DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2013

Office of Inspector General

Justification of Estimates for Appropriations Committees

Notes:

The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. As such, all figures in this document assume OIG's allocation of these adjustments in the FY 2012 Enacted Level and in comparisons made in the narrative.

Revisions have been made to this document since initial publication in February 2012. Details regarding the changes are found in footnotes on the affected pages.

Message From the 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) 2013 Performance Budget Submission. This submission is in accordance with the Inspector General Act, as amended (5 U.S.C. App. 3). It presents my office's aggregate budgetary requirements for meeting its responsibility to protect the integrity of hundreds of HHS programs as well as the health and welfare of the beneficiaries whom they serve.

This submission includes $370 million in furtherance of OIG's mission in FY 2013, including:

- $59 million, an increase of +$9 million above the FY 2012 Level for oversight of HHS's more than 300 non-Medicare/Medicaid programs. Their diverse missions range from vital efforts such as ensuring food safety to ensuring that parents who owe back child support pay their debts. These programs account for approximately $100 billion in spending and have grown significantly in size and scope during the last decade. The requested funds will enable OIG to target emerging priorities and to monitor the implementation of the Patient Protection and Affordable Care Act.

- $311 million, an increase of +$5 million above the FY 2012 Level for Medicare and Medicaid oversight. This request will support the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and related program integrity efforts.

We are committed to working with other HHS Offices to reduce improper payments and prevent fraud, waste, and abuse. Our efforts resulted in estimated savings and expected recoveries of approximately $25 billion in FY 2011. Such efforts are increasingly important as our Nation works to reduce Government spending while providing high-quality health care to beneficiaries.

Since its establishment in 1976, this office has consistently achieved commendable results and positive returns on investment. Our office continues to produce recommendations that, if implemented, will contribute to overall deficit reduction. I am confident that the funding requested would ensure similar future benefits for American taxpayers and their families.

Daniel R. Levinson
Inspector General

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The FY 2013 Justification of Estimates for Appropriations Committees

U.S. Department of Health and Human Services
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The FY 2013 Justification of Estimates for Appropriations Committees

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Department of Health and Human Services
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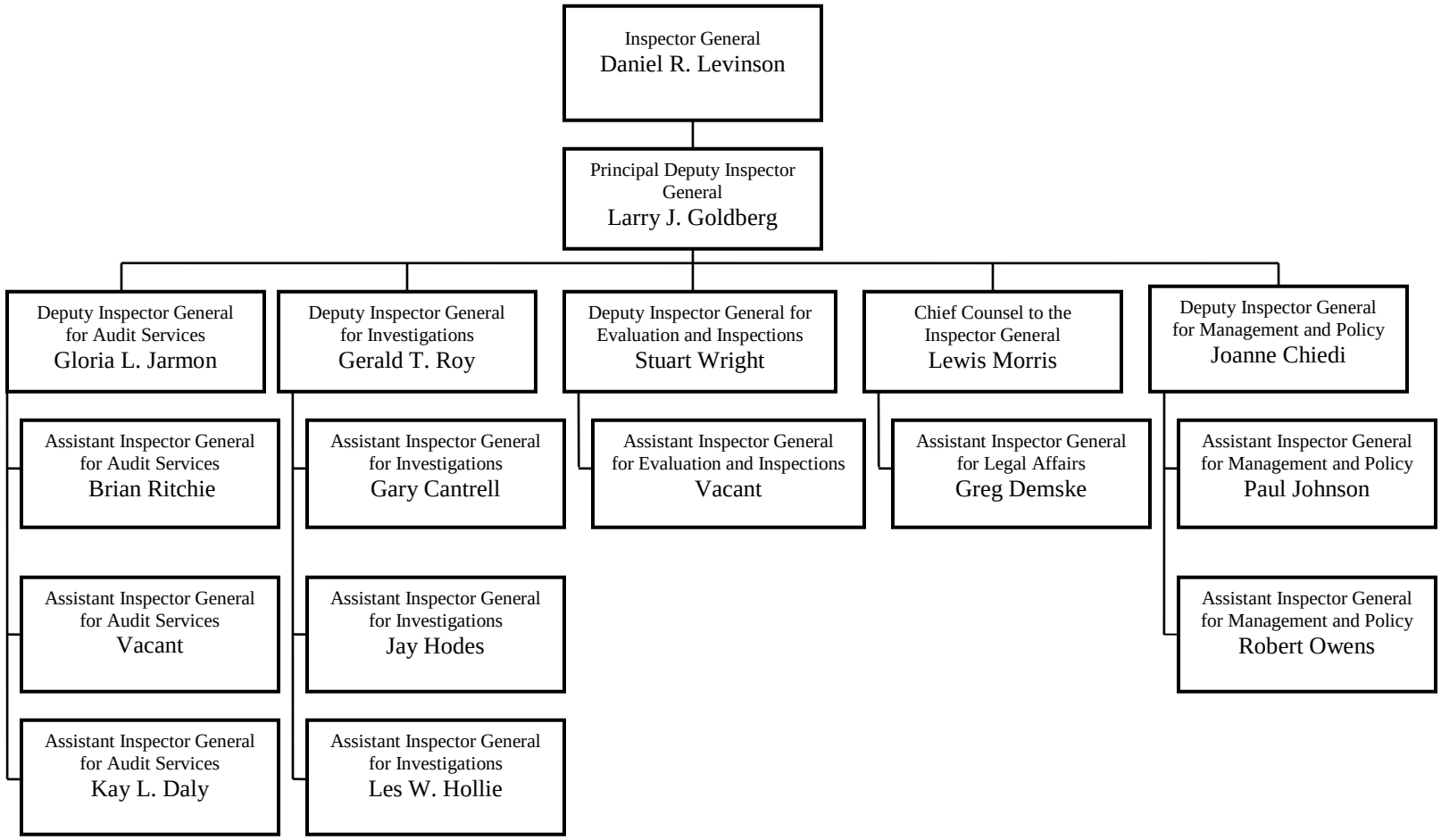
Organizational Chart



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Overview

The Office of Inspector General (OIG) is an independent and objective oversight organization that promotes economy, efficiency, and effectiveness in the programs and operations of the U.S. Department of Health and Human Services (HHS or the Department). HHS consists of 11 operating divisions and the Office of the Secretary and is designed to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. HHS's mission is carried out by the following entities:

- Administration for Children and Families (ACF)
- Agency for Health Care Research and Quality (AHRQ)
- Agency for Toxic Substances and Disease Registry (ATSDR)
- Administration on Aging (AoA)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Office of the Secretary (OS), which includes 18 staff divisions dedicated to departmental management and coordination, such as the Assistant Secretary for Preparedness and Response and the National Coordinator for Health Information Technology.

OIG's program integrity and oversight activities are shaped by legislative and budgetary requirements and adhere to professional standards established by the Government Accountability Office (GAO) and the Inspector General (IG) community. Since the creation of the Health Care Fraud and Abuse Control (HCFAC) Program in 1997, approximately 80 percent of OIG's annual funding and workload have been dedicated exclusively to oversight and enforcement activities with respect to health care fraud and abuse in the Medicare and Medicaid programs.

Mission

OIG's mission is to protect the integrity of HHS programs as well as the health and welfare of beneficiaries by detecting and preventing fraud, waste, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; providing industry guidance; and holding accountable those who do not meet program requirements or who violate Federal laws.

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Overview of Budget Request

OIG's FY 2013 budget submission includes a program level of $369,748,000 and 1,974 full-time equivalents (FTE), an increase of +$13,948,000, of which $5,437,000 is to support current operations that were previously funded by appropriations that have since expired and an additional +13 FTE above the fiscal year (FY) 2012 Enacted[1] Level. Program increases include:

- Public Health, Human Services, and Departmentwide (PHHS) Oversight (+$8,496,000): Ensuring oversight of HHS activities and key priority areas, such as grant oversight, including recommendations for suspensions and debarments, and monitoring the Patient Protection and Affordable Care Act (ACA) programs. Of the amount requested as an increase, $5,437,000 is requested to support 33 FTE that were previously supported with American Reinvestment and Recovery Act (Recovery Act) (P.L. No. 111-5) funding and to redirect their efforts towards emerging priorities.

- CMS Oversight (+$5,452,000): Sustaining the multiagency initiative to focus on preventing health care fraud and enforcing current antifraud laws around the country through the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative and continuing to address a range of program integrity efforts, including reducing improper payments. While this funding is requested through the budget for CMS, information on OIG-specific activities can be found in this document.

The specific focus of OIG's oversight activities in FY 2013 will be determined through the annual work-planning process and the assessment of the top management and performance challenges facing HHS in FY 2013. The top management challenges from the most recent year will provide the foundation for OIG's identification and assessment of priorities in future years. In developing the FY 2013 request, OIG has set the following goals and priorities:

- Protecting the integrity of Medicare and Medicaid and the well-being of beneficiaries.
    - Assess program vulnerabilities and recommend actions to reduce improper payments and prevent fraud.
    - Foster a culture of compliance within the health care industry both by issuing formal guidance and reaching out to other Federal and State agencies, stakeholder organizations, providers, and the public.

[1] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. As such, all figures in this document assume OIG's allocation of these adjustments in reference to the FY 2012 Enacted Level and in comparisons made in the narrative.

  - Hold accountable perpetrators of Medicare and Medicaid fraud, with specific attention to combating organized crime and corporate fraud.

  - Increase OIG's capacity to effectively use data to target resources to areas with the greatest vulnerability.

- Protecting the integrity of HHS's public health and human services programs and the people they serve.

  - Assess HHS operations and recommend actions to address program integrity vulnerabilities and improve program effectiveness.

  - Provide HHS with vital information that will hold accountable grantees and contractors that manage large grant awards and contracts, and ensure the integrity of these significant expenditures.

- Increasing public confidence by providing innovation and responsible stewardship of HHS resources.

  - Allocate resources on the basis of risk assessments and OIG and stakeholder priorities (e.g., quality of care, patient safety, the ACA, and the Recovery Act).

  - Consistently deliver high-quality reports that are accurate, compelling, and relevant.

  - Protect the confidentiality, integrity, and availability of information and information systems.

Overview of Performance

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

- Planning: OIG plans its work and allocates its resources on the basis of a number of factors. These include the purpose limitations in the agency's various funding sources, authorizing statutes and mandates, stakeholder input, and annual risk assessments of HHS programs. One practice that contributes to priority setting is the annual work-planning process, which results in a published *Work Plan*. As part of this process, OIG engages stakeholders to identify the issues with the greatest potential impact on HHS programs and beneficiaries. Throughout the year, OIG responds to emerging issues and makes adjustments. Priorities identified in the work-planning process often address issues outlined in the HHS *Top Management and Performance Challenges*.

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

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

Significant Accomplishments

As reported in OIG's Fall 2011 *Semiannual Report to Congress*, OIG reported savings and expected recoveries of approximately $25.0 billion for FY 2011. This includes $19.8 billion from legislative and other cost-saving actions that were supported by recommendations in audits and evaluations, $4.6 billion in investigative receivables (which includes $0.9 billion in non-HHS investigative receivables resulting from OIG's work in areas such as States' share of Medicaid restitution), and $0.6 billion in audit receivables.

Additionally, in FY 2011, OIG excluded 2,662 individuals and organizations from participation in Federal health care programs. OIG reported 723 criminal actions against individuals or organizations that engaged in crimes against HHS programs and 382 civil and administrative enforcement actions, including False Claims Act and unjust enrichment suits filed in Federal district court, civil monetary penalties (CMP) law settlements, and administrative recoveries related to provider self-disclosure matters. OIG work also prevents fraud and abuse through industry outreach and guidance and recommendations to remedy program vulnerabilities.

