DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2019

Office of Inspector General

Justification of Estimates for Appropriations Committees

Note: A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Further Continuing Appropriations Act, 2018 (P.L. 115–31). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

Mission, Vision, and Values

The Department of Health and Human Services (HHS or the Department) 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 mission of the Office of Inspector General (OIG) 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. It works to ensure that Federal dollars are used appropriately and that HHS programs will serve the people who use them.

Vision

OIG's vision is to drive positive change in HHS programs and in the lives of the people served by these programs. It pursues 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. OIG assesses the Department's performance, administrative operations, and financial stewardship. It evaluates risks to HHS programs and recommends 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. OIG applies these values to its 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 its stakeholders—Congress, HHS, States, 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. Among other uses, OIG uses stakeholder input to develop its Work Plan, identify HHS's *Top Management and Performance Challenges,* and inform OIG's goals, priorities, and strategies for its oversight work.

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

I am pleased to present the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), fiscal year (FY) 2019 budget submission. This submission is in accordance with the Inspector General Act, as amended (5 U.S.C. App. 3). It represents OIG's budgetary requirements for meeting its responsibility to protect the integrity of more than a hundred HHS programs as well as the health and welfare of the beneficiaries they serve.

OIG's FY 2019 budget requests a total of $387.5 million to provide oversight of HHS programs. This includes $80 million for oversight of HHS's Public Health and Human Services (PHHS) programs and $307.5 million for oversight of the Medicare and Medicaid programs, including law enforcement activities coordinated with HHS and the Department of Justice.

OIG's 2019 budget request will support OIG's PHHS oversight and the Health Care Fraud and Abuse Control (HCFAC) Program activities. OIG works to achieve the greatest impact across HHS's diverse programs by focusing on priority areas, such as protecting beneficiaries from prescription drug abuse, including opioid abuse; enhancing program integrity in noninstitutional care settings; improving program integrity for childcare grant programs; and enhancing Medicaid program integrity. In addition, OIG will use resources for oversight of other critical PHHS programs and issues, including protecting HHS grant and contract funds, promoting quality and safety in the Indian Health Service, overseeing HHS's emergency preparedness, and strengthening the use and security of data and technology. With respect to additional HCFAC activities, OIG will also use requested resources to combat Medicare and Medicaid fraud, waste, and abuse and strengthen oversight of the Medicare Advantage program.

OIG protects HHS programs and the well-being of beneficiaries by identifying opportunities to decrease costs and increase efficiency and effectiveness and by holding accountable those who fail to meet program requirements or violate Federal laws. OIG uses Data Driven Decision Making to produce outcome-focused results. For instance, OIG leverages sophisticated data analysis to identify and target potential fraud schemes and areas of program waste and abuse. OIG continues to improve its capabilities to provide quality, timely, and actionable data to frontline staff and to its public and private sector partners. OIG will continue to use data and technology to support its dedicated and talented personnel in their mission to strengthen HHS program integrity. Further, OIG will continue to use the full complement of its tools and authorities to pursue potential fraud, identify HHS's most significant risks, and make actionable recommendations to address them.

Since its establishment in 1976, OIG has consistently achieved significant results and returns on investment. In FY 2016, the HCFAC program, in which OIG is a major participant, returned to the Federal Government $5 for every $1 invested. OIG remains committed to its mission of combating fraud, waste, and abuse, and the funding requested will advance OIG's mandate to protect the health and welfare of all Americans.

/s/
Daniel R. Levinson
Inspector General

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The FY 2019 Justification of Estimates for the Appropriations Committees

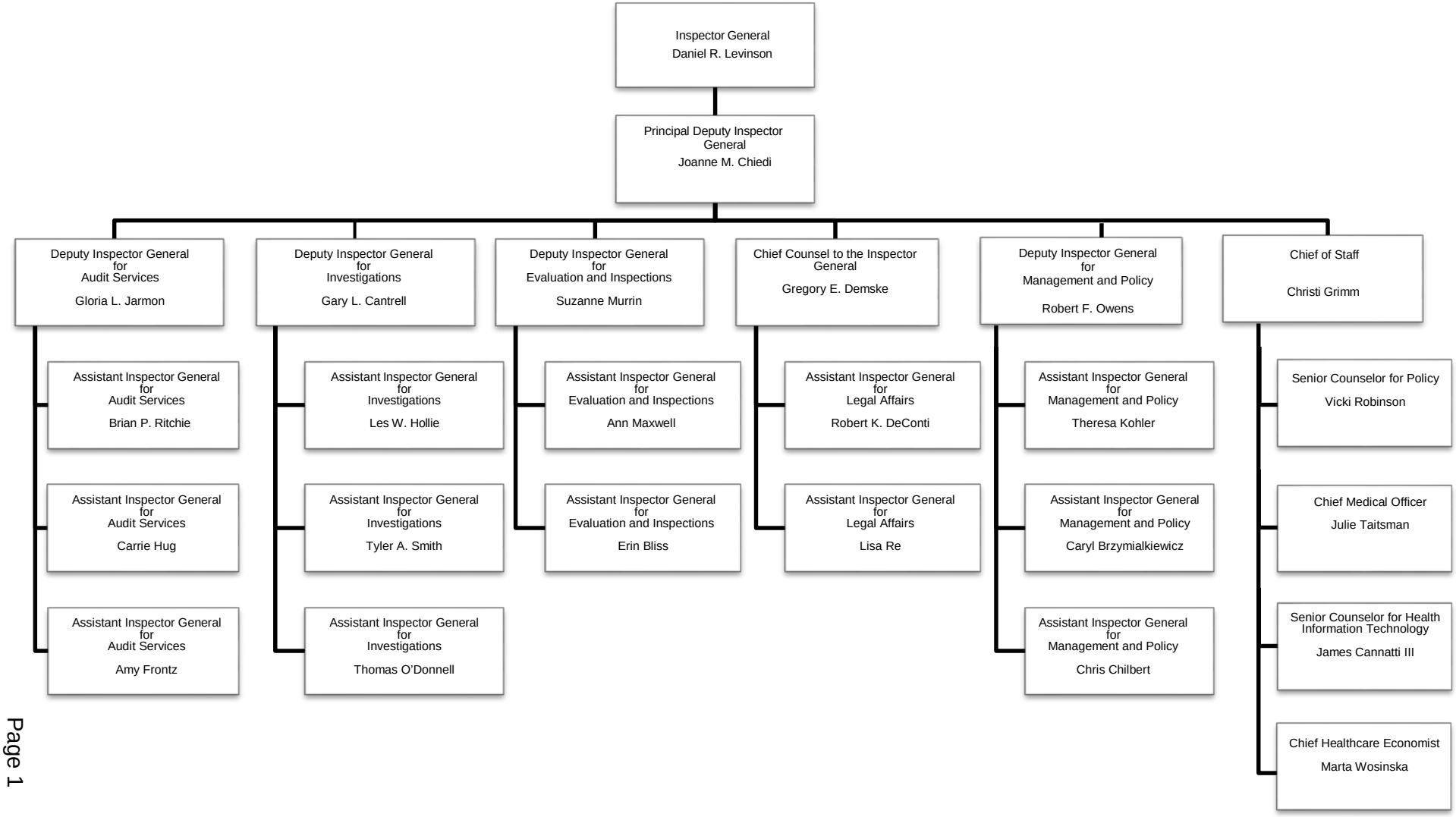
U.S. Department of Health and Human Services
Office of Inspector General

https://oig.hhs.gov

EXECUTIVE SUMMARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Organizational Chart



Overview of Budget Request

The 2019 request for the Office of Inspector General (OIG) is $387.5 million, an additional $22.8 million above the fiscal year (FY) 2018 annualized Continuing Resolution (CR) (post-sequester). The FY 2019 request does not estimate sequestration. OIG's funding is divided into two main categories: (1) Public Health and Human Services (PHHS) Oversight and (2) Medicare and Medicaid Oversight. The FY 2019 overall requests and program increases for these categories include:

PHHS Oversight:[1] $80 million[2] and 357 full-time equivalent (FTE), a decrease of $947,000 from the FY 2018 annualized CR.

The PHHS programs of the Department of Health and Human Services (HHS or the Department) represent nearly $100 billion in spending. OIG will strengthen the Department's PHHS programs by leveraging data, technology, and specialized expertise to target high-risk areas and maximize the impact of OIG's oversight activities. OIG advances its mission through a strategic program of investigations, audits, evaluations, enforcement actions, and compliance efforts.

In FY 2019, OIG will focus on the successful implementation by HHS of new authorities under the 21st Century Cures Act. Among other provisions, the 21st Century Cures Act provided $1 billion in new grants for prevention and treatment of opioid addiction and a new civil monetary penalty (CMP) authority for fraud involving HHS grants and contracts.

Additionally, OIG will focus on promoting quality and safety in Indian Health Service (IHS) and childcare facilities; preventing fraud, waste, and abuse in grants and contracts; ensuring proper operation of the Food and Drug Administration (FDA); strengthening preparation for public health emergencies; and supporting the efficient and secure use of data and technology, including the smooth sharing of health information across the care continuum.

Medicare and Medicaid Oversight: $307.5 million and 1,265 FTE ($23.7 million above the FY 2018 President's Budget post-sequester)

- Health Care Fraud and Abuse Control Program (HCFAC) Mandatory: $208.2 million, an increase of $18.1 million over the FY 2018 annualized CR
- HCFAC Discretionary: $87.2 million, an increase of $5.1 million over the FY 2018 annualized CR
- HCFAC Collections: $12.0 million estimated

This funding level 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 will continue HCFAC oversight activities to combat fraud, waste, and abuse in Medicare and Medicaid. OIG is a leader in the fight against Medicare and Medicaid fraud and will continue to use sophisticated data analytics and multidisciplinary state-of-the-art investigative techniques to detect crime and conduct criminal investigations of fraud. OIG will continue its FY 2018 work to combat opioid and other prescription drug abuse as well as enhance work focused on home health services and services in other noninstitutional settings, including reducing improper payments. OIG will also strengthen oversight of Medicare Advantage and Medicaid Program Integrity.

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

[2]The request does not include the $1.5 million transfer from FDA in previous appropriations acts.

Overview of Performance: Outcome Focused

OIG employs Data Driven Decision Making to achieve outcome-focused results. OIG continues to modernize its infrastructure capacity to deliver high-quality, timely, actionable data to frontline staff. OIG has established a Chief Data Officer position, a first in the IG community, and has focused the organization on developing Key Performance Indicators (KPIs) to further drive results in priority areas and measure the impact of OIG's work. OIG delivers financial savings to taxpayers while minimizing risks to beneficiaries and safeguarding programs from mismanagement and fraud.

Strategic Plan

OIG's mission is to protect the integrity of HHS programs and the health and welfare of the people they serve. OIG's Strategic Plan focuses on four goals that drive OIG's work:

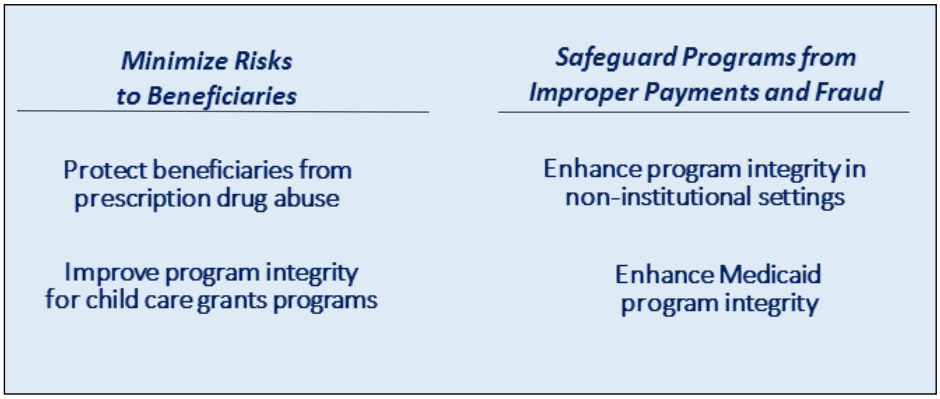
1. Fight fraud, waste, and abuse.
2. Promote quality, safety, and value.
3. Secure the future.
4. Advance excellence and innovation.

OIG's priority outcome areas, described below, demonstrate our focus on strategically targeted oversight, driving measurable results, and achieving overarching performance goals.

Changes to OIG Performance Metrics

With a $1 trillion portfolio to oversee, OIG sets priority outcomes to achieve the greatest impact across HHS's diverse programs. OIG's initial priority outcome areas fall into two broad categories:

1. Minimize risks to beneficiaries.
2. Safeguard programs from improper payments and fraud.



These priority outcome areas reflect only some of the important work OIG performs. They address key vulnerabilities identified in the HHS publication, *Top Management and Performance Challenges*. OIG is developing specific measures for each area.

Integrating Performance Management

OIG's work processes integrate performance management and strategic planning efforts to drive positive change with maximum efficiency. To do so, OIG integrates data into management decision making through business case reviews, executive-level working sessions and progress meetings, and regular reviews of data with managers. OIG evaluates a number of factors when considering potential projects, including authorizing statutes and mandates, stakeholder input, risk assessments, work performed by other oversight organizations (e.g., the Government Accountability Office (GAO)), implementation of previous OIG recommendations, and, of growing importance, data analysis of potential fraud trends and risk.

Significant Accomplishments

OIG provided significant contributions to the Department's program integrity in FY 2017. The HCFAC program, of which OIG is a major participant, returned $5 to the Federal Government for every $1 invested in FY 2016.[3] Additionally, OIG's expected recoveries from its involvement in health care audits and investigations totaled $4.7 billion, which resulted in a return on investment (ROI) of $14 to $1. While the HCFAC recoveries are actual dollars returned to the Federal Government. OIG's expected recoveries are anticipated from FY 2017 judgements, settlements, and audit disallowances. These returns demonstrate that OIG continues to achieve positive and impactful results for the Department and the beneficiaries it serves.

