls into two broad categories, PHHS and CMS oversight. For each of these areas, this submission includes:

- PHHS Oversight: An increase of +$4,000,000 above the FY 2014 Enacted Level is requested to ensure oversight of HHS activities and key priority areas. The request reflects the pressing demand for OIG oversight of the non-CMS programs, which represent over $100 billion in spending and are critical to the health and well-being of Americans.

  The request will enable OIG to oversee the efficient and effective administration of vital public health and human services programs and to focus on key priority areas, including preventing and deterring fraud, waste, and abuse related to the Marketplaces and other new ACA programs; overseeing the management of cross-Departmental operations, such as grants and contracts and IT security; addressing significant existing and emerging matters, such as ensuring the safety of the Nation's domestic and imported food, drugs,

biologics, and medical devices; ensuring appropriate expenditures of emergency preparedness funding; and expanding OIG's capacity to leverage data and to identify fraud trends in the non-CMS program areas. Additional detail about OIG's tactical and strategic approaches in this area can be found in the PHHS subsection beginning on page 33.

- CMS Oversight: An increase of +$101,014,000 above the FY 2014 Enacted Level is requested to support OIG's CMS-related program integrity efforts, including the HEAT initiative, and sustaining and expanding Medicare Fraud Strike Forces. The resources will support OIG's efforts to leverage technology and data to address emerging trends; adapt its workforce and approach to changing health care systems; increase its efforts to identify questionable billings, address improper payments, and improve patient safety and quality of care; and oversee the growth in Medicaid.

  The current ROI for the HCFAC program is over $8 to $1. Through 2013, over $25.9 billion has been returned to the Medicare Trust funds. Additional information about OIG's efforts in this area and this request can be found in the CMS subsection beginning on page 41.

The FY 2015 President's Budget seeks to replace funding for Medicare and Medicaid oversight that was previously provided from other sources and has expired (e.g., funds provided by the DRA). In FYs 2012 and 2013, OIG instituted a number of actions to reduce costs, including instituting a hiring freeze beginning in FY 2012; reducing nonpersonnel budgets; and, twice in 2013, offering employees early retirement through Voluntary Early Retirement Authority and separation incentive payments through Voluntary Separation Incentive Payments. Since the beginning of FY 2012, OIG has lost approximately 200 staff because of financial constraints. This drop in staff has hindered priority initiatives, such as Strike Forces. The funding increase provided in the FY 2014 appropriations has stabilized and expanded OIG's PHHS Oversight activities; the FY 2015 request would similarly restore and expand OIG's oversight of Medicare and Medicaid, at a time when these programs are changing and expanding.

Work Planning and Allocating OIG Resources

OIG plans its work and allocates its resources on the basis of a number of factors, including the purpose limitations in the agency's various funding sources, authorizing statutes, and mandates. Thus, in FY 2015, OIG's resource allocation and annual *Work Plan* will reflect the responsibilities assigned by Congress via the IG Act, HIPAA, and various other statutes that mandate certain OIG work. OIG also gives significant consideration to its annual assessments of top management and performance challenges facing HHS.

Each year OIG issues a *Work Plan*, which describes the audits and evaluations that OIG plans to undertake. In addition, OIG has other responsibilities, such as criminal, civil, and administrative investigations; compliance monitoring; and issuance of advisory opinions that are designed to be responsive to priorities as they arise. As such, they often are not identified in advance in a published work plan. Furthermore, the workload is adjusted throughout the year to meet new

priorities and respond to emergencies, unforeseen events, and emerging issues identified through the strategic use of field intelligence and data analysis.

In developing and evaluating specific *Work Plan* proposals for FY 2015, OIG will consider a number of factors, including the following:

- requirements in laws, regulations, or other directives;
- requests made or concerns raised by Congress, HHS management, and other stakeholders;
- significant management and performance challenges facing HHS, which OIG identifies as part of the HHS annual agency financial report;
- analysis of HHS program operations and spending for patterns that indicate possible fraud, waste, and abuse;
- work performed by other oversight agencies, such as GAO;
- management's actions to implement OIG recommendations from previous reviews; and
- timing and overall need, relevance, and impact.

Chief among the factors considered by OIG is the level of vulnerability of each HHS program to fraud, waste, and abuse and the estimated effect of the vulnerabilities on HHS programs and beneficiaries. Two considerations dominate when assessing this risk: the likelihood of occurrence and reoccurrence of a given vulnerability and the magnitude of its impact. For example, weak internal controls or significant or rapid growth in program authority or spending may signal a greater likelihood of fraud, waste, or abuse. The number of beneficiaries served by a program may be an indicator of impact.

Reviews will be prioritized for implementation when the consequence of mismanagement, noncompliance, or other deficiencies in a specific program area could:

- undermine the intent and effectiveness of HHS programs;
- compound known and inherent financial risks;
- negatively impact health care, quality of services, and/or beneficiary safety; or
- reduce productivity, economy, or efficiency of HHS operations or systems.

Highlights of ongoing and planned work for FY 2014 can be found in the PHHS and CMS oversight budget request subsections of this document (pages 33 and 41, respectively).

OIG-Wide Performance Table

Key Outcomes[1]	Most Recent Result (FY 2013)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Expected recoveries resulting from OIG involvement in health care fraud and abuse oversight activities (dollars in millions)	$4,725 (Target exceeded)	$4,000	$4,000	--
ROI resulting from OIG involvement in health care fraud and abuse oversight activities	$18.1:$1 (Target exceeded)	$15:$1	$15:$1	--
Number of quality and management improvement recommendations accepted	232 (Target exceeded)	150	175	+25
PL funding (dollars in millions)	$276	$295	$400	+$105
Key Outputs	**Most Recent Result (FY 2013)**	**FY 2014 Target**	**FY 2015 Target**	**FY 2015 +/- FY 2014**
Audits:				
Audit reports started	364 (Target exceeded)	180	194	+14
Audit reports issued	346 (Target exceeded)	230	224	-6
Audit reports issued within 1 year of start (percentage)	56% (Target not met)	63%	63%	--
Evaluations:				
Evaluation reports started	77 (Target exceeded)	60	62	+2
Evaluation reports issued	74 (Target exceeded)	52	52	--
Evaluation reports issued within 1 year of start (percentage)	64% (Target exceeded)	55%	55%	--
Investigations:				
Complaints received for investigation	4,215 (Target not met)	4,500	4,500	--
Investigative cases started	2,151 (Target met)	2,214	2,313	+99
Investigative cases closed	2,147 (Target exceeded)	2,017	2,104	+87
PL funding (dollars in millions)	$276	$295	$400	+$105

[1] The "expected recoveries" and ROI performance measures are calculated using 3-year moving averages.

Performance Measures
Among other indicators, OIG uses three key outcome measures to express progress in accomplishing OIG's mission of combating fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in HHS programs and operations:

- the 3-year moving average of expected recoveries from OIG's health care oversight activities that resulted in investigative receivables and audit disallowances,

- the 3-year moving average of the expected ROI from OIG's health care oversight activities that resulted in investigative receivables and audit disallowances, and

- the number of accepted quality and management improvement recommendations.

These measures (also shown on the table on the previous page) generally reflect the culmination of investigation, audit, and evaluation efforts initiated in prior years. Moreover, these measures are expressions of OIG's joint success and joint efforts with a network of program integrity partners at all levels of government. For example, OIG investigators and attorneys work closely with DOJ; Medicaid Fraud Control Units; and other Federal, State, and local law enforcement organizations to develop cases and pursue appropriate enforcement actions, which often include criminal or administrative sanctions and restitution to the Federal and State governments and other affected parties. Similarly, OIG audits and evaluations generate findings and recommendations intended to save money or improve programs. While OIG is not authorized to implement its recommendations, it informs Congress and HHS program officials of potential cost disallowances and corrective actions that may be taken to address the vulnerabilities OIG identifies.

As shown in the table on the previous page, several outputs contribute to OIG's success in meeting its goals. Many factors are considered when identifying OIG's output targets. An increase in resources in one fiscal year may not necessarily yield results in the same fiscal year. Performance targets reflect the time required to hire and train new staff. Similarly, a lack of resources can negatively impact performance results in future years. Thus, OIG's targets for audit reports started and issued have declined to reflect recent staff reductions and hiring freeze, as well as a focus on producing fewer, but higher impact, reports.

A breakdown of OIG's output measures by PHHS and CMS oversight can be found on pages 39 and 52, respectively.