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

FY 2013 Budget by HHS Strategic Goal

(Dollars in Millions)

HHS Strategic Goals [1]	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Pres. Bud
4. Increase Efficiency, Transparency and Accountability of HHS Programs (subtotal)	**$290**	**$356**	**$370**
4.A Ensure program integrity and responsible stewardship of resources	58	71	74
4.B Fight fraud and work to eliminate improper payments	232	285	296
TOTAL	**$290**	**$356**	**$370**

OIG's Contributions to the HHS Strategic Plan

The HHS Strategic Plan outlines how HHS will advance its mission of enhancing the health and well-being of Americans. The goals and objectives in the Strategic Plan correspond to specific HHS operating divisions and the programs and initiatives they administer. OIG's program integrity activities support the Department's responsible stewardship of taxpayer money, which includes combating fraud, waste, and abuse in all HHS programs. In particular, OIG is directed by law to conduct independent and objective audits, evaluations, analyses, and investigations to assess the effectiveness and efficiency of policy and program implementation and to identify noncompliance. These independent inquiries and associated recommendations strengthen the integrity of HHS's programs.

OIG assigns approximately 20 percent of its program costs to Objective 4.A because this objective aligns closely with OIG's PHHS oversight efforts, which represent approximately 20 percent of OIG's budget authority. Following a similar rationale, OIG assigns approximately 80 percent of its program costs to Objective 4.B because of the objective's close link to OIG's CMS oversight program, which represents approximately 80 percent of OIG's budget authority. While OIG has distributed its full program costs between two objectives for the purpose of fulfilling its commitment to specific HHS strategic goals, the results of OIG's oversight activities often encompass more than any single HHS strategic objective by addressing threats to the financial integrity of all HHS programs and the well-being of beneficiaries.

[1] For display purposes, only the HHS strategic goals with OIG attributable costs are displayed in the above table.

All-Purpose Table

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Pres. Bud.	FY 2013 +/- FY 2012
Public Health, Human Services, and Departmentwide Issues[1, 2] (PHHS) Oversight:				
Discretionary Budget Authority (BA)	$50,178	$50,083	58,579[1]	+8,496[1]
Subtotal, PHHS BA	**50,178**	**50,083**	**58,579**	**+8,496**
CMS Oversight[2]				
Health Care Fraud and Abuse Control Program (HCFAC) Mandatory BA[3]	197,998	196,090	196,669	+579
HCFAC Discretionary BA[3]	29,730	97,627[4]	102,500	+4,873
Subtotal, CMS Oversight BA	**227,728**	**293,717**	**299,169**	**+5,452**
HCFAC Collections[5]	12,000	12,000	12,000	--
Subtotal, CMS Oversight Program Level (PL)	**239,728**	**305,717**	**311,169**	**+5,452**
Total, BA	**277,906**	**343,800**	**357,748**	**+13,948**
Total, PL	**$289,906**	**$355,800**	**$369,748**	**+$13,948**
FTE[6]	1,753	1,961	1,974	+13

[1] The FY 2013 President's Budget includes $5 million to support 33 FTE currently on board. In prior years, these FTE were supported with Recovery Act funding. Additional details regarding this request are included in the PHHS subsection beginning on page 33.

[2] Table excludes non-HCFAC reimbursable funding. In FY 2011, OIG obligated $17 million in non-HCFAC reimbursable funding. The estimate for both FYs 2012 and 2013 is $24 million. This estimate includes funds made available in section 6201 of the ACA for OIG to evaluate a nationwide program for national and State background checks on direct patient access employees of long-term-care facilities and providers. OIG obligated $160,000 for this effort in FY 2011 and anticipates spending approximately $150,000 in both FYs 2012 and 2013.

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

[4] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

[5] In FY 2011, OIG collected $10 million. For purposes of comparability, the table includes the FY 2011 estimate. For FYs 2012 and 2013, the funding level for HCFAC Collections is an estimate, and the amount obligated will depend on the amount collected.

[6] Totals for FYs 2011 and 2012 include FTE supported by Recovery Act funding.

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Appropriations Language

Office of Inspector General

For expenses necessary for the Office of Inspector General, including the hire of passenger motor vehicles for investigations, in carrying out the provisions of the Inspector General Act of 1978, [$50,178,000]*$58,579,000*: Provided, That of such amount, necessary sums shall be available for providing protective services to the Secretary *of Health and Human Services* and investigating non-payment of child support cases for which non-payment is a Federal offense under 18 U.S.C. Section 228 [: Provided further, That at least 40 percent of the funds provided in this Act for the Office of Inspector General shall be used only for investigations, audits, and evaluations pertaining to the discretionary programs funded in this Act]. (P.L. 112-74 Consolidated Appropriations Act, 2012)

Language Analysis

Language Provision	Explanation
Provided further, That at least 40 percent of the funds provided in this Act for the Office of Inspector General shall be used only for investigations, audits, and evaluations pertaining to the discretionary programs funded in this Act	OIG proposes that the bracketed language be deleted from the latest enacted Appropriations Bill because: • the distribution of OIG's workload for prior years continues to meet this criterion and • the requirement has the potential to limit OIG's flexibility to implement risk responsive oversight efforts to address known and emerging issues of importance to Congress, HHS, and taxpayers.

Language Analysis, continued

Provided, That of such amount, necessary sums shall be available for providing protective services to the Secretary *of Health and Human Services* and investigating non-payment of child support cases for which non-payment is a Federal offense under 18 U.S.C. Section 228	OIG proposes that "*of Health and Human Services*" be added to the latest Appropriations Bill to provide greater clarity to the Appropriations language.

Amounts Available for Obligation

(Dollars in Thousands)

	FY 2011 Actual	FY 2012 Enacted	FY 2013 Pres. Bud.
Discretionary			
General Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$50,278	$50,178	$58,579
Rescission (L/HHS)	-100	-95	--
Subtotal, Appropriation (L/HHS)	50,178	50,083	58,579
Total, Discretionary Appropriation	**50,178**	**50,083**	**58,579**
Offsetting collections from:			
Trust fund HCFAC Discretionary	29,730	97,627[1]	102,500
Offsetting collections from:			
Trust Fund HCFAC	197,998	196,090	196,669
HCFAC Collections[2]	12,000	12,000	12,000
Subtotal, HCFAC Mandatory	209,998	208,090	208,669
Total Discretionary and Mandatory			
Unobligated balance, lapsing	614	--	--
Unobligated balance, start of year	83,471	50,702	21,263
Unobligated balance, end of year[3]	50,702	21,263	21,263
Unobligated balance, Recovery Act, start of year	10,396	5,437	--
Unobligated balance, Recovery Act, end of year	5,437	--	--
Total Obligations	**327,020**	**390,676**	**369,748**
Obligations Less Recovery Act	**$322,061**	**$385,239**	**$369,748**

Note: Table excludes non-HCFAC reimbursable funding. In FY 2011, OIG obligated $17 million in non-HCFAC reimbursable funding. The estimate for both FYs 2012 and 2013 is $24 million.

[1] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

[2] In FY 2011, OIG collected $10 million. For purposes of comparability, the table includes the FY 2011 estimate. For FYs 2012 and 2013, the funding level for HCFAC Collections is an estimate, and the amount obligated will depend on the amount collected.

[3] In addition to including funds directly appropriated to OIG, the total includes funds from HCFAC Collections and HCFAC Discretionary, which have multiyear availability, but come to OIG as reimbursements.

Summary of Changes

(Dollars in Thousands)

2012	
Total, BA	$50,083
Obligations	50,083
2013	
Total, Estimated BA	58,579
Estimated Obligations	58,579
Net Change	+$8,496

	FY 2013 Estimate FTE	FY 2013 Estimate Budget Authority	Change From Base FTE	Change From Base Budget Authority
Increases:				
A. Built in:				
1. Provide for salary of FTE	301	$38,548	+46	+$6,013
a. Pay to support FTE previously funded by the Recovery Act (non-add)	*33*	*4,210*	*+33*	*+4,210*
b. Pay to support additional FTE (non-add)	*13*	*1,659*	*+13*	*+1,659*
c. Increase due to 0.5% pay raise (non-add)	--	*144*	--	*+144*
2. Increased costs related to General Services Administration (GSA) rent	--	3,186	--	+576
Subtotal, Built-in Increases	**301**	**41,734**	**+46**	**+6,589**
B. Program:				
1. Costs related to general operating expenses	--	16,845	--	+1,907
Subtotal, Program Increases	**--**	**--**	**--**	**+1,907**
Total, Increases	**301**	**$58,579**	**+46**	**+$8,496**

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

Budget Authority by Activity

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted	FY 2013 Pres. Bud.
Public Health, Human Services, and Departmentwide Issues (PHHS) Oversight:			
Discretionary BA	$50,178	$50,083	$58,579
Subtotal, PHHS Oversight BA	**50,178**	**50,083**	**58,579**
CMS Oversight			
HCFAC Mandatory BA[1]	197,998	196,090	196,669
HCFAC Discretionary BA[1]	29,730	97,627[2]	102,500
Subtotal, CMS Oversight BA	**227,728**	**293,717**	**299,169**
[HCFAC Collections[3]]	[12,000]	[12,000]	[12,000]
[Subtotal, CMS Oversight PL]	**[239,728]**	**[305,717]**	**[311,169]**
Total, BA	**277,906**	**343,800**	**357,748**
[Total PL]	**[$289,906]**	**[$355,800]**	**[$369,748]**
FTE[4]	1,753	1,961	1,974

Note: Table excludes non-HCFAC reimbursable funding. In FY 2011, OIG obligated $17 million in non-HCFAC reimbursable funding. The estimate for both FYs 2012 and 2013 is $24 million. This estimate includes funds made available in section 6201 of the ACA for OIG to evaluate a nationwide program for national and State background checks on direct patient access employees of long-term-care facilities and providers. OIG obligated $160,000 for this effort in FY 2011 and anticipates spending approximately $150,000 in both FYs 2012 and 2013.

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

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

[2] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

[3] In FY 2011, OIG collected $10 million. For purposes of comparability, the table includes the FY 2011 estimate. For FYs 2012 and 2013, the funding level for HCFAC Collections is an estimate, and the amount obligated will depend on the amount collected.

[4] Totals in FY 2011 and FY 2012 include FTE supported by Recovery Act funding.

Authorizing Legislation

(Dollars in Thousands)

	FY 2012 Amount Authorized	FY 2012 Enacted	FY 2013 Amount Authorized	FY 2013 Pres. Bud.
Office of Inspector General:				
Inspector General Act of 1978 (P.L. No. 95-452, as amended)	Indefinite	$50,279	Indefinite	$58,579
Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191, as amended), HCFAC Mandatory	$196,090	$196,090	$196,669	$196,669
HIPAA, as amended, HCFAC Discretionary	Indefinite	$97,627[1]	Indefinite	$102,500[2]
HIPAA, as amended, HCFAC Collections	Indefinite	$12,000[2]	Indefinite	$12,000[1]
Supplemental Appropriations Act of 2008 (P.L. No. 110-252, as amended)	25,000	--	25,000	--

[1] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

[2] The funding level for HCFAC Collections is an estimate. The amount obligated in FYs 2012 and 2013 will depend on the amount collected.

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2004				
Discretionary Direct	$39,497,000	$39,497,000	$39,497,000	$39,094,000
Rescission	--	--	--	-403,000
HCFAC Mandatory	160,000,000	160,000,000	160,000,000	160,000,000
FY 2005				
Discretionary Direct	40,323,000	40,323,000	40,323,000	39,930,000
Rescission	--	--	--	-393,000
HCFAC Mandatory	160,000,000	160,000,000	160,000,000	160,000,000
FY 2006				
Discretionary Direct	39,813,000	39,813,000	39,813,000	39,813,000
Rescission	--	--	--	-398,000
HCFAC Mandatory	160,000,000	160,000,000	160,000,000	160,000,000
Medicaid Oversight (MIP)	25,000,000	--	--	25,000,000
FY 2007				
Discretionary Direct	43,760,000	41,415,000	43,760,000	39,808,000
HCFAC Discretionary Allocation Adjustment	11,336,000	--	--	--
HCFAC Mandatory	160,000,000	160,000,000	160,000,000	165,920,000
Medicaid Oversight (MIP)	25,000,000	--	--	25,000,000
Never Events[1]	--	--	--	3,000,000
FY 2008				
Discretionary Direct	44,687,000	44,687,000	45,687,000	44,000,000
Rescission	--	--	--	-769,000
HCFAC Discretionary Allocation Adjustment	17,530,000	36,690,000	36,690,000	--
HCFAC Mandatory	169,238,000	--	--	169,736,000
Medicaid Oversight (MIP)	25,000,000	--	--	25,000,000
FY 2009				
Discretionary Direct	46,058,000	44,500,000	46,058,000	45,279,000
HCFAC Discretionary Allocation Adjustment	18,967,000	18,967,000	18,967,000	18,967,000
HCFAC Mandatory	174,998,000	--	--	177,205,000
Medicaid Oversight (MIP)	25,000,000	--	--	25,000,000

[1] The Tax Relief and Health Care Act of 2006 (TRHCA) (P.L. No. 109-432) included $3,000,000 for OIG to study Medicare "never events." For TRHCA purposes, the term "never event" means "an event that is listed and endorsed as a serious reportable event by the National Quality Forum as of November 16, 2006." TRHCA, § 203(d).

