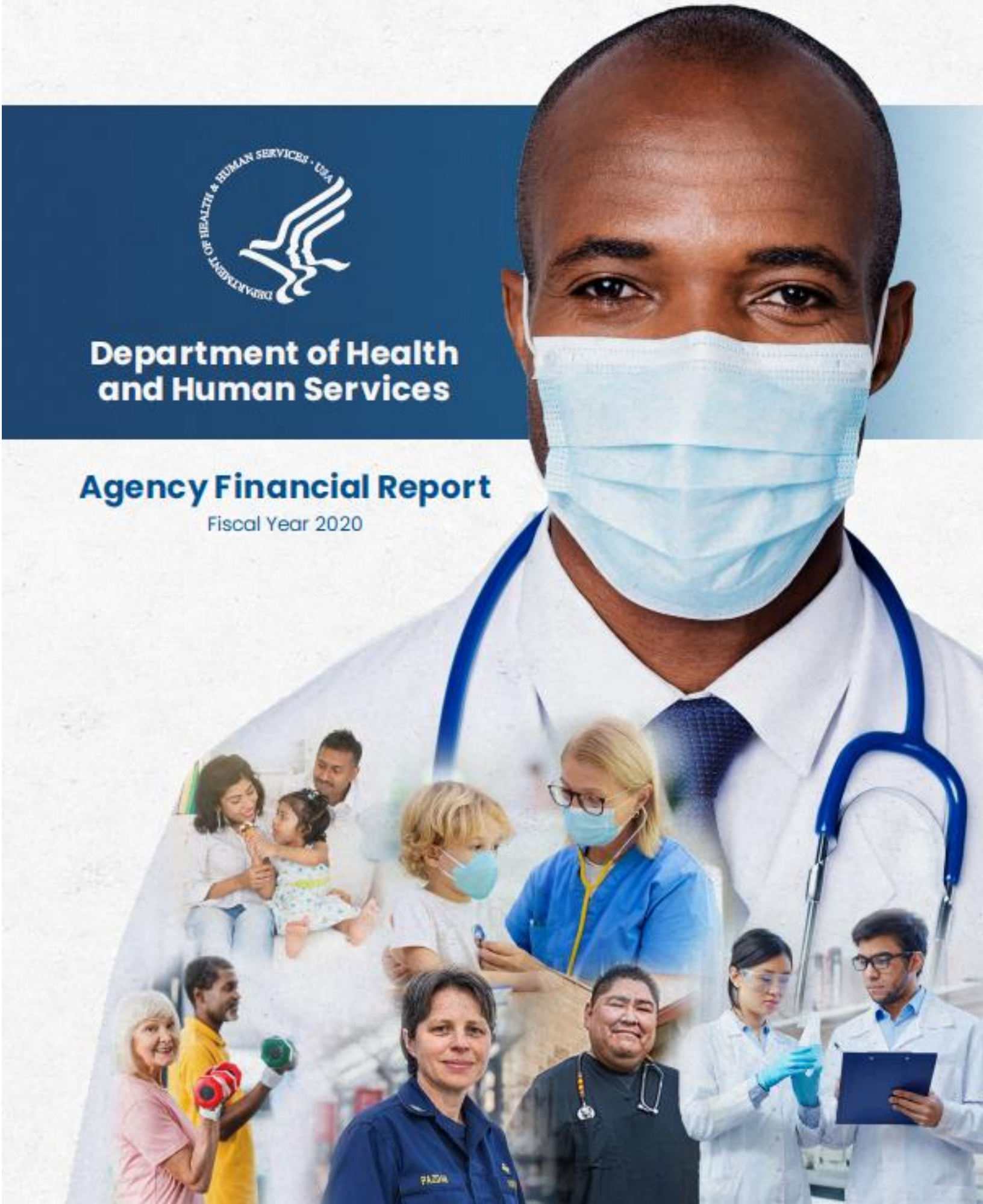
Department of Health and Human Services

Agency Financial Report

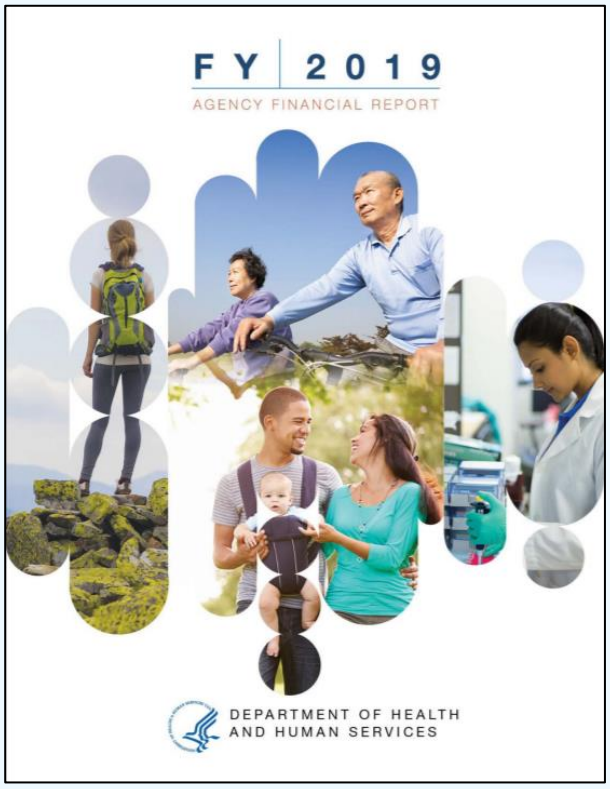
Fiscal Year 2020



Certificate of Excellence in Accountability Reporting

The Department of Health and Human Services (HHS) promotes effective and responsible financial management by producing award-winning financial reports, aligning with its strategic plan. For 7 consecutive years, the Association of Government Accountants (AGA) has recognized HHS's merit of its Agency Financial Report through the Certificate of Excellence in Accountability Reporting (CEAR) Program. The CEAR Program was established in collaboration with the Chief Financial Officers Council and Office of Management and Budget to assist federal government agencies with performance and accountability reporting. Through this program, agencies improve accountability by streamlining reporting and enhancing the effectiveness of reports to clearly highlight what an agency accomplished throughout a fiscal year and discuss any challenges that remain.

The CEAR Program also recognizes agencies as a Best-In-Class for notable or creative reporting practices that pique the public's interest. In August 2020, AGA awarded HHS a Best-In-Class Award for our Fiscal Year 2019 Presentation of Strategic Framework.



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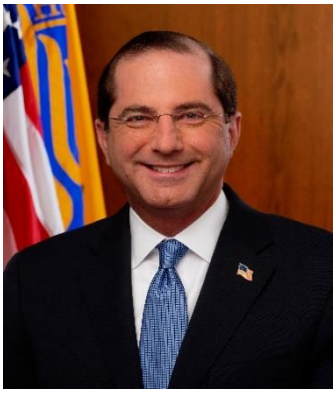
Message from the Secretary



Alex M. Azar II

I am proud to present the Fiscal Year (FY) 2020 Agency Financial Report for the United States (U.S.) Department of Health and Human Services (HHS). This report contains our financial and performance highlights for the FY that ended September 30, 2020.

The COVID-19 pandemic has challenged and continues to challenge our nation, but with the dedicated efforts of the men and women of HHS and President Trump's all-of-America approach, our nation is moving forward with renewed strength and determination. We will emerge from this crisis not only stronger as a country, but better prepared to prevent and combat future health threats and ensure every American has access to the healthcare they need. Even as we face a global pandemic, we have continued making historic progress on our efforts to facilitate patient-centered markets in health care, protect life and lives, promote independence, and support effective and efficient management and stewardship. This report discusses a number of HHS's accomplishments and challenges, particularly in the "Management's Discussion and Analysis" section.

As soon as the U.S. became aware of the novel coronavirus in China, HHS began an immediate and aggressive response. Beginning on January 1, the Centers for Disease Control and Prevention (CDC) began developing situation reports that were shared with HHS leadership. Two days later, we offered CDC experts to China to help them understand the spread of the virus. On January 17, we began enhanced border screenings at the airports that receive the most travelers from the epicenter of the outbreak in Wuhan. On January 31, 2020, HHS declared a public health emergency to support the response to the outbreak. The same day, to slow down the spread of the virus to the U.S. and make it easier to detect and control once it arrived on our shores, President Trump took decisive action, with the support of public health experts from HHS, to restrict travel from China.

On January 11, the morning after the virus's gene sequence was shared by Chinese researchers, scientists at the National Institutes of Health (NIH) began working on a vaccine candidate. That vaccine candidate is now one of the products supported by Operation Warp Speed (OWS), a partnership among scientific leaders across HHS and scientists from other federal agencies and private companies to develop, manufacture, and distribute a safe and effective COVID-19 vaccine in substantial quantities by January 2021. This is the most ambitious biomedical program in American history. Because of the strategic approach of OWS, providing support for simultaneous development and manufacturing efforts on a strategically selected portfolio of products, a task that would normally take years can be completed in months. Our efforts have already yielded results. Hundreds of thousands of Americans have recovered from COVID-19 and now play a key role by donating convalescent plasma, a treatment to which Americans enjoy broader access to than patients in any other country. Beginning in February, we supported clinical trials for the antiviral remdesivir, eventually securing access to more than 90 percent of the world's supply through September.

HHS has deployed thousands of medical professionals—more than two-thirds of the U.S. Public Health Service (USPHS) force and every team of the National Disaster Medical System—across the nation and U.S. territories to help local officials meet pressing community needs, such as training, screening, testing, and treatment. In June, we officially launched the Ready Reserve Corps of the USPHS to provide surge capacity for deploying clinical care and health professionals for both domestic and global future response efforts. The Reserve Corps will also give us new specialized capabilities to deploy for future health threats and help us minimize disruption from deployments at agencies that rely on USPHS officers for their day-to-day mission.

To support the COVID-19 response, we have also built an unprecedented public-private national testing system that has performed far more tests any other country on earth. We have engaged public health labs, hospitals, universities, laboratory companies, and biotech firms developing new forms of tests, drawing on all the resources possible to provide the right tests, in the right places, at the time. In partnership with states, we pioneered 41 initial Community-Based Testing Sites in locations prioritized by the CDC. That partnership demonstrated a prototype that is now duplicated in nearly every state, with more than 1,000 sites established throughout the country. New testing technologies, with support from HHS, continue to enter the market, including through the strategic federal distribution of 150 million rapid point-of-care tests throughout the fall of 2020 that can be deployed in K–12 schools, nursing homes, assisted living facilities, and elsewhere.

Another key piece of the effort has been advancing our public health data work and cooperation with state and local governments. Our team at the CDC provides vital public health information and guidance that can be used by states, local governments, hospitals, employers, school systems, and so many other institutions. We have revolutionized how public health data is collected and disseminated, moving from specialized reporting systems to the use of HHS Protect, a secure hub for storing, analyzing, and parsing data. Protect draws on 225 datasets across the United States, from all 50 states, six U.S. territories, and all cabinet-level federal agencies—just within HHS, including CDC, the Agency for Healthcare Research and Quality, the Office of the Assistant Secretary for Preparedness and Response, the Centers for Medicare and Medicaid Services, the Food and Drug Administration, the Health Resources and Services Administration (HRSA), the Indian Health Service, and NIH. This is the future model for federal and public health data work. In the long run, we hope that we can aggregate much of the data we need from places like hospitals and nursing homes that already gather it, using electronic health records—a step made more feasible by the interoperability rule we finalized this year.

COVID-19's impacts go beyond the virus. Social isolation, reduced access to many healthcare services, and the economic crisis have taken a significant toll. In response, HHS has worked to ensure mental health providers have the resources they need during these challenging times. The Substance Abuse and Mental Health Services Administration (SAMHSA) has distributed hundreds of millions of dollars in emergency funding for state and local mental health programs, suicide prevention, and community behavioral health clinics, and taken steps to ensure that medication-assisted treatment and other services can remain available via telehealth. In 2020, the Administration for Community Living sent more than $1 billion in supplemental funding to networks of community-based organizations that help Americans with disabilities and older Americans with challenges like getting to the doctor and grocery store, or doing household chores, part of our broader efforts to support Americans' independence.

Our huge expansion of telehealth—through broader Medicare coverage, flexibilities for using everyday technologies like FaceTime, and co-pay waivers—provided new opportunities for safe and convenient delivery of mental health care and other important services. Virtual visits in Medicare fee-for-service alone went from approximately 14,000 per week before the pandemic to nearly 1.7 million per week at their peak in April. We have already taken steps to make these expansions permanent in Medicare, and believe patients will come to see this expansion as a durable and desirable shift in American healthcare.

Though COVID-19 demands much of our attention, we did not lose focus in executing on our strategic vision for HHS. HHS continues to execute its 5-Point Opioid Strategy to successfully combat our country's drug abuse and overdose crisis, and the results are encouraging. In 2020, SAMHSA awarded $1.5 billion in State and Tribal Opioid Response grants—which we have ensured can be used to combat stimulant misuse as well—and HRSA awarded over $101 million to strengthen prevention, treatment, and recovery services in rural America. These efforts are yielding results: SAMHSA's 2020 National Survey on Drug Use and Health showed that the number of Americans living with

opioid use disorder dropped from 2.1 million to 1.6 million from 2018 to 2019, and the number of Americans initiating heroin use dropped by 57 percent.

HHS continued our efforts to end the HIV epidemic in America, because we have the right data, tools, and leadership to make it happen. Ending the HIV Epidemic: A Plan for America aims to reduce the number of new HIV infections in the United States by 75 percent by 2025, and by 90 percent by 2030. At the end of July, CDC released $109 million to public health authorities in the 57 state and local jurisdictions that are prioritized under the initiative, which together amount for more than half of the new HIV infections in America.

We have continued progress on other impactable health challenges, including through innovative public-private partnerships. In July, HHS and the American Society of Nephrology announced the six winners of the $3 million KidneyX: Redesign Dialysis Phase 2 competition, recognizing the transformative work and creativity these innovators brought to reimagining dialysis care. Since 2018, KidneyX has awarded prizes totaling more than $4 million, fueling innovation to improve the lives of millions living with kidney diseases.

Transforming kidney care is one part of our efforts to move from a healthcare system that pays for health and outcomes rather than sickness and procedures. In 2020, HHS launched two separate models toward this goal in kidney care: a model to prevent kidney failure and to promote alternatives to dialysis, as well as a new mandatory oncology model and a set of primary care models that will offer renewed focus on care management to Medicare beneficiaries.

We have made progress on our efforts to promote independence, too. Under the Administration for Children and Families' efforts to promote adoption, the number of public adoptions reached its highest level in history in FY 2019, and a reduction in the number of children who are waiting in the system to be adopted.

Stewardship

As the single largest cabinet agency by spending, representing approximately one-third of the total federal budget, HHS maintained its reputation for excellence in budgetary management and enhanced its financial practices. For the 22nd consecutive year, we obtained an unmodified (clean) opinion on the Consolidated Balance Sheets, Statements of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources.

The auditors disclaimed an opinion on the sustainability financial statements, which encompass the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. This disclaimer is primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential legal changes affecting underlying assumptions of financial projections. These statements were developed based upon current law using information from the 2020 Medicare Trustees Report, as required by standards issued by the Federal Accounting Standards Advisory Board. The "Financial Section" of this report includes more detailed information.

We evaluate our internal control and financial management systems annually, as required by the *Federal Managers' Financial Integrity Act* and the Office of Management and Budget's Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control.* These evaluations helped us identify material noncompliances with the *Payment Integrity Information Act of 2019* related to error rate measurement, as well as with the *Social Security Act* related to the Medicare appeals process. The "Management's Discussion and Analysis" section of this report includes further details. Based on our internal assessments, I can provide reasonable assurance that the financial and performance information contained in this report is complete, reliable, and accurate.

Future Challenges and Priorities

We are tremendously proud of the dedicated women and men of HHS and their heroic efforts through the COVID-19 pandemic. Despite our accomplishments, there are opportunities to improve, as demonstrated in this report's "Looking Ahead" section. We worked closely with the Office of Inspector General to understand our most significant management and performance challenges, which are presented in the "Other Information" section.

Conclusion

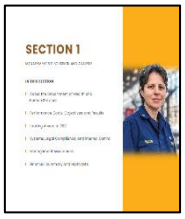
The HHS team is proud to serve our fellow Americans through our vast portfolio of programs. Everyone at HHS plays an essential role in achieving our mission to improve the health and well-being of every American. This report highlights HHS's achievements and progress, as well as the opportunities to improve our programs. FY 2020 was unprecedented in so many ways, but I am proud of the response HHS has mounted, and I am confident we will continue to overcome any future challenges.

/Alex M. Azar II/

Alex M. Azar II
Secretary
November 13, 2020

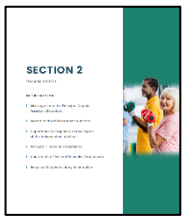
About the Agency Financial Report

The HHS FY 2020 Agency Financial Report (AFR) provides fiscal and summary performance results that enable the President, Congress, and the American people to assess our accomplishments for the reporting period October 1, 2019, through September 30, 2020. This report provides an overview of our programs, accomplishments, challenges, and management's accountability for the resources entrusted to us. We prepared this report in accordance with the requirements of Office of Management and Budget Circular A-136*, Financial Reporting Requirements.* This document consists of three primary sections and a supplemental section for the appendices.



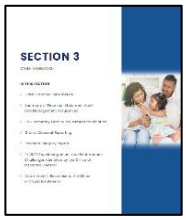
Section 1: Management's Discussion and Analysis

This section provides an overview of HHS's mission, activities, organizational structure, and program performance. It also includes an overview of the systems environment; a summary of the Department's financial results and compliance with laws and regulations; and provides management's assurances on HHS's internal control.



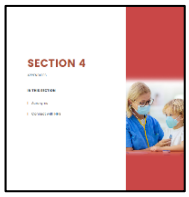
Section 2: Financial Section

This section begins with a message from the Principal Deputy Assistant Secretary for Financial Resources. It continues with the independent auditor's report, management's response to the audit report, financial statements with accompanying notes, and required supplementary information, including the Combining Statement of Budgetary Resources, Deferred Maintenance and Repairs, and Social Insurance information.



Section 3: Other Information

This section contains additional information, such as other financial information, real property, the summary of the financial statement audit and management assurances, civil monetary penalties, grant closeout reporting, and a detailed payment integrity report. It concludes with the Office of Inspector General's assessment of the Department's top management and performance challenges.



