## In this Section:

- Other Financial Information
- Improper Payments Information Act Report
- Management Report on Final Action
- FY 2013 Top Management and Performance Challenges Identified by OIG
- Department's Response to OIG Top Management Challenges
- Glossary
- Laws, Regulations and Guidance

# Other Information

The Other Information (OI) section contains additional financial information including the Schedule of Spending, the Office of Inspector General's (OIG) FY 2013 assessment of management challenges facing the Department, a Management Report on Final Action and the Improper Payments Information Act Report, as well as a glossary and legal regulations relevant to this AFR.

# OTHER FINANCIAL INFORMATION

## Combining Schedule of Spending by Object Class

As of September 30, 2013
(in Millions)

| What Money is Available to Spend? | FY 2013 |
|---|---|
| Total Resources | $ 1,323,724 |
| Less: Amount Available but Not Agreed to be Spent | 32,092 |
| Less: Amount Not Available to be Spent | 9,596 |
| **Total Amounts Agreed to be Spent** | $ 1,282,036 |

| How was the Money Spent? | Grants, Subsidies and Contributions | Insurance Claims and Indemnities | Other Contractual Services | Personnel Compensation | Supplies and Materials | Personnel Benefits | Rent, Communications and Utilities | Other | FY 2013 |
|---|---|---|---|---|---|---|---|---|---|
| Medicaid | $ 283,398 | $ - | $ 72 | $ 12 | $ 3,422 | $ 4 | $ 10 | $ 2 | $ 286,920 |
| Medicare Hospital Insurance | - | 266,543 | 38 | - | - | - | - | 10,528 | 277,109 |
| Medicare Supplementary Medical Insurance | - | 241,977 | 44 | - | - | - | - | 10,412 | 252,433 |
| Payments to Trust Funds | 246,922 | - | - | - | - | - | - | 780 | 247,702 |
| Medicare Prescription Drug Benefit (Medicare Part D) | - | 69,357 | - | - | - | - | - | 390 | 69,747 |
| Temporary Assistance for Needy Families | 16,660 | - | 61 | 1 | - | - | - | - | 16,722 |
| State Children's Health Insurance Program | 9,472 | - | 20 | - | - | - | 33 | - | 9,525 |
| Children and Families Services | 8,928 | - | 344 | 118 | 1 | 32 | 17 | 10 | 9,450 |
| Foster Care and Adoption Assistance | 6,489 | - | 145 | - | - | - | - | - | 6,634 |
| Medicare Health Information Technology Incentive | - | 6,059 | - | - | - | - | - | - | 6,059 |
| Indian Health Services | 2,494 | 1 | 823 | 964 | 437 | 325 | 39 | 99 | 5,182 |
| National Cancer Institute | 2,915 | - | 1,345 | 386 | 32 | 106 | 10 | 31 | 4,825 |
| Child Support Enforcement and Family Support | 3,156 | - | 1,121 | - | - | - | - | - | 4,277 |
| Allergy and Infectious Diseases | 2,381 | - | 1,504 | 233 | 39 | 66 | 3 | 24 | 4,250 |
| Primary Health Care | 3,053 | - | 164 | 53 | 1 | 17 | 8 | 2 | 3,298 |
| Low Income Home Energy Assistance | 3,248 | - | 7 | - | - | - | - | - | 3,255 |
| Heart, Lung, and Blood Institute | 2,266 | - | 501 | 114 | 17 | 32 | 1 | 13 | 2,944 |
| Child Care Entitlement to States | 2,894 | - | 40 | - | - | - | - | - | 2,934 |
| Mental Health | 1,972 | - | 298 | 75 | 5 | 20 | 2 | 11 | 2,383 |
| Affordable Insurance Exchange Grants | 2,266 | - | 31 | 4 | - | 1 | 5 | - | 2,307 |
| General Medical Sciences | 2,142 | - | 122 | 21 | - | 6 | - | 1 | 2,292 |
| Public Health and Social Services | 291 | - | 1,160 | 100 | 604 | 25 | 23 | 36 | 2,239 |
| Ryan White HIV/AIDS Program | 2,132 | - | 81 | 16 | - | 5 | 2 | 2 | 2,238 |
| Child Care and Development Block Grant | 2,182 | - | 24 | - | - | - | - | - | 2,206 |
| Social Services Block Grant | 2,154 | - | 14 | 1 | - | - | - | - | 2,169 |
| Substance Abuse Treatment | 1,937 | 1 | 171 | 5 | - | 1 | - | 1 | 2,116 |
| Diabetes and Digestive and Kidney Diseases | 1,478 | - | 229 | 85 | 13 | 23 | 1 | 9 | 1,838 |
| Pre-existing Condition Insurance Plan | - | - | 1,773 | 1 | - | - | 2 | - | 1,776 |
| Health Care Fraud and Abuse | - | - | 1,540 | 36 | - | 11 | 10 | 1 | 1,598 |
| Neurological Disorders and Stroke | 1,238 | - | 202 | 63 | 9 | 17 | 1 | 12 | 1,542 |
| Aging Services Programs | 1,394 | - | 18 | 13 | - | 4 | 3 | - | 1,432 |
| Service and Supply Fund | - | - | 742 | 194 | 53 | 55 | 276 | 22 | 1,342 |
| Disease Control Research and Training | 373 | - | 473 | 222 | 83 | 70 | 50 | 70 | 1,341 |
| Child Health and Human Development | 865 | - | 292 | 77 | 9 | 21 | 1 | 8 | 1,273 |
| Public Health Preparedness and Response | 604 | - | 164 | 78 | 371 | 26 | 2 | 11 | 1,256 |
| National Institute on Drug Abuse | 768 | - | 234 | 50 | 4 | 14 | 1 | 5 | 1,076 |
| HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention | 732 | - | 137 | 123 | 4 | 43 | 1 | 8 | 1,048 |
| National Institute on Aging | 822 | - | 146 | 50 | 9 | 13 | 3 | 5 | 1,048 |
| Refugee and Entrant Assistance | 931 | - | 62 | 4 | - | 1 | 2 | 1 | 1,001 |
| Other Agency Budgetary Accounts | 11,582 | 868 | 12,757 | 4,332 | 363 | 1,446 | 539 | 1,362 | 33,249 |
| **Total Amounts Agreed to be Spent** | $ 630,139 | $ 584,806 | $ 26,899 | $ 7,431 | $ 5,476 | $ 2,384 | $ 1,045 | $ 23,856 | $ 1,282,036 |
| | | | | | | | | | $ 1,282,036 |

| Who did the Money go to? | FY 2013 |
|---|---|
| Federal | 30,608 |
| Non-Federal | 1,251,428 |
| **Total Amounts Agreed to be Spent** | $ 1,282,036 |

# Consolidating Balance Sheet by Budget Function

**As of September 30, 2013**

**(in Millions)**

| | Education, Training & Social Services | Health | Medicare | Income Security | Agency Combined Totals | Intra-HHS Eliminations | HHS Consolidated Totals |
|---|---|---|---|---|---|---|---|
| **Assets (Note 2)** | | | | | | | |
| **Intragovernmental Assets** | | | | | | | |
| Fund Balance with Treasury (Note 3) | $ 8,807 | $ 129,513 | $ 9,448 | $ 11,424 | $ 159,192 | $ - | $ 159,192 |
| Investments, Net (Note 4) | - | 5,550 | 276,173 | - | 281,723 | - | 281,723 |
| Accounts Receivable, Net (Note 5) | 26 | 1,695 | 66,027 | 11 | 67,759 | (64,110) | 3,649 |
| Advances (Note 8) | 1 | 39 | 113 | - | 153 | (50) | 103 |
| **Total Intragovernmental Assets** | **$ 8,834** | **$ 136,797** | **$ 351,761** | **$ 11,435** | **$ 508,827** | **$ (64,160)** | **$ 444,667** |
| Accounts Receivable, Net (Note 5) | - | 3,714 | 7,216 | 3 | 10,933 | - | 10,933 |
| Inventory and Related Property, Net (Note 6) | - | 8,602 | - | - | 8,602 | - | 8,602 |
| General Property, Plant and Equipment, Net (Note 7) | - | 5,056 | 308 | - | 5,364 | - | 5,364 |
| Advances (Note 8) | - | 34 | - | - | 34 | - | 34 |
| Other Assets | - | 655 | - | - | 655 | - | 655 |
| **Total Assets** | **$ 8,834** | **$ 154,858** | **$ 359,285** | **$ 11,438** | **$ 534,415** | **$ (64,160)** | **$ 470,255** |
| **Stewardship Property, Plant and Equipment** (Note 1) | | | | | | | |
| **Liabilities** (Note 9) | | | | | | | |
| **Intragovernmental Liabilities** | | | | | | | |
| Accounts Payable | $ 5 | $ 124 | $ 64,410 | $ - | $ 64,539 | $ (63,974) | $ 565 |
| Other Liabilities (Note 13) | 31 | 1,263 | 900 | 1 | 2,195 | (186) | 2,009 |
| **Total Intragovernmental Liabilities** | **$ 36** | **$ 1,387** | **$ 65,310** | **$ 1** | **$ 66,734** | **$ (64,160)** | **$ 2,574** |
| Accounts Payable | 12 | 546 | 104 | - | 662 | - | 662 |
| Entitlement Benefits Due and Payable (Note 10) | - | 28,663 | 48,614 | - | 77,277 | - | 77,277 |
| Accrued Grant Liability (Note 12) | 679 | 2,577 | (17) | 710 | 3,949 | - | 3,949 |
| Federal Employee and Veterans Benefits (Note 11) | 5 | 11,549 | 12 | - | 11,566 | - | 11,566 |
| Contingencies and Commitments (Note 14) | - | 7,600 | 1,300 | - | 8,900 | - | 8,900 |
| Other Liabilities (Note 13) | 19 | 1,301 | 1,248 | 13 | 2,581 | - | 2,581 |
| **Total Liabilities** | **$ 751** | **$ 53,623** | **$ 116,571** | **$ 724** | **$ 171,669** | **$ (64,160)** | **$ 107,509** |
| **Net Position** | | | | | | | |
| Unexpended Appropriations - Funds from dedicated collections (Note 21) | - | (100) | 4,569 | - | 4,469 | - | 4,469 |
| Unexpended Appropriations - Other funds | 8,071 | 86,954 | - | 10,703 | 105,728 | - | 105,728 |
| Unexpended Appropriations, Total | $ 8,071 | $ 86,854 | $ 4,569 | $ 10,703 | $ 110,197 | $ - | $ 110,197 |
| Cumulative Results of Operations - Funds from dedicated collections (Note 21) | - | 5,851 | 238,145 | - | 243,996 | - | 243,996 |
| Cumulative Results of Operations - Other funds | 12 | 8,530 | - | 11 | 8,553 | - | 8,553 |
| Cumulative Results of Operations, Total | 12 | 14,381 | 238,145 | 11 | 252,549 | - | 252,549 |
| **Total Net Position** | **$ 8,083** | **$ 101,235** | **$ 242,714** | **$ 10,714** | **$ 362,746** | **$ -** | **$ 362,746** |
| **Total Liabilities and Net Position** | **$ 8,834** | **$ 154,858** | **$ 359,285** | **$ 11,438** | **$ 534,415** | **$ (64,160)** | **$ 470,255** |

# Consolidated Balance Sheet by Operating Division

**As of September 30, 2013**

**(in Millions)**

| | ACF | ACL | AHRQ | CDC | CMS | FDA | HRSA | IHS | NIH | OS | PSC | SAMHSA | Agency Combined Totals | Intra-HHS Eliminations | HHS Consolidated Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Assets (Note 2)** | | | | | | | | | | | | | | | |
| **Intragovernmental Assets** | | | | | | | | | | | | | | | |
| Fund Balance with Treasury (Note 3) | 19,589 | 642 | 124 | 6,759 | 76,609 | 3,630 | 7,509 | 2,082 | 31,013 | 7,639 | 478 | 3,118 | 159,192 | - | 159,192 |
| Investments, Net (Note 4) | - | - | - | - | 278,270 | - | 3,428 | - | 25 | - | - | - | 281,723 | - | 281,723 |
| Accounts Receivable, Net (Note 5) | 14 | 23 | 28 | 33 | 3,371 | 13 | 17 | 36 | 54 | 142 | 216 | 4 | 3,951 | (302) | 3,649 |
| Advances (Note 8) | - | 1 | - | 3 | 114 | - | 10 | - | - | 4 | 1 | 20 | 153 | (50) | 103 |
| **Total Intragovernmental Assets** | 19,603 | 666 | 152 | 6,795 | 358,364 | 3,643 | 10,964 | 2,118 | 31,092 | 7,785 | 695 | 3,142 | 445,019 | (352) | 444,667 |
| Accounts Receivable, Net (Note 5) | 3 | - | - | 4 | 10,637 | 175 | 6 | 106 | 1 | - | 1 | - | 10,933 | - | 10,933 |
| Inventory and Related Property, Net (Note 6) | - | - | - | 3,202 | - | - | 2 | 7 | 34 | 5,353 | 4 | - | 8,602 | - | 8,602 |
| General Property, Plant and Equipment, Net (Note 7) | - | - | - | 1,432 | 369 | 334 | 1 | 1,038 | 2,090 | 94 | 6 | - | 5,364 | - | 5,364 |
| Advances (Note 8) | - | - | - | 27 | - | - | - | - | 2 | 5 | - | - | 34 | - | 34 |
| Other Assets | - | - | - | - | 407 | 10 | 237 | 1 | - | - | - | - | 655 | - | 655 |
| **Total Assets** | 19,606 | 666 | 152 | 11,460 | 369,777 | 4,162 | 11,210 | 3,270 | 33,219 | 13,237 | 706 | 3,142 | 470,607 | (352) | 470,255 |
| **Stewardship Property, Plant and Equipment** (Note 1) | | | | | | | | | | | | | | | |
| **Liabilities** (Note 9) | | | | | | | | | | | | | | | |
| **Intragovernmental Liabilities** | | | | | | | | | | | | | | | |
| Accounts Payable | 5 | 1 | 2 | - | 655 | 18 | 12 | 4 | 24 | 10 | 2 | 2 | 735 | (170) | 565 |
| Other Liabilities (Note 13) | 31 | - | 2 | 109 | 1,473 | 21 | 15 | 325 | 28 | 38 | 115 | 34 | 2,191 | (182) | 2,009 |
| **Total Intragovernmental Liabilities** | 36 | 1 | 4 | 109 | 2,128 | 39 | 27 | 329 | 52 | 48 | 117 | 36 | 2,926 | (352) | 2,574 |
| Accounts Payable | 12 | - | 6 | 37 | 147 | 5 | 50 | 26 | 271 | 77 | 22 | 9 | 662 | - | 662 |
| Entitlement Benefits Due and Payable (Note 10) | - | - | - | - | 77,277 | - | - | - | - | - | - | - | 77,277 | - | 77,277 |
| Accrued Grant Liability (Note 12) | 1,289 | 100 | 29 | 375 | (424) | (5) | 512 | 22 | 1,736 | 157 | - | 158 | 3,949 | - | 3,949 |
| Federal Employee and Veterans Benefits (Note 11) | 5 | - | - | 37 | 15 | 32 | 21 | 82 | 67 | 19 | 11,276 | 12 | 11,566 | - | 11,566 |
| Contingencies and Commitments (Note 14) | - | - | - | - | 7,366 | 1 | 533 | 1,000 | - | - | - | - | 8,900 | - | 8,900 |
| Other Liabilities (Note 13) | 30 | 2 | 15 | 177 | 1,354 | 187 | 95 | 267 | 296 | 92 | 50 | 16 | 2,581 | - | 2,581 |
| **Total Liabilities** | 1,372 | 103 | 54 | 735 | 87,863 | 259 | 1,238 | 1,726 | 2,422 | 393 | 11,465 | 231 | 107,861 | (352) | 107,509 |
| **Net Position** | | | | | | | | | | | | | | | |
| Unexpended Appropriations - Funds from dedicated collections (Note 21) | - | - | - | - | 4,569 | (100) | - | - | - | - | - | - | 4,469 | - | 4,469 |
| Unexpended Appropriations - Other funds | 18,227 | 547 | 65 | 6,245 | 37,655 | (2,920) | 6,711 | 1,157 | 27,762 | 7,411 | 50 | 2,818 | 105,728 | - | 105,728 |
| **Unexpended Appropriations, Total** | 18,227 | 547 | 65 | 6,245 | 42,224 | (3,020) | 6,711 | 1,157 | 27,762 | 7,411 | 50 | 2,818 | 110,197 | - | 110,197 |
| Cumulative Results of Operations - Funds from dedicated collections (Note 21) | - | - | - | 49 | 238,145 | 2,381 | 2,925 | 63 | 430 | - | - | 3 | 243,996 | - | 243,996 |
| Cumulative Results of Operations - Other funds | 7 | 16 | 33 | 4,431 | 1,545 | 4,542 | 336 | 324 | 2,605 | 5,433 | (10,809) | 90 | 8,553 | - | 8,553 |
| Cumulative Results of Operations, Total | 7 | 16 | 33 | 4,480 | 239,690 | 6,923 | 3,261 | 387 | 3,035 | 5,433 | (10,809) | 93 | 252,549 | - | 252,549 |
| **Total Net Position** | 18,234 | 563 | 98 | 10,725 | 281,914 | 3,903 | 9,972 | 1,544 | 30,797 | 12,844 | (10,759) | 2,911 | 362,746 | - | 362,746 |
| **Total Liabilities and Net Position** | 19,606 | 666 | 152 | 11,460 | 369,777 | 4,162 | 11,210 | 3,270 | 33,219 | 13,237 | 706 | 3,142 | 470,607 | (352) | 470,255 |

## Net Cost of Top 15 Programs

**For the Years Ended September 30, 2013 and 2012**
**(in Millions)**

| HHS Program | HHS Net Cost ($) FY 2013 | HHS Net Cost ($) FY 2012 | Rank by ($) FY 2013 | Rank by ($) FY 2012 | Budget Function | HHS Responsibility Segment |
|---|---|---|---|---|---|---|
| Medicare | $ 498,576 | $ 477,687 | 1 | 1 | Medicare | CMS |
| Medicaid | 266,624 | 247,508 | 2 | 2 | Health | CMS |
| Research | 31,125 | 32,362 | 3 | 3 | Health | NIH |
| Temporary Assistance to Needy Families | 18,021 | 17,131 | 4 | 4 | Education, Training & Social Services / Income Security | ACF |
| Children's Health Insurance Program (CHIP) | 9,548 | 9,260 | 5 | 5 | Health | CMS |
| Head Start | 7,915 | 7,805 | 6 | 6 | Education, Training & Social Services / Income Security | ACF |
| Child Welfare | 7,719 | 7,643 | 7 | 7 | Education, Training & Social Services / Income Security | ACF |
| Child Care | 5,211 | 4,982 | 8 | 9 | Education, Training & Social Services / Income Security | ACF |
| *Affordable Care Act* Program | 5,047 | 3,800 | 9 | 12 | Health | ACL, CDC, CMS, OS & SAMHSA |
| Immunization and Respiratory Diseases (including Infectious Diseases)* | 4,331 | 5,484 | 10 | 8* | Health | CDC |
| Child Support Enforcement | 4,085 | 3,955 | 11 | 10 | Education, Training & Social Services / Income Security | ACF |
| Low-Income Home Energy Assistance | 3,495 | 3,860 | 12 | 11 | Education, Training & Social Services / Income Security | ACF |
| Primary Care | 3,328 | 3,411 | 13 | 13 | Health | HRSA |
| Clinical Services | 2,378 | 2,402 | 14 | 15 | Health | IHS |
| HIV/AIDS Programs | 2,203 | 2,414 | 15 | 14 | Health | HRSA |
| **Total Top 15 Programs** | **$ 869,606** | **$ 829,704** | | | | |
| All Other HHS Programs | 26,833 | 26,001 | | | Various | Various |
| **Total Combined Net Costs** | **$ 896,439** | **$ 855,705** | | | | |
| Eliminations | (189) | (158) | | | | |
| **Total Consolidated Net Costs of Operations** | **$ 896,250** | **$ 855,547** | | | | |

**CDC restructured the GPRA programs based on appropriations bills approved by Congress in FY 2012. The Infectious Disease program that was previously presented, is now included in the Immunization and Respiratory Diseases program in FY 2013.*

## Supplemental Statement of Net Cost

**For The Years Ended September 30, 2013 and 2012**
**(in Millions)**

**2013**

| Responsibility Segments | Agency Combined Totals | Inter-Agency Eliminations: Costs (-) | Inter-Agency Eliminations: Earned/Exchange Revenues (+) * | Consolidated Totals |
|---|---|---|---|---|
| ACF | $ 50,559 | $ (53) | $ 23 | $ 50,529 |
| ACL | 1,445 | (3) | 8 | 1,450 |
| AHRQ | 188 | (15) | 414 | 587 |
| CDC | 10,299 | (129) | 460 | 10,630 |
| CMS | 779,791 | (615) | 46 | 779,222 |
| FDA | 1,750 | (237) | 13 | 1,526 |
| HRSA | 8,847 | (217) | 36 | 8,666 |
| IHS | 4,441 | (156) | 165 | 4,450 |
| NIH | 31,125 | (897) | 214 | 30,442 |
| OS | 3,571 | (260) | 537 | 3,848 |
| PSC | 1,041 | (31) | 476 | 1,486 |
| SAMHSA | 3,382 | (71) | 103 | 3,414 |
| **Net Cost of Operations** | **$ 896,439** | **$ (2,684)** | **$ 2,495** | **$ 896,250** |

**2012**

| Responsibility Segments | Agency Combined Totals | Inter-Agency Eliminations: Costs (-) | Inter-Agency Eliminations: Earned/Exchange Revenues (+) * | Consolidated Totals |
|---|---|---|---|---|
| ACF | $ 49,134 | $ (44) | $ 36 | $ 49,126 |
| ACL | 1,489 | (6) | 5 | 1,488 |
| AHRQ | 238 | (17) | 415 | 636 |
| CDC | 9,945 | (179) | 481 | 10,247 |
| CMS | 737,823 | (616) | 16 | 737,223 |
| FDA | 2,134 | (242) | 30 | 1,922 |
| HRSA | 8,782 | (223) | 49 | 8,608 |
| IHS | 5,766 | (209) | 173 | 5,730 |
| NIH | 32,362 | (945) | 128 | 31,545 |
| OS | 3,325 | (223) | 490 | 3,592 |
| PSC | 1,338 | 110 | 521 | 1,969 |
| SAMHSA | 3,369 | (66) | 158 | 3,461 |
| **Net Cost of Operations** | **$ 855,705** | **$ (2,660)** | **$ 2,502** | **$ 855,547** |

**Eliminations for non-exchange revenue are reported in the Consolidated Statement of Changes in Net Position*

## Consolidating Statement of Net Cost by Budget Function

**For the Year Ended September 30, 2013**
**(in Millions)**

| Responsibility Segments | Education, Training, & Social Services | Health | Medicare | Income Security | Agency Combined Totals | Intra-HHS Eliminations Cost (-) | Intra-HHS Eliminations Revenue | Consolidated Totals |
|---|---|---|---|---|---|---|---|---|
| ACF | $ 12,214 | $ - | $ - | $ 38,345 | $ 50,559 | $ (53) | $ 23 | $ 50,529 |
| ACL | 1,445 | - | - | - | 1,445 | (3) | 8 | 1,450 |
| AHRQ | - | 188 | - | - | 188 | (15) | 414 | 587 |
| CDC | - | 10,299 | - | - | 10,299 | (129) | 460 | 10,630 |
| CMS | - | 281,215 | 498,576 | - | 779,791 | (615) | 46 | 779,222 |
| FDA | - | 1,750 | - | - | 1,750 | (237) | 13 | 1,526 |
| HRSA | - | 8,847 | - | - | 8,847 | (217) | 36 | 8,666 |
| IHS | - | 4,441 | - | - | 4,441 | (156) | 165 | 4,450 |
| NIH | - | 31,125 | - | - | 31,125 | (897) | 214 | 30,442 |
| OS | - | 3,571 | - | - | 3,571 | (260) | 537 | 3,848 |
| PSC | - | 1,041 | - | - | 1,041 | (31) | 476 | 1,486 |
| SAMHSA | - | 3,382 | - | - | 3,382 | (71) | 103 | 3,414 |
| **Net Cost of Operations** | **$ 13,659** | **$ 345,859** | **$ 498,576** | **$ 38,345** | **$ 896,439** | **$ (2,684)** | **$ 2,495** | **$ 896,250** |

## Gross Cost and Exchange Revenue

**For the Year Ended September 30, 2013**
**(in Millions)**

| Responsibility Segments | Intragovernmental | | | | | | With the Public | | Consolidated Net Cost of Operations |
|---|---|---|---|---|---|---|---|---|---|
| | Gross Cost | | | Less: Exchange Revenue | | | | | |
| | Combined | Eliminations | Consolidated | Combined | Eliminations | Consolidated | Gross Cost | Less: Exchange Revenue | |
| ACF | $ 186 | $ (53) | $ 133 | $ (41) | $ 23 | $ (18) | $ 50,433 | $ (19) | $ 50,529 |
| ACL | 11 | (3) | 8 | (7) | 8 | 1 | 1,441 | - | 1,450 |
| AHRQ | 43 | (15) | 28 | (414) | 414 | - | 578 | (19) | 587 |
| CDC | 860 | (129) | 731 | (580) | 460 | (120) | 10,040 | (21) | 10,630 |
| CMS | 1,256 | (615) | 641 | (68) | 46 | (22) | 848,326 | (69,723) | 779,222 |
| FDA | 1,101 | (237) | 864 | (34) | 13 | (21) | 2,530 | (1,847) | 1,526 |
| HRSA | 357 | (217) | 140 | (43) | 36 | (7) | 8,580 | (47) | 8,666 |
| IHS | 580 | (156) | 424 | (207) | 165 | (42) | 5,127 | (1,059) | 4,450 |
| NIH | 1,751 | (897) | 854 | (322) | 214 | (108) | 29,837 | (141) | 30,442 |
| OS | 544 | (260) | 284 | (581) | 537 | (44) | 3,616 | (8) | 3,848 |
| PSC | 152 | (31) | 121 | (852) | 476 | (376) | 1,809 | (68) | 1,486 |
| SAMHSA | 114 | (71) | 43 | (121) | 103 | (18) | 3,389 | - | 3,414 |
| Totals | **$ 6,955** | **$ (2,684)** | **$ 4,271** | **$ (3,270)** | **$ 2,495** | **$ (775)** | **$ 965,706** | **$ (72,952)** | **$ 896,250** |

# IMPROPER PAYMENTS INFORMATION ACT REPORT

## 1.0 Overview

The Department of Health and Human Services' (HHS or the Department) Fiscal Year (FY) 2013 *Improper Payments Information Act* Report includes a discussion of the following information, as required by *the Improper Payments Information Act of 2002* (IPIA) as amended by the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA)*,* Office of Management and Budget (OMB) Circular A-136, and Appendix C of OMB Circular A-123:

- Program Descriptions (Section 1.10)
- Risk Assessments (Section 2.0)
- Statistical Sampling Process (Section 3.0)
  - Error Rate Presentation (Section 3.10)
- Corrective Action Plans (Section 4.0)
  - Corrective Actions for Grants (Section 4.10)
- Accountability in Reducing and Recovering Improper Payments (Section 5.0)
- Information Systems and Other Infrastructure (Section 6.0)
- Mitigation Efforts Related to Statutory or Regulatory Barriers (Section 7.0)
- Progress and Achievements (Section 8.0)
  - Fiscal Year 2013 Progress (Section 8.10)
  - Fiscal Year 2013 Achievements (Section 8.20)
- Improper Payment Reduction Outlook (Section 9.0)
  - Accompanying Improper Payment Reduction Outlook Notes (Section 9.10)
- Program-Specific Reporting Information (Section 10.0)
  - Medicare Fee-For-Service (FFS) (Parts A and B) (Section 10.10)
  - Medicare Advantage (Part C) (Section 10.20)
  - Medicare Prescription Drug Benefit (Part D) (Section 10.30)
  - Medicaid (Section 10.40)
  - Children's Health Insurance Program (CHIP) (Section 10.50)
  - Temporary Assistance for Needy Families (TANF) (Section 10.60)
  - Foster Care (Section 10.70)
  - Child Care Development Fund (CCDF) (Section 10.80)
- Recovery Auditing Reporting (Section 11.0)

## 1.10 Program Descriptions

The following is a brief description of the risk-susceptible programs discussed in this report:

1. **Medicare Fee-For-Service (Parts A and B)** - A Federal health insurance program for people age 65 or older, people younger than age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease
2. **Medicare Advantage (Part C)** - A Federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan
3. **Medicare Prescription Drug Benefit (Part D)** - A Federal prescription drug benefit program for Medicare beneficiaries
4. **Medicaid** - A joint Federal/State program, administered by the States, that provides health insurance to certain low income individuals
5. **Children's Health Insurance Program (CHIP)** - A joint Federal/State program, administered by the States, that provides health insurance for qualifying children
6. **Temporary Assistance for Needy Families (TANF)** - A joint Federal/State program, administered by the States, that provides time-limited assistance to needy families with children to promote work, responsibility and self-sufficiency
7. **Foster Care** - A joint Federal/State program, administered by the States, for children who need placement outside their homes in a foster family home or a child care facility.
8. **Child Care Development Fund (CCDF)** - A joint Federal/State program, administered by the States, that provides child care financial assistance to low income working families

## 2.0 Risk Assessments

In addition to the programs deemed by OMB to be susceptible to significant improper payments, HHS also reviews other programs to determine if they are susceptible to significant improper payments. In FY 2012, HHS incorporated the improper payment risk assessment requirements under IPERA and OMB Circular A-123, Appendix C, into a new risk assessment tool used for multiple purposes. This integrated approach increased efficiency for our programs without compromising the assessment process. HHS continued using the new integrated risk assessment approach in FY 2013 and conducted risk assessments on 32 programs; all 32 programs were determined not to be at-risk for significant improper payments.