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2009 (continued)				
Medicaid Oversight (Supplemental)	--	--	--	25,000,000
Recovery Act: Medicaid Oversight (Mandatory)	--	--	--	31,250,000
Recovery Act Oversight (Discretionary)	--	--	--	17,000,000
FY 2010				
Discretionary Direct	50,279,000	50,279,000	50,279,000	50,279,000
HCFAC Discretionary Allocation Adjustment	29,790,000	29,790,000	29,790,000	29,790,000
HCFAC Mandatory[1]	177,205,000	--	--	177,205,000
Medicaid Oversight (MIP)	25,000,000	--	--	25,000,000
FY 2011				
Discretionary Direct	50,279,000	--	54,754,000	50,278,000
Rescission	--	--	--	-100,000
HCFAC Discretionary Allocation Adjustment	29,790,000	--	94,830,000	29,730,000
Rescission	--	--	--	-59,000
HCFAC Mandatory	197,998,000	--	--	197,998,000
FY 2012				
Discretionary Direct	53,329,000	50,178,000	50,178,000	50,178,000
Rescission	--	--	--	-95,000
PHS Evaluation Set-Aside	10,000,000	--	--	--
HCFAC Discretionary Allocation Adjustment	97,556,000	97,556,000	97,556,000	97,627,000[2]
Rescission	--	--	--	-56,000
HCFAC Mandatory	195,550,000	--	--	196,090,000
FY 2013				
Discretionary Direct	58,579,000	--	--	--
HCFAC Discretionary	102,500,000	--	--	--
HCFAC Mandatory	196,669,000	--	--	--

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

[2] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

OIG Summary of Request

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted[1]	FY 2013 Request	FY 2013 +/- FY 2012
PHHS Oversight	$50,178	$50,083	$58,579	+$8,496
CMS Oversight[2]	239,728	305,717	311,169	+5,452
Total Request	**$289,906**	**$355,800**	**$369,748**	**+$13,948**
FTE	1,753	1,961	1,974	+13

Authorizing Legislation ..... Inspector General Act of 1978, as amended
FY 2012 Authorization ..... Indefinite
Allocation Method ..... Direct Federal

Program Description

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

OIG's areas of oversight fall into two broad categories: (1) PHHS and (2) CMS. In a given year, the amount of work conducted in each category reflects the purpose of the funding that OIG is appropriated. Approximately 80 percent of OIG's efforts and resources[3] are directed toward safeguarding the integrity of the Medicare and Medicaid programs and the health and welfare of beneficiaries. The remaining approximately 20 percent of OIG's efforts and resources[4] focus on HHS's other programs and management processes, including key issues such as food and drug safety, child support enforcement, conflict-of-interest and financial disclosure

[1] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

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

[3] It is projected to be approximately 84 percent in FY 2013.

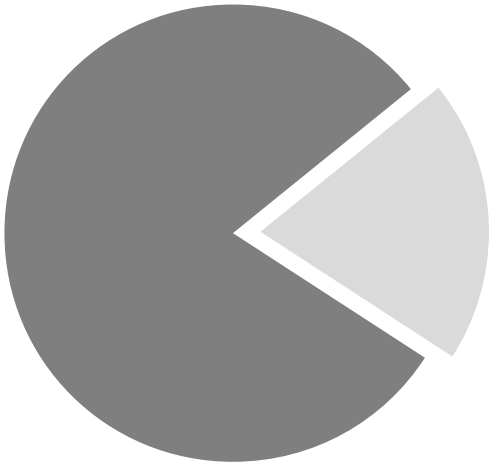
[4] It is projected to be approximately 16 percent in FY 2013.

policies governing HHS staff, and the integrity of departmental contracts and grants management processes and transactions.

OIG's Areas of Oversight

CMS Oversight, Areas Include:

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



PHHS Oversight, Areas Include:

- Food and drug safety (FDA)
- Child support enforcement (ACF)
- Conflict-of-interest and financial disclosure policies (NIH, FDA)
- Grants and contracts management

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

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

- Office of Investigations (OI): OI conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in almost every State and the District of Columbia, OI actively coordinates with the Department of Justice (DOJ) and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, civil judgments or settlements, civil monetary penalties (CMPs), and program exclusions.

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

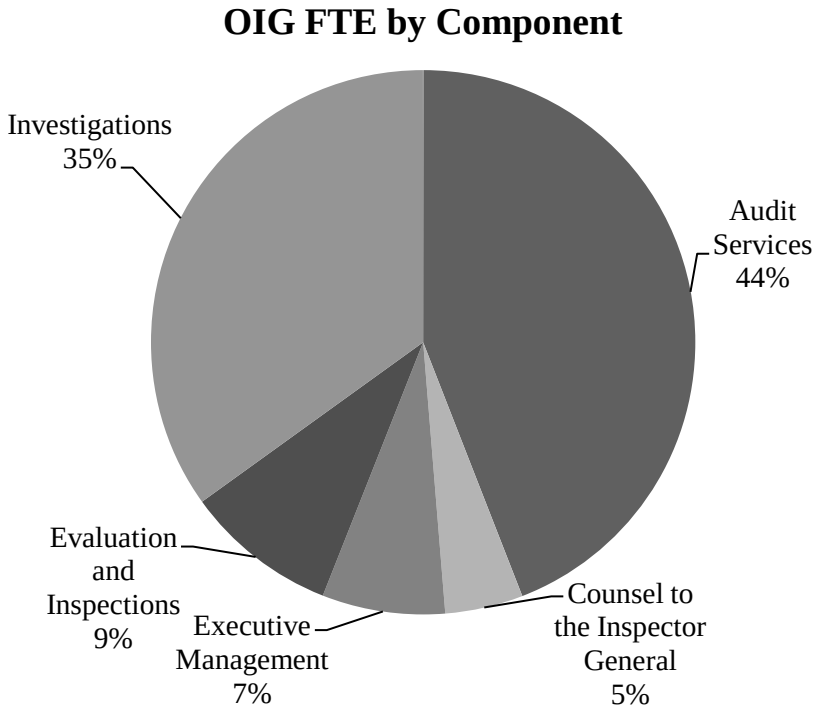
- Office of Counsel to the Inspector General (OCIG): OCIG provides legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud cases involving HHS programs,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

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

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

OIG maintains a Washington, D.C., office and a nationwide network of regional and field offices; approximately 75 percent of employees live and work outside the Washington, D.C., metropolitan area. At all levels, OIG staff work closely with HHS and its operating and staff divisions, DOJ and other agencies in the executive branch, Congress, and States to bring about systemic changes, successful prosecutions, negotiated settlements, and recovery of funds to protect the integrity of HHS programs and expenditures and the well-being of beneficiaries.

In FY 2011, the OIG staff was composed of 1,753 FTE, who were distributed among the 5 components as follows:



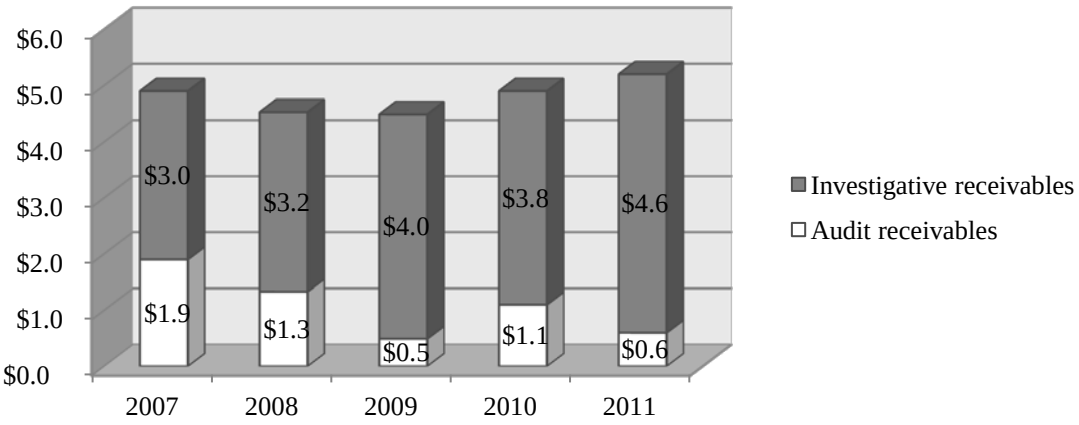
Accomplishments

OIG makes significant contributions to safeguarding HHS programs from threats of fraud, waste, and abuse and to promoting economy, efficiency, and effectiveness in those programs. Examples include reported savings and expected recoveries resulting from OIG's efforts, preventing certain individuals and businesses from participating in federally funded health care programs, and bringing civil and criminal actions against those who have committed fraud.

In OIG's fall 2011 *Semiannual Report to Congress*, OIG reported savings and expected recoveries of approximately $25.0 billion for FY 2011. This includes $19.8 billion from legislative and other cost-saving actions that were supported by recommendations in audits and evaluations and $5.2 billion in expected recoveries—$4.6 billion in investigative receivables (which includes $0.9 billion in non-HHS investigative receivables resulting from OIG's work in areas such as States' share of Medicaid restitution) and $0.6 billion in audit receivables.

- Expected Recoveries: FY 2011 represents the highest expected recoveries yet for OIG: $5.2 billion in total investigative and audit receivables. As reflected in the following graph, OIG's expected recoveries continue to trend upward and have increased more than 6 percent over a 5-year period.[1] This success is in part attributable in part to increases in staffing and the availability and better use of data.

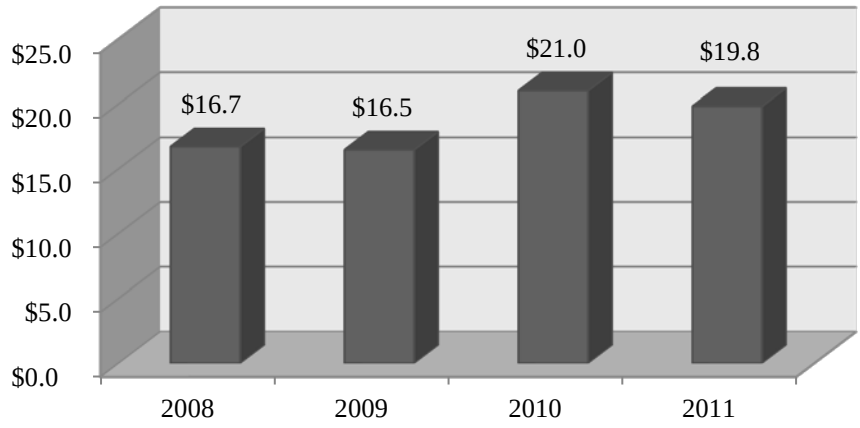
OIG Expected Recoveries FYs 2007 - 2011
(Dollars in Billions)



- Cost savings: OIG reported $19.8 billion in cost savings estimated for FY 2011 that resulted from legislative and other actions that were supported by recommendations in audits and evaluations. These savings reflect the enactment of laws involving HHS programs that include provisions that OIG's recommendations and overall body of work supported, as well as changes OIG recommended, whether legislative, regulatory, or administrative. For regulatory and administrative changes, savings estimates are determined by the responsible HHS operating or staff division or by OIG. For legislative savings, OIG uses estimates prepared by the Congressional Budget Office. These savings represent HHS funds made available for better use as a result of actions taken, such as reductions in budget outlays, reductions in costs incurred, and preaward grant reductions. The graph on the following page shows funds available for better use as a result of the implementation of OIG recommendations.