Subsection: Public Health, Human Services, and Departmentwide Issues Oversight

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Direct BA	$47,465	$71,000	$75,000	+$4,000
Disaster Relief Approp. Act of 2013	4,748	--	--	--
Total PL	**$52,213**	**$71,000**	**$75,000**	**$4,000**
FTE[1]	245	379	397	+18

Program Description

HHS is the Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS's eight U.S. Public Health Service agencies, two human services agencies, and Center for Consumer Information and Insurance Oversight[2] (CCIIO) operate hundreds of programs, featuring diverse missions, ranging from ensuring food safety to operating community health centers. OIG oversight helps ensure the integrity and efficiency of the services each agency provides to the public. During FY 2013, OIG's oversight effort for PHHS was allocated across HHS OPDIVs and STAFFDIVs as follows:

HHS ODPDIVs and STAFFDIVs	Percentage
Administration for Children and Families (ACF)	33%
Administration for Community Living (ACL)	<1%
Agency for Health Care Research and Quality (AHRQ)	<1%
Centers for Disease Control and Prevention (CDC) / Agency for Toxic Substances and Disease Registry (ATSDR)	2%
Food and Drug Administration (FDA)	3%
Health Resources and Services Administration (HRSA)	6%
Indian Health Service (IHS)	3%
National Institutes of Health (NIH)	14%
Substance Abuse and Mental Health Services Administration (SAMHSA)	3%
Office of the Secretary (OS)[3]	19%
Other PHHS Programs[4]	17%

[1] FTE reflect those targeted to PHHS oversight and the Disaster Relief Appropriations Act of 2013.

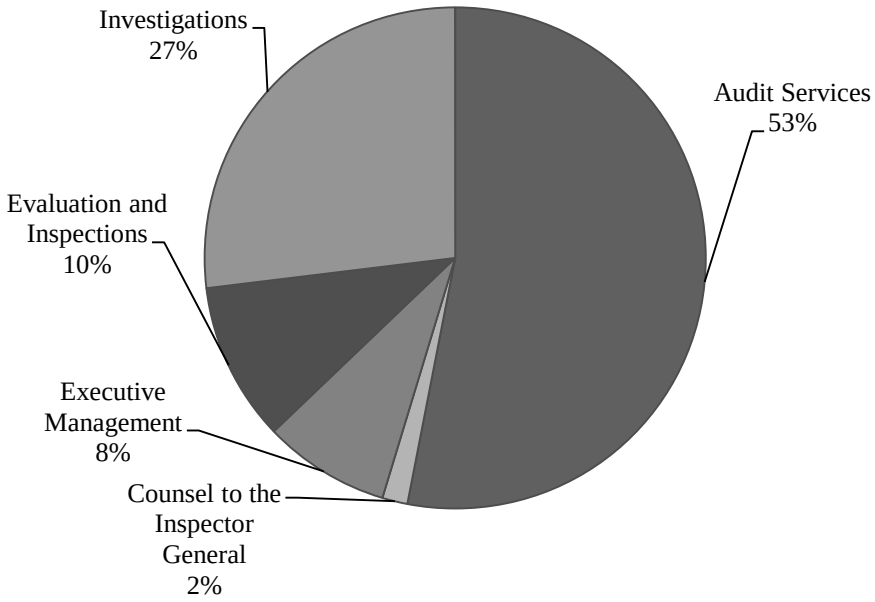
[2] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by CCIIO, a component of CMS.

[3] OS includes oversight efforts related to OS STAFFDIVs, such as the Assistant Secretary for Preparedness and Response, as well as Secretarial Protection and the Chief Financial Officer Audit.

[4] Examples of these efforts include (1) oversight of programs authorized in Title I of the ACA and administered by CCIIO and (2) grant and contract oversight that crosses multiple OPDIVs.

In FY 2013, funding for PHHS Oversight supported 245 FTE, who were assigned across OIG's 5 components as follows:

Allocations of OIG FTE to PHHS Oversight, by Component



Accomplishments

In FY 2013, OIG issued 115 audits and 16 evaluations related to PHHS oversight. In addition, OIG continued to participate in the highly successful child support enforcement collaborative effort with the Office of Child Support Enforcement in ACF which contributed to 61 criminal actions or convictions and $3.6 million in restitution, fines, penalties, settlements, and recoveries. Although these funds are not returned to HHS, they do result in payments of vital child support to custodial parents. During FY 2013, 232 CMS and PHHS program quality and management improvement recommendations were accepted. The following accomplishments are recent examples from FYs 2012 and 2013 of the impact of OIG recommendations on PHHS programs.

- Creating Accountability for Scientific Disagreements Regarding Medical Device Regulatory Decisions: In response to recommendations in an OIG report, FDA's Center for Devices and Radiological Health (CDRH) revised its standard operating procedures for resolving internal differences of opinion in regulatory decisionmaking. The procedures now require all disputes, whether resolved formally or informally, to be fully documented. CDRH has also trained 75 percent of its reviewers and managers on these new procedures and tracked which employees have been trained. CDRH's regulatory decisions have significant implications for the public's health.

- Identifying IHS Health Facilities Through a Single Database: In response to OIG's report on access to kidney dialysis services at IHS and tribal facilities, IHS completed a

map and single database of all IHS and tribal health facilities, neither of which had previously existed. IHS also launched a web site, organized by location and services available, to provide easy access to information about the facilities. The web site will improve access to care for American Indians and Alaska Natives by identifying where services are located and the types of services available.

Priority Unimplemented Recommendations–PHHS

OIG presents opportunities for cost savings and/or improvements in program efficiency and effectiveness in its *Compendium of Unimplemented Recommendations.*

- Cross-Cutting: Improve HHS's financial analysis and reporting systems.
- ASPR: Improve States' and localities' medical surge preparedness for pandemics.
- NIH: Require NIH grantee institutions to identify, report, and address institutional financial conflicts of interest.
- FDA: Improve and strengthen food facilities' compliance with records requirements for traceability of food products.
- HRSA: Improve oversight of health centers' quality assurance plans, provision of required primary care service, and progress toward meaningful use of electronic health records.
- ACF: Improve oversight of health and safety requirements for ACF-funded grantees.

- Investigating Grant Fraud: Following an OIG investigation, Craig Grimes was sentenced to 3 years and 5 months of incarceration and ordered to pay $640,660 in restitution after pleading guilty to charges of wire fraud, false statements, and money laundering. Grimes's research company, SentechBiomed, had received a grant of nearly $1.2 million from NIH to perform research related to the measurement of gases in a patient's blood. The conditions of the grant required that Grimes direct nearly half of the grant to the Hershey Medical Center to conduct clinical research on adult and infant subjects. However, Grimes never paid the center to conduct the studies and trials and, instead, misspent the money for personal use.

- Improving FDA's Foreign Clinical Trial Guidance: In FY 2012, as a result of a recent OIG report that highlighted the increased globalization of foreign clinical trials and the challenges faced as a result, FDA issued guidance for industry and staff on conducting foreign clinical trials. The guidance addresses the importance of standardized data, which will contribute to improved economy and efficiency.

Funding History

The funding history in the table below includes the BA provided to OIG for PHHS oversight. The funds displayed are provided to OIG through an annual discretionary direct appropriation

included within the Labor, Health and Human Services, Education and Related Agencies appropriations bill.

FY	PHHS Oversight
2011	$50,178,000
2012	$50,083,000
2013	$47,465,000
2014	$71,000,000
2015	$75,000,000

Budget Request

With funding from its annual discretionary direct appropriation, OIG conducts program integrity and enforcement activities with regard to PHHS programs and operations, including oversight of the Marketplaces and related programs created by Title I of the ACA. These programs number in the hundreds, represent over $100 billion in spending each year, and are carried out by approximately 70,000 HHS employees spread across the globe.

OIG prioritizes the allocation of these resources to comply with the requirements in appropriations language and other directives established in law. These include requirements that OIG conduct or oversee reviews under the Federal Information Security Management Act (FISMA) (P.L. No. 107-347) and the Single Audit Act (P.L. No. 98-502), other IT audits, and investigations of interstate nonpayment of child support obligations. In addition, OIG provides protective services for the HHS Secretary using its discretionary appropriation.

OIG's FY 2015 budget request for PHHS oversight is $75,000,000, which is an increase of +$4,000,000 and +13 FTE above the FY 2014 Enacted Level. In addition to requesting funds for new priorities emerging across the Department's 300-plus non-Medicare and non-Medicaid programs, the FY 2015 request will allow OIG to advance tactical and strategic approaches for maximizing positive impact on HHS programs. Strategies to be used with additional FY 2015 resources include:

- *Cross-cutting reviews that address Department-wide management challenges and programmatic reviews focusing on vulnerabilities arising from the changing health care landscape.* This approach incudes expanding OIG's systemic reviews of internal controls, performance evaluations, management assessments, and technical assistance on:
    - *Functional Issues:* operational and management issues that cut across the Department and its programs. These include issues related to grant and contract management, IT security, compliance with appropriations requirements, ethics programs, and other business operations.

- *Programmatic Issues:* management, performance, internal controls, and coordination related to significant programmatic issues, including those that affect multiple programs or operating divisions. Examples include electronic health records, implementation of Marketplaces, and public health outcomes.

OIG will target these reviews by assessing relative risks to HHS programs and by conducting coverage assessments to identify issues of coordination, duplication, and managements that may not be evident from a risk assessment of a single program.

Work Plan Highlights— Approach to the ACA Oversight

In FY 2014, OIG's oversight of the Marketplaces, also known as the Health Insurance Exchanges, will focus on payment accuracy, eligibility systems, contract oversight, and data security and consumer protection. Focusing on these key areas, OIG's goal is to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently and is secure.