## 3.0 Statistical Sampling Process

Each program's statistical sampling process is discussed in *Section 10: Program-Specific Reporting Information*. Unless otherwise stated in *Section 10*, all programs complied with the IPIA guidance requiring that all estimates be based on the equivalent of a statistically valid random sample of sufficient size to yield an estimate with a 90 percent confidence interval of plus or minus 2.5 percentage points around the estimate of the percentage of erroneous payments. In addition, the seven programs currently reporting error rates used a statistical contractor.

### 3.10 Error Rate Presentation

OMB Circular A-136 allows agencies to report net error rates in addition to the required gross error rates. Table 1 in *Section 9.0: Improper Payment Reduction Outlook* presents each program's gross and net error rates.

The *gross error rate* is the official program error rate; it is calculated by adding the sample's overpayments and underpayments and dividing by the total dollar value of the sample. The *net error rate* reflects the overall estimated monetary loss to the program; it is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample.

## 4.0 Corrective Action Plans

Each program's Corrective Action Plan (CAP) for reducing the estimated rate of improper payments can be found in *Section 10: Program-Specific Reporting Information*. CAPs are used to set aggressive, realistic targets and outline a timetable to achieve scheduled targets. OMB approves all out-year error rate targets. The Department reviews CAPs annually to ensure plans focus on the root causes of the errors, thus making it more likely that targets are met. If targets are not met, HHS will develop new strategies, adjust staffing and other resources, and possibly revise targets.

### 4.10 Corrective Actions for Grants

In addition to continuing HHS' engagement in the development of government-wide grants circulars, as well as our continuing implementation of HHS regulations and internal policies, the Department has taken the following actions to strengthen the stewardship of grant funds:

- HHS released 11 major internal grants administration policies as part of its update to the Grants Policy Administration Manual (GPAM). These policies covered a wide range of topics including but not limited to: grants closeout, suspension and debarment, grants systems, and grants payments. The updated guidance will facilitate greater financial transparency and accountability, outline consistent grants administration practices, and foster program integrity.
- As part of the GPAM update, HHS launched a departmental effort to utilize subaccounting for HHS' newly awarded grants, and to transition HHS' existing grants that receive new funding to subaccounts. This internal policy change and procedural adjustment will increase financial accountability across the HHS grants community.

## 5.0 Accountability in Reducing and Recovering Improper Payments

Strengthening program integrity throughout the Department is a top priority of Secretary Sebelius, extending to HHS Senior Executives and program officials at each of our agencies and programs. As evidence of this focus, beginning with senior leadership and cascading down, performance plans contain strategic goals that are related to strengthening program integrity, protecting taxpayer resources, and reducing improper payments. Senior Executives and programs officials are evaluated as part of their semi-annual and annual performance evaluation on their progress toward achieving these goals.

## 6.0 Information Systems and Other Infrastructure

*Section 10: Program-Specific Reporting Information* details each program's information systems and other infrastructure.

## 7.0 Mitigation Efforts Related to Statutory or Regulatory Barriers

*Section 10: Program-Specific Reporting Information* reports each program's statutory or regulatory barriers, if any, to reduce improper payments.

## 8.0 Progress and Achievements

### 8.10 FY 2013 Progress

Since FY 2009, Head Start has reported a consistent decline in its improper payment rate. Head Start reported annual error rates of 0.6 percent in FY 2011 and FY 2012, demonstrating at least two consecutive years of improper payments below the IPIA reporting threshold. Based on Head Start's strong internal controls, monitoring systems, and low reported error rate, OMB approved HHS' request for relief from annual improper payment reporting. In lieu of an annual error rate measurement, HHS will oversee Head Start's performance through existing internal controls and monitoring systems, and incorporate the program into the improper payment risk assessment cycle. In addition, beginning in September 2014, HHS will submit an annual report to OMB that describes Head Start's policies, controls, and corrective actions to prevent and mitigate improper payments in the program, as well as any control deficiencies, risks, and trends that are identified.

### 8.20 FY 2013 Achievements

#### 8.21 Improving Program Integrity in Medicare and Medicaid

In FY 2013, HHS strengthened its efforts to reduce and recover improper payments in Medicare and Medicaid. While a few of these efforts are highlighted below, more detailed information on the FY 2013 Medicare and Medicaid programs' performance and corrective actions can be found in *Section 10: Program-Specific Reporting Information*. In addition, information on the Medicare and State Medicaid Recovery Auditor Contractor (RAC) programs can be found in *Section 11.0: Recovery Auditing Reporting*.

***Affordable Care Act Enrollment Moratorium***

Section 6401 of the *Affordable Care Act* added new section 1866(j)(7) to the *Social Security Act* (SSA), which provides HHS with the authority to impose a moratorium on the enrollment of new providers and suppliers to prevent or combat fraud, waste, or abuse in Medicare, Medicaid, or CHIP. On July 30, 2013, HHS launched the first temporary (six month) enrollment moratorium under the *Affordable Care Act* for Miami-area and Chicago-area home health agencies and ground ambulance suppliers in the Houston-area. The focus of these efforts is to prevent and deter fraud, waste, and abuse in problematic services and areas across the country.

***Medicare Fraud Prevention System***

HHS launched the Fraud Prevention System (FPS) on June 30, 2011, as required by the *Small Business Jobs Act of 2010*. The FPS analyzes all Medicare FFS claims prior to payment using risk-based algorithms developed by HHS and the private sector. HHS uses the FPS to target investigative resources to suspect claims and providers and swiftly impose administrative action when warranted. The system generates alerts in priority order, allowing program integrity analysts to further investigate the most egregious, suspect, or aberrant activity. HHS and its program integrity contractors use the FPS information to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

Within the first year of implementing the FPS, HHS took administrative action against providers based solely on FPS leads. Through these actions, HHS saved an estimated $115.4 million in payments, comprised of $31.8 million in estimated actual savings and $83.6 million in estimated projected savings. The FPS also generated leads for 536

new investigations, augmented information for 511 ongoing investigations, and prompted 617 provider interviews and 1,642 beneficiary interviews to verify whether legitimate Medicare services and supplies were provided. HHS continues to take action based on the FPS leads and will report updated information as required by the *Small Business Jobs Act of 2010*.

***Medicaid Integrity Program***

Under the authority of the *Deficit Reduction Act of 2005* (DRA), HHS' Medicaid Integrity Program has two broad responsibilities:

- To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
- To provide effective support and assistance to States in their efforts to combat Medicaid provider fraud, waste, and abuse.

HHS analyzed Medicaid recoveries, which show that since the enactment of the DRA there has been a strong focus on Medicaid integrity. For example, the Medicaid Integrity Program has provided the assistance of Federal staff specializing in program integrity and contractor support to bolster State activities. Based on States' quarterly reports to HHS, this assistance resulted in $1.1 billion in recoveries in FY 2013. HHS is also positioned to provide support to States through funding and technical assistance to implement innovative technology to achieve additional savings.

### 8.22 Public Assistance Reporting Information System

The Public Assistance Reporting Information System (PARIS) is a Federal/State partnership with all 50 States, the District of Columbia, and Puerto Rico that provides State public assistance agencies detailed information and data to maintain program integrity and detect and deter improper payments in TANF, Medicaid, Workers' Compensation, Child Care, and Supplemental Nutrition Assistance Program (SNAP).

HHS, the Department of Veterans Affairs (VA), and the Department of Defense (DOD) have partnered to advance the PARIS project at no cost to States. The DOD's Manpower Data Center (DMDC) provides computer resources to produce a match file, using Social Security numbers submitted by the States, VA, and DOD as the key match indicator. States verify the matched individual's eligibility and take any necessary action. HHS contributes to this effort by establishing Computer Matching Agreements and coordinating the quarterly matches. PARIS led to reported savings or cost avoidance of approximately $62 million in FY 2013 alone. More information on this partnership can be found at: http://www.acf.hhs.gov/paris.

## 9.0 Improper Payment Reduction Outlook FY 2012 through FY 2016

The following table displays HHS' IPIA results for the current year (CY) FY 2013, the prior year (PY) FY 2012, and targets for FYs 2014 through 2016. The table includes the following information by year and program: fiscal year outlays, the error rate or future target (IP%), and dollars paid or projected to be paid improperly (IP$). In addition, for the CY, HHS included: the amount of overpayments (CY Overpayments), the amount of underpayments (CY Underpayments), and the net error rate (CY Net IP%) and the corresponding overpayments, when available.

# Table 1
## Improper Payment Reduction Outlook
## FY 2012- FY 2016
## (in Millions)

| Program or Activity | PY Outlays $ | PY IP % | PY IP $ | CY Outlays $ | CY IP % | CY IP $ | CY Over payment $ | CY Under payment $ | CY Net IP % | CY Net IP $ | CY+1 Est. Outlays $ | CY+1 IP % | CY+1 IP $ | CY+2 Est. Outlays $ | CY+2 IP % | CY+2 IP $ | CY+3 Est. Outlays $ | CY+3 IP % | CY+3 IP $ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicare FFS | 349,673 Note (a) | 8.5 | 29,571 | 357,397 Note (b) | 10.1 Note (1) | 36,033 | 34,609 | 1,424 | 9.3 | 33,185 | 376,820 Note (c) | 9.9 | 37,305 | 392,171 | 9.8 | 38,433 | 424,500 | 9.7 | 41,177 |
| Medicare Part C | 115,183 Note (d) | 11.4 | 13,100 | 123,696 Note (e) | 9.5 | 11,767 | 9,313 | 2,453 | 5.6 | 6,860 | 156,158 Note (f) | 9.0 | 14,054 | 155,916 | 8.5 | 13,253 | 167,599 | 8.1 | 13,576 |
| Medicare Part D | 51,140 Note (g) | 3.1 | 1,593 | 57,056 Note (h) | 3.7 | 2,091 | 1,741 | 351 | 2.4 | 1,390 | 72,453 Note (i) | 3.6 | 2,608 | 81,055 | 3.5 | 2,837 | 92,150 | 3.4 | 3,133 |
| Medicaid | 271,011 Note (j) | 7.1 | 19,235 | 246,931 Note (k) | 5.8 Note (2) | 14,376 | 13,943 | 461 | 5.5 | 13,495 | 270,490 | 5.6 | 15,147 | 307,788 | 5.5 | 16,928 | 334,624 | 5.4 | 18,070 |
| CHIP | 8,629 Note (l) | 8.2 | 704 | 9,065 Note (m) | 7.1 Note (3) | 646 | 635 | 12 | 6.9 | 624 | 9,763 | N/A Note (4) | N/A | 9,783 | N/A | N/A | 10,240 | N/A | N/A |
| TANF | 16,538 | N/A | N/A | 16,521 | N/A Note (5) | N/A | N/A | N/A | N/A | N/A | 17,058 Note (n) | N/A | N/A | 16,848 | N/A | N/A | 16,817 | N/A | N/A |
| Foster Care | 1,294 | 6.2 | 80.2 | 1,326 | 5.3 | 70 | 63 | 7 | 4.2 | 56 | 1,211 Note (o) | 5.1 | 62 | 1,049 | 4.9 | 51 | 877 | 4.7 | 41 |
| Child Care | 5,170 | 9.4 Note (6) | 488 | 5,188 | 5.9 | 306 | 283 | 23 | 5.0 | 260 | 5,192 Note (p) | 5.0 | 260 | 5,195 | 4.5 | 234 | 5,195 | 4.0 | 208 |

Note: For presentation purposes, this table uses rounded numbers. Therefore, some calculations using the figures in the table may not produce the amounts in other cells. For example, the CY Over Payment $ and CY Under Payment $ cells may not add to the CY IP $ cell, and the CY Outlays $ cell times the CY IP % cell may not equal the CY IP $ cell.

Note: The Current Year (CY) CY+1, CY+2 and CY+3 estimated dollars paid improperly (IP$) is calculated based on the target error rate and estimated outlays for each year, respectively. However, it is important to note that the measurement periods for each program vary. Therefore, the future outlay estimates presented may not be the actual amounts against which the error rates will be applied to compute the dollars paid improperly in future years.

## 9.10 Accompanying Improper Payment Reduction Outlook Notes

a) Medicare FFS PY benefit outlays are from the FY 2012 Medicare FFS Improper Payments Report (based on claims from July 2010 – June 2011).

b) Medicare FFS CY benefit outlays are from the FY 2013 Medicare FFS Improper Payments Report (based on claims from July 2011 – June 2012).

c) Medicare FFS CY+1, CY+2, CY+3 benefit outlays are based on the FY 2014 Midsession Review (Medicare Benefit Outlays current law (CL)).

d) Medicare Part C PY benefit outlays reflect 2010 Part C payments, as reported in the FY 2012 Medicare Part C Payment Error Final Report.

e) Medicare Part C CY benefit outlays reflect 2011 Part C payments, as reported in the FY 2013 Medicare Part C Payment Error Final Report.

f) Medicare Part C CY+1, CY+2, CY+3 benefit outlays are based on the FY 2014 Midsession Review (Medicare Benefit Outlays (CL)).

g) Medicare Part D PY outlays reflect 2010 Part D payments, as reported in the FY 2012 Medicare Part D Payment Error Final Report.

h) Medicare Part D CY outlays reflect 2011 Part D payments, as reported in the FY 2013 Medicare Part D Payment Error Final Report.

i) Medicare Part D CY+1, CY+2, CY+3 benefit outlays are based on the FY 2014 Midsession Review (Medicare Benefit Outlays (CL)).

j) Medicaid PY benefit outlays are from the FY 2012 Medicaid Annual Error Rate Report (based on FY 2011 claims).

k) Medicaid CY (based on FY 2012 expenditures) and CY+1, CY+2, CY+3 benefit outlays ((based on FY 2013 – FY 2015 estimated expenditures) (Medicaid Net Benefit Outlays (CL), excluding CDC Program Vaccine for Children obligations)), are from the FY 2014 Midsession Review.

l) CHIP PY benefit outlays are based on the FY 2012 CHIP Annual Error Rate Report (based on FY 2011 claims).

m) CHIP CY (based on FY 2012 expenditures) and CY+1, CY+2, CY+3 benefit outlays ((based on FY 2013 – FY 2015 estimated expenditures) (CHIP Total Benefit Outlays with CHIPRA Bonus and Health Care Quality Provisions (CL))), are from the FY 2014 Midsession Review.

n) TANF CY+1, CY+2, CY+3 outlays are based on the FY 2014 Midsession Review (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs, and excluding the TANF Contingency Fund).

o) Foster Care CY+1, CY+2, CY+3 outlays are based on the FY 2014 Midsession Review, and reflect the Federal share of maintenance payments.

p) Child Care CY+1, CY +2, CY+3 outlays are based on the FY 2014 Midsession Review.

1. Beginning with the FY 2012 AFR, HHS modified the report period by moving it back six months to more accurately measure the improper payment rate in the Medicare FFS program. As a result, the FY 2013 Medicare FFS report period consists of claims from July 1, 2011 through June 30, 2012. In addition, in FY 2012, in consultation with OMB, HHS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services should have been provided as outpatient services. HHS continued this methodology in FY 2013. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.6 percentage points to 10.1 percent or $36.0 billion in projected improper payments. Additional information regarding these methodology changes and the adjustment factor can be found on pages 166-167 of HHS' FY 2012 AFR (available at: http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

2. In FY 2013, after consultation with OMB, HHS made two improper payment rate calculation methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate. These enhancements include: (1) replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate, and (2) incorporating prior year State-level improper payment rate recalculations.

   In past AFRs, HHS reported a three-year weighted average national Medicaid improper payment rate representing the percentage of expenditures improperly paid over the past three years. The three-year rate was calculated by utilizing a weighted average of the Payment Error Rate Measurement (PERM) cycle error rates from the three most recent years. This methodology was implemented to ensure Medicaid improper payment rate reporting included findings from all States.

   In response to a HHS Office of Inspector General report (OIG report A-06-08-00078, *Oversight and Evaluation of the Fiscal Year 2007 Payment Error Rate Measurement Program*), HHS is now reporting a single-year rolling national Medicaid improper payment rate, a more precise estimate that represents the percentage of expenditures improperly paid during one fiscal year. The single-year rolling rate is calculated by multiplying each State's most recent error rate by that State's expenditures from the fiscal year being reported and dividing by the expenditures for that fiscal year. The single-year rolling rate treats the three most recent PERM cycles as a contiguous sample (as if all States were observed in the fiscal year being reported), which allows HHS to report on findings from all States with improved precision.

   Additionally, past AFRs did not incorporate State-level error rate recalculations that occur after the cycle cut-off date. For the most recent cycle of States measured, these recalculations occur after AFR publication. In response to a Government Accountability Office report (GAO-13-229, *Enhancements Needed for Improper Payments Reporting and Related Corrective Action Monitoring*), State-level error rate recalculations for the previous two cycles measured are now incorporated into the national Medicaid improper payment rate, and will be incorporated in future calculations.

   HHS calculated and is reporting the national Medicaid error rate that is based on measurements that were conducted in FYs 2011, 2012 and 2013. The national Medicaid error component rates are: Medicaid FFS: 3.6 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 3.3 percent. Under the old calculation methodology the FY 2013 national Medicaid error rate would have been 6.1 percent or $15.0 billion instead of the 5.8 percent or $14.4 billion reported in FY 2013 using the new calculation methodology.

3. The two Medicaid improper payment rate calculation methodology enhancements described in *note (2)* also apply to the CHIP improper payment rate estimate with one difference. For FY 2013, only two cycles of States have been measured for CHIP requiring a slightly different approach to the single-year CHIP rolling improper payment rate. For FY 2013, the 34 measured States will be treated as a contiguous sample and projected to the 17 States that have not yet been measured. HHS calculated and is reporting a national CHIP error rate based on measurements that were conducted in FYs 2012 and 2013. The national CHIP error component rates are: CHIP FFS: 5.7 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 5.1 percent. Under the

old calculation methodology the FY 2013 national CHIP error rate would have been 7.5 percent or $0.7 billion instead of the 7.1 percent or $0.6 billion reported in FY 2013 using the new calculation methodology.

4. The baseline measurement for CHIP, based on the measurement of 50 States and the District of Columbia over a three-year period (FYs 2012 to FY 2014), will be published in the FY 2014 AFR. Therefore, setting out-year target rates for CHIP is not applicable at this time.

5. The TANF program is not reporting an error rate for FY 2013. Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement.

6. After the publication of the FY 2012 AFR, HHS determined that it had overstated the FY 2012 Child Care improper payment estimate due to incorrect data for a small number of States that was not detected prior to the AFR's publication. HHS implemented corrective actions – including additional data reviews – to prevent this mistake from reoccurring. The FY 2012 improper payment estimate was 9.2 percent or $474 million rather than the published improper payment estimate of 9.4 percent or $488 million. For consistency with the FY 2012 AFR, this table includes the improper payment estimate that was reported in the FY 2012 AFR.

## 10.0 Program-Specific Reporting Information

## 10.10 Medicare Fee-for-Service or FFS

### 10.11 Medicare FFS Statistical Sampling Process

Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment estimate. The CERT program considers any claim paid when it should have been denied or was paid in the wrong amount (including both overpayments and underpayments) to be an improper payment. To meet this objective, a random sample of Medicare FFS claims is reviewed to determine if claims were paid properly under Medicare coverage, coding, and billing rules. If these criteria are not met, the claim is counted as either a total or partial improper payment, depending on the error category. Approximately 54,000 claims were sampled during the FY 2013 report period. The CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from this sample reflects all claims processed by the Medicare FFS program during the report period. Additional information on the Medicare FFS improper payment methodology can be found on pages 166-167 of HHS' FY 2012 AFR, available at: http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf.

The Medicare FFS gross improper payment estimate for FY 2013 is 10.1 percent or $36.0 billion. The FY 2013 net improper payment estimate is 9.3 percent or $33.2 billion.

### 10.12 Medicare FFS Corrective Action Plans

The primary cause of improper payments is Administrative and Documentation errors (63 percent), in large part due to insufficient documentation. The other cause of improper payments is classified as Authentication and Medical Necessity errors (37 percent), caused by medically unnecessary services, and to a lesser extent, incorrect diagnosis coding.

Data shows that many improper payments resulted from claims paid for services that are clinically appropriate, if provided in less intensive settings. Physicians and DME suppliers contributed substantially to insufficient documentation errors, and hospitals contributed substantially to medical necessity errors. Coding errors were most prevalent in physician services.

HHS developed an Error Rate Reduction Plan (ERRP) that outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. Of particular importance are three corrective actions that HHS believes will have a considerable effect in preventing and reducing improper payments:

- First, HHS is expanding the use of Medicare FFS RACs in the Medicare FFS program. Over the past several years, Medicare FFS RACs have recovered billions of taxpayer dollars by finding improper payments that have already been paid by the Medicare FFS program. HHS now allows the Medicare FFS RACs to review certain types of claims that historically have high amounts of improper payments before they are paid, therefore preventing improper payments from being made in the first place. This demonstration project began for claims processed on or after September 1, 2012. Through this prepayment demonstration, HHS has already saved approximately $22.3 million in improper payments from being made. More information on the Medicare FFS RAC prepayment review demonstration can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html.
- Second, on September 1, 2012, HHS instituted a prior authorization demonstration program in seven States with the expectation of reducing improper payments for power mobility devices. This demonstration project

has already led to a decrease in the expenditures for power mobility devices in the demonstration States as well as in the non-demonstration States. Specifically, based on claims submitted as of September 30, 2013, monthly expenditures for the power mobility devices included in the demonstration States decreased from $20 million in September 2012 to $9 million in August 2013, and from $12 million to $4 million in the non-demonstration States for the same time period. Prior authorization reviews are being performed timely, industry feedback has been positive, and HHS has received no complaints from beneficiaries. HHS continues to closely monitor and evaluate the effectiveness of the demonstration and plans to analyze demonstration data to assist in the investigation and prosecution of fraud. More information on the power mobility device prior authorization demonstration can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Prior-Authorization-of-PMDs-Demonstration-Status-Update-.html.

- Third, HHS implemented two major policies pertaining to inpatient hospital claims that are expected to reduce improper payments:
  - HHS issued an interim measure, Centers for Medicare & Medicaid Services (CMS) Ruling 1455–R (78 FR 16614, issued on March 13, 2013), which ended the demonstration project that allowed hospital participants to bill for inpatient Part B claims when their Part A claim was denied as not reasonable and necessary, and expanded this concept for all hospitals. Proposed Rule 1455-P (78 PR 16632, issued on March 13, 2013), as finalized in 1599-F (78 FR 50495, issued on August 2, 2013), permitted inpatient Part B billing within one year from the date of service. The final measure 1599-F became effective, and Ruling 1455-R became inapplicable, on October 1, 2013.
  - Final measure 1599-F (78 FR 50495) also clarified and modified HHS policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A and how Medicare review contractors will assess hospital inpatient claims for payment purposes.

In addition to these three major efforts and the ongoing corrective actions reported on pages 167-169 of HHS' FY 2012 AFR, HHS has implemented additional efforts to reduce improper payments in the Medicare FFS program as outlined below.

***Corrective Actions: Administrative and Documentation Errors***

- HHS continues to build the Healthcare Fraud Prevention Partnership (HFPP), a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse. Public and private partners, including Federal and State partners, private payers, associations, and law enforcement exchange data and successful anti-fraud practices within the HFPP, helping to prevent and detect fraud across sectors.

- HHS, in close collaboration with its Regional Offices, holds program integrity education events for physicians and other providers. These events, typically held in medical schools or hospitals, offer continuing medical education credits (CME) through local provider organizations. As part of its broader outreach activities, HHS created educational materials tailored specifically for physicians, industry stakeholders, and beneficiaries. These materials include fact sheets, guidance documents, frequently asked questions, and CME through Medscape, a company that offers free online news and education for providers. HHS also engaged in direct outreach through live events and speaking engagements.

- HHS requires its Medicare review contractors to focus their medical review efforts on identifying documentation errors in certain error prone claim types, such as home health, hospital outpatient, skilled nursing facility (SNF), and nonhospital-based hospice claims.

***Corrective Actions: Authentication and Medical Necessity Errors***

- HHS contracted with a Supplemental Medical Review/Specialty Contractor to perform medical reviews focused on vulnerabilities identified by HHS internal data analysis, the CERT program, professional organizations, and Federal oversight agencies. The contractor evaluates medical records and related

documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules.

- HHS implemented the Medicare Part B Outpatient Therapy Cap Exceptions Process, which mandates manual medical review on claims when the beneficiary exceeds the annual $3,700 therapy threshold. On April 1, 2013, the Medicare FFS RAC program began prepayment manual medical review on therapy claims above the threshold in 11 demonstration States. In the remaining States, the Medicare FFS RAC program conducted post-payment manual medical reviews on therapy claims above the threshold.
- HHS continues to allow Medicare Administrative Contractors (MACs) and RACs to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. The MACs' medical review resulted in a projected savings of $5.6 billion in FY 2013.
- HHS continues to develop and issue Comparative Billing Reports (CBRs) to help non-hospital providers analyze their coding and billing practices for specific procedures or services. CBRs are proactive statements that enable providers to examine their billing patterns compared to their peers in the State and nation.

### 10.13 Medicare FFS Improper Payment Recovery

The actual overpayments identified in the FY 2013 Medicare FFS Improper Payments Report were $40,000,013. The identified overpayments are to be recovered by the Medicare contractors via standard payment recovery methods. As of the report publication date, Medicare contractors reported collecting $33,196,339 or 83 percent of the actual overpayment dollars identified in the report.

### 10.14 Medicare FFS Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure it needs to reduce improper Medicare FFS payments to the targeted levels. HHS' systems have the ability to identify developing and continuing aberrant billing patterns based upon a comparison of local payment rates with national rates. The systems at both the Medicare contractor level and the HHS level are tied together by a high-speed secure network that allows rapid transmission of large data sets between systems. No other systems or infrastructure are needed at this time.