[1] Since initial publication of this document, OIG's expected recoveries reported in the above chart have been adjusted to achieve comparability between years. The figures originally reported for FYs 2007 and 2008 did not include non-HHS investigative receivable amounts and have since been corrected.

HHS Funds Available for Better Use as a Result of Implementation of Recommendationsin OIG Audits and Evaluations
(Dollars in Billions)



Savings of this kind generally reflect not only OIG's recommendations, but the contributions of others, such as HHS operating and staff divisions and GAO. At all levels, OIG works closely with its Federal partners to bring about successful systemic improvements through modifications to administrative policies, processes, or procedures; changes to existing regulations and law; or improvements in information technology.

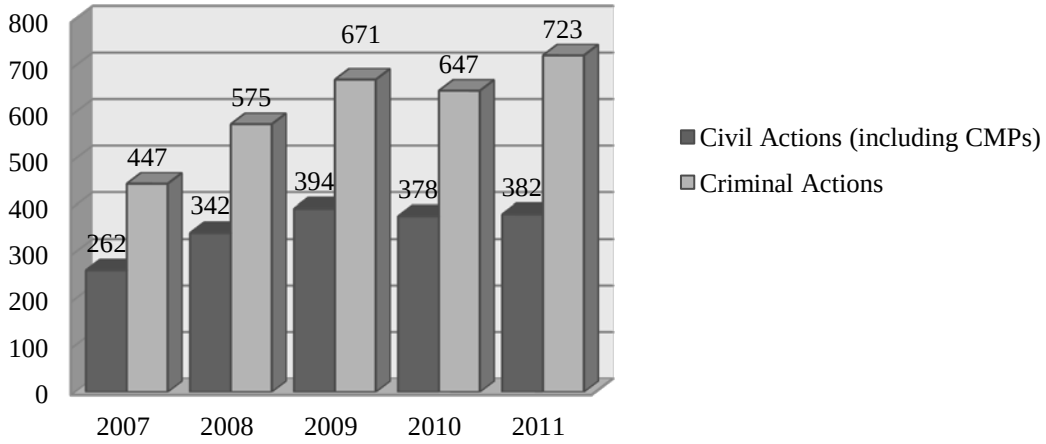
- Program Exclusions and Criminal and Civil Actions: In FY 2011, OIG excluded 2,662 individuals and organizations from participation in Federal health care programs. Included in the FY 2011 exclusions were those based on convictions for crimes related to Medicare and Medicaid (1,105) or to other health care programs (233), patient abuse or neglect (206), or licensure revocations (897). Additionally, bases for exclusion include convictions for default on Health Education Assistance Loans.

  Also in 2011, OIG reported 723 criminal actions against individuals or organizations that engaged in crimes against HHS programs. These crimes included various health care fraud violations. Additionally, OIG reported 382 civil and administrative actions. Among other things, civil and administrative actions include False Claims Act suits filed in Federal district court, CMP law settlements, and administrative recoveries related to provider self-disclosure matters. The number of criminal, civil, and administrative actions represented an increase of almost 60 percent since FY 2007.[1] During FY 2011,

[1] Since initial publication of this document, OIG's civil actions reported in the chart on the following page have been adjusted to achieve comparability between years. The figures originally reported for FYs 2007 through 2010 did not include all civil actions and have since been corrected.

OIG concluded CMP settlements involving more than $14.5 million in penalties and assessments.

Criminal and Civil Actions
FYs 2007 - 2011



OIG often negotiates compliance obligations with providers and other entities as part of the settlement of investigations arising under a variety of civil and administrative false claims statutes. A provider or an entity consents to these obligations as part of the civil settlement and in exchange for OIG's agreement not to seek the provider's or the entity's exclusion from participation in Federal health care programs. These agreements are known as corporate integrity agreements and typically last for 5 years. OIG monitors entities' compliance with these agreements and holds accountable those who violate them. Corporate integrity agreements generally include penalties for failure to meet certain terms, and OIG may exclude a provider who has committed a breach of its agreement. During FY 2011, OIG entered into 39 new such agreements and, at the close of the year, was monitoring compliance with 245 such agreements.

- Advisory Opinions, Education, and Other Guidance. As part of continuing efforts to promote the highest level of health care industry ethics and lawful conduct, OIG issues advisory opinions and other guidance to educate industry and other stakeholders on how to avoid fraud, waste, and abuse. This enables OIG to help industry navigate the complexities of the anti-kickback statute and safe harbor provisions and other OIG health care fraud and abuse sanctions. During FY 2011, OIG received 66 advisory opinion requests and, in consultation with DOJ, issued 22 advisory opinions.[1] The Web link to OIG's advisory opinions is at http://oig.hhs.gov/compliance/.

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

OIG also develops materials and conducts training to assist in teaching about the Federal laws designed to protect the Medicare and Medicaid programs and beneficiaries from fraud, waste, and abuse. For example, during FY 2011, OIG conducted free compliance training for providers, compliance professionals, and attorneys through the HEAT Provider Compliance Training initiative. The training included presenters from OIG, CMS, DOJ, and State Medicaid Fraud Control Units and was presented to over 700 in-person attendees in 6 cities. The final session in Washington, D.C., was Webcast live to over 2,000 participants. OIG developed comprehensive training materials to accompany the sessions, and those materials are now available online, together with 16 video modules dividing the Webcast by subject area. In 2011, the slides used during the training sessions were the second most downloaded item from OIG's Website. In 2012, OIG has begun to expand on this effort by making these materials available via podcast. The online training will continue reaching the health care community with OIG's message of compliance and prevention.

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

–Daniel R. Levinson, Inspector General

Budget Request

The FY 2013 request for OIG includes a total estimate of $369,748,000 and 1,974 FTE, an increase of +$13,948,000, of which $5,437,000 is to support current operations that were previously funded by appropriations that have since expired and support an additional +13 FTE above the FY 2012 Enacted Level. Specifically, this submission includes:

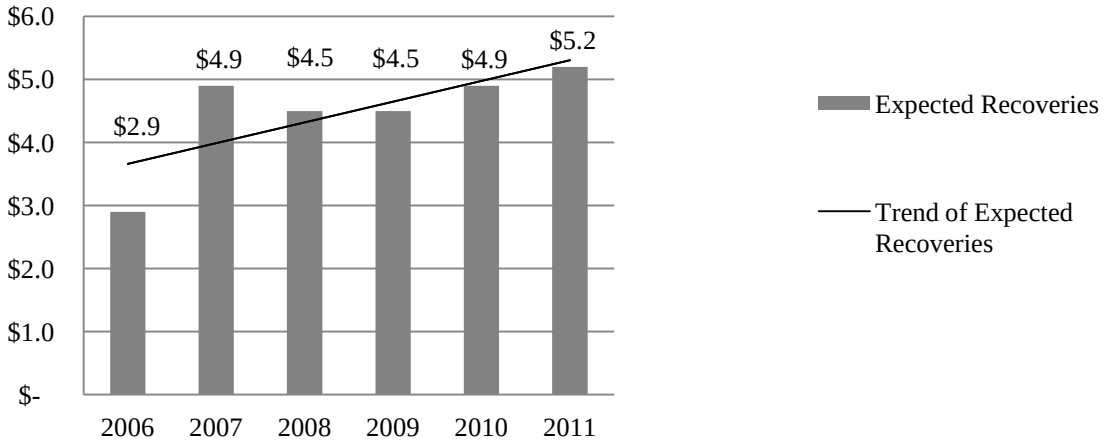
- PHHS Oversight: An increase of +$8,496,000 above the FY 2012 Enacted Level is requested to support current operations that were previously funded by appropriations that have since expired and to support efforts in key priority areas, such as grant oversight and monitoring the implementation of the ACA. Funding provided to OIG will build on activities begun in FYs 2011 and 2012, continuing to safeguard HHS programs against fraud, waste, and abuse. Additional detail about OIG's efforts in this area and this request can be found in the PHHS subsection beginning on page 33.

- CMS Oversight: An increase of +$5,452,000 above the FY 2012 Enacted Level is requested to support OIG's CMS-related program integrity efforts, including sustaining and expanding HEAT efforts, such as the Medicare Fraud Strike Forces; focusing investigation efforts on civil enforcement, as well as complex fraud schemes that require long-term investigations; and improper payments. While there are many varying methods to account for returns on investment (ROI) for HCFAC funding, CMS actuaries project that for each new dollar invested in program integrity efforts, there is a $1.5 to $1 ROI; through 2011, over $20 billion has been returned to the Government. Additional information about OIG's efforts in this area and this request can be found in the CMS subsection beginning on page 41.

The FY 2013 request includes funding to support one Physician Comparability Allowance (PCA). The PCA helps to ensure that OIG has the specific 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. Additional details are found on page 51.

OIG's FY 2013 request includes an increase of +13 FTE over the FY 2012 Enacted Level. The accomplishments described in the previous section are the direct result of investigations, audits, and evaluations by OIG staff. The following graph shows that during FYs 2006 through 2011, OIG's expected recoveries increased by almost 80 percent.[1] During the same period of time, OIG's FTE levels increased by approximately 20 percent.

OIG Expected Recoveries
FYs 2006- 2011
(Dollars in Billions)



Work Planning and Allocating OIG Resources

OIG plans its work and allocates its resources on the basis of a number of factors, including the purpose limitations in the agency's various funding sources, authorizing statutes, and mandates. Thus, in FY 2013, OIG's resource allocation and annual *Work Plan* will reflect the responsibilities assigned by Congress via the IG Act, as amended, HIPAA, OIG's annual discretionary appropriation, and various other statutes that provide OIG with funding or mandate certain activities. OIG also gives considerable weight to its annual assessments of top management and performance challenges facing HHS.

At the start of each FY, OIG issues a *Work Plan*, which describes the audits and evaluations that OIG plans to undertake during the coming year. In addition, OIG has law enforcement and prevention responsibilities, such as compliance monitoring and advisory opinions, that cannot be

[1] Since initial publication of this document, OIG's expected recoveries reported in the above chart have been adjusted to achieve comparability between years. The figures originally reported for FYs 2006 through 2008 did not include non-HHS investigative receivable amounts and have since been corrected.

prescribed in advance in a work plan but respond to allegations and risks as they arise. Furthermore, the workload is often adjusted throughout the year to meet new priorities and respond to emergencies, unforeseen events, and emerging issues.

In developing and evaluating specific *Work Plan* proposals for FY 2013, OIG will consider a number of factors, including the following:

- requirements in laws, regulations, or other directives;
- requests made or concerns raised by Congress and HHS management;
- significant management and performance challenges facing HHS, which OIG identifies as part of the HHS annual agency financial report;
- data analysis identifying aberrant trends in Medicare and Medicaid claims data and patterns that indicate possible fraud, waste, and abuse;
- work performed by other oversight agencies, such as GAO;
- management's actions to implement OIG recommendations from previous reviews;
- timing (e.g., a program may be reviewed because it is approaching reauthorization); and
- risk assessment metrics established by the GAO's *Government Auditing Standards* (Yellow Book).

Chief among the factors considered by OIG will be the levels of vulnerability and of risk to HHS programs and funds to fraud, waste, and abuse and their estimated effect on HHS programs and beneficiaries. Two factors considered heavily when assessing risk are the likelihood of occurrence and reoccurrence and the magnitude of impact for a given vulnerability. For example, weak internal controls or significant growth in program authority or spending may signal a greater likelihood of fraud, waste, or abuse, and the number of beneficiaries served by a program may be an indicator of impact. Reviews will be prioritized for implementation when the consequence of mismanagement, noncompliance, or other deficiencies in a specific program area could:

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

Highlights from the FY 2012 *Work Plan* can be found in the PHHS and CMS Oversight Budget Request subsections of this document (pages 33 and 41, respectively).