In FY 2017, OIG excluded 3,244 individuals and organizations from participation in Federal health care programs. Among these were exclusions based on criminal convictions for crimes related to Medicare and Medicaid (1,281) or to other health care programs (309), for patient abuse or neglect (266), and as a result of licensure revocations (973). Exclusion helps protect these programs from fraudulent billing and beneficiaries from being harmed. OIG also issued 243 audits and evaluations with 682 recommendations that, when implemented, would correct program vulnerabilities and save program funds.

In its Fall 2017 *Semiannual Report to Congress*, OIG reported 881 criminal actions against individuals or organizations that engaged in crimes against HHS programs and 826 civil and administrative enforcement actions, including False Claims Act (FCA) lawsuits filed in Federal district court, and CMP law settlements, some of which related to provider self-disclosure matters. OIG concluded cases involving approximately $49.1 million in CMPs in FY 2017. OIG work also prevents fraud and abuse through industry outreach and guidance and recommendations to HHS to remedy program vulnerabilities.

Moreover, nearly $24.4 billion in cost savings were attributed to FY 2017 from policy decisions supported by OIG recommendations reflected in legislation, regulations, or other directives from prior years. This figure reflects the most recently available savings estimates issued by third-party appraisers, such as the Congressional Budget Office (CBO) or HHS actuaries; actual savings may be higher or lower.

FY 2017 Facts

$4.7 billion
Expected Recoveries

$5:$1[3]
HCFAC ROI

$14:$1
OIG Expected ROI

3,244
Exclusions

881
Criminal Actions

826
Civil and Administrative Enforcement Actions

243
Audits and Evaluations

682
Recommendations

$49.1 Million
CMP Recoveries

[3] The FY 2017 annual HCFAC report, which will include the FY 2017 return on investment, is due for release in FY 2018 after the release of the President's Budget.

All-Purpose Table[4]

(Dollars in millions)

	FY 2017 Enacted	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
PHHS Oversight[5]				
Discretionary Budget Authority (BA)[6]	$81,500	$80,947	$80,000	-$947
Subtotal, PHHS Oversight BA	**$81,500**	**$80,947**	**$80,000**	**-$947**
Medicare/Medicaid Oversight				
HCFAC Mandatory BA	185,906	190,389	208,290	+17,901
HCFAC Discretionary BA	82,132	82,132	87,230	+5,098
Subtotal, Medicare/Medicaid Oversight BA[7]	**268,038**	**272,521**	**295,520**	**+22,999**
HCFAC Estimated Collections[8]	9,664	11,208	12,000	+792
Subtotal, Medicare/Medicaid Oversight PL	**277,702**	**283,729**	**307,520**	**+23,791**
Total BA	**349,538**	**353,468**	**375,520**	**+22,052**
Total PL	**$359,202**	**$364,676**	**$387,520**	**+ $22,844**
FTE	1,608	1,622	1,650	+28

[4] Table excludes non-HCFAC reimbursable funding. In FY 2017, OIG obligated $16.2 million in non-HCFAC reimbursable funding. The estimate for FYs 2018 and 2019 is $21 million. This estimate includes funds from § 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 $56,769 for this effort in FY 2017.

[5] 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.

[6] The PHHS Oversight amount includes the $1.5 million transfer from the FDA appropriation in FYs 2017 and 2018. FY 2019 request is equal to FY 2017 enacted discretionary BA level, excluding the FDA transfer.

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

[8] In FY 2017, OIG collected $10.3 million under authority of 42 U.S.C. 1320a-7c (§ 1128C of the Social Security Act), and the actual amount sequestered is $716,241. 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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BUDGET EXHIBITS

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, $80,000,000: Provided, that of such amount, necessary sums shall be available for providing protective services to the Secretary and investigating nonpayment of child support cases for which nonpayment is a Federal offense under 18 U.S.C. Section 228.

Amounts Available for Obligation[9]

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
General Fund Discretionary Appropriation:			
Annual appropriation (Labor/HHS)	$80,000	$79,457	$80,000
Rescission (CR, PL 115-31)		-543	-
Total, Discretionary Appropriation	**80,000**	**79,457**	**80,000**
Transfers:			
Transfer from FDA	1,500	1,490	-
Total, Transfer	**1,500**	**1,490**	**-**
Offsetting Collections from:			
Trust Fund HCFAC Discretionary	82,132	82,132	87,230
Amount Sequestered	-	-	-
Total, HCFAC Discretionary	**82,132**	**82,132**	**87,230**
Offsetting Collections from:			
Trust Fund HCFAC Mandatory	199,685	203,842	208,290
Amount Sequestered	-13,778	-13,454	-
Additional Amounts	-	-	-
Recoveries from prior years	-	-	-
Estimated Collections[10]	10,380	12,000	12,000
Amount Sequestered from Collections	-716	-792	-
Previously Sequestered, but Available	816	828	828
Total, HCFAC Mandatory	**196,387**	**202,424**	**221,118**
Total Amount Sequestered	-14,494	-14,246	-
Offsetting collections from:			
Unobligated balance, start of year	37,805	41,341	20,119
Unobligated balance, end of year[11]	41,341	20,119	13,103
Unobligated balance, lapsing	562	-	-
Total obligations	**$372,202**	**$386,724**	**$400,348**

[9] Table excludes non-HCFAC reimbursable funding. In FY 2016, OIG obligated $16.2 million in non-HCFAC reimbursable funding. The estimate for both FYs 2018 and 2019 is $21 million.

[10] The table includes the estimated amounts for FY 2018 and FY 2019.

[11] The FY 2017 end of year unobligated balance includes $13 million in unobligated balances that OIG de-obligated at the beginning of FY 2018.

Summary of Changes

(Dollars in thousands)

2018 Enacted	
Total estimated budget authority	$80,947
(Obligations)	$80,947
2019 President's Budget	
Total estimated budget authority	$80,000
(Obligations)	$80,000
Net Change	-$947

	FY 2018 Estimate FTE	FY 2018 Estimate BA	FY 2019 PB FTE	FY 2019 PB BA	FY 2019 +/- FY 2018 BA
Increases:					
A. Built-in:					
1. Provide for salary of FTE	347	$57,266	347	$57,454	+$198
a. Increase due to .475-percent pay (non-add)	-	*$1,141*	-	*$198*	*-$943*
2. Provide for General Services Administration (GSA) rent	-	$4,892	-	$4,892	-
a. Increase in GSA rent (non-add)	-	*$472*	-	-	*-$472*
Subtotal, Built- Increases	**347**	**$62,158**	**347**	**$62,356**	**+$198**
Total Increases	**347**	**$62,158**	**347**	**$62,356**	**+$198**
Decreases:					
A. Built-in:					
1. Provide for salary of FTE					
a. Pay shift to HCFAC oversight (non-add)	-	*-$1,638*	-	-	+$1,638
Subtotal, Built-in Decreases	**-**	**-**	**-**	**-**	**-**
B. Program:					
1. Costs related to general operating expenses	-	$18,789		$17,644	-$1,145
a. Change in operating expenses (non-add)	-	*-$230*		*-$1,144*	*-$914*
Subtotal, Program Increases	**-**	**$18,789**	**-**	**$17,644**	**-$1,145**
Total Decreases	**-**	**$18,720**	**-**	**$17,575**	**-$1,145**
Net Change	**347**	**$80,947**	**347**	**$80,000**	**-$947**

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[12]

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
PHHS Oversight			
Discretionary BA[13]	$80,000	$79,459	$80,000
FDA Transfer	1,500	1,489	0
Subtotal, PHHS Oversight	**81,500**	**80,948**	**80,000**
Medicare and Medicaid Oversight			
HCFAC Mandatory BA	185,906	190,389	208,290
HCFAC Discretionary BA	82,132	82,132	87,230
Subtotal, Medicare and Medicaid Oversight BA[14]	**268,038**	**272,521**	**295,520**
[HCFAC Collections[15]]	[9,664]	[11,172]	[12,000]
[Subtotal, Medicare and Medicaid Oversight PL]	**[277,702]**	**[284,233]**	**[307,520]**
Total, BA	**349,538**	**353,469**	**375,520**
[Total, PL]	**[$359,202]**	**[$365,181]**	**[$387,520]**
FTE	1,608	1,622	1,650

[12] Table excludes non-HCFAC reimbursable funding. In FY 2017, OIG obligated $16.2 million in non-HCFAC reimbursable funding. The estimate for FYs 2018 and 2019 is $21 million. This estimate includes funds made available in § 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 $56,769 for this effort in FY 2017.

[13] In FYs 2017-2018, OIG's Discretionary BA includes $1.5 million, transferred from the FDA.

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

[15] In FY 2017, OIG collected $10.3 million under authority of 42 U.S.C. 1320a-7c (§ 1128C of the Social Security Act), and the actual amount sequestered is $716,241. 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 2018 Amount Authorized	FY 2018 Amount Appropriated	FY 2019 Amount Authorized	FY 2019 President's Budget
OIG:				
1. Inspector General Act of 1978 (P.L. No. 95-452, as amended)	Indefinite	$79,947	Indefinite	$80,000
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. No.104-191, as amended), HCFAC Mandatory……..	$190,389	$190,389	$208,290	$208,290
HIPAA, as amended, HCFAC Discretionary.....	Indefinite	$82,132	Indefinite	$87,230
HIPAA, as amended, HCFAC Collections[16]	Indefinite	$11,208	Indefinite	$12,000
Unfunded authorizations:				
1. Supplemental Appropriations Act of 2008 (P.L. No. 110-252, as amended)…….	$25,000	$0	$25,000	$0
2. 21st Century Cures Act (P.L. No 114-255, as amended)……	$10,000	$0	$10,000	$0

[16] The table includes estimates for HCFAC collections for FYs 2018 and 2019, and the amounts available will depend on the amounts actually collected.

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2010				
Direct Discretionary	$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[17]	$177,205,000	-	-	$177,205,000
Medicaid Oversight	$25,000,000	-	-	$25,000,000
FY 2011				
Direct Discretionary	$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
FY 2012				
Direct Discretionary	$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				
Direct Discretionary	$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[18]	$196,669,000	-	-	$196,299,000
Sequestration	-	-	-	($10,011,228)
Disaster Relief Appropriations Act of 2013	-	-	-	$5,000,000
Sequestration	-	-	-	($251,849)
FY 2014				
Direct Discretionary	$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				
Direct Discretionary[19]	$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	-	-	-	($14,652,449)
FY 2016				
Direct Discretionary[19]	$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

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

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

[19] The Direct Discretionary amount for FY 2015—2018 includes $1.5 million transferred from FDA, consistent with the annual appropriations acts.

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
Sequestration		-	-	($13,688,377)
FY 2017				
Direct Discretionary[19]	$85,000,000	$86,500,000	$76,500,000	$76,500,000
Rescission	-	-	-	($145,427)
HCFAC Discretionary Allocation Adjustment	$121,824,000	$67,200,000	$79,355,000	$67,200,000
HCFAC Mandatory	$200,273,000	-	-	$199,684,560
Sequestration	-	-	-	($13,778,235)
FY 2018				
Direct Discretionary[1]	$68,085,000	$81,500,000	$81,500,000	
HCFAC Discretionary Allocation Adjustment	$74,246,000	$82,132,000	$84,398,000	
HCFAC Mandatory	$203,842,374	$203,842,374	$203,842,374	$203,842,374
Sequestration	($13,453,597)	($13,453,597)	($13,453,597)	($13,453,597)
FY 2019				
Direct Discretionary	$80,000,000	-	-	-
HCFAC Discretionary Allocation Adjustment	$87,230,000	-	-	-
HCFAC Mandatory	$208,289,651	-	-	-
Sequestration	-	-	-	-

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NARRATIVE BY ACTIVITY

OIG Summary of Request

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
PHHS Oversight[20]	$81,500	$80,947	$80,000	-$947
Medicare and Medicaid Oversight[21]	277,702	283,729	307,520	+23,791
Total	**$359,202**	**$364,676**	**$387,520**	**+$22,844**
FTE	**1,608**	**1,622**	**1,650**	**+28**

Authorizing Legislation ..... Inspector General Act of 1978, as amended
FY 2018 Authorization ..... Indefinite
Allocation Method ..... Direct Federal

Program Description

For more than 40 years, OIG has protected HHS expenditures and HHS program beneficiaries. Legislative and budgetary requirements shape OIG's activities. OIG carries out its activities in accordance with professional standards established by GAO, the 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 HHS program beneficiaries. HHS is a complex agency with approximately 80,000 employees in the United States and across the globe. It is the largest grant-making agency and the fourth-largest contracting agency in the Federal Government. OIG investigates HHS employee, contractor, and grantee misconduct or violations of criminal law. OIG criminal investigators also provide physical protection for the Secretary of Health and Human Services.

FY 2017 Fast Facts

1976 Established

70+ Locations

1,600+ Staff Onboard

$359 Million Budget

+$1 Trillion HHS Spending

78% Mandatory
22% Discretionary

OIG's areas of oversight fall into two broad categories: (1) PHHS, which includes oversight of more than a hundred HHS programs 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 2017, 22 percent of OIG's resources were directed toward HHS's PHHS programs and management processes. This included food and drug safety, disaster relief, IHS, child support enforcement, the integrity of departmental contracts and grants programs and transactions, and oversight of the health insurance exchanges. The majority (78 percent) of OIG's funding was directed toward oversight of the Medicare and Medicaid programs.

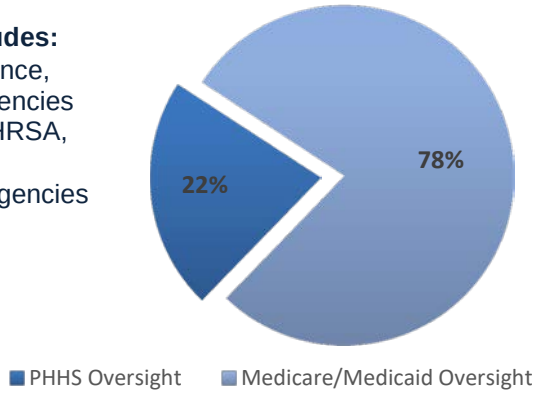
[20] PHHS oversight includes programs authorized in Title I of the ACA and administered by CMS.