### 10.15 Medicare FFS Statutory or Regulatory Barriers That Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 10.16 Medicare FFS Best Practices

The CERT program has incorporated the following best practices to ensure the highest degree of efficiency:

- HHS provides multiple resources to educate providers and suppliers about the CERT program, including several websites, a toll-free customer service telephone line, and on-line reference materials.
- HHS holds weekly calls with all CERT contractors and MACs to facilitate communication, solve problems, and improve the CERT process.
- CERT collaborates with other review contractor entities, such as the MACs and Medicare FFS RACs, to clarify unclear policies, in an effort to ensure review consistency.
- HHS provides interim improper payment rate data to the MACs to help them focus on problematic areas and identify emerging vulnerabilities.

In addition, HHS continues to improve the Medicare FFS improper payment rate measurement program to ensure that providers and suppliers submit the required documentation. Such improvements include:

- HHS coordinates provider outreach and education task forces. These task forces consist of MAC medical review professionals who meet regularly to develop strategies addressing provider education in areas prone

to improper payments. The task forces hold open door forums to discuss documentation requirements and answer provider and supplier questions, and distribute informational articles as needed to improve documentation and to educate providers on Medicare policies. The articles are maintained online on the Medicare Learning Network (MLN) and can be accessed by the public at the MLN website: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/mlngeninfo.

- HHS conducts ongoing education to inform providers and suppliers about the importance of submitting thorough and complete documentation. This education involves national training sessions, individual meetings with providers or suppliers with high improper payment rates, presentations at industry association meetings, and the dissemination of educational materials.
- HHS revises medical record request letters, as needed, to clarify the components of the medical record required for CERT review. The letter serves as a checklist for the provider or supplier to ensure their record submission is complete. Follow-up medical record request letters have also been developed to explain the missing documentation that needs to be submitted.
- When a supplier is contacted for documentation, HHS notifies the ordering provider that they may be contacted by the supplier in order to provide supporting documentation. In addition to this notification, HHS contacts third party providers to request documentation when the billing provider indicates that a portion of the medical record is possessed by a third party. For example, a third party provider may be a physician who orders a power wheelchair from a supplier that submits the claim.
- HHS regularly examines the reasons for errors and makes efforts to collect medical documentation that support the submitted claim, such as through additional phone calls requesting the specific documentation that is missing.

## 10.20 Medicare Advantage or Part C

### 10.21 Part C Medicare Advantage Statistical Sampling Process

The FY 2013 Medicare Part C gross improper payment estimate, based on 2011 payments is 9.5 percent or $11.8 billion. The FY 2013 net improper payment estimate is 5.6 percent or $6.9 billion.

The Part C methodology estimates errors resulting from incorrect beneficiary risk scores. The primary component of a beneficiary's risk score is based on clinical diagnoses submitted by plans. If the diagnoses submitted to HHS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C estimate is based on medical record reviews conducted under HHS' annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

The FY 2013 methodology consists of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in CY 2011, where the strata are high, medium, and low risk scores,
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries,
- Calculation of beneficiary-level payment error for the sample, and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

As disclosed in the FY 2012 AFR, due to significant improvements in the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) component estimate, the MPE was not included in the FY 2013 Part C error rate calculation per OMB approval, and will not be included in future measurements.

### 10.22 Medicare Advantage Corrective Action Plans

The root cause (100 percent) of FY 2013 Medicare Part C improper payments resulted from Administrative and Documentation errors due to insufficient documentation to support diagnoses submitted by the plans.

HHS has implemented three key initiatives as part of its corrective action plan to address errors in the Part C program. The three initiatives are as follows:

- *Contract-Level Audits*: HHS has proceeded with the RADV contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by Medicare Advantage (MA) organizations for risk adjusted payment. RADV audits are HHS' primary corrective action to recoup improper payments. HHS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment. HHS expects to conduct RADV audits for approximately 30 MA contracts annually. RADV audits of payment year 2011, expected to begin in FY 2014, will be the first HHS reviews to conduct payment recovery based on extrapolated estimates.
- *Medicare Advantage Organization Guidance and Training*: HHS conducts national training sessions for MA organizations that provide comprehensive assistance for submitting accurate risk adjustment data. In addition, HHS has identified risk adjustment diagnoses that are more likely to be associated with payment error. HHS will continue to analyze diagnoses to determine high-error diagnoses and use these findings to conduct outreach, education, and provide guidance to MA organizations.

  Furthermore, HHS implemented a process to assist plans' submission of medical record documentation. To assist plans and reduce administrative error, HHS extended the medical record submission timeframe and provided outreach to plans during the National Risk Adjustment payment error data validation process. HHS also provides preliminary results to the MA plans and feedback on the validity of submitted records to ensure they are suitable for the Part C error estimate reviews.
- *Physician Outreach*: HHS enhances physician understanding of HHS payment procedures for MA organizations and the payment methodology impact on physicians. This outreach seeks to improve physicians' medical record documentation practices to support risk adjustment diagnoses.

### 10.23 Medicare Advantage Program Improper Payment Recovery

The Part C error estimate is based on a national sample of beneficiaries across all MA plans. Since this type of sample design does not allow for collection at the MA plan level, no payment recovery had been initiated until FY 2012, when HHS recovered approximately $3.4 million for the first five plans involved in the 2007 RADV audits (the pilot audits) (Note: The FY 2012 Medicare Part C RADV audit amount recovered was amended from $3.5 million, as reported in the FY 2012 AFR, to $3.4 million, due to a reporting discrepancy that was identified after the AFR was published). In FY 2013, HHS continued payment recovery for plans under the 2007 RADV audits and recovered approximately $5 million.

### 10.24 Medicare Advantage Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Part C payments. HHS uses the following internal Medicare systems to make and validate the Part C payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, and the MARx payment system. No other systems or infrastructure are needed at this time.

### 10.25 Medicare Advantage Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 10.26 Medicare Advantage Program Best Practices

HHS has taken several steps to ensure payment accuracy in the Part C program, including the corrective actions that were outlined earlier in *Section 10.22*.

## 10.30 Medicare Prescription Drug Benefit or Part D

### 10.31 Medicare Prescription Drug Statistical Sampling Process

The Medicare Part D gross improper payment estimate for FY 2013 is 3.7 percent or $2.1 billion. The FY 2013 net improper payment estimate is 2.4 percent or $1.4 billion.

The FY 2013 Part D Composite Payment Error Rate combines four component payment error measures:

- Payment Error Related to Low Income Subsidy Status (PELS),
- Payment Error Related to Medicaid Status (PEMS),
- Payment Error Related to Prescription Drug Event Data Validation (PEPV), and
- Payment Error Related to Direct and Indirect Remuneration (PEDIR).

Combining these four component measures poses complex technical and statistical challenges in calculating a confidence interval for the composite rate. As a result, HHS calculated the precision level for each component independently, and each component meets OMB precision requirements.

The FY 2013 national Part D improper payment rate for each component is:

- *PELS*: 0.2 percent
- *PEMS*: 0.4 percent
- *PEPV*: 2.8 percent
- *PEDIR*: 0.3 percent

The methodology for calculating the PELS, PEMS, PEPV, and PEDIR rates was not altered from FY 2012. A description of the methodology may be found on pages 173-175 of HHS' FY 2012 AFR. In addition, as disclosed in the FY 2012 AFR, due to significant improvements in the MPE component estimate, the MPE component was not included in the FY 2013 Part D calculation per OMB approval, and will not be included in future measurements.

### 10.32 Medicare Prescription Drug Corrective Action Plan

The root cause of all FY 2013 Part D improper payments (100 percent) is Administrative and Documentation errors. HHS conducted the following corrective actions to address errors in the respective Part D component measures:

- HHS analyzed the PELS error estimate to further understand the PELS population and identify additional steps that can be taken to address errors. In addition, HHS provided guidance to Part D sponsors to update beneficiary LIS status prior to reconciliation.

- The Medicaid corrective actions identified in *Section 10.42* will assist in reducing the PEMS error estimate, as this component is driven by the Payment Error Rate Measurement (PERM) program findings.

- HHS continued national training sessions for Medicare Part D plans. Training provides comprehensive information on all aspects of Part D payment and data submission requirements, including sessions focusing on improvements in prescription drug event (PDE) record submission, which is reflected in the PEPV error rate estimate.

- To assist plans with improved DIR reporting in the future, HHS required plans to submit DIR amounts by National Drug Code (NDC).

### 10.33 Medicare Prescription Drug Benefit Improper Payment Recovery

HHS conducted the following improper payment recovery activities in FY 2013 for each error rate component:

- *PELS Component*: Further investigation must be done to better determine how to conduct payment recovery.
- *PEMS Component*: Application of the national Medicaid active case eligibility error rate to Part D payments does not allow HHS to identify which dual eligible beneficiaries actually had incorrect Medicaid status. Thus, it is not possible to identify beneficiary-level payments that HHS could recover.
- *PEPV Component*: The FY 2013 PDE validation is based on a national sample of PDEs and the imputation of these results onto the Part D population; therefore, payment errors cannot be linked to specific beneficiaries for payment recovery purposes.
- *PEDIR Component*: The original data used to develop the FY 2013 error rate was based on 2010 audits. Plans submit updates to their reported DIR amounts on a flow basis. HHS will, therefore, address payment recovery through the 2010 Part D reconciliation.

### 10.34 Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS has the information systems and other infrastructure needed to reduce improper Medicare Part D payments. HHS uses the following internal Medicare systems to make and validate the Part D payments: the Medicare Beneficiary Database, the Risk Adjustment System, the Health Plan Management System, the MARx payment system, and the Integrated Data Repository. No other systems or infrastructure are needed at this time.

### 10.35 Medicare Prescription Drug Benefit Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 10.36 Medicare Prescription Drug Benefit Program Best Practices

In addition to the corrective actions outlined in *Section 10.32*, HHS has taken steps to ensure payment accuracy in the Medicare Part D program, including: (1) contacting plans before and during the PEPV data collection and validation process, which provides an open forum for improving instructions for data submission, and (2) extending the data collection period, which increased response rates.

## 10.40 Medicaid

### 10.41 Medicaid Statistical Sampling Process

The national FY 2013 Medicaid error rate is based on measurements conducted in FYs 2011, 2012, and 2013. Medicaid improper payments are estimated on a Federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of Federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

The PERM program uses a 17 State three-year rotation for measuring Medicaid improper payments. For information on how HHS grouped States into each of the three cycles, please see pages 177-179 of HHS' FY 2012 AFR.

***FFS and Managed Care Component***

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data

processing review. Managed care payments are subject only to a data processing review. The FFS sample size was between 260 and 968 claims per State and the managed care sample size was between 240 and 280 payments per State. For FY 2013, the sample sizes were based on each State's historical FFS and managed care improper payment rate data. When a State's FFS component or managed care component accounted for less than two percent of the State's total Medicaid expenditures, the State's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred in five of the 17 States in this year's cycle.

***Eligibility Component***

States conducted an eligibility review on a randomly selected sample of between 144 and 972 active cases and between 132 and 420 negative cases. The difference in sample sizes is based on the State's historical eligibility improper payment rate data.

Active cases contain information on a beneficiary who is enrolled in the program in the month that eligibility is reviewed. Negative cases contain information on an individual who applied for benefits and was denied, or whose program benefits were terminated based on the State agency's eligibility determination in the month that eligibility is reviewed.

HHS calculated two error rates for active cases, the payment error rate and the case error rate.

- The *payment error rate* is calculated using the weighted dollar value of payments made for services provided to beneficiaries who were ineligible for the program or received a service that was not included in the beneficiary's benefit package divided by the weighted dollar value of claims for the sample of beneficiaries each month (i.e., weighted dollars in error over total weighted dollars in the sample). HHS combines the State reported eligibility component payment error rates to develop a national eligibility error rate for Medicaid.
- The *case error rate* is calculated by dividing the projected number of ineligible beneficiaries by the projected total number of beneficiaries. HHS calculates only a case error rate for negative cases, because no payments were made.

In August 2013, HHS released guidance announcing temporary changes to future PERM eligibility reviews, in light of changes to the way States adjudicate eligibility for Medicaid and CHIP starting in 2014. These changes will impact Medicaid and CHIP improper payment rates reported starting with the FY 2015 AFR.

***Calculations and Findings***

The national Medicaid program improper payment rate represents the combination of each State's Medicaid FFS, managed care, and eligibility improper payment rates. In addition, individual State improper payment rate components are combined to calculate the national improper payment rates for each component. National component improper payment rates and the Medicaid program improper payment rate are weighted by State size, so that a State with a $10 billion program "counts" 10 times more toward the national rate than a State with a $1 billion program. A small correction factor ensures that Medicaid eligibility improper payments do not get "double counted."

In FY 2013, HHS made two improper payment rate methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate:

- <u>Single-year Rolling Rate</u>: HHS replaced the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate.

- Error Rate Recalculations: HHS incorporated prior year State-level improper payment rate recalculations. Seven State-level FFS error rates were recalculated subsequent to FY 2012 reporting and are incorporated into FY 2013 improper payment rate reporting.

See *Section 9.10: Accompanying Improper Payment Reduction Outlook Notes, note (2)* for detailed information on the two improper payment rate calculation methodology enhancements.

The national Medicaid gross improper payment estimate for FY 2013 is 5.8 percent or $14.4 billion. The FY 2013 net improper payment estimate is 5.5 percent or $13.5 billion.

The FY 2013 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 3.6 percent
- *Medicaid managed care*: 0.3 percent
- *Medicaid eligibility*: 3.3 percent

Within the Medicaid eligibility improper payment rate, the active case improper payment rate is 2.9 percent and the negative case improper payment rate is 4.2 percent.

Under the old calculation methodology the FY 2013 national Medicaid error rate would have been 6.1 percent or $15.0 billion instead of the 5.8 percent or $14.4 billion reported in FY 2013 using the new calculation methodology enhancements.

### 10.42 Medicaid Corrective Action Plans

States reviewed for the FY 2013 AFR measurement were the same States reviewed in FY 2010. The re-measurement of these States reflects the impact of effective corrective action plans implemented after the last measurement. The improper payment rate for these States dropped from 9.0 percent in FY 2010 to 5.7 percent in FY 2013, causing a decrease in the FY 2013 national Medicaid error rate. The eligibility component reported the greatest improvement, dropping from 7.6 percent to 3.3 percent.

Overall, the largest cause of the FY 2013 improper payments (by dollar amount) was Verification errors (46 percent), which were mostly caused by cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined, and system pricing errors. The second largest cause of improper payments was Administrative and Documentation errors (35 percent), which were mostly due to insufficient documentation. The remaining improper payments were attributed to Authentication and Medical Necessity errors (19 percent), and were mostly due to diagnosis coding errors.

HHS works closely with all States to develop State-specific Corrective Action Plans (CAPs). All States are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs. HHS received CAPs from all States whose Medicaid programs were previously measured, and all States measured in FY 2013 are in the process of developing their CAPs for submission to HHS. When developing the CAPs, States focus their efforts on the major causes of improper payments where the State can clearly identify patterns. In addition, States also take steps to reduce errors identified during the measurement.

Because much of the Medicaid FFS improper payment rate in the past was due to missing or insufficient documentation, the majority of State CAPs focused on provider communication and education. These methods included holding provider training sessions and meetings with provider associations; issuing provider notices, bulletins, newsletters, alerts, and surveys; implementing improvements and clarifications to written State policies emphasizing documentation requirements; and performing more provider audits. State CAPs also target eligibility

errors through the leveraging of technology and available databases to obtain eligibility verification information without client contact; providing caseworker training, particularly in areas determined by the PERM review to be error-prone; and providing additional eligibility policy resources through a consolidated manual and web-based training.

In addition to the development, execution, and evaluation of the State-specific CAPs and the ongoing corrective actions reported on pages 179 – 181 of HHS' FY 2012 AFR, HHS has implemented additional efforts to lower improper payments rates:

- HHS began "mini-PERM audits" with two States. Mini-PERM audits are voluntary State-specific improper payment reviews, intended to assist States in identifying and eliminating improper payments during years States are not measured under PERM. These reviews assist States in developing targeted CAPs to decrease Medicaid improper payments.
- As of September 30, 2013, 45 States and the District of Columbia have implemented Medicaid RAC programs to identify and recover overpayments and identify underpayments made for services in their Medicaid programs. The remaining five States have HHS-approved exceptions.
- HHS created a process to allow States to share information on terminated providers and to view information on Medicare providers and suppliers with revoked billing privileges.
- HHS formed a State systems workgroup (that includes representatives from HHS and State staff) to address individual State system problems that may cause payment errors. More information on this effort can be found in *Section 10.44: Medicaid Information Systems and Other Infrastructure*.

### 10.43 Medicaid Program Improper Payment Recovery

HHS identified $1,516,184; $1,633,991; and $153,188 in Medicaid overpayments eligible for recovery for FYs 2011, 2012 and 2013, respectively. The decrease in Medicaid overpayments eligible for recovery in FY 2013 compared to FYs 2011 and FY 2012 was due to: (1) a decrease in the dollar value of overpayments that were identified in the sample, and (2) the exclusion of overpayments due to eligibility errors because PERM does not recover overpayments for the eligibility component. In addition, the amount of Medicaid overpayments eligible for recovery for FYs 2011 and 2012 was amended from information previously reported in HHS' FY 2012 AFR to also exclude overpayments due to eligibility errors.

HHS works closely with States to recover overpayments identified from the FFS and managed care claims sampled and reviewed. The recoveries of Medicaid improper payments are governed by Section 1903(d)(2) of the SSA and related regulations at 42 CFR Part 433, Subpart F under which States must return the Federal share of overpayments. Section 6506 of the *Affordable Care Act* amended section 1903(d)(2) to allow States up to one year from the date of discovery of an overpayment for Medicaid services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment.

### 10.44 Medicaid Information Systems and Other Infrastructure

Since Medicaid payments occur at the State level, information systems and other infrastructure needed to reduce Medicaid improper payments would need to be implemented at the State level. PERM faced many challenges with State payment systems that had paper only and aggregate claims, changes in information systems at the State level during the course of the measurement cycle, and a wide variation of system designs and capabilities. HHS has encouraged and supported States in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS), which will produce greater efficiencies in the PERM measurement and strengthen program integrity. The State systems workgroup meets regularly to identify and discuss vulnerabilities and the

impact on the measurement of improper payments. In addition, HHS developed a methodology to measure aggregate claims that have been incorporated into the PERM processes.

HHS developed a comprehensive plan to modernize the Medicaid and CHIP data systems. The primary goal of this plan is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so that HHS can provide more effective oversight of its programs. The plan will also result in a reduction of State burden and the availability of more robust data for the PERM program.

HHS is also developing the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate State submission of timely claims data to HHS, expand the MSIS dataset, and allow HHS to review the completeness and quality of State MSIS submittals in real-time. HHS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, HHS will not only acquire higher quality data, but will also reduce State data requests. States will move to T-MSIS on a rolling basis with the goal of having all States submitting data monthly by July 1, 2014.

### 10.45 Medicaid Statutory or Regulatory Barriers that could limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 10.46 Medicaid Program Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the States, HHS continues the pre-cycle phase of the PERM measurement. The pre-cycle phase occurs prior to a State's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the States. In addition to the ongoing measures reported on pages 182 - 183 of HHS' FY 2012 AFR, HHS incorporated the following efforts into the Medicaid measurement process:

- HHS issued State-specific error rate targets. State-level goals for reducing improper payments provide a foundation for meeting national Medicaid improper payment targets. Collaboration between HHS and the States is vital to achieve national and State-specific targets.
- HHS issued updated CAP development guidance for States and improved protocols for HHS' review of State CAPs. These improvements ensure that State CAPs fully address errors and reduce improper payments.
- HHS continues to offer training, technical assistance, and support to State Medicaid program officials through the Medicaid Integrity Institute (MII). Between FYs 2008 and 2013, the MII provided training to over 4,000 State employees and officials from 50 States, the District of Columbia, and Puerto Rico.

## 10.50 Children's Health Insurance Program or CHIP

### 10.51 CHIP Statistical Sampling Process

HHS calculated and reports the national CHIP improper payment rate based on measurements conducted in FYs 2012 and 2013. CHIP improper payments are estimated on a Federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. HHS, through its use of Federal contractors, measures the FFS and managed care components and States perform the eligibility component measurement.

CHIP utilizes the same State sampling process as Medicaid. HHS determined that CHIP can be measured in the same States selected for Medicaid review each fiscal year with a high probability that the CHIP improper payment rate will meet the IPIA required confidence and precision levels. Since CHIP and Medicaid will be measured in the same States each year, each State will be measured for CHIP once every three years. For information on how HHS grouped States into each of the three cycles, please see pages 177-179 of HHS' FY 2012 AFR.

***FFS and Managed Care Component***

States submit quarterly adjudicated claims data from which a randomly selected sample of FFS claims and managed care payments are drawn each quarter. Each selected FFS claim is subjected to a medical and data processing review. Managed care payments are subject only to a data processing review. The average FFS sample size was 520 claims per State and the average managed care sample size was 280 payments per State.

Under Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), beginning in FY 2012 States could elect to accept or reject their previously reported CHIP improper payment rate. If a State elected to accept their previous CHIP improper payment rate, the State would utilize a State-specific sample size based on that rate. Since no historical improper payment rate data was available for States reviewed in FY 2013, State-specific samples were not utilized during this measurement cycle.

When a FFS component or managed care component for a State accounted for less than two percent of the State's total CHIP expenditures, the State's FFS and managed care claims were combined into one component for sampling and measurement purposes. This consolidation occurred for claims in three States.

***Eligibility Component***

States conducted an eligibility review on a randomly selected sample of 504 active cases and 204 negative cases. Since no historical eligibility improper payment rate data was available for States reviewed in FY 2013, State-specific sample sizes were not utilized during this measurement cycle.

HHS calculated two error rates for active cases, the payment error rate and the case error rate. The methodologies for these calculations are the same as those applied to Medicaid. Please see *Section 10.41* for further explanation of active and negative cases. In addition, the temporary changes to future PERM eligibility reviews that are discussed in *Section 10.41* also apply to the CHIP measurement.

***Calculations and Findings***

All payment error rate calculations for the CHIP program (the FFS component, managed care component, eligibility component, and national CHIP error rate) are based on the ratio of estimated dollars of improper payments to the estimated dollars of total payments. Individual State improper payment rate components are combined to calculate the national component improper payment rates. The national CHIP improper payment rate is calculated by combining the individual State improper payment rates. National component improper payment rates and the CHIP improper payment rate are weighted by State size, so that a State with a $1 billion program "counts" 5 times more toward the national rate than a State with a $200 million program. The national CHIP improper payment rate represents the combination of FFS, managed care, and eligibility improper payment rates. A small correction factor ensures that CHIP eligibility improper payments do not get "double counted."

The two Medicaid improper payment rate methodology enhancements described in *Section 10.41* also apply to the CHIP improper payment rate estimate with one difference. For FY 2013, only two cycles of States have been measured for CHIP requiring a slightly different approach to the single-year CHIP rolling improper payment rate until all three cycles of States are measured in FY 2014. For FY 2013, the 34 measured States will be treated as a contiguous sample and projected to the 17 States that have not yet been measured. Only two State-level FFS error rates were recalculated subsequent to FY 2012 reporting and are incorporated into FY 2013 improper payment rate reporting. See *Section 9.10: Accompanying Improper Payment Reduction Outlook Notes, notes (2) and (3)* for detailed information on the two improper payment rate methodology enhancements.

The national CHIP improper payment estimate for FY 2013 is 7.1 percent or $646 million. The FY 2013 net improper payment estimate is 6.9 percent or $624 million.

The FY 2013 national CHIP improper payment rate for each component is:

- *CHIP FFS* – 5.7 percent
- *CHIP managed care* – 0.2 percent
- *CHIP eligibility* – 5.1 percent

Within the CHIP eligibility error rate, the active case error rate is 7.2 percent and the negative case error rate is 3.7 percent.

Under the old calculation methodology the FY 2013 national CHIP error rate would have been 7.5 percent or $0.7 billion instead of the 7.1 percent or $0.6 billion reported in FY 2013 using the new calculation methodology enhancements.

### 10.52 CHIP Corrective Action Plans

HHS actively works with States to develop CAPs to address errors. HHS' experience is that improper payments are typically higher in the early years of improper payment measurement programs because the process is new. HHS expects CHIP improper payments to decrease as States refine their outreach and documentation efforts. Overall, the majority of the FY 2013 improper payments (by dollar amount) were a result of Verification errors (50 percent), which were mostly caused by cases reviewed for eligibility that were not eligible. The second largest cause of improper payments was Authentication and Medical Necessity errors (29 percent), which were mostly due to policy violations. The third leading cause of errors was Administrative and Documentation errors (21 percent), which were mostly due to insufficient and no documentation errors.

HHS works closely with all States to develop State-specific CAPs. All States are responsible for implementing, monitoring and evaluating the effectiveness of their CAPs. HHS received CAPs from all States whose CHIP programs were measured and reported in FY 2012, and all States that measured in FY 2013 are in the process of developing their CAPs for submission to HHS. When developing the CAPs, States focus their efforts on the major causes of improper payments where the State can clearly identify patterns. In addition, States take steps to reduce errors identified during the measurement.

Because much of the CHIP FFS improper payment rate has been due to missing or insufficient documentation, the majority of State CAPs focused on strengthening provider communication and education. These methods included enhancing provider training, presentations, newsletters, notices, bulletins, and provider broadcasts; conducting outreach to public providers; and performing more provider audits. For eligibility errors, State corrective actions included clarifying written State policies, particularly documentation requirements; launching a more advanced and improved electronic client eligibility system; providing refresher training for eligibility staff, particularly in areas determined by the PERM review to be error-prone; and producing informational broadcasts regarding error information and changes to eligibility policy and procedures. In addition to the development, execution, and evaluation of the State-specific CAPs, HHS has also made significant efforts to lower improper payments rates:

- HHS began "mini-PERM audits" with three States. Mini-PERM audits are voluntary, State-specific improper payment reviews, intended to assist States in identifying and eliminating improper payments during years States are not measured under PERM. These reviews assist States in developing targeted CAPs to decrease CHIP improper payments.
- HHS created a process to allow States to share information on terminated providers and to view information on Medicare providers and suppliers with revoked billing privileges.

- HHS continues provider outreach efforts, provider open forum calls, PERM+ data submission option implementation, aggregate payments methodology implementation, national best practice calls, post-CAP meetings, and State system workgroup meetings as discussed on pages 180-181, of HHS' FY 2012 AFR.

### 10.53 CHIP Program Improper Payment Recovery

HHS identified $355,399 and $172,482 in CHIP overpayments eligible for recovery for FYs 2012 and 2013 respectively. The decrease in CHIP overpayments eligible for recovery in FY 2013 compared to FY 2012 was due to: (1) a decrease in the dollar value of overpayments that were identified in the sample, and (2) exclusion of overpayments due to eligibility errors because PERM does not recover overpayments for the eligibility component. In addition, the amount of CHIP overpayments eligible for recovery for FY 2012 was amended from information previously reported in HHS' FY 2012 AFR to also exclude overpayments due to eligibility errors.

HHS works closely with States to recover overpayments identified from the FFS and managed care claims sampled and reviewed. Recoveries of CHIP improper payments are governed by Section 2105(e) of the SSA and related regulations at 42 CFR Part 457, Subpart B under which States must return the Federal share of overpayments. States reimburse HHS for the Federal share on the CHIP CMS-21 expenditure report. Section 2105(c)(6)(B) of the SSA incorporated the overpayment requirements of Section 1903(d)(2) for CHIP. Section 6506 of the *Affordable Care Act* amended section 1903(d)(2) to allow States up to one year from the date of discovery of an overpayment for services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment.

### 10.54 CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the State level, information systems and other infrastructure needed to reduce CHIP improper payments would need to be implemented at the State level. Please refer to *Section 10.44: Medicaid Information Systems and Other Infrastructure* for information on HHS- and State-led efforts to modernize information and data systems at the national and State level.