Section 4: Appendices

This section includes information that supports the sections of the AFR, such as the glossary of acronyms used throughout the report and additional resources for connecting with the Department.

The Department produces an AFR and *Annual Performance Plan and Report*. Additional reports that will be available on our website, in conjunction with the release of the *FY 2022 President's Budget* in February 2021 include:

1. FY 2022 *Annual Performance Plan and Report*
2. FY 2022 *Congressional Budget Justification*

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SECTION 1

MANAGEMENT'S DISCUSSION AND ANALYSIS

IN THIS SECTION

- About the Department of Health and Human Services
- Performance Goals, Objectives, and Results
- Looking Ahead to 2021
- Systems, Legal Compliance, and Internal Control
- Management Assurances
- Financial Summary and Highlights

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About the Department of Health and Human Services

Our Mission

The mission of the United States (U.S.) Department of Health and Human Services (HHS or the Department) is to enhance the health and well-being of Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

Who We Are

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS accomplishes its mission through a wide spectrum of programs, initiatives, and activities, serving and protecting Americans at every stage of life.

HHS is responsible for approximately a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. HHS's Medicare program is the nation's largest health insurer, handling more than one billion claims per year. Medicare and Medicaid together provide health care insurance for 1 in 3 Americans.

What We Do

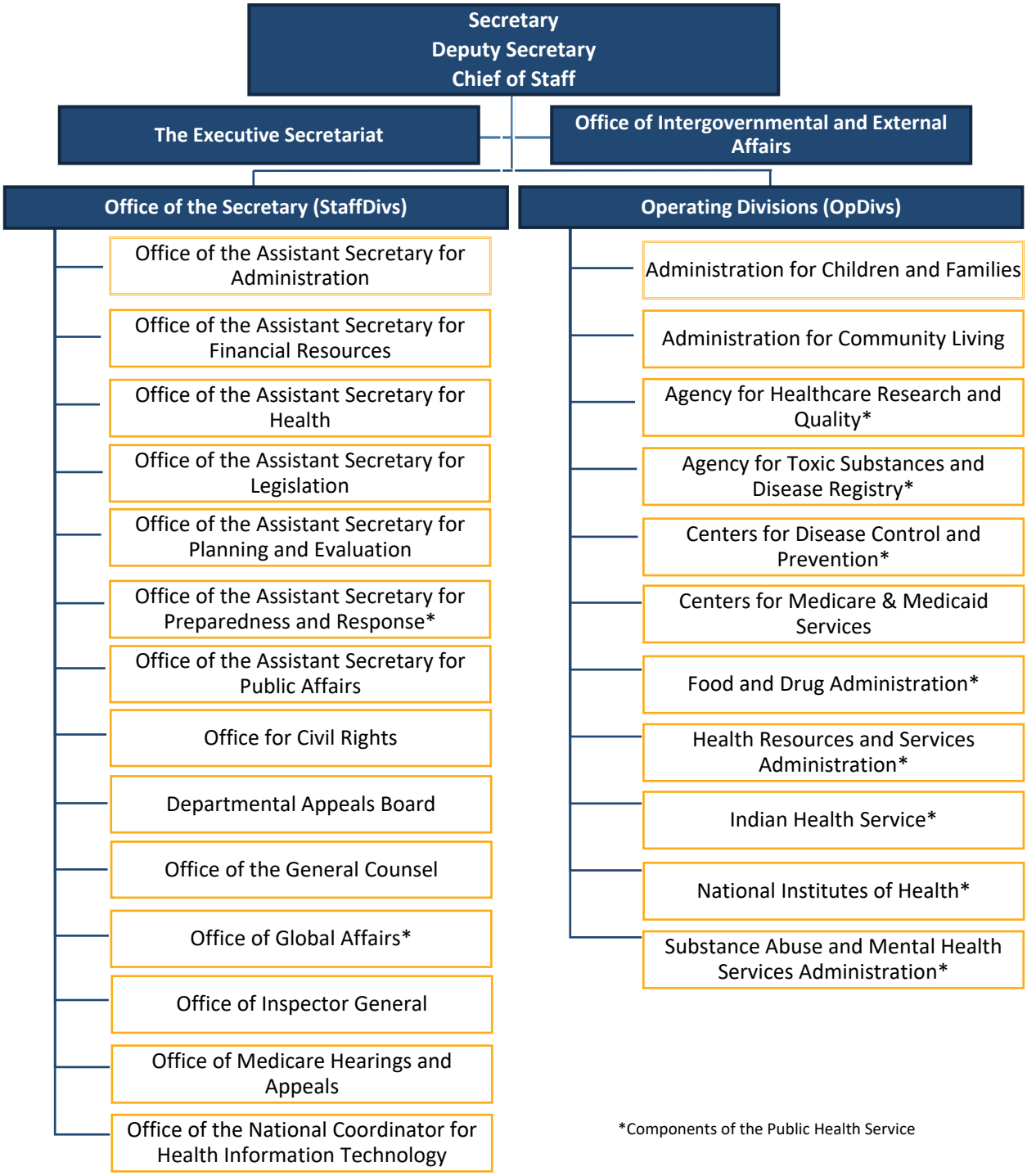
HHS works closely with U.S. state, local, territorial, and tribal governments; state or county agencies; private sector grantees; tribes; and tribal and Urban Indian organizations that provide many HHS-funded services at the local level. While HHS is a domestic agency working to protect and promote the health and well-being of the American people, the interconnectedness of our world requires that HHS engage globally to fulfill its mission. The HHS Office of the Secretary and the 11 Operating Divisions (OpDiv), including Public Health Service and human service agencies, administer HHS's programs. In addition, Staff Divisions (StaffDiv) provide leadership, direction, and policy guidance to the Department.

Through its programs and partnerships, HHS:

- Provides health care coverage to more than 100 million people through Medicare, Medicaid, and the Children's Health Insurance Program (CHIP);
- Promotes patient safety and health care quality in health care settings and by health care providers by assuring the safety, effectiveness, quality, and security of foods, drugs, biologics, and medical devices;
- Conducts health, social science, and medical research while creating hundreds of thousands of jobs for scientists in universities and research institutions in every state across America and around the globe;
- Leverages health information technology (IT) to improve the quality of care and to use data to drive innovative solutions to health care, public health, and human services challenges;
- Improves maternal and infant health; promotes the safety, well-being, and healthy development of children and youth; and supports young people's successful transition to adulthood;
- Supports wellness efforts across the life span, from protecting mental health, to preventing risky behaviors such as tobacco use and substance abuse, to promoting better nutrition and physical activity;
- Prevents and manages the impacts of infectious diseases and chronic diseases and conditions, including the top causes of disease, disability, and death;
- Serves as a responsible steward of the public's investments; and
- Prepares and protects Americans by providing comprehensive responses to health, safety, and security threats, both foreign and domestic, natural or man-made.

Organizational Structure

HHS's organizational structure is designed to accomplish its mission and provide a framework supporting sound business operations and management controls. Led by the HHS Secretary, the Office of the Secretary establishes the overarching vision and strategic direction for the Department and its OpDivs to provide a wide range of services and benefits to the American people. For more information, refer to the HHS website.



Each OpDiv contributes to our mission and vision as follows:

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

ACF is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities. ACF programs aim to empower families and individuals to increase their economic independence and productivity, and encourage strong, healthy, supportive communities that have a positive impact on quality of life and the development of children. Visit ACF for more information.

ADMINISTRATION FOR COMMUNITY LIVING (ACL)

ACL was created around the fundamental principle that all people, regardless of age or disability, should be able to live independently and fully participate in their communities. By advocating across the federal government for older adults, people with disabilities, and families and caregivers; funding services and supports primarily provided by networks of community-based organizations; and investing in training, education, research, and innovation, ACL helps make this principle a reality for millions of Americans. Visit ACL for more information.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

AHRQ produces evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and works within HHS and with other partners to make sure that evidence is understood and used. This mission is supported by focusing on: (1) investing in research on the nation's health delivery system that goes beyond the "what" of health care to understand "how" to make health care safer and improve quality; (2) creating materials to teach and train health care systems and professionals to put the results of research into practice; and (3) generating measures and data used by providers and policymakers. Visit AHRQ for more information.

AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY (ATSDR)

ATSDR is charged with the prevention of exposure to toxic substances and the prevention of the adverse health effects and diminished quality of life associated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment. Visit ATSDR for more information.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

CDC collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. CDC works to protect America from health, safety, and security threats, both foreign and domestic. Whether diseases start at home or abroad, are curable or preventable, due to human error or deliberate attack, CDC fights diseases and supports communities and citizens to do the same. Visit CDC for more information.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS administers Medicare, Medicaid, CHIP, and the Health Insurance Exchanges, which together provide health care coverage for more than 100 million people. CMS acts as a catalyst for enormous changes in the availability and quality of health care for all Americans. In addition to these programs, CMS has the responsibility to ensure effective, up-to-date health care coverage, and to promote quality care for beneficiaries. Visit CMS for more information.

Did You Know?

In FY 2020, CMS allowed states to enroll eligible beneficiaries more quickly in programs that care for the elderly and people with disabilities. These changes to state rules enhanced access and delivery of services for vulnerable populations in home and community-based settings. For more CMS accomplishments, visit CMS's website.

FOOD AND DRUG ADMINISTRATION (FDA)

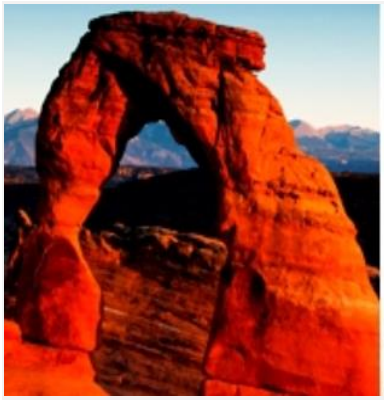
FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. FDA is also responsible for advancing public health by helping to speed innovations that make medicines more effective, safer, and more affordable, and by helping the public get the accurate, science-based information it needs to use medicines and foods to maintain and improve their health. FDA is also responsible for regulating the manufacturing, marketing, and distribution of tobacco products to protect the public health and to reduce tobacco use by minors. Finally, FDA plays a significant role in the nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats. Visit FDA for more information.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA programs provide health care to people who are geographically isolated and economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers, and their families, and those otherwise unable to access high-quality health care. HRSA also supports access to health care in rural areas, the training of health professionals, the distribution of providers to areas where they are needed most, and improvements in health care delivery. In addition, HRSA oversees organ, bone marrow, and cord blood donation. It compensates individuals harmed by vaccination, and maintains databases that protect against health care malpractice, waste, fraud, and abuse for federal, state, and local use. Visit HRSA for more information.

INDIAN HEALTH SERVICE (IHS)

IHS is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. IHS is the principal federal health care provider and health advocate for the Indian people, with the mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states. Visit IHS for more information.



Did You Know?

American Indian/Alaska Native (AI/AN) refers to persons belonging to the Indigenous tribes of the continental U.S. and Alaska. There are 574 sovereign tribal nations with a formal nation-to-nation relationship with the U.S. government. These tribal nations are located across 37 states within the U.S. geographical borders; however, each tribal nation exercises its own sovereignty and is legally defined as a federally recognized tribal nation.

NATIONAL INSTITUTES OF HEALTH (NIH)

NIH is the primary agency of the U.S. Government responsible for biomedical and public health research. NIH provides leadership and direction to programs designed to improve the health of the nation by seeking fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. Visit NIH for more information.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA is responsible for reducing the impact of substance abuse and mental illness on America's communities. SAMHSA accomplishes its mission by providing leadership, developing service capacity, communicating with the public, setting standards, and improving behavioral health practice in communities, in both primary and specialty care settings. Visit SAMHSA for more information.

The following StaffDivs report directly to the Secretary, managing programs and supporting the OpDivs in carrying out the Department's mission. The primary goal of the Department's StaffDivs is to provide leadership, direction, and policy guidance to the Department. The StaffDivs are:

IMMEDIATE OFFICE OF THE SECRETARY (IOS)

IOS is responsible for operations and coordination of the work of the Secretary. Within IOS, there are two offices, the Executive Secretariat and the Office of Intergovernmental and External Affairs (IEA). The Executive Secretariat manages the Department's policy review and decision-making processes, coordinating the development, clearance, and submission of all policy documents for the Deputy Secretary and Secretary's review and approval. IEA represents both the government and external perspective in federal policymaking and clarifies the federal perspective to government officials and external parties.

OFFICE OF THE ASSISTANT SECRETARY FOR ADMINISTRATION (ASA)

ASA provides leadership for HHS departmental management, including human resource policy and departmental operations. The Program Support Center (PSC), a component of ASA, is a shared services organization dedicated to providing support services to help its customers achieve mission-oriented results.

OFFICE OF THE ASSISTANT SECRETARY FOR FINANCIAL RESOURCES (ASFR)

ASFR provides advice and guidance to the Secretary on budget, financial management, acquisition policy and support, grants management, and small business programs. ASFR also directs and coordinates these activities throughout the Department.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH (OASH)

OASH advises on the nation's public health and oversees HHS's U.S. Public Health Service for the Secretary.

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION (ASL)

ASL provides advice on legislation and facilitates communication between the Department and Congress.

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE)

ASPE advises on policy development and contributes to policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.

OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE (ASPR)

The mission of ASPR is to save lives and protect Americans from 21st century health security threats. ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR collaborates with hospitals, healthcare coalitions, biotech firms, community members, state, local, tribal, and territorial governments, and other partners across the country to improve readiness and response capabilities.

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS (ASPA)

ASPA provides centralized leadership and guidance on public affairs for HHS's StaffDivs, OpDivs, and regional offices. ASPA also administers the *Freedom of Information and Privacy Act*.

OFFICE FOR CIVIL RIGHTS (OCR)

OCR enforces federal laws that prohibit discrimination on the basis of race, color, national origin, disability, sex, age, religion, or conscience by health care and human services providers that receive funds from HHS, as well as the federal laws and regulations governing the privacy and security of health information and the rights of individuals with respect to their health information.

DEPARTMENTAL APPEALS BOARD (DAB)

DAB provides impartial review of disputed legal decisions involving HHS.

OFFICE OF THE GENERAL COUNSEL (OGC)

OGC provides quality representation and legal advice on a wide range of highly visible national issues.

OFFICE OF GLOBAL AFFAIRS (OGA)

OGA provides leadership and expertise in global health diplomacy and policy to protect the health and well-being of Americans.

OFFICE OF INSPECTOR GENERAL (OIG)

OIG protects the integrity of HHS programs as well as the health and welfare of the program participants.

OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA)

OMHA administers nationwide hearings for the Medicare program.

OFFICE OF THE NATIONAL COORDINATOR FOR HEALTH INFORMATION TECHNOLOGY (ONC)

ONC provides counsel for the development and implementation of a national health IT framework.

For more information regarding our organization, visit our website.

Performance Goals, Objectives, and Results

Overview of Strategic and Agency Priority Goals

The *Government Performance and Results Act Modernization Act of 2010* (GPRAMA) requires agencies to update their strategic plans every 4 years. The HHS Fiscal Year (FY) 2018—2022 Strategic Plan identifies the Department's mission and its strategic goals and objectives. Each of the Department's OpDivs and StaffDivs contributes to developing the Strategic Plan. HHS tracks progress on each strategic objective through performance goals, which HHS reports annually in the HHS Annual Performance Plan and Report. In addition, HHS engages in a variety of efforts to support the Secretary's Agency Priority Goals (APG), the President's Management Agenda (PMA), and the government-wide Cross-Agency Priority (CAP) Goals.

The Department's strategic planning, enterprise risk management, performance management, and evaluation and evidence-based policymaking functions are the foundations of the Department's strategic management approach, illustrated in **Figure 1** below, and ensures HHS is on the right paths to achieving its mission and strategic goals.

Figure 1: Strategic Management at HHS

Strategic Goals

The HHS Strategic Plan FY 2018–2022 is comprised of five strategic goals, representing input from all HHS OpDivs and StaffDivs, as well as over 13,000 public comments. HHS aligns its focus, strategies, and activities to achieve these strategic goals and objectives. The Department's five strategic goals are:

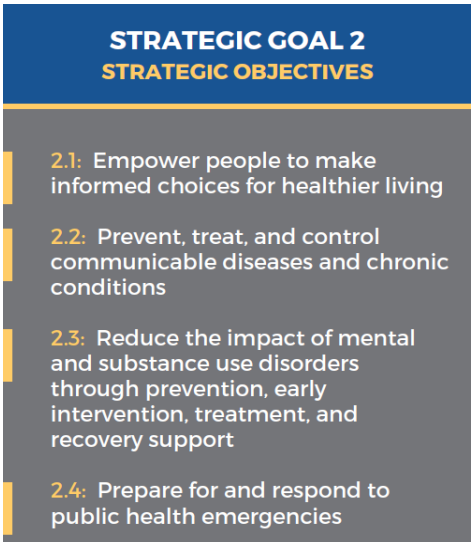
1. Reform, Strengthen, and Modernize the Nation's Healthcare System;
2. Protect the Health of Americans Where They Live, Learn, Work, and Play;
3. Strengthen the Economic and Social Well-Being of Americans Across the Lifespan;
4. Foster Sound, Sustained Advances in the Sciences; and
5. Promote Effective and Efficient Management and Stewardship.

Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System

For a nation to thrive, the population must be physically and mentally healthy. To improve the nation's health, the Department is working with its public and private partners to enhance the quality of health care, while making it more affordable and accessible. Improving access to health care goes beyond affordability. HHS is working to overcome access issues, which exacerbate health problems, increase costs, and prevent better health outcomes. The Department is also making investments to strengthen and expand the health care workforce. This Strategic Goal seeks to improve health care outcomes for all people across the lifespan, including the unborn, children, youth, adults, and older adults across diverse health care settings.

Supporting Divisions – ACL, AHRQ, CDC, CMS, FDA, HRSA, IHS, OCR, ONC, and SAMHSA.

Progress Spotlight – As a result of the telehealth flexibilities Medicare instituted as part of the COVID-19 pandemic response, 43.5 percent of Medicare primary care visits in April 2020 were provided via telehealth, compared to 0.1 percent in February. HHS continues to overcome access issues, which exacerbate health problems, increase costs, and prevent better health outcomes.



Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play

HHS aims to protect and improve the health of Americans by promoting health and wellness knowledge, preparing for fatal outbreaks or natural disasters, and improving accessibility to health care. HHS programs help Americans take control of their health. Healthy living involves more than avoiding risky behavior and disease; health and wellness improves with healthy eating, regular physical activity, preventive care, and positive relationships. Mental illness and substance abuse create health risks and place a heavy burden on affected individuals and their families. HHS invests in programs focused on prevention, screening, and early detection of these risks, including those related to opioid misuse. HHS also focuses on environmental health and reducing the burden caused by disease and other conditions.

Supporting Divisions – ACF, ACL, AHRQ, ATSDR, CDC, CMS, FDA, HRSA, IHS, NIH, OCR, ASA, OASH, ASPR, ASPA, OGA, IEA, Office of National Security, and SAMHSA.

Progress Spotlight – In September 2020, FDA and CDC released findings from the *2020 National Youth Tobacco Survey* showing that 1.8 million fewer U.S. youth are currently using e-cigarettes compared to 2019. HHS continues to promote healthy living to reduce the e-cigarette use among younger Americans.

Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan

A core component of the HHS mission commits to improving the well-being of Americans, which includes those individuals and populations who are at high risk of social and economic challenges. Overall wellness goes beyond physical health: it entails positive social and economic development. HHS focuses on fostering environments where individuals and families can be socially and economically independent. A strong family can lead to many positive outcomes for the health, social, and economic status of both adults and children.

Supporting Divisions – ACF, ACL, CDC, CMS, HRSA, IHS, OASH, and SAMHSA.

Progress Spotlight – HHS has taken steps to ensure that children's interests are prioritized and represented in internal and interagency decisions affecting the Unaccompanied Children Program. The Office of Refugee Resettlement (ORR) within ACF coordinates with federal partners, including the Department of Homeland Security, to ensure expeditious transfer of children to shelters or unified with a family member or sponsor. ORR and its partners are developing a Unified Immigration Portal that will connect relevant data from multiple agencies to enable more complete understanding of an individual's journey through the immigration process.

Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences

HHS's success is contingent on scientific advances and discovery. Scientific investments through foundations, charities, private industry, and government entities strive to unlock mysteries that improve health and well-being; reduce death, disease, and disability; and extend and improve quality of life. These types of decisions rely on data acquired through surveillance, epidemiology, and laboratory services. Achievements in science tie to the other strategic goals, such as protecting Americans from disease outbreaks or reaching advances in public health care. Success in this domain starts with a high caliber workforce devoted to achieving award-winning breakthroughs. HHS aims to expand the capacity of the research workforce, equipping them with the tools to make discoveries of the future. To be effective, HHS must share, adopt, and implement scientific discoveries with fidelity. The Department is working to promote evidence-informed practices that improve health and human service fields.

Supporting Divisions – ACF, ACL, AHRQ, CDC, CMS, FDA, HRSA, NIH, OCR, OGA, OASH, ASPR, and SAMHSA.

Progress Spotlight – HHS supports multiple clearinghouses that catalog, review, and disseminate evidence related to programs, such as ACF's Research and Evaluation Clearinghouses on Self-Sufficiency and Child Care and Early Education, AHRQ's U.S Preventive Services Task Force, and SAMHSA's Evidence-Based Practices Resource Center.

Strategic Goal 5: Promote Effective and Efficient Management and Stewardship

HHS promotes sound stewardship for the financial resources the American taxpayers and Congress entrust to the Department through cultivation of top talent, development of robust and responsive information management systems, and the creation of a safe and secure environment for human, digital, and physical assets. Efforts such as *ReImagine HHS* improve the efficiency and accountability of the Department. *ReImagine HHS* is the Department's robust reform and transformation effort with goals to streamline processes, reduce burden, and realize cost savings. As the nation's largest grant-awarding agency, HHS is responsible for approximately a quarter of federal outlays and administers more grant dollars than all other federal agencies combined. HHS prioritizes the integrity of expenditures by maintaining effective risk management and internal controls for payments, grants, contracts, and other financial transactions, and by developing a financial management workforce with the expertise to comply with legislative mandates and requirements.

Supporting Divisions – ASFR, ASA, Office of the Chief Technology Officer, OGC, and Office of National Security.

Progress Spotlight – Efforts such as *ReImagine HHS*, which gathered over 1,900 bold ideas to lay out 6 strategic shifts with 10 self-sustaining initiatives, has improved the efficiency and accountability of the Department. Under the *ReImagine HHS*, the HHS Reinvent Grants Management initiative helping HHS to be selected as a best-in-class grants service provider by the Office of Management and Budget (OMB). Their stellar accomplishments include generating efficiencies through streamlined services by creating the Grant Recipient Digital Dossier to streamline HHS Grant review time from 4 hours to 15 minutes. In the *ReImagine HHS* *Buy*Smarter initiative, HHS leveraged buying power for enterprise infrastructure, achieving over $700 million in projected savings over 10 years. In addition, HHS is pioneering an effort to improve how agencies within HHS share, integrate, analyze, and visualize federated data to inform policy and evidence-based decision-making through the *Reimagine* Data Insights Initiative.

Agency Priority Goals

APGs are a set of ambitious but realistic performance objectives that the Department expects to achieve within a 24-month period. APGs involve effort coordinated across HHS components that provide cohesive themes for the Secretary's priorities. APGs include multiple performance measures reporting on HHS progress and provide a strong representation of how the Department coordinates to meet the HHS mission. APG results rely on strong agency implementation and do not require new legislation or additional funding. General areas of focus for APGs include customer service, efficiencies, and advances in progress toward longer-term, outcome-focused strategic goals and objectives. The APGs for FY 2020 – 2021 are:

1. End the HIV epidemic by reducing new HIV infections;
2. Reduce opioid-related morbidity and mortality; and
3. Reduce morbidity and mortality associated with end-stage renal disease and increase patient choice by improving access to alternatives to center-based dialysis.

For more information on HHS's APGs, visit Performance.gov. HHS performance initiatives continue to influence plans and policies identified in the Strategic Plan.

Cross-Agency Priority Goals

CAP Goals are government-wide goals defined by the PMA and identified below in **Figure 2**. The PMA provides a long-term vision for modernizing the federal government in key areas that will improve the ability of agencies to deliver mission outcomes, provide excellent service, and effectively steward taxpayer dollars on behalf of the American people. CAP Goals drive the implementation of the PMA. These goals provide accountability for results and utilize concrete, measurable performance indicators to track progress.

HHS aligns its management and business process improvement efforts to support CAP Goals. Senior accountable officials within the Department facilitate oversight and ensure effective progress toward goal achievement. HHS shares a government-wide leadership role on several CAP Goals, including "Results-Oriented Accountability for Grants," "Sharing Quality Services," and "Getting Payments Right." For more information on HHS performance and contributions to the PMA and CAP Goals, visit Performance.gov.

Figure 2: PMA CAP Goals

* Source: President's Management Agenda on Performance.gov

Performance Management

Performance goals and measures are powerful tools to advance an effective, efficient, and productive government. HHS regularly collects and analyzes performance data to inform decisions, gauge meaningful progress toward objectives, and identify more cost-efficient ways to achieve results. Responding to opportunities afforded by GPRAMA, HHS continues to institute significant performance management improvements that include:

- Developing, analyzing, reporting, and managing APGs, and conducting quarterly performance reviews between OpDivs and StaffDivs and HHS leadership to monitor progress toward achieving key performance objectives;
- Conducting the Strategic Reviews process to support decision-making and performance improvement across the Department;
- Overseeing and aligning strategic planning, budgeting, enterprise risk management, and performance management activities within the Department;
- Fostering a network of OpDiv/StaffDiv Performance Officers who support, coordinate, and implement performance management efforts across HHS; and
- Sharing best practices in performance management at HHS through webinars and other media.

Data Quality

HHS follows GPRAMA guidelines for reporting data quality. For all measures that appear in APG reporting or in the HHS Strategic Plan, HHS publicly reports:

- Processes used to verify and validate measured values;
- Sources for the data;
- Confirmation that the data meets the level of accuracy required for its intended use;

- Any limitations to the data at the required level of accuracy; and
- How the agency will compensate for such limitations if needed to reach the required level of accuracy.

Each agency within HHS is responsible for certifying that this data undergo a thorough quality assurance process and provides to the Performance Improvement Officer a signed letter of attestation. Data quality information for the APG-related measures mentioned below can be found online at Performance.gov. Data source and validation information on other data analyses, such as improper payment measures discussed in the "Other Information" section, can be found at HHS Budget and Performance.

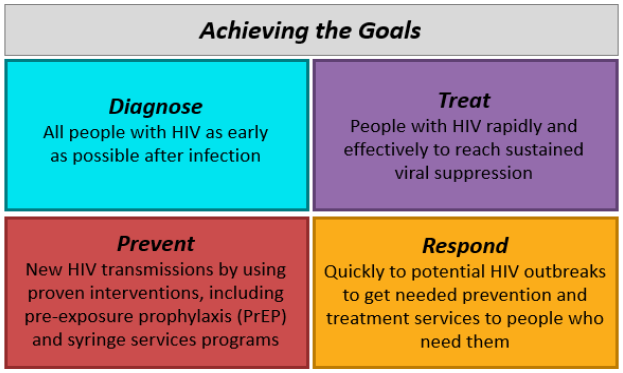
Performance Results

In FY 2020, HHS monitored over 900 performance measures to manage departmental programs and activities and to improve the efficiency and effectiveness of these programs. Due to a lag in data availability and the time of AFR publication, the final FY 2020 performance results will be available on the HHS Budget and Performance website by February 2021. The HHS Schedule of Spending in the "Financial Section" highlights the total spending by each material program. Funding represents one of many factors that may influence performance results. For more detailed information on HHS program performance and funding, refer to the Department's Budget in Brief, Annual Performance Plan and Report, and Congressional Budget Justifications available on the HHS website. For this report, HHS chose to highlight the achievements in three APGs: Ending the HIV Epidemic, Reducing Opioid-related Morbidity and Mortality, and Kidney Care. For additional information on HHS's APG accomplishments, refer to the HHS page on Performance.gov.

1. Ending the HIV Epidemic

Since 1981, more than 700,000 American lives have been lost to HIV/AIDS. While new HIV infections have declined since the early 2000s, CDC data indicates that progress has stalled and there are approximately 38,000 new infections per year. The U.S. government spends over $20 billion annually on direct health care for HIV prevention and care. HHS budgeted $270 million in FY 2020 for the Ending the HIV Epidemic (EHE) initiative. The *Ending the HIV Epidemic: A Plan for America* utilizes up-to-date epidemiological data as well as new biomedical prevention and treatment options to reduce the number of new HIV infections in the U.S. by 75 percent by 2025 and by 90 percent by 2030. This will prevent an estimated 200,000 new HIV cases over those 10 years, while protecting and preserving the health of people currently living with HIV.

HHS established collaborative working relationships and enhanced partnerships with 15 state health departments and 30 EHE priority counties to develop, implement, and evaluate EHE strategies. The EHE initiative is founded on evidence-based strategies within four pillars shown below:



Phase I efforts focus on 48 counties, D.C., and San Juan, which accounted for over 50 percent of all new HIV diagnoses in 2016 and 2017, as well as the 7 states with substantial burden of HIV in rural areas.

HHS provided reference material to keep patients and providers informed with the latest HIV findings. HRSA also released Notices of Funding Opportunity and pre-application technical assistance webinars for programming within the Ryan White HIV/AIDS Program to be conducted using Minority HIV/AIDS Program funds. For National HIV Testing Day, HRSA provided resources to health centers with the theme of "Knowing that Together We Can End the HIV Epidemic," which kept health centers and patients in-the-know about HIV testing, prevention, and treatment options. Additionally, CDC published the EHE in Action web page with first collection of success stories and lessons learned from jump-start programs in Phase I jurisdictions.

HHS conducted outreach to communities disproportionately impacted with HIV (e.g., LGBTQ+, YBMSM, AA, Latinx) to determine common themes and challenges to ensure program interventions are relevant to communities served. To inform at-risk communities, such as the American Indian/Alaska Native (AI/AN) population, the Albuquerque Area Southwest Tribal Epidemiology Center developed an HIV/AIDS Resource Guide for the 27 tribal communities in New Mexico and southwestern Colorado. The guide contains data on HIV, Hepatitis C Virus, and other sexually transmitted infections (STI) in the geographic regions and highlights area resources in the communities that provide HIV testing and pre-exposure prophylaxis (PrEP). Albuquerque Area Southwest Tribal Epidemiology Center also developed a factsheet featuring indicators on injection drug use and sexual behaviors in youth that may contribute to the spread of HIV/Hepatitis C Virus/STI in New Mexico.

Visit the HHS website for more information.

HHS conducted an assessment of HIV Telehealth services in the regions and shared best practices across jurisdictions to improve HIV program outcomes. Using state-based data from CDC and the New Mexico Department of Health, the team developed a factsheet highlighting data on sexual behaviors and STI prevalence among AI/AN adults in New Mexico. The National Indian Health Board created two toolkits: HIV-related social media and PrEP for AI/AN health care providers and community members.

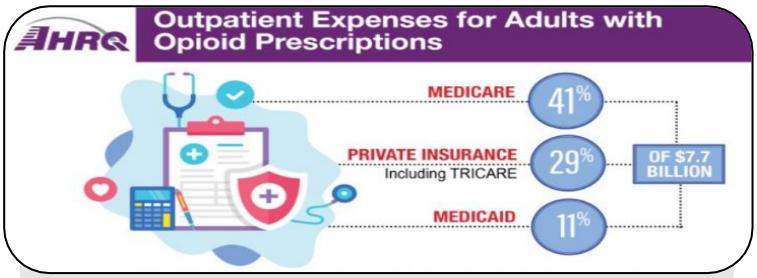
COVID-19 Impacts on APG. HHS assessed the impact of COVID-19 on HIV services and provided resources to support provider organizations to maintain services in the regions. Many AIDS service organizations and Community-Based Organizations closed their doors or reduced services during the COVID-19 pandemic. Emergency room visits have reduced by 42 percent, resulting in a decline in the number of people receiving HIV and STI screenings, and Syringe Services Programs operations have reduced by 50 percent. Most disease intervention specialists were redirected to focus on the COVID-19 pandemic. Staff from the Ryan White HIV/AIDS Program Parts A and B (local and state health departments) and Part C (clinics) were deployed to COVID-19 hot spots, which reduced their ability to focus on EHE activities. HRSA's HIV/AIDS Bureau anticipates that some EHE activities will be delayed until 2021. There are some important lessons learned from the COVID-19, such as the use of telehealth, which will be relevant for EHE going forward.


In response to the pandemic, CDC released guidance to grantees and partners to help programs, such as PrEP, adapt to the unprecedented challenges of battling HIV and COVID-19. CDC also provides FAQs on HIV self-tests for contactless and private testing. To learn more about HIV and COVID-19, visit CDC's website.

2. Reducing Opioid-related Morbidity and Mortality

Opioid misuse and overdose present a nationwide public health challenge. The crisis of opioid addiction and overdose in the U.S. continues to claim far too many lives, driven by highly potent illicit synthetic opioids in the drug supply. In 2018, 2 million people in the U.S. had an opioid use disorder; 46,802 Americans died from a drug overdose involving opioids, accruing an enormous societal toll. In response to this public health emergency, HHS announced a 5-Point Strategy for combatting opioid morbidity and mortality:

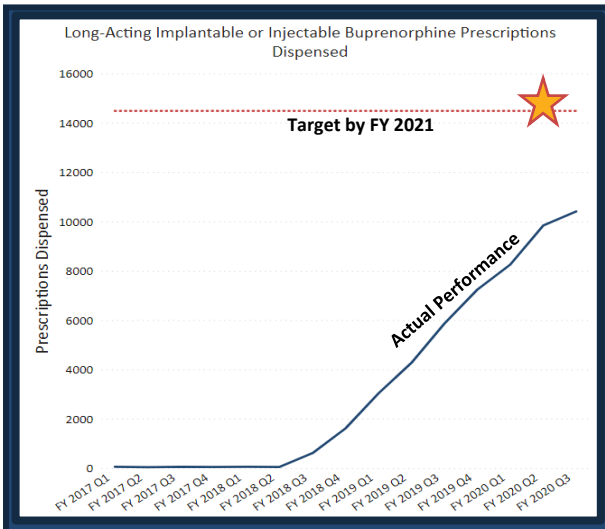
1. Improve access to prevention, treatment and recovery support services;
2. Strengthen public health data and reporting;
3. Advance the practice of pain management;
4. Target the availability and distribution of overdose-reversing drugs; and
5. Support cutting-edge research.



For more information, check out the AHRQ Medical Expenditure Panel Survey Statistical Brief #529.

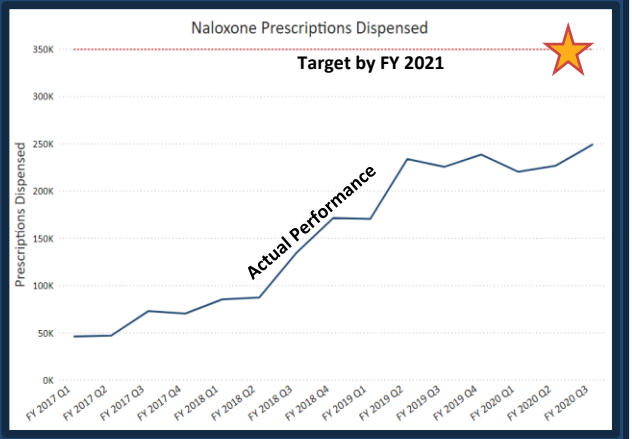
HHS continues to monitor progress on the implementation of this 5-Point Strategy through a variety of reporting tools, including the HHS Reducing Opioid-related Morbidity and Mortality APG. This APG reports multiple key indicators; HHS provides three in this report: 1) the number of naloxone prescriptions dispensed, 2) the number of extended-release naltrexone prescriptions dispensed, and 3) the number of long-acting implantable or injectable buprenorphine prescriptions dispensed. For other data charts or additional information on the remaining key indicators and other report updates, refer to Performance.gov.

Due to a lag in data availability and the time of AFR publication, the performance results presented in the charts below represent data from the third quarter of FY 2020.