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

OIG's Areas of Oversight
FY 2017

PHHS Oversight includes:

- Public Health, Science, and Regulatory Agencies (CDC, NIH, FDA, HRSA, SAMHSA, AHRQ)
- Human Services Agencies (ACF, ACL)
- IHS
- Health Insurance Exchanges



Medicare and Medicaid Oversight includes:

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

OIG comprises a multidisciplinary team – investigators, auditors, evaluators, lawyers, data analysts, program specialists, clinicians, a health care economist, and other experts. OIG brings multiple professional skills, tools, and perspectives together to tackle complicated health and human services issues and sophisticated fraud schemes. This cross-cutting approach allows OIG to use its expertise and authorities comprehensively to address fraud, starting with prevention and detection and, where necessary, ending with enforcement.

OIG maintains a Washington, DC, office and a nationwide network of regional and field offices; more than 70 percent of employees work outside the Metropolitan Washington area.

In FY 2017, OIG's total funding supported an estimated 1,608 FTE across OIG's five components.

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 Department programs and HHS grantees and contractors in carrying out their respective responsibilities and provide independent assessments of HHS programs and operations. These assessments produce recommendations to collect misspent payments and correct policies and practices that give rise to waste, abuse, and mismanagement.

	PHHS	Medicare/ Medicaid	Total
Reports Started	54	161	**215**
Reports Issued	57	139	**196**
FTE	184	449	**633**

Office of Evaluation and Inspections (OEI)

OEI performs nation-wide evaluations that proactively identify salient issues using innovative, state-of-the-art, and rigorous methods to provide decision makers with independent, useful, and reliable information. These evaluations include recommended solutions for improving programs and their ability to serve the public. These evaluations focus on promoting economy, efficiency, and effectiveness in Department programs as well as preventing fraud, waste, and abuse.

	PHHS	Medicare/ Medicaid	Total
Evaluations Started	16	39	**55**
Evaluations Issued	12	35	**47**
FTE	38	99	**137**

Office of Investigations (OI)

OI conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. OI coordinates with DOJ and other Federal, State, and local law enforcement authorities. OI's investigations often lead to criminal convictions, civil recoveries, CMPs, and exclusions from participation in Federal health care programs.

	PHHS	Medicare/ Medicaid	Total
Complaints Received	469	2,992	**3,461**
Cases Opened	306	1,854	**2,160**
Cases Closed	322	1,685	**2,007**
FTE	103	506	**609**

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 FCA, program exclusion, and CMP cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements (CIAs). OCIG renders advisory opinions, promotes compliance and issues compliance program guidance, publishes fraud alerts and special bulletins, develops provider education resources, and provides other guidance to the health care and life sciences industries as well as State and local governments concerning the anti-kickback statute and other OIG enforcement authorities.

	PHHS	Medicare/ Medicaid	Total
FTE	8	78	**86**

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 coordinating OIG activities and providing mission support, including setting vision and direction for OIG's priorities and strategic planning; ensuring effective management of budget, finance, 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. EM provides critical data analytics, data management, and information technology (IT) infrastructure that enables OIG components to conduct their work efficiently and effectively.

	PHHS	Medicare/ Medicaid	Total
FTE	32	111	**143**

Significant Accomplishments

FY 2017 Opioids Data Brief and Takedown

Opioid abuse and overdose deaths are at epidemic levels in the United States. In FY 2017 OIG conducted and released a data brief as part of a larger strategy by the OIG to fight the opioid crisis and address one of its top-priority outcomes—to protect beneficiaries from prescription drug abuse. It provided baseline data on the extent to which beneficiaries receive extreme amounts of opioids and appear to be "doctor shopping." It also identified prescribers who have questionable opioid prescribing patterns. OIG found that one in three Medicare Part D beneficiaries received a prescription opioid in 2016, about 500,000 beneficiaries received high amounts of opioids, and 90,00 beneficiaries are at serious risk. Further, about 400 prescribers had questionable opioid prescribing patterns for beneficiaries at serious risk.

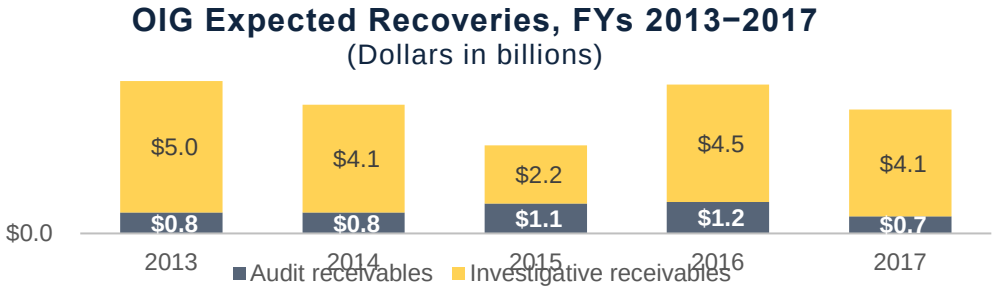
The data brief was instrumental in the FY 2017 National Health Care Fraud Takedown. In July 2017, OIG, along with its State and Federal law enforcement partners, participated in the largest health care fraud takedown in history. The data brief helped OIG identify more than 400 defendants in 41 Federal districts who were subsequently charged with participating in fraud schemes involving approximately $1.3 billion in false billings to Medicare and Medicaid. That is a 37 percent increase in defendants charged and a 44 percent increase in false billings compared to the FY 2016 takedown. OIG also issued exclusion notices to 295 doctors, nurses, and other providers on the basis of conduct related to

opioid diversion and abuse. Takedowns protect the Medicare and Medicaid programs and deter fraud—sending a strong signal that theft from these taxpayer-funded programs, and the associated harm to patients, will not be tolerated.

Expected Recoveries[22]

In FY 2017, OIG reported expected recoveries of approximately $4.7 billion in fines, penalties, and stolen and misspent funds. Expected recoveries are the amount the Government expects to recover or receive because of OIG's oversight and enforcement efforts. The FY 2017 expected recoveries have resulted in an OIG ROI on health-care-related oversight of $14:$1.

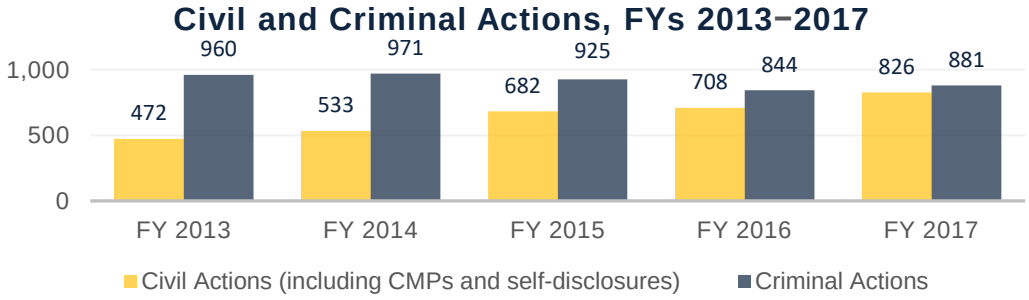
Over the last 5 years, OIG's average expected recoveries were $4.9 billion annually. Changes in the amount of expected recoveries from year to year are due to the particular mix of cases resolved in a given year, as well as continued efforts to work with OPDIVs to implement OIG recommendations.



Note: Audit and investigative receivable subtotals above may not equal reported OIG totals due to rounding.

Criminal and Civil Actions

Working in concert with its law enforcement partners to fight fraud and abuse in FY 2017, OIG conducted investigations that resulted in 881 criminal actions against individuals or entities that engaged in crimes against HHS programs, and 826 civil actions, which include False Claims Act lawsuits filed in Federal district court and CMP settlements, many of which related to provider self-disclosure matters. Since April 2017, OIG provider self-disclosure cases resulted in more than $12.6 million in HHS receivables. During FY 2017, OIG imposed 3,391 administrative sanctions in the form of program exclusions or administrative actions for alleged fraud or abuse or other activities that posed a risk to Federal health care programs and their beneficiaries.



Corporate Integrity Agreements

CIAs are one tool used to prevent fraud, help ensure that program beneficiaries have access to needed services, and promote quality, safety, and value. OIG often negotiates compliance obligations with corporations and individuals as part of the settlement of allegations arising under civil and administrative false claims and fraud statutes. The settling party consents to these obligations as part of the settlement and in exchange for OIG's agreement not to seek exclusion from participation in

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

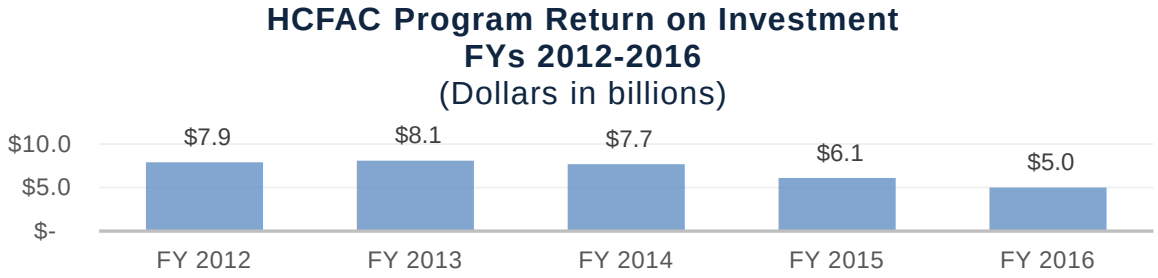
Federal health care programs. CIAs typically last for 5 years and include penalties for failure to meet certain terms. OIG monitors compliance with CIAs and holds accountable those who violate them by seeking exclusion for breaches and imposing stipulated penalties on a per-day basis for failure to comply with CIA obligations.

Advisory Opinions and Other Guidance

As part of continuing efforts to promote the highest level of ethics in the health care industry, OIG issues advisory opinions (which are required by statute) and other guidance to educate the health care industry and other stakeholders on how to strengthen compliance efforts and avoid practices that might implicate various fraud and abuse laws. This guidance helps industry navigate the anti-kickback statute, safe harbor regulations, and other OIG health care fraud and abuse authorities. During FY 2017, OIG received 49 requests for advisory opinions and issued 9 opinions and 1 modification to an advisory opinion.[23] Since the inception of the HCFAC program, OIG has issued more than 350 advisory opinions and 20 modifications to advisory opinions. Recently, OIG issued a Policy Statement Regarding Gifts of Nominal Value to Medicare and Medicaid Beneficiaries.[24]

HCFAC Program ROI

Under the joint direction of the Attorney General and the Secretary of Health and Human Services acting through OIG, the HCFAC Program coordinates Federal, State, and local law enforcement activities with respect to health care fraud and abuse. The most recent ROI from the FY 2016 annual HCFAC report for the HCFAC program is approximately $5 returned for every $1 invested.[25] 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 $31 billion to the Medicare trust fund. The HCFAC program'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.



Program Improvements through Recommendations Implemented

Preventing fraud, waste, and abuse from occurring or recurring is central to OIG's mission to protect HHS programs and the beneficiaries they serve. Toward this end, OIG recommends program and management improvements, program integrity safeguards, and cost-saving changes to programs or policies. In FY 2017, OIG made 632 recommendations stemming from 196 audits and 50 recommendations stemming from 47 program evaluation reports. In FY 2017, 280 audit recommendations and 3 evaluation recommendations were implemented to improve the efficiency and effectiveness of HHS programs and operations.

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[23] OIG closes many advisory opinion requests without issuing opinions, frequently because the requests are withdrawn.

[24] This document is available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf.

[25] The FY 2017 annual HCFAC report, which will include the FY 2017 return on investment is due for release in FY 2018 after the release of the President's Budget. HCFAC ROI is based on a 3-year rolling average.

Overview

The FY 2019 President's Budget request for OIG includes $387.5 million to strengthen oversight of HHS programs. With these resources, OIG is responsible for oversight of approximately $1 trillion in HHS spending. This represents about a quarter of every Federal dollar spent, covering a complex portfolio of programs ranging from health insurance to clinical research and epidemiology and public health services. OIG's FY 2019 request falls into the following two broad categories:

PHHS Oversight:[26]
$80 million[27] and 357 FTE
($947,000 less than the FY 2018 CR)

HHS's PHHS programs represent nearly $100 billion in spending and include HHS's international operations. With the requested funding, OIG will strengthen the Department's PHHS programs by leveraging data and specialized expertise to target the most pressing vulnerabilities identified by its analysis and directing OIG's oversight activities at those high-risk areas. OIG advances its mission through a robust program of criminal and civil investigations, audits, evaluations, enforcement actions, and compliance efforts.

In FY 2019, OIG will focus on the successful implementation by HHS of new authorities under the 21st Century Cures Act, which, among other things, provided $1 billion in new grants for prevention and treatment of opioid addiction. OIG will continue its oversight activities from FY 2018, including work focused on quality and safety in IHS facilities and in childcare programs; fraud, waste, and abuse in grants and contracts; emergency preparedness; and the efficient and secure use of data and technology, including the smooth sharing of health information across the care continuum.

Medicare and Medicaid Oversight:
$307.5 million and 1,293 FTE
($23.8 million more than the FY 2018 CR)

- HCFAC Mandatory: $208.3 million, an increase of $17.9 million over the FY 2018 level, post-FY 2018 sequestration. The FY 2019 level does not include sequestration, which will be estimated after the release of the FY 2019 President's Budget.
- HCFAC Discretionary: $87.2 million, an increase of $5.1 million over the FY 2018 annualized CR
- HCFAC Collections: $12.0 million estimated

This funding level 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 will continue HCFAC oversight activities to combat fraud, waste, and abuse in Medicare and Medicaid. OIG is a leader in the fight against Medicare and Medicaid fraud and will continue to use sophisticated data analytics and multidisciplinary, state-of-the-art investigative techniques to detect fraud and conduct criminal investigations. OIG will continue its FY 2018 work to combat prescription drug abuse, including opioid abuse, and will enhance work focused on strengthening oversight of services provided in noninstitutional settings, including reduction of improper payments for home health, Medicare Advantage, and Medicaid.