### 10.55 CHIP Statutory or Regulatory Barriers that Could Limit Corrective Actions

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 10.56 CHIP Best Practices

Based on lessons learned through previous PERM cycles and in an effort to address challenges faced by the States, HHS continues the pre-cycle aspect of the PERM measurement. The pre-cycle phase occurs prior to a State's first data submission, and allows HHS to disseminate information on changes in the program and to conduct individual orientation and education sessions with the States. In addition to the Medicaid Program Best Practices outlined in *Section 10.46*, the following measures have been incorporated into the CHIP measurement process:

- States are educated on the PERM process through HHS-initiated cycle calls and website activity.
- HHS designated a cycle manager as the lead for a fiscal year measurement and the main point of contact at HHS for that year.
- HHS utilized dashboards, a compilation of the contractors' and States' work, to monitor the progress of the measurement. The dashboards enable HHS to monitor problems in the measurement early and provide assistance to resolve issues that could delay the measurement process.
- HHS used monthly all-contractor meetings to facilitate communication and problem solving between HHS and its contractors to improve the PERM process.
- For States having difficulty providing complete data, HHS has provided onsite technical assistance.

## 10.60 Temporary Assistance for Needy Families or TANF

### 10.61 TANF Statistical Sampling Process

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an error rate for FY 2013.

### 10.62 TANF Corrective Action Plans

Since TANF is a State-administered program, corrective actions that could help reduce improper payments would have to be implemented at the State level. The TANF statute prohibits HHS from requiring State TANF agencies to implement and report on corrective actions. Despite the limitations, HHS has taken the following actions to assist States in reducing improper payments:

- HHS is working with States to analyze Single Audit findings related to TANF and to implement corrective actions to address these findings.
- HHS performed a detailed risk assessment of the TANF program. As part of this process, HHS identified potential programmatic risks at the Federal level and is working to mitigate these programmatic risks.
- HHS awarded two TANF Program Integrity Innovation Grants to State human service agencies with funding from OMB's Partnership Fund for Program Integrity Innovation. The grantees will conduct pilot projects that are designed to reduce improper payments and improve administrative efficiency in their TANF programs. Lessons learned from the pilots will be used to improve internal efficiency and provide guidance to other State human service agencies looking to improve TANF program integrity.
- HHS released guidance to State human service agencies, in a question and answer format, related to appropriate use of TANF program funds.

### 10.63 TANF Improper Payments Recovery

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement. As a result, HHS is not reporting an error rate or any results from improper payment recoveries for FY 2013.

### 10.64 TANF Information Systems and Other Infrastructure

Information systems and other infrastructure needed to reduce TANF improper payments would need to be implemented at the State level. States utilize PARIS, the National Directory of New Hires (NDNH), and the Income and Eligibility Verification System (IEVS) to minimize improper payments. No other systems or infrastructure are needed at this time.

### 10.65 TANF Statutory or Regulatory Barriers

Statutory limitations prohibit HHS from requiring States to participate in a TANF improper payment measurement.

### 10.66 TANF Program Best Practices

HHS encourages States to stress the importance of payment accuracy for TANF cases and seriously consider measures that will reduce the incidence of erroneous payments. Actions that may prove beneficial include, but are not limited to:

- Conduct local office quality control reviews for eligibility and payment processes at both the initial intake and redetermination stages of the case, and perform periodic "checks" of case records, paying particular attention to documentation such as a current application and facts supporting income, household composition, participation in work activities, and cooperation with child support enforcement.

- Develop and maintain a reminder system for critical follow-up actions on cases such as responding to reports of non-cooperation with child support, IEVS "hits", redeterminations of eligibility, or failure to fulfill work requirements.

- Remind TANF recipients periodically of their responsibility to accurately report income, resources, and other changes in family circumstances to the local TANF agency on a timely basis; to use NDNH information to verify the eligibility of adult TANF recipients residing in the State; and to modify benefits or close the case if the individual is not eligible for assistance.

- Conduct training on investigative interviewing techniques for intake workers and case managers.

- Establish and monitor internal procedures to ensure that TANF payments are adjusted on a timely basis when family circumstances change and affect case eligibility or the amount of payment, and establish a process for the collection of TANF overpayments from the applicable recipients.

## 10.70 Foster Care

### 10.71 Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for *Title IV-E* Foster Care in FY 2013. The Foster Care improper payment estimate is calculated each year using data collected in the most recent Foster Care Eligibility Review for each State. Under the regulatory review promulgated at *45 CFR 1356.71*, Foster Care Eligibility Reviews are conducted systematically in each State every three years. Each regulatory review identifies the number of error cases and amount of payment errors, as determined from the review of a sample drawn from the State's overall *Title IV-E* Foster Care caseload for its six-month Period Under Review (PUR). The sample is a random sample drawn from the universe of cases having at least one *Title IV-E* Foster Care maintenance payment during the PUR. Since each State is reviewed every three years, each year's data incorporates new review data for about one-third of the States. For a more detailed description of the Foster Care improper payments statistical sampling and estimation methodology, please see pages 189-190 of HHS' FY 2012 AFR.

The Foster Care gross improper payment estimate for FY 2013 is 5.3 percent or $69.7 million. The FY 2013 net improper payment rate is 4.2 percent or $56.0 million.

### 10.72 Foster Care Corrective Action Plans

All payment errors (100 percent) in the *Title IV-E* Foster Care Program are Administrative and Documentation errors due to incorrect case classification and payment processing by State agencies. The Foster Care program designs corrective action plans to help States address these payment errors that contribute most to *Title IV-E* improper payments.

Corrective actions have decreased the overall number of payment errors and altered the composition of identified payments errors. For example, following years of work with State Court Improvement Programs and outreach to heighten judicial awareness, judiciary-related errors, once the most prevalent error type, are now among the least common.

HHS continues to monitor review results and analyze the types of payment errors in the Foster Care program to target corrective action planning. In FY 2013, the most common payment errors included:

- Underpayments (29 percent of errors),
- Ineligible payments (e.g., therapy or unallowable transportation costs) (11 percent of errors),
- Family not eligible for the Aid to Families with Dependent Children program at time of removal (8 percent of errors),

- Duplicate or excessive maintenance payments to providers (8 percent of errors),
- Provider not licensed or approved (7 percent of errors), and
- Provider criminal records check not completed (6 percent of errors).

Together these six items continue, as in past years, to account for nearly 70 percent of Foster Care payment errors; however, the overall frequency of all types of payment errors in the composite Foster Care sample decreased by 9 percent from FY 2012 to FY 2013. In addition, although underpayments represent nearly one-third of all errors in terms of frequency, the dollar amount of the underpayments decreased, as the underpayment rate improved from 0.7 percent in FY 2012 to 0.5 percent in FY 2013.

In FY 2013, HHS undertook the following key actions to reduce improper payments:

- Program leadership convened meetings with Federal Regional Office staff to share information about the Foster Care program's improper payment estimates and to highlight the importance of achieving HHS' performance goals.
- The National Team Leader for the *Title IV-E* Foster Care Eligibility Reviews conducted training at all ten Regional Offices on current Foster Care eligibility requirements and guidance on identifying improper payments. This in-depth training enhanced Federal staff's knowledge of program requirements, allowing them to better work with States to improve performance.

In addition, HHS continued the following ongoing corrective actions:

- HHS conducts onsite and post-site review activities to validate the accuracy of State claims for reimbursement of payments made on behalf of children and their Foster Care providers. Specific feedback is provided onsite to the State agency to positively affect proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents findings of the review to the State agency. The final report serves as the basis for the development of a Program Improvement Plan (PIP) for States that exceed the error threshold.

- HHS requires non-compliant States (those that exceed the error threshold) to develop and execute State-specific PIPs that link corrective actions to the root cause of payment errors. The PIP identifies the specific action steps necessary to target and correct error root causes. To ensure the timely error correction, each action strategy is required to have a projected completion within one year from the date HHS approved the PIP. PIPs are a proven and effective strategy, as reflected in the decrease of the national *Title IV-E* error rate since FY 2004.

- HHS provides training and technical assistance to States to develop and implement program improvement strategies, even when States are not required to develop a PIP. The intent of this assistance is to help States expand organizational capacity and promote more effective program operations.

- HHS conducts secondary reviews, as applicable, and takes appropriate disallowances consistent with the review findings, including an extrapolated disallowance if the State is found not in substantial compliance. These additional disallowances, in conjunction with the development and implementation of the PIP, serve as a strong incentive to States to improve compliance.

### 10.73 Foster Care Improper Payment Recovery

As a result of conducting Foster Care eligibility reviews in 18 States during the 12-month period between July 2012 and June 2013, HHS recovered over $1.1 million in *Title IV-E* improper payments. The recovered funds are comprised of $627,686 in disallowed maintenance payments and $459,781 in disallowed administrative payments.

Improper payment recovery occurs through *post-payment review*, through both eligibility reviews as well as audit reviews. The Foster Care program does not systematically track cost recovery through OIG reviews or Single Audit reports; rather, the program obtains this information from HHS reports generated as part of the audit clearance process. Specifically, the program identifies and tabulates audit findings where the audit has been closed and a recommended cost recovery has been sustained for the *Title IV-E* Foster Care program. These recovery amounts are in addition to the amounts identified through the eligibility reviews and are presumed to be recovered in the fiscal year when the audit is closed. Recoveries of improper payments through audits may include *Title IV-E* Foster Care maintenance assistance payments, administration, training, and automated systems development costs. See *Section 11.0* for further information on payment recovery.

### 10.74 Foster Care Information Systems and Other Infrastructure

HHS uses the Adoption and Foster Care Analysis and Reporting System for the regulatory reviews. Utilization of this system reduces the burden on States to draw their own samples, promotes uniformity in sample selection, and employs the database in a practical and beneficial manner. Since Foster Care payments occur at the State level, information systems and other infrastructure needed to reduce Foster Care improper payments would need to be implemented at the State level. No other systems or infrastructure are needed at this time.

### 10.75 Foster Care Statutory or Regulatory Barriers

No statutory or regulatory barriers that could limit corrective actions have been identified at this time.

### 10.76 Foster Care Best Practices

Since the inception of its improper payment reporting, HHS has maintained a diligent focus on improper payment identification and reduction efforts in the Foster Care program. Refinements to the error rate methodology have included steps to ensure systematic examination and consideration of underpayments in eligibility reviews and modifying data retention practices to permit shifting from case-based extrapolation to dollar-based extrapolation.

Concurrent with these efforts to continually refine its identification and reporting of improper payments, HHS works with State child welfare agencies to improve administrative procedures for tracking and documenting eligibility. HHS also works with the judiciary to support adherence to requirements for timely and thoroughly documented case hearings and court orders. These efforts have yielded reductions in eligibility errors and improper payments, as well as the recovery of $17.9 million in improper payments.

In addition to the ongoing efforts to address improper payments as outlined above, the Foster Care program continues to lay the groundwork for a new methodology to review administrative payments (i.e., Administrative Cost Review or ACR). In FY 2013, HHS issued final reports for two FY 2012 pilot tests of the ACR methodology and transmitted the results to State agency leadership for their consideration. Recommendations focused on improving allocation and assignment of administrative costs to *Title IV-E* Foster Care. HHS has compiled all ACR pilot results (nine reviews conducted between FY 2007 and FY 2012), and HHS is currently analyzing these results to determine how best to utilize the ACR process in the future.

## 10.80 Child Care or CCDF

### 10.81 Child Care Statistical Sampling Process

There were no changes to the statistical sampling process in FY 2013. For the CCDF improper payments statistical sampling methodology, please see: http://www.acf.hhs.gov/sites/default/files/occ/data_final_0.pdf.

The CCDF methodology distinguishes between authorizations for payment and actual payments made to providers. Therefore, the amount of improper authorizations for payment identified during the review process does not

represent actual improper payments. In general, the amount of payments is lower, computed to be on average about 17 percent lower.

The CCDF gross improper authorizations for payment estimate for FY 2013 is 5.9 percent or $306 million. The FY 2013 net improper payment estimate is 5.0 percent or $260 million.

### 10.82 Child Care Corrective Action Plans

Administrative and Documentation errors account for an estimated 51 percent of errors identified in the CCDF Improper Authorizations review process. Errors were primarily due to missing or insufficient documentation. The most frequently cited errors due to missing or insufficient documentation include:

- Insufficient documentation of earned income, unearned income, and income deductions,
- Insufficient documentation of the hours of care needed,
- Missing or incomplete documentation about the work, or educational or training activity of the head of household, and
- Missing case records.

Verification errors represent approximately 49 percent of errors found in the reviews. Verification errors occur when there is a lack of information to verify portions of the case record. These errors consist of the failure to apply policy correctly, including:

- Income calculation errors (inability to determine income calculation method, or use of an incorrect monthly conversion factor),
- Incorrect computation of the hours of care needed,
- Inclusion or exclusion of income,
- Co-pay calculation errors, including incorrect use of the fee schedule,
- Failure to process reported changes, and
- Data errors.

HHS and States have established corrective actions targeting both error types. States' efforts include:

- *Performing ongoing case record reviews:* Eight of 17 States measured in FY 2013 conducted reviews or re-reviews of cases to monitor error-prone policy areas and review supporting documentation to ensure correct policy application.
- *Developing comprehensive training plans:* Twelve of 17 States measured in FY 2013 developed aggressive training plans that included policy clarifications, calculation tools, and checklists for supervisors and workers to ensure accuracy in eligibility processing and the targeting of specific errors, such as income calculation, co-payment, and fee schedules.
- *Enhancing automated systems:* Ten of 17 States measured in FY 2013 implemented automation changes to track attendance, issue caseworker alerts for action items, produce monitoring reports, and generate computer edits.
- *Performing ongoing program monitoring*: Eight of 17 States measured in FY 2013 created performance improvement plans, performance expectations, and targeted corrective actions for managers to include in their monitoring procedures.

HHS' corrective actions include:

- Providing technical assistance through on-site visits, webinars, interactive online meetings, conference calls, and written documents. These were specifically designed to help States focus on staff training, eligibility determination policies and procedures, documentation requirements, routine case reviews, and overall program administration.
- Providing States with an opportunity for peer-to-peer sharing of both error causes and program improvements, in an effort to reduce and/or eliminate improper payments. States were able to share information with each other during Regional calls with State Administrators, at Regional and National meetings, and through conference calls.
- Implementing the technical assistance tool "Grantee Internal Control Self-Assessment Instrument" with States with high error rates to help them assess their internal control system, identify areas of risk, develop mitigation strategies, and receive technical assistance as they implement corrections. Seven of the States measured during FY 2013 were visited by HHS representatives to help complete the self-assessment between their previous review and this review.

### 10.83 Child Care Program Improper Payment Recovery

The cumulative FY 2013 CCDF improper overauthorizations for payments amount is $505,094. The overall error estimate is comprised of three review cycles: FYs 2011, 2012, and 2013. The improper overauthorizations for payments are as follows for each cycle: Year One States (reported in FY 2011) - $155,883, Year Two States (reported in FY 2012) - $146,914, and Year Three States (reported in FY 2013) - $202,297. (Note: After the publication of HHS' FY 2012 AFR, HHS determined that it had provided incorrect totals for the improper overauthorizations identified in previous reviews. The figure for Year 1 States' (reported in FY 2011) estimated improper overauthorizations was previously reported as $159,012, but the correct figure is $155,883.)

The FY 2013 review cycle represents the second time that Year Three States have conducted the error rate measurement. Compared to FY 2010, the last time this cycle of States was measured, the improper overauthorizations for payment amount declined by $193,932 (from $396,229 to $202,297). (Note: After the publication of HHS' FY 2012 AFR, HHS determined that it had provided incorrect totals for the improper overauthorizations identified in previous reviews. The figure for the Year 3 States' (reported in FY 2010) estimated improper overauthorizations was previously reported as $384,748, but the correct figure is $396,229.)

Overall, States estimate that they will recover 16 percent of the $505,094 identified as overauthorizations during the complete review cycle. Year Three States expect to recover an estimated 21 percent, or $42,117, of the $202,297 in overauthorizations for payment identified during the review. The current review methodology only requests that States provide an estimate for projected recoveries identified from the sampled cases. Requesting information regarding actual collections would violate the *Paperwork Reduction Act.* The planned revision, effective in FY 2014, to measure payments instead of authorizations for payment, will require grantees to provide information on both the estimate they expect to recover in the future and any funds recovered from prior reviews.

### 10.84 Child Care Program Information Systems and Other Infrastructure

Since CCDF payments occur at the State level, information systems and other infrastructure needed to reduce CCDF improper payments would need to be implemented at the State level. In addition to the efforts outlined on page 198 of HHS' FY 2012 AFR, States reported a range of improvements to information systems including:

- Incorporating the Federal case review worksheet or a facsimile in the automated eligibility system, and,
- Providing eligibility staffs with access to eligibility systems for other programs like TANF and SNAP.

### 10.85 Child Care Program Statutory or Regulatory Barriers

No statutory or regulatory barriers that would limit corrective actions have been identified at this time.

### 10.86 Child Care Program Best Practices

The "best practices" or "lessons learned" most frequently cited by the Year Three States, based on their experiences in two review cycles, include the following:

- *Centralized case-record reading*: This practice supported the re-review process through consistent policy interpretation, error definition, and copying record materials; regular reviewer meetings to discuss issues; and the management of operational costs.
- *Starting the planning process early:* All phases of the measurement process took longer than States expected. Starting the process earlier allowed time to react to the unexpected, such as sampling problems or delays, review-team issues, or record-reading problems.
- *Ongoing case-record reviews:* Several Year Three States continued or began to incorporate case record reviews into ongoing monitoring processes to improve practices and reduce errors. Results from these reviews informed training needs, policy and procedure revisions, and increased productivity and accuracy.

## 11.0 Recovery Auditing Reporting

From FY 2004 to FY 2006, HHS awarded a contingency fee contract to a recovery auditing firm to review $24 billon in contract payments made from FY 2002 to FY 2005. During that review, the recovery auditors found the HHS payment systems to be without major program integrity issues. The auditors identified approximately $1.6 million in potential recoveries and HHS recovered $74,401. We have not sought a contractor to attempt to recover funds beyond FY 2005 because our efforts to date have produced such small recoveries.

More recently, HHS created a risk-based strategy to implement the recovery auditing provisions of *IPERA*. Specifically, HHS is focusing initially on implementing recovery audit programs in Medicare and Medicaid, which accounted for 85 percent of HHS' outlays in FY 2013. In addition, HHS is also exploring implementing recovery audit programs in a cost-effective manner for additional programs, which account for the remaining HHS' outlays. In the meantime, we are making substantial progress in recovering improper payments in Medicare and Medicaid, as described below.

***Medicare FFS RACs***

Section 302 of the *Tax Relief and Health Care Act of 2006* required HHS to implement the Medicare FFS RAC program in all 50 States no later than January 1, 2010. In FY 2013, the Medicare FFS RAC program demanded approximately $4.2 billion and recovered $3.7 billion in overpayments by the end of the fiscal year. The difference in the amount of improper payments identified compared to the amount of improper payments recovered was due to several factors, including: extended repayment plans; bankruptcies; investigations by the HHS Office of Inspector General, the Department of Justice, or Zone Program Integrity Contractors; and provider or supplier appeals of overpayment determinations. During FY 2013, the Medicare FFS RACs focused their reviews on short hospital stays and claims for durable medical equipment. HHS continues to monitor and make continuous improvements to the Medicare FFS RAC program activities.

In addition to using the Medicare FFS RACs to identify overpayments, HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2013, HHS released four Provider Compliance Newsletters that provided detailed information on 30 findings identified by the Medicare FFS RACs. Based on these findings, HHS also implemented local and/or national system edits to automatically prevent improper payments.

More information on the Medicare FFS RAC program can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/.

***Medicare Part C and Part D RACs***

Section 6411(b) of the *Affordable Care Act* expanded the RAC program to Medicare Parts C and D. Procurement activities for the Part C RAC are ongoing and an award is expected in FY 2014.

The Part D RAC program became fully operational in FY 2012, and is currently reviewing prescription drug claims for calendar years 2008 through 2011. Since its launch, the Part D RAC identified overpayments made as a result of prescriptions written by excluded providers or filled at excluded pharmacies. In FY 2013, approximately $1.8 million in overpayments were recouped from plans as a result of overpayments that were identified during FY 2012 (but that were not recovered that year). Similarly, at the end of FY 2013, HHS sent notification letters for additional overpayments totaling approximately $3.4 million to plans. For those plans that do not appeal, overpayment recoupment will begin in FY 2014 and will be reported in the FY 2014 AFR.

In FY 2014, the Part D RAC will review excluded providers, duplicate payments, and Direct and Indirect Remuneration (which includes discounts, rebates, cash discounts, and other types of benefits). In the future, the Part D RAC may expand its reviews.

More information on the Medicare Part C and Part D RAC programs can be found at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/.html.

***State Medicaid RACs***

Section 6411(a) of the *Affordable Care Act* required each State to establish State Medicaid RAC programs by submitting a State plan amendment, which attests that its program meets the statutory requirements by December 31, 2010. States were required to implement RAC programs by January 1, 2012; thus, FY 2013 is the first full Federal fiscal year of reporting State Medicaid RAC recoveries. As States continue to implement their State Medicaid RAC programs, State Medicaid RAC Federal-share recoveries reported by States increased from $57.6 million in FY 2012 to $74.5 million in FY 2013. States have increased the total Federal and State share combined amount of Medicaid RAC recoveries from $95.6 million in FY 2012 to $124.3 million in FY 2013.

HHS regulations align the State Medicaid RAC requirements to existing Medicare FFS RAC program requirements, where feasible, and provide each State the flexibility to tailor its RAC program where appropriate. As of September 30, 2013, 45 States and the District of Columbia have implemented Medicaid RAC programs. The remaining 5 States have time-limited HHS-approved exemptions.

HHS provides guidance to States as each State implements its Medicaid RAC program. In September 2012, HHS launched a tool to encourage transparency and monitoring called the State Medicaid RACs At-A-Glance website. This tool can be found at: http://w2.dehpg.net/RACSS/Map.aspx. The website contains State-reported information on each State's Medicaid RAC program, the name of each RAC vendor and Medical Director, and contact information for the State Program Integrity Director.

***Recovery Auditing Reporting Tables***

OMB Circular A-136 requires agencies to provide detailed information on their recovery audit programs, as well as other efforts related to the recapture of improper payments. Some of our programs have results to report in this area and those results are included in the following tables. If a program is not listed on a certain table, it is because they do not yet have results in that area.

# Table 2
## Payment Recapture Audit Reporting
## FY 2013
(in Millions)

| Type of Payment | Amount Subject to Review for CY Reporting | Actual Amount Reviewed and Reported (CY) | Amount Identified for Recovery (CY) | Amount Recovered (CY) | % of Amount Recovered out of Amount Identified (CY) | Amount Outstanding (CY) | % of Amount Outstanding out of Amount Identified (CY) | Amount Determined Not to be Collectable (CY) | % of Amount Determined Not to be Collectable out of Amount Identified (CY) | Amounts Identified for Recovery (PYs) | Amounts Recovered (PYs) | Cumulative Amounts Identified for Recovery (CY + PYs) | Cumulative Amounts Recovered (CY + PYs) | Cumulative Amounts Outstanding (CY+PYs) | Cumulative Amounts Determined Not to be Collectable (CY+PYs) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicare FFS Recovery Auditors | N/A | N/A | $4,234.9 | $3,650.9 Note 1 | 86% | $584.0 | 14% | N/A | N/A | $3,731.1 Note 2 | $3,164.2 Note 2 | $7,966.0 | $6,815.1 | $1,150.9 | N/A |
| Medicare Part C Recovery Auditors | N/A Note 3 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Medicare Part D Recovery Auditors | N/A | N/A | $3.4 Note 4 | $1.8 Note 5 | 53% | $1.6 | 47% | N/A | N/A | $1.8 Note 6 | N/A | $5.2 | $1.8 | $3.4 | N/A |
| State Medicaid Recovery Auditors | N/A | N/A | N/A Note 7 | $74.5 | N/A | N/A | N/A | N/A | N/A | N/A | $57.6 Note 8 | N/A | $132.1 | N/A | N/A |
| HHS Contracts | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | $1.6 Note 9 | $0.074 | $1.6 Note 9 | $0.074 | N/A | N/A |

Notes:

1. The Medicare FFS recovery auditors Amount Recovered (CY) column is the amount recovered in FY 2013, regardless of the year the overpayment was identified
2. The Medicare FFS recovery auditors Prior Year (PYs) columns reflect recovery audit information reported in the FY 2010, FY 2011, and FY 2012 AFRs.
3. HHS expects to award a contract for a Medicare Part C RAC program in FY 2014. Accordingly, HHS is not reporting Medicare Part C RAC results in the FY 2013 AFR.
4. The Medicare Part D recovery auditor Amount Identified for Recovery (CY) column reflects the amount HHS identified in the notification of improper payment letters issued to plans in FY 2013.
5. The Medicare Part D recovery auditor Amount Recovered (CY) column reflects the amount recovered in FY 2013, regardless of the year the overpayment was identified.
6. The Medicare Part D recovery auditor identified $1.8 million in overpayments in FY 2012. HHS did not report that amount in the FY 2012 AFR, but has included the totals in the FY 2013 AFR.
7. The State Medicaid recovery auditors are only required to report the amount of recoveries, and no other information like the amount of improper payments identified, amount of improper payments outstanding, or how the States use the recovered funds. The State Medicaid recovery auditors Amount Recovered (CY) and Amounts Recovered (PYs) columns represent the Federal-share of the State recoveries.
8. The State Medicaid recovery auditors Amounts Recovered (PYs) column was not reported in Table 3 of the FY 2012 AFR since HHS did not have a full year of results to report at the time. HHS has included FY 2012 and FY 2013 information in the FY 2013 AFR since the Department is reporting full year results for FY 2013.
9. The HHS Contracts Amounts Identified for Recovery (PYs) and Cumulative Amounts Identified for Recovery (CY + PYs) columns were amended from $1.5 million, as reported in the FY 2012 AFR, to $1.6 million. As noted in Table 2 and Section 11.0, HHS recovered approximately $74,401 out of $1.6 million identified by the recovery auditors. The remaining funds are not included in Table 2 for reasons including, but not limited to, they were collected through other mechanisms and do not fit in the reporting columns.

# Table 3

## Payment Recapture Audit Targets

## FY 2013

(in Millions)

| Type of Payment | CY Amount Identified | CY Amount Recovered | CY Recovery Rate (Amount Recovered / Amount Identified) | CY + 1 Recovery Rate Target | CY + 2 Recovery Rate Target | CY + 3 Recovery Rate Target |
|---|---|---|---|---|---|---|
| Medicare FFS Recovery Auditors | $4,234.9 | $3,650.9 | 86% | 85% | 85% | 85% |
| Medicare Part D Recovery Auditors | $3.4 | $1.8 | 53% | 85% | 85% | 85% |

Note: The State Medicaid recovery auditors are not included in this table since States do not report information to HHS that would allow the Department to calculate the amount of overpayments identified, the recovery rate, or the recovery rate targets.

# Table 4

## Aging of Outstanding Overpayments

## FY 2013[1]

(in Millions)

| Type of Payment | CY Amount Outstanding (0 – 6 months) | CY Amount Outstanding (6 months to 1 year) | CY Amount Outstanding (over 1 year) |
|---|---|---|---|
| Medicare FFS Recovery Auditors | $1,004.2<br>Note 2 & Note 3 | $210.4 | N/A |
| Medicare Part D Recovery Auditors | N/A<br>Note 4 | N/A | N/A |

Notes:

1. The State Medicaid recovery auditors are not included in this table since States do not report information to HHS that would allow the Department to calculate the amount of overpayments that are currently outstanding.
2. The amount of outstanding Medicare FFS recovery auditors overpayments identified in this table ($1,214.6 million) does not match the amount outstanding identified in Table 3 because this table includes information from FY 2013 only whereas Table 3 includes information on recoveries from multiple years.
3. Under the Medicare FFS recovery auditors program, recovery of identified overpayments cannot begin until the overpayment is at least 41 days old. Therefore, the CY Amount Outstanding (0-6 months) includes identified overpayments that HHS cannot begin collecting.
4. Recoupments of FY 2013 overpayments will not begin on the Medicare Part D recovery auditors' overpayments until the appeals process is complete. The appeals process is ongoing, but is expected to be completed by the 3rd quarter of FY 2014.

