DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2017

Office of Inspector General

Justification of Estimates for Appropriations Committees

Mission, Vision, and Values

The Department of Health and Human Services (HHS) touches the lives of all Americans through programs that provide health insurance, promote public health, protect the safety of food and drugs, and fund medical research, among other activities.

Mission

The Office of Inspector General's (OIG) mission is to protect the integrity of HHS programs and the health and welfare of the people they serve. As established by the Inspector General Act of 1978, OIG is an independent and objective organization that fights fraud, waste, and abuse and promotes efficiency, economy, and effectiveness in HHS programs and operations. We work to ensure that Federal dollars are used appropriately and that HHS programs well serve the people who use them.

Vision

Our vision is to drive positive change in HHS programs and in the lives of the people served by these programs. We pursue this vision through independent oversight of HHS programs and operations and by providing HHS and Congress with objective and reliable information for use in policymaking. We assess the Department's performance, administrative operations, and financial stewardship. We evaluate risks to HHS programs and the people they serve and recommend improvements. The law enforcement component of OIG investigates fraud and abuse against HHS programs and holds wrongdoers accountable for their actions.

Values

OIG strives to be relevant, impactful, customer focused, and innovative. We apply these values to our work in order to persuade others to take action by changing rules, policies, and behaviors to improve HHS programs and operations. OIG strives to serve as a model for good government. Of key importance is engagement with our stakeholders—Congress, HHS, health and human services professionals, and consumers—to understand their needs, challenges, and interests in order to identify areas for closer scrutiny and offer recommendations for improvement. We do this throughout the year, but most visibly through the development of our *Work Plan* and HHS's *Top Management and Performance Challenges*. The goals, priorities, and strategies in these documents reflect our ongoing stakeholder engagement and our assessment of the input we receive.

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 2017 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 over a hundred HHS programs, as well as the health and welfare of the beneficiaries whom they serve.

The FY 2017 budget requests a total of $419 million to oversee the administration of HHS, including $85 million to support oversight of HHS's Public Health and Human Services (PHHS) programs and Health Insurance Marketplaces, and $334 million to support oversight of the Medicare and Medicaid programs while continuing the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative.

This is a time of growth and change for HHS programs. OIG's 2017 budget request will further its examination of core risk areas and top management challenges facing HHS. Priority areas of oversight will include overseeing the Health Insurance Marketplaces; protecting HHS grants and contract funds from fraud, waste, and abuse; ensuring the privacy and security of information; oversight of HHS's international programs and emergency preparedness; addressing prescription drug diversion and other such issues at a national scale; overseeing changes in Medicaid; ensuring patient safety and quality of care; overseeing reforms in how health care is delivered and payment accuracy; and the meaningful and secure exchange and use of electronic health information. In addition, OIG will continue to promote greater compliance with Federal health care laws in the health care industry by providing guidance to health care providers and pursuing administrative enforcement actions against those who commit fraud.

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

I am confident that the funding requested is crucial to improving programs that protect the health and welfare of all Americans.

Daniel R. Levinson

Daniel R. Levinson
Inspector General

http://oig.hhs.gov/

The FY 2017 Justification of Estimates for Appropriations Committees

U.S. Department of Health and Human Services
Office of Inspector General

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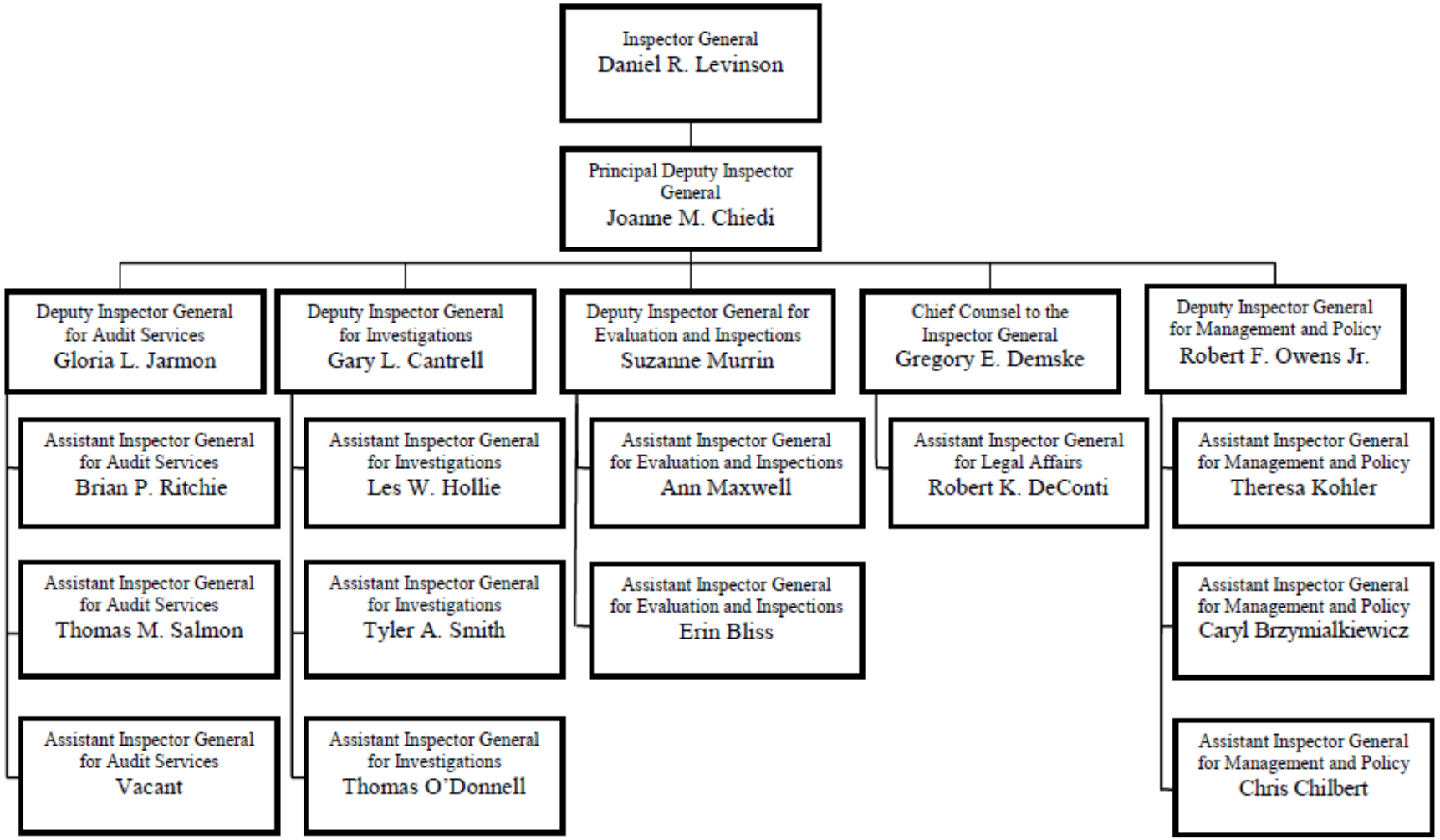
Department of Health and Human Services
Office of Inspector General
Organizational Chart



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Overview of Budget Request

The fiscal year (FY) 2017 request for Office of Inspector General (OIG) is $419 million, +$77 million above the FY 2016 Enacted Level. Program increases include:

- Public Health and Human Services (PHHS) Oversight[1] ($85 million, +$8.5 million above FY Enacted Level 2016): The FY 2017 request is $85 million, +$8.5 million above the FY 2016 Enacted Level. The request includes $1.5 million for oversight of Food and Drug Administration (FDA) programs and operations, consistent with the Consolidated Appropriations Act, 2016, and continues support for oversight of the Health Insurance Marketplaces and other ACA Title I programs.

  The Department of Health and Human Services (HHS or the Department) PHHS programs represent approximately $100 billion in spending and include international operations. The request will strengthen oversight of the Department's PHHS programs by leveraging data and specialized expertise to target and maximize the impact of OIG's oversight activities. OIG advances its mission through a robust program of investigations, audits, evaluations, enforcement actions, and compliance efforts. Specific programmatic focus areas include grants and contracts oversight, oversight of the Health Insurance Marketplaces, international and emergency preparedness issues, food and drug safety, and the efficient and secure use of data and technology.

- Medicare and Medicaid Oversight ($334 million, +$68 million above FY 2016 Enacted Level): The FY 2017 request is $334 million, +$68 million above the FY 2016 Enacted Level. This includes $200 million in Health Care Fraud and Abuse Control Program (HCFAC) Mandatory funds, $121 million in HCFAC Discretionary funds, and an estimated $12 million in HCFAC Collections. This increase reflects increases in the HCFAC discretionary cap adjustment level in the Budget Control Act, as well as the projection of increases based on the Consumer Price Index-Urban. The request assumes sequestration does not occur.

  OIG's oversight work in FY 2017 will target fraud and wasteful spending, including improper payments, unsafe or poor quality health care and security of data and technology. OIG is a leader in the fight against Medicare and Medicaid fraud and we will continue to use sophisticated data analytics and state-of-the-art investigative techniques to detect and investigate fraud; including the rising level of prescription drug fraud and associated patient harm. Oversight of specific programmatic areas include: Medicare payment reforms included in the Medicare Access and Children's Health Insurance Program Reauthorization Act, which begins in 2017; Medicare and Medicaid provider screening and enrollment; a continued focus on Medicaid expansion, including beneficiary enrollment, managed care, and the sufficiency of data used for oversight; promoting industry compliance; contracting and contractor oversight; Medicare Advantage payment accuracy; adverse events; home health agency compliance and payments; and new payment and delivery models in Medicare and Medicaid.

[1] PHHS oversight includes oversight of programs authorized in Title I of the Affordable Care Act (ACA) and administered by the Centers for Medicare & Medicaid Services (CMS).

Overview of Performance

OIG's Strategic Plan outlines the vision and priorities that guide OIG 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 that drive OIG's work:

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

OIG ensures an efficient and effective use of its resources through integrated planning, monitoring, and reporting processes. Together these processes are used to set organizational priorities that best further our strategic goals, measure and analyze the impact of our work, and 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 OIG's various funding sources, authorizing statutes and mandates, stakeholder input, and risk assessments of HHS programs. OIG plans work on an ongoing basis and publishes a *Work Plan*. 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*. Throughout the year, OIG responds to emerging issues and adjusts its work priorities. For example, our Medicare Fraud Strike Force Teams use real-time data and national law enforcement intelligence to quickly identify fraud and shift investigative resources to prevent financial losses and protect vulnerable program beneficiaries from harm.

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

Significant Accomplishments

As described in OIG's Fall 2015 *Semiannual Report to Congress*, OIG reported expected recoveries of approximately $3.3 billion for FY 2015. This includes $2.2 billion in investigative receivables (which includes $286.6 million in non-HHS investigative receivables resulting from OIG's work in areas such as States' share of Medicaid restitution) and $1.1 billion in audit receivables.

Additionally, in FY 2015, OIG excluded 4,112 individuals and organizations from participation in Federal health care programs, which protects these programs from potential fraudulent billing and protects beneficiaries from being harmed or rendered substandard care. In its 2015 *Semiannual Report to Congress*, OIG reported 925 criminal actions against individuals or organizations that engaged in crimes against HHS programs and 682 civil and administrative enforcement actions, including False Claims Act and unjust enrichment suits filed in Federal district court, Civil Monetary Penalty (CMP) law settlements, and administrative recoveries related to provider self-disclosure matters. OIG work also prevents fraud and abuse through industry outreach and guidance and recommendations to HHS to remedy program vulnerabilities.

For a more complete discussion of OIG's outcome and output measures and recent performance results, refer to the sections of this document describing OIG's PHHS (beginning on page 27) and Medicare and Medicaid (beginning on page 37) oversight work.

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All-Purpose Table[1]

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
PHHS Oversight: [2]				
Discretionary Budget Authority (BA)[3]……	$72,500	+$76,500	$85,000	+$8,500
Subtotal, PHHS Oversight BA……...	**72,500**	**76,500**	**85,000**	**+8,500**
Medicare and Medicaid Oversight:				
HCFAC Mandatory BA……	186,066	187,617	200,273	+12,656
HCFAC Discretionary BA……	67,200	67,200	121,824	+54,624
Subtotal, Medicare and Medicaid Oversight BA[4]……...	**253,266**	**254,817**	**322,097**	**+67,280**
HCFAC Estimated Collections[5]……	9,230	11,184	12,000	+816
Subtotal, Medicare and Medicaid Oversight Program Level (PL)……...	**262,496**	**266,001**	**334,097**	**+68,096**
Total BA……...	**325,766**	**331,317**	**407,097**	**+75,780**
Total PL……...	**$334,996**	**$342,501**	**$419,097**	**+$76,596**
Full-Time Equivalent (FTE) employees……	**1,524**	**1,616**	**1,830**	**+214**

[1] Table excludes non-HCFAC reimbursable funding. In FY 2015, OIG obligated $16 million in non-HCFAC reimbursable funding. The estimate for FYs 2016−2017 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 $66,000 for this effort in FY 2015.

[2] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by the Center for Consumer Information and Insurance Oversight (CCIIO), a component of CMS.

[3] In FYs 2015−2016, OIG's Discretionary BA includes $1.5 million, transferred from the FDA.

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

[5] In FY 2015, OIG collected $9.9 million under authority of 42 U.S.C. 1320a-7c (section 1128C of the Social Security Act), and the actual amount sequestered is $0.7 million. The table includes estimates for HCFAC collections for FYs 2016 and 2017, and the amounts available will depend on the amounts actually 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, [$75,000,000**]** *in addition to funds otherwise available for such purposes other than for Medicare and Medicaid oversight, $85,000,000*: *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.

Language Analysis

Language Provision	Explanation
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, [$75,000,000**]** *in addition to funds otherwise available for such purposes other than for Medicare and Medicaid oversight, $85,000,000*	Provides funding for the Office of Inspector General to carry out oversight of HHS programs and activities. Clarifies that these funds can continue to be used for activities including oversight of the ACA, but not for Medicare and Medicaid oversight activities, which are funded through HCFAC. Language is only necessary if proposed changes in HCFAC discretionary appropriation is adopted. Please see CMS justification for details on proposed changes to HCFAC.