In addition, OIG will focus on Medicaid program integrity, including the accuracy of eligibility determinations and matching percentages related to expanded eligibility. Information on this can be found on page 49. Increasing Medicaid enrollment and spending heighten the importance of OIG's work to fight fraud, waste, and abuse in this program. OIG will also conduct work to ensure sound expenditure of grant funds authorized by ACA.

- *Multidisciplinary efforts to address specific known or suspected fraud, waste, or abuse.* The FY 2015 request will support OIG's multidisciplinary efforts to address serious and concentrated instances of fraud or waste in HHS programs through enforcement actions, audit disallowances, and management recommendations. With a focus on high–risk areas, such as grants and contracts, this approach would build on the successes of the HEAT "Strike Force" model in the Medicare context, which has produced unprecedented results.

- *Enhanced analysis of and followup on OIG recommendations and corrective actions.* The FY 2015 request will support efforts to build on existing efforts and develop new capacities in assessing the status, implementation, and effectiveness of corrective actions and synthesizing findings and recommendations across HHS programs to develop systemic solutions.

- *Enhanced enforcement tools to HHS grant programs and contracts.* Building on successful enforcement tools in Medicare and Medicaid, the request supports efforts to provide additional enforcement tools for oversight of HHS grant programs and contracts. Additional information on this can be found in the "Significant Item" section of this document, beginning on page 67.

While OIG is employing these strategies, potential programmatic areas of oversight include the Marketplaces and related programs created by the ACA (see text box for additional information about OIG's approach to ACA oversight); the integrity and security of health information systems and data; and the safety of the Nation's domestic and imported food, drugs, biologics, and medical devices.

Performance Table for PHHS Oversight

Key Outputs	Most Recent Result (FY 2013)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Audits:				
Audit reports started	100	48	62	+14
Audit reports issued	115	77	71	-6
Evaluations:				
Evaluation reports started	14	20	20	--
Evaluation reports issued	16	10	15	+5
Investigations:				
Complaints received for investigation	386	420	440	+20
Investigative cases started	282	290	324	+34
Investigative cases closed	276	284	316	+32
PL funding (dollars in millions)	$47	$71	$75	+$4

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Subsection: Medicare & Medicaid Oversight

(Dollars in Thousands)

	FY 2013 Final	FY 2014 Enacted	FY 2015 Pres. Bud	FY 2015 +/- FY 2014
HCFAC Mandatory BA[1]	$186,287	$184,979	$285,129	+$100,150
Current law (non-add)	*186,287*	*184,979*	*200,333*	*+15,354*
Proposed Law (non-add)	--	--	*84,796*	*+84,796*
HCFAC Discretionary BA	28,122	28,122	28,122	--
HCFAC Estimated Collections	9,608	11,136	12,000	+864
Total Program Level	**$224,017**	**$224,237**	**$325,251**	**+$101,014**
FTE	1,394	1,188	1,454	+266

Program Description

CMS administers three of the Nation's largest health care programs: Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). In 2013, these programs accounted for over $860 billion in Federal Government spending. Medicare, the single largest health insurance program in the Nation, processes more than 1 billion claims per year. Medicaid and CHIP are operated by States, but they are funded jointly with the Federal Government. They offer medical coverage to the most vulnerable Americans, including low-income families with dependent children; pregnant women; children; and aged, blind, and disabled individuals.

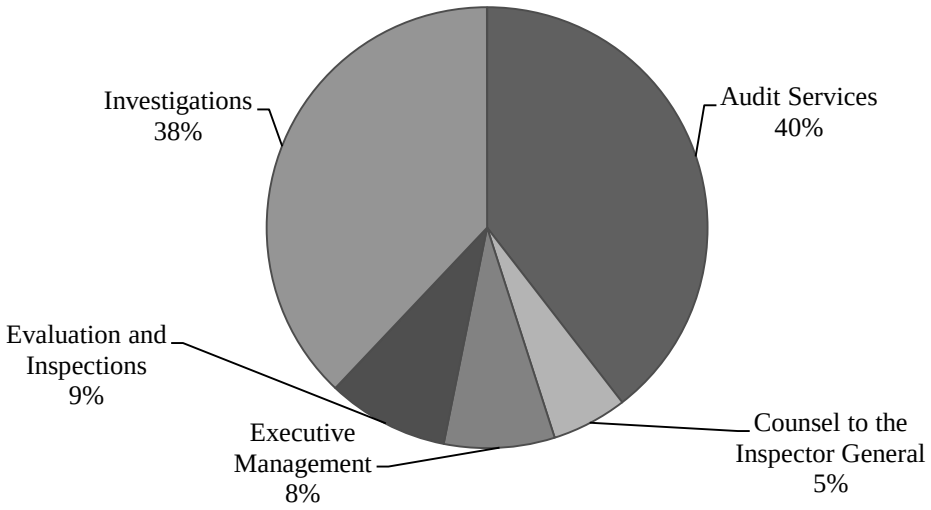
Together, these programs serve approximately one in four Americans, and the majority of OIG's annual budget is devoted to their oversight. Using a multidisciplinary approach, including an important partnership with DOJ, OIG works to save taxpayer dollars while ensuring that patients receive medically appropriate care and service.

HIPAA established HCFAC under the direction of the Attorney General and the Secretary of HHS acting through the IG to combat fraud, waste, and abuse in health care. OIG funds under HIPAA are dedicated exclusively to activities relating to the Medicare and Medicaid programs. The ACA added significant new Medicare and Medicaid program integrity protections and included a small increase in resources. Overall, HCFAC funding constitutes the major portion of OIG's annual operating budget.

[1] HCFAC funding is drawn from the Medicare Hospital Insurance Trust Fund (sec. 1817(k)(3) of the Social Security Act) and is requested and provided through the CMS budget. Information in this section provides an overview of OIG's CMS oversight activities.

In FY 2013, funding for CMS oversight supported 1,394 FTE, who were assigned across OIG's 5 components as follows:

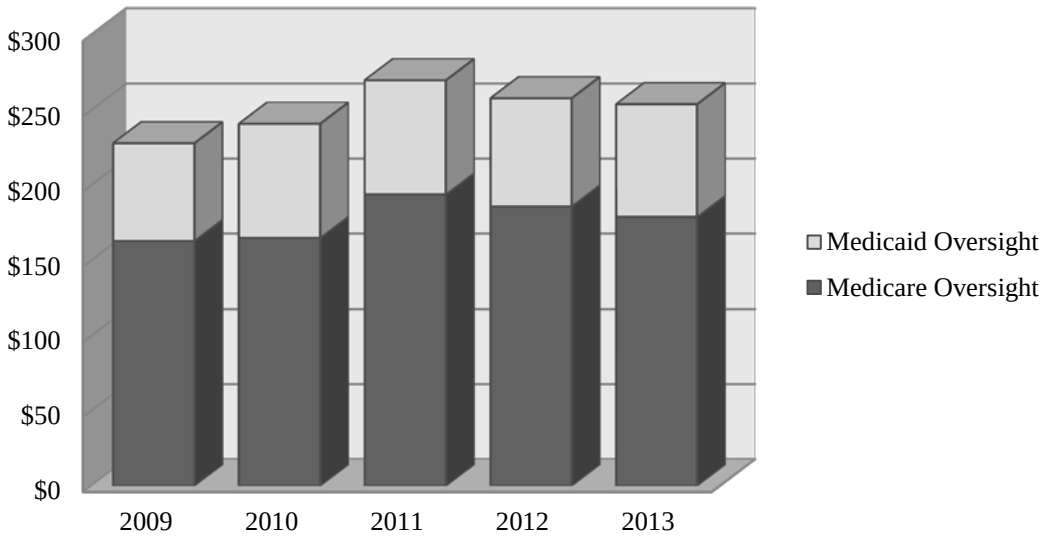
Allocation of OIG FTE to CMS Oversight, by Component



In FY 2013, approximately 70 percent of OIG's appropriated resources for activities with respect to CMS were allocated to Medicare oversight and approximately 30 percent of OIG's CMS oversight resources were allocated to Medicaid. Many OIG activities targeted to either Medicare or Medicaid affect both programs.

OIG Obligations for CMS Oversight

(Dollars in Millions)



Accomplishments

As reported in other sections of the document, during FY 2013 OIG's oversight of CMS programs resulted in significant expected health care recoveries (which include non-HHS investigative receivables resulting from OIG's work, such as the States' shares of Medicaid restitution). Specific examples of OIG's recent CMS oversight work include:

- Hospital Compliance Review – Inpatient and Outpatient Payments to Acute Care Hospitals: As a result of 71 audit reports issued to acute care hospitals across the United States, approximately $33.2 million was recovered to the Medicare Trust Fund. Using prior audits, investigations, and inspections, along with computer and data-matching techniques, OIG identified multiple areas of risk to be reviewed in a single audit. The goal of these audits is to identify overpayments for recovery, assist the hospitals in improving their internal controls and compliance with Medicare rules, and increase provider awareness.

- Investigating Health Care Fraud: Following an OIG investigation, Kenny Msiakii was sentenced to over 8 years of incarceration and ordered to pay $2.5 million in restitution after being convicted on charges of health care fraud. Msiakii's company, Joy Supply and General Services, billed Medicare for medical equipment that was not medically necessary and, in some cases, was never provided.