# Table 5
## Disposition of Recaptured Funds
## FY 2013[1]
(in Millions)

| Type of Payment | Agency Expenses to Administer the Program | Payment Recapture Auditor Fees | Financial Management Improvement Activities | Original Purpose | Office of Inspector General | Returned to Treasury |
|---|---|---|---|---|---|---|
| Medicare FFS Recovery Auditors | $152.4 | $301.7 | N/A | $3,094.4 Note 2 | N/A | N/A |
| Medicare Part D Recovery Auditors | N/A | $0.2 | N/A | $1.6 Note 3 | N/A | N/A |

Notes:
1. The State Medicaid recovery auditors are not included in this table since States do not report information to HHS on how the recoveries are used.
2. For the Medicare FFS recovery auditors program, funds included under the "Original Purpose" column were returned to the Medicare Trust Funds after taking into consideration agency expenses to administer the program and recovery auditors contingency fees (amounts are listed above) and underpayments to providers ($102.4 million).
3. For the Medicare Part D recovery auditors program, funds included under the "Original Purpose" column were returned to the Medicare Trust Funds.

# Table 6

## Overpayments Recaptured Outside of Payment Recapture Audits FY 2013

(in Millions)

| Agency Source | Amount Identified (CY) | Amount Recovered (CY) | Amount Identified (PYs) | Amount Recovered (PYs) | Cumulative Amount Identified (CY+PYs) | Cumulative Amount Recovered (CY+PYs) |
|---|---|---|---|---|---|---|
| Medicare FFS Error Rate Measurement | $40.0 | $33.2 | $30.9 | $25.5 Note 1 | $70.9 | $58.7 |
| Medicare Contractors | $14,204.6 Note 2 | $12,559.2 Note 2 | $24,882.9 Note 3 | $19,487.1 Note 3 | $39,087.5 | $32,046.3 |
| Medicare Part C Note 4 | $0 | $0 | $1.7 | $0 | $1.7 | $0 |
| Medicare Part D Note 4 | $0 | $0 | $0.2 | $0 | $0.2 | $0 |
| Medicare Part C RADV Audits | $5.0 | $5.0 | $3.4 Note 5 | $3.4 Note 5 | $8.4 | $8.4 |
| Medicaid Error Rate Measurement | $0.2 | $0.7 | $3.5 Note 6 | $1.3 | $3.7 | $2.0 |
| CHIP Error Rate Measurement | $0.2 | $0.2 | $0.3 Note 6 | $0.01 | $0.5 | $0.21 |
| Medicaid Integrity Contractors-Federal Share-FMAP rates | $14.1 Note 7 | $2.6 | $8.0 | $1.8 | $22.2 Note 7 | $4.4 |
| Foster Care Eligibility Reviews = Post-Payment Reviews | $1.1 | $1.1 | $16.8 | $16.8 | $17.9 | $17.9 |
| Foster Care OIG Reviews | $4.0 | $0.2 | $203.1 Note 8 | $102.7 | $207.1 Note 8 | $102.9 |
| Foster Care Single Audits | $0.5 | $0.2 | $34.4 | $33.2 | $34.9 | $33.4 |
| Child Care-Single Audit | $2.0 | $2.5 | $4.9 | $3.3 | $6.9 | $5.8 |
| Child Care-Error Rate Measurement | $0.2 | $0 | $0.7 Note 9 | $0 | $0.9 | $0 |
| Head Start- OIG Reviews | $1.9 | $0 | $5.1 Note 10 | $5.1 Note 10 | $7.0 | $5.1 |
| Head Start- Single Audits | $1.8 | $0.8 | $2.1 | $3.5 | $3.9 | $4.3 |

Notes:

1. The Medicare FFS Error Rate Measurement's Amount Recovered (PYs) amount of $27.2 million that was reported in the FY 2012 AFR was amended $25.5 million to exclude amounts that were later overturned on appeal.
2. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program, which are reported in Table 3, and the Medicare FFS Error Rate Measurement program, which are reported separately in Table 7.
3. This total reflects amounts reported by the Medicare FFS Contractors excluding the amounts reported for the Medicare FFS recovery auditors program, which are reported in Table 3, and the Medicare FFS Error Rate Measurement program, which are reported separately in Table 7. In addition, the Amount Identified (PYs) and Amount Recovered (PYs) amounts that were reported in the FYs 2011 and 2012 AFR were amended to remove amounts associated with the Medicare FFS Error Rate Measurement program and to reflect revisions made after the FY 2012 AFR publication date. The Amount Identified (PYs) information was changed from $24,913.9 million to $24,882.9 million, and the Amount Recovered (PYs) information was changed from $19,513.0 million to $19,487.1 million.
4. These amounts represent money owed to HHS by health plans that terminated their Part C or Part D contracts.
5. The Medicare Part C RADV Audits Amount Identified (PYs) and Amount Recovered (PYs) columns were amended from $3.5 million, as reported in the FY 2012 AFR, to $3.4 million.
6. For the Medicaid and CHIP error rate measurements, the Amount Identified (PYs) information that was reported in the FY 2012 AFR was amended to exclude improper payments that were due to eligibility errors, which HHS and States are unable to recover. The Medicaid error rate measurement's Amount Identified (PYs) was amended from $4.3 million to $3.5 million, while the CHIP error rate measurement's Amount Identified (PYs) amount was amended from $0.5 million to $0.3 million.
7. For Medicaid, the Medicaid Integrity Contractors (MICs) identified total overpayments which include both the Federal and State shares. For the Amount Identified (CY) column, HHS has reported the actual Federal share across audits. For the Amount Identified (PYs) column, HHS applied FY 2012 State FMAP rates to estimate the Federal share of overpayments, although not all overpayments identified were based on FY 2012 paid claims. Lastly, adding the $14.1 million figure in the Amount Identified (CY) cell and the $8.0 million figure in the Amount Identified (PYs) cells produces $22.1 million, not the $22.2 million figure in the Cumulative Amount Identified (CY + PYs) cell, due to using rounded numbers in the table for presentation purposes.
8. The Foster Care OIG Reviews information that was published in the FY 2012 AFR contained $217.8 million in the Amount Identified (PYs) and Cumulative Amount Identified (CY+PY) columns. Theses prior year totals were amended to reflect the issuance in FY 2013 of revised sustained amounts associated with previously sustained audit report recommended disallowances (four from FY 2010 and one from FY 2011). The net impact of these changes reduced the totals for the Amounts Identified (PYs) and the Cumulative Amounts Identified (CY + PYs) columns by approximately $14.8 million.
9. The Child Care Error Rate Measurement information reflects overpayments that are identified through the statistical sampling process. The information reported represents the amount that is subject to disallowance. For the Child Care Error Rate Measurement Amount Recovered (CY) information, States are required to recover child care payments that are the result of fraud and have discretion as to whether to recover misspent funds that were not the result of fraud, such as in cases of administrative error.
10. In FY 2012 the amount reported for the Amount Identified (CY) and Amount Recovered (CY) columns was $0.3 million. However, this total did not reflect an additional $4.8 million that was also identified through OIG reviews and subsequently recovered. Therefore, the amount reported in FY 2013 as Amount Identified (PYs) and Amount Recovered (PYs) columns were amended to reflect the true total of $5.1 million.

# MANAGEMENT REPORT ON FINAL ACTION

**October 1, 2012 – September 30, 2013**

## Background

*The Inspector General Act Amendments of 1988* require departments and agencies to report to Congress on the actions they have taken and the amount of funds recovered or saved in response to OIG audit recommendations. This annual management report provides the status of OIG A-133 audit reports (reports) in the Department and summarizes the results of actions taken to implement OIG audit recommendations during the reporting period. As part of the U.S. Chief Financial Officer Council's Streamlining Effort of FY 1996, the Management Report on Final Action has been incorporated in the AFR.

## Four Key Elements to the HHS Audit Resolution and Follow-Up Process

1. HHS OPDIVs have a lead responsibility for implementation and follow-up on OIG and independent auditor recommendations;
2. The Assistant Secretary for Financial Resources establishes policy and monitors HHS OPDIVs' compliance with audit follow-up requirements;
3. The audit resolution process indicates the ability to appeal disallowances administratively under such programs as Head Start, Foster Care and Medicaid pursuant to the Departmental Grant Appeals Board's regulations in 45 C.F.R. Part 16; and
4. If necessary, the Conflict Resolution Council resolves conflicts between the HHS OPDIVs and OIG.

## Status of Audits in the Department

In general, HHS OPDIVs have followed up on OIG recommendations effectively and within regulatory time limits. HHS Agencies usually reach a management decision within the 6-month period that is prescribed by the *Inspector General Act Amendments of 1988* and OMB Circular A-50, *Audit Follow-up*. For the most part, they also complete their final actions on reports, including collecting disallowed costs and carrying out corrective action plans, within a reasonable amount of time. However, the Department continues to monitor this area to improve procedures and ensure compliance with corrective action plans.

## Departmental Conflict Resolution

In the event that HHS OPDIVs and OIG staff cannot resolve differences on specific report recommendations, a conflict resolution mechanism is available. During FY 2013, there were no disagreements requiring the convening of the Conflict Resolution Council.

## Final Action Tables and Departmental Findings

Table 1, Management Action on Costs Disallowed in OIG Reports, presents costs that HHS challenged because a grantee had violated a law, regulation, grant term or condition.

- In FY 2013, HHS initiated Recovery Action, through collection, offset or other means, on 334 reports for a total of $767,400,888.

- In FY 2013, HHS completed Recovery Action, through collection, offset or other means, on 300 reports for a total of $553,507,193.

E. As of September 30, 2013, HHS identified 228 reports with outstanding balances over one year old totaling $2,019,398,540 . Forty-three percent of these accounts receivable are currently being pursued for collection. These accounts receivable are owed by state and local governments (132), hospital and medical related organizations (54), non-profit organizations (21), Indian tribes (19) and educational institutions (2). A detailed list of reports over one year old with outstanding balances to be collected can be found at: http://www.hhs.gov/asfr/of/finpollibrary/financialpolicies.html - Audit Guidance.

## TABLE 1
### Management Action on Costs Disallowed in OIG Reports
*As of September 30, 2013*

| | Number | Disallowed Costs |
|---|---|---|
| A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1. | 303 | $ 2,357,574,840 |
| B. Reports on which management decisions were made during the reporting period. See Note 2. | 334 | 767,400,888 |
| **Subtotal (A + B)** | **637** | **$ 3,124,975,728** |
| C. Reports for which final action was taken during the reporting period: | | |
| i. The dollar value of disallowed costs that was recovered through collection, offset, property in lieu of cash, or otherwise. | 300 | 553,507,193 |
| ii. The dollar value of disallowed costs that were written off by management. | 4 | 2,886,847 |
| **Subtotal (i + ii)** | **304** | **$ 556,394,040** |
| D. Reports for which no final action has been taken by the end of the reporting period. See Note 3. | 333 | $ 2,568,581,688 |

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.
2. Represents the amount of management concurrence with the OIG's recommendations. For this fiscal year, the OIG's reconciliation with the HHS Agencies showed a variance that represents only timing differences between the OIG's and the OPDIVs' records.
3. In addition to current unresolved reports, this figure includes reports over one year old with outstanding balances totaling $2,019,398,540 (e.g., audits under current collection schedule or audits under administrative or judicial appeal).

Table 2, Management Action on OIG Reports with Recommendations that Funds Be Put to Better Use, appears below. “Funds to be put to better use” relates to those costs associated with cost avoidances, budget savings, etc. identified by the OIG.

- In FY 2013, HHS initiated action on $821,434,473 in OIG recommendations to put funds to better use.
- In FY 2013, HHS completed action on $149,503,974 in OIG recommendations to put funds to better use.

## TABLE 2

### Management Action on OIG Reports with Recommendations that Funds Be Put to Better Use

As of September 30, 2013

| | Number | Disallowed Costs |
|---|---|---|
| A. Reports for which final action had not been taken by the commencement of the reporting period. See Note 1. | 7 | $ 439,029,967 |
| B. Reports on which management decisions were made during the reporting period. | 30 | 821,434,473 |
| **Subtotal (A + B)** | **37** | **$ 1,260,464,440** |
| C. Reports for which final action was taken during the reporting period: | | |
| i. The dollar value of recommendations that were actually completed based on management action or legislative action. | 24 | 149,503,974 |
| ii. The dollar value of recommendations that management has subsequently concluded should not or could not be implemented or completed. | | |
| **Subtotal (i + ii)** | **24** | **$ 149,503,974** |
| D. Reports for which no final action has been taken by the end of the reporting period. | 13 | $ 1,110,960,466 |

Notes:

1. Includes adjustments of amended disallowance and disallowance excluded from the previous reporting period.

# FY 2013 TOP MANAGEMENT AND PERFORMANCE CHALLENGES IDENTIFIED BY OFFICE OF INSPECTOR GENERAL (OIG)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

**TO:** The Secretary — December 12, 2013

Through: DS ________
COS ________
ES ________

**FROM:** Inspector General

**SUBJECT:** Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2013

This memorandum transmits the Office of Inspector General's (OIG) list of top management and performance challenges facing the Department of Health and Human Services (the Department). The *Reports Consolidation Act of 2000*, Public Law 106-531, requires OIG to identify these management challenges, assess the Department's progress in addressing each challenge, and submit this statement to the Department annually.

The OIG's top management and performance challenges for fiscal year 2013 are:

1) Overseeing the Health Insurance Marketplaces
2) Transitioning to Value-Based Payments for Heath Care
3) Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid
4) Protecting the Integrity of an Expanding Medicaid Program
5) Fighting Fraud and Waste in Medicare Parts A and B
6) Preventing Improper Payments and Fraud in Medicare Advantage
7) Ensuring Quality of Care in Nursing Facilities and Home- and Community-based Settings
8) Effectively Using Data and Technology to Protect Program Integrity
9) Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse
10) Ensuring the Safety of Food, Drugs and Medical Devices

OIG looks forward to continuing to work with the Department to identify and implement strategies to protect the integrity of the Department's programs and the well-being of the beneficiaries of these programs. If you have any questions or comments, please contact me, or your staff may contact Erin Bliss, Director of External Affairs, at (202) 205-9523 or Erin.Bliss@oig.hhs.gov.

/Daniel R. Levinson/

Daniel R. Levinson

## Management Challenge 1: Overseeing the Health Insurance Marketplaces

***Why This Is a Challenge***

The Health Insurance Marketplaces (Marketplaces), also known as the Health Insurance Exchanges, add a substantial new dimension to the Department's program landscape.

The Marketplaces include State, Federal, and Partnership Marketplaces, each of which must implement and successfully operate a complex set of program requirements. Individuals use the Marketplaces to get information about their health insurance options, be assessed for eligibility (for, among other things, qualified health plans, premium tax credits, and cost sharing reductions), and enroll in the health plan of their choice. Sufficient enrollment, including enrollment of relatively healthy individuals, is essential for producing a stable and effective insurance market.

The Department faces significant challenges in several key areas, including eligibility systems, payment accuracy, contractor oversight, and data security and consumer protection. Coordination among Federal and State agencies, private insurers, and contractors is necessary to achieve program objectives and poses an additional challenge to the Department.

*Eligibility Systems*. The Federally Facilitated Marketplace (FFM) operates via the Department's healthcare.gov website. Healthcare.gov also serves as a gateway for consumers to reach State-run Marketplaces. The Department has acknowledged that it faces significant, well-publicized challenges in ensuring that healthcare.gov operates successfully. These reported challenges include hardware and software issues. The Department must ensure that healthcare.gov verifies consumers' personal information; accurately determines eligibility for Marketplace insurance, tax credits, and cost-sharing subsidies; operates effectively and easily for consumers; and transmits complete, accurate, and timely information to insurers regarding enrollees. The Marketplaces must also successfully facilitate Medicaid enrollment for those who qualify (see Challenge 4, Protecting the Integrity of an Expanding Medicaid Program).

CMS operates and oversees the Data Services Hub (Hub), which allows for exchange of data between the Marketplaces and Government databases to verify applicant eligibility, in coordination with partners at the Social Security Administration, Internal Revenue Service (IRS), Department of Homeland Security, Department of Justice (DOJ), and the States.

The Department must also be attentive to State Marketplace operations to ensure States' compliance with requirements, including requirements for making eligibility determinations and for transmitting accurate and timely data used for purposes of Federal payments, such as determinations related to subsidies.

*Contractor Oversight*. Contractors have played, and will continue to play, a vital role in building, maintaining, and fixing the systems that underpin the FFM. Early reports reflected that these systems, as constructed, did not function as they were intended. The Department must ensure, to the greatest extent possible, that the Government obtains specified products and services from its various contractors on time and within budget. The Department faces a challenge to ensure proper management of, and payment under, the various contracts entered into for implementation and operation of the FFM, including the Hub. This challenge is heightened by, among other things, the large number of contracts and the need to coordinate work across multiple contractors. For general information on challenges associated with contract administration, see Management Challenge 9.

*Payment Accuracy*. Ensuring accurate payments related to the Marketplaces also poses a substantial management challenge. The Department needs to implement financial management and payment systems to ensure accurate and timely payments to insurers of advance premium tax credits, cost-sharing subsidies, and premium stabilization payments. These payments involve complex calculations and offsets, adjustments, and reconciliations, which pose challenges for making accurate payments. Monitoring and accounting for these payments can also be challenging. In addition, some payments will rely on information obtained from private insurers. The Centers for Medicare & Medicaid Services (CMS) will need to work closely with insurers to ensure that information is timely, complete, and accurate. Given the amount of Federal funds involved, the Department should undertake a thorough risk assessment and, where appropriate, develop error rates to measure the integrity of program payments.

*Security.* Effective operation of the Marketplaces requires rapid, accurate, and secure integration of data from numerous Federal and State sources and individuals who use the Marketplaces. It requires means for real-time communication among many Federal and State systems on a large scale. Because these systems handle consumers' sensitive personal information, security of data and systems is paramount. Where the Department offers consumers alternate pathways for enrollment that do not require consumers to use healthcare.gov, such as submitting paper applications or using a call center, the Department also must ensure that those pathways incorporate effective security and eligibility safeguards and work well for consumers and insurers.

Another key responsibility is educating consumers about the Marketplaces and how to use them. It is also important to educate consumers about protecting themselves from fraud schemes, such as identity theft, since criminals often take advantage of new programs. Potential fraud schemes include identity thieves posing as legitimate assisters offering to help individuals purchase insurance in exchange for money or personal identifying information; imposters misleading Medicare beneficiaries into falsely believing they need to purchase new insurance; and sham websites that appear to be legitimate. The Department must also ensure that navigators, agents and brokers, and other assisters are qualified and properly trained to help consumers and provide reliable information.

***Progress in Addressing the Challenge***

On December 1, 2013, the Administration reported significant improvement in the operations of healthcare.gov. The report identified improvement on several system performance metrics, including response time, error rate, system stability, and number of concurrent users.

With respect to the Hub, CMS obtained its necessary security authorization on September 6, 2013. OIG had reviewed CMS's implementation of security controls for the Hub from March through June 2013. CMS has reported that all key steps that remained at the time of our review have since been completed.

CMS has issued regulations and guidance regarding numerous aspects of the Marketplaces and the related subsidies and premium stabilization programs. This includes a final rule on program integrity provisions for the Marketplaces and related programs intended to safeguard Federal funds and protect consumers. In addition to these regulations, CMS reports providing technical assistance and other support to States regarding Marketplace implementation.

The Department and Office of Inspector General (OIG) are working closely with Government partners, including the Federal Trade Commission (FTC), DOJ, and State Attorneys General, among others, to prevent and respond to consumer fraud in connection with the Marketplaces. OIG and the Department have conducted consumer education and outreach on how to protect oneself against fraud and identity theft. The FTC and States have primary jurisdiction for responding to consumer fraud allegations, and OIG has updated the OIG fraud hotline to seamlessly route consumer fraud complaints to the FTC, as well as routing consumer inquiries about the Marketplaces to CMS.

***What Needs To Be Done***

The Department must continue to upgrade and improve healthcare.gov, including both the front-facing consumer functions, as well as the back-end administrative and financial management functions. The Department also must ensure that alternate pathways for enrollment operate with integrity and that consumers' personal information is secure. The Department must ensure that issuers and consumers receive accurate enrollment and subsidy information and that systems for paying insurers operate with sound safeguards and internal controls. States and consumers must receive accurate information about potential Medicaid enrollment. Vigilant monitoring and testing of the Marketplaces and rapid mitigation of identified vulnerabilities are essential.

The Department must address challenges in the short run to facilitate the ongoing open enrollment for 2014, when most people will be required to have health insurance. In addition, where the Department uses temporary mechanisms for the current enrollment period, the Department must develop permanent solutions that ensure the smooth and successful operation of the Marketplaces for special enrollment periods, the 2015 open enrollment period that is scheduled to start on November 15, 2014, and beyond. Moreover, the Department must address full implementation of the online SHOP Exchange.

The Department must also complete its development and implementation of financial management and payment systems and ensure that payments to insurers, which are scheduled to begin in January 2014, are accurate. While in the near-term the Department faces immediate challenges related to healthcare.gov operations, eligibility verification, payment accuracy, contracting, and security of data, the Department will face continuing challenges as the program evolves over time. The Department will need to adjust its management and oversight approaches accordingly to ensure that problems are prioritized and addressed. As with other new programs, the Department must monitor for known fraud, waste, and abuse risks and detect emerging new risks to protect the Federal investment in health care reform. If fraud schemes are identified, the Department must respond quickly and effectively.

Further, the Department must continue to coordinate closely with States and with other Federal agencies to monitor the operations and security of the Marketplaces and to implement the subsidies and other programs that begin on January 1, 2014. OIG will monitor the implementation and operations of the Marketplaces and plans to conduct oversight work initially focused on core risk areas, such as eligibility systems, payment accuracy, IT security, and contracting. In particular, OIG will conduct an audit of safeguards to prevent the submission of fraudulent or inaccurate information pursuant to the mandate at Public Law 113-46, Section 1001(c). OIG is coordinating closely with its oversight partners at GAO, other IGs (such as the Treasury IG for Tax Administration), and State auditors to develop complementary work and maximize the Government's limited oversight resources.

***Key OIG Resource***

- OIG testimony on security controls for the data services hub, September 2013

## Management Challenge 2: Transitioning to Value-Based Payments for Heath Care

***Why This Is a Challenge***

To secure the future of the public health care programs, the Department must be vigilant in reducing waste and increasing value in health care. The Institute of Medicine (IOM) estimated that 20-30% of U.S. Health Spending (public and private) in 2009—roughly $750 billion – was wasted. Other estimates suggest similar levels of waste. Waste in health care programs is a multi-dimensional problem. The IOM report identified six major areas of waste: unnecessary services, inefficient delivery of care, excess administrative costs, inflated prices, prevention failures, and fraud. OIG work has identified waste in these areas; see also Management Challenges 3, 4, 5, 6, and 7 for more discussion on issues specific to prescription drugs, Medicaid, Medicare Parts A & B, Medicare Advantage (MA) and quality of care.

There is widespread agreement among experts that the incentives created by paying for health care based on the volume of items or services furnished, generally known as a fee-for-service system, contributes to waste in health care by encouraging unnecessary utilization and fragmented, poor quality care. Moreover, poor quality care harms beneficiaries and can result in additional costs; for example, OIG found that adverse events (i.e., patient harm caused by care) for hospitalized Medicare beneficiaries cost over $4 billion in one year. For these and other reasons, the Department is transitioning to value-based payments in Medicare and Medicaid intended to produce higher quality care at lower costs, in part by rewarding high-quality care, penalizing low -quality care, or enhancing care coordination. These models include, for example, value-based payments for hospitals, penalties for hospital readmissions, pay-for-performance systems, shared savings programs, gainsharing, care coordination payments, and bundled payments. These new models hold promise for improving health care delivery and efficiency; at the same time, they present long-standing and new program-integrity challenges.

<u>Aligning Incentives.</u> In a complex health care system, designing payment mechanisms that encourage desired goals (e.g., quality outcomes and cost efficiencies) while avoiding incentives that lead to unintended and undesirable outcomes (e.g., overutilization or stinting on care) is a key challenge. This is a particular challenge for models that use the traditional fee-for-service payment structure alongside, or in addition to, value-based payments, such as the Medicare Shared Savings Program, which includes both fee-for-service payments and shared savings payments. When considering such hybrid payment methodologies, it is important to carefully assess: (1) the financial incentives that arise from each payment component, (2) new or different financial incentives that might arise from their combination, and (3) the potential fraud, waste, and abuse risk areas corresponding to the multiple types of payment. Longstanding program and enforcement experience illustrates that how Medicare and Medicaid pay for services influences the types of misconduct that arise. For example, fee-for-service payments raise the risk of overutilization and payment for unnecessary services; some risk-based or bundled payments may reduce overutilization risks, but increase risks of underutilization or stinting on care. For models that are untested for the Department and for providers under Medicare and Medicaid, it can be challenging to anticipate and account for all of the potential impacts – both benefits and risks – of significant changes in payment methodology.

An additional challenge arises because certain initiatives could raise costs in one part of a program but lead to greater savings elsewhere. For example, greater investments in chronic disease management could improve patients' overall health and reduce the need for expensive emergency care. Similarly, effective care coordination across multiple programs – such as for individuals eligible for both Medicare and Medicaid -- is important not only because of the potential for better patient care, but also because costs may increase for one program but decrease under another. For example, increased use of personal care services (covered by Medicaid) may increase Medicaid and therefore States' costs while saving money for Medicare and the Federal Government by reducing or avoiding hospitalizations. The Department needs to be mindful of these incentives when structuring cross-cutting care coordination initiatives.

*Program Design and Integrity*. Designing, implementing, and overseeing many new and sometimes complex payment models and demonstrations, combined with the complexity and scope of the Medicare and Medicaid programs and evolving health care landscape, poses significant management and program integrity challenges. Designing payments and programs with incentives in mind is essential, but it is only one facet. The Department must track and coordinate new models to ensure effective administration and must be alert to issues that impact more than one program, such as provider participation and beneficiary alignment. The Department must continually review the underlying market and provider practice assumptions, including those related to quality, on which payment structures and the resulting payments are based. The Department must be alert to new program integrity risks that may emerge as a result of changing financial incentives and deploy appropriate program integrity tools to prevent and detect fraud, waste, and abuse.

Getting value-based payment structures and rates right can be difficult. OIG work has illustrated the challenges in structuring accurate bundled payments, which cover related services and/or products or an episode of care. For example, OIG found that Medicare's bundled payment for global surgery fees, which provides one fee for the surgery and related pre- and post-surgical care, has not been adjusted to reflect evolving physician practices. As a result, the payment model assumes more services than are typically provided, resulting in inflated payments. Examples of other design and rate setting challenges include ensuring that payment bundles avoid creating incentives and opportunities to furnish and bill for services outside the bundle to increase payments, that providers participating in multiple incentive payment programs are not receiving duplicative incentive payments, and that payment mechanisms encompassing services furnished across multiple provider settings work properly and reimburse correctly.

*Integrity of Information*. When payments are linked to quality, outcomes, or performance, the Department must ensure the reliability of underlying data. Many value-based payment mechanisms rely on complex data, electronic health information, and sophisticated quality and performance measures. To ensure reliable results, data must be accurate, complete, and timely. Measures must be appropriate and meaningful. Outcomes must be correctly assessed to ensure correct payment. When quality or performance is determined on the basis of Medicare or Medicaid claims billed, ensuring accurate and reliable claims information – and detecting improper claims -- is also critical.

In addition, the data CMS provides to the industry must be accurate. For example, programs such as the Pioneer Accountable Care Organization (ACO) Model, the Medicare Shared Savings Program (MSSP), and the Medicare fee for service (FFS) Physician Feedback Program call for CMS to provide performance or clinical data to providers so they can use it to improve the care they furnish. To be effective, the data must be correct, the metrics meaningful, and the information usable.

In sum, the linkage between quality, performance, and payment presents new challenges for administering Medicare and Medicaid payment systems.