Amounts Available for Obligation[1]

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.
Discretionary			
General Fund Discretionary Appropriation:			
Appropriation (Labor/HHS)	$71,000	$75,000	$85,000
Rescission/Increase (Labor/HHS)	--	--	--
Subtotal, Appropriation (Labor/HHS)	**71,000**	**75,000**	**85,000**
Amount sequestered	--	--	--
Total, Discretionary Appropriation	**71,000**	**75,000**	**85,000**
Transfers			
Transfer of funds from FDA	1,500	1,500	--
Amount sequestered	--	--	--
Total, Disaster Relief Appropriations Act	**1,500**	**1,500**	**--**
Offsetting collections from:			
Trust Fund HCFAC Discretionary	67,200	67,200	121,824
Rescission/Increase (Labor/HHS)	--	--	--
Subtotal, HCFAC Discretionary	**67,200**	**67,200**	**121,824**
Amount sequestered	--	--	--
Total, Discretionary Offsetting Collections	**67,200**	**67,200**	**121,824**
Offsetting collections from:			
Trust Fund HCFAC Mandatory	200,718	201,305	200,273
Amount sequestered	-14,652	-13,689	--
Trust Fund HCFAC Mandatory Additional Amounts	--	--	--
HCFAC Mandatory Recoveries	2,430	--	--
Estimated HCFAC Collections[2]	9,957	12,000	12,000
Amount sequestered[3]	-727	-816	--
Amounts previously sequestered, but available	835	727	816
Total, Mandatory Offsetting Collections	**198,561**	**199,527**	**213,089**
Total Discretionary and Mandatory			
Unobligated balance, lapsing	1,314	--	--
Unobligated balance, start of year	21,768	31,547	33,190
Unobligated balance, end of year	31,547	33,190	49,365
Total, Obligations	**$327,168**	**$341,584**	**$403,738**

[1] Table excludes non-HCFAC reimbursable funding. In FY 2015, OIG obligated $16 million in non-HCFAC reimbursable funding. The estimate for both FYs 2016 and 2017 is $21 million.

[2] The table includes an estimate of $12 million for FY 2016 and FY 2017.

[3] The table includes an estimate of $12 million for FY 2016 and FY 2017.

Summary of Changes
(Dollars in Thousands)

2016	
Total, BA	$76,500
Obligations	76,500
2017	
Total, Estimated BA	85,000
Estimated Obligations	85,000
Net Change in BA	+$8,500

	FY 2017 Estimate FTE	FY 2017 Estimate BA	Change From Base FTE	Change From Base BA
Increases:				
A. Built in:				
1. Provide for salary of FTE	400	$64,539	+42	+$7,028
a. Pay to support additional FTE (non-add)	42	$6,257	*+42*	*+6,527*
b. Increase due to one-percent pay raise (non-add)	--	$771	--	*+771*
2. Increased costs related to General Services Administration (GSA) rent	--	4,114	--	-224
Subtotal, Built-in Increases	400	**$68,653**	**+42**	**+$6,804**
B. Program:				
1. Costs related to general operating expenses	--	$16,347	--	+1,696
Subtotal, Program Increases	**--**	**$16,347**	**--**	**+1,696**
Total, Increases	**+400**	**$85,000**	**+42**	**+$8,500**

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 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.
PHHS Oversight			
Discretionary BA[1]	$72,500	$76,500	$85,000
Subtotal, PHHS Oversight BA	**72,500**	**76,500**	**85,000**
[Subtotal, PHHS Oversight PL]	**[72,500]**	**[76,500]**	**[85,000]**
Medicare and Medicaid Oversight			
HCFAC Mandatory BA	186,066	187,617	200,273
HCFAC Discretionary BA	67,200	67,200	121,824
Subtotal, Medicare and Medicaid Oversight BA[2]	**253,266**	**254,817**	**322,097**
[HCFAC Collections[3]]	[9,230]	[11,184]	[12,000]
[Subtotal, Medicare and Medicaid Oversight PL]	**[262,496]**	**[266,001]**	**[334,097]**
Total, BA	**325,766**	**331,317**	**407,097**
[Total PL]	**[$334,996]**	**[$342,501]**	**[$419,097]**
FTE	1,524	1,616	1,830

Note: Table excludes non-HCFAC reimbursable funding. In FY 2015, OIG obligated $16 million in non-HCFAC reimbursable funding. The estimate for FYs 2016−2017 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 $66,000 for this effort in FY 2015.

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

[1] In FYs 2015−2016, OIG's Discretionary BA includes $1.5 million, transferred from the FDA.

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

[3] In FY 2015, OIG collected $9.9 million under authority of 42 U.S.C. 1320a-7c (section 1128C of the Social Security Act), and the actual amount sequestered is $0.7 million. The table includes estimates for HCFAC collections for FYs 2016 and 2017, and the amounts available will depend on the amounts actually collected.

Authorizing Legislation

(Dollars in Thousands)

	FY 2016 Amount Authorized	FY 2016 Actual	FY 2017 Amount Authorized	FY 2017 Pres. Bud.
OIG:				
Inspector General Act of 1978 (P.L. No. 95-452, as amended)	Indefinite	$76,500	Indefinite	$85,000
Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. No.104-191, as amended), HCFAC Mandatory	$201,305	$187,617	$200,273	$200,273
HIPAA, as amended, HCFAC Discretionary	Indefinite	$67,200	Indefinite	$121,824
HIPAA, as amended, HCFAC Collections	Indefinite	$11,184[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 2016 and 2017, and the amounts available will depend on the amounts actually collected.

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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
FY 2011				
Discretionary Direct	51,754,000	--	54,754,000	50,278,000
Rescission	--	--	--	-100,000
HCFAC Discretionary Allocation Adjustment	94,830,000	--	94,830,000	29,730,000
Rescission	--	--	--	-59,000
HCFAC Mandatory	177,205,000	--	--	197,998,000

[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." A "Never Event" is a particularly shocking medical error (such as wrong-site surgery) that should never occur. Over time, the list has expanded to include adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable.

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

[4] The 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 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 Adjustment	97,556,000	--	97,556,000	29,730,000
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 Adjustment	102,500,000	--	102,500,000	29,855,000
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 Adjustment	29,790,000	--	107,541,000	28,122,000
HCFAC Mandatory	278,030,000	--	--	199,331,000
Sequestration	--	--	--	-14,351,831
FY 2015				
Discretionary Direct[2]	75,000,000	--	72,500,000	72,500,000
HCFAC Discretionary Allocation Adjustment	28,122,000	--	112,918,000	67,200,000
HCFAC Mandatory	285,129,000	--	--	200,718,000
Sequestration	--	--	--	-13,652,449
FY 2016				
Discretionary Direct[3]	83,000,000	75,000,000	72,500,000	76,500,000
HCFAC Discretionary Allocation Adjustment	118,631,000	67,200,000	77,275,000	67,200,000
HCFAC Mandatory	203,262,000	--	--	201,305,000
Sequestration	--	--	--	-13,689,000

[1] The HCFAC Mandatory amount for FY 2013 does not include $7.1 million that was allocated to OIG by HHS.
[2] The Discretionary Direct amount for FY 2015 includes $1.5 million transferred from FDA, consistent with the Consolidated and Further Continuing Appropriations Act, 2015.
[3] The Discretionary Direct amount for FY 2016 includes $1.5 million transferred from FDA, consistent with the Consolidated Appropriations Act, 2016.

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2017				
Discretionary Direct	85,000,000	--	--	--
HCFAC Discretionary Allocation Adjustment	121,824,000	--	--	--
HCFAC Mandatory	$200,273,000	--	--	--
Sequestration	--	--	--	--

OIG Summary of Request

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Public Health and Human Services (PHHS) Oversight[1]	$72,500	$76,500	$85,000	+$8,500
Medicare/Medicaid Oversight[2]	$262,496	$266,001	$334,097	+$68,096
Total	**$334,996**	**$342,501**	**$419,097**	**+$76,596**
FTE	1,524	1,616	1,830	+214

Authorizing Legislation ..... Inspector General Act of 1978, as amended
FY 2017 Authorization ..... Indefinite
Allocation Method .....Direct Federal

Program Description

For over 35 years, OIG has safeguarded HHS expenditures and beneficiary well-being and has promoted the economy, efficiency, and effectiveness of HHS programs. Legislative and budgetary requirements shape OIG activities. These activities are carried out in accordance with professional standards established by the Government Accountability Office (GAO), Department of Justice (DOJ), and the Inspector General (IG) community. At all levels, OIG staff work closely with HHS and its operating divisions (OPDIVs) and staff divisions (STAFFDIVs); DOJ, other IG offices, and other Federal agencies in the executive branch; Congress; and States to bring about systemic improvements, successful prosecutions, negotiated settlements, and recovery of funds to protect the integrity of HHS programs and expenditures and the well-being of beneficiaries.

OIG's areas of oversight fall into two broad categories: (1) PHHS, which includes oversight of the Health Insurance Marketplaces and other programs created by Title I of the ACA, and (2) Medicare and Medicaid. In a given year, the amount of work conducted in each category is set by the purpose limitations in OIG's appropriations.

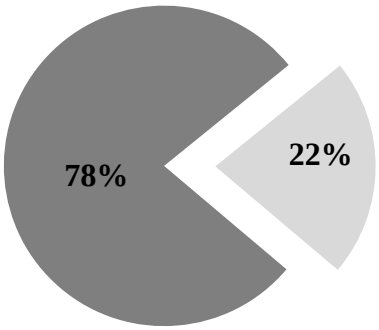
In FY 2015, 22 percent of OIG's efforts were directed toward HHS's PHHS programs and management processes, including food and drug safety, disaster relief, child support enforcement, the integrity of departmental contracts and grants programs and transactions, and oversight of the ACA-established Health Insurance Marketplaces, and 78 percent of OIG's funding was directed toward oversight of the Medicare and Medicaid programs.

[1] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by CMS.
[2] The request for Medicare and Medicaid 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 and Medicaid Oversight includes:

- Medicare Parts A, B, and C
- Prescription Drugs (Part D)
- Medicaid
- Children's Health Insurance Program (CHIP)



PHHS Oversight includes:

- Health Insurance Marketplaces
- Public Health, Science, and Regulatory Agencies (CDC, NIH, FDA)
- Human Services Agencies (ACF, HRSA)

OIG accomplishes its mission through the complementary efforts of five components. The specialties and technical skills of OIG's multidisciplinary professionals enable OIG to implement a multifaceted approach to program integrity. OIG assesses HHS programs at a systemic level to promote economy, efficiency, and effectiveness, while also identifying and addressing specific instances of suspected fraud, waste, and abuse.

In FY 2015, OIG's total funding supported 1,524 FTE, who were assigned across the five components as follows:

- Office of Audit Services (OAS): OAS provides auditing services for HHS, either by conducting audits with its own resources or by overseeing audit work performed by others. Audits examine the performance of HHS programs and 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. FY 2015 FTE and Key Outputs are below.

	PHHS	Medicare/Medicaid	Total
FTE[1]	201	435	636
Reports Started	61	183	244
Reports Issued	63	177	240

- 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

[1] Includes 16 FTE supported with funding from the Disaster Relief Appropriations Act, 2013 and non-HCFAC reimbursable funding.

investigations often lead to criminal convictions, civil recoveries, CMPs, exclusions from participation in Federal health care programs, and administrative sanctions. FY 2015 FTE and Key Outputs are below:

	PHHS	Medicare/Medicaid	Total
FTE	84	481	565
Complaints Received	472	3,044	3,516
Cases Opened	327	1,650	1,977
Cases Closed	350	1,719	2,069

- Office of Evaluation and Inspections (OEI): OEI conducts national evaluations to provide HHS, Congress, and the public with useful and reliable information on significant issues. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in departmental programs. OEI reports also present practical recommendations for improving program operations. FY 2015 FTE and Key Outputs are below.

	PHHS	Medicare/Medicaid	Total
FTE[1]	36	89	125
Evaluations Started	12	41	53
Evaluations Issued	12	48	60

- 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 special bulletins, develops provider education resources, promotes compliance, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities. FY 2015 FTE are below.

	PHHS	Medicare/Medicaid	Total
FTE	7	71	78

[1] Includes 4 FTE supported with funding from the Disaster Relief Appropriations Act, 2013 and non-HCFAC reimbursable funding

- 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 other components; setting vision and direction, in collaboration with the components, for OIG's priorities and strategic planning; employing data analytics and data management; ensuring effective management of budget, finance, information technology (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. FY 2015 FTE are below.

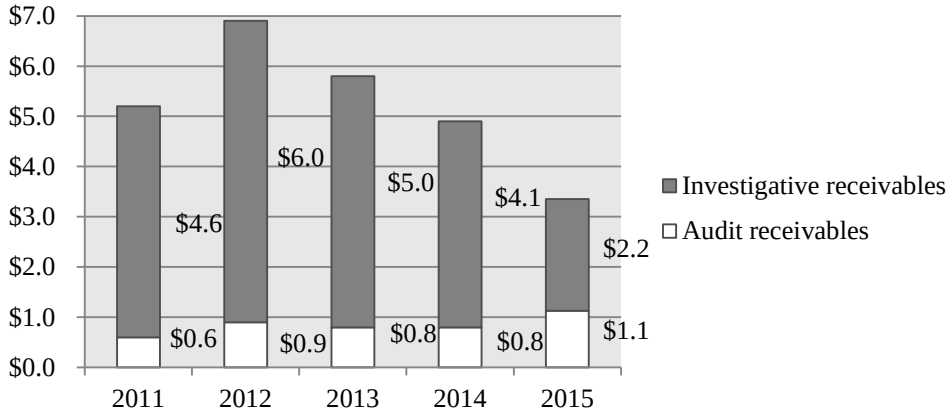
	PHHS	Medicare/Medicaid	Total
FTE	27	93	120

Significant Results

- Expected Recoveries[1]: Toward the goal of fighting fraud, waste, and abuse in FY 2015, OIG reported expected recoveries of approximately $3.35 billion. Expected recoveries are the amount the Government expects to recover or receive as a result of OIG's oversight efforts. This includes $2.22 billion in investigative receivables (which includes approximately $286.6 million in non-HHS investigative receivables resulting from OIG's work, such as States' shares of Medicaid restitution) and $1.13 billion in audit receivables.

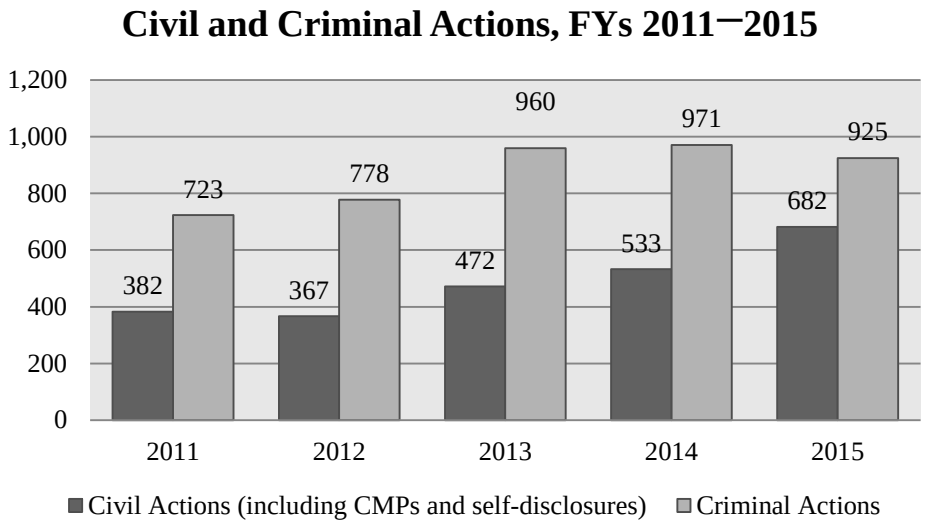
  Over the last 5 years, OIG's expected recoveries have averaged $5.2 billion annually. Changes in the amount of expected recoveries from year to year are due to the particular mix of cases resolved in a given year, as well as continued efforts to work with OPDIVs to implement OIG recommendations.