[26] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by CMS.

[27] The request does not include the $1.5 million transfer from FDA in previous appropriations acts.

OIG-Wide Performance Table

Key Outcomes[28]	Most Recent FY 2017 Actual	FY 2018 Target[29]	FY 2019 Target	FY 2019 +/- FY 2018
Expected recoveries resulting from OIG involvement in health care fraud and abuse oversight activities (dollars in millions)	$3,701 (Target Met)	$3,500	$3,500	+$-
ROI resulting from OIG involvement in health care fraud and abuse oversight activities	$14:$1 (Target Met)	$14:$1	$14:$1	+$-
Number of quality and management improvement recommendations accepted	147 (Within Target Range)[29]	150	154	+4
PL funding (dollars in millions)	**$359.2**	**$364.7**	**$387.5**	**+$22.8**
Key Outputs	**Most Recent FY 2016 Actuals[29]**	**FY 2018 Target[2]**	**FY 2019 Target**	**FY 2018 +/- FY 2019**
Audits:				
Audit reports started	215 (Target Met)	178	180	**+2**
Audit reports issued	196 (Within Target Range)[29]	178	180	**+2**
Audit reports issued within 1 year of start (percentage)	36% (Target Not Met)[29]	46%	46%	**--%**
Evaluations:				
Evaluation reports started	55 (Target Met)	36	38	**+2**
Evaluation reports issued	47 (Within Target Range)[29]	44	46	**+2**
Evaluation reports issued within 1 year of start (percentage)	64% (Target Met)	56%	56%	**--%**
Investigations:				
Complaints received for investigation	3,461 (Target Met)	2,799	2,827	**+28**
Investigative cases opened	2,160 (Target Met)	1,783	1,801	**+18**
Investigative cases closed	2,007 (Target Met)	1,842	1,860	**+18**
PL funding (dollars in millions)	**$359.2**	**$364.7**	**$387.5**	**+$22.8**

[28] The "expected recoveries" and ROI performance measures are calculated using 3-year rolling averages. Performance was within 10 percent of projected target.

Performance Goals

Among other indicators, OIG uses three key outcome measures to express OIG's progress in fighting 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 in 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. 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 program 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 risk and vulnerabilities.

As shown in the table on the previous page, several outputs contribute to OIG's success and performance impact. Many factors are considered in the development of OIG's output targets, such as resources and capacity. An increase in resources in one fiscal year may not necessarily yield results in the same fiscal year, as most actions are multiyear efforts. Performance targets reflect the best estimate of the time required to hire and train new staff as well as the ability to hire.

OIG Priority Outcomes

OIG has introduced performance indicators that align with OIG's priority outcomes. OIG wants to drive action, unleash its organizational creativity, and measure its impact to provide solutions and improve outcomes for HHS programs and beneficiaries. The initial priority outcome areas were selected based on past and ongoing work, top challenges facing HHS, ability to collect data, and ability to influence outcomes. The initial priority outcome areas are:

- ***Priority Outcome:*** **Protect beneficiaries from prescription drug abuse, including opioid abuse**

  Opioids can serve a useful role in treating certain kinds of pain. However, opioids can also cause significant adverse effects, including addiction and fatal overdose. These risks and benefits vary from patient to patient and across situations. Recognizing this variability, OIG uses a risk-based approach to focus its resources to address the opioid epidemic. OIG's key performance indicator focuses on Part D prescribers with questionable prescribing patterns for beneficiaries as identified by OIG. Identifying prescribers with questionable prescribing patterns is an important first step to identifying physicians whose prescribing may be inappropriate and would benefit from targeted oversight and educational resources. The ultimate goal of such assessments and interventions is to promote appropriate prescribing practices and reduce misuse of opioids in order to protect Medicare beneficiaries and the integrity of the Medicare Part D program. OIG employs a multidisciplinary approach in its efforts to reduce inappropriate prescribing and will use the full range of our authorities, including audits, evaluations, investigations, and exclusions. It will also leverage key partnerships across the Federal, State, and private sector to prevent and detect inappropriate prescribing and hold bad actors accountable.

Key Outcomes	Most Recent Actual	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
Reduction of prescribers who OIG identified as having questionable prescribing patterns[30]	401 CY 2016	-30% from CY 2017	-30% from CY 2018	-30%

- ***Priority Outcome:*** **Enhance program integrity in noninstitutional settings**
  Home health services, which account for approximately $18 billion in Medicare spending per year, have long been recognized as a program area that is particularly vulnerable to fraud, waste, and abuse. Using data analytics, OIG identified four geographic areas—Florida, Texas, and select areas in Southern California and the Midwest—that have large numbers of home health providers with characteristics that OIG determined, based on its previous work, to be suspect. OIG seeks to both reduce fraud, waste, and abuse and enhance program integrity in noninstitutional settings in these four geographic "hot spots" through outreach, education, audits, evaluations, investigations, and administrative enforcement. OIG efforts already have contributed to a 5-percent decrease in home health payments in the four geographic hot spots from CY 2015 through CY 2016. Nationally, the decrease in home health spending over this same time was 1 percent.

Key Outcomes	Most Recent Actual	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
Reduction in Medicare spending to home health providers in geographic hot spots from CY 2015 baseline	$6.68 billion CY 2015	-11%	-14%	-3%

- ***Priority Outcome:*** **Improve program integrity for childcare grant programs**
  OIG is working to improve program integrity of childcare grant programs. Specifically, OIG is looking to increase the number of States that have policies and procedures in place to ensure licensed Child Care Development Fund (CCDF) providers conduct criminal background checks for prospective and existing staff members at least once every 5 years. To measure progress, OIG will track the number of States that have implemented each of the required databases for conducting criminal background checks (intrastate/interstate databases and national databases). OIG will reassess any updated CCDF State Plan information related to criminal background checks, conduct outreach to the Administration for Children and Families (ACF) Office of Child Care, and determine the nature and scope of audits, evaluations, and investigations that could be conducted to assess ACF's, States', and childcare providers' implementation of the Child Care and Development Block Grant Act criminal background check requirement.

Key Outcomes	Most Recent Actual	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
Increase the number of States and territories requiring CCDF providers to conduct criminal background checks at least once every 5 years (intrastate)	29 FY 2017	40	56	+16
Increase the number of States and territories requiring CCDF providers to conduct criminal background checks at least once every 5 years (interstate)	0 FY 2017	10	15	+5

[30] Baseline and targets are based on calendar year.

- ***Priority Outcome:*** **Enhance Medicaid program integrity**
  As part of its oversight of the Medicaid program, OIG is working to maximize the effectiveness of State Medicaid Fraud Control Units (MFCUs), thereby empowering States to better serve their populations. OIG actions to drive MCFU effectiveness include enhancing OIG oversight with increased use of data, expanding the MFCU program to better align with a growing and evolving Medicaid program, targeting MFCU training, and increasing collaboration between MCFUs and OIG. MFCU outcomes related to fraud investigations are tracked by indictments, convictions, civil settlements and judgments, and recoveries.

Key Outcomes	Most Recent Actual	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
Improve Medicaid Fraud Control Unit indictment rates	18% FY 2015	18.5%	19%	+.5%
Improve Medicaid Fraud Control Unit conviction rates	91% FY 2015	91%	91%	Maintain

SUBSECTION: OVERSIGHT OF PHHS AND DEPARTMENT-WIDE ISSUES

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
PHHS BA[31]	$80,000	$79,457	$80,000	+$543
FDA Transfer	1,500	1,490	$0	-1,490
Total BA	**$81,500**	**$80,947**	**$80,000**	**-$947**
FTE[32]	365	357	357	-

Program Description

OIG uses funding from its annual direct discretionary appropriation to conduct program integrity and enforcement activities for PHHS programs and operations, including public health, safety, and scientific research programs, IHS, childcare, other human services grants programs, community health centers, and the health insurance exchanges. These programs represent approximately $100 billion in spending each year and are carried out by approximately 80,000 HHS employees around the world.

During FY 2017, OIG's oversight effort for PHHS was allocated across HHS OPDIVs and STAFFDIVs as follows:

HHS OPDIV and STAFFDIV Oversight	Resource Allocation
Administration for Children and Families (ACF)	33%
Administration for Community Living (ACL)	<1%
Agency for Health Care Research and Quality (AHRQ)	<1%
Centers for Disease Control and Prevention (CDC)	4%
CMS – Exchanges/Title I Programs	3%
Food and Drug Administration (FDA)	7%
Health Resources and Services Administration (HRSA)	7%
Indian Health Service (IHS)	7%
National Institutes of Health (NIH)	8%
Substance Abuse and Mental Health Services Administration (SAMHSA)	2%
Office of the Secretary (OS)[33]	13%
Other PHHS Programs[34]	15%
Total	**100%**

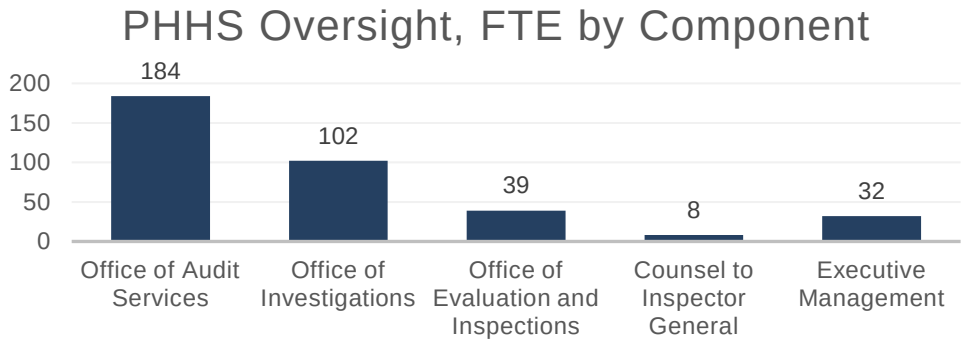
[31] PHHS oversight includes oversight of programs authorized in Title I of the ACA and administered by CCIIO, a component of CMS.

[32] The PHHS discretionary FTE includes 10 reimbursable FTE.

[33] OS includes oversight efforts related to OS STAFFDIVs, such as the Assistant Secretary for Preparedness and Response and protective services for the Secretary, and the Chief Financial Officer Audit.

[34] Examples of these efforts include grant and contract oversight that crosses multiple OPDIVs.

In FY 2017, OIG's FTE, supported with its direct discretionary appropriation, were assigned across OIG's five components as follows:



Accomplishments

In FY 2017, implementation of more than 37 OIG recommendations positively impacted public health and human services programs and program beneficiaries. Noteworthy examples of OIG's recent PHHS oversight accomplishments include the following.

Child Care and Development Fund Block Grant Program Integrity

Approximately $5.7 billion of CCDF funds are administered through block grants to States to serve 1.4 million children. OIG work consistently identifies fraud and improper payments in the CCDF program. OIG has also identified health and safety concerns at childcare facilities that receive CCDF block grants. For example, in January 2017 OIG conducted a review to determine whether Puerto Rico's Department of the Family's controls for provider and client eligibility determinations and for processing CCDF program claims were effective. OIG found that none of the provider eligibility controls that were tested for provider background checks, required provider forms, and provider rate agreements were effective. In addition, several client eligibility controls were not effective. Although Puerto Rico's controls for verifying clients' citizenship were effective, Puerto Rico was not implementing Federal law regarding client eligibility. Puerto Rico also lacked sufficient written policies and procedures, sufficient staff to effectively oversee licensed providers, and adequate procedures to monitor nonlicensed providers in relation to its CCDF program. Puerto Rico concurred with OIG's recommendation to improve its controls and to establish sufficient policies and procedures.

Indian Health Service

IHS is the principal Federal health care provider for American Indians and Alaska Natives. OIG evaluations in FY 2017 identified longstanding challenges that IHS faces in providing quality care through its hospitals. OIG issued a call to action to HHS and made recommendations for systemic improvements. OIG also recommended actions for IHS to strengthen its monitoring of the quality of care in its hospitals. OIG continues to prioritize quality and safety in IHS care and started two new evaluations and four new audits focused on these issues during FY 2017. In addition, OIG works to promote the integrity and effectiveness of HHS grant programs serving American Indian/Alaska Native (AI/AN) populations. In audits of two Tribes, OIG identified improper administration of Low-Income Home Energy Assistance Program (LIHEAP) grant funds. Grant funds totaling $1.2 million for one Tribe and almost $600,000 for the other Tribe were not administered in compliance with Federal requirements. These funds could have been used to provide additional benefits to eligible LIHEAP beneficiaries. Moreover, OIG also provides ongoing technical assistance and training to IHS staff and Tribal communities. In April 2017, OIG conducted a well-attended training program for IHS and Tribal officials on health care and grants management compliance in South Dakota.

Centers for Disease Control and Prevention (CDC), President's Emergency Plan for AIDS Relief (PEPFAR) Award Compliance

OIG's team of investigators works to address significant vulnerabilities within the Department's overseas operations of global health-funded programs, including PEPFAR and Zika-mitigation efforts. PEPFAR was authorized to receive $48 billion in funding for the 5-year period beginning October 1, 2008, to assist foreign countries in combating HIV/AIDS, tuberculosis, and malaria. CDC awards PEPFAR funds to and works with ministries of health and other partners in 60 countries to combat HIV/AIDS globally. Additional funds were authorized to be appropriated through 2018. OIG met with senior diplomatic officials and provided fraud awareness and anticorruption presentations to CDC's international staff and cooperative agreement partners in Uganda, Tanzania, and Kenya. In a June 2017 report, OIG reported on audit work examining CDC's compliance with policies, finding that CDC did not comply with one or more HHS or internal policies in some awards and making recommendations for improvements. OIG found that Management and Development for Health, located in Dar es Salaam, Tanzania, did not always manage PEPFAR funds in accordance with award requirements. To date, OIG's efforts to fight fraud, waste, and abuse in international programs have increased the number of international complaint referrals and resulted in policy changes by CDC to strengthen oversight of these funds.