***Progress in Addressing the Challenge***

The Department is continuing to implement value-based payment programs and develop new demonstration programs. CMS recently reported positive initial results from the first year of the Pioneer ACO program – all ACOs achieved quality goals, and 13 ACOs generated a total savings of $87.6 million, of which $33 million was returned to the Medicare Trust Fund. In 2013, CMS began implementing the Bundled Payment for Care Improvement (BPCI) Initiative, which includes four models testing different payment mechanisms that include quality and accountability measurements. CMS continues to develop, implement, and test new value-based payment structures.

The Department has taken steps to foster integrity in these new programs, as illustrated by the regulations for the MSSP and Participation Agreements for the BPCI Initiative, which incorporate various safeguards intended to mitigate potential vulnerabilities. It is too early to assess the outcomes of these program integrity efforts, but CMS's attention to, and integration of, safeguards into the design of the MSSP and BPCI Initiative demonstrate a focus on program integrity that should be replicated in all programs.

CMS has reported that it is developing management and tracking systems and procedures to support new value-based payment structures and other new models. CMS also reports that it has established internal review processes to promote the use of effective measurement strategies, to coordinate across components regarding quality measurement, and to identify areas where beneficiaries are impacted by more than one value-based payment initiative. CMS also provides technical assistance to participants in new models.

***What Needs to be Done***

The Department should continue to prioritize the effective transition to value-based payment mechanisms and the development and refinement of quality, outcomes, and performance metrics. Data systems supporting programs that link payment to quality and value must be scrutinized for timeliness, accuracy, and completeness. The Department should continue to develop and maintain internal controls to ensure effective coordination among value-based payment programs and to avoid duplicative payments and operational inefficiencies. The Department must scrutinize bundled payments, shared savings programs, and other value-based payments to ensure that payment methodologies are appropriate, payments are calculated accurately, and that performance-based incentives are aligned with beneficial outcomes for Medicare, Medicaid, and patients. CMS should also continue its efforts to provide technical assistance to participants in its demonstration and other value-based programs.

CMS should continue to strengthen its program integrity tools and apply them as needed to ensure integrity in new models. In overseeing new models, the Department should monitor financial incentives to ensure that they achieve quality and efficiency goals and do not result in undesirable outcomes. The Department's oversight is critical and must consider the full range of potential risks. For example, shared savings or bundled payments may pose a heightened risk of stinting or underutilization compared to traditional fee-for-service payments, for which the larger risk may be provision of unnecessary care or overly expensive care. Models that incorporate both types of payments may raise both types of risks or different risks. CMS must continue to assess emerging fraud, waste, and abuse risks in new models and, as necessary, develop and implement new tools to detect and prevent them. Moreover, the Department should continue to monitor cost, quality, utilization, outcomes, and experience of care and to disseminate lessons learned to improve new programs.

As demonstration programs continue to unfold, the Department should carefully monitor for successes and benefits that can be scaled and replicated, as well as for potential problems -- including inefficiencies, misaligned incentives, or abuses. The Department must rigorously evaluate results of demonstration programs and other new value-based purchasing payment mechanisms. As with any innovation and experimentation, missteps may occur; it is critical that the Department address missteps effectively and take appropriate actions to prevent their recurrence.

## Management Challenge 3: Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid

***Why This Is a Challenge***

Ensuring the appropriate use of prescription drugs by Medicare and Medicaid beneficiaries is vital for financial reasons as well as patient safety and quality of care. In 2012, Medicare Part D provided prescription drug coverage to more than 37 million beneficiaries at a cost of almost $67 billion. In 2010, Medicaid provided prescription drug coverage to 28 million beneficiaries at a cost of $19 billion. The following are concerns about appropriate prescribing and dispensing of drugs as well as deficiencies in the safeguards intended to protect beneficiaries and the programs from drug overutilization, fraud, and abuse.

*Prescription Drug Diversion and Abuse*. The Centers for Disease Control and Prevention (CDC) has characterized prescription drug abuse as an epidemic, and in 2010, overdose of prescription painkillers was one of the leading causes of accidental death in the United States. Prescription drug abuse is a serious and growing problem for Medicare Part D and Medicaid – OIG's investigations of abuses in this area have increased dramatically over the past 5 years. Prescription drug diversion is a complex crime that involves many co-conspirators, ranging from simple street traffickers to complex criminal enterprises of health care professionals, pharmacies, and even patients. Fraud schemes bill Medicare and Medicaid for services and drugs that are unnecessary or never provided, resulting in patient harm and financial loss to the program.

Prescription drug fraud and diversion often involve controlled drugs but can also include billing for unnecessary non-controlled prescriptions. For example, an OIG investigation led to the conviction of a pharmacist who owned 26 pharmacies and used an elaborate web of physicians, pharmacists, and patient recruiters to fraudulently bill Part D and Medicaid. This pharmacist paid kickbacks, bribes, and other inducements to physicians to write unnecessary prescriptions for controlled drugs and expensive non-controlled drugs. The physicians directed their patients to fill their prescriptions at 1 of the 26 pharmacies, which then billed Medicare and Medicaid for unnecessary controlled substances it dispensed to the beneficiaries and for expensive non-controlled drugs that it did not dispense.

*Prescriber Qualifications.* As a basic safeguard, prescription drugs must be prescribed in accordance with State law by an appropriate medical professional to qualify for Part D reimbursement. This safeguard is not operating as effectively as it should; Medicare Part D inappropriately paid $5.4 million in 2009 for 72,552 prescriptions written by unauthorized prescribers, such as massage therapists, veterinarians, and athletic trainers. Medicare should never pay for drugs ordered by unauthorized individuals.

*Questionable Prescribing and Billing Patterns.* OIG has identified questionable prescribing by hundreds of general-care physicians. Some 736 physicians demonstrated extreme patterns of prescribing relative to their peers with respect to: number of drugs prescribed per beneficiary; number of pharmacies filling their prescriptions; percentages of expensive brand-name drugs; or percentages of Schedule II drugs like morphine and oxycodone, which are more susceptible to abuse. In total, Medicare paid $352 million for Part D drugs ordered by questionable prescribers in 2009.

In addition, OIG uncovered questionable billing patterns by 2,637 retail pharmacies nationwide with billing patterns far outside the norm. These pharmacies billed extremely high numbers of drugs per beneficiary or per prescriber or billed extremely high percentages of Schedule II or III drugs, brand-name drugs, or refills relative to other pharmacies. In 2009, Medicare paid these pharmacies a total of $5.6 billion. It is important to note that while these practices are not necessarily fraudulent they raise flags that warrant further attention.

*Schedule II Refills.* Federal law requires an original prescription each time a Schedule II drug is dispensed; nonetheless, OIG found that Medicare Part D inappropriately paid $25 million for Schedule II drugs billed as refills in 2009. Part D plan sponsors should not have paid for Schedule II refills. Paying for refills of these addictive drugs raises public health concerns and may contribute to the diverting of controlled substances. Three-quarters of Part D plan sponsors paid for these refills, indicating that many do not have adequate controls in place.

*Atypical Antipsychotic Drug Use In Nursing Homes.* OIG has raised concerns about overmedication of Medicare nursing home residents, particularly the use of atypical antipsychotic drugs for beneficiaries with dementia. More than 20 percent of claims for atypical antipsychotic drugs for Medicare patients in nursing homes indicated a failure to satisfy Federal standards that protect nursing home residents from unnecessary drug use. OIG also found that nursing homes generally were not meeting all requirements for assessments and care plans for residents receiving antipsychotics.

*Ineffective Oversight of Part D Utilization.* Part D plan sponsors and CMS's Medicare Drug Integrity Contractor (MEDIC) are key lines of defense in identifying and addressing drug overutilization, fraud, and abuse. However, OIG found evidence that oversight is inconsistent across sponsors and may be lacking overall. Some plan sponsors did not identify any potential fraud, waste, and abuse incidents; most potential fraud, waste, and abuse incidents were associated with only a small number of plan sponsors. In addition, the MEDIC has not fully utilized data analytics to identify potential fraud, waste, and abuse.

***Progress In Addressing the Challenge***

CMS has taken steps to strengthen oversight of appropriate drug utilization in Medicare Part D. For example, CMS responded to a prior OIG recommendation by requiring that all Part D claims submitted to CMS include a valid National Provider Identifier for the prescriber – this safeguard is one step toward ensuring and monitoring appropriate prescribing. Plan sponsors are required to maintain compliance programs to help detect, prevent and correct fraud, waste, and abuse. CMS also provided guidance and educational outreach to sponsors and providers about the overutilization of prescription drugs, including support for State Prescription Drug Monitoring Programs. Moreover, CMS has increased monitoring of prescribers through the Part D Recovery Audit Contractors (RACs), which identify and recover Part D improper payments. CMS has also reported providing information and guidance to sponsors about high risk pharmacies and prescribers to combat prescription drug diversion. In addition, CMS has reported taking steps to redirect the MEDIC to focus more acutely on proactive data analysis.

CMS has also described its efforts to curb overprescribing by developing metrics at the beneficiary level that trigger follow-up actions. If a beneficiary's drug use exceeds certain clinical standards, this triggers a review of the beneficiary's medical management by his/her physician(s). If this review does not substantiate a clinical need for the high utilization, the Part D plan will implement prior authorization reviews for that beneficiary's claims.

In March 2012, CMS launched the National Partnership to Improve Dementia Care (the Partnership), aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. The Partnership set a goal to reduce antipsychotic drug use in nursing homes by 15 percent by the end of 2012, and CMS reported a national drop in antipsychotic use of 11.4 percent by the second quarter of 2013. CMS also provided guidance and training in May 2013 to assist surveyors in determining whether nursing homes are meeting minimum standards of care governing antipsychotic drug use.

***What Needs To Be Done***

In addition to the steps described above, CMS must take further action to ensure that each claim for a prescription contains both a valid identifier and authorized prescriber. Additionally, CMS should ensure that the MEDIC routinely analyzes billing data to detect pharmacies and providers with extreme billing patterns. CMS should also require that sponsors identify and refer potential fraud, waste, and abuse to CMS for further review. CMS must

also better ensure that Part D plans do not pay for prohibited refills of Schedule II drugs. In addition, CMS needs to implement its plans described to OIG to develop predictive models and utilize data analytics that will target aberrant billing patterns in the future.

OIG remains concerned that some instances of atypical antipsychotic drug use by nursing home residents may not represent the best clinical care for the patients; in addition, inappropriate Part D payments for some of these prescriptions may persist. CMS should facilitate access to information, like diagnosis codes, that are necessary to ensure appropriate care and accurate coverage and reimbursement determinations.

***Key OIG Resources***

- Testimony of Deputy Inspectors General on Curbing Prescription Drug Abuse in Medicare. June 24, 2013
- Medicare Atypical Antipsychotic Drug Claims For Elderly Nursing Home Residents. May 2011

## Management Challenge 4: Protecting the Integrity of an Expanding Medicaid Program

***Why This Is a Challenge***

In 2014, States have the option to expand Medicaid eligibility to qualifying adults earning up to 133 percent of the Federal poverty level. In addition to the challenges in implementing this expansion, increases in the Medicaid population and spending also heighten the urgency of addressing the program integrity challenges that Medicaid already faces. These include reducing waste associated with excessive payment rates, avoiding or recovering Medicaid improper payments and payments for which a third party is liable, and preventing fraud, waste, and abuse in Medicaid managed care programs. (Other key challenges for Medicaid are addressed elsewhere – prescription drug abuse in Management Challenge 3; vulnerabilities in nursing homes and home- and community-based settings in Challenge 7; and limitations in the national Medicaid database in Challenge 8.)

*Expansion of Medicaid Eligibility*. For individuals who are "newly eligible" under the Affordable Care Act (ACA) expanded income limits, the Federal Government will pay the full costs of their care through 2016; after which the Federal share gradually falls to 90 percent by 2020 and continues at 90 percent thereafter. For other Medicaid beneficiaries, the Federal Government will continue to share costs with States according to its standard Federal Medical Assistance Percentage (FMAP), which ranges by State from 50 to 74 percent. These eligibility expansions are expected to increase the number of Medicaid beneficiaries and Federal spending on Medicaid significantly. Many individuals eligible for Medicaid will use the ACA created Marketplaces to enroll in Medicaid and thus the Marketplaces must effectively facilitate that enrollment (see Challenge 1, Overseeing the Health Insurance Marketplaces.)

Challenges involve the implementation of this expansion and the financial and internal controls needed to ensure that the Federal Government pays the appropriate share of costs for each beneficiary depending on the criteria under which he or she qualified for coverage. It may be challenging to apply Medicaid eligibility requirements accurately, and to the extent that States miscategorize beneficiaries, the financial implications for the Federal and State financial shares could be significant.

*Problems Identifying and Recovering Improper Payments*. OIG found that CMS Federal Medicaid Integrity Contractors (MIC) had limited success identifying Medicaid overpayments. Review MICs initially identified over 113,000 providers with potential overpayments of $282 million, but after performing audits, the Audit MICs found actual overpayments to only 25 of these providers, totaling less than $300,000. Likewise, 80 percent of the audits that OIG reviewed either did not find an overpayment or were unlikely to find overpayments. OIG found similarly limited results for Medicaid from the Medicare-Medicaid Data Match program (Medi-Medi Program). Of the total

$46.2 million in expenditures recouped through the program during 2007 and 2008, more than three-quarters – $34.9 million – was recouped for Medicare.

OIG has also found that longstanding challenges persist in recovering payments from third parties. Millions of Medicaid beneficiaries have additional health insurance through third-party sources. If beneficiaries have another insurance source, it should pay before Medicaid does, up to the extent of its liability. However, since 2001, States have consistently reported challenges in getting third parties to provide complete coverage information and to process or pay claims. As a result, as of 2011, $4 billion in claims remained at risk of not being recovered.

*Program Integrity in Managed Care Programs*. As of 2011, almost three-quarters of all Medicaid beneficiaries were enrolled in some type of managed care system. The private plans and Medicaid share financial risk; fraud, waste, and abuse by health care providers or beneficiaries drive up costs for both the plans and Medicaid. Fraud or abuse by the managed care plan (e.g., manipulating its bids) can further increase Medicaid costs.

CMS's guidelines identify six areas of fraud, waste, and abuse in Medicaid managed care: (1) managed care contract procurement, (2) marketing and enrollment, (3) underutilization of services, (4) claims submission and billing procedures, (5) fee-for-service payments within managed care, and (6) embezzlement and theft. OIG found that the predominant concerns of both States and plans were provider fraud – billing for services that were not provided, medically unnecessary, or upcoded – and beneficiary fraud including prescription drug abuse.

*Excessive Payments to Public Providers*. OIG has raised long-standing concerns about States' Medicaid payment rates to public providers. For example, we found that in 2009, New York Medicaid paid $2.27 billion ($1.13 billion Federal share) to 15 State-run developmental centers. New York's payments to these centers were not based on actual costs. If New York had used actual costs in its rate-setting, Medicaid reimbursements to the developmental centers could have been up to $1.41 billion lower that year, saving the Federal Government up to $701 million.

In some cases, the excess Medicaid payments are returned to the State and not retained by the facilities to provide care to Medicaid beneficiaries. In essence, this can serve as a mechanism for States to use Federal Medicaid funds to subsidize non-Medicaid costs.

***Progress In Addressing the Challenge***

CMS has reported that it is working to promote program integrity with respect to the Medicaid expansion by providing tools and technical assistance to the States, developing new procedures and practices for ensuring eligibility verification and payment accuracy, and training State staff on reporting and accounting for expenditures associated with newly eligible individuals.

CMS has also reported actions to improve the MIC and Medi-Medi programs consistent with OIG recommendations, such as assigning more Medicaid audits through the collaborative process, which showed greater success than the traditional process. This progress includes assigning 516 collaborative audits in 32 States as of August 2013. CMS is also reconfiguring its approach to Medicaid program integrity contractors, including letting the Review MIC contracts expire. In the future, CMS expects to develop a Unified Program Integrity Contractor model in which program integrity contractors will cover Medicare and Medicaid.

In addition, CMS stated that it will continue working with States and third parties to address problems identified by States with identification and collection from liable third parties. CMS also stated that it will review existing authorities to identify options for increased enforcement to deal with uncooperative third parties.

In 2011, OIG reported that States and managed care plans were taking important steps to protect against fraud, waste, and abuse. These included providing program integrity training to managed care plans' staffs and to providers in their networks. States conduct desk reviews of managed care plans' compliance plans, and many States also conducted onsite reviews. States also reported requiring managed care plans to disclose ownership and control information. CMS is working to update guidelines to States on program integrity in Medicaid managed care settings.

Finally, CMS is continuing to work with New York to revise its methodology for Medicaid payments to State-run developmental centers to better align them with costs. In addition, CMS issued guidance on Medicaid upper payment limits and is requiring all States to demonstrate annually the upper payment liability to the Federal Government for services that are subject to these limits.

***What Needs To Be Done***

CMS should continue its efforts to develop robust oversight for the Medicaid expansion. CMS must be vigilant in addressing program integrity risks associated with the expansion, including monitoring States' compliance with eligibility requirements and FMAP expenditures.

CMS should continue to build on its progress addressing MIC and Medi-Medi performance in identifying Medicaid overpayments. In particular, CMS should expand its use of collaborative audits to ensure that all States and the District of Columbia are actively engaged with the MICs in the identification and auditing of providers.

CMS should work with States to explore options to strengthen enforcement of third party liability. CMS could facilitate a conversation with States about additional enforcement authorities at the State and Federal levels.

Given that concerns about identifying fraud and abuse remained among States and plans, particularly with respect to provider and beneficiary fraud, CMS should update guidance to States to reflect these concerns. CMS should work with States to ensure that contracts with managed care organizations contain adequate provisions for the identification and referral of potential fraud cases.

OIG recommends that Medicaid payments to public providers be limited to the costs of providing services. In 2008, CMS issued a final rule that, among other things, would limit Medicaid payments to public providers to their costs of providing care, but the rule was ultimately vacated by Federal District Court. CMS should issue new regulations to prevent excessive payments to public providers.

***Key OIG Resources***

- Office of Inspector General testimony on Medicaid overpayments to public providers. September 20, 2012
- Office of Inspector General testimony on Medicaid contractors. June 14 2012
- Medicaid Third-Party Liability Savings Increased, But Challenges Remain. January 2013
- Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards. December 2011

## Management Challenge 5: Fighting Fraud and Waste in Medicare Parts A & B

***Why This is a Challenge***

While all fraud is waste, not all waste is fraud. Waste is inefficiency that may be, for example, a medically unnecessary service, inefficient delivery of care, inflated prices, excess administrative costs, or prevention failures, and as such, addressing it is a multi-dimensional problem. (For challenges related to maximizing value in health care, see Management Challenge 2.) The Department must take necessary steps to address improper payments and payment inefficiencies that waste Medicare dollars and divert finite resources away from beneficiary care and services. In fiscal year (FY) 2013, CMS reported an error rate of 10.1 percent for Medicare Fee-for-Service. This exceeds the 10-percent threshold set by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and is an increase from FY 2012.

*Waste.* OIG work has spotlighted various types of waste in Medicare Parts A and B:

- *Hospital Billing Errors:* Our reviews of hospital's billing compliance have consistently found inappropriate claims for inpatient and outpatient services. Some of the most common problems include billing for short inpatient stays that should have been billed as outpatient or outpatient-with-observation services, transfers to other hospitals or post-acute care, incorrect diagnosis codes that result in higher payments, same-day discharges and readmissions, billing separately for services that should be bundled into the inpatient bill, and unreported credits from medical device manufacturers.
- *Improper Payments to Skilled Nursing Facilities (SNFs):* SNFs billed one-quarter of all claims in error in FY 2009, resulting in $1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded, i.e., the SNF reported a higher level of therapy than was provided, resulting in an inflated payment. In other cases, a SNF provided a higher level of therapy than the Medicare patient needed or could benefit from.
- *Misaligned Payment Rates:* OIG compared Medicare payments for 20 high-volume/high-expenditure lab tests to payments by State Medicaid and Federal Employees Health Benefit plans and found that Medicare paid between 18 and 30 percent more than other payers. Medicare could have saved up to $901 million in 2011 if it had paid providers at the lowest established rate in each geographic area. In another example, Medicare's bundled payments for global surgery fees have not always been adjusted to reflect evolving physician practices; in certain instances, the OIG has found that fewer services are provided than assumed in Medicare's payment model. Revising the payment methodology to more closely reflect the services typically provided in medical care today could result in more efficient provision of surgical services.

RACs are one important tool that CMS uses to identify and recover improper payments. In FYs 2010 and 2011, RACs identified errors in half of all claims they reviewed, resulting in improper payments totaling more than $1 billion. CMS took corrective actions to address the majority of vulnerabilities identified by the RACs in FYs 2010 and 2011. However, CMS may not be taking full advantage of this tool, as it did not evaluate the effectiveness of its corrective actions therefore, significant improper payments continue. In addition, CMS's RAC performance evaluations did not include metrics to evaluate compliance with all contract requirements.

*Fraud.* Fraud is one significant cause of waste in Medicare, resulting in funds being paid for services or products that were not rendered, were not medically necessary, or did not meet quality standards. Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries, and the Department must continue to direct all necessary resources toward fraud prevention, detection, and remediation. Adding to this challenge, fraud is a crime of deception, and perpetrators design their schemes to make claims appear legitimate.

Fraud schemes shift over time, but certain Medicare services have been consistent targets. OIG work has consistently raised concerns about fraud in Medicare Parts A & B. For example, OIG investigations continue to uncover durable medical equipment (DME) suppliers, home health agencies, community mental health centers, ambulance operators, and outpatient therapy providers that are defrauding the Medicare program. In national assessments, OIG has identified questionable billing patterns by home health agencies and community mental health centers and is conducting similar analysis of questionable billing by ambulance providers.

CMS's contractors play a key role in fighting Medicare fraud. However, there are indications that CMS is not realizing the full potential of this oversight tool. In 2011, OIG found that four of the Zone Program Integrity Contractors (ZPICs) did not identify any vulnerabilities related to home health, despite this being a source of numerous fraud investigations and convictions at that time, and the ZPICs varied substantially in their efforts to detect and deter fraud. Medicare also inappropriately paid some home health agencies with suspended or revoked billing privileges. In another review, we found that only one of nine Medicare Administrative Contractors (MACs) performed activities to detect and deter fraud by community mental health centers (another provider type known to have high risk for fraud) in 2010; most of these activities were part of a CMS-led special project. Other contractors performed minimal activities to detect and deter fraudulent billing by community mental health centers, despite having jurisdiction over fraud-prone areas. Additionally, Medicare paid community mental health centers that did not comply with its requirements after their revocations were effective and while their revocations were being processed.

***Progress in Addressing the Challenge***

The Department has made progress in its fight against fraud in Medicare Parts A & B. The Health Care Fraud Prevention and Enforcement Action Team (HEAT) operations, including the Medicare Fraud Strike Force teams, have demonstrated reductions in claims submitted to Medicare and payments made by Medicare for Part A & B services susceptible to fraud, including DME suppliers, home health agencies, and community mental health centers. Medicare Fraud Strike Force operations also have taken down ambulance and outpatient therapy fraud schemes. Significantly, CMS for the first time used the provider enrollment moratoria authority granted by the ACA. CMS instituted 6-month moratoria on the enrollment of new home health agencies in the Miami and Chicago areas, and ambulance suppliers in the Houston area. CMS continues to use its payment suspension authority to stop payments to certain providers and suppliers suspected of fraud. Another of CMS's major tools in fraud prevention is the Fraud Prevention System – this is discussed in Management Challenge 8.

CMS reported that it has improved its performance metrics for the ZPICs for all contracts that take effect in FY 2014. According to CMS, these new metrics will evaluate the contractors' performance in critical program integrity areas, including the accuracy and timeliness of implementing payment suspensions and revocations. CMS also reported efforts to improve coordination between RACs and ZPICs. It added to the RAC Statement of Work a requirement to meet with the ZPICs at least quarterly to discuss potential fraud referrals and trends they are seeing in the applicable jurisdictions.

The Department has also made progress in combatting waste in Medicare Parts A & B. CMS issued a final rule to implement its Hospital Readmissions Reduction Program, effective October 1, 2012, under which Medicare payments may be reduced to applicable hospitals with high patient readmission rates. In that same final rule, CMS also expanded its list of existing hospital-acquired conditions with some updated billing codes and added two new conditions to this list. CMS also issued a final rule in August 2013 that modifies and clarifies review and payment rules regarding inpatient hospital admissions and services under Parts A & B, which it expects will lower improper payments in this problem area.

In addition, the Department continues to implement the Competitive Bidding Program for DME, which holds promise for addressing prior OIG findings that Medicare paid significantly more than market prices for many types of DME. Regarding global surgery fees, CMS indicated that it will continue to work in conjunction with the American Medical Association Relative Value Update Committee and relevant specialty societies to identify potentially mis-valued services. CMS annually reviews hundreds of codes, many of which are codes with global surgery periods. CMS also continues to monitor hospice claims at each MAC through inclusion of hospice as part of their medical review strategies for the year.

***What Needs to be Done***

Fraud in Medicare Parts A & B remains a major challenge, and experience shows that schemes migrate among provider and supplier types as well as geographically. The Department must improve its use of data and program integrity tools to address shifting fraud schemes. For example, CMS should consider instituting additional temporary enrollment moratoria for certain types of providers in geographic areas at significant risk for fraud. Also, CMS should implement the surety bond requirement for home health agencies, and CMS should consider increasing surety bond amounts above $50,000 for those home health agencies with high overall Medicare payment amounts.

CMS should continue to build on its progress in addressing program integrity contractor performance and oversight challenges, including developing additional performance evaluation metrics, particularly for high-risk providers such as home health agencies and community mental health centers in fraud-prone areas. CMS also should facilitate increased collaboration between RACs and program integrity contractors and provide training to RACs to help them refer potential fraud, as appropriate.

More needs to be done to reduce improper payments. For instance, CMS should increase and expand reviews of claims by SNFs and follow up with SNFs that billed in error. CMS should also address payment inefficiencies, such as adjusting bundled payments for surgery fees, and should seek legislative fixes where necessary, for example, by seeking legislative authority to reduce Medicare payments for lab tests.

***Key OIG Resources***

- Example of one of numerous hospital audits (North Shore Medical Center). March 2013
- OIG Spotlight on "Bad Bargains" (payment misalignments). August 2013
- OIG Spotlight on Skilled Nursing Facilities. February 2013
- Summary of Medicare Fraud Strike Force cases and accomplishments in OIG's Semiannual Report to Congress, April 2013. (See pages 35-36)
- Selected OIG reports on CMS contractors – RAC oversight and actions to address improper payments, August 2013; ZPICs' and MACs' oversight of home health. December 2012
- OIG report on questionable billing by community mental health centers. August 2012

## Management Challenge 6: Preventing Improper Payments and Fraud in Medicare Advantage

***Why This is a Challenge***

Improper payments to MA plans pose a significant vulnerability for CMS and cost taxpayers billions of dollars. In FY 2013, the Department reported an error rate of 9.5 percent for MA, corresponding to an estimate of almost $11.8 billion in improper payments (consisting of about $9.3 billion in overpayments and about $2.6 billion in underpayments). The MA error rate measures errors related to risk-adjustment payments.

In general, Medicare makes capitated payments to MA organizations to deliver a specified set of health care benefits to qualified beneficiaries. MA organizations submit bids to CMS related to their expected costs for the upcoming year to calculate a standard monthly payment rate per beneficiary. This standard rate is then risk-adjusted (increased or decreased) based on the health characteristics of individual enrolled beneficiaries; i.e., Medicare will make higher monthly payments on behalf of sicker beneficiaries. To calculate risk-adjustment payments, MA organizations submit beneficiaries' clinical diagnoses to CMS. If a diagnosis submitted is not supported by the beneficiary's medical record, the risk-adjustment will be inaccurate and result in payment errors.

OIG has audited risk-adjustment payments to MA organizations. In OIG audits of six MA organizations' risk data from payment year 2007, we identified approximately $650 million in aggregate extrapolated overpayments to these plans because the medical records did not support the reported diagnosis.

Improper payments by MA organizations to providers (including those resulting from provider fraud) also raise concerns. These improper payments are not measured or reported in the MA error rate because CMS does not reimburse MA organizations on a claim-by-claim basis. However, such improper payments raise costs for MA organizations, and in turn, raise costs for Medicare and beneficiaries.