OIG Expected Recoveries, FYs 2011−2015
(Dollars in Billions)



[1] These amounts are typically post-adjudicated amounts and CMPs resulting from investigations and, in the case of audits, recommended disallowances and audit recoveries that HHS management has agreed to and taken action on. Additional details are available in OIG's *Semiannual Report to Congress*.

- Criminal and Civil Actions: Working in concert with our law enforcement partners to fight fraud, waste, and abuse in FY 2015, OIG undertook 925 criminal actions against individuals or entities that engaged in crimes against HHS programs, and 682 civil actions, which include False Claims Act and unjust-enrichment lawsuits filed in Federal district court, CMP settlements, and administrative recoveries related to provider self-disclosure matters.



- Program Exclusions: OIG's authority to exclude individuals advances our goal of securing bad actors from participating in Federal health care programs. In FY 2015, OIG reported exclusions of 4,112 individuals and entities from participation in Federal health care programs.

- Corporate Integrity Agreements (CIAs): OIG believes that prevention is crucial to meeting our goal of fighting fraud, waste, and abuse and CIAs are one tool used to promote quality, safety, and value, and help ensure program beneficiaries maintain access to needed services. OIG often negotiates compliance obligations with persons (e.g., corporations, individuals) as part of the settlement of allegations arising under civil and administrative false claims and fraud statutes. A person consents to these obligations as part of the civil settlement and in exchange for OIG's agreement not to seek exclusion from participation in Federal health care programs. CIAs typically last for 5 years. OIG monitors persons' compliance with CIAs and holds accountable those who violate them. CIAs include penalties for failure to meet certain terms, and OIG may seek exclusion for breaches.

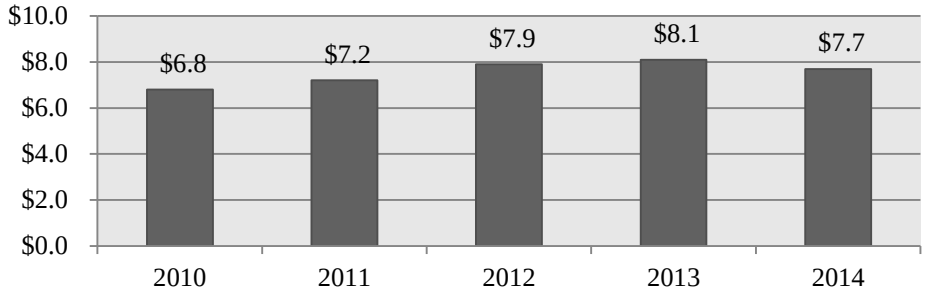
- Advisory Opinions and Other Guidance: As part of continuing efforts to promote the highest level of health care industry ethics and lawful conduct towards our goal of securing the future, OIG issues advisory opinions (which are required by statute) and other guidance to educate industry and other stakeholders on how to avoid fraud and abuse. This enables OIG to help industry navigate the anti-kickback statute, safe harbor regulations, and other OIG

health care fraud and abuse authorities. During FY 2015, OIG received 76 advisory opinion requests and issued 15 advisory opinions.[1] Since the inception of the HCFAC program, OIG has issued over 329 advisory opinions.

- Other Guidance: To advance our goal of fighting fraud, waste, and abuse, OIG also issues special fraud alerts, compliance guidance, advisory bulletins, and other guidance. These documents, directed at various segments of the health care industry, provide tools to encourage compliance and identify practices that may implicate various fraud and abuse laws. Recently, OIG issued a fraud alert regarding physician compensation arrangements. We also issued an alert to tribes and tribal organizations to exercise caution in using Indian Self-Determination and Education Assistance Act funds.

- HCFAC Program Return on Investment (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 most recent ROI for the HCFAC program is approximately $7.7 to $1, the third highest in the history of the program.[2] This is a ratio of actual monetary returns to the Government to total HCFAC program appropriations. From the HCFAC program's inception in 1997, program activities have returned more than $27.8 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.

HCFAC Program Return on Investment
FYs 2010–2014



[1] OIG closes many advisory opinion requests without issuing opinions, frequently because the requests are withdrawn.
[2] HCFAC ROI is based on a 3-year rolling average.

- Recommendations Implemented: In FY 2015, over 410 OIG recommendations, stemming from more than 135 audit and 65 evaluation reports, were implemented to improve the efficiency and effectiveness of HHS programs and operations.

Budget Request

The FY 2017 budget request for OIG includes $419 million to strengthen oversight of HHS programs. With these resources, OIG is charged with overseeing nearly $1 trillion dollars in HHS spending, which represents approximately a quarter of every Federal dollar spent, covering programs ranging from health insurance to clinical research and epidemiology, public health services, and education. This is a complex set of programs that continue to grow.

Consistent with its funding, OIG's spending falls into two broad categories: (1) PHHS, including ACA Title I programs; and (2) Medicare and Medicaid oversight. For each of these areas, this budget request includes:

- PHHS Oversight: $85 million to strengthen oversight of PHHS programs and key priority areas. Such funding will enable OIG to support an additional 42 FTE to reduce waste, fight fraud, promote effectiveness, and protect beneficiaries across PHHS programs. The exact mix of staff will be assessed in the budget year. Staff will be increased where the Inspector General determines they will have maximum impact. Specific programmatic focus areas include grants and contracts oversight, oversight of the Health Insurance Marketplaces, international and emergency preparedness issues, food and drug safety, and the efficient and secure use of data and technology. Additional information is available on page 27.

- Medicare and Medicaid Oversight: $334 million in HCFAC funding ($200 million Mandatory, $122 million Discretionary, and an estimated $12 million Collections) to support and strengthen OIG's efforts to protect Medicare and Medicaid from fraud, waste, and abuse. This request will enable OIG to support an additional 172 FTE to reduce waste, fight fraud, promote effectiveness, and protect beneficiaries across the Medicare and Medicaid programs. The exact mix of staff will be assessed in the budget year. OIG will enhance law enforcement efforts, including the Medicare Strike Force teams and affirmative litigation of civil monetary penalty cases, which will increase recoveries and deter future fraud. OIG will also strengthen its emphasis on targeting improper payments, questionable billing, wasteful payment policies, patient safety and quality of care, and security of data and technology. Oversight of specific programmatic areas include: Medicare payment reforms included in the Medicare Access and Children's Health Insurance Program Reauthorization Act, which begins in 2017; Medicare and Medicaid provider screening and enrollment; a continued focus on Medicaid expansion, including beneficiary enrollment, managed care, and the sufficiency of data used for oversight; prescription drug fraud and abuse; promoting industry compliance; contracting and contractor oversight; Medicare Advantage payment accuracy; adverse events; home health agency compliance and payments; and new payment and delivery models in Medicare and Medicaid. Additional information is available on page 37.

OIG-Wide Performance Table

Key Outcomes[1]	Most Recent Result (FY 2015)	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
Expected recoveries resulting from OIG involvement in health care fraud and abuse oversight activities (dollars in millions)	$3,800 (Target Within Range)	$3,500	$3,500	+$-
ROI resulting from OIG involvement in health care fraud and abuse oversight activities	$15:$1 (Target Met)	$14:$1	$14:$1	+$-
Number of quality and management improvement recommendations accepted	174 (Target Met)	150	150	--
PL funding (dollars in millions)	$335	$343	$419	+$76
Key Outputs	**Most Recent Result (FY 2015)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 +/- FY 2016**
Audits:				
Audit reports started	244 (Target Not Met[2])	250	255	+5
Audit reports issued	240 (Target Not Met[2])	247	252	+5
Audit reports issued within 1 year of start (percentage)	44% (Target Not Met[2])	45%	46%	+1%
Evaluations:				
Evaluation reports started	53 (Target Not Met[3])	40	42	+2
Evaluation reports issued	60 (Target Not Met[3])	50	52	+2
Evaluation reports issued within 1 year of start (percentage)	56% (Target Met)	56%	56%	--
Investigations:				
Complaints received for investigation	3,516 (Within Target Range[4])	3,596	3,669	+73
Investigative cases opened	1,977 (Target Not Met[4])	2,023	2,063	+40
Investigative cases closed	2,069 (Target Met)	2,117	2,160	+43
PL funding (dollars in millions)[5]	$335	$343	$419	+$76

[1] The "expected recoveries" and ROI performance measures are calculated using 3-year rolling averages.
[2] Performance was within 10% of projected target.
[3] Performance was within 10% of projected target.
[4] Performance was within 10% of projected target.
[5] Figures in OIG-Wide Performance Table may not sum to totals because of rounding.

Performance Goals

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:

- Three-year moving average of expected recoveries from OIG's HHS oversight activities that resulted in investigative receivables and audit disallowances,
- Three-year moving average of the expected ROI from OIG's HHS oversight activities that resulted in investigative receivables and audit disallowances, and
- 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, improve the efficiency and economy of programs, or increase protections for the health and welfare of beneficiaries. While OIG is not authorized to implement its recommendations, it informs Congress and HHS program officials of potential cost disallowances and corrective actions that OIG recommends to address identified vulnerabilities.

As shown in the table on the previous page, several outputs contribute to OIG's success and performance impact. 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, as some actions are multiyear matters. 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.

In FY 2017, OIG will incorporate additional data analytics to increase insights and capabilities for assessing performance outcomes. OIG will use these metrics to conduct performance reviews and data analysis around key performance indicators to increase our effectiveness in HHS program oversight and contributions to mission results.

A breakdown of OIG's output measures by PHHS and Medicare and Medicaid oversight can be found on pages 35 and 52, respectively.

http://oig.hhs.gov/

Subsection: Public Health, Human Services (PHHS), and Department-Wide Issues Oversight

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Direct BA	$72,500	$76,500	$85,000	+$8,500
FTE[1]	355	367	409	+42

Program Description

OIG uses funding from its annual Discretionary Direct appropriation to conduct program integrity and enforcement activities for PHHS programs and operations, including oversight of the Health Insurance Marketplaces and related programs created by Title I of the ACA. These programs represent approximately $100 billion in spending each year, and are carried out by approximately 70,000 HHS employees spread across the globe.

During FY 2015, OIG's oversight effort for PHHS was allocated across HHS OPDIVs and STAFFDIVs as follows:

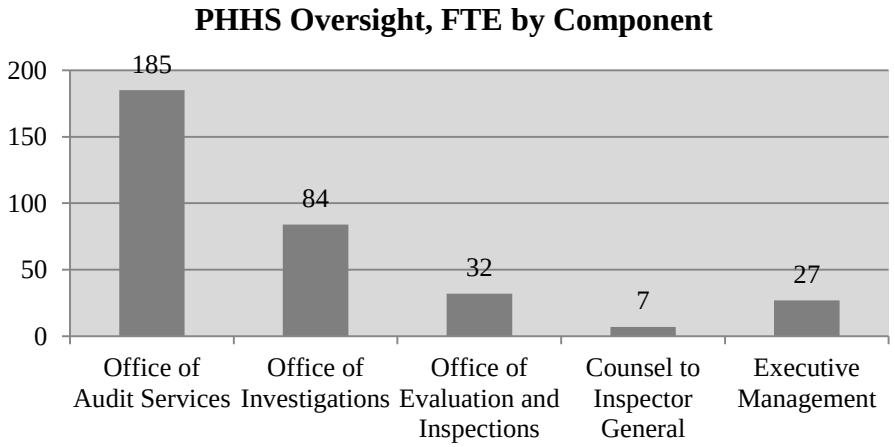
HHS OPDIV and STAFFDIV Oversight	Percentage
ACA – Marketplaces/Title I Programs	33%
Administration for Children and Families (ACF)	17%
Administration for Community Living (ACL)	<1%
Agency for Health Care Research and Quality (AHRQ)	<1%
Centers for Disease Control and Prevention (CDC)	4%
Food and Drug Administration (FDA)	3%
Health Resources and Services Administration (HRSA	7%
Indian Health Service (IHS)	3%
National Institutes of Health (NIH)	7%
Substance Abuse and Mental Health Services Administration (SAMHSA)	1%
Office of the Secretary (OS)[2]	10%
Other PHHS Programs[3]	14%
Total	100%

In addition to audits, investigations, and evaluations of the PHHS OPDIVs and STAFFDIVs listed above, OIG uses its direct appropriation to comply with the requirements in appropriations language and other directives established in law. These include the following.

[1] Includes 20 FTE supported with funding from the Disaster Relief Appropriations Act, 2013 and non-HCFAC reimbursable funding.
[2] OS includes oversight efforts related to OS STAFFDIVs, such as the Assistant Secretary for Preparedness and Response, as well as protective services for the Secretary, and the Chief Financial Officer Audit.
[3] Examples of these efforts include grant and contract oversight that crosses multiple OPDIVs.

- OIG conducts or oversees reviews under the Federal Information Security Modernization Act (P.L. No. 113-283) and the Single Audit Act (P.L. No. 98-502).
- Investigations of interstate nonpayment of child support obligations in collaboration with the Office of Child Support Enforcement in ACF. In FY 2015, these efforts contributed to over 55 criminal actions and approximately $2.73 million in restitution, fines, penalties, settlements, and recoveries.
- Protective services for the HHS Secretary.
- Requests from Members of Congress to conduct specific reviews.

In FY 2015, OIG's FTE supported with its direct discretionary appropriation were assigned across OIG's five components as follows:



For additional performance information and key outputs, please see page 35.

Accomplishments

In FY 2015, more than 130 OIG recommendations were implemented to positively impact public health and human services programs and program beneficiaries.

Since the release of OIG's March 2015 *Compendium of Unimplemented Recommendations*, changes following top OIG recommendations now affect many PHHS program functions. Examples include the Assistant Secretary for Financial Resources' (ASFR) facilitation of Department-wide information sharing about methods to identify use of grant funds for prohibited lobbying activities and State efforts to ensure that child day-care homes obtain criminal history and child protection reports for every adult frequenting the premises.

Noteworthy examples of OIG's recent PHHS oversight accomplishments include:

- Overseeing the Health Insurance Marketplaces: OIG's oversight of the Marketplaces focuses on payments, eligibility, management and administration, and information security.

By focusing on these key areas, OIG helps to ensure that taxpayer dollars are spent for their intended purposes in a system that operates efficiently, effectively, and securely.

Recent OIG reports address vulnerabilities in the eligibility verification procedures for Marketplaces. Our work found that not all internal controls at reviewed Marketplaces were effective during the first open enrollment. CMS and State Marketplaces that were included in the review concurred with OIG's recommendations to strengthen internal controls that ensure the eligibility of consumers. Other OIG work has found that CMS's internal controls did not effectively ensure the accuracy of nearly $2.8 billion in advance premium tax credits and cost-sharing reductions payments made to qualified health plans offered through the Marketplaces. CMS generally concurred with OIG's recommendations to improve its internal controls. OIG is conducting follow-up work examining CMS's resolution of inconsistencies in consumer application information. In addition, our work found that when awarding the Federal Marketplace contracts, CMS did not always meet contracting requirements. HHS and CMS agreed with OIG's recommendations to improve planning for future contracts and have reported using OIG's report as an opportunity to make needed changes. For example, CMS has appointed a task force to strategically manage Federal Marketplace acquisitions, is enforcing a stricter governance structure for contracts, and is training a stronger acquisition workforce.