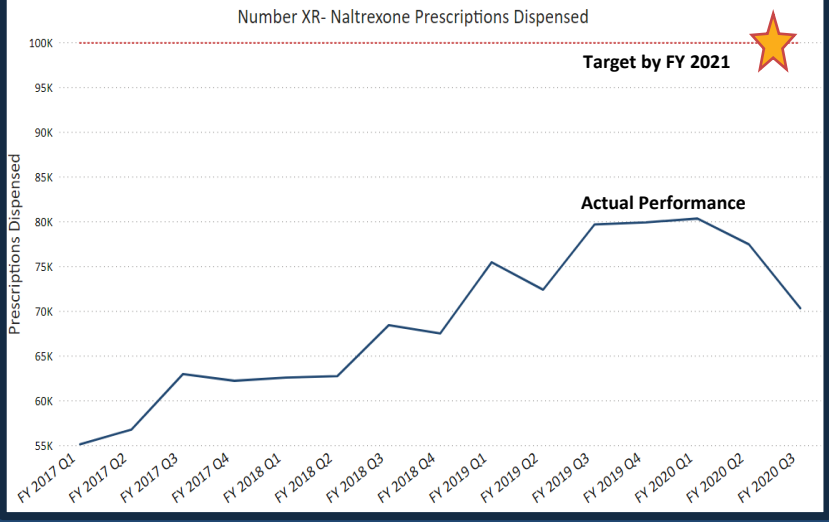


The number of long-acting buprenorphine prescriptions increased 162-fold following the entrance of an injectable form to the market after FDA's approval in November 2017.

The rate of increase in naloxone prescriptions has declined since mid-2019, though in recent quarters the trajectory has gone up. This leveling off may reflect naloxone sources outside of prescriptions, such as community distribution.



COVID-19 Impacts on APG. HHS's programs saw increases in mortality from stimulants with and without opioid combinations and a prevalence of overdose from fentanyl, which are harder to reverse. Since the declaration of COVID-19 as a national emergency, Millennium Health data reported an increase in positive urine drug tests for non-prescribed fentanyl (31.96 percent) and heroin (12.53 percent). Additionally, overdose submissions reported to the Overdose Mapping and Application Program showed similar increases. Fewer overdose patients are being treated in the emergency department and there is a reduction in referral to treatment. Social distancing has caused anecdotal reports of longer wait times and treatment facility closures.



The number of naltrexone prescriptions dispensed was level before declining in Q3 FY 2020; reasons for Q3 decline are uncertain, but could reflect impact of COVID-19 pandemic.

Social isolation, financial burdens, and other consequences of COVID-19 may contribute to increases in substance use; opioid-related lung impairment may increase risk for serious effects from COVID-19. The burden of COVID-19 on health care systems may be a barrier to treatment for substance use disorder and patients may not seek care in order to avoid exposure to the virus. HHS cannot be certain these factors directly affected APG progress; however, it may be the cause for the decline in FY 2020.

Despite the challenges from the COVID-19 pandemic, HHS took action to overcome these obstacles. Since March 2020, HHS and its partners made policy changes to address COVID-19 impacts. For example, in March 2020, SAMHSA issued guidance to facilitate substance use disorder treatment during the pandemic, including the use of telemedicine and telephone. SAMHSA also issued guidance allowing 28 days of take-home methadone doses for stable patients, and 14 days of take-home doses for less stable patients deemed able to handle the dosage. In partnership with the U.S. Department of Justice's Drug Enforcement Administration, SAMHSA released guidance for e-prescribing and initiating medication for opioid use disorder. This allows prescribing of buprenorphine without an in-person medical evaluation; however, treating new patients with methadone requires an in-person evaluation.

On March 17, 2020, CMS's Medicare program expanded telemedicine reimbursement rules to allow providers to conduct telehealth visits with SUD patients, bill for telehealth services (both video and audio-only), practice remote care across state lines, and deliver care to both established and new patients through telehealth.

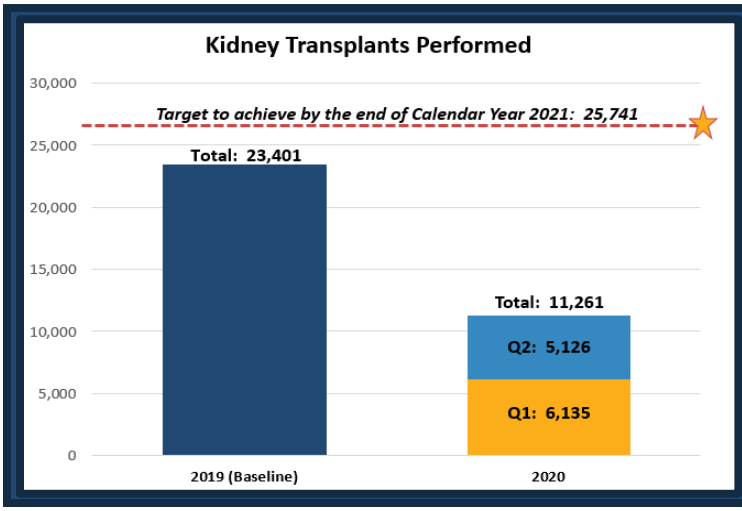
3. Kidney Care

Approximately 37 million Americans have kidney disease, and, in 2017 kidney disease was the ninth-leading cause of death in the U.S. The primary form of treatment for kidney failure, often referred to as end-stage renal disease (ESRD), is dialysis, which is one of the most burdensome, draining long-term treatments modern medicine has to offer. A system that pays for kidney health, rather than kidney sickness, would produce much better outcomes, often at a lower cost, for millions of Americans.

HHS developed a plan for Advancing American Kidney Health, which includes the following goals:

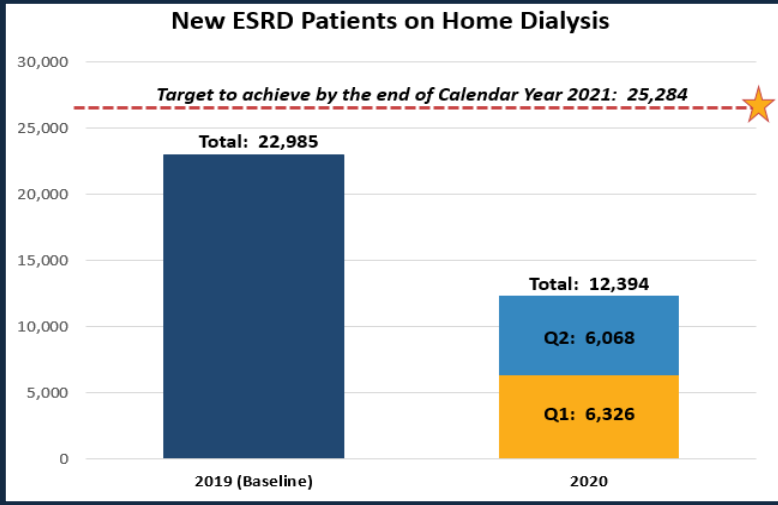
- Reduce the risk of kidney failure;
- Improve access to and quality of person-centered treatment options; and
- Increase access to kidney transplants.

HHS established the Kidney Care APG in FY 2020. HHS tracks progress toward the achievement of these goals through the key indicators included in the Kidney Care APG. The charts below demonstrate HHS's progress in 2020 compared to the baseline data leveraged from 2019 as of the second quarter of calendar year 2020. The federal fiscal year begins one quarter prior to the calendar year, accounting for the discrepancy of a quarter between this APG and the others that report on a fiscal year basis. Due to the lag in data availability and the time of AFR publication, the charts include available data as of September 2020. To find the most recent data, visit Performance.gov.



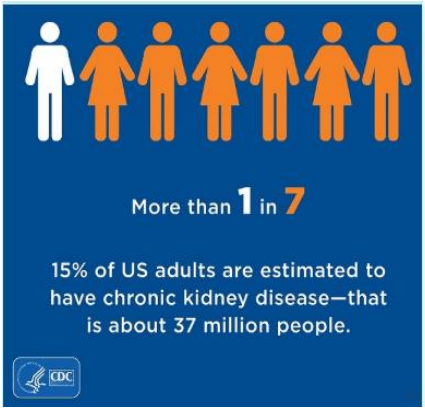
The Q2 of calendar year 2020 results (5,126 kidney transplants performed) are included in the 2020 Year-to-date amount, which is displayed relative to the 2019 Baseline. HHS aims to achieve the Target line by the end of calendar year 2021. The baseline is larger than the Q2 calendar year 2020 result total because it includes all four quarters of the year.

In FY 2020, CMS made strides toward achieving this APG. CMS announced the Kidney Care Choices Model, which will provide incentives for kidney care providers to improve management of care for patients with late-stage chronic kidney disease and ESRD to delay the onset of dialysis and encourage kidney transplant. CMS proposed a rule for Organ Procurement Organizations that revises key outcome metrics to encourage Organ Procurement Organizations to increase the organ donor pool and the rate of actual transplant of acquired organs. For more on the federal rulemaking process, refer to the Office of the Federal Register's



The calendar year 2020 Q2 results (6,068 new end-stage renal disease patients on home dialysis) are included in the 2020 Year-to-date amount, displayed relative to the Baseline (calendar year 2019) and the Target to achieve by end of calendar year 2021. The calendar year 2019 baseline reflects all new ESRD patients for that year.

guide. CMS also finalized rulemaking to implement the ESRD Treatment Choices Model to encourage increased use of home dialysis and kidney transplantation for Medicare ESRD beneficiaries. The model will provide resources to ESRD facilities and clinicians managing ESRD patients to support provision of home dialysis and transplant services. Additionally, CMS finalized its proposal to allow transitional add-on payments to ESRD facilities for purchasing new and innovative home dialysis machines. This proposal will allow ESRD facilities that purchase new and innovative home dialysis machines for individual patient's home-use to receive an additional payment for 2 years, which will offset the cost of acquiring and integrating innovative equipment into their operations to support home dialysis. Finally, CMS finalized the ESRD Quality Incentive Program, a quality measure to encourage ESRD facilities to assist eligible dialysis patients in getting on the kidney transplant waitlist beginning in 2021.



Did You Know?

HHS partnered with the American Society of Nephrology to accelerate innovation in the prevention, diagnosis, and treatment of kidney diseases. KidneyX seeks to improve their lives by accelerating the development of drugs, devices, biologics, and other therapies across the spectrum of kidney care. KidneyX engages a community of researchers, innovators, and investors to bring breakthrough therapies. To learn more about KidneyX, visit the HHS website.

In April 2020, OCR resolved a compliance review of the State of Alabama after the state removed ventilator rationing guidelines that allegedly contained exclusion criteria that allowed for denying ventilator care to patients on the basis of disability and age, including patients with ESRD under certain circumstances. As a result of OCR's intervention, the State of Alabama released new guidelines without such exclusions and clarified that it would not single out certain disabilities for unfavorable treatment or use categorical age cutoffs in its current or future guidelines. In addition to Alabama, OCR has reached similar resolutions throughout FY 2020 with the States of Pennsylvania, Connecticut, and Tennessee to remove potentially discriminatory provisions from their crisis standards of care plans.

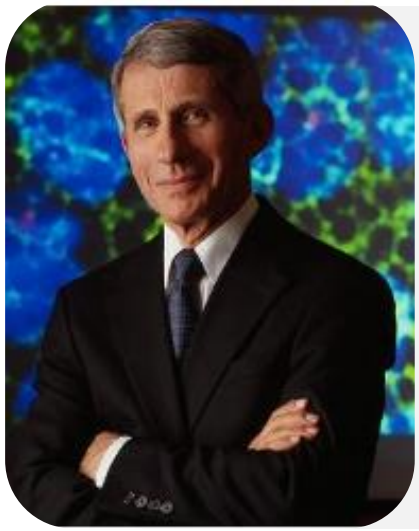
HHS continues to release guidance materials to help providers and patients in managing their kidney care. For example, OASH and CDC published "Assessing Solid Organ Donors and Monitoring Transplant Recipients for Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus Infection — U.S. Public Health Service Guideline, 2020" in the June 26, 2020, *Morbidity and Mortality Weekly Report*. CDC is developing education and communication materials including patient and provider factsheets related to the revised Public Health Service Guideline. CDC and IHS also published an article on kidney care data among AI/AN, titled "Sustained Lower Incidence of Diabetes-Related End-Stage Kidney Disease Among American Indians and Alaska Natives, Blacks, and Hispanics in the U.S., 2000-2016" in Diabetes Care. IHS continues to monitor diabetes-care measures among IHS patients. For people with diabetes, control of blood sugar and blood pressure, along with regular monitoring of kidney function are important to help prevent kidney failure. As more data becomes available, HHS will continue to release guidance information to its stakeholders.

COVID-19 Impacts on APG. The volume of kidney transplants (both living and deceased donors) decreased dramatically during the COVID-19 public health emergency. The number of kidney transplants performed from April to June 2020 represents a 16.4 percent decrease from the number of kidney transplants reported for January to March 2020. HRSA anticipates performance on this measure may be impacted for the duration of the public health emergency as hospitals prioritize resources to COVID-related activities and reassess the potential transmission risk to transplant recipients. Additionally, AI/AN were impacted as IHS facilities focused on providing COVID-related

services and other emergency care during this pandemic response. To avoid potential COVID-19 exposure risk, there have been fewer in-person diabetes visits; however, increased utilization of telehealth helped address some of the needs for chronic disease management. The rate of new kidney failure patients starting on home dialysis decreased slightly during Q2, likely due to diversion of resources away from training and initiation due to the COVID-19 public health emergency. We anticipate this rate will increase as operations return to normal and facilities encourage in-home dialysis as a means of infection control.

To assist in the pandemic response, ASPR procured and deployed 50 portable dialysis platforms in order to provide care to patients succumbing to acute kidney injury associated with complications from COVID-19. ASPR developed, and is executing towards, a requirement for 50 more portable dialysis platforms and 500 continuous renal replacement therapy devices in order to address the kidney care needs associated with COVID-19. These platforms are FDA-approved and will continue to be deployed to COVID-19 hotspots, as requested by state and local authorities during disaster responses.

OCR's enforcement and policy work has also increased in response to the COVID-19 pandemic. OCR received over 600 civil rights complaints related to COVID-19. As a response, OCR initiated multiple detailed compliance reviews of states with crisis standards of care plans that could discriminate against patients based on disability and age in rationing health care, including dialysis. Fifteen of the COVID-19 complaints are related to dialysis facilities or someone who has kidney disease, diabetes, or is on dialysis. OCR also released several bulletins intended to assist covered entities in complying with civil rights laws during the pandemic to ensure individuals receive necessary care. This work is relevant to ensure that older patients and patients with disabilities, including kidney patients, are not subjected to discrimination in the delivery of health and human services, including dialysis care and kidney transplantation.



Did You Know?

As the 2020 Federal Employee of the Year, Dr. Fauci was awarded the Samuel J. Heyman Service to America Medal for his significant contributions to the health, safety, and prosperity of our country. In 1984, Dr. Anthony Fauci was appointed Director of the National Institute of Allergy and Infectious Diseases (NIAID), under NIH. During his 36 years as NIAID Director, Dr. Fauci advised six presidents on domestic and global health issues. He oversees an extensive research portfolio of basic and applied research to prevent, diagnose, and treat established infectious diseases, including emerging diseases such as Ebola, Zika, and COVID-19. To learn more about Dr. Fauci, visit the NIAID website.

Looking Ahead to 2021

HHS is the U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. While HHS is a domestic agency, the interconnectedness of our world requires HHS to engage globally to fulfill its mission. Our 11 OpDivs, including 8 agencies in the U.S. Public Health Service and 3 human services agencies, administer HHS's programs. In addition, StaffDivs provide leadership, direction, and policy guidance to achieve the Department's strategic goals and objectives.

Through the guidance of the HHS Strategic Plan, in 2021 HHS will address important health care, public health, and human services issues that impact all Americans.

HHS Strategic Goal 1: Reform, Strengthen, and Modernize the Nation's Healthcare System

Telehealth: HHS will use lessons learned from increased telehealth services during the COVID-19 pandemic to better understand how providing health care services virtually can expand access to quality services without increasing overall spending.

The Health Care Workforce and Infrastructure: HHS will continue to identify and address gaps in the health care workforce to enhance and improve the capacity of the existing workforce, and identify opportunities to maximize health care productivity. We will evaluate promising programs and innovations, and reduce barriers to more widespread adoption.

Drug Pricing: HHS will continue its efforts to lower the list prices of prescription drugs through competition and pricing incentives to ensure that Americans have access to affordable prescription drugs. We will continue reforms to increase competition in areas such as approval of generic drugs and biosimilars, as well as pursue payment policies to help patients take advantage of this competition.

Insurance Reform: HHS will continue to focus on the cost and availability of health insurance to ensure Americans have access to affordable insurance that meets their needs. In addition, we will continue our efforts to restore balance and enhance sustainability in the Medicaid program and eliminate barriers for people looking to move from dependence on Medicaid to independence.

Price and Quality Transparency: HHS will continue to focus on improving and developing price and quality transparency initiatives to ensure that consumers and their families can make well-informed decisions about their health.

Value Based Care: HHS is putting patients at the center of the health care system, making sure they have the information they need to determine value and make appropriate choices. We will continue to address the value of health care services by moving from a system where payments are based on the volume of services to a system where payments are based on outcomes and value.

HHS Strategic Goal 2: Protect the Health of Americans Where They Live, Learn, Work, and Play

COVID-19 Response: HHS will continue its ongoing efforts to support consumers, providers, states, tribal and territorial governments, and other stakeholders during the COVID-19 pandemic. HHS aims to deliver access to safe and effective vaccines and therapeutics as the nation continues fighting COVID-19. We will remain particularly focused on efforts to address the needs of those disproportionately impacted by COVID-19, including frontline healthcare workers, the elderly, racial and ethnic minorities, and people living in long-term care facilities.

Looking Ahead to 2021

Disparities: COVID-19 has taken a disproportionate toll on the nation's racial and ethnic minorities. As the Department continues addressing the pandemic, HHS will ensure that our intervention impact on minority populations, in terms of morbidity and mortality, is taken into account. In addition, we will continue to implement our comprehensive response to tackle the drivers of these disparities.

Rural Health: Guided by the Department's Rural Action Plan, HHS will continue to improve access and quality of care in rural and underserved areas by identifying policies that deliver the right care, at the right place, at the right time in rural America.