MA organizations share risk with the Government and have incentives to detect and prevent fraud; however, not all MA organizations have done so effectively. OIG found wide variability across MA organizations in their identification and reporting of fraud and abuse incidents (ranging from 1 incident to 1.1 million incidents). In addition, not all MA organizations took appropriate steps to respond to suspected fraud incidents.

Further, OIG found that from 2010 to 2011, CMS's contractor charged with oversight of MA program integrity (known as the MEDIC) produced limited results and faced significant barriers to effectively safeguarding this program. For example, lack of a centralized MA data repository hindered the MEDIC's ability to identify and investigate MA fraud and abuse. The MEDIC also lacked administrative authority to recommend recoupment of payments associated with inappropriate services.

***Progress In Addressing the Challenge***

CMS's reported error rate for MA decreased from 11.4 percent for FY 2012 to 9.5 percent for FY 2013. CMS described changes to its process for measuring MA payment errors in FY 2013 intended to ensure that the error rate reflects MA organizations' submissions of inaccurate diagnoses and not "false positives" associated with the procedures for submitting medical record documentation. These changes included extending the time allotted for MA organizations to submit medical records, providing interim feedback on the validity of those records, and providing preliminary coding results to MA organizations.

CMS has reported that it is implementing three initiatives to reduce the errors in risk-adjustment data and resulting improper payments. One is by contracting for audits of risk-adjustment data to verify the accuracy of plan-reported diagnoses through medical record review and recouping improper payments identified by these audits. CMS launched these audits in November 2013 and plans to audit about 30 MA contracts per year. The second is conducting training for MA organizations about accurate diagnosis reporting, including identifying the

diagnoses most often resulting in errors. The third is educating physicians to improve their medical record documentation in support of patient diagnoses.

Building on a model for identifying and collecting overpayments for Medicare Parts A & B, the ACA required CMS to develop a RAC program for MA. CMS is working to implement this requirement.

CMS has updated its reporting requirements for the MEDIC to better oversee its performance in safeguarding MA program integrity. CMS has reported that the MEDIC has access to a new data source, which facilitates analysis of a large volume of data and increases data storage capacity. CMS expects that this will help the MEDIC perform proactive analyses targeting MA fraud and abuse in the future.

***What Needs to Be Done***

CMS needs to ensure that MA organizations submit accurate beneficiary diagnoses for setting risk-adjustment payments and recoup overpayments that were based on inaccurate data reported by plans. It should continue to monitor the effectiveness of its initiatives aimed at this goal and take additional steps if error rates remain high.

CMS should also develop administrative mechanisms to recover or otherwise remedy overpayments that MA organizations have made to providers so that these do not increase costs for Medicare. Implementation of the RAC program in MA may provide such an opportunity.

CMS should work with MA organizations to ensure that they implement effective programs to detect, correct, and prevent fraud, waste, and abuse, as required in their compliance plans. In addition, CMS should require MA organizations to report suspected fraud incidents to the CMS and/or the MEDIC for further review and potential referral to law enforcement. CMS should also develop a centralized repository of MA data, and provide access to that repository to the MEDIC, to facilitate more effective program oversight. CMS should continue working to ensure that the MEDIC successfully carries out proactive data analyses targeting MA fraud and abuse, as planned.

***Key OIG Resources***

- OIG audit of risk adjustment data (Excellus Health Plan, one of six audits). October 2012
- OIG report on MEDIC integrity activities in Parts C & D. January 2013
- OIG report on MA organizations' identification of fraud and abuse. February 2012

## Management Challenge 7: Ensuring Quality of Care in Nursing Facilities and Home- and Community-Based Settings

***Why This Is a Challenge***

As the median age of Americans continues to age and as more Americans live with chronic medical conditions, the Department faces challenges in ensuring that beneficiaries who require nursing facility services receive high quality care. It is also critical to ensure that appropriate home- and community-based care is available, allowing beneficiaries whose needs and preferences are better served by remaining in their own homes or other community-based settings to avoid institutionalization. Nursing facility and home- and community-based services are important for individuals' well-being and can often prevent the need for acute inpatient hospitalizations. OIG work has uncovered various problems with nursing home care, including inadequate staffing, failure to provide adequate nutrition and hydration, inadequate wound care resulting in pressure wounds (bedsores), inappropriate medication practices, failure to develop adequate care plans, and excessive therapy services that are medically unnecessary or even harmful to beneficiaries.

Medicaid is a major payer of personal care services, spending more than $12 billion annually. The Department is committed to ensuring that Medicaid beneficiaries enjoy adequate home- and community- based care options and as such, expenditures for personal care services may be expected to increase. Many Medicaid programs support beneficiary-directed models for the delivery of personal care services. While these systems offer certain advantages for promoting patient choice and preferences, OIG investigators have found such systems particularly vulnerable to fraud and abuse.

***Progress in Addressing the Challenge***

The Department has taken steps to improve quality of nursing home and home- and community-based care. For example, the Department has initiated a review of the requirements for nursing homes to participate in the Medicare and Medicaid programs. This review promises to emphasize patient-centered care, quality improvement, and preventable rehospitalization. The Department has long recognized problems with patients cycling between nursing homes and acute care hospitals. As part of the Partnership for Patients Initiative, the Department specifically committed $300 million towards a Community-Based Care Transition Program to improve patient outcomes following hospital discharge. The Department has launched the National Nursing Home Quality Care Collaborative that proposes to identify best practices from high performing facilities and promote dissemination and replication of those practices to improve care. Increased involvement of Quality Improvement Organizations also offers potential improvement in quality of nursing home care. Through its Nursing Home Compare initiative, the Department also attempts to disseminate information about nursing home quality that may help inform beneficiaries and their families when selecting facilities. In 2013, CMS also released guidance that strengthens nursing home requirements in areas such as: the use of unnecessary medication, access and visitation, handling linens and infection control, and the provision of basic life support services for residents.

OIG continues to pursue enforcement actions against nursing homes that render substandard care. CMS and OIG continue to work closely with law enforcement partners at the Department of Justice and through the Federal Elder Justice Interagency Working Group to promote better care for elderly persons and to prosecute providers that subject them to abuse or neglect. Additionally, State Medicaid Fraud Control Units (MFCUs), which receive oversight and funding from OIG, devote substantial resources to the investigation and prosecution of patient abuse and neglect in both Medicaid-funded facilities and board and care facilities. The President's FY 2014 Budget includes a legislative proposal to expand MFCU jurisdiction to review patient abuse and neglect in home- and-community based settings, as well.

The decision to force a nursing home to shut down or stop serving Federal health care program beneficiaries is never taken lightly, as the experience of being transferred may be traumatic to displaced beneficiaries and locating nearby facilities to adequately serve them can be challenging. Therefore, OIG invests substantial efforts in helping facilities improve. OIG has developed an innovative quality-oriented corporate integrity agreement process to work with facilities so they may properly serve beneficiaries. OIG has placed more than 750 nursing homes under corporate integrity agreements that include quality-monitoring provisions designed to ensure that beneficiaries receive the care they deserve.

Ensuring high quality home- and community-based services, enabling beneficiaries to avoid institutionalization, relies heavily on appropriate personal care services. In another promising initiative, the Department funded the National Direct Service Workforce Resource Center to develop the Road Map of Core Competencies for the Direct Service Workforce. A planned component of this initiative is to develop nationally validated core competencies for personal care service providers and reduce State variation. As OIG has previously noted, developing the standards will be a good first step, but getting States to adopt them may require more forceful action from the Department.

***What Needs To Be Done***

The Department should continue to prioritize quality of nursing home and home- and community-based care. OIG has offered recommendations that can assist the Department in this mission. For example, OIG suggested enhancements to nursing home oversight to ensure that Medicare does not pay nursing homes to overmedicate or otherwise inappropriately medicate beneficiaries (See Challenge 3 for more information). The Department should also continue denying payments for services of such low quality that they are virtually worthless and work with OIG to exclude providers that have rendered grossly substandard care, thereby preventing additional harm to vulnerable beneficiaries.

The Department should ensure integrity of Medicaid-funded personal care services by establishing minimum Federal qualification standards for providers, improving CMS's and States' ability to monitor billing and care quality, and issuing operational guidance for claims documentation, beneficiary assessments, plans of care, and supervision of attendants. The Department should also issue guidance to States regarding adequate prepayment controls and help States access data necessary to identify overpayments. CMS should continue developing and then implement its comprehensive action plan, including the input it gathered from the roundtable it held in April 2013 to consider feasible and effective practices for improving program integrity in personal care services.

***Key OIG Resources***

- Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement. November 2012
- OIG Spotlight on Skilled Nursing Facilities. February 2013
- Example of Fraudulent Substandard Care: press release on nursing home operator health care fraud sentencing. August 2012

## Management Challenge 8: Effectively Using Data and Technology to Protect Program Integrity

***Why This is a Challenge***

The Department compiles an enormous amount of data related to Federal health insurance programs, public health and human services, and the beneficiaries whom they serve. It continues to face challenges in effectively using these data to detect and prevent improper payments and to ensure consumer and patient safety and quality of care. It also faces challenges to protect the privacy and security of the data it collects and maintains.

*Improving the Effectiveness of Medicaid Data.* Federal Medicaid payments are expected to increase an average of 8 percent each year from 2013 through 2023, according to recent Congressional Budget Office estimates. As Medicaid expands, it is imperative that CMS have a functional, national Medicaid database so that CMS may monitor Medicaid payments and services. OIG work has found that the current national Medicaid data are not complete, accurate, or timely and that additional data are needed to conduct national Medicaid program integrity activities. OIG has recommended several actions for improvement, including that CMS establish a deadline for when national Medicaid data of sufficient completeness and quality will be available and ensure that States submit required data. CMS has attempted to improve the access and quality of Medicaid data, most recently through the Transformed Medicaid Statistical Information System (T-MSIS) initiative. Although implementation is still early, analysis completed in January 2013 showed that T-MSIS has made limited progress in addressing Medicaid data concerns. (For additional information on challenges related to Medicaid, see Challenge 4).

*Demonstrating Impact from the Fraud Prevention System (FPS).* As the Department continues to implement predictive analytics technologies to help identify fraudulent claims before they are paid, it must produce reliable information demonstrating the effectiveness of these technologies. The Small Business Jobs Act of 2010 required CMS to use predictive analytics to identify and prevent the payment of improper claims in the Medicare fee-for-service program. In response, CMS implemented the FPS in 2011 and now uses the predictive analytics program to identify potential health care fraud, waste, and abuse. However, after its first year of implementation, challenges remain in demonstrating the FPS's impact. OIG found that some reporting requirements were not met and that its methodology for calculating estimates on savings, recoveries, and return on investment included some invalid assumptions that may have affected the accuracy of those amounts.

*Ensuring HHS Data and Systems Are Secure.* All information collected, processed, transmitted, stored, or disseminated by HHS agencies, their contractors, States, and hospitals must be adequately protected pursuant to the Privacy Act, Office of Management and Budget (OMB) guidelines, and other authorities. OIG has identified vulnerabilities in a variety of information systems controls, including implementation of directives and guidance on information security controls, access controls, and configuration management controls, which may lead to unauthorized access to and disclosure of sensitive information or disruption of critical operations and limit the ability to ensure the confidentiality, integrity, and availability of critical information and systems. As discussed in Challenge 1, the Department also faces challenges in the development of systems for and effective operation of the Marketplaces, which require rapid, accurate, and secure integration of data from numerous Federal and State sources and individuals who use the Marketplaces.

*Protecting Information Contained in Electronic Health Records (EHR) and Guarding Against Fraud.* With the enactment of the Recovery Act and the HITECH Act, the Department has played a leading role in the nationwide adoption of EHRs and other health IT. These innovations offer opportunities for improved patient care and more efficient practice management. However, as the volume of electronically-stored medical information grows, protecting the privacy, security, and integrity of EHRs has become more critical. Data security breaches and

medical identity theft are growing concerns, with thousands of cases reported each year.[17] The Department faces challenges as it maximizes implementation of promising health IT while maintaining the privacy and security of sensitive health information.

Experts in health information technology caution that use of EHRs can make it easier to commit fraud. In the Department's efforts to promote EHR adoption, it focused largely on developing criteria, defining meaningful use, and administering incentive payments. It has given less attention to the risks EHRs may pose to program integrity. Certain features, such as cut-and-paste and auto-fill templates may be used to mask true authorship of the medical record and distort information to inflate health care claims. An examination of hospitals that received Medicare incentive payments as of March 2012 revealed that while nearly all hospitals had recommended audit functions in place, they may not be using them to their full extent. For example, nearly half of hospitals reported being able to turn off audit logs, and few hospitals report using audit logs to identify potentially fraudulent or abusive practices.

***Progress in Addressing the Challenge***

CMS has taken action to improve its data and technology capabilities. Beginning in 2012, CMS partnered with 12 volunteer States on the planning and development of T-MSIS. OIG found that the 12 States had made some progress in implementing T-MSIS. CMS stated that all States are expected to participate in T-MSIS by the end of 2013 and to demonstrate operational readiness to submit timely T-MSIS data by July 1, 2014. CMS issued a letter to State Medicaid Directors in August 2013 that included a deadline for when all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data. CMS also reports that it has added terms and conditions to various Medicaid funding mechanisms to provide incentive for States to report timely, complete and accurate data. CMS created a set of tools to help States prepare to submit T-MSIS data, including establishing a CMS liaison for States and the creation of a T-MSIS State collaboration workgroup.

In implementing FPS in July 2011, CMS met legislative timeline requirements and implemented the largest scale predictive analytics program used to identify potential health care fraud, waste, and abuse ever developed. With regard to demonstrating the impact of FPS, CMS has shown leadership by coordinating and leveraging relationships with public and private entities to discern best practices for measuring the impact of program integrity activities. CMS has also continued to take steps to refine its methodologies for calculating cost savings from costs avoided due to FPS.

Some HHS agencies, States, and hospitals have made progress in addressing recommendations made by OIG in audits of information security systems. However, CMS continues to have significant deficiencies in its planning, implementation, and execution of its overall information security directives and guidance; and implementing controls to prevent unauthorized access to sensitive information.

Through its EHR adoption incentive programs regulations and its EHR certification criteria regulations, HHS has addressed privacy and security matters in limited ways. The Office of the National Coordinator for Health IT (ONC), which coordinates the adoption, implementation, and exchange of EHRs, awarded a contract to develop

---

[17] CMS tracks nearly 300,000 compromised Medicare-beneficiary numbers. The Office for Civil Rights has received more than 77,000 complaints regarding breaches of health information privacy and completed more than 27,000 investigations, which have resulted in more than 18,000 corrective actions.

recommendations to enhance data protection; increase data validity, accuracy, and integrity; and strengthen fraud protection in EHR technology; however, the Department did not directly address all recommended safeguards through certification criteria and meaningful use requirements. CMS has acknowledged the potential for EHRs to be used to commit fraud and intends to develop guidelines to ensure appropriate use of the copy/paste feature in EHRs. Additionally, CMS audits providers who received EHR incentive payments to gauge the accuracy of, among other things, attestations that risk analyses designed to protect electronic health information were conducted. If the Department takes steps to that ensure meaningful use requirements include necessary safeguards, these audits may be a helpful oversight tool.

***What Needs To Be Done***

CMS and the 12 volunteer States participating in T-MSIS have made some progress, particularly toward planning for T-MSIS implementation. However, early implementation outcomes raised questions about the completeness and accuracy of T-MSIS data upon national implementation. CMS should continue to work with States to ensure the submission of complete, accurate, and timely data. It should also establish a deadline for when T-MSIS data will be available for use. If States fail to begin submitting T-MSIS data by the implementation deadline, CMS should use its statutory enforcement mechanisms or seek legislative authority to employ alternative tools to compel State participation.

To ensure effective operations during the planned expansion and enhancement of FPS over the next few years, CMS will need to address FPS's reporting and measurement vulnerabilities. OIG will continue monitoring the FPS and analyze future modifications or refinements to it.

The Department, States, and hospitals should continue improving systems controls to help ensure that system assets are protected from unauthorized usage and that only authorized personnel are granted access to data and programs.

The Department should continue to focus on oversight and enforcement of privacy and security protections to ensure that sensitive data are protected. It should also do more to ensure that EHRs contain safeguards and that providers use these safeguards to protect against health care fraud involving electronic systems. The Department should also provide additional guidance on information technology security standards and best practices that the health care industry should adopt for EHRs.

***Key OIG Resources***

- Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology. December 2013
- Early Outcomes Show Limited Progress for the T-MSIS. September 2013
- The Department and CMS Financial Statement Reports *which can be found on the HHS website after December 16, 2013*. Fiscal Year 2013
- Security Gaps May Threaten Electronic Health Records. June 2011
- Protect Yourself Against Medical Identity Theft.
- CMS Response to Breaches and Medical Identity Theft. October 2012
- OIG report on implementation predictive analytics. September 2012

## Management Challenge 9: Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse

***Why This Is a Challenge***

HHS is the largest grant-making organization in the Federal Government, and its funding of health and human services programs touches the lives of almost all Americans. In FY 2012, the Department awarded over 81,000 grants totaling approximately $347 billion. Of these, approximately 80,000 grants totaling approximately $90 billion were for programs other than Medicare or Medicaid. According to HHS's Tracking Accountability in Government Grants System, in FY 2013, HHS issued over 20,000 new awards totaling over $272 million. These grants include those added to the HHS grant portfolio by the ACA and the Recovery Act, thus expanding the oversight responsibilities of grant managers and project officers.

HHS is also the third largest contracting agency in the Federal Government; in FY 2013, HHS awarded over $19 billion in contracts across all program areas. Under ACA, contractors have played, and will continue to play, a vital role in building, maintaining, and fixing the computer systems that underpin the implementation of Marketplaces and the Data Hub. HHS faces a challenge to ensure proper management and oversight of these contracts. (See Challenge 1 for more information on ACA contractor management and oversight.) Additionally, several HHS Operating Divisions (OPDIVs) funded Small Business Innovation Research (SBIR) and Small Business Technology Transfer (STTR) grants and contracts. In calendar year 2012, HHS spent $755 million for grants and contracts in these programs. In contracts alone, HHS awarded $13 million in SBIR contracts and $463,000 in STTR contracts in FY 2013. HHS is the second largest payer under the SBIR and STTR programs (the Department of Defense is the first).

The size and scope of departmental awards make their operating effectiveness crucial to the success of programs designed to improve the health and well-being of the public. Yet OIG has noted weaknesses in the oversight of grantees, as demonstrated by late or absent financial and related reports, insufficient documentation on progress toward meeting program goals, and failure to ensure that grantees obtain required annual financial audits.

At the grantee level, a common problem uncovered by our reviews is that grantees lack robust financial management systems. Some grantees cannot even account for specific grants on a grant-by-grant basis. Without this basic ability, grantees cannot account for costs associated with specific grant awards. Accountability suffers as a result. Collectively, when combined with frequent significant findings of unallowable expenses, these conditions suggest the need for more purposeful oversight and consistency in oversight processes.

Additionally, OMB is in the process of finalizing extensive revisions to the grants management circulars and associated cost principles for Federal grant awards, which will result in implementation challenges for the Department, including changes to HHS regulations and potential adjustments to some grant oversight practices.

With respect to contracts, OIG raised concerns about HHS's use of appropriations to fund contracts as well as its efforts to monitor contractor performance. OIG audits of NIH contracts revealed instances of improper funding in 11 of 18 contracts. Follow-up audit work is underway to assess the effectiveness of the remedial actions outlined by the Department in its 2011 report of Antideficiency Act violations.

OIG has also identified weaknesses in contracting processes and contract management. An audit of CDC contracts revealed that CDC failed to meet Government requirements for contractor performance assessments. Failure to conduct these assessments and make contractor evaluations available through the Federal Awardee Performance and Integrity Information System (FAPIIS) deprives CDC's and other agencies' contracting officers of valuable performance information that should be used in determining whether a contractor is responsible and should receive another Federal award. During FY 2013 the Department focused on contractor performance assessments

and posting performance information in the FAPIIS, resulting in an overall improvement from 7.91% (baseline FY 2009 – FY 2012) to 14.88% (FY 2009 – FY 2013).

With respect to misconduct involving grants or contracts, HHS faces various challenges pursuing criminal, civil or administrative actions. While HHS has established a suspension and debarment program, in FY 2013, the implementation of this tool to impose suspensions and debarments remains limited. HHS faces the challenge of educating its grant and contract officers on these administrative remedies and encouraging their use.

***Progress in Addressing the Challenge***

HHS is strengthening its program integrity efforts by working with its OPDIVs and Staff Divisions (STAFFDIVs) to implement a uniform risk management approach. The Department has established a Program Integrity Coordinating Council to look across programs for common challenges and solutions. Additionally, HHS has actively participated in the Government-wide grants reform guidance project, and is in the process of updating its own internal grants administration manual to foster greater program integrity, accountability, and transparency throughout the grants lifecycle.

With respect to systemic contract funding problems, the Department continues to provide its contracting workforce with an online reference tool for contract funding, formation, and appropriations law compliance. The Department conducts appropriations law compliance reviews of all contract actions exceeding $5 million or $10 million, depending on the type of requirement reviewed and the awarding OPDIV or STAFFDIV. HHS has also revised its contract funding guidance to more accurately describe appropriations law and policy; these revisions incorporated best practices and lessons learned. All Heads of Contracting Activities have developed guidance for their contracting workforce on contractor performance evaluation.

With respect to grant and contract misconduct, the Department has participated in training related to fraud, waste and abuse in the grant and contract area. OIG, a member of the President's Financial Fraud Enforcement Task Force Grant Fraud Subcommittee, collaborated to produce guidance to be used by all Federal agencies as a framework for grant training to reduce grant fraud risk and has offered to assist the Department in developing training specific to HHS OPDIVs.

In outreach efforts, OIG provided fraud, waste, and abuse training to SBIR/STTR program staff in multiple OPDIVs and to staff at CMS's Center for Medicare and Medicaid Innovation. OIG created an Intranet Web Page for HHS OPDIV officials to use to refer allegations of fraud or to submit questions about fraud to OIG.

With respect to suspension and debarment, the Suspension and Debarment Official (SDO) and her staff continue to have monthly coordination meetings with OIG, the Office of Research Integrity and the Office of the General Counsel. The SDO is also developing procedures and tools to assist HHS grants and contracts officials.

***What Needs To Be Done***

Sustained focus by the Department is needed to address vulnerabilities in its grant programs and contract administration. With respect to grant oversight, OPDIVs need continued vigilance in monitoring grant resources stemming from the ACA, the Recovery Act, and other grant programs. Implementation of planned program integrity initiatives, such as evaluating and mitigating risks, identifying and addressing cross-cutting issues, resolving grantee audit findings, and sharing best practices across the Department will better position HHS to integrate program integrity into all aspects of its operations and culture.

OIG is continuing to examine grants management practices across the Department. For example, OIG is reviewing the extent to which OPDIVs mitigate grantee risks and share information about high risk grantees. We are also reviewing OPDIVs' oversight of the SBIR program as it pertains to ensuring grantee compliance with program eligibility requirements.

With respect to contract funding, the Department has advised that it is focused on preventing new violations and that it is taking legally appropriate actions to ensure that there are no further violations of the Antideficiency Act among ongoing contracts. OIG continues to recommend that the Department correct the improper funding of contracts that resulted in appropriations violations and continue to ensure that appropriate officials attend mandated training, that future contracts are funded properly, and that policy guidance is consistently followed.

The Department and OIG should continue to provide training on identifying and pursuing misconduct in HHS grants and contracts. The Department also needs to continue to refine its Suspension and Debarment Procedures, including streamlining the referral and decision process, setting up a department-wide tracking system, training officials throughout the Department on suspension and debarment, and decreasing the processing time of suspension and debarment referrals.

***Key OIG Resources***

- OIG Spotlight on Grants Management and Oversight. February 2013
- OIG review of CDC's contract monitoring. July 2013

## Management Challenge 10: Ensuring the Safety of Food, Drugs and Medical Devices

***Why This Is a Challenge***

The Department, through the Food and Drug Administration (FDA), is responsible for protecting public health by ensuring the safety, efficacy, and security of drugs, medical devices, biologicals, and much of our Nation's food supply. The Department must ensure that once a drug, biologic, or device has been approved for use, it is marketed appropriately. During a food emergency, the Department is also responsible for finding the contamination source and overseeing the removal by manufacturers of these products from the market. However, OIG work has revealed weaknesses in FDA's ability to adequately oversee the safety of drugs, biologics, medical devices, and food. These challenges include:

*Limited oversight of drug safety.* A fall 2012 nationwide meningitis outbreak caused by contaminated injections raised major concerns about the use of drugs supplied by compounding pharmacies. OIG reviewed hospitals' use of compounded drugs and found that in 2012, 92 percent of hospitals used compounded sterile preparations (CSPs). Additionally, we found that 56 percent of hospitals made changes or planned to make changes to CSP sourcing practices in response to the fall 2012 meningitis outbreak. In recent congressional hearings about vulnerabilities in the oversight of compounding pharmacies, FDA has raised concerns that its enforcement authority might not be sufficient to take action against inappropriate compounding practices.

Similarly, OIG's review of Risk Evaluation and Mitigation Strategies (REMS) raised concerns about FDA's monitoring of the risks associated with drugs that have known or potential risks that may outweigh the drugs' benefits. REMS are enforceable, structured plans to manage specific risks associated with these drugs. We found that nearly half of sponsor assessments for the REMS we reviewed did not include all information requested in FDA assessment plans. Moreover, FDA does not have the authority to take enforcement actions against drug sponsors that do not include all information requested in FDA assessment plans.

*Inadequate food facility and dietary supplement manufacturer recordkeeping.* In the past, OIG have found that food facilities' failure to comply with FDA's recordkeeping requirements impedes the Department's ability to ensure the safety of the Nation's food supply. OIG found that 59 percent of selected food facilities did not comply with FDA's recordkeeping requirements. In recent reviews of manufacturers of dietary supplements, OIG found that 28 percent of contacted companies failed to register with FDA as required. Of the companies that did register, 72 percent failed to provide the complete and accurate information required in the registry.

*Potentially misleading claims made by manufacturers of dietary supplements.* The Government Accountability Office (GAO) and public interest groups have raised concerns about a specific type of claim called a structure/function claim that manufacturers may use on dietary supplement labels. Manufacturers have used these claims to promote health benefits of their products. Stakeholders have urged FDA to strengthen oversight of these claims because they are potentially misleading and may lack scientific support. Manufacturers must have competent and reliable scientific evidence to show that claims are truthful and not misleading, but they do not have to submit the substantiation to FDA, and FDA has only voluntary standards for it. A manufacturer must notify FDA when it uses structure/function claims. OIG found that substantiation documents for the supplements reviewed were inconsistent with FDA guidance on competent and reliable scientific evidence. OIG also found that FDA could not readily determine whether manufacturers had submitted the required notification for their claims. These results raise questions about the extent to which structure/function claims are truthful and not misleading.

*Ensuring Compliance With Marketing Requirements*. Manufacturers of drugs, biologicals, and medical devices gain approval for sale of their products for specific uses once FDA determines that the products are safe and effective for those uses. Once approved for sale, qualified medical providers may prescribe them for any uses on the basis of their medical judgment. However, manufacturers are prohibited from promoting products for uses for which FDA has not specifically approved them (known as off-label uses). OIG, in conjunction with its law enforcement partners, including FDA's Office of Criminal Investigations, has investigated many instances in which manufacturers illegally promoted products for off-label uses. Off-label promotion can undermine the system intended to ensure that drugs are safe and effective and can put patients at risk. Additionally, this illegal off-label promotion may lead to fraudulent claims for payment submitted to Federal health care programs, including Medicare and Medicaid. FDA faces ongoing challenges in adequately monitoring and preventing illegal off-label promotional activities.