Improving FDA Oversight of Food Safety

Each year roughly 48 million people in the United States get sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases. FDA is tasked with ensuring the safety of much of the Nation's food supply. OIG work has identified shortcomings in FDA's food safety oversight, including inadequacies in the processes to recall adulterated foods and FDA's inspections of domestic food facilities. In 2017, OIG released an audit that identified deficiencies in FDA's oversight of recall initiation, monitoring, and systems based on review of recalls between 2012 and 2015 and made recommendations for improvements. This report followed an OIG Early Alert issued to FDA in June 2016 addressing insufficient voluntary recall policies and procedures, in response to which FDA reported making major changes to FDA's oversight of the process, including, for example, implementing a new quality system recall audit plan. In an evaluation, OIG found that although FDA is on track to meet the inspection timeframes mandated by the Food Safety Modernization Act (FSMA), this did not result in a greater number of facilities being inspected. The overall number of food facilities FDA inspected—excluding the number of facilities it attempted to inspect—decreased over time. In addition, FDA did not always take swift and effective action to ensure that facilities corrected significant inspection violations.

Office of Refugee Resettlement, Improved Coordination and Outreach to Promote the Safety and Well-Being of Unaccompanied Alien Children

Each year, tens of thousands of children without legal status enter the United States unaccompanied by their parents or legal guardians. These children are referred to as unaccompanied alien children (UAC). In 2008, OIG examined the placement, care, and release of UAC and found a lack of clarity between HHS and the Department of Homeland Security (DHS) regarding their roles and responsibilities related to UAC. OIG recommended that HHS establish a formal agreement with DHS to delineate each Department's roles and responsibilities as they relate to UAC. In 2017, the OIG found that HHS improved its coordination with DHS, thus implementing OIG's prior recommendations. The OIG also found that HHS increased its efforts to promote the safety and well-being of UAC after their release from HHS custody. Through these efforts, HHS identified concerns about the safety and well-being of these children and reported the concerns to investigative agencies.

Funding History

The funding history in the table below includes the budget authority appropriated to OIG for PHHS oversight. The funds displayed are provided to OIG through an annual discretionary direct appropriation included in the Labor, Health and Human Services, Education and Related Agencies appropriations bill. FYs 2015 through 2018 include $1.5 million from the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies appropriations bill for oversight of FDA.

Fiscal Year	PHHS Oversight
2015	$72,500,000
2016	$76,500,000
2017	$81,500,000
2018 Annualized CR	$80,947,000
2019 President's Budget	$80,000,000

Budget Request

In FY 2019, OIG's PHHS President's Budget request is $80 million and 357 FTE for OIG's oversight of PHHS programs. Funding will provide for audits, evaluations, and CMPs to increase its grant oversight efforts of high-risk grant programs. This includes oversight of grants for services to children such as the CCDF as well as substantial funding provided under the 21st Century Cures Act, including nearly $1 billion in Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding for opioid abuse prevention and treatment and billions of dollars of new funding for the National Institutes of Health (NIH).

OIG will use the requested funding to continue its work to identify fraud, waste, and abuse and inform the Department about detected vulnerabilities and potential solutions in the following priority areas.

Preventing Fraud, Waste, and Abuse in HHS Grants and Contracts

HHS awards more grants than any other Federal entity, with more than $100 billion in grants—excluding Medicaid—and nearly $25 billion in contracts in FY 2017. Responsible stewardship of these program dollars is vital to public health and well-being. Operating a financial management and administrative infrastructure that employs appropriate internal controls to minimize risk and protect resources remains a challenge for HHS. When grant and contract fraud arises in HHS programs, DOJ often does not prosecute these cases using its authorities because of the high burden of proof and competing priorities. With additional resources, OIG can use its CMP authorities, including new authorities from the 21st Century Cures Act, for these cases.

The 21st Century Cures Act (enacted on December 13, 2016) gave OIG new authority to impose CMPs for grant and contract fraud. OIG has successfully used CMPs for nearly three decades to fight fraud in Medicare and Medicaid. To successfully implement the new 21st Century Cures Act CMP authority, OIG requires attorneys, investigators, and contracting resources to impose penalties against recipients and subrecipients of HHS grants and contracts that commit fraud related to the use of HHS funds. Additional funding will quickly and effectively enable OIG to issue interpretive regulations, develop industry guidance to foster compliance, promote self-disclosure of grant and contract fraud to OIG, and use data and other tools to target oversight efforts on the highest risk contracts and grants.

Ensuring Privacy and Security

OIG will enhance its cyber threat intelligence data and increase testing of HHS systems and the effectiveness of HHS security controls. 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 IT and the exchange, storage, and use of electronic health information. The frequency of notable data breaches has increased significantly, and those 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, including computer hacking groups that are intent on compromising systems and releasing sensitive data, criminals stealing data to commit fraud, and persons who would misuse access to HHS systems. OIG conducts general security control audits of information and technology supporting HHS programs and conducts network and Web application penetration testing to assess the Department's network security to determine whether these networks and applications are susceptible to hacking.

Preparation for Public Health Emergencies

OIG will also increase oversight of HHS grants for emergency preparedness and provide training and education to promote preparedness and prevent fraud, waste, and abuse. Effective protection against public health threats requires a well-coordinated public health infrastructure that can rapidly respond to emergencies at home and internationally. In dealing with infectious diseases such as Zika and Ebola or any other new, unpredictable threat, proper grant mechanisms need to be in place to foster effective response coordination with domestic and international partners. Moreover, HHS Operating Divisions must ensure effective and efficient planning and implementation of strategies to address the national opioid epidemic.

Indian Health Service

OIG's will focus resources on oversight efforts with respect to IHS facilities and operations, with an emphasis on quality of care and program administration. OIG will also continue law enforcement efforts to address potential criminal violations, such as theft of prescription drugs at IHS facilities, as well as misuse of IHS and other HHS funds in connection with services provided to Tribal members. The IHS faces longstanding challenges in providing quality care that it may not overcome without broad and sustained attention. The IHS provides a range of clinical, public health, community, and facilities infrastructure services to health services to approximately 2.2 million of the 3.7 million American Indians and Alaska Natives who are primarily members of 567 federally recognized Tribes. IHS provides comprehensive primary health care and disease prevention services through a network of over 608 hospitals, clinics, and health stations on or near Indian reservations. IHS directly operates 26 hospitals, 53 health centers, 30 health stations, and 4 school health centers that operate health care at the service unit and community level.[35] HHS has a responsibility to provide adequate access to care and quality of care for IHS beneficiaries. Pressing challenges include recruiting and retaining essential clinical staff, maintaining aging facilities, providing competent emergency hospital care, and managing limited financial resources to refer patients to specialty care providers.

[35] Indian Health Service, *FY 2018 Congressional Justification,* https://www.ihs.gov/budgetformulation/includes/themes/responsive2017/display_objects/documents/FY2018CongressionalJustification.pdf. Accessed on January 25, 2018.

Performance Information for Public Health and Human Services Oversight

Key Outputs	FY 2017 Actual	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
Audits:				
Audit Reports Started	54	34	35	**+1**
Audit Reports Issued	57	34	35	**+1**
Evaluations:				
Evaluation Reports Started	16	7	8	**+1**
Evaluation Reports Issued	12	8	9	**+1**
Investigations:				
Complaints Received for Investigation	469	532	547	**+15**
Investigative Cases Opened	306	339	349	**+10**
Investigative Cases Closed	322	350	359	**+9**
PL funding (Dollars In Millions)	**$81.5**	**$80.9**	**$80.0**	**-$0.9**

FY 2017 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	Rec's Issued	Rec's Concur Implemented	Questioned Cost[36]	Funds Put to Better Use[37]
ACF	15	16	60	5	$16,264	-
ACL	-	-	-	-	-	-
AHRQ	-	-	-	-	-	-
CDC	5	8	40	14	$885	-
CMS–Exchanges	2	6	23	11	$175,157	-
FDA	3	1	-	-	-	-
HRSA	4	3	8	1	$1,479	-
IHS	7	2	10	1	-	-
NIH	5	4	12	1	$299	-
SAMHSA	3	1	-	-	-	-
OS	9	7	20	2	-	$49,445
PHHS Other[38]	1	9	1	1	$1,311	-
Total	**54**	**57**	**194**	**36**	**$195,422**	**$49,445**

[36] Questioned Cost reflects disallowed cost and/or potential recoveries in which management concurred with the audit recommendation.

[37] Funds put to Better Use reflects potential savings on those audit recommendations that achieve identifiable monetary savings.

[38] PHHS-related matters that span multiple OPDIVs.

Office of Evaluation and Inspections

Category	Evaluation Started	Evaluations Issued	Rec's Issued	Rec's Concur Implemented
ACF	1	1	-	-
ACL	1	-	-	-
AHRQ	1	-	-	-
CDC	1	1	-	-
CMS–Exchanges	-	1	1	1
FDA	4	3	7	-
HRSA	-	1	-	-
IHS	2	1	5	-
NIH	-	1	-	-
SAMHSA	1	-	-	-
OS	3	2	4	-
Other[39]	2	1	1	-
Total	**16**	**12**	**18**	**1**

Office of Investigations

(Dollars in thousands)

Category	Cases Opened	Cases Closed	Criminal Actions	Civil Actions	Complaints received	Monetary Results
ACF	121	152	68	-	152	$8,087
ACL	3	2	-	-	6	$235
AHRQ	-	-	-	-	-	-
CDC	10	9	1	-	11	$13
CMS–Exchanges	-	-	-	-	-	-
FDA	18	23	-	-	30	-
HRSA	10	8	2	-	2	$17,810
IHS	17	18	6	-	41	$2,704
NIH	-	-	-	-	-	-
SAMHSA	-	-	-	-	-	-
OS	38	36	2	-	87	$10
Other[39]	89	74	14	6	140	$43,516
Total	**306**	**322**	**93**	**6**	**469**	**$72,375**

[39] PHHS-related matters that span multiple OPDIVs.

SUBSECTION: MEDICARE AND MEDICAID OVERSIGHT

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
HCFAC Mandatory BA	$185,906	$190,389	$208,290	+$17,901
HCFAC Discretionary BA	82,132	82,132	87,230	+5,098
HCFAC Estimated Collections[40]	9,664	11,208	12,000	+792
Total Program Level[41]	**$277,702**	**$283,729**	**$307,520**	**+$23,791**
FTE	1,243	1,265	1,293	+28

Program Description

Through its multidisciplinary oversight work, OIG saves taxpayer dollars and works to ensure that patients receive medically appropriate care in the Nation's largest health insurance programs—Medicare and Medicaid. OIG relies on principles of prevention, detection, and enforcement to address fraud, waste, and abuse in these programs. Two key focus areas are sound fiscal management of the programs and ensuring that beneficiaries have access to high-quality care in the right setting in keeping with Medicare and Medicaid coverage requirements and as determined by the beneficiary and his or her medical providers.

Medicare and Medicaid are high-risk programs administered by CMS that require sustained focus on effective administration. These programs serve approximately one in four Americans and in 2017 accounted for more than $992 billion in Federal spending. In its FY 2016 Agency Financial Report, HHS reported an estimate of almost $97 billion in Medicare and Medicaid improper payments

States operate Medicaid and the Children's Health Insurance Program (CHIP), which are funded jointly with the Federal Government. Medicaid enrollment increased 3.9 percent in FY 2016 and 2.7 percent in FY 2017. In FY 2017, Medicaid and CHIP served more than 74 million enrollees at a cost of $553 billion.

OIG protects these programs through important partnerships with DOJ and State MFCUs, among others. The mission of MFCUs is to investigate Medicaid provider fraud and patient abuse or neglect cases, and to prosecute those cases under State law or refer them to other prosecuting offices. Currently, 49 States and the District of Columbia operate MFCUs. OIG provides oversight of the MFCU program and administers a Federal grant award to each Unit equivalent to 75 percent of total expenditures. In FY 2017, combined Federal and State expenditures for the Units totaled $250 million. As part of its oversight, OIG recertifies each Unit annually by conducting a desk review to assess compliance with applicable laws, regulations, and OIG policy transmittals and adherence to 12 performance standards. OIG also conducts periodic, in-depth onsite reviews of the Units. Finally, OIG collects and disseminates performance data and provides training and technical assistance to the Units.

[40] In FY 2017, OIG received $10.3 million in collections under authority of 42 U.S.C. 1320a-7c (§ 1128C of the Social Security Act), and the actual amount to be sequestered was $792,000. The table includes estimates for HCFAC collections for FYs 2018 and 2019, and the amounts available will depend on the amounts actually collected.

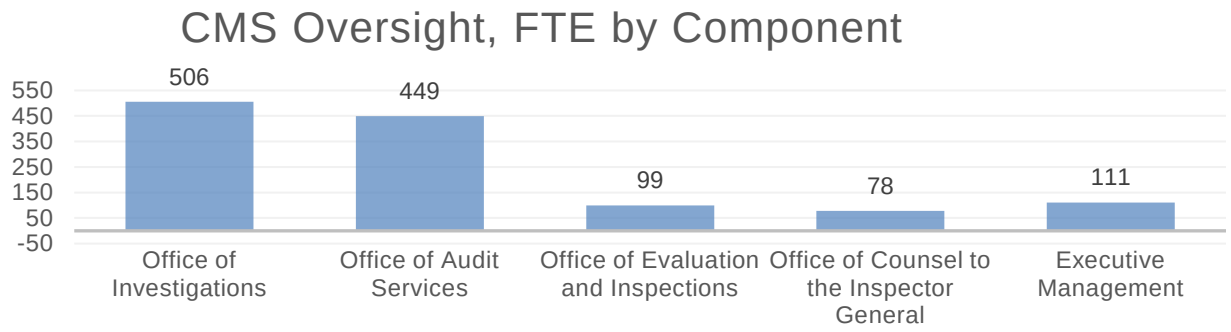
[41] OIG's HCFAC funding is drawn from the Medicare Hospital Insurance Trust Fund (§ 1817(k)(3) of the Social Security Act) and is requested and provided through the CMS budget.