Other related OIG work examined the security of the Multidimensional Insurance Data Analytics System (MIDAS), a central repository for insurance-related data that provides reporting and performance metrics to the Department for various initiatives mandated by the ACA. We sought to determine whether CMS had implemented security controls to secure personally identifiable information related to MIDAS and supporting databases. Although we found that CMS—which is responsible for providing guidance and oversight for the MIDAS—needed improvement in its information security controls, our work and the resulting recommendations prompted swift CMS action. We shared with CMS information about our "vulnerability scan" findings immediately following the scan and informed CMS about other preliminary findings in advance of issuing our draft report. CMS began fixing these issues before OIG completed our fieldwork. In written comments, CMS concurred with all of our recommendations and reported that it remediated all vulnerabilities and addressed all OIG's findings before we issued our final report. We then reviewed the supporting documentation and verified CMS's remediation.

In addition, OIG has reviewed the status of Consumer Operated and Oriented Plans (CO-OPs), to determine whether enrollment and profitability met the projections on their initial loan applications. OIG found that most of the CO-OPs reviewed had not met their initial program enrollment and profitability projections as of the end of the period covered by the review (December 31, 2014), and had exceeded their 2014 calendar year projected losses as reported in the loan award application feasibility studies. Based on these findings, OIG issued four recommendations to CMS in order to improve financial oversight and solvency of the CO-OPs, including continuing to place underperforming CO-OPs on enhanced oversight or corrective action plans, working closely with State insurance regulators to identify and correct underperforming CO-OPs, providing guidance or establishing criteria to determine

when a CO-OP is no longer viable or sustainable, and pursuing available remedies for recovery of funds from terminated CO-OPs.

- The Indian Country Grant Fraud Initiative: The Indian Country Grant Fraud Initiative has resulted in 52 Federal criminal indictments; 46 convictions; court-ordered restitutions exceeding $6 million; penalties/fines of $135,625; 17 suspension and/or debarment actions; and 18 HHS OIG Exclusion actions. The project involves the review of various HHS grant programs—primarily the Low Income Home Energy Assistance program (LIHEAP), Temporary Assistance for Needy Families program, and Head Start program—overseen by HHS OPDIVs such as ACF, IHS, and HRSA.

  The initiative includes Project Guardian, an anticorruption strike force created by the U.S. Attorney's Office in Montana, which is a collaborative effort between a number of agencies including several OIGs, the Internal Revenue Service, and the Federal Bureau of Investigation. The project has exposed a number of fraudulent schemes, including theft and embezzlement; bribery of tribal officials and grantees; provision of false information on applications by recipients; unauthorized or inflated salaries (paid to staff, family, and friends); wages paid even though work was not performed or completed; and use of grant funds for personal travel. Based on the success of Project Guardian in Montana, the initiative has been duplicated in South Dakota. The project is in the initial stages and will continue to focus on grant fraud in Indian Country.

  OIG has also issued an alert to tribes and tribal organizations to exercise caution in issuing Indian Self-Determination and Education Assistance funds. Our work in this area helps preserve limited resources and ensures that they are available to serve vulnerable and needy populations.

- Investigating Head Start and American Recovery and Reinvestment Act (ARRA) Grant Fraud: Linda Harvey-Irvin was sentenced to 7 years and 1 month in jail and ordered to pay $531,236 in joint and several restitution after pleading guilty to theft or bribery concerning programs receiving Federal funding. Harvey-Irvin was the deputy director of the non-profit organization Mississippi Gulf Coast Community Action Agency (GCCAA), a Head Start and ARRA grantee. According to the investigation, Harvey-Irvin embezzled funds belonging to GCCAA by entering into contracts on behalf of GCCAA with Markuntala Croom, the owner of Croom Management Services, for consulting work. Croom, who was paid $750 per day for every day she was under contract with GCCAA, would in turn pay a portion of the proceeds received from GCCAA to Harvey-Irvin. Much of the work purportedly conducted by Croom was, in fact, fictitious or not actually performed. Croom received more than $500,000 for the purported consulting work, and she paid Harvey-Irvin close to $70,000 as a reward for hiring her. In addition to her arrangement with Croom, Harvey-Irvin also rigged the bidding process for construction work paid for by GCCAA to ensure that Donald Walton, owner of Walton Construction, would be awarded virtually all the contracts he bid on. Walton Construction received over $130,000 from GCCAA, and Walton in turn paid Harvey-Irvin approximately $31,000 as a reward for winning the bids. Both Croom and Walton pleaded guilty to theft or bribery concerning programs receiving Federal funding and were

sentenced to 4 years and 9 months and 3 years and 1 month in jail, respectively.

- Ensuring Quality Health Care for Children: OIG found that nearly a third of children in foster care supported by ACF grants who were enrolled in Medicaid in four States did not receive at least one health screening as required by their respective States' plans for health services oversight and coordination. Missing screenings may prevent the identification and treatment of children's mental health, physical health, and developmental issues. ACF concurred with OIG's recommendation to identify and disseminate State strategies to ensure that all children in foster care receive required health screenings. We also found, in a five-State evaluation, that medical reviewers identified quality-of-care concerns in the medical records of 67 percent of claims for second-generation antipsychotics (SGAs) prescribed to children in Medicaid. The most common quality-of-care concern was lack of monitoring to assess side effects, identified in 53 percent of claims.

- Strengthened Accountability Over the President's Emergency Plan for AIDS Relief (PEPFAR): As a result of our audits of PEPFAR, CDC indicates that it has implemented a range of corrective actions and program improvements, among them a comprehensive review of cooperative agreements, updated standard operating procedures, project officer refresher training, quality control checks, development of annual monitoring plans for each grantee, detailed documentation of site visits, and rigorous progress-report oversight. PEPFAR allocates billions of dollars annually to foreign countries for combating HIV/AIDS, tuberculosis, and malaria. CDC awards funds to governments of these countries and other recipients to achieve the objectives of the program. To date, OIG has conducted 18 audits in 5 nations on 2 continents, Asia and Africa. OIG's PEPFAR oversight has helped CDC and other HHS staff as well as contractors and grant recipients learn important grant and program integrity lessons that apply in ongoing and future responses to emerging infectious diseases like the Ebola virus.

- Oversight and Response to Emergent Issues (Ebola, Unaccompanied Children): OIG oversight over the Department's response to emergent issues can take many forms, but it requires redeploying resources to ensure OIG can appropriately monitor and report on the Department's activities. Notably, to oversee U.S. government resources used in support of the international Ebola response and related preparedness programs and activities, we worked in close collaboration with the Offices of Inspector General for U.S. Agency for International Development, Department of Defense, and Department of State to establish a strategic plan, begin oversight work, and provide updates to stakeholders.

  Additionally, OIG has dedicated time and resources to the important humanitarian and programmatic issue of unaccompanied minor children migrating into the U.S. Our law enforcement officers have monitored, tracked, and in appropriate instances investigated allegations of sexual misconduct by contract staff in Office of Refugee Resettlement (ORR) contracted facilities, extortion scams of ORR sponsor families, and the potential for grant fraud associated with the program. OIG has also provided in-service training to auditors, evaluators, attorneys and criminal investigators responding to this matter. OIG coordinates

with both ACF/ORR and other stakeholders to ensure this multi-dimensional issue is fully addressed on all fronts.

- Improved Food Safety: The Food Safety Modernization Act improves, in a manner consistent with OIG recommendations, FDA's inspections program, such as increasing the overall number of food facility inspections and improving FDA's access to certain records during the inspection process. The legislation requires FDA to increase the number and types of facilities FDA inspects each year, which will improve food safety. The legislation also gives FDA access to records during an inspection, which will ensure the facility is in compliance with regulations. FDA also continues to implement provisions related to tracking and tracing of foods. It has completed the mandated pilots related to tracing food through the supply chain.

Funding History

The funding history in the table below includes the budget authority 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. In FY 2015 and FY 2016, $1.5 million was included in the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies appropriations bill for oversight of FDA.

Fiscal Year	PHHS Oversight
2013	$47,465,000
2014	71,000,000
2015	72,500,000
2016	76,500,000
2017	85,000,000

Budget Request

OIG's FY 2017 request includes $85 million, which will enable OIG to support 42 additional FTE to strengthen PHHS oversight through additional recommendations, findings, and law enforcement actions. This investment will help root out fraud, waste, and abuse and increase the ability of HHS programs to be the Department's first line of defense against fraud, waste, and abuse. Further, these funds will provide the flexibility needed to oversee new and emerging issues, such as HHS's international and domestic response to public health concerns, ensuring the safety and security of select (toxic) agents that could pose threats to public health, and new cyber security threats facing the Department.

In FY 2017, the requested +$8.5 million will be invested in the following areas. Together, these investments will strengthen the integrity of PHHS programs:

- Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse: In FY 2015, HHS awarded approximately $410 billion in grants and over $21 billion in contracts.

Responsible stewardship of these program dollars is vital, and operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and protect resources is a top management challenge for HHS.

OIG will hire additional auditors, evaluators, investigators, and attorneys to expand its expertise and increase its oversight of grants and contracts through audits, evaluations, and enforcement and administrative actions, such as suspensions and debarments of HHS grantees and contractors. OIG will also increase the capacity of its Consolidated Data Analysis Center (CDAC) to conduct data analysis on HHS's major grant and contracting programs to identify potential fraud patterns and target oversight efforts where they will have the most impact.

Additional resources will also build on the success of the Indian Country Grant Fraud Initiative, which has resulted in 52 Federal criminal indictments; 46 convictions; court-ordered restitutions exceeding $6 million; penalties and fines of $135,625; 17 suspension and/or debarment actions; and 18 HHS OIG Exclusion actions. Lessons learned from this initiative will be applied to vulnerabilities in other HHS programs.

- International Programs and Emergency Preparedness: HHS leads medical and public health responses to naturally occurring and human-made disasters that threaten Americans' health, safety, and well-being. Protecting public health requires international cooperation on a host of issues, including combating global outbreaks of disease and illness. OIG needs to acquire staff and to build an infrastructure to support the unique expertise required to conduct high-impact international work. It is important to build on related work done on the PEPFAR program and in coordination with the Offices of Inspector General for U.S. Agency for International Development, Department of Defense, and Department of State to fulfill responsibilities regarding the Overseas Contingency Operation related to Ebola.

  With the requested funding, OIG will expand its oversight of HHS's preparedness for and response to disasters and emergencies, including the ability to exchange health information in such situations as well as communicate and coordinate with partners at the Federal, State, and local levels. Additionally, the request will ensure that program participants and beneficiaries have access to appropriate, effective public health and emergency services. OIG will also increase oversight of OPDIVs and STAFFDIVs to ensure that they have the capacity and the ability to administer grants and contracts effectively and promptly during an emergency.

- Ensuring Privacy and Security of Information: The Department must ensure that the data it creates and maintains are protected. Equally important is the need to ensure appropriate protection of health information when considering and implementing policies related to the adoption of health information technology (IT) and the exchange, storage, and use of electronic health information. The frequency of notable data breaches has increased significantly and data breaches can have serious consequences for the health care industry, the Department, and those the Department serves. OIG is working to increase its oversight and investigative response to threats ranging from computer hacking groups intent on compromising systems and releasing sensitive data, to criminals stealing data to commit

fraud, to those who would misuse access to HHS systems. OIG conducts general security control audits of information and technology supporting HHS programs and also conducts network and Web application penetration testing to assess HHS's and its OPDIVs'network security to determine whether these networks and applications are susceptible to being hacked.

Additional funds will support OIG investments in state-of-the-art tools, technology, expertise, and strategies to ensure that HHS systems and data are secure and accurate and that security breaches or threats are appropriately detected, reported, and addressed. New investments will also support OIG's conducting criminal investigations concerning cyber-security allegations and incidents, primarily involving violations of the Computer Fraud and Abuse Act, which affect Department programs and operations. OIG work will continue to focus on privacy and security in order to support the Department's efforts to minimize the risk of unauthorized access to its sensitive information. OIG work will also focus on such issues in the regulated community and related agencies to address concerns about security risks for health information.

Performance Information for PHHS Oversight

Key Outputs	FY 2015 Final	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
Audits:				
Audit reports started	61	63	64	+1
Audit reports issued	63	66	67	+1
Evaluations:				
Evaluation reports started	12	10	11	+1
Evaluation reports issued	12	12	13	+1
Investigations:				
Complaints received for investigation	472	491	499	+8
Investigative cases opened	327	340	345	+5
Investigative cases closed	350	364	370	+6
PL funding (Dollars in Millions)	$72.5	$76.5	$85.0	+$8.5

FY 2015 PHHS Major Outputs by OIG Component
Audits, Evaluations, Cases, and Monetary Impact by OPDIV

Office of Audit Services
(Dollars in Thousands)

Category	Audit Started	Audit Issued	Audit Recommendations Cost Questioned Concur	Audit Recommendations Cost Questioned Non Concur
ACA - Marketplaces	8	6	-	-
ACF	11	10	$15,105	$4,189
ACL	-	-	652	-
AHRQ	-	-	-	-
CDC	5	7	15,785	77
FDA	1	1	-	-
HRSA	3	6	470	-
IHS	2	2	-	-
NIH	5	3	957	-
SAMHSA	1	1	1	-
OS	7	10	356	-
Other	18	17	16,305	3,267

Total	**61**	**63**	**$49,632**	**$7,533**

Office of Evaluation and Inspections

Category	Evaluation Started	Evaluations Issued	Evaluation Recommendations	Evaluation Recommendations Concur
ACA - Marketplaces	-	2	6	6
ACF	4	1	2	2
ACL	1	-	-	-
AHRQ	-	-	-	-
CDC	1	-	-	-
FDA	2	1	3	3
HRSA	1	1	-	-
IHS	-	1	-	-
NIH	1	1	2	2
SAMHSA	-	1	-	-
OS	1	1	3	3
Other	1	3	13	13
Total	**12**	**12**	**29**	**29**

Office of Investigations

(Dollars in Thousands)

Category	Cases Opened	Cases Closed	Criminal Actions	Civil Actions	Complaints Received for Investigation	Monetary Results
ACA - Marketplaces	6	4	-	-	11	-
ACF	206	231	80	3	244	$36,953
ACL	1	3	-	-	4	-
AHRQ	-	-	-	-	-	-
CDC	6	8	-	-	10	-
FDA	19	13	2	-	29	901
HRSA	5	7	2	-	10	31
IHS	20	28	24	-	42	1,279
NIH	-	-	-	-	-	-
SAMHSA	-	-	-	-	-	-
OS	33	28	2	2	62	4,802
Other[1]	31	28	15	8	60	41,933
Total	**327**	**350**	**125**	**13**	**472**	**$85,899**

[1] PHHS related matters that span multiple OPDIVs.