- Improving Billing Practices and Overall Spending in Skilled Nursing Facilities: OIG reports on payments to skilled nursing facilities (SNF) contributed to policy changes that resulted in a forecast of lower than projected spending for SNF services. As noted in a recent Medicare Board of Trustees report, the decreased spending is one of the factors that positively impacted the solvency of the Hospital Insurance Trust Fund; the Fund is now estimated to remain solvent 9 years longer than previously estimated. In addition, CMS addressed a key recommendation made in the report series by developing and implementing a SNF model in its Fraud Prevention System to identify SNFs with aberrant billing practices.

- Recouping Payments to Ineligible Beneficiaries—Unlawfully Present and Incarcerated: As a result of OIG recommendations, CMS has initiated actions to recoup $125.2 million in overpayments for care rendered to unlawfully present and incarcerated beneficiaries. OIG found that when CMS received untimely information indicating that a beneficiary's unlawful presence or incarceration dates overlapped with the dates of service on previously paid Medicare claims, CMS did not notify Medicare's contractors of this updated information. In the absence of such notification, the contractors did not detect and recoup improper payments. OIG made several recommendations to CMS to improve its processes for detecting and recouping such improper payments. OIG has also expanded the review of improper payments made for unlawfully present and/or incarcerated beneficiaries to the Medicare Part C and Part D programs.

- Excessive Rates Found at New York State-Operated Intermediate Care Facilities: New York's Medicaid daily rate for 15 selected State-operated intermediate care facilities

(ICFs or development centers) for individuals with intellectual and developmental disabilities did not meet Federal requirements that payments be consistent with economy and efficiency. The daily rate for Medicaid beneficiaries to reside in the selected developmental centers grew from $195 per day in State fiscal year (SFY) 1985 to $4,116 per day in SFY 2009 (a rate more than nine times the average of all other State- and privately operated ICFs). The growth occurred because the State's rate-setting methodology significantly inflated the Medicaid daily rate for the developmental centers. Following issuance of the report, OIG testified before Congress on the developmental center rates, which led to a New York State plan amendment (effective April 1, 2013) that changed the rate to be more reflective of the actual costs of providing care. As a result of this change, the Federal Government is expected to save approximately $1.2 billion from April 2013 through September 2014.

- Wyeth Pharmaceuticals Pays $490.9 Million To Resolve Violations of the False Claims Act and the Federal Food, Drug, and Cosmetic Act: Wyeth Pharmaceuticals entered into a settlement with DOJ to resolve its civil and criminal liability over unlawful marketing of the prescription drug Rapamune. The settlement stemmed from two *qui tam* lawsuits alleging that Wyeth promoted Rapamune for unapproved uses. Wyeth's actions had resulted in the submission of false claims to government health care programs. Additionally, Wyeth pled guilty to a misbranding violation under the Federal Food, Drug, and Cosmetic Act. Wyeth will pay $257.4 million and

Priority Unimplemented Recommendations–Medicare and Medicaid Oversight

OIG presents opportunities for cost savings and/or improvements in program efficiency and effectiveness in its *Compendium of Unimplemented Recommendations.*

- Ensure that Part D sponsors establish and enforce controls to address inappropriate drug prescribing and billing and potential fraud and prescription drug abuse.
- Improve monitoring and reporting of adverse events (incidents of patient harm resulting from care) in hospitals.
- Ensure that States report complete, accurate, and timely information to the national Medicaid database (known as T-MSIS) to support effective oversight.
- Address wasteful payment policies, by seeking legislative authority as needed, including better aligning Medicare payments for clinical laboratory tests with market prices and reassessing the status of critical access hospitals to ensure that enhanced payments are made only to hospitals that continue to qualify on the basis of community needs.
- Limit enhanced payments to public providers to cost and require that Medicaid payments returned by public providers be used to offset the Federal share.
- Establish and enforce strong controls over claims for Medicare services with known program integrity vulnerabilities, including home health care, community mental health services, and skilled nursing services.

$233.5 million to settle civil and criminal violations, respectively. Wyeth, which has since been acquired by Pfizer, will be subject to Pfizer's CIA with HHS.

- Investigating Health Care Fraud: Following an OIG investigation, 26 defendants were convicted for their roles in a widespread scheme to defraud Medicare and Medicaid of nearly $58 million. According to the indictment, Babubhai Patel was a licensed pharmacist who either owned or controlled 26 pharmacies in Michigan. Patel concealed his ownership and control over many of his pharmacies through the use of straw owners. Patel offered and paid kickbacks, bribes, and other inducements to prescribers in exchange for their writing fraudulent prescriptions for patients with Medicare, Medicaid, and private insurance and directing the patients to fill their prescriptions at one of Patel's pharmacies. Patel and his pharmacists billed Medicare and other insurers for dispensing the medications, despite the fact that the medications were medically unnecessary and/or were never provided. Since January 2009, Patel's pharmacies dispensed approximately 250,000 doses of Oxycontin, 4.6 million doses of Vicodin, 1.5 million doses of Xanax, and 6,100 pint bottles of codeine cough syrup. Patel's pharmacies falsely billed Medicare and Medicaid approximately $57.8 million for medications purportedly provided to beneficiaries over the course of the scheme.

- Nationwide Review of Medicare Outpatient Services Results in Recoveries and Future Savings: In a nationwide series of audits of Medicare outpatient services in which payments exceeded charges, an OIG audit team achieved high-impact results through an innovative risk-based approach, which included the use of data mining and analysis that significantly reduced the resources required on the front end of each audit. The team completed a series of reviews whose objectives and scopes required auditing all 15 Medicare contractors and approximately 2,600 hospitals. Pooling their resources for a more efficient approach, the team issued a total of 26 final reports to the Medicare contractors, resulting in expected recoveries totaling $106 million. In addition, because of CMS's verification policy edit implemented as a result of these OIG audits, the Federal Government will save about $30.3 million in future Medicare payments each year.

Funding History

The funding history in the table below includes the BA provided to OIG for CMS oversight. The funds displayed are provided to OIG through a number of sources, including HCFAC Mandatory; HCFAC Discretionary Allocation Adjustment; and HCFAC Collections.

FY	CMS Oversight
2011	$239,728,000
2012	$237,764,000
2013	$224,017,000
2014	$224,237,000
2015	$325,251,000

Budget Request[1]

As indicated in the "Accomplishments" sections of this document, OIG's efforts hold individuals and entities accountable through criminal, civil, and administrative enforcement actions (including exclusions from participation in Federal health care programs) while providing HHS policymakers, program officials, and the Congress with recommendations for improving the health care system through audits and evaluations.

The FY 2015 President's Budget for CMS oversight is $325,251,000, which is an increase of +$101,014,000 above the FY 2014 Enacted Level. The OIG estimate includes:

- $285,129,000 in HCFAC Mandatory funding, an increase of +$100,150,000 above the FY 2014 Enacted Level. This includes:
    - $200,333,000 in current law, an increase of +$15,354,000, which includes the FY 2015 projection for the Consumer Price Index-Urban as well as the restoration of funds previously sequestered, and
    - $84,796,000 in proposed law, which is discussed below.
- $28,122,000 in HCFAC Discretionary funding.
- $12,000,000 in HCFAC Collections, which, to a limited extent, reimburse OIG for its costs of conducting investigations, audits, and compliance monitoring. This amount is an estimate and amount available will depend on the amount actually collected.

The FY 2015 request continues the Administration's priority of aggressively addressing fraud, waste, and abuse in Federal health care programs. The request invests additional resources in proposed mandatory HCFAC funding above current levels and continues discretionary appropriations in FY 2015. This approach would provide a dedicated source of funding to perform program integrity activities. Additional details concerning this approach are included in the HCFAC section of the CMS Budget Justification, and OIG's portion is discussed below.

The FY 2015 President's Budget proposes $84,796,000 for OIG's allocation of new mandatory funding, of which $25,000,000 would replace funding that has expired. The FY 2015 request will support the Administration's HEAT initiative, including sustaining and expanding Medicare Fraud Strike Force efforts; leveraging technology and data to continue program integrity efforts to address emerging fraud trends; adapting to a changing and expanding health care system; increasing efforts to address improper payments and other waste; improving patient safety and quality of care; and overseeing the expansion of Medicaid. The funds will ensure that resources are available to sustain and expand Strike Force activities, as well as our efforts in other program integrity areas.

[1] This section includes funding estimates for all OIG CMS oversight activities. All of OIG's CMS oversight funding is mandatory, except for the HCFAC Discretionary Allocation Adjustment.

Strike Forces exemplify the impact of these funding priorities, having proven to be an effective means of identifying fraud and enforcing anti-fraud laws since 2007. The Strike Forces work in nine locations: Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; southern Louisiana[1]; Tampa, FL; Chicago, IL; and Dallas, TX. The joint HHS and DOJ Strike Force teams have charged more than 1,727 defendants, who collectively billed Medicare more than $5.5 billion in claims. In FY 2013 alone, OIG Strike Force efforts resulted in[2]:

- charges filed against more than 274 individuals or entities and
- more than 251 convictions, resulting in expected receivables of over $333 million (HHS and non-HHS).