Fraudulent providers often cheat both Medicare and Medicaid (and their beneficiaries). Thus, OIG fraud-fighting and patient-protection activities often have crosscutting impacts. The Health Insurance Portability and Accountability Act (HIPAA) established HCFAC under the direction of the Attorney General and the Secretary of Health and Human Services acting through OIG to combat fraud, waste, and abuse in Medicare- or Medicaid-funded health care. The funds OIG receives under HCFAC are dedicated exclusively to activities relating to Medicare and Medicaid. Overall, HCFAC funding constitutes the major portion of OIG's annual operating budget.

During FY 2017, OIG's Medicare and Medicaid oversight funding was allocated as follows:

Medicare and Medicaid Oversight	%
Medicare	71%
Medicaid	29%

HHS and DOJ coordinate Medicare and Medicaid oversight by harnessing resources, expertise, data, and technology to prevent, detect, and enforce fraud, waste, and abuse. In FY 2017, funding for Medicare and Medicaid oversight supported 1,243 FTE, which were assigned across OIG's five components as follows:



Accomplishments

HHS program changes that aligned with 473 Medicare- and Medicaid-specific OIG recommendations in FY 2017 are expected to achieve significant savings, reduce wasteful spending, or otherwise improve program efficiency and effectiveness.

Other noteworthy examples of OIG's recent Medicare and Medicaid oversight accomplishments include the following.

Collaboration in Fighting Health Care Fraud and Other Enforcement Actions

In collaboration with its HCFAC program partners, OIG harnesses resources, expertise, data, and technology to prevent and combat fraud, waste and abuse in Medicare and Medicaid and identify and hold accountable those who seek to defraud those programs. Health Care Fraud Strike Force teams coordinate operations conducted jointly by Federal, State, and local law enforcement entities. The teams have a record of successfully analyzing data quickly to identify, investigate, and prosecute fraud. During FY 2017, OIG's Strike Force efforts resulted in the filing of charges against 186 individuals or entities, 264 criminal actions, 2 civil actions, and $771.5 million in investigative receivables. For example, an individual who owned and managed three home health agencies in Miami was convicted in a scheme that involved kickbacks to doctors and patient recruiters in return for referrals of Medicare beneficiaries and the purported furnishing of home health services that were not provided or were not medically necessary. Further, OIG, along with our State and Federal law enforcement partners,

participated in the largest health care fraud takedown in history in July 2017. More than 400 defendants in 41 Federal districts were charged with participating in fraud schemes involving about $1.3 billion in false billings to Medicare and Medicaid.

In another troubling example, Narco Freedom, Inc., a now-defunct provider of outpatient drug rehabilitation services, agreed to resolve FCA allegations that it submitted claims to Medicaid for services predicated on illegal kickbacks and services not rendered. As a part of the settlement, Narco Freedom admitted that between 2006 and 2014 it induced beneficiaries to use its outpatient programs by providing the beneficiaries with subsidized housing. Narco Freedom also admitted that between 2008 and 2011 it paid operators of other short-term residences to condition residency at their residences on enrollment in, and attendance at, a Narco Freedom outpatient program. It also admitted that in 2010 it directed employees to falsify records to reflect that counselors had treated certain Medicaid beneficiaries when they had not. As part of the settlement, Narco Freedom, which is currently in Chapter 7 bankruptcy, agreed that the United States will receive a $50.5 million bankruptcy claim. For its conduct, Narco Freedom is excluded from all Federal health care programs for 50 years.

Curbing the Opioid Epidemic

OIG has a longstanding and extensive history of investigative and oversight work focused on the alarming problem of prescription drug abuse, including opioids, as well as noncontrolled substances that are often abused along with opioids (known as “potentiators”). OIG investigates opioid fraud and diversion cases and uses advanced data analytics and tools to detect suspected problems for further review. OIG’s work focuses on strengthening the integrity of HHS’s prescription drug and addiction treatment programs and protecting at-risk beneficiaries. OIG investigations led to arrests, convictions, imprisonment, and/or exclusion of entities that contributed to the opioid abuse epidemic. In one illustrative case, a doctor of osteopathic medicine worked with Pagans Motorcycle Club, an organization known for violence and drug dealing, to operate a “pill mill” out of his medical offices. The doctor wrote fraudulent prescriptions for oxycodone and other drugs, while the Pagans recruited “pseudo-patients” to buy the fraudulent prescriptions and then resell the pills on the street. The doctor was sentenced to 30 years in Federal prison and ordered to pay $5.3 million in restitution after being found guilty of 123 of 127 counts, including distribution of controlled substances resulting in death. Additionally, as part of the July 2017 National Health Care Fraud Takedown, OIG issued exclusion notices to 295 doctors, nurses, and other providers based on conduct related to opioid diversion and abuse.

OIG also released a data brief on opioid use in Medicare. The data brief used advanced data analytics to identify Medicare beneficiaries at serious risk of opioid abuse and the high-risk providers associated with these Medicare beneficiaries. Specifically, OIG identified 90,000 Medicare Part D patients at serious risk of opioid misuse or overdose. OIG was able to use Medicare claims data to identify Medicare beneficiaries receiving high or extremely high amounts of opioids and those who may be “doctor shopping” (e.g., receiving opioids from four or more providers and four or more pharmacies) to amass large quantities of opioids. Many of these beneficiaries were receiving opioid dosages two-and-a-half times above what CDC recommends as the outer limit for safe opioid use. In addition, this analysis identified 401 Medicare providers with questionable opioid prescribing patterns for beneficiaries at serious risk. These providers are now being further evaluated for possible action by HHS OIG, DOJ, CMS, and other partners with enforcement and administrative authorities to address prescription drug fraud and diversion. The beneficiaries the OIG identified as being at risk are undergoing further evaluation and intervention by CMS.

In another case investigated by OIG, three co-conspirators connected with a health care provider, Compassionate Doctors, PC, were convicted of charges resulting from their involvement in an unlawful prescription drug operation. The defendants were sentenced to a combined 46 years and 4 months in prison and ordered to pay $10.7 million in restitution.

Prescription Drug Pricing and Reimbursement

In 2017, an OIG evaluation demonstrated that high-price drugs are increasing Federal payments for Medicare Part D catastrophic coverage. Federal payments for catastrophic coverage exceeded $33 billion in 2015, which is more than triple the amount paid in 2010. OIG found that spending for high-price drugs contributed significantly to this growth. By 2015, high-price drugs were responsible for almost two-thirds of the total drug spending in catastrophic coverage. Moreover, 10 high-price drugs accounted for nearly one-third of all drug spending for catastrophic coverage in 2015. The average prices for each of these drugs ranged from $1,200 to almost $34,000 per month, leading to high out-of-pocket costs for some beneficiaries in catastrophic coverage.

Recently, a pharmaceutical company, Mylan N.V., entered into a CIA with OIG requiring, among other things, that an independent review organization annually review multiple aspects of Mylan's practices relating to the Medicaid drug rebate program. The 5-year CIA requires intensive outside scrutiny to assess whether Mylan is complying with the rules of the Medicaid drug rebate program as well as individual accountability by Mylan board members and executives.

Protecting Federal Funds and Beneficiaries in Nursing Homes and Noninstitutional Settings

OIG's goal to promote quality, safety, and value includes a focus on protecting Medicare and Medicaid beneficiaries from substandard care, abuse, and neglect. OIG directs particular oversight attention to those who may be especially susceptible to these risks, such as nursing home residents and beneficiaries with developmental disabilities who receive care from community-based providers. HHS policies or practices sometimes result in inefficiencies when unintended loopholes or other problems invite exploitation or hinder consistent payment determinations. Improper payments and false billings occur when the programs do not effectively prevent, deter, identify, or address inappropriate or excessive billing by providers and suppliers. Fighting home health services fraud in Medicare and Medicaid is an OIG priority and represents a significant portion of our enforcement efforts. OIG home health investigations resulted in more than 400 criminal and civil actions and $1 billion in receivables for FYs 2011–2016.[42] OIG investigations continue to identify and address fraudulent payments.

Home health fraud cases generally involve home health agencies (HHA) that bill for services that are not medically necessary and/or not provided. For example, OIG uncovered more than 100 instances of potential abuse or neglect of Medicare beneficiaries in skilled nursing facilities (SNFs). OIG reviewed records from emergency room visits by Medicare beneficiaries residing in SNFs indicating that the injuries of 134 beneficiaries may have resulted from potential abuse or neglect. More than a quarter of these incidents may not have been reported to law enforcement at the time. OIG referred all 134 incidents to appropriate law enforcement officials and CMS and issued an Early Alert in 2017 to CMS suggesting immediate actions for CMS to take to better protect beneficiaries. A case pursued by OIG and its law enforcement partners resulted in the March 2017 conviction of a physician and guilty pleas of co-conspirators in a $40 million fraud scheme involving undisclosed business relationships and submission of false claims for Medicare home health services, generally for the most costly services. More than 97 percent of patients served received home health services whether they needed them or not. One defendant has been ordered to pay more than $4 million in restitution.

Protecting the Integrity of the Medicare and Medicaid Program

OIG work continues to result in meaningful improvements in Medicaid program integrity. OIG protects Medicaid patients from unscrupulous providers and the program from improper payments. For example, OIG found challenges in State Medicaid implementation of program integrity tools like payment suspension. Payment suspensions allows States to stop Medicaid payments as early as possible when there is a credible allegation of fraud against a provider. However, OIG found that most States imposed 10 or fewer suspensions in all of FY 2014, and States reported significant challenges

[42] This total includes investigative receivables due to HHS as well as non-HHS investigative receivables (e.g., amounts due to State Medicaid programs and private health care programs).

with imposing payment suspensions. In another evaluation, OIG found that pharmaceutical manufacturers may have owed an additional $1.3 billion in rebates from 2012 to 2016 for the 10 potentially misclassified drugs with the highest total reimbursement in 2016. CMS does not have the authority to compel manufacturers to correct inaccurate classification data to ensure all of the required rebates are paid.

In another example, in August 2017 OIG found that Kentucky did not always determine Medicaid eligibility in accordance with Federal and State requirements. OIG estimated that Kentucky made Federal Medicaid payments on behalf of 69,931 potentially ineligible beneficiaries totaling $72.8 million.

Further, Medicaid group homes provide Medicaid beneficiaries the opportunity to live independently in a community setting rather than in an institution. OIG work looking at Medicaid group homes revealed nation-wide weaknesses in the systems used to safeguard these susceptible beneficiaries. OIG found a lack of reporting and investigation into critical incidents of patient harm and death. OIG's work is focusing critical attention on this issue, and now multiple agencies and stakeholders are working to develop better practices to protect beneficiaries.

In an audit of Medicare electronic health record (EHR) incentive payments designed to promote the adoption of EHRs, OIG identified more than $700 million in improper Medicare incentive payments to providers who did not meet Federal requirements for "meaningful use." CMS also made $2.3 million in incentive payments for the wrong payment year when providers switched between Medicare and Medicaid incentive programs.

In another audit, OIG found that data shortcomings may increase Medicare's and beneficiaries' costs for recalled and failed devices. Limitations in claims data impede CMS's ability to readily identify and effectively track Medicare's total costs related to the replacement of devices that were recalled or that failed prematurely. Our FY 2017 report estimated these costs totaled $1.5 billion for Medicare and $140 million for beneficiaries over the 10-year period ending on December 31, 2014, for seven recalled and prematurely failed cardiac devices; the report also made recommendations for improvements.

OIG works to improve Medicaid program integrity through its extensive work with State MFCUs. The MFCUs, which exist in 49 States and the District of Columbia, are the primary State-level agencies to investigate and prosecute Medicaid provider fraud as well as patient abuse and neglect in U.S. health care facilities. OIG works closely with the MFCUs on joint cases and initiatives and provides grant oversight to the 50 MFCUs. During 2017, OIG piloted a new risk-based process for conducting onsite review of the MFCUs and developed a strategic framework for improving MFCU effectiveness. In FY 2017, the MFCUs collectively were responsible for 1,528 convictions, 1,761 indictments, 961 civil settlements and judgements, and $1.8 billion in recoveries.

Funding History

The funding history in the table below includes the budget authority given 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
2015	$262,496,000
2016	$266,001,000
2017	$264,278,000
2018 Annualized CR	$283,728,777
FY 2019 President's Budget	$307,519,651

Budget Request

OIG's FY 2019 President's Budget request for Medicare and Medicaid oversight includes $307.5 million, which is an increase of $23.8 million above the FY 2018 annualized CR (post-sequester). The FY 2019 request does not assume sequestration. Sequestration reductions will be determined after the release of the FY 2019 President's Budget. The OIG estimate includes:

- $208.3 million in HCFAC mandatory funding, an increase of $17.9 million above the FY 2018 annualized CR (post-sequester);

- $87.2 million in HCFAC discretionary funding. Of this funding, $30.9 million is not subject to discretionary budget caps, consistent with § 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985; and

- $12.0 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 2019 President's Budget request supports the Administration's priorities of addressing fraud, waste, and abuse in Federal health care programs. OIG's work addresses issues of access and affordability, accuracy in Medicare and Medicaid enrollment and spending, innovations in health care and data analytics, quality of care, and the increase in complexity and technical sophistication of fraud schemes. OIG will continue its work from FY 2018, including work to combat opioid and other prescription drug abuse, and will use the additional $23.8 million in HCFAC funding to address fraud, waste, and abuse in home health and other noninstitutional-based services and to strengthen oversight of Medicare Advantage and Medicaid Program Integrity. If sequestration reductions continue in FY 2019, OIG will reduce the amounts below accordingly. OIG is a major contributor to the HCFAC program, which had an ROI of $5:$1 from OIG oversight in FY 2016.[43]

Home Health and Other Noninstitutional-Based Services ($8.0 million above the FY 2018 annualized CR)

Services provided in a beneficiary's home or other noninstitutional settings, including home health, hospice, and other home- and community-based services, are susceptible to fraud. For example, OIG home health investigations resulted in more than 350 criminal and civil actions and more than $975 million in receivables for FYs 2011–2015. Common schemes include billing for services that are not needed or not provided or paying kickbacks to recruiters, providers who order or certify the services, and patients. Program integrity in noninstitutional settings takes on heightened urgency as consumers increasingly seek and prefer services provided in those settings, including in their own homes.