Subsection: Medicare and Medicaid Oversight

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
HCFAC Mandatory BA[1]	$186,066	$187,617	$200,273	+$12,656
HCFAC Discretionary BA	67,200	67,200	121,824	+54,624
HCFAC Estimated Collections	9,230	11,184	12,000	+816
Total Program Level	**$262,496**	**$266,001**	**$334,097**	**+$68,096**
FTE	1,169	1,249	1,421	+172

Program Description

Through its oversight work, OIG saves taxpayer dollars and works to ensure that patients receive medically appropriate care in the Nation's largest health care programs—Medicare and Medicaid. OIG's efforts to ensure that program beneficiaries receive medically appropriate care, while harder to quantify or monetize, effect substantial improvements in quality of life for beneficiaries and their caregivers by ensuring high quality care at the right time and in the right setting.

The size and scope of the Medicare and Medicaid programs create challenges to and heighten the importance of effective program administration, and OIG's oversight role and program improvement recommendations are crucial. Together, these programs, administered by CMS, serve approximately one in four Americans. In 2015, these programs accounted for over $836 billion in Federal Government spending[2]. 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, and are funded jointly with the Federal Government. They offer medical coverage to low-income individuals and families with dependent children, pregnant women, children, and aged and blind individuals and persons with disabilities. The ACA created the option for States to provide Medicaid coverage for low-income adults without children, effective January 1, 2014. The size and scope, in terms of both dollars spent and individuals served, are growing significantly, with an additional 18 million Medicaid enrollees predicted by 2018.

OIG protects these programs and their beneficiaries using a multidisciplinary approach and through important partnerships, including with DOJ. 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. The funds OIG receives under HIPAA are dedicated

[1] HCFAC funding is drawn from the Medicare Hospital Insurance Trust Fund (section 1817(k)(3) of the Social Security Act) and is requested and provided through the CMS budget. Information in this section of the budget request provides an overview of OIG's Medicare and Medicaid oversight activities.
[2] Source: USASpending.gov, accessed January 6, 2016.

exclusively to activities relating to the Medicare and Medicaid programs. The ACA added significant new requirements and authorities to protect Medicare and Medicaid, many of which were based on OIG recommendations. Overall, HCFAC funding constitutes the major portion of OIG's annual operating budget.

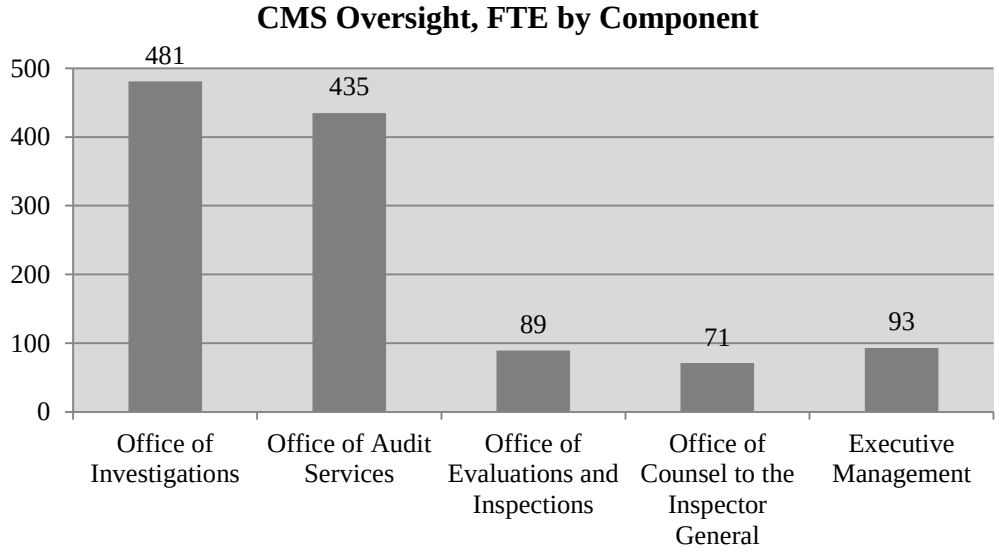
The Health Care Fraud Prevention and Enforcement Action team (HEAT) was started in 2009 by HHS and the DOJ to strengthen Medicare and Medicaid program integrity and to invest new resources and technologies to prevent and combat health care fraud, waste and abuse. OIG is a key partner in HEAT, particularly through Medicare Strike Force teams, which coordinate law enforcement operations conducted jointly by Federal, State, and local law enforcement entities.

During FY 2015, OIG's oversight effort for Medicare and Medicaid oversight was allocated between Medicare and Medicaid as follows:

Medicare and Medicaid Oversight	%
Medicare	68%
Medicaid	32%

Many OIG activities benefit both the Medicare and Medicaid programs. For example, excluding a provider who committed Medicare fraud also protects the Medicaid program from potential fraudulent billing by that provider and protects Medicare and Medicaid beneficiaries from being harmed or rendered substandard care by that provider.

In FY 2015, funding for Medicare and Medicaid oversight supported 1,169 FTE, which were assigned across OIG's five components as follows:



For additional performance information and key outputs, please see page 52.

Accomplishments

HHS program changes that aligned with over 310 Medicare and Medicaid-specific OIG recommendations in FY 2015 are expected to achieve significant savings, reduce wasteful spending, or otherwise improve program efficiency and effectiveness.

Since the release of OIG's March 2015 *Compendium of Unimplemented Recommendations*, CMS made progress to achieve significant savings, reduce wasteful spending and improve program efficiency and effectiveness by implementing some of OIG's top recommendations, including: create a plan for oversight of home health agencies through the Supplemental Medical Review Contractor (SMRC); implement systems to recalculate outlier claims to facilitate reconciliations; develop a quality measure that describes nursing home rates of resident hospitalization; and extend the Medicaid inflation-based rebate for brand-name drugs to generic drugs beginning in 2017.

Noteworthy examples of OIG's recent Medicare and Medicaid oversight accomplishments include those in the following categories.

Law Enforcement

- Nationwide Health Care Fraud Takedown: In June 2015, the Medicare Strike Force conducted the largest health care fraud "takedown" in history, resulting in charges against 243 individuals including 46 doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $712 million in false billings. This takedown is almost twice the size of previous takedowns and involved more than 900 Federal, State, and local law enforcement personnel in a 3-day operation across 14 States. This operation targeted fraud related to Medicare Part D prescription drugs, Medicaid personal care services, and Medicare home health care.

- Strike Forces—Targeting and Investigating Health Care Fraud in High-Risk Locales: Medicare Strike Force teams, since their inception in 2007, have proven to be an effective means of identifying fraud and enforcing antifraud laws. The Strike Forces work in nine locations: Miami, Florida; Los Angeles, California; Detroit, Michigan; South Texas; Brooklyn, New York; southern Louisiana;[1] Tampa, Florida; Chicago, Illinois; and Dallas, Texas. In FY 2015 alone, OIG's Strike Force efforts resulted in charges filed against more than 232 individuals or entities and more than 225 criminal actions with expected receivables of over $357.8 million.

  In addition, Medicare billing trends demonstrate the positive impact of Strike Force enforcement and prevention efforts. For example, Medicare payments for home health care increased from 2006 until 2010. In 2009, Federal enforcement actions (initiated by the HEAT Strike Force case *U.S.* v. *Zambrana* in Miami), followed by OIG reports highlighting abuse of home health outlier payments, influenced CMS to change Medicare's home health agency (HHA) outlier coverage policy. Since 2010, Medicare payments for home health care decreased nationally by more than $1 billion annually. In Miami, payments for HHAs

[1] While the Strike Force in southern Louisiana started in Baton Rouge, it now operates in New Orleans as well.

decreased by $100 million per quarter since the peak in 2009; in Dallas and McAllen, Texas, payments for HHAs are down by $30 million per quarter; while in Detroit, payments for HHAs decreased by $25 million per quarter since peaking in 2009. This may suggest that the home health fraud convictions not only eliminated some of the "bad actors" but also deterred "would be" fraudsters. We have seen similar patterns of decreased billing for durable medical equipment (DME) and community mental health services following concentrated law enforcement initiatives and administrative fraud prevention efforts.

- Investigating Patient Harm—Dr. Farid Fata: Oncologist Farid Fata was sentenced to 45 years in prison and ordered to forfeit more than $17 million after pleading guilty to charges of health care fraud, conspiracy to pay or receive kickbacks, and money laundering. Fata, who owned and operated the cancer treatment clinic Michigan Hematology Oncology, P.C., admitted that he prescribed and administered aggressive chemotherapy, cancer treatments, intravenous iron, and other infusion therapies to 553 patients who did not need these therapies, in order to increase his billings to Medicare and other insurance companies. He then submitted fraudulent claims to Medicare and other insurers for these unnecessary treatments. In total, Fata submitted approximately $34 million in fraudulent claims to Medicare and private insurance companies.

Prescription Drugs

- Ensuring the Integrity of Medicare Prescription Drug Plan (Part D): In June 2015, OIG published a portfolio presenting an overview of our investigations, audits, evaluations, and legal guidance related to Medicare Part D conducted since the program's inception in 2006. It synthesizes numerous OIG reports that have identified weaknesses in Part D program integrity, and provides updates on Departmental efforts to address these weaknesses related to the use of data to identify vulnerabilities, as well as in the oversight by all parties responsible for protecting Part D: Part D plan sponsors, the Medicare Drug Integrity Contractor, and CMS. OIG concurrently released a report highlighting questionable billing and geographic hotspots pointing to potential fraud and abuse in Medicare Part D. These products were developed and issued in conjunction with as the nationwide health care fraud takedown as a multifaceted effort to combat fraud, waste, and abuse in Medicare Part D.

- Helping Private Stakeholders Fight Prescription Drug Fraud and Abuse: OIG actively worked with members of the National Health Care Antifraud Association to implement policy changes based on our recommendations fighting prescription drug fraud in Medicare Part D, findings from our recent Part D data brief, and the measures we used to identify questionable billing patterns associated with pharmacies, prescribers, beneficiaries, and certain drugs. Public and private payers can use this information to fight fraud in their programs. In addition, OIG met with representatives from the independent pharmacy industry and shared our methodology for our Part D analysis and discussed ways for OIG to partner with them to fight pharmacy fraud and abuse. The Office of Investigations additionally partners with the Drug Enforcement Agency to provide anti-fraud education at numerous Pharmacy Diversion Awareness Conferences (PDACs) held in cities across the U.S.

Medicaid

- Access to Care in Medicaid Managed Care: As of October 2015, over 71 million individuals were enrolled in Medicaid and CHIP[1], and Medicaid expansion is predicted to add 18 million additional enrollees to the program by 2018. Most of these new enrollees are expected to be served by Medicaid managed care plans. Given the magnitude of these changes, OIG analyzed provider availability as an indication of whether enrollees were experiencing problems getting access to care. We found that 51 percent of providers listed as participating in Medicaid managed care plans could not offer an appointment to new patients. OIG also found that among the providers who could offer appointments, a significant number had extremely long wait times. We also found that access standards vary widely by State and States vary in how effectively they are enforcing the standards that they create.

- Extending Rebates for Generic Drugs in Medicaid: In a review of generic drug price increases, we found that the increases exceeded the specified Medicaid statutory inflation factor applicable to brand-name drugs for 22 percent of the quarterly AMPs we reviewed. If the provision for additional rebates that applies to brand-name drugs that exceed the specified statutory inflation factor were extended to generic drugs, the Medicaid program would have received additional rebates. We calculated that Medicaid would have received a total of $1.4 billion in additional rebates for the top 200 generic drugs, ranked by Medicaid reimbursement, from 2005 through 2014. The additional rebates for the top 200 generic drugs would have increased in most years, from more than $39 million in 2005 to more than $464 million in 2014. Our findings are consistent with our previous work and support our prior recommendation that CMS consider seeking legislative authority to extend the Medicaid inflation-based rebate provisions to generic drugs. On November 2, 2015, the Bipartisan Budget Act of 2015 (P.L. No. 114-74) was enacted and included such a provision. The additional rebate for generic drugs will apply to rebate periods beginning with the first quarter of 2017.

- Medicaid Fraud Control Units: Medicaid Fraud Control Units (MFCU) investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. Currently, MFCUs operate in 49 States and in the District of Columbia. Forty-four of the MFCUs are located as part of Offices of State Attorneys General; the remaining 6 are in other State agencies. OIG certifies, and annually recertifies, each MFCU. OIG collects information about MFCU operations and assesses whether they comply with statutes, regulations, and OIG policy. As part of OIG's recertification of the 50 MFCUs, OIG evaluates whether each MFCU adheres to performance standards and otherwise uses resources effectively and efficiently. The recertification process includes both an annual collection of performance information from the MFCUs and from other stakeholders, as well as an in-depth onsite review of 10 – 12 MFCUs each year. OIG uses the information from both the recertification and onsite reviews to provide technical assistance, training, and formal recommendations to assist the MFCUs in achieving strong outcomes. The OIG's Office of Investigations frequently works with MFCU partners on joint investigative efforts

[1] https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/october-2015-enrollment-report.pdf

affecting both Medicare and Medicaid.

- 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 our report and OIG testimony before Congress on the developmental center rates, New York State submitted a plan amendment (effective April 1, 2013) that changed the rate to better reflect the actual costs of providing care. As a result of this change, the Federal Government saved approximately $1.2 billion from April 2013 through September 2014. In addition, on March 20, 2015, New York and CMS entered into a settlement agreement to resolve the issues regarding excessive Medicaid payment rates to State-operated providers. As part of the settlement, New York agreed to pay a total of $1.95 billion to the Federal Government.

Nursing Homes and Hospice

- Enhancing Monitoring of Antipsychotic Drug Use in Nursing Homes: After the release of an OIG report that found 88 percent of Medicare claims for antipsychotics prescribed in nursing homes were for treating symptoms of dementia even though the drugs are not approved for that, the Federal Government started a campaign to get nursing homes to reduce their use of antipsychotics. The Partnership to Improve Dementia Care in Nursing Home's official outcome measure shows a decrease of 21.7% in the use of antipsychotics from 2011 to 2015. In addition, CMS added this measure of nursing home resident antipsychotic use to Nursing Home Compare in February 2015.

- Strengthening Oversight of Hospices: The Improving Medicare Post-Acute Care Act of 2014 set specific and more frequent timeframes for hospice recertification, consistent with an OIG recommendation. Recertification is a critical component of ensuring that hospices meet Medicare conditions of participation, which set standards of care. The Act now requires hospices to be recertified every 36 months, as opposed to the requirement of 6 to 8 years on average prior to the enactment of the law.