In addition, the impact of HEAT enforcement and prevention is being seen in CMS billing data. For example, the graph on the following page shows dramatic decreases in Medicare payments for community mental health services (CMHS) between 2008 and 2012. National CMHS payments had peaked in 2008 at over $270 million annually. Targeted enforcement activities—centered in Miami, Baton Rouge, and Houston—also began in 2008, and major enforcement actions occurred in all three cities from 2010 through 2012. In 2012, payment levels fell to $31 million. This may suggest that the CMHS fraud convictions not only eliminated some of the "bad actors" but also deterred "would-be" fraudsters.

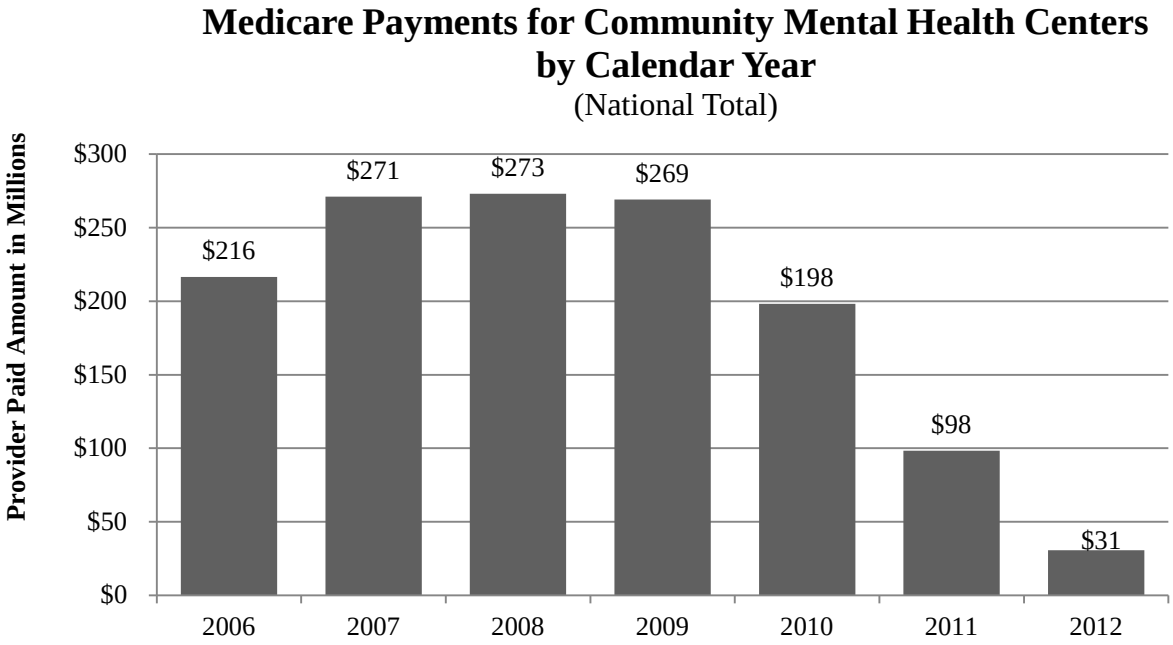
Work Plan Highlights—Medicare and Medicaid Oversight

Examples of OIG's work in progress and planned reviews of CMS programs for FY 2014 follow.

- Assessing financial impacts of hospital policies and practices, including those for outlier payments, and new patient admission criteria.
- Measuring rates of adverse events (incidents of patient harm resulting from care) in nursing facilities and inpatient rehabilitation facilities.
- Medical equipment suppliers' compliance with payment requirements, including those for power mobility devices, lower limb prosthetics, and diabetic supplies.
- CMS oversight and management of contractors.
- State Medicaid claims and adjustments of Federal reimbursement, including monetary drawdowns, reporting of State collections, and application of the enhanced Federal matching rate for enrollees under the Medicaid expansion.
- State Medicaid payments to managed care plans, including plans' medical loss ratio.

[1] While the Strike Force in southern Louisiana started in Baton Rouge, it now operates in New Orleans as well.
[2] The 2013 HEAT accomplishments are reported by OIG; DOJ figures are below. The DOJ statistics may include some cases not worked by OIG and capture different statistical elements.

- 137 indictments involving charges filed against 345 defendants, who collectively had allegedly billed Medicare more than $1.1 billion;
- 234 guilty pleas, 34 jury trials litigated, and guilty verdicts against 48 defendants; and
- 229 defendants sentenced, averaging more than 52 months of incarceration.



Note: The results of this analysis are subject to changes as claims are adjusted or deleted. Medicare timely filing requires providers to submit their claims within 12 months of the date of service. *Medicare Claims Processing Manual*, Chapter 1, section 70.1

This significant success of the Strike Force model is due to the combination of intelligence gathered by agents, proactive data analysis, and availability of attorneys dedicated to prosecuting Medicare fraud. Strike Force teams seek to identify individuals and groups actively involved in Medicare fraud and stop the fraud activity early, preventing possibly significant losses to the affected programs and potential harm to patients. Analysts use near-real-time data to examine Medicare claims to identify potentially fraudulent providers and patterns of suspected fraud. The analysis includes studies of disproportionate payment levels for various services and ratios of services as compared with national averages. These and other assessments enable OIG to identify, and adapt enforcement efforts to, emerging trends as they evolve. For example, since the inception of the Strike Force model in 2007, the use of more sophisticated data analysis has enabled OIG to identify and pursue health care fraud schemes in a variety of sectors, among them: Durable Medical Equipment supplier and infusion clinic services, home health care, community mental health, and other types of fraud. The FY 2015 request would ensure that OIG is poised to respond as new schemes emerge.

As OIG, DOJ, and CMS adjust to a new environment of greatly enhanced data availability, OIG will analyze data for targeted and timely enforcement. This could include placing additional agents in geographical areas with high fraud-risk indicators, complementing enforcement efforts with audits and evaluations, or increasing resources for civil fraud schemes that require long-term investigations. As part of this effort, OIG is using data mining, predictive analytics, and modeling to better identify fraud vulnerabilities and target oversight. The expertise of OIG agents, auditors, analysts, and evaluators, using a combination of technologies and traditional

skills, is highly effective in the fight against fraud, waste, and abuse, as the ROI on page 26 indicates.

In addition to the creation and operation of the Marketplaces, other important changes are taking place across the health care industry. These changes are fueled by innovations in science and IT, the need to address health care spending, the shift from volume-based to value-based payment, advances in quality measurement, and ways to increase access to care. Other shifts include an emphasis on coordinated care and an increased use of electronic health records. OIG will need to adopt oversight approaches that are suited to an increasingly sophisticated health care system and that are tailored to protect programs and patients from existing and new vulnerabilities. While overseeing this transforming health care system, additional issues and possible areas of oversight to be considered for 2015 include:

"As systems transition toward quality- and outcomes-based payment systems, law enforcement will be presented with new challenges. Investigators will need the skills to determine the reliability of data used for measuring quality and performance because false data could skew payments."

–Daniel R. Levinson
Inspector General

- *Leveraging Technology and Data To Continue Program Integrity Efforts and Address Emerging Trends:* Advances in data analysis have changed the way OIG detects and investigates health care fraud and significantly reduced the average time from investigation to indictment. However, health care fraud itself has become more sophisticated as criminals use technology, including electronic health records, to their advantage. Evidence collection is moving increasingly away from paper files to an unprecedented amount of electronic evidence to be seized and analyzed. As such, there is an increasing demand for forensic enhancements to more effectively analyze investigative data.

  Advances in data analysis have the potential to provide OIG, and its law enforcement partners, with more leads to investigate than ever before. Advances in OIG's efforts in this area, along with those of CMS, through its Fraud Prevention System, increase the urgency that OIG have the resources needed to analyze data and to investigate allegations of fraud.

- *Overseeing the Changes in Medicaid*: Growth in the Medicaid program, including growth in Medicaid expansion States, is projected to result in tens of millions of new enrollees. CMS's National Health Statistics Group projects the number of individuals covered by Medicaid to grow approximately 40% by 2022[1]. As enrollment grows, OIG

[1] CMS, Office of the Actuary. National Health Expenditure Projections 2012-2022. Prepared by the National Health Statistics Group. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

has a unique opportunity to promote integrity, accountability, and potential cost savings in Medicaid through reports that recommend recoupment of overpayments, changes to policies to better protect Medicaid resources, and improvements that lead to better quality of care for Medicaid beneficiaries.

"Many of the [Medicaid] expansion States are intending to rely on an expansion of managed care, which provides its own set of challenges to fraud enforcement efforts."

–Daniel R. Levinson
Inspector General

The expansion of the program also poses new challenges related to eligibility and enrollment determinations and ensuring appropriate Federal Medical Assistance Percentages (FMAP) calculations and associated Federal payments. Further, many States opting to expand Medicaid are planning to do so through the use of managed care models.[1] OIG's FY 2015 request supports targeted Medicaid program integrity efforts, and could include expanding ongoing work involving Medicaid managed care, including reviewing effectiveness of current models; access to services; and State oversight.