Performance Measures

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

- the 3-year moving average of expected recoveries from OIG's health care oversight activities that resulted in investigative receivables and audit disallowances,
- the 3-year moving average of the expected ROI from OIG's health care oversight activities that resulted in investigative receivables and audit disallowances, and
- the number of accepted quality and management improvement recommendations.

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

As shown in the following table, several output measures contribute to OIG's success in meeting its goals. Many factors are considered when setting OIG's output targets. One such factor is that OIG is a human capital organization that invests in its workforce. An increase in resources in one fiscal year may not necessarily yield results in the same fiscal year. Performance targets reflect the time required to hire and train new staff, which may result in an increase in outputs in future years. A breakdown of OIG's output measures by PHHS and CMS oversight can be found on pages 40 and 49, respectively.

OIG-Wide Performance Table

Key Outcomes[1]	Most Recent Result (FY 2011)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Expected recoveries resulting from OIG involvement in health care fraud and abuse oversight activities (dollars in millions)	FY 2011: $4,005 Target: $3,300 (Target exceeded)	$3,400	$3,400	--
Return on Investment (ROI) resulting from OIG involvement in health care fraud and abuse oversight activities	FY 2011: $16.2 Target: $13.0 (Target exceeded)	$12.0	$12.0	--
Number of quality and management improvement recommendations accepted	FY 2011: 134 Target: 120 (Target exceeded)	123	123	--
PL funding (dollars in millions)	$290	$356	$370	+$14

Key Outputs	Most Recent Result (FY 2011)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Audits:				
Audit reports started	FY 2011: 520 Target: 217 (Target exceeded)	249	249	--
Audit reports issued	FY 2011: 402 Target: 338 (Target exceeded)	315	315	--
Audit reports issued within 1 year of start (percentage)	FY 2011: 68% Target 63% (Target exceeded)	63%	63%	--
Evaluations:				
Evaluation reports started	FY 2011:77 Target: 57 (Target exceeded)	57	59	+2
Evaluation reports issued	FY 2011: 50 Target: 50 (Target met)	52	52	--
Evaluation reports issued within 1 year of start (percentage)	FY 2011: 58% Target:55% (Target exceeded)	55%	55%	--

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

Key Outputs (continued)	Most Recent Result (FY 2011)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Investigations[1]**:**				
Complaints received for investigation	FY 2011: 7,606 Target: 5,363 (Target exceeded)	6,290	6,290	--
Investigative cases started	FY 2011: 2,437 Target: 2,070 (Target exceeded)	2,176	2,176	--
Investigative cases closed	FY 2011: 2,090 Target: 1,978 (Target exceeded)	2,033	2,033	--
PL funding (dollars in millions)	$290	$356	$370	+$14

[1] OIG's "Most Recent Result (FY 2011)" for investigations has been corrected since initial publication of this document. The figures originally reported for both FY 2011 results and targets were for evaluation reports (see previous page), not investigations. The figures have been corrected to show the FY 2011 actual results and targets for investigations.

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

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Estimate	FY 2013 Pres. Bud.	FY 2013 +/- FY 2012
Direct BA	$50,178	$50,083	$58,579	+$8,496
FTE[1]	255	255	301	+46

Program Description

HHS is the Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS's 8 U.S. Public Health Service agencies and 2 human services agencies (not including CMS) operate over 300 programs, featuring diverse missions, ranging from ensuring food safety to operating community health centers. OIG oversight helps ensure the integrity and efficiency of the services each agency provides to the public. OIG's direct annual discretionary appropriation is used to fund a multidisciplinary approach to improving the efficiency of PHHS programs.

During FY 2011, OIG's expenditures for PHHS oversight were allocated across HHS operating and staff divisions as follows:

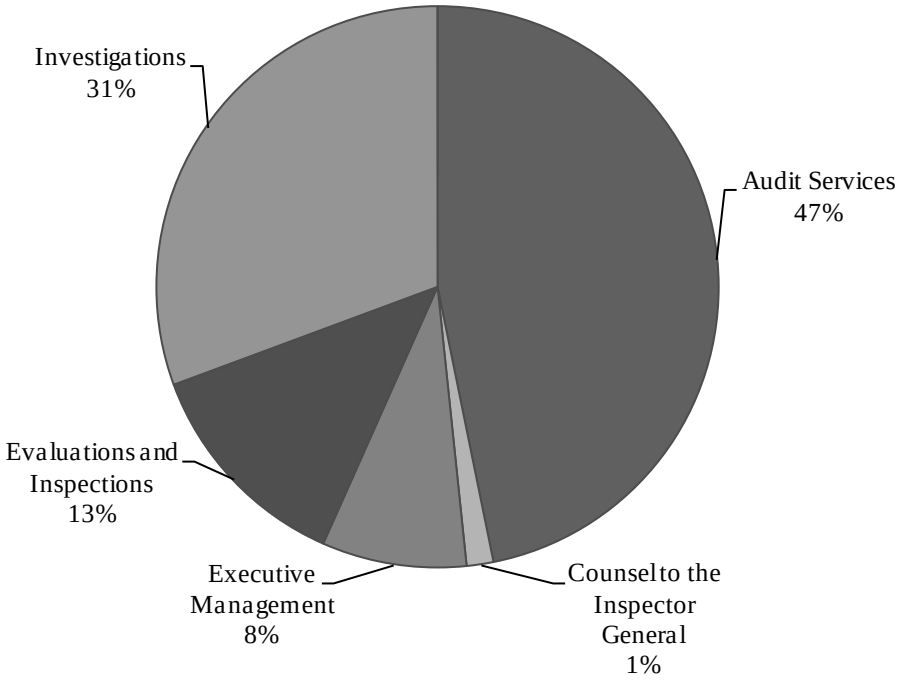
FY 2011 Allocation of Expenditures for OIG's Direct Appropriation

HHS Operating and Staff Divisions	Percentage
ACF	33%
AHRQ	1%
AoA	1%
CDC / ATSDR	6%
FDA	9%
HRSA	8%
IHS	4%
NIH	16%
SAMHSA	1%
OS	21%

[1] FTE reflect those targeted to PHHS oversight and attributed to OIG's direct discretionary BA. FTE supported with Recovery Act oversight funds and reimbursable funds are not included.

These resources were used for funding OIG's 5 components and approximately 255 FTE in FY 2011 as follows:

Allocations of OIG FTE by Component, PHHS Oversight



Accomplishments

In FY 2011, OIG issued 157 audits and 7 evaluations related to PHHS oversight. In addition, OIG continued to participate in the highly successful child support enforcement collaborative effort with the Office of Child Support Enforcement in ACF that contributed to 67 criminal actions or convictions and $3.7 million in restitution, fines, penalties, settlements, and recoveries. Importantly, these recoveries result in payments of vital child support to custodial parents.

The impact of OIG's efforts is seen in the number of accepted quality and management improvement recommendations generated by OIG audits and evaluations (see OIG-Wide Performance Table beginning on page 30). This measure captures an important aspect of OIG's efforts to identify and recommend corrections to systemic weaknesses in HHS programs. During FY 2011, 134 quality and management improvement recommendations were accepted. The following accomplishments are recent examples of the impact of OIG recommendations on PHHS programs.

- Improving Food Safety: The FDA Food Safety Modernization Act, enacted in January 2011, implemented several recommendations made in OIG evaluation reports. For example, OIG recommended that FDA seek additional statutory authority to improve

food traceability. When seeking this authority, the Administration repeatedly cited OIG's report, and the legislation now authorizes FDA to establish a new product-tracking system. Additionally, OIG recommended that FDA seek statutory authority to require facilities to reregister on a routine basis. The legislation now requires facilities to renew their registration every 2 years. Finally, the legislation implements several key recommendations designed to improve FDA's inspections program, such as increasing the overall number of food facility inspections and improving FDA's access to certain records during the inspection process.

- Improving Cost Effectiveness and Increasing Access to HIV/AIDS Medications: In 2000, OIG recommended that HRSA seek legislation to change the 340B ceiling price calculation (which limits the cost of outpatient drugs to certain Federal grantees and other safety net providers), reporting that the change would lead to significant savings for AIDS Drug Assistance Programs (ADAP). Recently, HRSA implemented the Alternative Method Demonstration Project, which allows 340B entities, such as community health centers, with multiple pharmacies to achieve greater savings by allowing them to access the lower 340B ceiling prices. Maximizing savings on drugs enables ADAPs to purchase more drugs for the same amount of funding and enables ADAPs to serve more individuals in need of HIV/AIDS drug therapy.

- Improving the Transparency of Conflicts of Interest at CDC: In response to OIG's report on the conflicts of interest among Special Government Employees (SGE), who often serve as subject matter experts on Federal advisory committees and play a role in public policy and decision making, CDC addressed all recommendations. In April 2010, CDC issued guidance on conflict-of-interest waivers. The guidance states that waivers must be granted before SGEs engage in a potentially prohibited activity, that waivers must be based upon a full disclosure by SGEs of all relevant facts, and that conflict-of-interest waivers must be issued in writing. Additionally, CDC now requires that all SGEs take ethics training and send written

Priority Unimplemented Recommendations–PHHS

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

- CDC: Improve States' and localities' medical and surgical preparedness for pandemics.
- FDA and NIH: Ensure that clinical investigators disclose all financial interests.
- NIH: Increase oversight of grantee institutions to ensure compliance with Federal financial conflict-of-interest regulations.
- IHS: Reduce overpayments for contract health services hospital claims and cap payments for nonhospital services at the Medicare rate for those services.

confirmation to CDC that they have done so. This report received the Award for Excellence in Government Ethics presented by the Council of the Inspectors General on Integrity and Efficiency (CIGIE).

Funding History

The funding history in the table below includes the budget authority provided to OIG for PHHS oversight. The funds displayed are provided to OIG through an annual discretionary direct appropriation included within the Labor, HHS, Education and Related Agencies appropriations bill.

FY	PHHS Oversight
2008	$43,231,000
2009	45,279,000
2010	50,279,000
2011	50,178,000
2012	50,083,000

Budget Request

With funding from its annual discretionary direct appropriation, OIG conducts program integrity and enforcement activities with regard to PHHS programs and operations. OIG prioritizes the allocation of these resources to comply with the requirements in appropriations language and other directives established in law. These include requirements that OIG conduct or oversee reviews under the Federal Information Security Management Act (FISMA) (P.L. No. 107-347) and the Single Audit Act (P.L. No. 98-502), other information technology audits, and investigations of interstate nonpayment of child support obligations. In addition, OIG provides protective services for the HHS Secretary and uses its discretionary appropriation to support this function.

OIG's FY 2013 budget request for PHHS oversight is $58,579,000, which is +$8,496,000 above the FY 2012 Enacted Level and would support 301 FTE. Of the amount requested, $5,437,000 is to support 33 FTE that were previously supported with Recovery Act funding and to redirect their efforts to emerging issues, such as the ones identified on the following page. The remaining $3,059,000 will support +13 new FTE as well as FY 2013 operating costs, such as increases associated with the FY 2013 pay increase and rent.

While it is difficult to predict emerging issues with certainty, OIG has identified the following general priorities for its 2013 efforts:

- Assess HHS operations and recommend actions to address program integrity vulnerabilities and improve program effectiveness.

- Provide HHS with vital information that will hold accountable grantees and contractors that manage large grant awards and contracts and ensure the integrity of their expenditures.