Medicare Parts A and B

- Hospital Compliance Review—Inpatient and Outpatient Payments to Acute Care Hospitals: Using prior audits, investigations, and evaluations, along with computer and data-matching techniques, OIG identified multiple areas of risk to be reviewed in a single audit at each facility. OIG has completed 144 of these audits over the past 5 years and has identified $135 million in Medicare overpayments to the selected hospitals. These audits have uncovered and sought to remedy improper billing and payments for myriad issues, such as incorrect billing for transfers to post-acute care and inaccurate patient diagnosis codes, and have increased provider awareness of common billing errors and the importance of

compliance. These reviews served an important role in highlighting systemic vulnerabilities in hospital billing and returning improper payments to the Medicare trust funds. It is our hope that hospitals and their compliance departments will continue to use the results of our reviews to reduce the number of billing errors and to strengthen the culture of compliance at their facilities.

- Aligning Medicare Payments for Clinical Laboratory Tests with Market Prices: The Protecting Access to Medicare Act of 2014 (PAMA) changes the way Medicare pays for lab tests, consistent with an OIG recommendation, and is projected to achieve billions of dollars in cost savings. Beginning January 1, 2016, and every 3 years thereafter, laboratories must report the payment rate(s) paid by each private payer for each lab test that they furnished during the period. Beginning January 1, 2017, the payment rate for a lab test will be equal to the weighted median of the rates reported by the laboratories. PAMA included a requirement for OIG to annually analyze and report on payments for the top 25 lab tests by Medicare payments and assess CMS's implementation of the new payment system.

- Recouping Payments for Services Billed on Behalf of Ineligible Beneficiaries—Unlawfully Present and Incarcerated: As a result of OIG reviews, potentially $190 million in overpayments was identified for care rendered to unlawfully present and incarcerated beneficiaries. OIG found that a beneficiary's unlawful presence or incarceration dates overlapped with the dates of service on paid Medicare claims. OIG made several recommendations to CMS to improve its processes for recovering some of the improper payments and ensuring that Medicare no longer pays for services provided to unlawfully present and incarcerated beneficiaries.

- Nationwide Review 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 15 Medicare contractors and approximately 2,600 hospitals. The team issued a total of 26 final reports to the Medicare contractors, resulting in expected recoveries totaling $106 million. In addition, CMS implemented a verification policy edit as a result of these OIG audits, which is projected to save about $30.3 million in future Medicare payments each year.

- Issuing Advisory Opinion Modifications for Charity Patient Assistance Programs (PAPs): To address changing practices within the health care industry, OIG issued a Supplemental Special Advisory Bulletin to provide additional guidance on PAPs operated by independent charities to address certain risks about these programs that have come to our attention in recent years.

Funding History

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

Fiscal Year	Medicare and Medicaid Oversight
2013	$224,017,000
2014	223,866,000
2015	262,496,000
2016	266,001,000
2017	334,097,000

Budget Request[1]

OIG's FY 2017 budget for Medicare and Medicaid oversight includes $334 million, which is an increase of +$68 million above the FY 2016 Enacted Level. The OIG estimate includes:

- $200 million in HCFAC Mandatory funding, an increase of $12 million above the FY 2016 Enacted (post-sequester).

- $122 million in HCFAC Discretionary funding. Of this funding, $92 million is not subject to discretionary budget caps, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985.

- $12 million 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 the amounts available will depend on the amount actually collected.

The FY 2017 request maintains the Administration's priority of aggressively addressing fraud, waste, and abuse in Federal health care programs, and builds on the investments made by Congress in FY 2016.

OIG's budget request will support work in preventing fraud, waste, and abuse and promote program integrity across a rapidly changing and increasingly complex health care environment. These changes are fueled by increased Medicare and Medicaid enrollment, innovations in science and data analytics, the rate of health care spending, advances in quality measurement, and the increase in complexity and technical sophistication of fraud schemes. OIG is also heightening its focus on care coordination and the movement toward value-based payment and

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

delivery system reform, and an increased use of technology, including electronic health records. OIG will conduct work that will promote sound administration, integrity of data, accuracy in payments, and quality of care. As new health care payment and delivery models mature, we plan to review the effectiveness of the link between payments to quality outcomes.

While overseeing this rapidly changing health care system, OIG will focus on the following key efforts and risk areas:

- Addressing Prescription Drug Vulnerabilities on a National Scale: Throughout the Medicare and Medicaid programs, OIG has uncovered improper and potentially harmful prescribing practices, pharmacies billing for drugs not dispensed, and diversion of prescription drugs. OIG has also identified waste related to payments for prescription drugs under HHS programs, increasing costs to taxpayers and beneficiaries. The need to invest additional resources in this area is clear, and the FY 2017 request would maintain funding to support the integrity of these two programs and ensure patient safety.

  For example, OIG has found that criminals are illegally obtaining and selling prescription drugs to treat HIV. Pharmacies are billing Medicare for drugs that beneficiaries never received, and beneficiaries' Medicare identification numbers are being stolen. Medicare paid $32 million for HIV drugs for beneficiaries with questionable utilization patterns in 2012.

  OIG has also focused on the growing problem of prescription drug abuse and diversion. Drug diversion is the transfer of legitimate prescription drugs for unlawful purposes. Controlled substances, such as opiate pain relievers, are potentially so dangerous that they require restrictions on their manufacture, possession, and use. CDC characterizes prescription drug abuse as an epidemic, reaching virtually all demographics and geographic locations. In one noteworthy example, an OIG investigation found that a health care worker infected with Hepatitis C diverted a controlled prescription drug from a hospital for his own personal use. The worker took syringes filled with a controlled prescription opioid, injected the drug into his arm, and refilled the same syringe with saline. Patient victims then underwent surgery without their prescribed pain medication. Further, because the worker used his contaminated syringes to switch the fluids, several patients treated from these vials contracted the infectious disease. The worker was sentenced to 39 years in prison and ordered to pay $22,680 in restitution after pleading guilty to charges of tampering with a consumer product and fraudulently obtaining controlled substances.

  In addition to increased investigative efforts, additional investments in addressing prescription drug vulnerabilities will include new or expanded work to (1) identify drug-related hospitalizations of Medicare beneficiaries and analyze the prescribers and pharmacies associated with those beneficiaries to identify patterns that merit more specific review or investigation; (2) evaluate early implementation of drug traceability requirements under the Drug Supply Chain Security Act, including conducting a drug traceability test to determine whether the new requirements work as intended; (3) evaluate States' Medicaid drug utilization review programs to examine clinical misuse of prescription drugs as well as potential fraud; and (4) examine Medicare and Medicaid payment policies and pricing trends

for specialty drugs, many of which are extremely high cost for the programs and for Medicare beneficiaries (through copayments), raising risks regarding beneficiary access and adherence to treatment regimens.

OIG work is yielding results through administrative actions. For example, as a result of an OIG report, CMS published a final rule requiring prescribers of Part D drugs to enroll in (or officially opt-out of) the Medicare fee-for-service program starting June 1, 2015. This enables CMS, Part D plans, and the Medicare program integrity contractor to verify that prescribers have the authority to prescribe Part D drugs before the claims are paid.

- Overseeing Changes in Medicaid: OIG's FY 2017 request will continue to support targeted Medicaid program integrity efforts that will include (1) oversight of the expansion of Medicaid eligibility, (2) managed care programs, (3) improving the effectiveness of Medicaid data and systems, (4) remediating State policies that inflate Federal costs, (5) ensuring the quality of care for children, and (6) investigative and enforcement efforts.

  The expansion of Medicaid poses new challenges related to eligibility and enrollment determinations and ensuring appropriate Federal Medical Assistance Percentages calculations and associated Federal payments. Further, managed care models are increasingly prevalent in the Medicaid program. OIG work has found that the predominant concerns of States and managed care plans are provider fraud (billing for services that are not provided, are medically unnecessary, or are upcoded), health plan fraud; and beneficiary fraud, including prescription drug abuse.

  OIG's work in this area will help ensure that the Federal Government pays the appropriate share of costs, improper payments are identified and collected as appropriate, eligibility is correctly determined, managed care programs engage in sufficient program integrity efforts, and payment rates to health care providers are economical.

- Culture of Compliance: OIG promotes compliance in the health care industry in two complementary ways: by providing compliance guidance to health care providers and pursuing enforcement where appropriate, which helps honest providers flourish by weeding out fraudsters.

  OIG has a long history of giving the majority of providers, who want to play by the rules, guidance to help navigate the complex regulatory environment of Federal health care programs. For example, the Anti-Kickback Statute broadly applies to many business arrangements in the health care field, and OIG publishes safe harbor regulations and issues advisory opinions to help define the scope of permissible conduct under the statute. More broadly, over the past 20 years, OIG has been instrumental in catalyzing and supporting the health care industry's extensive voluntary compliance efforts. Among other guidance efforts, OIG has published compliance program guidance to help those setting up compliance programs, issued special fraud alerts and bulletins to notify health care providers of risk areas and problematic conduct, conducted in-person compliance training programs, and produced a series of compliance videos available on its web site. Together, these efforts help honest

providers understand the rules that apply to them and operate effective compliance programs for their organizations.

OIG takes administrative enforcement action against those providers that choose not to comply with the rules and instead defraud Federal health care programs. OIG uses its administrative tools to complement DOJ criminal and civil enforcement efforts. For example, some unscrupulous providers may attempt to steer patients to their businesses by paying kickbacks. Strategic CMP enforcement against such unscrupulous providers helps honest providers flourish by weeding out fraudsters. Through OIG-initiated litigation, OIG is aiming to increase individual (as compared with corporate) accountability for fraudulent conduct, fill enforcement gaps, increase compliance with OIG's guidance, and amplify OIG's work through strategic case selection and litigation. In FY 2015, OIG entered into 110 CMP settlements (self-disclosures and OIG-initiated litigation) for a total recovery of over $70 million. In the first quarter of FY 2016, we have entered into 41 settlements for over $36.7 million. OIG also pursues individuals and entities for a wide range of other conduct, including submitting false claims and providing medically unnecessary services. Administrative enforcement also helps support OIG's highly successful self-disclosure protocol by initiating actions against, and collecting more money from, wrongdoers who fail to disclose their misconduct.

The FY 2017 request will maintain OIG's ability to provide significant guidance to health care providers and initiate significant administrative enforcement actions. With these funds, OIG will continue to update safe harbor regulations, issue guidance bulletins and alerts, and provide compliance education resources. Administrative enforcement actions will further support OIG compliance guidance and help level the playing field for honest providers. These actions would also protect the Federal health care programs and their beneficiaries from fraudulent providers. Finally, this investment will yield a substantial deterrent effect.

- Ensuring Patient Safety and Quality of Care: The FY 2017 request continues to support critical oversight for nursing home, hospice, and home- and community-based services (HCBS) programs. As the median age of Americans continues to rise and as more Americans live with chronic medical conditions, HHS faces challenges in ensuring that beneficiaries who require services for such conditions receive high quality care. High quality nursing home and HCBS programs are important for the continued well-being of people who need ongoing assistance with daily living, as well as those who need additional help recuperating from hospital stays or other acute care. Hospice care provides comfort for terminally ill beneficiaries by reducing pain and addressing physical and other needs. High quality nursing home, hospice, and HCBS personal care services can often prevent the need for disruptive and costly hospitalizations.

  OIG continues to identify various problems with nursing home and hospice care. For example, in reports on nursing homes, OIG raised concerns about the frequency of preventable adverse events (e.g., patient harm caused by care), the extent to which nursing homes comply with Federal regulations for reporting abuse and neglect, and the lack of monitoring of nursing homes' resident hospitalization rates. With respect to hospice care,

OIG has raised concerns about insufficient monitoring of hospice service use, as well as inadequate oversight of hospice certification surveys and hospice-worker licensure requirements. OIG has significant enforcement work in the area of HCBS and hospice care, with a focus on those cases that may result in patient harm.

It is critical to ensure effective oversight of HCBS programs and Medicaid-paid personal care services. For instance, the Medicare Strike Force conducted the largest health care fraud takedown in Strike Force history in June 2015, resulting in charges against 243 individuals including 46 doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $712 million in false billings. This operation targeted fraud in Medicare Part D prescription drugs, Medicaid personal care services, and Medicare home health benefits. HCBS programs are important, in part, because they enable beneficiaries whose needs and preferences are better served by remaining in their own homes or other community-based settings to avoid or delay institutionalization. These programs offer many advantages for promoting beneficiary choice and preferences, but OIG efforts have revealed persistent payment, compliance, and quality vulnerabilities.

OIG's additional emphasis on ensuring high quality care for HHS beneficiaries will include new or expanded work to identify frequency of and patterns in unnecessary testing and procedures, a comprehensive management review of the survey and certification process, a review of quality of care provided in ambulatory care settings, and an assessment of infection control practices in nursing homes and other settings.

- Delivery System Reform and Payment Accuracy: OIG will heighten its focus on delivery system reform, including accountable care organizations, bundled payment initiatives, and other innovate reforms designed to improve results and foster smarter spending. Significant reforms to payment systems in 2017, such as those included in the Medicare Access and Children's Health Insurance Program Reauthorization Act, should create new oversight needs from data, security, and payment perspectives.

  OIG will continue to conduct targeted reviews to determine the scope of improper payments, identify 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, medically unnecessary, 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 prevent and recover improper payments and fraud.

  OIG's additional emphasis on ensuring payment accuracy for HHS beneficiaries will include new or expanded work to: (1) assess the accuracy of Medicare payments to Medicare Advantage plans; (2) evaluate whether program measures are valid, data are accurate, reporting systems are efficient and not unduly burdensome, and payment models protect against incentives or opportunities to abuse the payment system; and (3) assess the evidence

accepted by Medicare Administrative Contractors in determining whether claims comply with national and local coverage policies.

Medical record review is a powerful tool to establish whether an improper payment was made or to render a judgment on the quality of care provided. Such reviews are costly, but can significantly increase the impact of OIG findings and recommendations. The FY 2017 request will maintain increased investment in medical record review that will be strategically performed to address high-risk and high-dollar services provided or paid for by HHS through Medicare, Medicaid, and IHS, and care provided at health centers. Medical record review could also be used to assess quality of care and compare outcomes across health care delivery and coordination models. In addition, the FY 2017 request will support OIG's efforts to use and assess quality-based data analytics and to perform analysis of quality metrics.

A key part of OIG's effort is to assess payment policies for potential waste and abuse. In some cases, payment rates and policies are not aligned with market prices or medical practices. This can inflate Medicare and Medicaid costs to both the programs and beneficiaries. Evidence from price and competitive bidding studies suggests that Medicare and Medicaid fees for some services and products may be too high, including those for DME and prescription drugs. Recent OIG work found that as much as $15 billion could be saved if outpatient surgical procedures that do not pose significant risk to patients were performed in an ambulatory surgical center instead of a hospital outpatient department.

The FY 2017 request will continue to support efforts to assess Medicare and Medicaid payment policies and will support new work examining the effectiveness and efficiency of new payment and delivery models, including, for example, accountable care organizations, bundled payments, and value-based purchasing programs. While rapid evolution in value-based payment may shift away from fee-for-service risk, new risks may emerge. Moreover, so long as fee-for-service structures continue to be a part of the Federal health care programs, oversight of fee-for-service payment will be critical.