- *Identifying Questionable Billing and Reducing Improper Payments*: OIG continues to conduct targeted reviews to determine the scope of improper payments and areas of questionable billing for specific service types and recommend actions to improve program safeguards. By reviewing billing data, medical records, and other documentation associated with claims, OIG identifies services that are questionable, undocumented, not medically necessary, or incorrectly coded, as well as duplicate payments and payments for services that were not provided. In doing so, OIG uncovers systemic payment vulnerabilities and makes recommendations to address them.

  Medical record review remains, in many cases, the only way to definitively establish whether an improper payment was made, as well as to render a judgment on the quality of care provided. Such reviews are costly, but significantly increase the impact of OIG findings and recommendations. Increased investment in medical record review could be strategically deployed to address high-risk and high-dollar services provided or paid for by HHS through Medicare, Medicaid, the Indian Health Service, and health centers. Medical record review could also be used to assess quality of care and compare outcomes across different health care delivery and coordination models.

- *Addressing Medicare Part D Vulnerabilities on a National Scale*: OIG saw a significant increase in its Part D investigative caseload in FY 2013. These cases range from beneficiaries to large-scale criminal enterprises engaged in high-dollar drug trafficking. While OIG investigative efforts have increased in this area (including HEAT and Strike Force efforts), Part D enrollment continues to grow. As a result, an increased

[1] *Medicaid Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2012.

caseload, continued use of Strike Force resources, and proactive data analysis of drug diversion are expected in the coming FY and beyond.

"Medically unnecessary services are particularly concerning as beneficiaries may be subjected to tests and treatments that serve no purpose and may even cause harm."

—Daniel R. Levinson
Inspector General

- *Improving Patient Safety and Quality of Care*: The challenge of ensuring that beneficiaries receive high quality health care has many dimensions, including overseeing providers' compliance with quality-of-care standards, ensuring patient safety, and recommending improvements in quality of care. OIG work in this area includes:

    - examining nursing facilities' compliance with selected Federal requirements for quality of care and

    - determining the extent to which Medicaid-enrolled children are prescribed atypical antipsychotic drugs.

  Further, coordination of health care and benefits between programs is increasingly complex. Beneficiaries may move in and out of eligibility for programs such as Medicare, CHIP, and subsidized insurance through Marketplaces, raising concerns about how their care is managed during and through these transitions. Promptly and accurately communicating beneficiaries' eligibility and enrollment status to all relevant programs and coordinating care for patients who are dually eligible for Medicare and Medicaid present additional coordination challenges. OIG work could determine whether care is effectively coordinated and identify approaches that lead to improved quality of care and cost savings.

Performance Table for CMS Oversight

Key Outputs	Most Recent Result (FY 2013)	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Audits:				
Audit reports started	264	132	132	--
Audit reports issued	231	153	153	--
Evaluations:				
Evaluation reports started	63	40	42	+2
Evaluation reports issued	58	42	37	-5
Investigations:				
Complaints received for investigation	3,829	4,080	4,060	-20
Investigative cases started	1,869	1,924	1,989	+65
Investigative cases closed	1,871	1,733	1,788	+55
PL funding (dollars in millions)	$224	$224	$325	+$101

Total Object Class

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$157,871	$188,647	+$30,776
Other than full-time permanent (11.3)	5,165	6,191	+1,026
Other personnel compensation (11.5)	534	631	+97
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	91	109	+18
Subtotal, Personnel	**163,661**	**195,578**	**+31,917**
Civilian benefits (12.1)	56,000	66,919	+10,919
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**219,661**	**262,497**	**+42,836**
Travel and transportation of persons (21.0)	8,124	10,844	+2,720
Transportation of things (22.0)	2,848	3,417	+570
Rental payments to the GSA (23.1)	20,597	20,088	-509
Rental payments to others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	3,332	3,926	+593
Printing and reproduction (24.0)	84	99	+15
Other contractual services:			
Advisory and assistance services (25.1)	434	542	+107
Other services (25.2)	2,975	17,582	+14,607
Purchases of goods and services from Government accounts (25.3)	44,871	52,686	+7,816
Operation and maintenance of facilities (25.4)	4,054	7,967	+3,913
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	2,594	4,190	+1,596
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**54,928**	**82,967**	**+28,039**
Supplies and materials (26.0)	3,681	6,496	+2,814
Equipment (31.0)	8,551	13,342	+4,791
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	24	29	+5
Refunds (44.0)	--	--	--
Subtotal, Nonpay Costs	**102,169**	**141,208**	**+39,039**
Total, Obligations[1]	**$321,829**	**$403,704**	**+$81,875**

[1] Figures in Object Class and Salaries and Expenses tables may not sum to totals due to rounding.

PHHS Oversight Object Class

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$38,979	$40,748	+$1,769
Other than full-time permanent (11.3)	1,212	1,267	+55
Other personnel compensation (11.5)	126	132	+6
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	23	24	+1
Subtotal, Personnel	**40,340**	**42,171**	**+1,831**
Civilian benefits (12.1)	13,868	14,498	+629
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**54,209**	**56,669**	**+2,461**
Travel and transportation of persons (21.0)	1,789	2,152	+363
Transportation of things (22.0)	660	697	+37
Rental payments to GSA (23.1)	174	170	-4
Rental payments to others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	789	816	+28
Printing and reproduction (24.0)	20	21	+1
Other contractual services:			
Advisory and assistance services (25.1)	3	3	--
Other services (25.2)	555	863	+308
Purchases of goods and services from Government accounts (25.3)	9,977	10,626	+650
Operation and maintenance of facilities (25.4)	445	470	+25
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	251	265	+14
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**11,231**	**12,228**	**+997**
Supplies and materials (26.0)	478	505	+27
Equipment (31.0)	1,645	1,737	+92
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	5	5	--
Refunds (44.0)	--	--	--
Subtotal, Nonpay Costs	**16,791**	**18,330**	**+1,539**
Total, Obligations	**$71,000**	**$75,000**	**+$4,000**

Note: The amounts in this table include only direct discretionary appropriations to OIG for PHHS oversight through the annual appropriations process.

CMS Oversight Object Class

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$117,019	$145,501	$+28,482
Other than full-time permanent (11.3)	3,926	4,881	+955
Other personnel compensation (11.5)	366	455	+89
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	68	84	+16
Subtotal, Personnel	**121,378**	**150,922**	**+29,544**
Civilian benefits (12.1)	41,510	51,614	+10,104
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**162,888**	**202,535**	**+39,647**
Travel and transportation of persons (21.0)	5,729	8,011	+2,283
Transportation of things (22.0)	2,144	2,676	+533
Rental payments to GSA (23.1)	20,423	19,918	-505
Rental payments to others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	2,526	3,091	+566
Printing and reproduction (24.0)	64	79	+14
Other contractual services:			
Advisory and assistance services (25.1)	432	539	+107
Other services (25.2)	2,419	16,320	+13,901
Purchases of goods and services from Government accounts (25.3)	15,613	22,291	+6,678
Operation and maintenance of facilities (25.4)	3,574	7,462	+3,888
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	2,342	3,924	+1,582
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**24,380**	**50,536**	**+26,156**
Supplies and materials (26.0)	3,168	5,955	+2,787
Equipment (31.0)	6,836	11,534	+4,698
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	19	23	+4
Refunds (44.0)	--	--	--
Subtotal, Nonpay Costs	**65,288**	**101,824**	**+36,536**
Total, Obligations	**$228,177**	**$304,360**	**+$76,183**

Note: The amounts in this table include the funding available to OIG for Medicare and Medicaid oversight.

Reimbursables Object Class

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$1,084	$1,095	+$11
Other than full-time permanent (11.3)	3	3	--
Other personnel compensation (11.5)	39	39	--
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	--	--	--
Subtotal, Personnel	**1,125**	**1,137**	**+11**
Civilian benefits (12.1)	340	344	+3
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**1,466**	**1,480**	**+15**
Travel and transportation of persons (21.0)	518	518	--
Transportation of things (22.0)	28	28	--
Rental payments to GSA (23.1)	--	--	--
Rental payments to others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	1	1	--
Printing and reproduction (24.0)	--	--	--
Other contractual services:	--	--	--
Advisory and assistance services (25.1)	--	--	--
Other services (25.2)	1	1	--
Purchases of goods and services from Government accounts (25.3)	-- 18,979	-- 18,965	-- -14
Operation and maintenance of facilities (25.4)	--	--	--
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	--	--	--
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**18,981**	**18,967**	**-14**
Supplies and materials (26.0)	3	3	--
Equipment (31.0)	4	4	--
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	--	--	--
Refunds (44.0)	--	--	--
Subtotal, Nonpay Costs	19,534	19,520	-14
Total, Obligations	**$21,000**	**$21,000**	--

Disaster Relief Oversight Object Class

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$790	$1,303	+$513
Other than full-time permanent (11.3)	25	41	+16
Other personnel compensation (11.5)	3	4	+2
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	--	--	--
Subtotal, Personnel	**817**	**1,348**	**+531**
Civilian benefits (12.1)	281	464	+183
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**1,098**	**1,812**	**+714**
Travel and transportation of persons (21.0)	89	163	+75
Transportation of things (22.0)	16	16	--
Rental payments to GSA (23.1)	--	--	--
Rental payments to others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	17	17	--
Printing and reproduction (24.0)	--	--	--
Other contractual services:	--	--	--
Advisory and assistance services (25.1)	--	--	--
Other services (25.2)	--	398	+398
Purchases of goods and services from Government accounts (25.3)	-- 302	-- 804	-- +502
Operation and maintenance of facilities (25.4)	34	35	+1
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	--	--	--
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**336**	**1,237**	**+901**
Supplies and materials (26.0)	32	33	+1
Equipment (31.0)	65	66	+1
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	--	--	--
Refunds (44.0)	--	--	--
Subtotal, Nonpay Costs	555	1,533	+978
Total, Obligations	**$1,653**	**$3,345**	**+$1,692**

Note: The amounts in this table include the funding available to OIG through the Disaster Relief Appropriations Act of 2013.