While the output of OIG's efforts will be counted by the number of PHHS audits, evaluations, and investigations and enforcement actions, the outcome will be in actions to prevent or reduce fraud, waste, and abuse. Such deterrent effect is difficult to measure reliably and affordably, but it is demonstrated partially in expected recoveries, exclusions, enforcement actions, and the acceptance of OIG recommendations to improve economy and efficiency and promote effectiveness in HHS programs. In this regard, OIG recommendations provide HHS policymakers and senior officials with facts for making key policy decisions. In 2011, 134 OIG recommendations were accepted by HHS program managers—recommendations that may result in significant improvements to the health and well-being of those served by HHS programs. Examples of the impact of OIG's recommendations are contained in the previous sections covering OIG's accomplishments. It is anticipated that increased investments in OIG will yield similar results.

With the requested resources and staff in FY 2013, a few of the areas that OIG has identified for possible PHHS oversight are as follows:

Increasing Evaluative Capacity: OIG evaluations focus on preventing fraud, waste, and abuse and promoting efficiency and effectiveness in Departmental programs by presenting practical recommendations for improving program operations. Unlike audits or investigations, which often focus on a single provider, grantee, contractor, or employee, an evaluation can result in important change to an entire program. Two examples of potential HHS program areas which could be reviewed because of the dollars involved and the associated vulnerabilities include HHS responsibilities under Title I of the ACA and IHS Contract Health Services. That said, actual work to be conducted will be determined through OIG's annual work planning process.

Increasing Medical Review Capacity: Medical record reviews are often essential to evaluate quality of care, access to appropriate services, and appropriateness of payments, but require significant resources to conduct. Funding would support contracts with medical experts to review case files and evaluate quality of care provided through PHHS programs. For example, OIG could assess the quality of care provided at IHS-funded facilities by determining the extent to which patients received appropriate preventive care or whether patients received care consistent with best practice guidelines for emergencies.

Safeguarding Data and Information Systems: New system development will bring new information security challenges as HHS addresses the privacy and security needs of HHS and its business partners, including those associated with the adoption of electronic health records. The fundamental challenge will be to ensure the confidentiality, availability, and integrity of these systems as new vulnerabilities are created and identified. The FY 2013 request will allow OIG to expand the scope of its existing work and help all of HHS safeguard its data and information systems, including the personally identifiable information of its beneficiaries and electronic health records deployed by eligible professionals. Additionally, the request will allow OIG to continue to monitor health information technology efforts initiated under the Recovery Act and other HHS programs.

FY 2012 *Work Plan* Highlights—PHHS Oversight

Examples of OIG's work in progress and planned reviews for FY 2012 include:

- FDA oversight of dietary supplements
- Internal controls for awarding Affordable Care Act grants
- Ryan White CARE Act Payer of Last Resort Provision
- Fraud vulnerabilities presented by electronic health records
- Preexisting condition insurance plans

Descriptions of these reviews can be found in OIG's FY 2012 *Work Plan*.

Increasing Oversight of HHS Grants and Contracts: HHS is the largest grant-awarding agency in the Federal Government. In FY 2011, the Department awarded approximately $377 billion in grants, of which over $91 billion were for non-CMS programs. Management and oversight of these ever-changing grant programs is a top priority. This work will continue to take on increasing importance and urgency as more ACA grant dollars are awarded and expended. In addition, the Department, in FY 2011 alone, awarded over $19 billion in contracts across all program areas. The rapid growth of HHS grant expenditures and the scope and size of HHS contracts make the management of these funds a significant challenge.

The FY 2013 request will allow OIG to supplement its existing grant oversight work—both audits and evaluations—while placing greater emphasis on grant and procurement fraud investigations. Such efforts could lead to further enforcement actions or suspensions and debarments of HHS grantees and contractors, which would have a sentinel effect of preventing payments to non-responsible entities and individuals.

Furthermore, OIG will use funding from the FY 2013 request to extend efforts begun under the Recovery Act to other HHS programs. Under the Recovery Act, OIG began an approach to oversight that used significant preventive efforts to ensure that funding was appropriately used. OIG engaged in a series of recipient capability audits that required a pre-award assessment of financial position, organizational structure, financial systems, project execution, procurements, and property. With the information gathered, HHS policymakers and program officials can take actions to safeguard funds in near-real time to identify possible troubled grantees; offer additional technical assistance; and, in some cases, cancel grant awards. Possible next steps include using the results of risk assessments such as these to target high-risk grantees, programs, and contracts to determine whether Federal funds have been appropriately used.

The table on the following page provides an overview of FY 2011 performance results and FYs 2012 and 2013 performance targets for OIG's PHHS oversight efforts.

Performance Table for PHHS Oversight

Key Outputs	Most Recent Result (FY 2011)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Audits:				
Audit reports started	177	73	73	--
Audit reports issued	157	109	109	--
Evaluations:				
Evaluation reports started	14	12	13	+1
Evaluation reports issued	7	10	10	--
Investigations:				
Complaints received for investigation	758	765	765	--
Investigative cases started	288	311	311	--
Investigative cases closed	297	332	332	--
PL funding (dollars in millions)	$50	$50	$59	+$9

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Subsection: Centers for Medicare & Medicaid Services Oversight

(Dollars in Thousands)

	FY 2011 Enacted	FY 2012 Enacted[1]	FY 2013 Request	FY 2013 +/- FY 2012
HCFAC Mandatory BA[2]	$197,998	$196,090	$196,669	+$579
HCFAC Discretionary BA	29,730	97,627	102,500	+4,873
HCFAC Collections	12,000	12,000	12,000	--
Total PL	**$239,728**	**$305,717**	**$311,169**	**+$5,452**
FTE	1,444	1,663	1,663	--

Program Description

CMS administers three of the Nation's largest health care programs: Medicare, Medicaid, and CHIP. In 2010, these programs accounted for approximately 85 percent, or approximately $727 billion, of HHS's expenditures. Medicare, the single largest health insurance program in the Nation, processes more than 1 billion claims per year. Medicaid and CHIP are operated by States, but they are funded in conjunction with the Federal Government, and offer medical coverage to the most vulnerable Americans, including low-income families with dependent children; pregnant women; children; and aged, blind, and disabled individuals.

Together, these programs cover one in four Americans, and approximately 80 percent of OIG's annual budget is devoted to their oversight. Using a multidisciplinary approach, including an important partnership with DOJ, OIG works to save taxpayer dollars while ensuring that patients receive the care and service they deserve. The following laws provide the basis for these important OIG efforts:

- HIPAA: Established HCFAC under the direction of the Attorney General and the Secretary of HHS, acting through the Inspector General, to combat fraud, waste, and abuse in Medicare and Medicaid. HCFAC funding constitutes a major portion of OIG's annual operating budget.

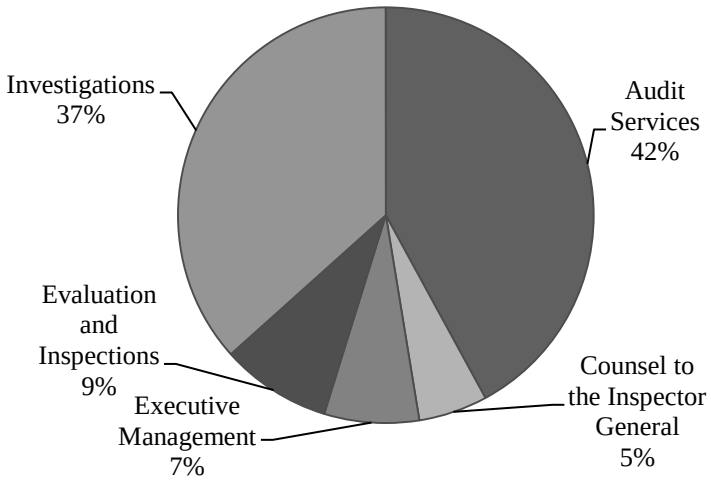
- The Deficit Reduction Act (DRA): Provided OIG annual funding of $25 million in FYs 2006–2010 to undertake fraud and abuse control activities related to Medicaid.

[1] The President's Budget proposes to increase the 2012 HCFAC Discretionary base funding to $311 million (which is fully offset) and to provide the additional $270 million in funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. OIG's allocation of these adjustments is displayed above.

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

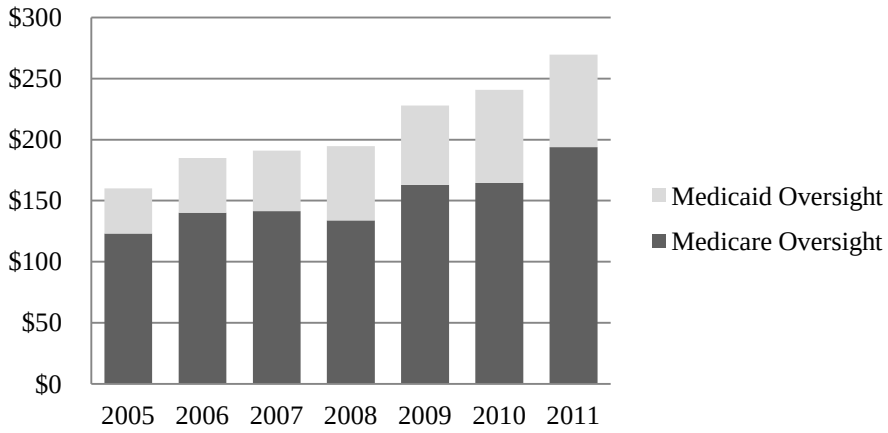
In FY 2011, funding for CMS oversight supported 1,444 FTE, who were assigned to CMS oversight activities across OIG's 5 components as follows:

Allocation of OIG FTE by Component, CMS Oversight



In FY 2011, approximately 70 percent of OIG's appropriated resources for activities with respect to CMS were allocated to Medicare oversight. Since FY 2005, the total amount and proportion of OIG's CMS-specific appropriations dedicated to Medicaid have increased steadily, with approximately 30 percent of OIG's CMS oversight resources allocated to Medicaid in FY 2011. Many OIG activities targeted to either Medicare or Medicaid often affect both programs.

OIG Obligations for CMS Oversight
(Dollars in Millions)



Accomplishments

During FY 2011, the Government's enforcement efforts resulted in 614 criminal actions and 375 civil actions against individuals or entities that engaged in health-care-related offenses. Further, OIG's CMS oversight efforts resulted in approximately $5.1 billion in expected health care recoveries (which include non-HHS investigative receivables resulting from OIG's work in areas such as the States' share of Medicaid restitution). Specific examples of OIG's recent CMS oversight work include:

- Medicare and Medicaid Prescription Drugs: AstraZeneca agreed to pay $520 million plus interest and enter into a 5-year corporate integrity agreement to resolve its civil False Claims Act liability in connection with the promotion of the atypical antipsychotic drug Seroquel. AstraZeneca was alleged to have promoted Seroquel between January 2001 and December 2006 for uses that were not approved by FDA as safe and effective. AstraZeneca also was alleged to have violated the Federal anti-kickback statute by offering and paying illegal remuneration to doctors in connection with services rendered by the doctors relating to the unapproved uses of Seroquel.

- Strengthening Medicare Screening of Providers: OIG indentified weaknesses in the Medicare provider enrollment process, which unscrupulous providers and suppliers have exploited to obtain Medicare billing privileges and defraud the program. The ACA required CMS to implement enhanced screening measures based on risk assessments to help prevent such fraud. In its final rule, which took effect on March 24, 2011, CMS incorporated many of OIG's recommendations and cited OIG's work in determining which types of providers and suppliers to classify as "medium" or "high" risk. Specifically, CMS cited OIG's findings of vulnerabilities related to durable medical equipment, imaging services, ambulance transports, hospice, and home health to support its requirement that these provider types undergo enhanced screening and monitoring.

- Adverse Events in Hospitals: In a November 2010 report, OIG provided the first nationally representative rate of Medicare patients being harmed in hospitals as a result of an adverse event. OIG found that one in seven hospitalized Medicare beneficiaries (13.5 percent) experienced harm, such as a prolonged hospital stay, or death or required actions to prevent death. An additional 13.5 percent of Medicare patients experienced less severe or temporary problems, such as allergic reactions or injuries from a fall. OIG determined that 44 percent of events were preventable and that adverse events resulted in additional hospital care, costing Medicare about $4.4 billion annually. CMS used these study results in designing the Administration's 2011 Partnership for Patients, a $1 billion patient-safety initiative focused on reducing preventable patient harm.