In these settings, OIG has uncovered risks for, and instances of, serious patient harm. For example, OIG audits at Medicaid group homes have revealed nation-wide weaknesses in the systems used to safeguard people with developmental disabilities. Hospice care provides comfort for terminally ill beneficiaries and supports family and other caregivers; yet OIG has found that hospices frequently fail to meet Medicare requirements for patient care, billing, certification, and licensure. Disturbingly, OIG has also investigated cases of hospice providers enrolling beneficiaries in hospice care without their consent.

In addition to fraud and risks of patient harm, improper payments for these services take a financial toll. CMS estimated that in FY 2017 Medicare made more than $10 billion in improper payments to home

[43] The FY 2017 annual HCFAC report, which will include the FY 2017 return on investment is due for release in FY 2018 after the release of the President's Budget. The HCFAC ROI is a 3-year average of actual recoveries to the Federal Government as a result of HCFAC activities compared with the HCFAC program expenditures.

health agencies. Through compliance audits of home health agencies, OIG has uncovered improper payments across a number of risk areas, such as medical necessity and homebound determinations.

The request will enable OIG to better protect taxpayer dollars and beneficiaries by expanding our oversight and enforcement work to combat these problems. OIG's combination of multidisciplinary skills, tools, and expertise in health care program integrity make it uniquely suited to drive positive change. OIG is a self-referring agency that leverages its investigators, evaluators, auditors, attorneys, and data analysts to fight fraud, waste, and abuse from all sides—prevention, detection, and enforcement. Further, OIG has proven to be a good investment.

With the requested resources to support evaluations and audits, OIG would develop new recommendations for targeted program safeguards that prevent fraud by bad actors while limiting burden on legitimate providers. Through data analytics, OIG would also detect new and emerging fraud schemes, enabling it to monitor trends and migration of known fraud schemes. With this reinvestment, OIG would also add "boots on the ground" to take appropriate enforcement actions against fraud perpetrators, including building its capacity to respond to the fraud referrals generated by its own analysts. For example, OIG analysts identified more than 500 home health agencies and more than 4,500 physicians with multiple characteristics commonly associated with home health fraud. OIG also identified 27 "hotspots" in 12 States where red flags for home health fraud are prevalent. With additional resources, OIG would open more criminal, civil, and administrative investigations, as warranted, and conduct more audits and monitoring of suspicious billers. It would also target certain hotspots to conduct site visits of high-risk home health agencies, for example. Importantly, these efforts would help ensure that consumers are protected and honest providers do not have to compete with dishonest ones.

Further, OIG would expand its audit work to assess safeguards to protect people in home- and community-based settings. An example of this is OIG's work on group homes for people with developmental disabilities. Onsite reviews tend to be resource intensive, but they enable OIG to uncover problems that would not be found solely from data analysis. Much of OIG's work that identifies improper payments and quality-of-care concerns involves contracting with clinical experts to conduct medical record review, which is costly.

Medicaid Program Integrity ($8.0 million above the FY 2018 annualized CR)
Medicaid and CHIP serve more than 74 million people, or 1 in 5 Americans. Total Federal and State Medicaid spending was about $574 billion in FY 2016, and the Medicaid fee-for-service improper payment rate was 10.48 percent. OIG work shows persistent and serious fraud vulnerabilities in Medicaid.

Because OIG administers grant funding to the State MFCUs and partners with MFCUs in Medicaid criminal and civil cases, we are uniquely suited to support States in identifying fraud trends and enhancing State program integrity efforts. MFCUs play an integral role in managing and protecting Medicaid. In FY 2017, MFCUs generated $1.8 billion in criminal and civil recoveries as well as 1,528 convictions, 1,761 indictments, and 961 civil settlements and judgments. MFCU staff are on the front lines of Medicaid fraud prevention and play a critical part in ensuring program integrity.

OIG will continue to partner with States to identify high-risk areas and providers and with MFCUs on joint criminal investigations to tackle fraud, including in home- and community-based services such as personal care services; in prescription drugs; and in both Medicare and Medicaid. OIG has a history of successful partnerships with State MFCUs, including last year's national health care fraud takedown in which 31 MFCU offices participated.

Further, OIG will continue Medicaid program integrity efforts that identify needed program improvements and best practices in critical areas, such as Medicaid provider enrollment, Medicaid data availability and accuracy, and safety and quality of care.

OIG will use additional requested resources to support State fraud-enforcement efforts. OIG will assist States by providing MFCUs with additional resources for specialized training and targeted technical assistance to ensure that MFCUs can perform at maximum effectiveness. OIG will leverage the most up-to-date Medicaid data submitted by States to assist MFCUs in identifying high-risk providers and rapidly identifying multi-State trends and outliers based on State comparisons.

OIG will also increase its work overseeing Medicaid managed care that will provide program integrity guidance and recommendations to States and managed care organizations to ensure that managed care can be a successful means to deliver cost-effective services.

Medicare Managed Care Program Integrity ($7.8 million above the FY 2018 annualized CR)
A paradigm shift is underway in the Nation's health care system—both public and private—to improve patient care, promote patient choice, and reduce wasteful spending through payment and delivery models that align incentives to reward high-value care, including better care coordination. Approximately 30 percent of Medicare beneficiaries are enrolled in Medicare Advantage (MA), a threefold increase since 2004. The program is expected to continue to grow, but oversight efforts have not kept pace. CMS estimated the FY 2017 gross improper payment rate for payments to MA plans at 8.6 percent. While fraud and abuse in managed care may take different forms than in traditional Medicare, OIG's work points to a critical need for new investments in oversight of Medicare managed care to ensure that the program operates with integrity in delivering services to beneficiaries and value to taxpayers. OIG has identified significant, emerging vulnerabilities at the plan and provider levels, including problematic plan conduct (e.g., schemes to game the risk adjustment methodology to increase payments from CMS to plans) and fraud by providers (e.g., knowingly billing plans for unnecessary services or services not rendered).

OIG requests additional resources to develop and implement a sustained, focused, and strategic initiative to combat fraud and abuse in MA. OIG will use audits, evaluations, investigations, and enforcement actions to prevent, detect, and remediate fraud and abuse in MA. These efforts will employ advanced data modeling and specialized clinical expertise (including medical record review). MA oversight is hampered by problems with the precision, uses, and sharing of encounter and other data important to effective oversight. OIG will use existing and new public–private partnerships (including with CMS, its contractors, and private plans) to pursue solutions that enhance data for both public and private sector partners. OIG will coordinate with its law enforcement partners, including DOJ, to identify and investigate fraud, and will make recommendations to strengthen MA program operations. Audit and evaluation focus areas might include payment accuracy, beneficiary access to care, potential provider misconduct, data validation, and CMS management and oversight efforts, such as the Risk Adjustment Data Validation audit process. OIG anticipates that enhanced oversight of MA would provide valuable lessons for effective prevention of fraud and abuse in other payment models (outside of the MA program) that seek to move away from volume-driven payment structures. In sum, enhanced oversight of MA—in coordination with public and private partners—promises to strengthen Medicare for the beneficiaries it serves and ensure that taxpayer funds are safeguarded.

Performance Information for Medicare and Medicaid Oversight

Key Outputs	FY 2017 Actual	FY 2018 Target	FY 2019 Target	FY 2019 +/- FY 2018
Audits:				
Audit Reports Started	161	144	145	**+1**
Audit Reports Issued	139	144	145	**+1**
Evaluations:				
Evaluation Reports Started	39	29	30	+1
Evaluation Reports Issued	35	36	37	+1
Investigations:				
Complaints Received For Investigation	2,992	2,267	2,281	+14
Investigative Cases Opened	1,854	1,444	1,453	+9
Investigative Cases Closed	1,685	1,492	1,501	+9
PL funding (Dollars In Millions)	**$277.7**	**$283.7**	**$307.5**	**+23.8**

FY 2017 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	Audits Issued	Rec's Issued	Rec's Imple-mented	Rec's Unimple-mented	Questioned Cost[44]	Funds Put to Better Use[45]
Medicare and Medicaid Oversight	**161**	**139**	**438**	**244**	**768**	**$517,145**	**$2,710,534**

Office of Evaluation and Inspections

Category	Evaluation Starts	Evaluations Issued	Rec's Issued	Rec's Implemented	Rec's Unimplemented
Medicare and Medicaid Oversight	**39**	**35**	**35**	**2**	**33**

Office of Investigations

(Dollars in thousands)

Category	Cases Opened	Cases Closed	Criminal Actions	Civil Actions	Complaints Received for Inv	Monetary Results
Medicare and Medicaid Oversight	**1,854**	**1,685**	**788**	**691**	**2,992**	**$3,988,661**

[44] Questioned Cost reflects disallowed cost and/or potential recoveries in which management concurred with the audit recommendation.

[45] Funds Put to Better Use reflects potential savings on those audit recommendations that achieve identifiable monetary savings.

SUPPLEMENTARY TABLES

Total Budget Authority by Object Class

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$178,178	$192,021	$197,310	+$5,288
Other than full-time permanent (11.3)	3,458	3,724	3,826	+102
Other personnel compensation (11.5)	3,116	3,329	3,413	+84
Military personnel (11.7)	8	8	8	+0
Special personnel services payments (11.8)	33	36	37	+1
Subtotal personnel compensation	**184,793**	**199,118**	**204,594**	**+5,476**
Civilian benefits (12.1)	69,114	73,394	75,331	+1,937
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**253,907**	**272,512**	**279,925**	**+7,413**
Travel and transportation of persons (21.0)	7,206	7,338	9,945	+2,607
Transportation of things (22.0)	3,539	2,549	2,765	+216
Rental payments to GSA (23.1)	20,351	22,186	22,358	+173
Rental payments to Others (23.2)	7	7	7	+0
Communication, utilities, and misc. charges (23.3)	5,643	5,699	5,793	+94
Printing and reproduction (24.0)	84	85	86	+1
Other Contractual Services:	-	-	-	-
Advisory and assistance services (25.1)	310	313	316	+2
Other services (25.2)	24,338	16,224	17,122	+898
Purchase of goods and services from government accounts (25.3)	48,038	55,245	55,707	+461
Operation and maintenance of facilities (25.4)	2,364	2,388	2,406	+19
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,935	2,964	2,987	+23
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**77,985**	**77,134**	**78,537**	**+1,403**
Supplies and materials (26.0)	1,097	1,108	1,115	+7
Equipment (31.0)	18,917	19,106	20,815	+1,709
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-	-
Interest and dividends (43.0)	44	-	-	-
Refunds (44.0)	-	-	-	-
Total Non-Pay Costs	**134,873**	**135,212**	**141,423**	**+6,210**
Total Budget Authority by Object Class	**$388,780**	**$407,724**	**$421,348**	**+$13,623**

PHHS Oversight Budget Authority by Object Class

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$40,270	$39,832	$40,021	+$189
Other than full-time permanent (11.3)	813	804	808	+4
Other personnel compensation (11.5)	959	949	953	+5
Military personnel (11.7)	8	8	8	+0
Special personnel services payments (11.8)	7	7	7	+0
Subtotal personnel compensation	**42,057**	**41,599**	**41,797**	**+198**
Civilian benefits (12.1)	15,707	15,667	15,667	-
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**57,764**	**57,266**	**57,464**	**+198**
		-	**-**	**-**
Travel and transportation of persons (21.0)	1,602	1,618	1,618	-
Transportation of things (22.0)	528	533	533	-
Rental payments to GSA (23.1)	4,420	4,892	4,892	-
Rental payments to Others (23.2)	1	1	1	-
Communication, utilities, and misc. charges (23.3)	1,091	1,102	1,102	-
Printing and reproduction (24.0)	15	15	15	-
Other Contractual Services:				
Advisory and assistance services (25.1)	66	67	67	-
Other services (25.2)	1,418	1,432	1,432	-
Purchase of goods and services from		-	-	-
government accounts (25.3)	8,030	7,702	6,558	-1,144
Operation and maintenance of facilities (25.4)	511	516	516	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	680	687	687	-
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**10,705**	**10,404**	**9,260**	**-1,144**
		-	**-**	**-**
Supplies and materials (26.0)	362	366	366	-
Equipment (31.0)	4,702	4,749	4,749	-
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-	-
Interest and dividends (43.0)	12	-	-	-
Refunds (44.0)	-	-	-	-
Total Non-Pay Costs	**23,438**	**23,680**	**22,536**	**-1,144**
	-			
Total Budget Authority by Object Class	**$81,202**	**$80,947**	**$80,000**	**-$946**

Medicare and Medicaid Oversight Budget Authority by Object Class

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$137,214	$151,482	$156,577	+$5,096
Other than full-time permanent (11.3)	2,645	2,920	3,018	+98
Other personnel compensation (11.5)	2,147	2,370	2,450	+80
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	26	29	30	+1
Subtotal personnel compensation	**142,032**	**156,800**	**162,075**	**+5,275**
Civilian benefits (12.1)	53,247	57,564	59,501	+1,936
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**195,279**	**214,365**	**221,576**	**+7,211**
				-
Travel and transportation of persons (21.0)	5,541	5,596	8,202	+2,606
Transportation of things (22.0)	3,005	2,004	2,220	+216
Rental payments to GSA (23.1)	15,931	17,293	17,466	+173
Rental payments to Others (23.2)	6	6	6	+0
Communication, utilities, and misc. charges (23.3)	4,552	4,598	4,691	+94
Printing and reproduction (24.0)	69	70	70	+1
Other Contractual Services:				
Advisory and assistance services (25.1)	244	246	249	+2
Other services (25.2)	22,920	14,791	15,689	+898
Purchase of goods and services from government accounts (25.3)	24,679	27,572	29,184	+1,612
Operation and maintenance of facilities (25.4)	1,853	1,872	1,890	+19
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,255	2,278	2,300	+23
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**51,951**	**46,759**	**49,312**	**+2,554**
Supplies and materials (26.0)	723	730	738	+7
Equipment (31.0)	14,215	14,357	16,066	+1,709
Land and Structures (32.0)	-	-	-	-
Investments and Loans (33.0)	-	-	-	-
Grants, subsidies, and contributions (41.0)	-	-	-	-
Interest and dividends (43.0)	32	-	-	-
Refunds (44.0)	-	-	-	-
Total Non-Pay Costs	**96,025**	**91,413**	**98,772**	**+7,359**
			-	
Total Budget Authority by Object Class	**$291,304**	**$305,778**	**$320,348**	**+$14,570**