Total Salary and Expenses

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$157,871	$188,647	+$30,776
Other than full-time permanent (11.3)	5,165	6,191	+1,026
Other personnel compensation (11.5)	534	631	+97
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	91	109	+18
Subtotal, Personnel	**163,661**	**195,578**	**+31,917**
Civilian benefits (12.1)	56,000	66,919	+10,919
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**219,661**	**262,497**	**+42,836**
Travel and transportation of persons (21.0)	8,124	10,844	+2,720
Transportation of things (22.0)	2,848	3,417	+570
Communication, utilities, and misc. charges (23.3)	3,332	3,926	+593
Printing and reproduction (24.0)	84	99	+15
Other contractual services:			
Advisory and assistance services (25.1)	434	542	+107
Other services (25.2)	2,975	17,582	+14,609
Purchases of goods and services from Government accounts (25.3)	44,871	52,686	+7,816
Operation and maintenance of facilities (25.4)	4,054	7,967	+3,913
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	2,594	4,190	+1,596
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**54,928**	**82,967**	**+28,039**
Supplies and materials (26.0)	3,681	6,496	+2,814
Subtotal, Nonpay Costs	**72,997**	**107,749**	**+34,752**
Total Salary and Expenses	**292,658**	**370,246**	**+77,588**
Rental payments to GSA	20,579	20,088	-509
Rental payments to others	--	--	--
Grand Total, Salary and Expenses and Rent	**$313,255**	**$390,334**	**+$77,079**
FTE	**1577**	**1861**	**+284**

PHHS Oversight Salary and Expenses

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$38,979	$40,748	+$1,769
Other than full-time permanent (11.3)	1,212	1,267	+55
Other personnel compensation (11.5)	126	132	+6
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	23	24	+1
Subtotal, Personnel	**40,340**	**42,171**	**+1,831**
Civilian benefits (12.1)	13,868	14,498	+629
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**54,209**	**56,669**	**+2,461**
Travel and transportation of persons (21.0)	1,789	2,152	+363
Transportation of things (22.0)	660	697	+37
Communication, utilities, and misc. charges (23.3)	789	816	+28
Printing and reproduction (24.0)	20	21	+1
Other contractual services:			
Advisory and assistance services (25.1)	3	3	--
Other services (25.2)	555	863	+308
Purchases of goods and services from Government accounts (25.3)	9,977	10,626	+650
Operation and maintenance of facilities (25.4)	445	470	+25
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	251	265	+14
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**11,231**	**12,228**	**+997**
Supplies and materials (26.0)	478	505	+27
Subtotal, Nonpay Costs	14,967	16,418	+1,451
Total Salary and Expenses	**69,175**	**73,087**	**+3,912**
Rental payments to GSA	174	170	-4
Rental payments to others	--	--	--
Grand Total, Salary and Expenses and Rent	**$69,350**	**$73,257**	**+$3,908**
FTE	371	384	+13

Note: The amounts in this table include only direct Discretionary appropriations to OIG for PHHS oversight through the annual appropriations process.

CMS Oversight Salary and Expenses

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$117,019	$145,501	+$28,482
Other than full-time permanent (11.3)	3,926	4,881	+955
Other personnel compensation (11.5)	366	455	+89
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	68	84	+16
Subtotal, Personnel	**121,378**	**150,922**	**+29,544**
Civilian benefits (12.1)	41,510	51,614	10,104
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**162,888**	**202,535**	**+39,647**
Travel and transportation of persons (21.0)	5,729	8,011	+2,283
Transportation of things (22.0)	2,144	2,676	+533
Communication, utilities, and misc. charges (23.3)	2,526	3,091	+566
Printing and reproduction (24.0)	64	79	+14
Other contractual services:			
Advisory and assistance services (25.1)	432	539	+107
Other services (25.2)	2,419	16,320	+13,901
Purchases of goods and services from Government accounts (25.3)	15,613	22,291	+6,678
Operation and maintenance of facilities (25.4)	3,574	7,462	+3,888
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	2,342	3,924	+1,582
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**24,380**	**50,536**	**+26,156**
Supplies and materials (26.0)	3,168	5,955	+2,787
Subtotal, Nonpay Costs	**38,011**	**70,349**	**+32,338**
Total Salary and Expenses	**200,899**	**272,884**	**+71,985**
Rental payments to GSA	20,423	19,918	-505
Rental payments to others	--	--	--
Grand Total, Salary and Expenses and Rent	**$221,322**	**$292,802**	**+$71,480**
FTE	**1,188**	**1,454**	**+266**

Note: The amounts in this table include the funding available to OIG for Medicare and Medicaid oversight

Reimbursable Salary and Expenses

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$1,084	$1,095	+$11
Other than full-time permanent (11.3)	3	3	--
Other personnel compensation (11.5)	39	39	--
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	--	--	--
Subtotal, Personnel	**1,125**	**1,137**	**+11**
Civilian benefits (12.1)	340	344	+3
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**1,466**	**1,480**	**+15**
Travel and transportation of persons (21.0)	518	518	--
Transportation of things (22.0)	28	28	--
Communication, utilities, and misc. charges (23.3)	1	1	--
Printing and reproduction (24.0)	--	--	--
Other contractual services:			
Advisory and assistance services (25.1)	--	--	--
Other services (25.2)	1	1	--
Purchases of goods and services from Government accounts (25.3)	18,979	18,965	-14
Operation and maintenance of facilities (25.4)	--	--	--
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	--	--	--
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**18,981**	**18,967**	**-14**
Supplies and materials (26.0)	3	3	--
Subtotal, Nonpay Costs	**19,530**	**19,516**	**-14**
Total Salary and Expenses	**20,995**	**20,996**	**+1**
Rental payments to GSA	--	--	--
Rental payments to others	--	--	--
Grand Total, Salary and Expenses and Rent	**$20,995**	**$20,996**	**+$1**
Reimbursable FTE	**10**	**10**	**--**

Note: The amounts in this table do not include HCFAC funding. HCFAC funding is displayed in the CMS oversight tables.

Disaster Relief Oversight Salary and Expenses

(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Pres. Bud.	FY 2015 +/- FY 2014
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$790	$1,303	+$513
Other than full-time permanent (11.3)	25	41	+16
Other personnel compensation (11.5)	3	4	+2
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	--	1	--
Subtotal, Personnel	**817**	**1,348**	**+531**
Civilian benefits (12.1)	281	464	+183
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**1,098**	**1,812**	**+714**
Travel and transportation of persons (21.0)	89	163	+75
Transportation of things (22.0)	16	16	--
Communication, utilities, and misc. charges (23.3)	17	17	--
Printing and reproduction (24.0)	--	--	--
Other contractual services:			
Advisory and assistance services (25.1)	--	--	--
Other services (25.2)	--	398	+398
Purchases of goods and services from Government accounts (25.3)	302	804	+502
Operation and maintenance of facilities (25.4)	34	35	+1
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	--	--	--
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**336**	**1,237**	**+901**
Supplies and materials (26.0)	32	33	+1
Subtotal, Nonpay Costs	**490**	**1,466**	**+977**
Total Salary and Expenses	**1,588**	**3,278**	**+1,690**
Rental payments to GSA	--	--	--
Rental payments to others	--	--	--
Grand Total, Salary and Expenses and Rent	**$1,588**	**$3,278**	**+$1,690**
Reimbursable FTE	**8**	**13**	**+5**

Note: The amounts in this table include the funding available to OIG through the Disaster Relief Appropriations Act of 2013.