The Opioid Crisis: The COVID-19 pandemic affected patients' access to care for pain management, opioid use disorder, and related conditions. These changes in access may have ongoing effects on patterns of opioid use, opioid-involved overdose, and opioid use disorder and treatment. HHS will continue to empower states and local communities on the frontlines of the opioid crisis by implementing its 5-Point Opioid Strategy. We will advance efforts to address the opioid crisis by:

1. Addressing workforce shortages and treatment coverage, including medication-assisted treatment;
2. Increasing the timeliness and accuracy of data to monitor opioid use, misuse, and overdose;
3. Improving pain management with a focus on increasing the availability of effective non-opioid alternatives;
4. Better targeting the availability of overdose-reversing drugs; and
5. Supporting cutting-edge research on both pain and substance use disorder.

HHS will also continue efforts (e.g., following up on interviews with state officials) to address the increasing number of psychostimulant-involved overdose deaths, sometimes referred to as the "fourth wave" of the opioid crisis.

Kidney Health: HHS aims to continue its focus on kidney health reducing morbidity and mortality associated with end-stage renal disease and increasing patient choice by reducing the risk of kidney failure through detection, prevention, and treatment of risk factors; improving access to home-based dialysis; encouraging the development of new renal replacement therapies such as an artificial kidney; and increasing access to kidney transplants. HHS will continue to engage with stakeholders in our efforts to increase public awareness of kidney health, support and empower patients living with kidney disease, introduce new payment models for kidney care, and invest in innovative research and development.

Maternal Health: To improve maternal health outcomes, HHS continues to develop new strategies for women to attain and maintain healthy outcomes throughout the life course; clinicians to screen and treat risk factors; and health systems to address maternal safety, health disparities, and social determinants of health. In support of these efforts, HHS will improve maternal health data collection and bolster research efforts to better understand risk factors while continuing to identify effective, evidence-based, best practices in maternal health.

Suicide Prevention: HHS will build on its interagency suicide prevention efforts. In recent years, suicide rates have risen among all age groups and in almost every state. Factors associated with the COVID-19 pandemic—such as bereavement, job loss, and changes in access to healthcare and social supports, among others—may have ongoing effects on suicide risk. HHS has increased attention on suicide risk among people without diagnosed mental disorders and is customizing prevention efforts to become culturally appropriate for different segments of the U.S. population.

HHS Strategic Goal 3: Strengthen the Economic and Social Well-Being of Americans Across the Lifespan

Economic Mobility and Resilience: To move families from dependence to independence and help them recover from the economic consequences of the COVID-19 pandemic, HHS will use federal levers and tools, such as program flexibilities, technical assistance, research analyses, and program coordination, to promote family-sustaining careers and economic mobility for low-income Americans and help displaced workers reconnect to the workforce. The new U.S. Interagency Council on Economic Mobility will continue to streamline and coordinate federal programs and policies designed to promote work and economic mobility across the lifespan, creating an accountable and effective structure for federal interagency collaboration.

Child Welfare and Adoption: HHS will continue work to increase child and family well-being by moving away from traditional, reactive child protection systems toward systems designed to proactively support child and family well-being, prevent child maltreatment and unnecessary family separation, and break harmful intergenerational cycles of trauma and poverty. We will continue to encourage increasing adoptions to achieve permanency for children in the child welfare system.

HHS Strategic Goal 4: Foster Sound, Sustained Advances in the Sciences

Data and Evidence: HHS develops, uses, and analyzes data to support the best science and generate new evidence. We will continue implementing the *Foundations for Evidence-Based Policymaking Act of 2018,* which creates a new paradigm for developing and using evidence for decision-making. Efforts continue across HHS to ensure better access to HHS data for lower-cost analysis; support patient-centered outcomes research; improve how we use evaluation and performance management data to drive learning, improvement, and analysis for better decision-making; and translate science into practice to ensure the best outcomes possible for the people served by HHS programs and policies.

HHS Strategic Goal 5: Promote Effective and Efficient Management and Stewardship

Accountability for COVID-related Funding: HHS is cognizant of the responsibility that accompanies the large infusion of FY 2020's COVID-related funding and pledges diligent attention, throughout the Department, to its effective use and management.

ReImagine HHS: In 2017, HHS launched *ReImagine HHS*, an agency-wide effort to transform operations and culture across the Department to become more effective, efficient, and accountable. Although the *ReImagine HHS* program "graduated" in FY 2020, its tactics and culture of innovation, improvement, and collaboration will carry forward sustainable partnerships between HHS offices and teams to create a long-term impact on the HHS mission.

Data Insights: The HHS Data Science CoLab is leveraging practices such as *ReImagine Data* to unlock the full potential of HHS's data. The *ReImagine* Data Insights Initiative is pioneering an effort to improve how agencies within HHS share, integrate, analyze, and visualize federated data to inform policy and evidence-based decision-making. HHS will use predictive artificial intelligence to mitigate pressing public health issues before they occur, such as predicting viral outbreaks or assisting health care providers in determining disease prevalence by geographic area, to better inform patient diagnoses and treatments. The HHS Data Science CoLab will continue to build a community of HHS employees and skilled data scientists to continuously improve data insights.

Systems, Legal Compliance, and Internal Control

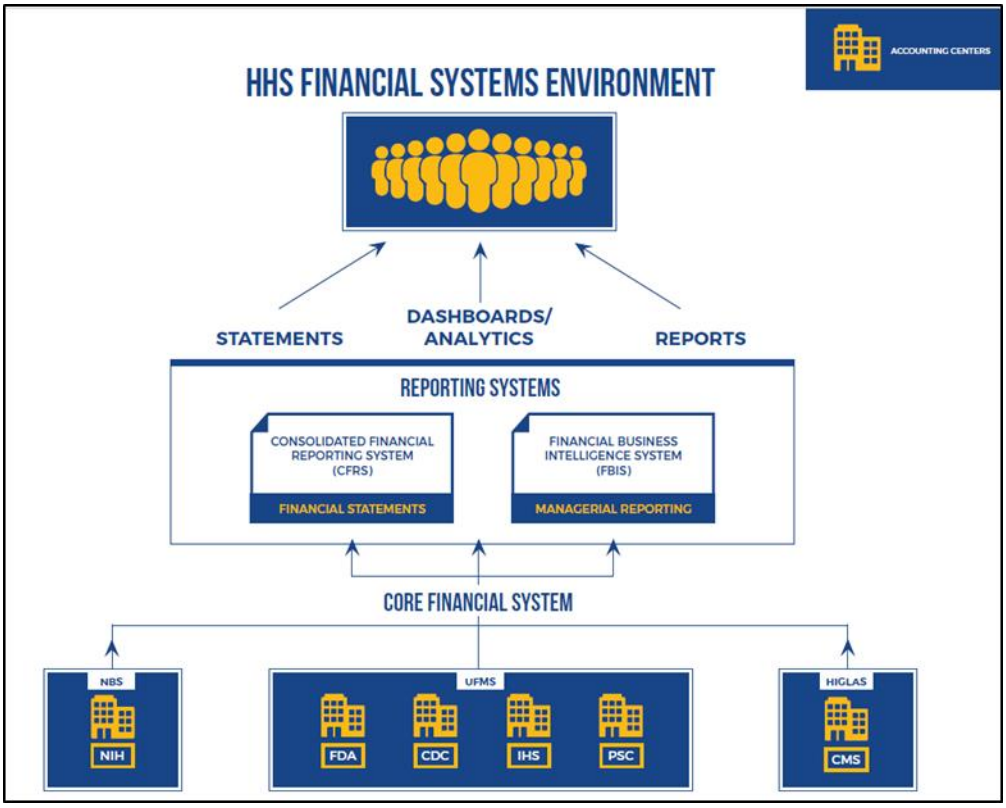
Systems

HHS's Chief Financial Officer (CFO) community continuously strives to enhance the financial management systems environment in an effort to sustain HHS's diverse portfolio of mission-oriented programs and business operations. The primary objective of the financial management systems environment is to: (1) efficiently process financial transactions in support of program activities and HHS's mission; (2) provide complete and accurate financial information for decision-making; (3) improve data integrity; (4) strengthen internal control; and (5) mitigate risk.

The financial systems framework at HHS provides the foundation to manage approximately $2.4 trillion in budgetary resources entrusted to the Department in FY 2020. These resources include the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act) and other supplemental funding vital to assisting citizens with the public health and economic impacts of COVID-19. HHS's financial systems environment supports and ensures the efficient and timely disbursement of funds, which is a critical factor in advancing HHS's COVID-19 relief efforts. Additionally, HHS's robust financial systems environment provides federal contract, grant, loan, and other financial assistance data to USASpending.gov, which presents clear, accurate, and timely awards information and promotes transparency and accountability to the American public.

Detailed in **Figure 3** below, the HHS financial management systems environment consists of a core financial system (with three instances, or components) and two Department-wide systems for financial reporting and managerial reporting. Together, these systems provide the Department's financial accounting and reporting needs.

Figure 3: HHS Financial Management Systems Environment



Core Financial System

The core financial system's three instances presented in the table below all operate on the same commercial off-the-shelf platform to promote Department-wide data standardization and facilitate Department-wide reporting.

Three Instances of the Core Financial System

Instance	Description
Healthcare Integrated General Ledger Accounting System (HIGLAS)	HIGLAS processes an average of five million transactions daily and supports four lines of CMS business: the Medicare Fee-for-Service (FFS), Medicare Secondary Payer, Federal Facilitated Marketplace, and the Administrative Program Accounting activities .
NIH Business System (NBS)	NBS combines NIH administrative processes and financial information under one centralized component, supporting NIH's diverse biomedical research program, and business, financial, acquisition, and logistics requirements for 27 NIH Institutes and Centers. NBS also supports grant funding for more than 300,000 researchers at over 2,500 universities, medical schools, and other research institutions in every state and around the world.
Unified Financial Management System (UFMS)	UFMS integrates with over 50 program, business, and administrative systems including U.S Department of the Treasury (Treasury) and the General Services Administration systems; HHS enterprise-wide acquisition, grant, and human resource systems; and program specific payment systems to provide a secure, reliable, and highly available financial management environment supporting the CDC, FDA, IHS, and PSC. PSC provides shared-service accounting support for ACF, ACL, HRSA, AHRQ, SAMHSA, and all StaffDivs within OS.

Reporting Systems

Reporting systems within the HHS financial management systems environment consist of two Department-wide applications that facilitate financial statement compilation, financial and managerial reporting, and data analysis.

HHS Reporting Systems

Reporting System	Description
Consolidated Financial Reporting System (CFRS)	CFRS systematically consolidates information from the core financial system's three instances to generate Departmental quarterly and year-end consolidated financial statements on a consistent and timely basis while supporting HHS in meeting regulatory reporting requirements.
Financial Business Intelligence System (FBIS)	FBIS is the financial enterprise business intelligence application that supports the information needs of HHS stakeholders, including executives, managers, and operational end-users, with making informed business decisions to support their organization's mission. FBIS retrieves, combines, consolidates, and reports data from the core financial system. It provides end-users with the functionality to analyze data and present actionable information, including metrics and key performance indicators, dashboards with graphical displays, interactive reports, and ad-hoc reporting.

Relevant Legislation and Guidance

The HHS financial management systems environment must comply with all applicable federal laws, regulations, and authoritative guidance. In addition, HHS must conform to federal financial management and systems requirements including:

- *Federal Managers' Financial Integrity Act of 1982*
- *Chief Financial Officers Act of 1990*
- *Government Management Reform Act of 1994*
- *Federal Financial Management Improvement Act of 1996*
- *Clinger-Cohen Act of 1996*
- *Federal Information Security Management Act of 2002*, as amended by the *Federal Information Security Modernization Act of 2014*
- *Digital Accountability and Transparency Act of 2014*
- *Federal Information Technology Acquisition Reform Act of 2014*
- *Fraud Reduction and Data Analytics Act of 2015*
- *Coronavirus Aid, Relief, and Economic Security Act*
- Office of Management and Budget directives and U.S. Department of the Treasury guidance related to these laws

Financial Systems Environment Improvement Strategy

HHS continues to promote a Department-wide strategy to advance its financial systems environment through two well-established programs: the Financial Systems Improvement Program (FSIP) and Financial Business Intelligence Program. The portfolio of projects within these programs addresses immediate business needs, which positions the Department to take advantage of state-of-the-art tools and technology. The strategy's goals are to improve the effectiveness and efficiency of the Department's financial management capabilities; mature the overall financial systems environment; and strengthen accountability and financial stewardship. Through this multi-year initiative HHS continues to make significant progress in the following six key strategic areas:

1. Financial Systems Modernization

Strategy: HHS initiated the FSIP with foundational projects that included a major core financial system upgrade and transition of key financial systems to a cloud service provider for hosting and application management. With those major initiatives successfully completed, HHS continues directing resources toward incrementally improving the efficiency and effectiveness of the modern financial systems environment. Together, the design of these projects will significantly mature the HHS financial systems environment, offering benefits that include: enhancing information access; complying with and implementing evolving federal requirements; achieving efficiencies and promoting standardization; safeguarding system security and privacy; eliminating security and control vulnerabilities; and maximizing the return on existing system investments.

Progress: In FY 2020, HHS enhanced the *Digital Accountability and Transparency Act of 2014* (DATA Act) solution to support the new CARES Act requirements. The Department streamlined business and system processes to accelerate the validation and submission of data to the Treasury to meet the new CARES Act monthly reporting requirements. The enhanced process significantly reduced the need for stakeholder data calls and enabled HHS to meet COVID-19

monthly reporting requirements in accordance with OMB Memorandum M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)* and the CARES Act. In addition, HHS modernized the foundational DATA Act solution to automate integration with Treasury, the first of its kind in the federal government. The modernized, flexible integration allows HHS to minimize the impact of unplanned changes made by Treasury, which in turn reduces complexity and maintenance costs, and increases HHS's data reliability to successfully perform monthly reporting.

HHS launched a Robotic Process Automation pilot to automate repetitive and manual tasks, improve agility and response time, and increase workforce capacity. Six labor-intensive system and financial management processes were selected for pilot automation. Building on success from these pilots, HHS is developing an Automation-as-a-Service strategy to accelerate the automation of manual processes, resulting in improved productivity, lower costs, increased efficiency, and enhanced business value.

Additionally, HHS undertook various initiatives to improve the security, reliability, and availability of HHS's financial systems environment, thereby enhancing service delivery to the end user. HHS established a Service Oriented Architecture infrastructure to incrementally modernize integration between the core financial system and over 50 feeder systems. HHS evaluated modern cloud environments in preparation for transitioning HHS's financial systems from its current cloud environment to a new, modern environment, taking advantage of advances in cloud capabilities, such as scalability, elasticity, and metered usage. DevSecOps is a set of practices that combines software development (Dev), Security (Sec) and Information Technology Operations (Ops) to increase speed and agility in managing financial systems. In FY 2020, HHS conducted a DevSecOps assessment and developed a roadmap to increase speed, enhance reliability, and improve quality of service in delivering changes to the financial system user community.

2. Business Intelligence and Analytics

Strategy: Leveraging the FBIS platform, HHS is expanding the use of business intelligence and analytics across the Department. The goal is to establish an information-driven financial management environment where stakeholders at all levels have access to timely and accurate information required for measuring performance, increasing transparency, and enhancing decision-making. This will allow the Department to more effectively meet evolving information demands for fiscal accountability, performance improvement, and external compliance requirements.

Progress: Since FY 2012, FBIS has provided operational and business intelligence capabilities to the HHS financial management community. FBIS offers accurate, consistent, and near real-time data from UFMS and NBS (together serving 5 of HHS's 6 Accounting Centers) and summary data from HIGLAS to support over 1,900 FBIS users Department-wide. To facilitate improved stewardship and decision-making, HHS enhanced FBIS's capabilities in FY 2020 by expanding its managerial reporting functionality and by developing new, insight-driven reports and dashboards. This included: (1) enhancing the FBIS Control Monitoring Dashboard by instituting a risk-based approach for monitoring Segregation of Duties (SOD) controls. This dashboard helps Accounting Centers analyze transactions for potential SOD violations by focusing monitoring around manual transactions processed by end-users, while relying on other internal controls for automated minimal risk transactions; (2) the FBIS Undelivered Orders Dashboard, which provides program managers comprehensive financial and program data to track Undelivered Orders and identify unused funds for deobligation; and (3) the FBIS COVID-19 Dashboard, which assists HHS OpDivs with monitoring COVID-19 supplemental funding including funds allotted and spent. Together, these dashboards have further strengthened HHS's culture of information-driven decision-making, by providing macro level data and enabling analytic capabilities to allow users to "dive deeper" into specific transactions.

In order to increase the use and maturity of FBIS, HHS implemented a Customer Strategy Initiative, which collected input from over 300 users and provided HHS with a better understanding of the end-user community's needs. This

initiative resulted in new and improved training to help expand users' knowledge of the system and more tailored communication to increase Department-wide FBIS adoption. As a result, from FY 2019 to FY 2020, the number of active FBIS users grew 12 percent; demonstrating increased reliance on FBIS for managerial reporting needs, especially for CARES Act funding monitoring and reporting. Further, through rigorous training, 15 percent of end-users now have the ability to create custom FBIS reports, which expands self-service capabilities and minimizes the time and cost previously needed to coordinate with IT subject matter experts.

3. Systems Policy, Security, and Controls

Strategy: The reliability, availability, and security of HHS's financial systems are of paramount importance. HHS places a high priority on enhancing its financial systems security and controls environment, strengthening policy, proactively monitoring emerging issues, and ensuring progress toward remediating identified weaknesses. HHS continues to implement a comprehensive enterprise-wide financial systems policy, security, and controls program to mature the environment and to decrease risk.

Progress: Since FY 2018, HHS continues to operate its financial management systems with no material weakness. These consecutive years of success are a result of the Department's ongoing strategy to mature its financial systems security, strengthen internal controls, and remediate vulnerabilities. Building on this significant progress, HHS is addressing persistent weaknesses and targeting efforts to further reduce risk across the financial management systems portfolio as the annual closure rate of findings in high-risk control areas (e.g., access controls, configuration management, and SOD) continues to increase year-over-year. In FY 2020, HHS continued to demonstrate internal control maturity and management oversight by remediating 84 percent of prior years' Federal Information System Controls Audit Manual (FISCAM) audit weaknesses. The total cumulative weaknesses identified by the FY 2020 FISCAM audit was reduced by 39 percent when compared to FY 2019.