- Reducing Improper Payments in Medicaid: OIG recommended that CMS encourage States to use Correct Coding Initiative (CCI) edits to help reduce improper Medicaid payments. Building on this recommendation, the ACA requires that States use the CCI for claims filed on or after October 1, 2010. Previously, the National CCI edits were used by Medicare and designed to prevent improper payments when providers report incorrect code combinations.

- Medicare Atypical Antipsychotic Drug Claims for Nursing Home Residents: In a May 2011 report, OIG found that too often, elderly residents are prescribed antipsychotic drugs in ways that violate Government standards for unnecessary drug use. OIG found that 83 percent of Medicare claims for these drugs were associated with off-label conditions and that, 88 percent of the time, these drugs were prescribed for elderly people with dementia. FDA identified this population as facing an increased risk of death when using this class of drugs, which is why the agency puts its strongest safety warning on antipsychotic drugs, cautioning prescribers about the risk of death when taken by elderly people with dementia. OIG made several recommendations to CMS on how to better promote compliance with Federal standards regarding unnecessary drug use in nursing homes.

- Health Care Fraud Takedown With Highest False Medicare Billings in Strike Force History: In August and early September 2011, Medicare Fraud Strike Force teams in 8 cities executed a nationwide operation that resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving more than $290 million in false billing. This coordinated operation involved the highest dollar amount of false Medicare billings in a single takedown in Strike Force history.

Funding History

The funding history in the table below includes the budget authority provided to OIG for CMS oversight. The funds displayed are provided to OIG through a number of sources, including HCFAC Mandatory; HCFAC Discretionary Allocation Adjustment; HCFAC Collections; and specifically for Medicaid oversight provided through the DRA, the Supplemental Appropriations Act of 2008, and the Recovery Act.

Priority Unimplemented Recommendations–CMS Oversight

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

- Reduce the rental period for Medicare home oxygen equipment. ***Estimated savings: $3.2 billion.***
- Modify payments to Medicare Advantage Organizations. ***Estimated savings: $1.97 billion.***
- Ensure that Medicaid reimbursement for brand-name drugs accurately reflects pharmacy acquisition costs. ***Estimated savings: $1.08 billion.***
- Establish connection between the calculation of Medicaid drug rebates and drug reimbursement. ***Estimated savings: $1 billion.***
- Extend additional rebate payment provisions to generic drugs. ***Estimated savings: $966 million.***

FY	CMS Oversight
2008	$204,736,000
2009	287,422,000
2010	239,351,000
2011	239,728,000
2012	305,717,000

Budget Request[1]

The FY 2013 estimate for CMS Oversight is $311,169,000, which is an increase of +$5,452,000 above the FY 2012 Enacted Level. The OIG estimate includes:

- $196,669,000 in HCFAC Mandatory funding, an increase of +$579,000 above the FY 2012 Enacted Level;
- $102,500,000 in HCFAC Discretionary funding, an increase of +$4,873,000 above the FY 2012 Enacted Level; and
- $12,000,000 in HCFAC Collections, which is mandatory but the amount available will depend on the amount collected.

As indicated in the "Accomplishments" sections of this document, OIG's efforts hold individuals and corporations accountable through criminal and civil actions and exclusions while providing HHS policymakers, program officials, and Congress recommendations for improving the health care system through audits and evaluations. While OIG has not completed its formal work-planning efforts for FY 2013, possible priorities for targeting its CMS oversight efforts include:

- Assessing program vulnerabilities and recommending actions to reduce improper payments and prevent fraud.
- Fostering a culture of compliance within the health care industry both by issuing formal guidance and reaching out to other Federal and State agencies, stakeholder organizations, providers, and the public.
- Holding accountable perpetrators of Medicare and Medicaid fraud, with specific attention to combating organized crime, criminal enterprise, and corporate fraud.
- Increasing OIG's capacity to effectively use data to target resources to areas with the greatest vulnerability.

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

FY 2012 *Work Plan* Highlights—CMS Oversight

Examples of OIG's work in progress and planned reviews of CMS programs for FY 2012 follow.

- Medicare hospice marketing practices
- Contractor error rate reduction plans
- Zone Program Integrity Contractors' activities to detect and deter fraud and abuse
- Safety and effectiveness of Part D drugs
- Home health services: screening of health care workers

These reviews are described in OIG's FY 2012 *Work Plan*.

The estimate includes an increase of +$4,873,000 in discretionary HCFAC funding in support of Medicare and Medicaid program integrity efforts, including supporting the Administration's HEAT initiative, including Medicare Fraud Strike Forces; addressing improper payments; and focusing investigative efforts on civil enforcement, as well as complex fraud schemes that require long-term investigations and may not lend themselves to short-term interventions. The estimate will ensure that resources are available to sustain Strike Force efforts and other program integrity efforts.

Strike Forces exemplify the impact of these funding priorities, as Strike Force efforts have proven to be a highly effective means of identifying fraud and enforcing current anti-fraud laws around the country. For example, in FY 2011, Strike Force efforts in 9 cities resulted in:

- 132 indictments involving charges filed against 323 defendants, who collectively had billed Medicare more than $1 billion;
- 172 guilty pleas negotiated, 17 jury trials litigated, and guilty verdicts rendered against 26 defendants; and
- imprisonment for 175 defendants sentenced during the fiscal year, averaging more than 47 months of incarceration.

Since their inception in 2007, Strike Force operations in 9 cities have charged more than 1,150 defendants for fraud schemes involving more than $2.9 billion in claims. This significant success is due to the combination of intelligence gathered by agents, proactive data analysis, and attorneys dedicated to prosecuting Medicare fraud. Strike Force teams identify individuals and groups actively involved in Medicare fraud schemes and stop the fraudulent activity early, preventing significant losses to the affected programs. Analysis teams use near-real-time data to examine Medicare claims for patterns of suspected fraud. The analysis includes studies of suspected fraud trends and ratios of allowed services as compared with national averages, as well as other assessments.

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

—Daniel R. Levinson, Inspector General

As OIG, DOJ, and CMS adjust to a new environment of greatly enhanced data availability, they will analyze data to provide recommendations for efficient and timely enforcement efforts. This could include placing additional agents and attorneys in geographical areas with high fraud-risk indicators, supporting enforcement efforts with complementary audits and evaluations, increasing resources directed at civil fraud investigations, or making targeted investments in critical information systems. As part of this effort, OIG is using data mining, predictive analytics, and modeling to better identify fraud vulnerabilities and target oversight efforts. The expertise of OIG agents, auditors, and evaluators, using a combination of technologies and traditional skills, is highly effective in the fight against fraud, waste, and abuse.

Since the Consolidated Appropriations Act of 2012 (P.L. no. 112–74) did not fully fund the discretionary HCFAC base or the cap adjustment for 2012, the President's Budget proposes to increase the 2012 HCFAC discretionary base funding to the level of funding allowed by the cap adjustment, consistent with section 251(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. For OIG, this represents an increase +$67,953,000 in FY 2012.

The HCFAC program, in which OIG plays a significant role, has been a major success. In FY 2011, HCFAC reported an ROI of $7.2 to $1. Additionally, CMS actuaries project that for each new dollar invested in program integrity efforts, there will be a $1.5 to 1 ROI.

In addition to Medicare Fraud Strike Force efforts and other investigative efforts, possible areas of oversight to be considered for 2013 include: reducing improper payments, ensuring that beneficiaries receive appropriate and quality care, and overseeing CMS's program and benefit integrity contractors. Additional details follow:

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

For example, OIG analyzed the $4.7 million in improper payments identified by CMS's Comprehensive Error Rate Testing contractor and found that $4.4 million, or 94 percent, was related to six types of providers: inpatient hospitals, durable medical equipment (DME) suppliers, hospital outpatient departments, physicians, skilled nursing facilities, and home health

agencies. OIG's analysis also showed that insufficient documentation, miscoded claims, and medically unnecessary services and supplies accounted for about 98 percent of the improper payments to these types of providers.

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

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

- determining whether the care provided in Medicaid home- and community-based settings follows the plans of care and assessing the extent of CMS's oversight of quality of care in these settings.

As discussed in the PHHS section, medical record reviews are often essential to evaluate quality of care, access to appropriate services, and appropriateness of payments, but require significant resources to conduct. Increased resources would provide valuable assistance to OIG auditors and evaluators in this effort.

Overseeing Program and Benefit Integrity Contractors: OIG's work has revealed persistent problems with CMS's program and benefit integrity contractors and ongoing vulnerabilities in CMS's oversight. With an ever-growing reliance on contractors to identify, prevent, and respond to fraud, abuse, and improper payments in Medicare and Medicaid, CMS must conduct adequate oversight and monitoring. In FY 2013 OIG oversight efforts may address the adequacy of contracts, contractor performance, and the sufficiency of CMS's oversight of contractor performance.

Performance Table for CMS Oversight

Key Outputs	Most Recent Result (FY 2011)	FY 2012 Target	FY 2013 Target	FY 2013 +/- FY 2012
Audits:				
Audit reports started	343	176	176	--
Audit reports issued	245	206	206	--
Evaluations:				
Evaluation reports started	63	45	46	+1
Evaluation reports issued	43	42	42	--
Investigations:				
Complaints received for investigation	6,848	5,525	5,525	--
Investigative cases started	2,149	1,865	1,865	--
Investigative cases closed	1,793	1,701	1,701	--
PL funding (dollars in millions)	$240	$306	$311	+$5

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Total Object Class

(Dollars in Thousands)

	FY 2012 Estimate	FY 2013 Pres. Bud.	Increase or Decrease
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$181,582	$184,168	+$2,587
Other than full-time permanent (11.3)	5,328	5,444	+116
Other personnel compensation (11.5)	4,012	4,057	+45
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	102	103	+1
Subtotal, Personnel	**191,023**	**193,773**	**+2,749**
Civilian benefits (12.1)	64,781	65,838	+1,056
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs[1]	**255,805**	**259,611**	**+3,806**
Travel and transportation of persons (21.0)	13,925	9,518	-4,407
Transportation of things (22.0)	3,556	3,996	+440
Rental payments to GSA (23.1)	18,398	18,739	+341
Rental payments to others (23.2)	84	86	+2
Communication, utilities, and misc. charges (23.3)	5,217	4,197	-1,019
Printing and reproduction (24.0)	146	106	-40
Other Contractual Services:			
Advisory and assistance services (25.1)	2	1	-1
Other services (25.2)	10,668	7,770	-2,898
Purchase of goods and services from Government accounts (25.3)	46,967	45,054	-1,914
Operation and maintenance of facilities (25.4)	22,052	12,688	-9,364
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	8,019	5,434	-2,584
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**87,708**	**70,947**	**-16,760**
Supplies and materials (26.0)	5,004	5,227	+223
Equipment (31.0)	24,500	20,985	-3,514
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	--	--	--
Receipts (61.0)	--	--	--
Subtotal, Nonpay Costs	**158,536**	**133,802**	**-24,734**
Total, Obligations by Object Class	**$414,341**	**$393,413**	**-$20,928**

Note: Numbers, as displayed, may not add because of rounding.

[1] Total for each year includes funds for one PCA. For each FY, $24,000 is included for the PCA payment. Additional details can be found on page 27.