Detail of FTE

	2013 Actual Civilian	2013 Actual Military	2013 Actual Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total
PHHS Oversight FTE:									
Discretionary:									
Direct	245	--	245	371	--	371	384	--	384
Reimbursable	21	--	21	10	--	10	10	--	10
Disaster Relief Appropriations Act of 2013:									
Direct	--	--	--	8	--	8	13	--	13
PHHS Oversight Subtotal	**266**	**--**	**266**	**389**	**--**	**389**	**407**	**--**	**407**
CMS Oversight FTE:									
HCFAC mandatory / collections									
Reimbursable	1,163	--	1,163	1,046	--	1,046	1,329	--	1,329
HCFAC discretionary:									
Reimbursable	231	--	231	142	--	142	125	--	125
CMS Oversight Subtotal	**1,394**	**--**	**1,394**	**1,188**	**--**	**1,188**	**1,454**	**--**	**1,454**
Total, OIG FTE	**1,660**	**--**	**1,660**	**1,577**	**--**	**1,577**	**1,861**	**--**	**1,861**

Detail of Positions

	2013 Actual	2014 Estimate	2015 Pres. Bud.
Executive Schedule (ES) Positions:			
Executive level X	1	1	1
ES-00	14	14	17
Subtotal, ES Positions	**15**	**15**	**18**
Senior Leader (SL) Positions:			
SL	1	1	1
General Schedule (GS) Positions:			
GS-15	107	104	120
GS-14	215	210	244
GS-13	635	620	613
GS-12	498	486	474
GS-11	83	81	181
GS-10	--	--	--
GS-9	48	47	171
GS-8	4	4	5
GS-7	8	8	70
GS-6	2	2	2
GS-5	1	1	1
Subtotal, GS Positions	**1,601**	**1,563**	**1,881**
Total, OIG Positions	**1,617**	**1,579**	**1,900**
Average GS Grade[1]	12.7	12.7	12.2
Average GS Salary	$102,144	$103,051	$103,570

Average GS Grade [1]

2011	12.1
2012	12.5
2013	12.7
2014	12.7
2015	12.2

[1] The average GS grade reflects a mathematical average of the number of positions at each grade level in the agency.

Physicians' Comparability Allowance Worksheet

(Dollars in Thousands)

	FY 2013 Actual	FY 2014 Estimate	FY 2015 Estimate
Physicians receiving PCAs	1	1	1
Physicians with 1-year PCA agreements	--	--	--
Average annual PCA physician pay (without PCA payment)	$140	$146	$150
Average annual PCA payment	$24	$27	$27
Physicians receiving PCA, category IV-B Health and Medical Administration	1	1	1

Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

OIG sets its annual PCA amount consistent with HHS policy. In 2013, $24,000 was provided to the physician in Category IV-B.

Explain the recruitment and retention problem for each category of physician in your agency.

The position in question is the OIG Chief Medical Officer (CMO), and the incumbent serves as OIG's internal medical consultant to all OIG offices on a wide array of OIG activities. The CMO is in a unique role in that the incumbent provides technical expertise on a variety of medical and clinical issues relating to investigations, litigation, and compliance involving potential fraud, quality-of-care violations, and other significant health-care-related issues. As this position is critical to the success of many OIG efforts, the PCA helps to ensure that the CMO position is competitive to qualified candidates and that, once selected, quality individuals are retained.

Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior FY.

See above response for detail. The position was not vacant in the prior FY, which is attributable, in part, to the PCA.

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Significant Item

The Joint Explanatory Statement accompanying the Consolidated Appropriations Act, 2014 (P.L. 113-76), included one Significant Item to report on in the FY 2015 budget request.

Item: *Enhanced Enforcement Tools.* The agreement requests the OIG develop specific recommendations on methods, tools, and approaches to enhance its oversight and enforcement efforts, particularly for issues related to contract or grant fraud. The OIG should contemplate how authorities similar to the civil money penalties used for Medicare program integrity activities might be beneficial or modified for other programs. If legislative action is required, the OIG is expected to submit technical assistance along with supporting information to the appropriate House and Senate Committees with the fiscal year 2015 budget request.

Response: OIG is constantly evaluating the enforcement and oversight tools needed for achieving its mission. This evaluation includes reviewing methods, tools, and approaches that are available and focused on current and existing areas of oversight, as well as those that are not used or even available because of resources or limitations in OIG authorities. Regarding the latter, below are two enforcement tools that have been successful in Medicare and Medicaid and could be applied to HHS grant programs and contracts:

- CMPs: CMPs have provided a strong and successful administrative remedy for fraud. Under existing authority, OIG can pursue CMPs against persons who engage in fraud against Federal health care programs but not those who defraud other HHS programs. Over the past 5 years, OIG has recovered over $92 million in 386 Medicare and Medicaid CMP cases. With new authority, OIG could pursue enforcement actions in grant/contract fraud cases in matters declined for prosecution by DOJ. This would require new authority for OIG, and OIG will provide technical assistance directly to the appropriate House and Senate Committees on this matter.

- Self-Disclosure Program for Contract and Grant Fraud: OIG's self-disclosure protocol for Medicare and Medicaid fraud has resulted in more than $280 million in recoveries. Medicare and Medicaid providers who wish to voluntarily disclose self-discovered evidence of potential fraud to OIG may do so under the Provider Self-Disclosure Protocol. Self-disclosure gives providers the opportunity to avoid the costs and disruptions associated with a Government-directed investigation and civil or administrative litigation. Contractors are required to self-disclose fraud, and OIG is planning to increase outreach and education to contractors to encourage and increase self-disclosures. If enacted into law, the grant and contract CMPs (discussed above) would provide OIG a new mechanism to resolve such self-disclosures in a timely and appropriate manner. With the CMP authority, OIG would further enhance outreach to contractors and initiate a grant fraud protocol to promote self-disclosures by grantees and recoveries in those cases.

In addition, OIG is also evaluating a law enforcement tool that is not currently available in any of its oversight areas, but has the potential to enhance its health care and grant and contract fraud enforcement efforts. Specifically, OIG is interested in pursuing legislative authorities necessary to participate in Federal asset seizures and forfeitures. The use of this authority ensures that criminals do not escape with assets that represent proceeds of, or were used to facilitate, Federal crimes affecting HHS programs. OIG is conferring with DOJ concerning the parameters of that authority and, consistent with the Committee's request, will provide technical assistance and supporting information to the House and Senate Committees on this authority.

Requirements of the Inspector General Act

Section 6 of the Inspector General Act (IG Act) was amended in 2008 by the Inspector General Reform Act (P.L. No. 110-409). Revised section 6 now reads:

> "(f)(1) For each fiscal year, an Inspector General shall transmit a budget estimate and request to the head of the establishment or designated Federal entity to which the Inspector General reports. The budget request shall specify the aggregate amount of funds requested for such fiscal year for the operations of that Inspector General and shall specify the amount requested for all training needs, including a certification from the Inspector General that the amount requested satisfies all training requirements for the Inspector General's office for that fiscal year, and any resources necessary to support the Council of the Inspectors General for Integrity and Efficiency. Resources necessary to support the Council of the Inspectors General on Integrity and Efficiency shall be specifically identified and justified in the budget request.
>
> "(2) In transmitting a proposed budget to the President for approval, the head of each establishment or designated Federal entity shall include –
>
> (A) an aggregate request for the Inspector General;
> (B) amounts for Inspector General training;
> (C) amounts for support of the Council of the Inspectors General on Integrity and Efficiency; and
> (D) any comments of the affected Inspector General with respect to the proposal.
>
> "(3) The President shall include in each budget of the United States Government submitted to Congress –
>
> (A) a separate budget statement of the budget estimate prepared in accordance with paragraph (1);
> (B) the amount requested by the President for each Inspector General;
> (C) the amount requested by the President for training of Inspectors General;
> (D) the amount requested by the President in support for the Council of the Inspectors General on Integrity and Efficiency; and
> (E) any comments of the affected Inspector General with respect to the proposal if the Inspector General concludes that the budget submitted by the President would substantially inhibit the Inspector General from performing the duties of the office."

HHS OIG meets the above requirement by providing the following information:

- OIG's aggregate budget estimate and request to HHS at the beginning of the FY 2015 process was $420 million.
- OIG's aggregate budget request to Congress for FY 2015 is $400 million.
- Funding requested for training is approximately $10 million.
- A total of $423,000 will be necessary to support the Council of the Inspectors General on Integrity and Efficiency (CIGIE).
- The IG comments on this budget request are contained within this document.

HHS OIG Training Requirements

In accordance with section 6(f)(3)(C) of the IG Act, this budget requests approximately $10 million in FY 2015 for training expenses, of which a portion will be funded from the discretionary budget. This amount is composed of OIG's baseline training budget for its entire staff, which, with the FY 2015 request, includes approximately 1,900 criminal investigators, auditors, program evaluators, attorneys, and administrative and management staff.

HHS OIG Financial Support for CIGIE

In support of the Governmentwide IG community, OIG contributes funds for the operation of CIGIE. In accordance with the reporting requirements of section 6(f)(3)(D) of the IG Act, this budget requests $423,000 in necessary expenses for OIG's support of CIGIE, of which a portion will be funded from the OIG's discretionary budget.

FY 2015 HHS Enterprise Information Technology and Governmentwide E-Gov Initiatives

OIG will use $17,592 of its FY 2015 budget to support Departmentwide enterprise information technology and Government-wide E-Government initiatives. STAFFDIVs help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process and the Governmentwide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board on the basis of funding availability and business case benefits. Development is collaborative and achieves HHS enterprisewide goals that produce common technology, promote common standards, and enable data and system interoperability. OIG's contributions are as follows:

FY 2015 E-Gov Initiatives[1]	**FY 2015**
Human Resources Management	$3,188
E-Rulemaking	11,337
Integrated Acquisition Environment	3,067
FY 2015 E-Gov Initiatives Total	**$17,592**

[1] Specific levels presented here are subject to change as redistributions to meet changes in resource demands are assessed.

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