Beyond monitoring the closure of weaknesses to assess progress, HHS continues to refine its comprehensive management framework to better evaluate overall progress, maturity of the security and control environment, and risk. This framework includes evaluation criteria and target measurements that provide HHS management with the evidence-based, objective data to prepare for and reduce the risk of a FISCAM-issued material weakness.

HHS developed integrated guidance based on the National Institute of Standards and Technology and FISCAM to support system controls identification, implementation, and assessment. HHS is working with the Office of the Chief Information Officer (CIO) to incorporate the guidance into the new version of HHS Information Security and Privacy Policy to promote a more secure, reliable, and auditable financial systems environment.

To encourage collaboration and communication across the Department, the Financial Management Governance Board (FGB) chartered a cross-functional working group with representation from OpDivs' CFO, CIO, and Chief Information Security Officer communities. The FGB working group meets monthly to address pervasive issues, recommend comprehensive remediation approaches, and monitor implementation progress. In FY 2020 the Department also hosted its third annual HHS IT Audit, Internal Control, and Risk Management workshop, which earned recognition from Department CIO and CFO leadership as a vital forum for driving improved IT security and control maturity across the Department.

4. Governance

Strategy: HHS established the FGB as an executive-level forum to address enterprise-wide concerns impacting HHS and its OpDivs, including concerns related to financial management policies and procedures, financial data, financial systems, and technology. Additionally, the FGB serves in an advisory capacity on Department-wide initiatives that may have a financial management impact. The FGB's goals include providing HHS financial management governance

through formal structures, policies, and accountability; providing people, processes, and technology to support governance; and engaging stakeholders through effective communication and management strategies.

Progress: To facilitate executive-level oversight of financial management-related areas, the FGB convenes monthly to engage OpDiv and StaffDiv senior leadership as well as finance, budget, acquisitions, grants, human resources, and IT. The FGB continues to effectively transform the way in which financial management initiatives and activities are accomplished in HHS, moving from a Division-specific, vertical focus to a more enterprise-wide approach. This governance structure continues to foster a sense of community through solving problems and implementing standards for financial management excellence.

Beyond improving collaboration and strengthening oversight across HHS's financial management and systems environment, the FGB provides actionable recommendations to support project teams, guide future initiatives, and respond to federal mandates. Recent areas of focus include the continued modernization of the Department's financial accounting systems, implementation of Treasury's Invoice Processing Platform to support Electronic Invoicing (E-Invoicing), and support of the PMA CAP Goals. The FGB anticipates continual focus on key topics that will enable the HHS financial management community to effectively govern critical financial management endeavors and address evolving opportunities and challenges.

5. Program Management

Strategy: HHS established Department-wide financial systems program management to support Financial Systems Modernization and enhance collaboration across project teams. Enterprise program management provides a sustaining framework for OpDivs, StaffDivs, and CFO community stakeholders supporting the realization of strategic goals and outcomes, while strengthening coordination, collaboration, and shared responsibilities related to programs and projects across the Department. In addition, enterprise program management provides support through developing and maintaining processes, standards, tools, and best practices for program and project management. This includes the Financial Systems Consortium (FSC), a body of federal project managers and contractors representing the three core financial system instances: UFMS, HIGLAS, and NBS. The FSC is designed to leverage and share work products to lower costs, reduce development timelines, and minimize purchasing similar work for related programs and projects. The FSC also provides an opportunity to introduce new tools, technologies, and industry best practices that may benefit HHS's financial management systems environment.

Progress: Department-wide program management and the FSC continue to play a critical role in support of major system enhancements. In FY 2020, enhancements included improving the existing Strategic Template and Resources Tools project management framework for enterprise-wide projects that align with HHS's Enterprise Performance Life Cycle process, assisting project managers in identifying necessary deliverables for successful implementation. The Enterprise Program Management Office continued its efforts in providing Strategic Template and Resources Tools training to the federal project managers and contractors to further enhance awareness, improve consistency, and standardize reporting. Self-paced training was developed and implemented to support work environment challenges due to COVID-19. As the Department's business needs evolve, the Enterprise Program Management Office continues to mature and support ongoing collaboration and coordination across the financial systems environments and modernization initiatives.

6. Sharing Opportunities

Strategy: As a key FSIP component, HHS is actively pursuing multiple initiatives to generate efficiencies and improve effectiveness by implementing shared solutions. The Department has an established framework to continuously identify sharing opportunities in its financial systems environment.

Progress: HHS developed a comprehensive assessment and implementation strategy for a Department-wide solution for E-Invoicing to drive efficiency through automation and standardization of current manual invoice processing. HHS developed a working group of over 170 members, spanning 6 Accounting Centers, 3 financial system owners, 11 acquisition offices, and integration with the Treasury Invoice Processing Platform implementation team, to complete an assessment and initiate a phased implementation**.** As of FY 2020, HHS completed E-Invoicing implementation for CMS and initiated implementation for OpDivs and StaffDivs supported by UFMS. NIH has been in the planning stages and will begin E-Invoicing implementation in FY 2021.

In addition, HHS plans for G-Invoicing implementation, a standardized government-wide solution to improve the quality of Intragovernmental Transactions Buy-Sell activity. OMB requires all Federal Program Agencies to adopt G-Invoicing by October 1, 2022. In FY 2020, HHS initiated a Department-wide assessment for the G-Invoicing solution, gathered requirements and identified opportunities for business process standardization.

Implementation of these solutions will increase efficiencies, improve consistency, automate workflows, improve the transparency of invoice status, and support specific business needs identified across HHS while maintaining compliance with the OMB and Treasury requirements.

Legal Compliance

Antideficiency Act

The *Antideficiency Act* (ADA) prohibits federal employees from obligating in excess of an appropriation, or before funds are available, or from accepting voluntary services. As required by the ADA, HHS notifies all appropriate authorities of any ADA violations. ADA reports can be found on U.S. Government Accountability Office (GAO) - ADA.

HHS management is taking necessary steps to prevent violations. On August 1, 2016, the Director of OMB approved HHS's updated Administrative Control of Funds policy, as required by United States Code, Title 31, *Money and Finance*, Section 1514, "Administrative Division of Apportionments." This policy provides HHS's guidelines for budget execution that specifies basic fund control principles and concepts, including the administrative control of all funds for HHS and its OpDivs, StaffDivs, and Accounting Centers. With respect to four potential issues, HHS is working through investigations and further assessment where necessary. HHS remains fully committed to resolving these matters appropriately and complying with all aspects of the law.

Coronavirus Aid, Relief, and Economic Security Act

The *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), was signed on March 27, 2020 to provide emergency assistance and health care response for individuals, families, and businesses affected by the COVID-19 pandemic. In addition to the CARES Act, HHS received supplemental appropriations through the *Coronavirus Preparedness and Response Supplemental Appropriations Act*, the *Families First Coronavirus Response Act*, and the *Paycheck Protection Program and Health Care Enhancement Act*. In total, HHS received $250.4 billion in supplemental appropriations for COVID-19 response and recovery, including $175 billion for the Provider Relief Fund, which supports hospitals and healthcare providers on the front lines.

The CARES Act established a Pandemic Response Accountability Committee (PRAC) under the Council of the Inspectors General on Integrity and Efficiency to ensure accountability of all COVID-19 relief funds. The PRAC is responsible for promoting transparency and supporting oversight of covered funds[1] for the COVID-19 response. The PRAC's oversight activities seek to detect fraud and abuse and mitigate major risks that span across multiple programs and federal agencies.

The CARES Act requires agencies to provide monthly reports to the OMB, Treasury's Bureau of the Fiscal Service, the PRAC, and multiple congressional committees, regarding any obligation or expenditure of large covered funds (i.e., funds in excess of $150,000).

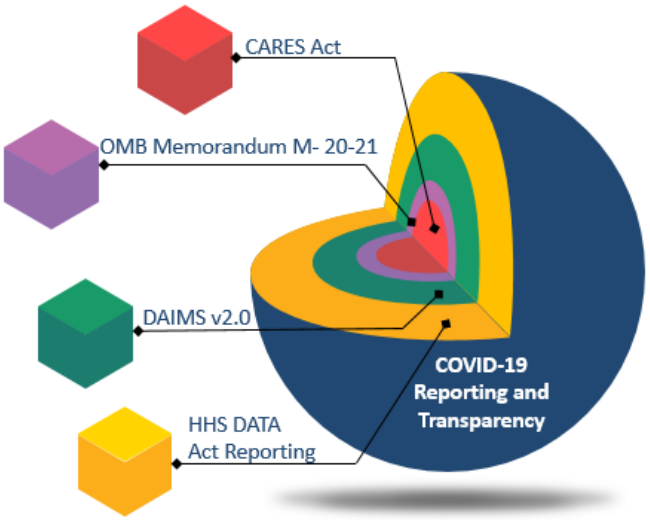
OMB Memorandum M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19),* directs agencies to leverage existing financial reporting processes under the DATA Act described below to assist in meeting the CARES Act reporting requirements. To provide the American public with timely and frequent insight on how COVID-19 relief funds are spent, HHS transitioned from quarterly to monthly DATA Act reporting submissions to USASpending.gov in the third quarter of FY 2020, which resulted in greater transparency and oversight of spending related to covered funds.

[1] Covered funds refers to any funds, including loans and loan guarantees, made available to non-federal entities by legislation primarily making appropriations for the COVID-19 response and related activities.

Digital Accountability and Transparency Act of 2014

The *Digital Accountability and Transparency Act of 2014* (DATA Act) expanded the *Federal Funding Accountability and Transparency Act of 2006* (FFATA) to increase accountability and transparency in federal spending, making federal expenditure information more accessible to the public. It directed the federal government to use government-wide data standards for developing and publishing reports, and to make more information, including award-related data, available on USAspending.gov. Among other goals, the DATA Act aimed to improve the quality of the information on USAspending.gov, as verified through regular reviews of posted data, and to streamline and simplify reporting requirements through clear data standards.

The DATA Act requires agencies to generate data from their financial accounting systems using common fields, formats, and definitions for financial and award data in accordance with the DATA Act Information Model Schema. Treasury collects procurement, financial assistance, and recipient award data from government-wide databases reported under other FFATA requirements and merges it with the financial data produced from the HHS financial system. On a quarterly basis, agencies must certify the accuracy, completeness, and timeliness of the data considered reportable under these standards. HHS is responsible for ensuring the linkage between these sets of internally-maintained and externally-managed data is valid and reliable.



Since May 2017, HHS has successfully submitted financial and award-level data for quarterly certification to Treasury's DATA Act Broker. The processes in place at the Department have successfully ensured alignment between the internally maintained records and the external data in all submissions since May 2017. HHS completely reconciles to an average of 98 percent of award-level obligations for FY 2020. HHS has undergone both GAO and OIG audits of its DATA Act submissions since May 2017, yielding a 'high quality' data rating in FY 2019 and FY 2020.

The third quarter of FY 2020 was a benchmark for successes in HHS DATA Act reporting as it marked the anniversary of the first successful transition to the Oracle-based solution. The system-based solution remediated the FY 2019 audit recommendation to reduce reliance on manual processes. This period was also the first submission that had to meet the overhauled reporting requirements stemming from the COVID-19 response efforts. The diagram above represents how multiple COVID-19 legislative publications each built on the prior one to create the holistic reporting and transparency approach, beginning with Section 15011 of the CARES Act at the core. OMB clarified that the DATA Act would be used as the reporting vehicle for COVID-19 spending data in OMB Memorandum M-20-21. Treasury further built on this requirement by issuing the revised DATA Act Information Model Schema for version 2.0 which laid out the methodology for agencies to provide public transparency of COVID-19 spending on a monthly basis. In FY 2020, DATA Act award-level obligations increased in total to $1,670.7 billion as compared to $1,319.5 billion in FY 2019. Of that $351.2 billion increase, $138.8 billion was related to COVID-19 resources.

Federal Information Technology Acquisition Reform Act

The *Federal Information Technology Acquisition Reform Act* (FITARA), enacted on December 19, 2014, established an enterprise-wide approach to federal IT investments and provided the CIO of CFO Act agencies with greater

authority over IT investments, including authoritative oversight of IT budgets, budget execution, and IT-related personnel practices and decisions. In FY 2020, HHS continued to strengthen performance with a new focus on data center optimization and the *Federal Information Security Management Act* cybersecurity cross agency priorities. With that focus, HHS increased its FITARA cyber score by two letter grades. Additionally, HHS migrated its network to the Managed Trusted Internet Protocol Services infrastructure. These actions were critical, not only in raising our FITARA score but also implementing modern tools and capabilities that enhanced HHS's cybersecurity posture in the midst of the COVID-19 pandemic when cybersecurity became more important than ever.

On August 3, 2020, the Committee on Oversight and Government Reform released its Biannual Scorecard 10.0, which was the first hearing where all agencies received a passing grade. HHS maintained the same overall grade under this new Scorecard's framework for measuring progress. Because of this success, the committee is planning to make major adjustments moving forward. The committee has already previewed a metric on infrastructure, signaled a renewed focus on data center optimization, and proposed new customer service metrics. HHS is actively engaging with regulators to understand what changes may come and in preparation for whatever metrics may be issued.

Federal Managers' Financial Integrity Act of 1982 and Federal Financial Management Improvement Act of 1996

The *Federal Managers' Financial Integrity Act of 1982* (FMFIA) requires federal agencies to annually evaluate and assert the effectiveness and efficiency of their internal control and financial management systems. Annually, agency heads must provide a statement of reasonable assurance that the agency's internal controls are achieving their intended objectives and the agency's financial management systems conform to government-wide requirements. Section 2 of the FMFIA outlines compliance with internal control requirements, while Section 4 dictates conformance with systems requirements. Additionally, agencies must report any identified material weaknesses and provide a plan and schedule for correcting the weaknesses.

In September 2014, GAO released an updated edition of its *Standards for Internal Control in the Federal Government*, effective FY 2016. The document takes a principles-based approach to internal control, with a balanced focus over operations, reporting, and compliance. In July 2016, OMB released revised Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. The revised Circular complements GAO's Standards, and it implements requirements of the FMFIA with the intent to improve accountability in federal programs and increase federal agencies' consideration of Enterprise Risk Management. The Department, with its OpDiv and StaffDiv stakeholders, are working together to implement these requirements.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires federal agency heads to assess the conformance of their financial management information systems to mandated requirements. FFMIA expanded upon FMFIA by requiring agencies to implement and maintain financial management systems that substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the U.S. Standard General Ledger at the transaction level. Guidance for determining compliance with FFMIA is provided in OMB Circular A-123, Appendix D, *Compliance with the FFMIA of 1996*.

HHS is fully focused on the requirements of FMFIA and FFMIA through its internal control program and a Department-wide approach to Enterprise Risk Management. Based on thorough ongoing internal assessments and FY 2020 audit findings, HHS provides reasonable assurance that controls are operating effectively. We are actively engaged with our OpDivs to correct their identified material weaknesses and noncompliances through a corrective action process focused on addressing the true root cause of deficiencies and supported by active management oversight. Refer to the "Internal Control Section" and the "HHS Statement of Assurance" for more information.

Patient Protection and Affordable Care Act

The *Patient Protection and Affordable Care Act* (PPACA) established Health Insurance Exchanges through which qualified individuals and qualified employers can purchase health insurance coverage. Many individuals who enroll in Qualified Health Plans through individual market Health Insurance Exchanges are eligible to receive a premium tax credit to reduce their costs for health insurance premiums. Premium tax credits can be paid in advance directly to the consumer's Qualified Health Plan insurer. Consumers then claim the premium tax credit on their federal tax returns, reconciling the credit allowed with any advance payments made throughout the tax year. HHS coordinates closely with the Internal Revenue Service on this process.

PPACA also included provisions that address fraud and abuse in health care by toughening the sentences for perpetrators of fraud, employing enhanced screening procedures, and enhancing the monitoring of providers. These authorities have facilitated the government's efforts to reduce improper payments. For detailed information on improper payment efforts, see the "Other Information" section of this AFR, under "Payment Integrity Report."

Payment Integrity Information Act of 2019

An improper payment occurs when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, or the recipient uses the funds in an improper manner. In addition, improper payments cited do not necessarily represent expenses that should not have occurred. Instances where there is insufficient or no documentation to support the payment as proper or improper are cited as improper payments. On March 2, 2020, the *Payment Integrity Information Act of 2019* (PIIA) repealed and replaced the *Improper Payments Information Act of 2002*, as amended by the *Improper Payments Elimination and Recovery Act of 2010* and the *Improper Payments Elimination and Recovery Improvement Act of 2012*. Similar to *Improper Payments Information Act of 2002*, PIIA requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments. For high risk programs, agencies must estimate the amount of improper payments, establish reduction targets, and develop and implement corrective actions. HHS works to better prevent, detect, and reduce improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls.

HHS has shown tremendous leadership in the improper payments arena. HHS has a robust improper payments estimation and reporting process that has been in place for many years and has taken many corrective actions to prevent, detect, and reduce improper payments in our programs. In accordance with the PIIA, HHS completed 23 improper payment risk assessments in FY 2020 and determined that these programs were not susceptible to significant improper payments. In addition, HHS is publishing improper payment estimates and associated information for 9 high risk programs in this year's AFR, of which 3 programs reported lower improper payment rates in FY 2020 compared to FY 2019. Lastly, HHS also utilizes the Do Not Pay portal to check payments and awardees to identify potential improper payments or ineligible recipients. In FY 2020, HHS screened more than $655.73 billion in Treasury-disbursed payments through the Do Not Pay portal. A detailed report of HHS's improper payment and fraud reduction activities and performance is presented in the "Other Information" section of this AFR, under "Payment Integrity Report."