PHHS Oversight Object Class

(Dollars in Thousands)

	FY 2012 Estimate	FY 2013 Pres. Bud.	Increase or Decrease
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$23,044	$27,408	+$4,364
Other than full-time permanent (11.3)	717	852	+136
Other personnel compensation (11.5)	500	595	+95
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	10	11	+2
Subtotal, Personnel	**24,271**	**28,867**	**+4,596**
Civilian benefits (12.1)	8,139	9,681	+1,541
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**32,410**	**38,548**	**+6,137**
Travel and transportation of persons (21.0)	1,699	3,149	+1,450
Transportation of things (22.0)	511	521	+10
Rental payments to GSA (23.1)	2,610	3,186	+576
Rental payments to others (23.2)	10	11	+1
Communication, utilities, and misc. charges (23.3)	985	1,003	+19
Printing and reproduction (24.0)	36	37	+1
Other contractual services:			
Advisory and assistance services (25.1)	--	--	--
Other services (25.2)	1,168	1,274	+106
Purchase of goods and services from Government accounts (25.3)	5,633	5,493	-140
Operation and maintenance of facilities (25.4)	2,007	2,190	+183
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	595	649	+54
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**9,403**	**9,607**	**+203**
Supplies and materials (26.0)	343	357	+14
Equipment (31.0)	2,076	2,162	+86
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	--	--	--
Receipts (61.0)	--	--	--
Subtotal, Nonpay Costs	**17,673**	**20,031**	**+2,358**
Total, Obligations by Object Class	**$50,083**	**$58,579**	**+$8,496**

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

CMS Oversight Object Class

(Dollars in Thousands)

	FY 2012 Estimate	FY 2013 Pres. Bud.	Increase or Decrease
Obligations			
Personnel compensation:			
Full-time permanent (11.1)	$154,649	$155,854	+$1,204
Other than full-time permanent (11.3)	4,522	4,574	+53
Other personnel compensation (11.5)	3,430	3,450	+20
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	93	92	-1
Subtotal, Personnel	**162,694**	**163,970**	**+1,276**
Civilian benefits (12.1)	55,473	55,855	+382
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Subtotal, Pay Costs	**218,167**	**219,825**	**+1,658**
Travel and transportation of persons (21.0)	10,754	6,331	-4,424
Transportation of things (22.0)	3,027	3,458	+431
Rental payments to GSA (23.1)	15,788	15,553	-235
Rental payments to others (23.2)	74	75	+1
Communication, utilities, and misc. charges (23.3)	4,232	3,194	-1,038
Printing and reproduction (24.0)	110	69	-41
Other Contractual Services:			
Advisory and assistance services (25.1)	2	1	-1
Other services (25.2)	9,416	6,417	-2,999
Purchase of goods and services from Government accounts (25.3)	19,044	17,281	-1,764
Operation and maintenance of facilities (25.4)	20,045	10,498	-9,547
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	7,412	4,774	-2,638
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**55,919**	**38,971**	**-16,949**
Supplies and materials (26.0)	4,660	4,870	+209
Equipment (31.0)	22,424	18,824	-3,600
Land and structures (32.0)	--	--	--
Investments and loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	--	--	--
Insurance claims and indemnities (42.0)	--	--	--
Receipts (61.0)	--	--	--
Subtotal, Nonpay Costs	**116,989**	**91,344**	**-25,645**
Total, Obligations by Object Class	**$335,156**	**$311,169**	**-$23,987**

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

Total Salary and Expenses
(Dollars in Thousands)

	FY 2012 Estimate	FY 2013 Pres. Bud.	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$181,582	$184,168	+$2,587
Other than full-time permanent (11.3)	5,328	5,444	+116
Other personnel compensation (11.5)	4,012	4,057	+45
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	102	103	+1
Subtotal, Personnel Compensation	**191,023**	**193,773**	**+2,749**
Civilian benefits (12.1)	64,781	65,838	+1,056
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Total, Pay Costs	**255,805**	**259,611**	**+3,806**
Travel and transportation of persons (21.0)	13,925	9,518	-4,407
Transportation of things (22.0)	3,556	3,996	+440
Rental payments to others (23.2)	84	86	+2
Communication, utilities, and misc. charges (23.3)	5,217	4,197	-1,019
Printing and reproduction (24.0)	146	106	-40
Other contractual services:			
Advisory and assistance services (25.1)	2	1	-1
Other services (25.2)	10,668	7,770	-2,898
Purchase of goods and services from Government accounts (25.3)	46,967	45,054	-1,914
Operation and maintenance of facilities (25.4)	22,052	12,688	-9,364
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	8,019	5,434	-2,584
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**87,708**	**70,947**	**-16,760**
Supplies and materials (26.0)	5,004	5,227	+223
Total, Nonpay Costs	**115,639**	**94,078**	**-21,561**
Total, Salary and Expenses	**$371,444**	**$353,688**	**-$17,755**
Total FTE	**1,961**	**1,974**	**+13**

Note: Numbers, as displayed, may not add because of rounding.

PHHS Oversight Salary and Expenses
(Dollars in Thousands)

	FY 2012 Estimate	FY 2013 Pres. Bud.	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$23,133	$27,408	+$4,364
Other than full-time permanent (11.3)	720	852	+136
Other personnel compensation (11.5)	502	595	+95
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	10	11	+2
Subtotal, Personnel Compensation	**24,364**	**28,867**	**+4,596**
Civilian benefits (12.1)	8,171	9,681	+1,541
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Total, Pay Costs	**32,535**	**38,548**	**+6,137**
Travel and transportation of persons (21.0)	1,699	3,149	+1,450
Transportation of things (22.0)	511	521	+10
Rental payments to others (23.2)	10	11	+1
Communication, utilities, and misc. charges (23.3)	985	1,003	+19
Printing and reproduction (24.0)	36	37	+1
Other contractual services:			
Advisory and assistance services (25.1)	--	--	--
Other services (25.2)	1,168	1,274	+106
Purchase of goods and services from Government accounts (25.3)	5,546	5,493	-140
Operation and maintenance of facilities (25.4)	2,007	2,190	+183
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	595	649	+54
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**9,403**	**9,607**	**+203**
Supplies and materials (26.0)	343	357	+14
Total, Nonpay Costs	**12,987**	**14,684**	**+1,697**
Total, Salary and Expenses	**$45,398**	**$53,232**	**+$7,834**
Direct FTE	**255**	**301**	**+46**

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

CMS Oversight Salary and Expenses

(Dollars in Thousands)

	FY 2012 Estimate	FY 2013 Pres. Bud.	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$154,649	$155,854	+1,204
Other than full-time permanent (11.3)	4,522	4,574	+53
Other personnel compensation (11.5)	3,430	3,450	+20
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	93	92	-1
Subtotal, Personnel Compensation	**162,694**	**163,970**	**+1,276**
Civilian benefits (12.1)	55,473	55,855	+382
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Total, Pay Costs	**218,167**	**219,825**	**+1,658**
Travel and transportation of persons (21.0)	10,754	6,331	-4,424
Transportation of things (22.0)	3,027	3,458	+431
Rental payments to others (23.2)	74	75	+1
Communication, utilities, and misc. charges (23.3)	4,232	3,194	-1,038
Printing and reproduction (24.0)	110	69	-41
Other contractual services:			
Advisory and assistance services (25.1)	2	1	-1
Other services (25.2)	9,416	6,417	-2,999
Purchase of goods and services from Government accounts (25.3)	19,044	17,281	-1,764
Operation and maintenance of facilities (25.4)	20,045	10,498	-9,547
Research and development contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	7,412	4,774	-2,638
Subsistence and support of persons (25.8)	--	--	--
Subtotal, Other Contractual Services	**55,919**	**38,971**	**-16,949**
Supplies and materials (26.0)	4,660	4,870	+209
Total, Nonpay Costs	**78,777**	**56,967**	**-21,811**
Total, Salary and Expenses	**$296,944**	**$276,792**	**-$20,152**
Direct FTE	**1,663**	**1,663**	**--**

Detail of Full-Time Equivalents

	2011 Actual Civilian	2011 Actual Military	2011 Actual Total	2012 Est. Civilian	2012 Est. Military	2012 Est. Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total
PHHS Oversight FTE:									
Discretionary:									
Direct	255	--	255	255	--	255	301	--	301
Reimbursable	10	--	10	10	--	10	10	--	10
Recovery Act oversight:									
Direct	36	--	36	33	--	33	--	--	--
Affordable Care Act Oversight									
Direct	8	--	8	--	--	--	--	--	--
PHHS Oversight Subtotal	**309**	**--**	**309**	**298**	**--**	**298**	**311**	**--**	**311**
CMS Oversight FTE:									
HCFAC Mandatory / Collections									
Reimbursable	987	1	988	988	--	988	1,097	--	1,097
HCFAC Discretionary:									
Reimbursable	193	--	193	566	--	566	566	--	566
Medicaid Oversight Supplemental:									
Direct	90	--	90	109	--	109	--	--	--
Medicaid Oversight Funded by Recovery Act:									
Direct	173	--	173	--	--	--	--	--	--
CMS Oversight Subtotal	**1,443**	**1**	**1,444**	**1,663**	**--**	**1,663**	**1,663**	**--**	**1,663**
Total, OIG FTE	**1,752**	**1**	**1,753**	**1,961**	**--**	**1,961**	**1,974**	**--**	**1,974**

Detail of Positions

	2011 Actual	2012 Estimate	2013 Pres. Bud.
Executive Schedule (ES) Positions:			
Executive level X	1	1	1
ES-00	14	15	15
Subtotal, ES Positions	**15**	**16**	**16**
General Schedule (GS) Positions:			
GS-15	109	122	123
GS-14	243	272	274
GS-13	599	670	675
GS-12	435	487	490
GS-11	171	191	193
GS-10	1	1	1
GS-9	183	205	206
GS-8	5	6	6
GS-7	54	60	61
GS-6	4	4	5
GS-5	19	21	21
GS-4	7	8	8
GS-3	1	1	1
Subtotal, GS Positions	**1,831**	**2,049**	**2,063**
Commissioned Corps	2	--	--
Total, OIG Positions	**1,846**	**2,065**	**2,079**
Average GS Grade[1]	12.1	12.1	12.1
Average GS Salary	$92,585	$91,740	$92,453

Average GS Grade[1]

2009	12.1
2010	12.1
2011	12.1
2012	12.1
2013	12.1

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

Requirements of the Inspector General Act

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

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

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

- OIG's aggregate budget estimate and request to HHS at the beginning of the FY 2013 process was $375 million.
- OIG's aggregate budget request to Congress for FY 2013 is $370 million.
- Funding requested for training is $9 million.
- A total of $468,000 will be necessary to support the Council of the Inspectors General on Integrity and Efficiency (CIGIE).
- The IG comments on this budget request are on page 1 of this submission in the section entitled "Message From the Inspector General."

HHS OIG Training Requirements

In accordance with section 6(f)(3)(C) of the IG Act, this budget requests $9 million in FY 2013 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 2013 request includes more than 2,000 criminal investigators, auditors, program evaluators, attorneys, and administrative and management staff.

HHS OIG Financial Support for CIGIE

In support of the Governmentwide IG community, OIG contributes funds to CIGIE for such expenses as maintaining www.IGNet.gov, maintaining the awards nomination database, and hosting the annual awards ceremony. In accordance with the reporting requirements of section 6(f)(3)(D) of the IG Act, this budget requests $468,000 in necessary expenses for OIG's support of CIGIE, of which a portion will be funded from the discretionary budget.

FY 2013 HHS Enterprise Information Technology and Governmentwide E-Gov Initiatives

OIG will use $35,035 of its FY 2013 budget to support Departmentwide enterprise information technology and Government-wide E-Government initiatives. Staff Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the Governmentwide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board on the basis of funding availability and business case benefits. Development is collaborative and achieves HHS enterprisewide goals that produce common technology, promote common standards, and enable data and system interoperability.

Of the amount specified above, $3,188 is allocated to developmental Governmentwide E-Government initiatives for FY 2013. This amount supports these initiatives as follows:

FY 2013 Developmental E-Gov Initiatives*	
Line of Business-Human Resources	$3,188

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

The investment in Lines of Business-Human Resources Management will enable the Department to use one data system to perform all necessary functions.

In addition, $31,847.00 is allocated to ongoing Governmentwide E-Government initiatives for FY 2013. This amount supports these initiatives as follows:

FY 2013 Ongoing E-Gov Initiatives[1]	
Rulemaking	$23,825
Integrated Acquisition Environment	$8,022
FY 2013 Ongoing E-Gov Initiatives Total	**$31,847**

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

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