Reimbursable Budget Authority by Object Class

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$694	$708	$711	+$3
Other than full-time permanent (11.3)	-	-	-	-
Other personnel compensation (11.5)	10	10	10	-
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**704**	**718**	**721**	**+3**
Civilian benefits (12.1)	160	163	164	+1
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**864**	**881**	**885**	**+4**
				-
Travel and transportation of persons (21.0)	63	124	125	+1
Transportation of things (22.0)	6	12	12	-
Rental payments to GSA (23.1)	-	-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
Other Contractual Services:	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	-	-	-	-
Purchase of goods and services from	-	-	-	-
government accounts (25.3)	15,329	19,971	19,965	-6
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-	-
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**15,329**	**19,971**	**19,965**	**-6**
Supplies and materials (26.0)	12	12	12	+0
Total Non-Pay Costs	-	-	-	-
	-	-	-	-
Total Salary and Expense	-	-	-	-
Direct FTE	-	-	-	-
Personnel compensation:	-	-	-	-
Full-time permanent (11.1)	-	-	-	-
Other than full-time permanent (11.3)	**15,410**	**20,119**	**20,114**	**-5**
Other personnel compensation (11.5)				
Military personnel (11.7)	**$16,274**	**$21,000**	**$21,000**	**-**

Total Salary and Expenses

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$178,178	$192,021	$197,310	+$5,288
Other than full-time permanent (11.3)	3,458	3,724	3,826	+102
Other personnel compensation (11.5)	3,116	3,329	3,413	+84
Military personnel (11.7)	8	8	8	+0
Special personnel services payments (11.8)	33	36	37	+1
Subtotal personnel compensation	**184,793**	**199,118**	**204,594**	**+5,476**
Civilian benefits (12.1)	69,114	73,394	75,331	+1,937
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**253,907**	**272,512**	**279,925**	**+7,413**
Travel and transportation of persons (21.0)	7,206	7,338	9,945	+2,607
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Rental payments to GSA (23.1)	20,351	22,186	22,358	+173
Rental payments to Others (23.2)	7	7	7	+0
Communication, utilities, and misc. charges (23.3)	5,643	5,699	5,793	+94
Printing and reproduction (24.0)	84	85	86	+1
Other Contractual Services:	-	-	-	-
Advisory and assistance services (25.1)	310	313	316	+2
Other services (25.2)	24,338	16,224	17,122	+898
Purchase of goods and services from government accounts (25.3)	48,038	55,245	55,707	+461
Operation and maintenance of facilities (25.4)	2,364	2,388	2,406	+19
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,935	2,964	2,987	+23
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**77,985**	**77,134**	**78,537**	**+1,403**
Supplies and materials (26.0)	1,097	1,108	1,115	+7
Total Non-Pay Costs	**115,912**	**116,106**	**120,608**	**+4,502**
Total Salary and Expense	**$369,819**	**$388,618**	**$400,533**	**+$11,915**
Direct FTE	**1,608**	**1,622**	**1,650**	**+28**

PHHS Oversight Salary and Expenses

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1).....	$40,270	$39,832	$40,021	+$189
Other than full-time permanent (11.3).....	813	804	808	+4
Other personnel compensation (11.5).....	959	949	953	+5
Military personnel (11.7).....	8	8	8	+0
Special personnel services payments (11.8).....	7	7	7	+0
Subtotal personnel compensation.....	**42,057**	**41,599**	**41,797**	**+198**
Civilian benefits (12.1).....	15,707	15,667	15,667	-
Military benefits (12.2).....	-	-	-	-
Benefits to former personnel (13.0).....	-	-	-	-
Total Pay Costs.....	**57,764**	**57,266**	**57,464**	**+198**
				-
Travel and transportation of persons (21.0).....	1,602	1,618	1,618	-
Transportation of things (22.0).....	528	533	533	-
Rental payments to GSA (23.1).....	4,420	4,892	4,892	-
Rental payments to Others (23.2).....	1	1	1	-
Communication, utilities, and misc. charges (23.3)..	1,091	1,102	1,102	-
Printing and reproduction (24.0).....	15	15	15	-
Other Contractual Services:		-	-	-
Advisory and assistance services (25.1).....	66	67	67	-
Other services (25.2).....	1,418	1,432	1,432	-
Purchase of goods and services from	-	-	-	-
government accounts (25.3).....	8,030	7,702	6,558	-1,144
Operation and maintenance of facilities (25.4).....	511	516	516	-
Research and Development Contracts (25.5).....	-	-	-	-
Medical care (25.6).....	-	-	-	-
Operation and maintenance of equipment (25.7)…	680	687	687	-
Subsistence and support of persons (25.8).....	-	-	-	-
Subtotal Other Contractual Services.....	**10,705**	**10,404**	**9,260**	**-1,144**
Supplies and materials (26.0).....	362	366	366	-
Total Non-Pay Costs.....	**18,724**	**18,931**	**17,787**	**-1,144**
Total Salary and Expense.....	**$76,488**	**$76,198**	**$75,251**	**-$946**
Direct FTE.....	**355**	**347**	**347**	**-**

Medicare and Medicaid Oversight Salary and Expenses

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$137,214	$151,482	$156,577	+$5,096
Other than full-time permanent (11.3)	2,645	2,920	3,018	+98
Other personnel compensation (11.5)	2,147	2,370	2,450	+80
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	26	29	30	+1
Subtotal personnel compensation	**142,032**	**156,800**	**162,075**	**+5,275**
Civilian benefits (12.1)	53,247	57,564	59,501	+1,936
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**195,279**	**214,365**	**221,576**	**+7,211**
Travel and transportation of persons (21.0)	5,541	5,596	8,202	+2,606
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Rental payments to GSA (23.1)	15,931	17,293	17,466	+173
Rental payments to Others (23.2)	6	6	6	+0
Communication, utilities, and misc. charges (23.3)	4,552	4,598	4,691	+94
Printing and reproduction (24.0)	69	70	70	+1
Other Contractual Services:	-	-	-	-
Advisory and assistance services (25.1)	244	246	249	+2
Other services (25.2)	22,920	14,791	15,689	+898
Purchase of goods and services from government accounts (25.3)	24,679	27,572	29,184	+1,612
Operation and maintenance of facilities (25.4)	1,853	1,872	1,890	+19
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	2,255	2,278	2,300	+23
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**51,951**	**46,759**	**49,312**	**+2,554**
Supplies and materials (26.0)	723	730	738	+7
Total Non-Pay Costs	**81,778**	**77,056**	**82,706**	**+5,651**
Total Salary and Expense	**$277,057**	**$291,420**	**$304,282**	**+$12,862**
Direct FTE	**1,243**	**1,265**	**1,293**	**+28**

Reimbursables Salary and Expenses

(Dollars in thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Personnel compensation:				
Full-time permanent (11.1)	$694	$708	$711	+$3
Other than full-time permanent (11.3)	-	-	-	-
Other personnel compensation (11.5)	10	10	10	+0
Military personnel (11.7)	-	-	-	-
Special personnel services payments (11.8)	-	-	-	-
Subtotal personnel compensation	**704**	**718**	**721**	**+3**
Civilian benefits (12.1)	160	163	164	+1
Military benefits (12.2)	-	-	-	-
Benefits to former personnel (13.0)	-	-	-	-
Total Pay Costs	**864**	**881**	**885**	**+4**
	-	**-**	**-**	
Travel and transportation of persons (21.0)	63	124	125	+1
Transportation of things (22.0)	6	12	12	+0
Rental payments to GSA (23.1)	-	-	-	-
Rental payments to Others (23.2)	-	-	-	-
Communication, utilities, and misc. charges (23.3)	-	-	-	-
Printing and reproduction (24.0)	-	-	-	-
	-	-	-	
Other Contractual Services:	-	-	-	-
Advisory and assistance services (25.1)	-	-	-	-
Other services (25.2)	-	-	-	-
Purchase of goods and services from	-	-	-	-
government accounts (25.3)	15,329	19,971	19,965	-6
Operation and maintenance of facilities (25.4)	-	-	-	-
Research and Development Contracts (25.5)	-	-	-	-
Medical care (25.6)	-	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-	-
Subsistence and support of persons (25.8)	-	-	-	-
Subtotal Other Contractual Services	**15,329**	**19,971**	**19,965**	**-6**
	-	**-**	**-**	
Supplies and materials (26.0)	12	12	12	+0
Total Non-Pay Costs	**15,410**	**20,119**	**20,114**	**-5**
Total Salary and Expense	**$16,274**	**$21,000**	**$21,000**	**-$1**
Direct FTE	**10**	**10**	**10**	**-**

Detail of FTE

	2017 Actual Civilian	2017 Actual Military	2017 Actual Total	2018 Est. Civilian	2018 Est. Military	2018 Est. Total	2019 Est. Civilian	2019 Est. Military	2019 Est. Total
PHHS Oversight:									
Direct:.....	355	-	355	347	-	347	347	-	347
Reimbursable:.....	10	-	10	10	-	10	10	-	10
Total:.....	365	-	365	357	-	357	357	-	357
Medicare and Medicaid Oversight:									
HCFAC Mandatory/Collections	906	-	906	922	-	922	943	-	943
HCFAC Discretionary.....	337	-	337	342	-	342	351	-	351
Total:.....	1,243	-	1,243	1,265	-	1,265	1,293	-	1,293
OIG FTE Total.....	**1,608**	**-**	**1,608**	**1,622**	**-**	**1,622**	**1,650**	**-**	**1,650**

Detail of Positions

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
ES Positions:			
Executive level X.....	1	1	1
ES-00.....	20	20	20
Subtotal ES positions.....	21	21	21
Total - ES Salary	$3,766,148	$4,133,347	$4,329,681
Senior Leader (SL) Positions	6	6	6
Subtotal SL positions.....	6	6	6
Total - SL Salary	$1,013,344	$1,112,145	$1,164,972
GS-15.....	125	125	125
GS-14.....	242	242	242
GS-13.....	751	751	751
GS-12.....	277	282	282
GS-11.....	59	61	61
GS-10.....	-		
GS-9.....	69	73	73
GS-8.....	1	1	1
GS-7.....	28	31	31
GS-6.....	1	1	1
GS-5.....	10	15	15
GS-4.....	29	41	41
GS-3.....	-	-	-
GS-2.....	-	-	-
GS-1.....	-	-	-
Subtotal	1,592	1,623	1,623
Total - GS Salary	$166,680,538	$182,931,890	$191,621,155
Total, OIG Positions	1,619	1,650	1,650
Average ES & SL salary.....	$177,018	$180,514	$181,372
Average GS grade.....	12.6	12.5	12.5
Average GS salary.....	$104,699	$104,727	$105,225

Physician's Comparability Allowance Worksheet

(Dollars in thousands)

	PY 2017 (Actual)	CY 2018 (Estimates)	BY* 2019 (Estimates)
Physicians Receiving PCAs	1	1	1
Physicians with 1-year PCA Agreements	0	0	0
Physicians with Multi-Year PCA Agreements	1	1	1
Average Annual PCA Physician Pay (without PCA payment)	$170	$183**	$190
Average Annual PCA Payment	$30	$30	$30
Physicians Receiving PCA, Category IV-B Health and Medical Administration	1	1	1

*BY data will be approved during the BY Budget cycle.

**CY 2018 and BY 2019 estimates reflect a conservative 2-percent performance-based increase that may be authorized consistent with OIG's Senior Professional Pay-for-Performance System and annual supplemental guidance.

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 2018, approximately $30,000 will be provided to the physician in Category IV-B.

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

The OIG Chief Medical Officer (CMO) serves as OIG's internal medical consultant to all OIG components on a wide array of OIG activities. The CMO 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 fiscal year, which is attributable, in part, to the PCA.

Regarding the increase in the average annual PCA physician pay (without PCA payment), the estimated salary of OIG's Chief Medical Officer reflects a conservative rating-based pay adjustment commensurate with this physician's individual performance and impact on achieving agency priorities and mission imperatives under an OPM-approved and certified "pay for performance" appraisal system that covers Senior-Level (SL) positions. Actual pay increases will be made in accordance with HHS and OIG policy and annual pay guidance issued by the OIG Office of Management and Policy.

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SIGNIFICANT ITEMS

This satisfies a requirement in the Explanatory Statement accompanying the House Subcommittee on the Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations Bill, 2017 (Report No. 114-669) to report in the FY 2019 budget request on the following Significant Items.

Item: *Lobbying.* Within the total provided, the Committee provides sufficient funding for 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 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 website 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 website 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 12, 15, and 21, 2015. This information on lobbying restrictions resides on the public HHS website 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.

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SPECIAL REQUIREMENTS

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 2019 process was $438.6 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).

OIG Training Requirements
In accordance with section 6(f)(3)(C) of the IG Act, this budget requests approximately $10 million in FY 2019 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 2019 request, includes approximately 1,650 criminal investigators, auditors, program evaluators, attorneys, and administrative and management staff.

OIG Financial Support for CIGIE
In support of the Government-wide IG community, OIG contributes funds for the operation of CIGIE. In accordance with the reporting requirements of section 6(f)(3)(D) of the Inspector General Act, this budget requests necessary funding for OIG's support of CIGIE, of which a portion will be funded from OIG's discretionary budget.