Internal Control

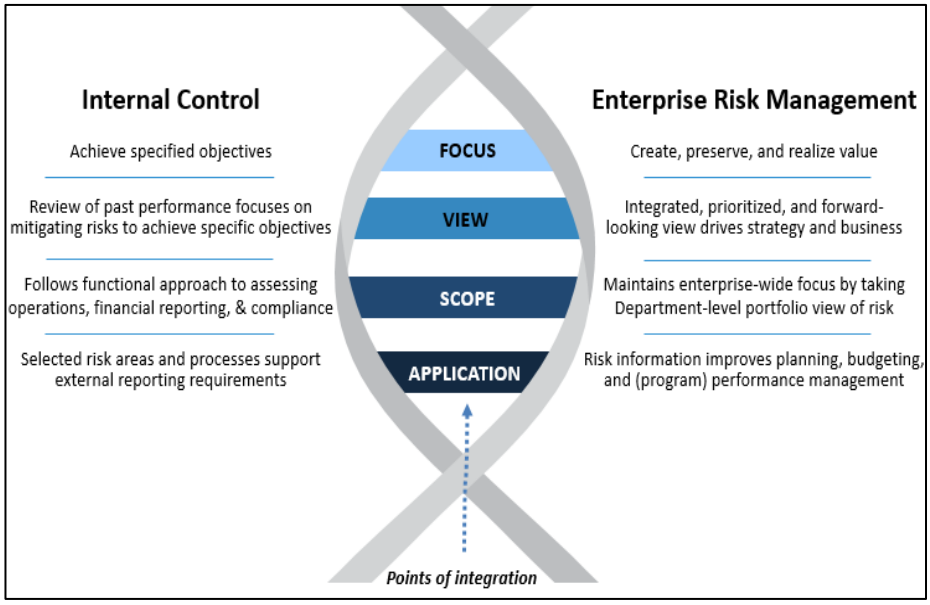
FMFIA requires agency heads to annually evaluate and report on the internal control and financial systems that protect the integrity of federal programs. This evaluation aims to provide reasonable assurance that internal controls are achieving the objectives of effective and efficient operations, reliable reporting, and compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives. HHS performs rigorous, risk-based evaluations of its internal controls in compliance with OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*. HHS is making progress in maturing Enterprise Risk Management and integrating with Internal Control.

HHS management is directly responsible for establishing and maintaining effective internal controls. As part of this responsibility, management regularly evaluates internal controls and HHS executive leadership provides annual assurance statements reporting on the effectiveness of internal controls at meeting objectives. The HHS Risk Management and Financial Oversight Board evaluates OpDivs' management assurances and recommends a Department assurance for the Secretary's consideration and approval, resulting in the Secretary's annual Statement of Assurance.

As part of overall internal controls efforts, HHS is following guidance laid out by OMB to provide oversight of COVID-19 funds. OMB Memorandum M-20-21 *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)* and OMB's June 17, 2020 memo for agency CFOs, *Risk-Based Financial Audits and Reporting Activities in Response to COVID-19*, direct agencies to "leverage existing transparency and accountability mechanisms whenever possible" and "apply a risk-based framework for balancing: (1) mission achievement, (2) expediency, and (3) transparency and accountability." In compliance with this guidance, HHS's OpDivs and StaffDivs are utilizing existing internal control plans and updated disaster-related internal control plans, and enhancing current processes as needed, to provide reasonable assurance that internal controls over COVID-19 funds are achieving management's objectives of effective and efficient operations, reliable reporting, and compliance with applicable laws and regulations.

HHS aims to strengthen its internal control assessment and reporting process to more effectively identify key risks, develop effective risk responses, and implement timely corrective actions. The HHS FY 2020 OMB Circular A-123 assessment recognizes material noncompliances with the *Payment Integrity Information Act of 2019* related to error rate measurement and the *Social Security Act* related to the Medicare appeals process. Other than these noncompliances, HHS provides reasonable assurance that internal controls comply with FMFIA, and its financial management systems substantially comply with the FFMIA.

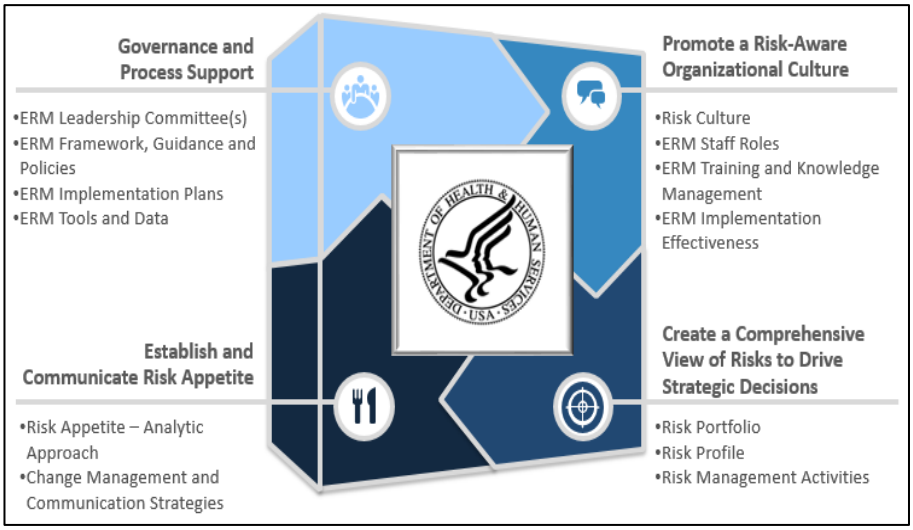
Enterprise Risk Management



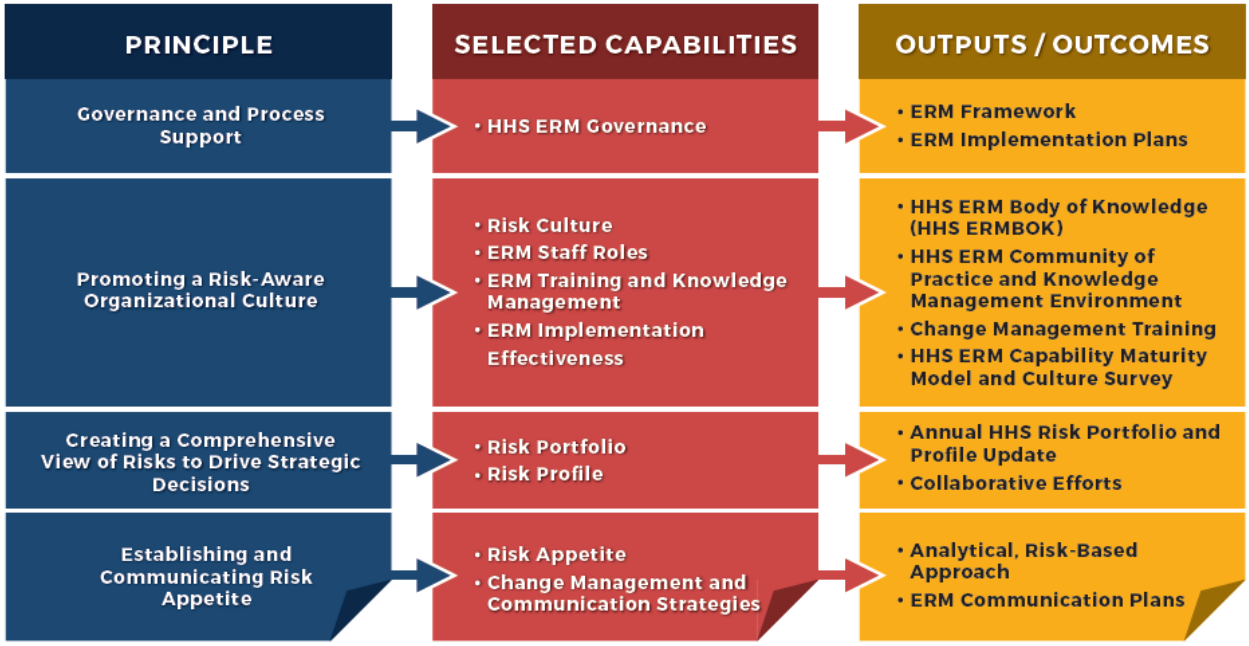
As required by OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, which was updated in 2016, federal agencies are charged with implementing Enterprise Risk Management (ERM) to improve accountability and effectiveness of Federal programs and mission support operations by identifying and managing mission and mission-support risks to reduce or eliminate the potential for disruptive events. ERM is a strategic discipline that enables agencies to proactively and deliberatively address the full spectrum of organizational risks. Integrating ERM into Department and division operations improves HHS's ability to deliver its mission of enhancing and protecting the health and well-being of all Americans. By incorporating ERM practices into daily operations, HHS has enhanced its speed and agility in adapting to uncertainties that might otherwise impact its ability to execute on mission, achieve goals, and meet objectives.

ASFR supports Department-wide ERM implementation by chairing the HHS ERM Council, which consists of senior career executives from across HHS's OpDivs and StaffDivs. The ERM Council was originally established in 2010 as the HHS Program Integrity Coordinating Council, to focus on program integrity risk management concerns. The Council expanded its focus in 2014 by adopting ERM to improve risk management efforts throughout the Department, and formally updated its charter and name in 2016 to the ERM Council. The ERM Council provides an internal forum for sharing and coordinating Department-wide risk management efforts. ASFR facilitates ERM implementation by: translating the Department-level ERM Framework displayed in **Figure 4** below into operational steps; serving as an ERM resource and liaison for Divisions; collaboratively developing ERM guidance, tools, and techniques that can be tailored by Divisions; and advising on ERM tools, techniques, and approaches to support Division-level ERM implementation. Working closely with Division ERM leads and subject matter experts, ASFR collaboratively supports implementation of a robust ERM culture and capabilities throughout the Department.

Figure 4. The Principles-Based HHS ERM Framework and Capabilities



The HHS ERM Framework in **Figure 4** outlines the principles-based approach and associated capabilities that HHS uses to implement and mature ERM. By focusing on principles and capabilities, rather than an annual risk profile, HHS's ERM Framework offers flexibility for OpDivs and StaffDivs to manage the pace of change. OpDivs and StaffDivs are encouraged to tailor the ERM Framework to align with their diverse operating cultures and missions. This includes tailoring the portfolio of risks considered and applicable governance to oversee risk management activities. HHS's ERM Framework includes the following:



Management Assurances

Statement of Assurance

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

The Department of Health and Human Services' (HHS or the Department) management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of *the Federal Managers' Financial Integrity Act of 1982* (FMFIA). These objectives are to ensure (1) effective and efficient operations; (2) reliable reporting; and (3) compliance with applicable laws and regulations. The safeguarding of assets is a subset of these objectives.

HHS conducted its assessment of risk and internal control in accordance with OMB Circular A-123*, Management's Responsibility for Enterprise Risk Management and Internal Control*. Based on the results of the assessment, the Department provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2020, with the exception of material non-compliances with the *Payment Integrity Information Act of 2019* (PIIA) related to Error Rate Measurement and the *Social Security Act* related to the Medicare appeals process.

HHS is taking steps to address the material non-compliance related to the Medicare appeals process and is addressing one instance of material noncompliance related to Error Rate Measurement as described in the "Corrective Action Plans" section. Remediation for the other instance of material noncompliance related to Error Rate Measurement relies on a modification to legislation requiring states to participate in an improper payment rate measurement.

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that substantially comply with federal financial management system requirements, federal accounting standards, and the United States Standard General Ledger at the transaction level. HHS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, HHS provides reasonable assurance that its overall financial management systems substantially comply with the FFMIA and substantially conform to the objectives of FMFIA, Section 4.

HHS will continue to ensure accountability and transparency over the management of taxpayer dollars, and strive for the continuing progress and enhancement of its internal control and financial management programs.

/Alex M. Azar II/

Alex M. Azar II
Secretary
November 13, 2020

Summary

1. Error Rate Measurement

HHS identified two instances of material noncompliance with the PIIA: (1) not reporting a Temporary Assistance for Needy Families (TANF) improper payment rate, and (2) reporting improper payment rates for Medicaid and Children's Health Insurance Program (CHIP) via the Payment Error Rate Measurement (PERM) program that are above the PIIA requirements.

HHS identified the TANF process limitation in prior years and it continues to exist in FY 2020. The TANF program is unable to report an error rate for FY 2020 due to statutory limitations precluding HHS from requiring states to participate in a TANF improper payment measurement.

HHS identified the Medicaid and CHIP noncompliance in FY 2019, and it continues to exist in FY 2020. The improper payment rates for Medicaid and CHIP are based on reviews of the Fee-For-Service, managed care, and eligibility components. The PERM program uses a 17-state rotational approach to measure the 50 states and the District of Columbia over a 3-year period. As a result, HHS measures each state once every 3 years. National improper payment rates include findings from the most recent three cycle measurements. Each time a cycle of states is measured, HHS removes the previous findings for that cycle and includes the newest findings. Factors that led to noncompliance in FY 2020 include:

- The reintegration of the PERM eligibility component for the second cycle of 17 states;
- Improper payments due to insufficient documentation to verify eligibility, related primarily to income or resource verification for (1) situations where the required verification was not done, (2) where there is an indication the verification was initiated but there was no documentation to validate the verification process was completed, and (3) noncompliance with eligibility redetermination requirements;
- Noncompliance with requirements for provider revalidation of enrollment and rescreening;
- Noncompliance with provider enrollment, screening, and National Provider Identifier requirements; and
- The CHIP improper payment rate was also driven by claims where the beneficiary was incorrectly determined to be eligible for CHIP, but upon review was eligible for Medicaid.

2. Medicare Appeals Process

Several factors, including the growth in Medicare claims – partially driven by the aging population – and HHS's continued investment and focus on ensuring program integrity, have led to more appeals than Levels 3 and 4 of the Medicare appeals process can adjudicate within contemplated time frames.

From FY 2010 through FY 2020, the HHS Office of Medicare Hearings and Appeals (OMHA) and the HHS Departmental Appeals Board (DAB) experienced a large increase in the number of Medicare related appeals received. As a result, at the end of Quarter 3 of FY 2020, 201,292 appeals were waiting to be adjudicated by OMHA and 18,485 appeals were waiting to be reviewed at the DAB. This has led to the inability to meet statutory decisional timeframes of 90 days at Levels 3 and 4 of the Medicare appeals process.

Under current resources and continuing ongoing administrative actions, it would take approximately 1 year for OMHA and 5 years for the DAB to process their respective backlogs.

Corrective Action Plans

1. Error Rate Measurement

TANF is a state-administered program, so corrective actions to reduce improper payments would be implemented at the state level. Since HHS cannot require states to participate in a TANF improper payment measurement, the Department is also unable to compel states to collect the required information to implement and report on

corrective actions. Despite these limitations, HHS uses a multi-faceted approach to support states in improving TANF program integrity and preventing improper payments, including efforts such as: conducting and using results of a detailed risk assessment to mitigate payment risks at the federal level; promoting and supporting innovation using TANF data to better understand how states ensure program integrity; and monitoring compliance with the final regulations regarding "State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations" (81 Federal Register 2092, January 15, 2016). In addition, the *FY 2021 President's Budget* includes a legislative proposal that would give HHS the authority to collect quantitative and qualitative program integrity information from TANF programs, which will lay the groundwork for the data collection efforts needed to provide information on states' improper payments.

To address Medicaid and CHIP PERM related errors, HHS continues to develop a multi-faceted approach to corrective actions, with several efforts concurrently underway to address the underlying causes. In June 2020, HHS released the *Comprehensive Medicaid Integrity Plan* for FYs 2019-2023 (CMIP), which incorporates the three pillars of flexibility, accountability, and integrity, and includes numerous existing and new or enhanced program integrity activities, including those that were part of the Medicaid Program Integrity Strategy released in June 2018. The Center for Medicaid and CHIP Services (CMCS) within HHS's Centers for Medicare & Medicaid Services (CMS) also published an Information Bulletin to states reiterating and clarifying existing federal requirements for beneficiary eligibility and enrollment processes. HHS will also complete the review of the remaining 17 states under the new eligibility component and establish a baseline in FY 2021 once all states are measured under the new requirements.

To further address PERM errors that may be related to a need for states to implement or increase operational process efficiencies, CMCS also conducted a project under the Medicaid and CHIP Learning Collaborative to identify state best practices in program integrity from a variety of sources to develop a training slide deck to further state efforts in this area. In summary, HHS will:

- Increase oversight frequency by leveraging the Medicaid Eligibility Quality Control (MEQC) program in the two off-cycle PERM years to help states address Medicaid beneficiary eligibility vulnerabilities, including areas not addressed through PERM reviews and areas identified as error-prone through the PERM program;
- Conduct additional risk-based audits of beneficiary eligibility determinations in states with known eligibility determination compliance concerns identified through PERM, OIG audits, and state auditor reviews;
- Conduct more robust state-specific outreach during off-cycle PERM years to address issues identified in corrective action plans;
- Share Medicare data to assist states with meeting Medicaid screening and enrollment requirements, including (1) Medicare provider enrollment records via the Provider Enrollment, Chain, and Ownership System (PECOS) administrative interface and data extracts from the PECOS system, (2) access to the PECOS State's page, which includes provider enrollment information such as Medicare enrollment status, site visit information, fingerprint results, ownership information, reassignments, Medicare risk levels, and more, and (3) all state-submitted terminations as well as all Medicare revocations, and HHS-OIG exclusion data through the Data Exchange System,
- Offer a data compare services that allows a state to rely on Medicare's screening in lieu of conducting a state screening, particularly during revalidation. This allows states to remove dual-enrolled providers from the revalidation workload; and
- Pilot a process to screen Medicaid-only providers on behalf of states and produce a report of the providers found with licensure issues, criminal activity, and Do Not Pay activity.

In addition, HHS works closely with all states through enhanced technical assistance and guidance on federal requirements for Medicaid screening and enrollment and to develop state- specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating their corrective action plan's effectiveness with assistance and oversight from HHS. When developing corrective action plans, states focus on addressing the major causes of improper payments.

Lastly, the *FY 2021 President's Budget* also includes a proposal that would strengthen CMS's ability to recoup Medicaid improper payments related to states' inaccurate beneficiary eligibility determinations. The proposal would give CMS additional authority to recover overpayments from states that receive federal resources for ineligible or misclassified beneficiaries. Other proposals in the *President's Budget* include a legislative proposal to strengthen Medicaid's ability to recoup Medicaid improper payments; a legislative proposal to enact financial penalties for states that are not complying with provider screening, enrollment, and revalidation requirements; a legislative proposal to strengthen HHS's ability to recover Medicaid and CHIP overpayments resulting from noncompliance with provider screening and enrollment requirements; and a proposal to consolidate provider enrollment screening for Medicaid and CHIP.

2. Medicare Appeals Process

HHS has a strategy to improve the Medicare appeals process through investing new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; taking administrative actions to reduce the number of pending appeals and encourage resolution of cases earlier in the process; and proposing legislative reforms that provide additional funding and new authorities to address the appeals volume.