- The Meaningful and Secure Exchange and Use of Electronic Information and Health Information Technology (health IT): In support of its mission and operations, the Department maintains and uses expanding amounts of sensitive information. Complete, accurate, and timely data can help ensure efficient operations of the Department and its programs, as well as support proactive program oversight. Similarly, the American health care system increasingly relies on health IT and the electronic exchange and use of health information. Health IT, including electronic health records (EHRs), offers opportunities for improved patient care, more efficient practice management, and improved overall public health. Issues related to electronic information and health IT cut across program areas, affecting not only the Medicare and Medicaid programs, but also multiple PHHS OPDIVs, including the Office of the National Coordinator for Health Information Technology and the Office for Civil Rights. A large portion of OIG's work in this area to date has been related to Medicare and Medicaid, given the size of their EHR Incentive Programs. As such, it is included under Medicare and Medicaid Oversight in this budget request. OIG has conducted related work under PHHS Oversight, and will conduct additional such work in the future.

Safeguarding privacy and ensuring data security are, and should remain, top priorities. The frequency of notable data breaches has increased significantly, and data breaches can have serious consequences for the health care industry, the Department, and those the Department serves. Those consequences can include identity theft, which, in the health care context, can negatively affect the care that patients receive and lead to wasteful, including fraudulent, spending of public funds.

Further, to make use of the benefits of the growing amounts of data in the health care context, data must be available, subject to appropriate privacy and security safeguards, where and when needed. For example, improving the appropriate flow of health information is critical to the success of many health-care-delivery-reform and other initiatives. However, enabling and encouraging the flow of information remains a challenge for the Department. Several factors may impede the flow of information, including behavioral issues, such as information blocking, which is of interest to OIG. In fact, OIG recently issued a Policy Reminder explaining how information blocking may affect safe harbor protection under the Federal anti-kickback statute.

It is important to ensure that the goals associated with the Department's investment in the widespread adoption and use of EHRs and other health IT, including those under the Health Information Technology for Economic and Clinical Health Act of 2009 incentive programs, are fulfilled.

OIG's increased emphasis in this area will include new or expanded work focusing on HHS computer systems' privacy and security to support the Department's efforts to decrease the risk of unauthorized access to its sensitive information. New or expanded work will also focus on privacy and security issues in the regulated community and on the related agencies to address concerns about similar risks for health information. This work may consider privacy and security issues that arise from the continuing expansion of the Internet of Things, such as connected medical devices. New or expanded work would also include reviewing the accuracy of Medicare and Medicaid EHR incentive payments and may examine health IT interoperability across providers (including those participating in accountable care organizations), across HHS, and between providers and patients, as well as examining outcomes from health IT investments.

- Enhanced Prevention and Enforcement: The FY 2017 request will maintain OIG's capacity to leverage technology and forensic audit techniques in addressing emerging trends and support efforts to deter misconduct through litigation.

  The FY 2017 request will maintain OIG's Strike Force efforts and continue to build on the successes of the Strike Force model, which has been extremely effective in targeting emerging patterns of fraud and holding wrongdoers accountable. The Strike Force model succeeds through a combination of intelligence gathered by agents, proactive data analysis, and availability of attorneys dedicated to prosecuting Medicare fraud. Analysts use near-real-time data to examine Medicare claims to identify potentially fraudulent providers and

patterns of suspected fraud, such as disproportionate payment levels for various services and ratios of services as compared with national averages. These and other assessments enable OIG to identify enforcement efforts and adapt them to emerging and evolving trends. For example, since the inception of the Strike Force model in 2007, OIG has identified and pursued health care fraud schemes in a variety of sectors, for example, DME supplier and infusion clinic services, home health care, community mental health, and most recently, prescription drug fraud.

Health care fraud itself has become more sophisticated as criminals use technology, including EHRs, to their advantage. Additionally, since the enactment of the HITECH Act, requirements for the implementation of EHR systems, and the ACA, approximately 83% of providers and 97% of hospitals have now adopted some level of EHR system. Accordingly, evidence collection is moving increasingly away from paper files to an unprecedented amount of electronic evidence. As a result, the amount of data collected by the Digital Investigations Branch of OIG's Office of Investigations grew tenfold since 2009. Moreover, there is an increasing demand for forensic enhancements, including forensic auditors with a thorough knowledge of fraud detection and prevention, to more effectively analyze large amounts of investigative data. Additionally, such advances have the potential to provide OIG and its law enforcement partners with more leads to investigate than ever before. OIG's efforts in this area, along with those of CMS, increase the urgency that OIG have the resources needed to analyze data in near real time to investigate suspected fraud that the data flag.

Performance Table for Medicare and Medicaid Oversight

Key Outputs	FY 2015 Final	FY 2016 Target	FY 2017 Target	FY 2017 +/- FY 2016
Audits:				
Audit reports started	183	187	191	+4
Audit reports issued	177	181	185	+4
Evaluations:				
Evaluation reports started	41	30	31	+1
Evaluation reports issued	48	38	39	+1
Investigations: Complaints received for investigation	3,044	3,105	3,170	+65
Investigative cases opened	1,650	1,683	1,718	+35
Investigative cases closed	1,719	1,753	1,790	+37
PL funding (Dollars in Millions)	$262	$266	$334	+$68

FY 2015 Medicare and Medicaid Major Outputs by OIG Component: Audits, Evaluations, Cases, and Monetary Impact by OPDIV

Office of Audit Services

(Dollars in Thousands)

Category	Audit Starts	Audit Issued	Audit Recommendations Cost Questioned Concur	Audit Recommendations Cost Questioned Non Concur	Audit Recommendations Funds Put To Better Use Concur	Audit Recommendations Funds Put To Better Use Non Concur
Medicare and Medicaid	183	177	$1,066,424	$127,991	$233,516	$713,932

Office of Evaluation and Inspections

Category	Evaluation Starts	Evaluations Issued	Evaluation Recommendations	Evaluation Recommendations Concur
Medicare and Medicaid	41	48	92	87

Office of Investigations

(Dollars in Thousands)

Category	Cases Opened	Cases Closed	Criminal Actions	Civil Actions	Complaints Received for Investigations	Monetary Results
Medicare and Medicaid	1,651	1,719	800	588	3,044	$2,082,839

Total Object Class
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$164,156	$175,925	$200,087	+$24,162
Other than full-time permanent	2,542	2,739	3,116	+378
Other personnel compensation	1,774	1,900	2,158	+258
Military personnel	--	--	--	--
Special personnel services payments	76	82	94	+11
Subtotal,	**168,548**	**180,647**	**205,455**	**+24,809**
Civilian benefits	61,746	66,245	75,341	+9,096
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**230,294**	**246,892**	**280,797**	**+33,905**
Travel and transportation of persons	7,361	7,792	8,824	+1,032
Transportation of things	2,108	2,252	2,597	+345
Rental payments to GSA	20,276	19,268	19,552	+284
Rental payments to others	--	--	--	--
Communication, utilities, and misc. charges	3,851	3,417	3,872	+455
Printing and reproduction	110	86	98	+11
Other contractual services:				
Advisory and assistance services	11	12	14	+2
Other services	15,307	14,450	17,623	+3,173
Purchases of goods and services from Government accounts	43,154	47,749	66,499	+18,750
Operation and maintenance of facilities	2,922	3,122	3,592	+470
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	3,623	3,671	4,466	+795
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**65,017**	**69,004**	**92,194**	**+23,190**
Supplies and materials	1,650	1,762	2,032	+270
Equipment	12,598	12,111	14,772	+2,662
Land and structures	--	--	--	--
Investments and loans	--	--	--	--
Grants, subsidies, and contributions	--	--	--	--
Insurance claims and indemnities	99	--	--	--
Refunds	--	--	--	--
Subtotal, Nonpay	**113,070**	**115,692**	**143,941**	**+28,249**
Total,	**$343,364**	**$362,584**	**$424,738**	**+$62,153**

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

PHHS Oversight Object Class

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$37,637	$40,778	$45,761	+$4,983
Other than full-time permanent	595	645	723	+79
Other personnel compensation	528	572	642	+70
Military personnel	--	--	--	--
Special personnel services payments	19	21	23	+3
Subtotal,	**38,779**	**42,015**	**47,150**	**+5,134**
Civilian benefits	14,302	15,496	17,389	+1,894
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**53,081**	**57,511**	**64,539**	**+7,028**
Travel and transportation of persons	1,769	1,726	1,929	+203
Transportation of things	516	551	627	+76
Rental payments to GSA	3,624	4,338	4,114	-224
Rental payments to others	746	761	851	+89
Communication, utilities, and misc. charges	15	19	21	+2
Printing and reproduction	53,081	57,511	64,539	+7,028
Other contractual services:				--
Advisory and assistance services	3	3	4	+0
Other services	1,685	1,430	1,648	+218
Purchases of goods and services from Government accounts	5,369	5,138	5,566	-- +429
Operation and maintenance of facilities	1,064	1,137	1,293	+156
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	782	836	951	+115
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**8,903**	**8,543**	**9,462**	**+919**
Supplies and materials	410	438	498	+60
Equipment	3,052	2,612	2,960	+348
Land and structures	--	--	--	--
Investments and loans	--	--	--	--
Grants, subsidies, and contributions	--	--	--	--
Insurance claims and indemnities	27	--	--	--
Refunds	--	--	--	--
Subtotal, Nonpay Costs	**19,062**	**18,989**	**20,462**	**+1,472**
Total, Obligations[1]	**$72,143**	**$76,500**	**$85,000**	**+$8,500**

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

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

Medicare and Medicaid Oversight Object Class

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$124,070	$134,397	$153,572	+$19,175
Other than full-time permanent	1,933	2,094	2,393	+299
Other personnel compensation	1,217	1,318	1,506	+188
Military personnel	--	--	--	--
Special personnel services payments	57	62	71	+9
Subtotal,	**127,277**	**137,871**	**157,542**	**+19,671**
Civilian benefits	46,595	50,473	57,675	+7,201
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**173,872**	**188,344**	**215,216**	**+26,872**
Travel and transportation of persons	5,540	6,022	6,852	+829
Transportation of things	1,592	1,701	1,970	+269
Rental payments to GSA	16,652	14,930	15,438	+508
Rental payments to others	3,105	2,656	3,022	+366
Communication, utilities, and misc. charges	95	67	76	+9
Printing and reproduction	**173,872**	**188,344**	**215,216**	**+26,872**
Other contractual services:				
Advisory and assistance services	8	9	10	+1
Other services	13,622	13,020	15,975	+2,954
Purchases of goods and services from Government accounts	22,642	22,691	41,018	+18,327
Operation and maintenance of facilities	1,858	1,985	2,299	+314
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	2,841	2,835	3,516	+680
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**40,971**	**40,541**	**62,818**	**+22,277**
Supplies and materials	1,239	1,324	1,533	+209
Equipment	9,546	9,499	11,813	+2,313
Land and structures	--	--	--	--
Investments and loans	--	--	--	--
Grants, subsidies, and contributions	--	--	--	--
Insurance claims and indemnities	17	--	--	--
Refunds	--	--	--	--
Subtotal, Nonpay	**78,812**	**76,740**	**103,521**	**+26,781**
Total,	**$252,684**	**$265,084**	**$318,738**	**+$53,654**

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

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

Reimbursables Object Class

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$740	$751	$754	+$3
Other than full-time permanent	-	-	-	--
Other personnel compensation	10	10	10	--
Military personnel	--	--	--	--
Special personnel services payments	--	--	--	--
Subtotal,	**750**	**761**	**764**	**+3**
Civilian benefits	273	276	278	+1
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**1,023**	**1,037**	**1,042**	**+5**
Travel and transportation of persons	30	43	43	--
Transportation of things	-	-	-	--
Rental payments to GSA	--	--	--	--
Rental payments to others	--	--	--	--
Communication, utilities, and misc. charges	--	--	--	--
Printing and reproduction	--	--	--	--
Other contractual services:	--	--	--	--
Advisory and assistance services	--	--	--	--
Other services	--	--	--	--
Purchases of goods and services from Government accounts	-- 15,143	-- 19,920	-- 19,915	-- -5
Operation and maintenance of facilities	--	--	--	--
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	--	--	--	--
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**15,143**	**19,920**	**19,915**	**-5**
Supplies and materials	0	--	--	--
Equipment	--	--	--	--
Land and structures	--	--	--	--
Investments and loans	--	--	--	--
Grants, subsidies, and contributions	--	--	--	--
Insurance claims and indemnities	--	--	--	--
Refunds	--	--	--	--
Subtotal, Nonpay	**15,173**	**19,963**	**19,958**	**-5**
Total,	**$16,196**	**$21,000**	**$21,000**	**--**

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

Disaster Relief Oversight Object Class[1]

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$1,708	--	--	--
Other than full-time permanent	14	--	--	--
Other personnel compensation	19	--	--	--
Military personnel	--	--	--	--
Special personnel services payments	--	--	--	--
Subtotal,	**1,742**	--	--	--
Civilian benefits	576	--	--	--
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**2,318**	--	--	--
Travel and transportation of persons	22	--	--	--
Transportation of things	--	--	--	--
Rental payments to GSA	--	--	--	--
Rental payments to others	--	--	--	--
Communication, utilities, and misc. charges	--	--	--	--
Printing and reproduction	--	--	--	--
Other contractual services:	--	--	--	--
Advisory and assistance services	--	--	--	--
Other services	--	--	--	--
Purchases of goods and services from Government accounts	--	--	--	--
Operation and maintenance of facilities	--	--	--	--
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	--	--	--	--
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	--	--	--	--
Supplies and materials	1	--	--	--
Equipment	--	--	--	--
Land and structures	--	--	--	--
Investments and loans	--	--	--	--
Grants, subsidies, and contributions	--	--	--	--
Insurance claims and indemnities	--	--	--	--
Refunds	--	--	--	--
Subtotal, Nonpay	23	--	--	--
Total,	**$2,341**	--	--	--

[1] The amounts in this table include the funding available to OIG through the Disaster Relief Appropriations Act of 2013. These funds were available until September 30, 2015.