***Progress in Addressing the Challenge***

Since September 2009, FDA has required food facilities to report to a new registry all instances when there is a reasonable probability that a food might cause serious adverse health consequences and to investigate the causes of any adulteration reported if the adulteration may have originated with the food facility. The Food Safety Modernization Act (FSMA), signed into law in January 2011, provides FDA important new authorities to better protect the Nation’s food supply. OIG will continue to oversee the Department’s management of food safety issues and FSMA implementation.

The Food and Drug Administration Safety and Innovation Act (FDASIA), enacted in July 2012, expands the FDA’s authorities and strengthens its ability to safeguard public health by authorizing the collection of user fees to fund reviews of drugs and devices; promoting innovation to expedite the development and review of certain new drugs; increasing stakeholder involvement in FDA decision making; and enhancing the safety of the drug supply chain. FDA has established a 3-year plan to implement these provisions, and the agency’s progress is updated monthly on a website.

OIG is continuing to work with law enforcement partners to investigate and prosecute drug and device manufacturers that engage in illegal activity. This year, as in past years, the Government entered several settlements with drug and device manufacturers relating to alleged off-label promotion. For example, in December

2012, Amgen Inc. agreed to pay a total of $762 million to resolve allegations of off-label promotion and other improper conduct. Amgen pled guilty to misdemeanor misbranding charges, entered a civil settlement agreement, and entered a comprehensive corporate integrity agreement with OIG to resolve its criminal, civil, and administrative liability for the improper conduct. In July 2013, TranS1, a medical device manufacturer, agreed to pay $6 million to resolve allegations under the False Claims Act that it caused false claims to be submitted to Medicare and Medicaid by, among other things, promoting its medical device for uses not approved or cleared by the FDA.

FDA has made progress in addressing OIG recommendations. For example, as a result of OIG's identifying vulnerabilities in FDA's oversight of regulatory decisions, FDA implemented new operating procedures for resolving scientific disagreements. However, other concerns raised by our office, such as weaknesses in ensuring the adequate monitoring of adverse-event reporting for medical devices and the accuracy of FDA's National Drug Code Directory, remain unaddressed.

***What Needs To Be Done***

The Department and FDA will need to continue issuing the rules and guidance documents necessary to fully implement the various provisions in FDASIA. In addition, FDA will need to continue its efforts to fully implement FSMA to better protect the Nation's food supply. FSMA addresses many of OIG's recommendations; however, we continue to recommend that FDA vigorously use its new authorities to remedy identified weaknesses in its inspections and recall procedures. FDA should also ensure that States properly conduct contracted food facility inspections. The Department also needs to focus on eliminating off-label promotion to protect patients and HHS health care programs.

***Key OIG Resources***

- OIG reports on food facility safety inspections (December 2011), structure/function claims by dietary supplements (October 2012), Risk Evaluation and Mitigation Strategies for drug safety (February 2013), and hospital outsourcing of high-risk compounded drugs (April 2013)
- DOJ press release: resolution with Amgen, Inc. settlement. December 19, 2012
- DOJ press release: resolution with TranS1, INC. July 3, 2013

# DEPARTMENT'S RESPONSE TO OIG TOP MANAGEMENT CHALLENGES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

To: Daniel R. Levinson, Inspector General

From: Ellen G. Murray, Assistant Secretary for Financial Resources and Chief Financial Officer

Subject: FY 2013 Top Management and Performance Challenges Identified by the Office of Inspector General (OIG)

On December 12, 2013, the Department received the OIG's report, *Fiscal Year 2013 Top Management and Performance Challenges Identified by Office of Inspector General*. The report, which is published annually in the Department of Health and Human Services (HHS) Agency Financial Report (AFR), provides an OIG assessment of major Agency management and performance challenges during the most recent fiscal year that pose significant risks related to waste, fraud, error, or mismanagement. This memorandum is in response to the OIG's Report.

We concur with OIG's findings concerning HHS top management and performance challenges, which include Transitioning to Value-Based Payments for Heath Care; Overseeing the Health Insurance Marketplaces; Ensuring Appropriate Use of Prescription Drugs in Medicare and Medicaid; Protecting the Integrity of an Expanding Medicaid Program; Fighting Fraud and Waste in Medicare Parts A & B; Preventing Improper Payments and Fraud in Medicare Advantage; Ensuring Quality of Care in Nursing Facilities and Home- and Community-based Settings; Effectively Using Data and Technology to Protect Program Integrity; Protecting HHS Grants and Contract Funds from Fraud, Waste, and Abuse; and Ensuring the Safety of Food, Drugs and Medical Devices. Our management is committed to working toward resolving these challenges and looks forward to continued collaboration with OIG to improve the health and well-being of the American people through these efforts.

We appreciate the cooperation and work conducted by OIG in helping us to continue to address the Department's major management and performance challenges. Many thanks to you and your staff for your continued commitment in helping us improve our management environment.

/Ellen G. Murray/

Ellen G. Murray
Assistant Secretary for Financial Resources and
Chief Financial Officer
December 16, 2013

# GLOSSARY

| ACRONYM | DESCRIPTION |
|---|---|
| AA | Associate of Arts |
| ACA | Affordable Care Act |
| ACF | Administration for Children and Families |
| ACL | Administration for Community Living |
| ACO | Accountable Care Organization |
| ACR | Administrative Cost Review |
| AFR | Agency Financial Report |
| AHRQ | Agency for Healthcare Research and Quality |
| AICPA | American Institute of Certified Public Accountants |
| AIDD | Administration for Intellectual and Development Disabilities |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALJ | Administrative Law Judge |
| AoA | Administration on Aging |
| ARRA | American Recovery and Reinvestment Act of 2009 |
| ASA | Office of the Assistant Secretary for Administration |
| ASC | Ambulatory Surgical Center |
| ASFR | Office of the Assistant Secretary for Financial Resources |
| ASL | Office of the Assistant Secretary for Legislation |
| ASPA | Office of the Assistant Secretary for Public Affairs |
| ASPE | Office of the Assistant Secretary for Planning and Evaluation |
| ASPR | Office of the Assistant Secretary for Preparedness and Response |
| ATSDR | Agency for Toxic Substances and Disease Registry |
| BA | Bachelor of Arts |
| BHPr | Bureau of Health Professions |
| BPCI | Bundled Payment Care Improvement |
| CAP | Corrective Action Plan |
| CAUTI | Catheter-Associated Urinary Tract Infections |
| CBO | Congressional Budget Office |
| CBRs | Comparative Billing Reports |
| CCDF | Child Care Development Fund |
| CFBNP | Center for Faith-Based and Neighborhood Partnerships |
| CDC | Centers for Disease Control and Prevention |
| CERT | Comprehensive Error Rate Testing |
| CFBNP | Center for Faith-Based and Neighborhood Partnerships |
| CFO | Chief Financial Officer |
| CFRS | Consolidated Financial Reporting System |
| CHIP | Children's Health Insurance Program |
| CHIPRA | *Children's Health Insurance Program Reauthorization Act of 2009* |
| CIO | Chief Information Officer |
| CISO | Chief Information Security Officer |
| CLABSI | Central Line-associated Bloodstream Infections |

| ACRONYM | DESCRIPTION |
|---|---|
| CLASS | Community Living Assistance Services and Support |
| CME | Continuing Medical Education Credits |
| CMMI | Center for Medicare and Medicaid Innovation |
| CMP | Civil Monetary Penalties |
| CMS | Centers for Medicare and Medicaid Services |
| CO-OP | Consumer Operated and Oriented Plan |
| COLA | Cost of Living Adjustment |
| COTS | Commercial Off the Shelf |
| CPI | Consumer Price Index |
| CPIM | Consumer Price Index-Medical |
| CRADA | Cooperative Research and Development Agreement |
| CSPs | Compounded Sterile Preparations |
| CSRS | Civil Service Retirement System |
| CUSP | Comprehensive Unit-based Safety Program |
| CY | Current Year |
| DAB | Departmental Appeals Board |
| DHS | Department of Homeland Security |
| DIR | Direct and Indirect Remuneration |
| DMDC | DOD's Manpower Date Center |
| DME | Durable Medical Equipment |
| DOD | Department of Defense |
| DOJ | Department of Justice |
| DOL | Department of Labor |
| DRA | Deficit Reduction Act of 2005 |
| ERRP | Early Retiree Reinsurance Program |
| EHR | Electronic Health Records |
| ESRD | End-Stage Renal Disease |
| FAPIIS | Federal Awardee Performance and Integrity Information System |
| FASAB | Federal Accounting Standards Advisory Board |
| FBIS | Financial Business Intelligence System |
| FBWT | Fund Balance with Treasury |
| FCA | False Claims Act |
| FCRA | Federal Credit Reform Act |
| FDA | Food and Drug Administration |
| FECA | Federal Employees' Compensation Act |
| FERS | Federal Employees' Retirement System |
| FETP | Field Epidemiology Training Program |
| FFM | Federally Facilitated Marketplace |
| FFMIA | *Federal Financial Management Improvement Act of 1996* |
| FFS | Fee-for-Service |
| FICA | Federal Insurance Contributions Act |
| FIFO | First-in/first-out |
| FISMA | *Federal Information Security Management Act of 2002* |
| FMFIA | *Federal Managers' Financial Integrity Act of 1982* |
| FPS | Fraud Prevention System |
| FSMA | Food Safety Modernization Act |
| FMAP | Federal Medical Assistance Percentage |

| ACRONYM | DESCRIPTION |
|---|---|
| FTC | Federal Trade Commission |
| FY | Fiscal Year |
| GAAP | Generally Accepted Accounting Principles |
| GAO | Government Accountability Office |
| GDP | Gross Domestic Product |
| GMRA | *Government Management Reform Act of 1994* |
| GPAM | Grants Policy Administration Manual |
| GPRA | *Government Performance and Results Act of 1993* |
| GSA | General Services Administration |
| GTEx | Genotype-Tissue Expression |
| HAIs | Healthcare-Associated Infections |
| HEAT | Health Care Fraud Prevention and Enforcement Action Team |
| HEW | Department of Health, Education and Welfare (now HHS) |
| HFPP | Healthcare Fraud Prevention Partnership |
| HHS | Department of Health and Human Services |
| HI | Hospital Insurance |
| HIGLAS | Healthcare Integrated General Ledger Accounting System |
| HIPAA | *Health Insurance Portability and Accountability Act of 1996* |
| HITECH | Health Information Technology for Economic and Clinical Health Act |
| HIV | Human Immunodeficiency Virus |
| HPSA | Health Professional Shortage Areas |
| HRSA | Health Resources and Services Administration |

| ACRONYM | DESCRIPTION |
|---|---|
| H5N1 | Avian Influenza |
| IBNR | Incurred But Not Reported |
| IEA | Office of Intergovernmental and External Affairs |
| IEVS | Income Eligibility Verification System |
| IG | Inspector General |
| IHS | Indian Health Service |
| IP | Improper Payments |
| IPERA | *Improper Payments Elimination and Recovery Act of 2010* |
| IPERIA | *Improper Payments Elimination and Recovery Improvement Act of 2013* |
| IPIA | *Improper Payments Information Act of 2002* |
| IRS | Internal Revenue Service |
| IT | Information Technology |
| LIS | Low-Income Subsidy |
| LLP | Limited Liability Partnership |
| LPR | Legal Permanent Resident |
| MA | Medicare Advantage or Part C |
| MACs | Medicare Administrative Contractors |
| MARx | Medicare Advantage Prescription Drug |
| MD&A | Management's Discussion and Analysis |
| MEDIC | Medicare Drug Integrity Contractors |
| MFCUs | Medicaid Fraud Control Units |
| MIC | Medical Integrity Contractors |
| MII | Medicaid Integrity Institute |
| MLN | Medicare Learning Network |

| ACRONYM | DESCRIPTION |
|---|---|
| MMA | *Medicare Prescription Drug, Improvement and Modernization Act of 2003* |
| MMIS | Medicaid Management Information Systems |
| MPD | Medicare Prescription Drug or Part D |
| MPE | MARx Payment Error |
| MSIS | Medicaid Statistical Information Systems |
| MSP | Medicare Secondary Payer |
| MSSP | Medicare Shared Saving Program |
| N/A | Not Applicable |
| NBS | NIH Business Systems |
| NDC | National Drug Code |
| NDNH | National Directory of New Hires |
| NHSC | National Health Service Corps |
| NHSN | National Healthcare Safety Network |
| NIH | National Institutes of Health |
| OAA | Title III Older Americans Act |
| OACT | Office of the Actuary |
| OASDI | Old-Age Survivors and Disability Insurance |
| OASH | Office of the Assistant Secretary for Health |
| OCR | Office for Civil Rights |
| OGA | Office of Global Affairs |
| OGC | Office of the General Counsel |
| OI | Other Information |
| OIG | Office of Inspector General |
| OMB | Office of Management and Budget |

| ACRONYM | DESCRIPTION |
|---|---|
| OMHA | Office of Medicare Hearings and Appeals |
| ONC | Office of the National Coordinator for Health Information Technology |
| OPD | Orphan Products Development |
| OPDIV | Operating Division |
| OS | Office of the Secretary |
| PARIS | Public Assistance Reporting Information System |
| PCMH | Patient Centered Medical Home |
| PDE | Prescription Drug Event |
| PEDIR | Payment Error related to Direct and Indirect Remuneration |
| PELS | Payment Error related to Low-Income Subsidy Status |
| PEMS | Payment Error related to Medicaid Status |
| PEPV | Prescription Drug Event Data Validation |
| PERM | Payment Error Rate Measurement |
| PHS | Public Health Service |
| PII | Program Integrity Initiative |
| PIP | Program Improvement Plan |
| P.L. | Public Law |
| PNS | Projects of National Significance |
| PP&E | Property, Plant and Equipment |
| PRRB | Provider Reimbursement Review Board |
| PSC | Program Support Center |
| PUR | Period Under Review |
| PY | Prior Year |
| QIO | Quality Improvement Organization |

| ACRONYM | DESCRIPTION |
|---|---|
| QRIS | Quality Rating and Improvement Systems |
| RAC | Recovery Audit Contractor |
| RADV | Risk Adjustment Data Validation |
| REMS | Risk Evaluation and Mitigation Strategies |
| RDS | Retiree Drug Subsidy |
| RMFOB | Risk Management and Financial Oversight Board |
| RSI | Required Supplementary Information |
| RSSI | Required Supplementary Stewardship Information |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIR | Small Business Innovation Research |
| SBR | Statement of Budgetary Resources |
| SCSIA | Statement of Changes in Social Insurance Amounts |
| SDO | Suspension and Debarment Official |
| SE | Salmonella Enteritidis |
| SECA | *Self Employment Contribution Act of 1954* |
| SF | Standard Form |
| SFFAS | Statement of Federal Financial Accounting Standards |
| SGR | Sustainable Growth Rate |
| SHOP | Small Business Health Options Program |

| ACRONYM | DESCRIPTION |
|---|---|
| SIR | Standardized Infection Ratios |
| SMI | Supplementary Medical Insurance |
| SNAP | Supplemental Nutrition Assistance Program |
| SNF | Skilled Nursing Facility |
| SNS | Strategic National Stockpile |
| SOSI | Statement of Social Insurance |
| SSA | Social Security Administration |
| SSF | Service and Supply Funds |
| STAFFDIV | Staff Division |
| STTR | Small Business Technology Transfer |
| TANF | Temporary Assistance for Needy Families |
| T-MSIS | Transformed Medical Shared Saving Program |
| Treasury | Department of the Treasury |
| UFMS | Unified Financial Management System |
| U.S. | United States |
| U.S.C. | U.S. Code |
| USDA | U.S. Department of Agriculture |
| USSGL | U.S. Standard General Ledger |
| VA | Department of Veterans Affairs |
| VFC | Vaccines for Children |
| VICP | Vaccine Injury Compensation Program |
| ZPIC | Zone Program Integrity Contractor |

# LAWS, REGULATIONS AND GUIDANCE

| **LONG TITLE** *(each title is linked to an official government source)* | **AVAILABLE AT:** | **SHORT TITLE** |
|---|---|---|
| Office of Management and Budget | | OMB |
| Public Law | | P.L. |
| United States Code | | U.S.C. |
| *Accountability of Tax Dollars Act of 2002* | http://www.gpo.gov/fdsys/pkg/PLAW-107publ289/pdf/PLAW-107publ289.pdf | *P.L. 107-289* |
| *Affordable Care Act of 2010* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf<br>http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf | *P.L. 111-148*<br>*and*<br>*P.L. 111-152* |
| *American Recovery and Reinvestment Act of 2009 (ARRA or Recovery Act)* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ5/pdf/PLAW-111publ5.pdf | *P.L. 111-5* |
| *Anti-Deficiency Act (§ 1341, 1342, 1349-1351 and 1511-1519)* | http://uscode.house.gov/view.xhtml?path=/prelim@title31/subtitle2/chapter13&edition=prelim | *31 U.S.C. Ch 13* |
| *Audit Follow-Up* | http://www.whitehouse.gov/omb/circulars_a050/ | *OMB Circular A-50* |
| *Budget Control Act of 2011* | http://www.gpo.gov/fdsys/pkg/PLAW-112publ25/pdf/PLAW-112publ25.pdf | *P.L. 112-25* |
| *Cash Management Improvement Act of 1990, as amended* | http://www.fms.treas.gov/cmia/statute.html | *P.L. 102-589* |
| *Chief Financial Officer (CFO) Act of 1990* | http://govinfo.library.unt.edu/npr/library/misc/cfo.html | *P.L. 101-576* |
| *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)* | https://www.cms.gov/HealthInsReformforConsume/Downloads/CHIPRA.pdf | *P.L. 111-3* |
| *Clinger-Cohen Act of 1996* | http://www.gpo.gov/fdsys/pkg/PLAW-104publ106/pdf/PLAW-104publ106.pdf | *P.L. 104-106* |
| *Community Living Assistance Services and Support (CLASS) Act* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf | *P.L. 111-148, § 8001* |
| *Computer Security Act of 1987* | https://www.govtrack.us/congress/bills/100/hr145/text | *P.L. 100-235* |
| *Debt Collection Improvement Act of 1996* | http://www.dol.gov/ocfo/media/regs/DCIA.pdf | *P.L. 104–134* |
| *Department of Defense and Full-Year Continuing Appropriations Act of 2011* | http://www.govtrack.us/congress/bills/112/hr1473/text | *P.L. 112-10* |
| *Department of Education Organization Act of 1979* | http://history.nih.gov/research/downloads/PL96-88.pdf | *P.L. 96-88* |

| | | |
|---|---|---|
| *Economy Act* | http://www.loc.gov/rr/frd/Military_Law/pdf/FLD_2013_Ch6.pdf | *31 U.S.C. Ch 15 § 1535* |
| *Federal Credit Reform Act of 1990 (FCRA)* | http://www.fms.treas.gov/ussgl/creditreform/fcratoc.html | *P.L. 101-508 § 500* |
| *Federal Employees' Compensation Act of 1916 (FECA)* | http://www.dol.gov/owcp/dfec/regs/statutes/feca.htm | *5 U.S.C. 751* |
| *Federal Financial Assistance Management Improvement Act of 1999* | http://www.gpo.gov/fdsys/pkg/PLAW-106publ107/pdf/PLAW-106publ107.pdf | *P.L. 106-107* |
| *Federal Financial Management Improvement Act of 1996 (FFMIA)* | http://www.gpo.gov/fdsys/pkg/PLAW-104publ208/pdf/PLAW-104publ208.pdf | *P.L. 104-208* |
| *Federal Information Security Management Act of 2002 (FISMA - Title III of the E-Government Act of 2002)* | http://www.gpo.gov/fdsys/pkg/PLAW-107publ347/pdf/PLAW-107publ347.pdf | *P.L. 107-347* |
| *Federal Insurance Contributions Act (FICA)* | http://www.gpo.gov/fdsys/granule/USCODE-2011-title26/USCODE-2011-title26-subtitleC-chap21/content-detail.html | *26 U.S.C. Ch 21* |
| *Federal Managers' Financial Integrity Act of 1982* | http://www.whitehouse.gov/omb/financial_fmfia1982 | *P.L. 97-255* |
| *Federal Records Act of 1950* | http://uscode.house.gov/view.xhtml?req=%22federal+records+act+of+1950%22&f=treesort&fq=true&num=2&hl=true&edition=prelim&granuleId=USC-prelim-title44-section3603 | *44 U.S.C. Ch 31 § 3101* |
| *Financial Management Systems* | http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a127/a127.html | *OMB Circular A-127* |
| *Financial Reporting Requirements* | http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a136/a136_revised_2012.pdf | OMB Circular A-136 |
| *Food, Drug, Cosmetic Act* | http://library.clerk.house.gov/reference-files/PPL_Title21_FoodDrugCosmeticAct.pdf | *P.L. 59-384* |
| *Freedom of Information Act of 1974* | http://uscode.house.gov/view.xhtml?req=freedom+of+information+act&f=treesort&fq=true&num=1&hl=true&edition=prelim&granuleId=USC-prelim-title5-section552 | *P.L. 93-502 or 5 U.S.C. Ch 5 §552* |
| *Government Management Reform Act of 1994* | http://www.gpo.gov/fdsys/pkg/BILLS-103s2170enr/pdf/BILLS-103s2170enr.pdf | *P.L. 103-356* |
| *Government Paperwork Elimination Act of 1998* | http://www.gpo.gov/fdsys/pkg/PLAW-105publ277/pdf/PLAW-105publ277.pdf | *P.L. 105-277 § 1701* |
| *Government Performance and Results Act of 1993* | http://www.whitehouse.gov/omb/mgmt-gpra/gplaw2m | *P.L. 103-62* |
| *Government Performance and Results Modernization Act of 2010* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ352/pdf/PLAW-111publ352.pdf | *P.L. 111-352* |
| *Health Care and Education* | http://www.gpo.gov/fdsys/pkg/PLAW- | *P.L. 111-152* |

| | | |
|---|---|---|
| *Reconciliation Act of 2010* | 111publ152/pdf/PLAW-111publ152.pdf | |
| *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* | http://library.clerk.house.gov/reference-files/PPL_HIPAA_HealthInsurancePortabilityAccountabilityAct_1996.pdf | *P.L. 104-191* |
| *Healthy-Hunger Free Kids Act* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ296/pdf/PLAW-111publ296.pdf | *P.L. 111-296* |
| *Improper Payments Elimination and Recovery Act (IPERA) of 2010* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ204/pdf/PLAW-111publ204.pdf | *P.L. 111-204* |
| *Improper Payments Information Act of 2002* | http://www.gpo.gov/fdsys/pkg/PLAW-107publ300/pdf/PLAW-107publ300.pdf | *P.L. 107-300* |
| *Inspector General Act Amendments of 1988* | http://uscodebeta.house.gov/view.xhtml;jsessionid=627131C92BBAA4188DA1AC4484416C65?req=granuleid%3AUSC-prelim-title44-chapter39&saved=%7CZ3JhbnVsZWlkOlVTQy1wcmVsaW0tdGl0bGU0NC1zZWN0aW9uMzkwMQ%3D%3D%7C%7C%7C0%7Cfalse%7Cprelim&edition=prelim | *P.L. 100-504 or 44 U.S.C. Ch 39* |
| *Internal Revenue Service Restructuring and Reform Act of 1998* | http://www.gpo.gov/fdsys/pkg/PLAW-105publ206/html/PLAW-105publ206.htm | *P.L. 105-206* |
| *Management of Federal Information Resources* | http://www.whitehouse.gov/omb/circulars_a130 | *OMB Circular A-130* |
| *Management of Federal Information Resources* | http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a127/a127.html | *OMB Circular A-127* |
| *Management's Responsibility for Internal Control* | http://www.whitehouse.gov/sites/default/files/omb/assets/omb/circulars/a123/a123_rev.pdf | *OMB Circular A-123* |
| *Medicare Prescription Drug, Improvement and Modernization Act of 2003 (a.k.a. Medicare Modernization Act, or MMA)* | http://www.gpo.gov/fdsys/pkg/PLAW-108publ173/pdf/PLAW-108publ173.pdf | *P.L. 108-173* |
| *Middle Class Tax Relief and Job Creation Act of 2012* | http://www.gpo.gov/fdsys/pkg/PLAW-112publ96/pdf/PLAW-112publ96.pdf | *P.L. 112-96* |
| *Omnibus Reconciliation Act of 1993* | http://www.gpo.gov/fdsys/pkg/BILLS-103hr2264enr/pdf/BILLS-103hr2264enr.pdf | *P.L. 103-66* |
| *Orphan Drug Act, as amended* | http://history.nih.gov/research/downloads/PL97-414.pdf | *P.L. 97-414* |
| *Paperwork Reduction Reauthorization Act of 1995* | http://www.gpo.gov/fdsys/pkg/PLAW-104publ13/pdf/PLAW-104publ13.pdf | *P.L. 104-13* |
| *Patient Protection and Affordable Care Act of 2010* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf | *P.L. 111-148* |
| *Preparation, Submission and Execution of the Budget* | http://www.whitehouse.gov/sites/default/files/omb/assets/a11_current_year/a_11_2011.pdf | *OMB Circular A-11* |
| *Privacy Act of 1974* | http://dpclo.defense.gov/privacy/documents/pa1974.pdf | *P.L. 93-579* |

| | | |
|---|---|---|
| *Prompt Payment Act Amended as of 1998* | http://uscode.house.gov/view.xhtml?hl=false&edition=prelim&req=granuleid%3AUSC-prelim-title31-chapter39&f=treesort&num=0&saved=%7CKHRpdGxlOjMxIGNoYXB0ZXI6MzkgZWRpdGlvbjpwcmVsaW0pIE9SIChncmFudWxlaWQ6VVNDLXByZWxpbS10aXRsZTMxLWNoYXB0ZXIzOSk%3D%7CdHJlZXNvcnQ%3D%7C%7C0%7Cfalse%7Cprelim | *P.L. 100-496 or 31 U.S.C. Ch 39* |
| *Public Health Service Act* | http://www.ssa.gov/OP_Home/comp2/F078-410.html | *P.L. 78-410 or 42 U.S.C. Ch 6A* |
| *Rehabilitation Act Amendments of 1998 (Workforce Investment Act)* | http://www.gpo.gov/fdsys/pkg/PLAW-106publ246/pdf/PLAW-106publ246.pdf | *P.L. 106-246 §2403* |
| *Reports Consolidation Act of 2000* | http://www.dol.gov/ocfo/media/regs/RCA.pdf | *P.L. 106-531* |
| *Sarbanes Oxley Act of 2002* | http://www.gpo.gov/fdsys/pkg/PLAW-107publ204/pdf/PLAW-107publ204.pdf | *P.L. 107-204* |
| *Self Employment Contributions Act (SECA) of 1954 (§1401 through §1403)* | http://uscodebeta.house.gov/view.xhtml?req=%22self+employment+contributions+act%22&f=treesort&fq=true&num=0&hl=true&edition=prelim&granuleId=USC-prelim-title26-section1403 | *26 U.S.C. Ch 2* |
| *Small Business Jobs Act of 2010* | http://www.gpo.gov/fdsys/pkg/PLAW-111publ240/pdf/PLAW-111publ240.pdf | *P.L. 111-240* |
| *Small Business Jobs Act of 2010, U.S. Small Business Administration Initiatives* | http://www.sba.gov/content/small-business-jobs-act-2010 | *P.L. 111-240* |
| *Social Security Act of 1935, as amended* | http://library.clerk.house.gov/reference-files/PPL_SocialSecurity.pdf | *P.L. 74-271* |
| *Tax Increase Prevention and Reconciliation Act of 2005* | http://www.gpo.gov/fdsys/pkg/BILLS-109hr4297enr/pdf/BILLS-109hr4297enr.pdf | *P.L. 109-222* |
| *Temporary Payroll Tax Cut Continuation Act of 2011* | http://www.gpo.gov/fdsys/pkg/PLAW-112publ78/pdf/PLAW-112publ78.pdf | *P.L. 112-78* |
| *Native American $1 Coin Act* | http://www.gpo.gov/fdsys/pkg/PLAW-110publ82/pdf/PLAW-110publ82.pdf | *P.L. 110-82* |

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**200 Independence Ave, S.W. ● Washington, DC 20201**

**877.696.6775 ● www.hhs.gov**