Total Salary and Expenses
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$164,156	$175,925	$200,087	+$24,162
Other than full-time permanent	2,542	2,739	3,116	+378
Other personnel compensation	1,774	1,900	2,158	+258
Military personnel	--	--	--	--
Special personnel services payments	76	82	94	+11
Subtotal,	**168,548**	**180,647**	**205,455**	**+24,809**
Civilian benefits	61,746	66,245	75,341	+9,096
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**230,294**	**246,892**	**280,797**	**+33,905**
Travel and transportation of persons	7,361	7,792	8,824	+1,032
Transportation of things	2,108	2,252	2,597	+345
Communication, utilities, and misc. charges	3,851	3,417	3,872	+455
Printing and reproduction	110	86	98	+11
Other contractual services:				
Advisory and assistance services	$11	12	14	+2
Other services	15,307	14,450	17,623	+3,173
Purchases of goods and services from Government accounts	43,154	47,749	66,499	+18,750
Operation and maintenance of facilities	2,922	3,122	$3,592	+470
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	3,623	3,671	4,466	+795
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**65,017**	**69,004**	**92,194**	**+23,190**
Supplies and materials	1,650	1,762	2,032	+270
Subtotal, Nonpay	**80,097**	**84,314**	**109,617**	**+25,303**
Total Salary and	**310,391**	**331,206**	**390,413**	**+59,208**
Rental payments to	20,276	19,268	19,552	+284
Rental payments to	--	--	--	--
Grand Total, Salary and Expenses and	**$330,667**	**$350,474**	**$409,965**	**+59,492**
FTE[1]	**1,524**	**1,616**	**1,830**	**+214**

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

PHHS Oversight Salary and Expenses

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$37,637	$40,778	$45,761	+$4,983
Other than full-time permanent	595	645	723	+79
Other personnel compensation	528	572	642	+70
Military personnel	--	--	--	--
Special personnel services payments	19	21	23	+3
Subtotal,	**38,779**	**42,015**	**47,150**	**+5,134**
Civilian benefits	14,302	15,496	17,389	+1,894
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**53,081**	**57,511**	**64,539**	**+7,028**
Travel and transportation of persons	1,769	1,726	1,929	+203
Transportation of things	516	551	627	+76
Communication, utilities, and misc. charges	746	761	851	+89
Printing and reproduction	15	19	21	+2
Other contractual services:	--	--	--	--
Advisory and assistance services	3	3	4	--
Other services	1,685	1,430	1,648	+218
Purchases of goods and services from Government accounts	-- 5,369	-- 5,138	-- 5,566	-- +429
Operation and maintenance of facilities	1,064	1,137	1,293	+156
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	782	836	951	+115
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**8,903**	**8,543**	**9,462**	**+919**
Supplies and materials	410	438	498	+60
Subtotal, Nonpay	**12,359**	**12,039**	**13,388**	**+1,349**
Total Salary and	**65,440**	**69,550**	**77,927**	**+8,376**
Rental payments to	3,624	4,338	4,114	-224
Rental payments to	--	--	--	--
Grand Total, Salary and Expenses and	**$69,064**	**$73,889**	**$82,040**	**+$8,152**
FTE[1]	**335**	**358**	**400**	**+42**

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

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

Medicare and Medicaid Oversight Salary and Expenses

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$124,070	$134,397	$153,572	+$19,175
Other than full-time permanent	1,933	2,094	2,393	+299
Other personnel compensation	1,217	1,318	1,506	+188
Military personnel	--	--	--	--
Special personnel services payments	57	62	71	+9
Subtotal,	**127,277**	**137,871**	**157,542**	**+19,671**
Civilian benefits	46,595	50,473	57,675	+7,201
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**173,872**	**188,344**	**215,216**	**+26,872**
Travel and transportation of persons	5,540	6,022	6,852	+829
Transportation of things	1,592	1,701	1,970	+269
Communication, utilities, and misc. charges	3,105	2,656	3,022	+366
Printing and reproduction	95	67	76	+9
Other contractual services:				
Advisory and assistance services	8	9	10	+1
Other services	13,622	13,020	15,975	+2,954
Purchases of goods and services from Government accounts	-- 22,642	-- 22,691	-- 41,018	+18,327
Operation and maintenance of facilities	1,858	1,985	2,299	+314
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	2,841	2,835	3,516	+680
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**40,971**	**40,541**	**62,818**	**+22,277**
Supplies and materials	1,239	1,324	1,533	+209
Subtotal, Nonpay	**52,542**	**52,311**	**76,270**	**+23,959**
Total Salary and	**226,414**	**240,655**	**291,487**	**+50,832**
Rental payments to	16,652	14,930	15,438	+508
Rental payments to	--	--	--	--
Grand Total, Salary and Expenses and	**$243,066**	**$255,584**	**$306,925**	**+$51,340**
FTE[1]	**1,169**	**1,249**	**1,421**	**+172**

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

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

Reimbursables Salary and Expenses

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$740	$751	$754	+$3
Other than full-time permanent	--	--	--	--
Other personnel compensation	10	10	10	--
Military personnel	--	--	--	--
Special personnel services payments	--	--	--	--
Subtotal,	**750**	**761**	**764**	**+3**
Civilian benefits	273	276	278	+1
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	1,023	1,037	1,042	+5
Travel and transportation of persons	30	43	43	--
Transportation of things	--	--	--	--
Communication, utilities, and misc. charges	--	--	--	--
Printing and reproduction	--	--	--	--
Other contractual services:	--	--	--	
Advisory and assistance services	--	--	--	--
Other services	--	--	--	--
Purchases of goods and services from Government accounts	-- 15,143	-- 19,920	-- 19,915	-5
Operation and maintenance of facilities	--	--	--	--
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	--	--	--	--
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	**15,143**	**19,920**	**19,915**	**-5**
Supplies and materials	--	--	--	--
Subtotal, Nonpay	**15,173**	**19,963**	**19,958**	**-5**
Total Salary and	**16,196**	**21,000**	**21,000**	--
Rental payments to	--	--	--	--
Rental payments to	--	--	--	--
Grand Total, Salary and Expenses and	**$16,196**	**$21,000**	**$21,000**	--
FTE[1]	**9**	**9**	**9**	--

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

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

Disaster Relief Oversight Salary and Expenses[1]

(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 Pres. Bud.	FY 2017 +/- FY 2016
Obligations				
Personnel compensation:				
Full-time permanent	$1,708	--	--	--
Other than full-time permanent	14	--	--	--
Other personnel compensation	19	--	--	--
Military personnel	--	--	--	--
Special personnel services payments	--	--	--	--
Subtotal,	**1,742**	**--**	**--**	**--**
Civilian benefits	576	--	--	--
Military benefits	--	--	--	--
Benefits to former personnel	--	--	--	--
Subtotal, Pay	**2,318**	**--**	**--**	**--**
Travel and transportation of persons	22	--	--	--
Transportation of things	--	--	--	--
Communication, utilities, and misc. charges	--	--	--	--
Printing and reproduction	--	--	--	--
Other contractual services:	--			
Advisory and assistance services	--	--	--	--
Other services	--	--	--	--
Purchases of goods and services from Government accounts	--	--	--	--
Operation and maintenance of facilities	--	--	--	--
Research and development contracts	--	--	--	--
Medical care	--	--	--	--
Operation and maintenance of equipment	--	--	--	--
Subsistence and support of persons	--	--	--	--
Subtotal, Other Contractual	--	**--**	**--**	**--**
Supplies and materials	1	--	--	--
Subtotal, Nonpay	**23**	**--**	**--**	**--**
Total Salary and Expenses	**2,341**	**--**	**--**	**--**
Rental payments to GSA	--	--	--	--
Rental payments to others	--	--	--	--
Grand Total, Salary and Expenses and Rent	**$2,341**	**--**	**--**	**--**
FTE	**11**	**--**	**--**	**--**

[1] The amounts in this table include the funding available to OIG through the Disaster Relief Appropriations Act of 2013. These funds were available until September 30, 2015.

Detail of FTE

	FY 2015 Final Civilian	FY 2015 Final Military	FY 2015 Final Total	FY 2016 Est. Civilian	FY 2016 Est. Military	FY 2016 Est. Total	FY 2017 Est. Civilian	FY 2017 Est. Military	FY 2017 Est. Total
PHHS Oversight FTE:									
Discretionary:									
Direct	335	--	335	358	--	358	400	--	400
Reimbursable	9	--	9	9	--	9	9	--	9
Disaster Relief Appropriations Act of 2013:									
Direct	11	--	11	--	--	--	--	--	--
PHHS Oversight Subtotal	**355**	**--**	**355**	**367**	**--**	**367**	**409**	**--**	**409**
Medicare and Medicaid Oversight FTE:									
HCFAC Mandatory / Collections:									
Reimbursable	792	--	792	846	--	846	895	--	895
HCFAC Discretionary:									
Reimbursable	377	--	377	403	--	403	526	--	526
Medicare and Medicaid Oversight Subtotal	**1,169**	**--**	**1,169**	**1,249**	**--**	**1,249**	**1,421**	**--**	**1,421**
Total, OIG FTE	**1,524**	**--**	**1,524**	**1,616**	**--**	**1,616**	**1,830**	**--**	**1,830**

Detail of Positions

	FY 2015 Final	FY 2016 Estimate	FY 2017 Pres. Bud.
Executive Schedule (ES) Positions:			
Executive level X	1	1	1
ES-00	15	17	19
Subtotal, ES Positions	**16**	**18**	**20**
Senior Leader (SL) Positions:			
SL	4	5	5
General Schedule (GS) Positions:			
GS-15	100	105	109
GS-14	226	234	263
GS-13	755	795	865
GS-12	365	390	425
GS-11	39	52	100
GS-10	--	--	--
GS-9	35	61	112
GS-8	4	4	5
GS-7	11	22	63
GS-6	1	1	1
GS-5	2	13	32
Subtotal, GS Positions	**1,538**	**1,677**	**1,975**
Total, OIG Positions	**1,558**	**1,700**	**2,000**
Average GS Grade[1]	12.8	12.7	12.4
Average GS Salary	$108,972	$105,623	$102,293

Average GS Grade[1]

2013	12.7
2014	12.8
2015	12.8
2016	12.7
2017	12.4

[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 2015 Final	FY 2016 Estimate	FY 2017 Estimate[1]
Physicians receiving physicians' comparability allowances (PCAs)	1	1	1
Physicians with 1-year PCA agreements	--	--	--
Average annual PCA physician pay (without PCA payment)	$157	$159	$161
Average annual PCA payment	$28	$30	$30
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 2015, $28,000 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.

[1] FY 2017 data will be approved during the FY 2018 budget cycle.

http://oig.hhs.gov/

Significant Items

This satisfies a requirement in the Joint Explanatory Statement accompanying the Consolidated Appropriations Act, 2016 (P.L. 114-113) (Act) to report in the FY 2017 budget request on the following Significant Items.

Item: *Lobbying.* Within the total provided, the Committee provides sufficient funding for the OIG to monitor HHS compliance with the provision that prohibits the use of federal funding for lobbying campaigns. The Committee remains concerned that certain HHS operating divisions have skirted the prohibition on using taxpayer funding to lobby State and or local governments. As such, the Committee requests that the OIG monitor grantee activities to ensure that no taxpayer resources are used for lobbying.

Response: In July 2014, OIG issued a report, entitled *Laws Prohibit the Use of HHS Grant Funds for Lobbying, but Limited Methods Exist To Identify Noncompliance* (OEI-07-12-00620), related to the use of HHS funds for lobbying.

In this report, OIG recommended that the Assistant Secretary for Financial Resources (ASFR) facilitate Department-wide information sharing among awarding agencies about methods to identify the use of grant funds for prohibited lobbying activities. We also recommended that ASFR centralize on its Web site the guidance pertaining to the prohibitions on the use of grant funds for lobbying.

ASFR concurred with both recommendations, and in May 2015, it updated a public Web site with information on "Federal Restrictions on Lobbying for HHS Financial Assistance Recipients." ASFR shared that information directly with HHS grants management officials via electronic correspondence and quarterly quality meetings on May 12th, May 15th, and again on May 21, 2015. This lobbying-restrictions information resides on the public HHS Web site at: http://www.hhs.gov/grants/grants/grants-policies-regulations/lobbying-restrictions.html

Also in May 2015, ASFR informed OIG that it intends to (1) continually update the online lobbying-restrictions guidance, as appropriate; (2) continue to hold quarterly discussions with Chief Grants Management Officers to share information on best practices to identify potentially prohibited lobbying activities; and (3) continue to include in Appropriations Action Transmittals a broad description of prohibited lobbying activities and actions required, until these provisions are included in annual appropriations.

As a result of these actions, OIG considers its two report recommendations implemented.

OIG has made grants management an organization-wide priority; ensuring that no taxpayer resources are used for lobbying will be incorporated into our work plans in this area.

Item: *Top-25 Unimplemented Recommendations.* The Committee again requests that within 90 days of enactment the OIG provide a revised top-25 unimplemented recommendations report

under the same terms and conditions as described in the Explanatory Statement accompanying the Consolidated Appropriations Act of 2014.

Response: OIG is preparing a report to the Secretary, as well as the House and Senate Appropriations Committees and appropriate authorizing committees, containing the top 25 unimplemented recommendations that, on the basis of the professional opinion of OIG, should be prioritized for implementation to better protect the integrity of departmental programs. OIG will submit the report not later than 90 days after enactment.

Item: *Health Reform Oversight.* The Committee appreciates the joint efforts of the OIG to work with the Treasury Inspector General for Tax Administration on reconciliation of the Advance Premium Tax Credit. The Committee encourages more and broader collaboration on other aspects of health reform and other HHS programs that may touch Treasury jurisdictions to reduce, fraud, overpayments, and enhance government operations.

Response: OIG appreciates the Committee's support, and values the important partnership between OIG and TIGTA. OIG has worked closely with TIGTA on reports related to the administration of the Advance Premium Tax Credit (APTC), and in March 2015 conducted and released a report covering the accounting structure used for administration of premium tax credits, which was signed by the Inspectors General of both agencies.

OIG will continue to work closely with TIGTA on the administration of the APTC and other cross-jurisdictional issues as appropriate. Future work may include assessments of vulnerabilities in payment systems and the appropriate use of Federal funds and back-end administrative functions, such as the financial reconciliation processes and systems to collect data on financial assistance payments.

Item: *Oversight of FDA.* The Committee notes that over the past 5 years FDA's responsibilities and resources have grown significantly. The Committee is concerned that oversight of FDA has not kept pace with the growth in the agency's regulatory authority or funding. Therefore, the Committee recommendation includes $1,500,000 for the HHS Office of Inspector General specifically for oversight of FDA activities. The funding provided under this appropriation is in addition to FDA oversight activities supported within the Inspector General's regular appropriation. The Committee instructs the Inspector General to submit a plan, within 60 days of the enactment of this act, on the additional oversight activities planned with this funding.

Response: OIG's FY 2016 *Work Plan* includes six FDA reviews underway or planned for FY 2016. These reviews focus primarily on oversight of postmarketing studies of approved drugs, inspections of high-risk food facilities, review of information exchange in the drug supply chain, monitoring of domestic and imported food recalls, as well as new work on controls over networked medical devices at hospitals, and tobacco establishments' compliance with the Family Smoking Prevention and Tobacco Control Act.

With the $1.5 million provided in the Consolidated Appropriations Act, 2016, OIG is committed to initiating additional reviews of key risk areas, with a particular focus on networked medical

devices. OIG has convened a working group to target work in this area and will submit the requested plan not later than 60 days after enactment.

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."

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 2017 process was $449 million.
- OIG's aggregate budget request to Congress for FY 2017 is $419 million.
- Funding requested for training is approximately $10 million.
- Funding will be necessary to support the Council of the Inspectors General on Integrity and Efficiency (CIGIE).
- The OIG comments on this budget request are contained within this document.

OIG Training Requirements

In accordance with section 6(f)(3)(C) of the IG Act, this budget requests approximately $10 million in FY 2017 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 2017 request, includes approximately 2,000 criminal investigators, auditors, program evaluators, attorneys, and administrative and management staff.

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 necessary funding for OIG's support of CIGIE, of which a portion will be funded from the OIG's Discretionary budget.