HHS has undertaken, and continues to explore, new administrative actions expected to have a favorable impact on the Medicare appeals backlog. The *FY 2021 President's Budget* request includes a comprehensive legislative package aimed at both helping the Department process a greater number of appeals and reducing the number of appeals that reach OMHA and DAB. Based on projected impacts of current administrative actions, and the proposed funding increases and legislative actions outlined in the *FY 2021 President's Budget*, HHS projects that the backlog at Level 3 would be approximately 70,000 appeals by the end of FY 2021, while the backlog at Level 4 could start decreasing in future years.

Financial Summary and Highlights

HHS received an unmodified audit opinion on the principal financial statements and notes[2] for the year ended September 30, 2020. This is the 22nd year for an unmodified opinion. HHS takes pride in the preparation of the financial statements, yet it can sometimes be difficult to draw the relationships between the information in the statements and the overall performance of an agency. This section is presented as an interpretation of the principal financial statements, which include the Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statement of Changes in Net Position, Combined Statement of Budgetary Resources, Statement of Social Insurance, and the Statement of Changes in Social Insurance Amounts, as well as selected notes to the principal financial statements. HHS presents these in the "Financial Section" of this report. Included in this analysis is a year-over-year summary of key financial balances, nature of significant changes, and highlights of key financial events to assist readers in establishing the relevance of the financial statements to the operations of HHS.

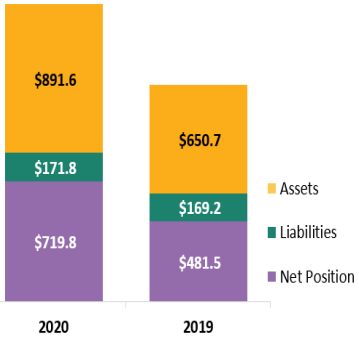
As a federal entity, HHS's financial position and activities are significant to the government-wide statements. Based on the *FY 2019 Financial Report of the United States Government*, HHS's net operating cost was larger than any single agency across the entire federal government.[3] A similar relationship exists within HHS, where the Department is significantly represented by one OpDiv, CMS. CMS alone consistently stewards the largest share of HHS's resources. Therefore, noteworthy changes in HHS balances are primarily related to fluctuations in CMS program activity.

Balance Sheets

To communicate performance for HHS at fiscal year-end, the Consolidated Balance Sheets show the resources available to HHS (Assets) and claims against those assets (Liabilities). The remainder represents the equity retained by HHS (Net Position). The table below summarizes the major components of the FY 2020 and FY 2019 year-end balances of HHS's assets available for use, the liabilities owed by HHS, and the equity retained by HHS.

Financial Conditions Summary
(in Billions)

	2020	2019	$ Change (2020-2019)	% Change (2020-2019)
Fund Balance with Treasury	$ 514.0	$ 296.3	$ 217.7	73%
Investments, Net	226.2	309.3	(83.1)	(27)%
Accounts Receivable	22.4	25.0	(2.6)	(10)%
Advances	108.1	2.6	105.5	4,058%
Other Assets	20.9	17.5	3.4	19%
Total Assets	**$ 891.6**	**$ 650.7**	**$ 240.9**	**37%**
Accounts Payable	$ 5.0	$ 2.4	$ 2.6	108%
Entitlement Benefits Due and Payable	116.9	110.1	6.8	6%
Accrued Liabilities	15.8	15.5	0.3	2%
Federal Employee and Veterans' Benefits	15.3	14.8	0.5	3%
Contingencies & Commitments	11.3	17.1	(5.8)	(34)%
Other Liabilities	7.5	9.3	(1.8)	(19)%
Total Liabilities	**$ 171.8**	**$ 169.2**	**$ 2.6**	**2%**
Net Position	**$ 719.8**	**$ 481.5**	**$ 238.3**	**49%**
Total Liabilities and Net Position	**$ 891.6**	**$ 650.7**	**$ 240.9**	**37%**



[2] Due to the uncertainty of the long-range assumptions used in the Statement of Social Insurance model, the auditors were not able to express an opinion on the Statement of Social Insurance, the Statement of Changes in Social Insurance Amounts, and associated footnotes.
[3] HHS's net cost is 24 percent of the federal government's total costs, Social Security Administration's net cost is 22 percent, Department of Defense's net cost is 18 percent, Department of Veterans Affairs' net cost is 8 percent, and Treasury's Interest on Treasury Securities Held by the Public's net cost is 8 percent. All remaining agencies combined only represent 20 percent. Source: *FY 2019 Financial Report of the United States Government*

Assets

Total Assets for HHS were $891.6 billion at year-end, representing the value of what HHS owns and manages. This is an increase of approximately $240.9 billion or 37 percent over September 30, 2019. Fund Balance with Treasury (FBwT) and Investments comprise $740.2 billion or 83 percent of HHS's total assets, and collectively increased $134.6 billion or 22 percent.

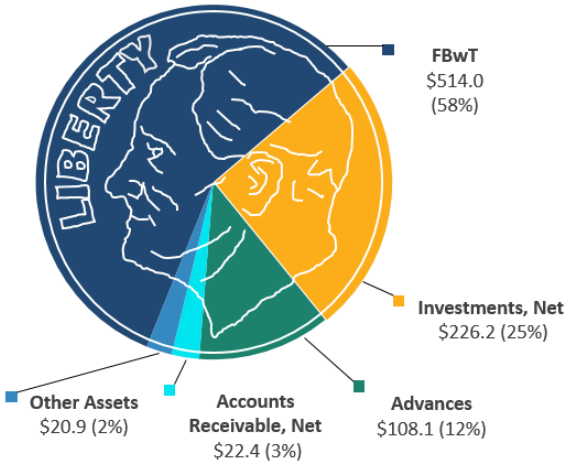
The FBwT line contains the largest net change between FY 2020 and FY 2019 with a $217.7 billion or 73 percent increase, which is primarily due to additional funding received for COVID-19.

Advances had an increase of $105.5 billion or 4,058 percent over FY 2019, which is primarily due to the issuance of the COVID-19 Accelerated and Advance Payment (AAP) program and for Public Health and Social Services Emergency Fund (PHSSEF) advances with the U.S. Department of Defense for personal protection equipment and test kits for COVID-19.

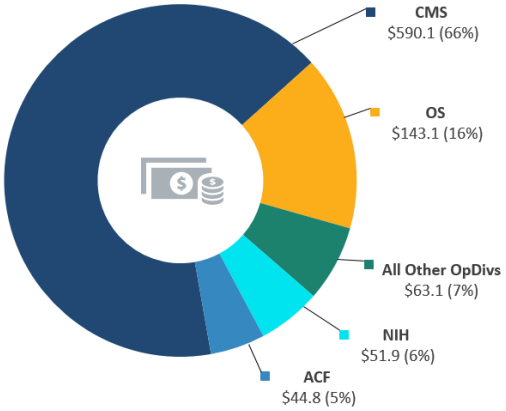
Investments had a decrease of $83.1 billion or 27 percent under FY 2019, which is mostly due to changes in Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) by $65.8 billion and $17.4 billion, respectively. This is primarily due to the issuance of the COVID-19 AAP program.

The HHS "Assets by OpDiv" chart demonstrates asset distribution within HHS, excluding eliminations. The OpDiv asset balances ranged from $352 million at AHRQ (shown in All Other OpDivs) to $590.1 billion at CMS. OS had the largest percentage and dollar value asset increase of $124.9 billion or 683 percent over FY 2019 primarily due to COVID-19 activities. CMS had an increase of $88.1 billion or 18 percent primarily due to the issuance of the COVID-19 AAP program.

Assets by Type
(in Billions)



Assets by OpDiv
(in Billions)

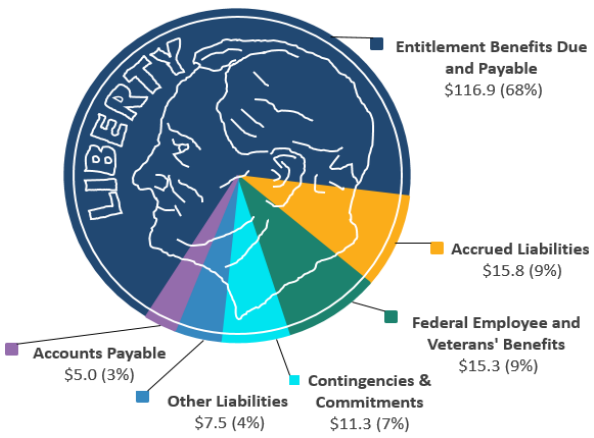


Liabilities

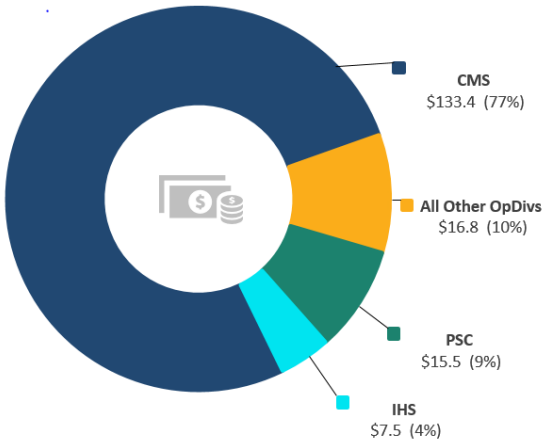
Total Liabilities for HHS were $171.8 billion at year-end, representing the amounts HHS owes from past transactions or events. This is an increase of approximately $2.6 billion or 2 percent over September 30, 2019.

This is attributed to increases in Entitlement Benefits Due and Payable and Accounts Payable. Entitlement Benefits Due and Payable had an increase of $6.8 billion or 6 percent over FY 2019, which is due to medical services and claims incurred but not reported reflecting the impact of COVID-19. Accounts Payable increased $2.6 billion or 108 percent over FY 2019, which is due to the PHSSEF for COVID-19. These increases are offset by a decrease in Contingencies & Commitments of $5.8 billion or 34 percent under FY 2019, which is due to the decrease in the Medicaid Statement Amendment accrual.

Liabilities by Type
(in Billions)



Liabilities by OpDiv
(in Billions)



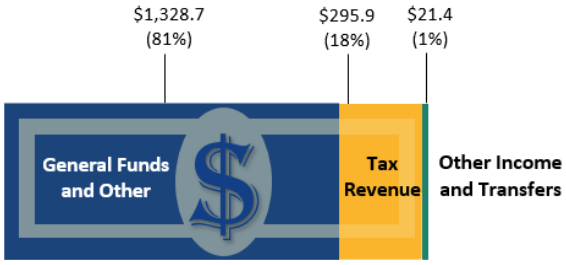
The HHS "Liabilities by OpDiv" chart shows liability distribution within HHS, excluding eliminations. With the majority share, CMS reports $133.4 billion or 77 percent of the HHS liabilities, while AHRQ (shown in All Other OpDivs) has liabilities of $27 million. OS had the largest OpDiv dollar value increase in liabilities over FY 2019 of $2.1 billion due to the increase in Accounts Payable mentioned above.

Refer to the Notes in "Financial Section" of this report for explanations for the remaining significant fluctuations.

Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position displays the activities affecting the difference between the beginning net position and ending net position, as shown on the HHS Consolidated Balance Sheets. This is also represented as the difference between assets and liabilities.

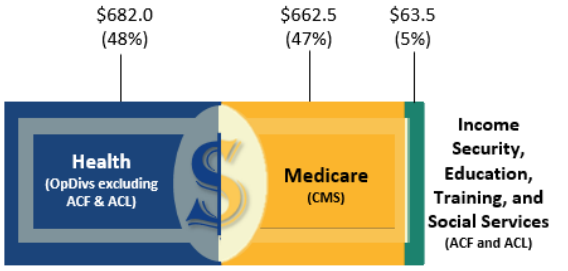
HHS Gets the Money From…
(in Billions)



Changes in assets are shown by identifying where HHS gets the money from, known as financing sources. Financing sources include both the Total Financing Sources and Total Budgetary Sources lines from the Statement of Changes in Net Position.

HHS receives the majority of the funding through Congressional appropriations and reimbursement for the provision of goods or services to other federal agencies. HHS's largest financing source, General Funds and Other, increased $364.6 billion or 38 percent over FY 2019. The fluctuations in tax revenue of $14.5 billion or 5 percent is related to the *Federal Insurance Contributions Act* (FICA) and *Self Employed Contributions Act* (SECA).

HHS Used the Money For…
(in Billions)



Statements of Net Cost

The Consolidated Statements of Net Cost represents how HHS spent the money. This can also be stated as the difference between the costs incurred by HHS's programs less associated revenues. The Net Cost of Operations for the year ended September 30, 2020 totaled approximately $1,407.7 billion. The "HHS Used the Money For …" chart shows consolidating costs by major budget function,[4] which are the categories displayed in the Federal Budget. Most agencies have one or two budget functions, whereas HHS has many.

[4] Totals in the chart are exclusive of intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function. This statement can be found in Section 3, Other Information.

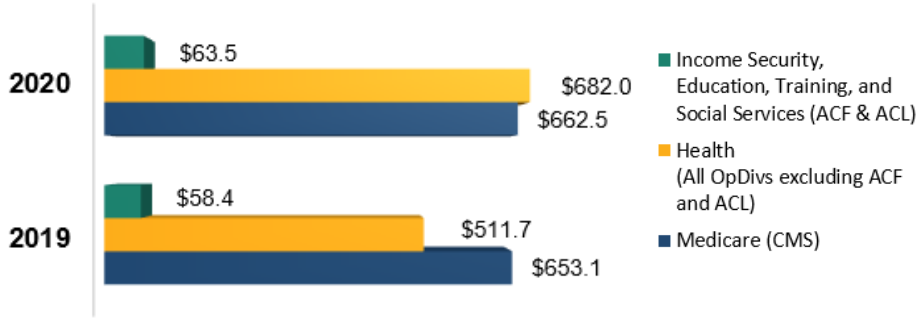
The table below presents the FY 2020 Consolidated Net Cost of Operations, which breaks costs into Responsibility Segments between CMS and the remaining OpDivs in Other Segments. Net cost for CMS increased by $69.7 billion or 6 percent over FY 2019, which included increases to Medicaid benefit expense of $47.4 billion and SMI and Other Activities expenses of $15.1 billion and $14.1 billion, respectively. These expenses were offset by increased revenues of $10.3 billion due to SMI premiums collected for Prescription Drug, Medicare Advantage, and *Affordable Care Act* Medicare Shared Savings programs. The increase in total Net Cost of Operations for the remaining HHS segments of $115.2 billion or 85 percent over FY 2019 is primarily due to the PHSSEF increase of $106.2 billion for COVID-19 relief.

Net Cost of Operations
(in Billions)

	2020	2019	$ Change (2020-2019)	% Change (2020-2019)
Responsibility Segments:				
CMS Gross Cost	$ 1,281.9	$ 1,201.6	$ 80.3	7%
CMS Exchange Revenue	(125.3)	(114.7)	(10.6)	9%
CMS Net Cost of Operations	$ 1,156.6	$ 1,086.9	$ 69.7	6%
Other Segments:				
Other Segments Gross Cost	$ 256.7	$ 141.9	$ 114.8	81%
Other Segments Exchange Revenue	(5.6)	(6.0)	0.4	(7)%
Other Segments Net Cost of Operations	$ 251.1	$ 135.9	$ 115.2	85%
Net Cost of Operations	**$ 1,407.7**	**$ 1,222.8**	**$ 184.9**	**15%**

HHS classifies costs by major budget functions such as Medicare, Health, Income Security, and Education, Training, and Social Services. This is shown on the Consolidating Statement of Net Cost by Budget Function in the "Other Information" section of this report. The graph below shows the 2-year cost trends for these major budget functions.[5] In FY 2020, total net costs for Health of $682.0 billion and Medicare of $662.5 billion account for 95 percent of HHS's annual net costs.

Net Cost by Major Budget Function
(in Billions)

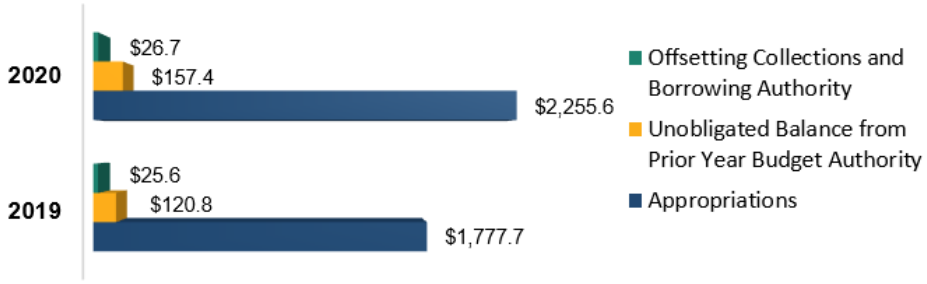


[5] Totals in the chart are exclusive of intra-HHS eliminations from the Consolidating Statement of Net Cost by Budget Function.

Statement of Budgetary Resources

The Combined Statement of Budgetary Resources displays the budgetary resources available to HHS throughout FY 2020 and FY 2019, and the status of those resources at the fiscal year-end. The primary components of HHS's resources, totaling approximately $2.4 trillion for FY 2020, are appropriations from Congress, resources not yet used from previous years (unobligated balances from prior year budget authority), and spending authority from offsetting collections and borrowing authority. This represents an increase of $515.6 billion or 27 percent over FY 2019. The following graph highlights trends in these balances over the past 2 fiscal years.

Total Budgetary Resources
(in Billions)



The increase in appropriations of $477.9 billion or 27 percent is primarily related to COVID-19 appropriations of $250.4 billion, as well as increases in HI of $72.2 billion, SMI of $46.4 billion, Medicaid of $56.1 billion, and Payments to the Trust Funds (PTF) of $36.3 billion. The *Social Security Act* provides for payments to the HI and SMI trust funds. SMI receives appropriated funds to provide for federal matching of SMI premium collections and HI for the Uninsured and Federal Uninsured Payments. The *Social Security Act* also prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the states and Transitional Assistance benefits be transferred from the general fund to the SMI trust fund; this occurs via the PTF account. For further details, see the Combining Statement of Budgetary Resources in the "Financial Section" of this report.

The increase of $36.6 billion or 30 percent in unobligated balance from prior year budget authority is primarily due to an increase in PTF of $36.0 billion in retention of prior year definite authority. Definite authority is budget authority that is a specified sum at the time it is enacted and is expressed as a "not to exceed" amount.

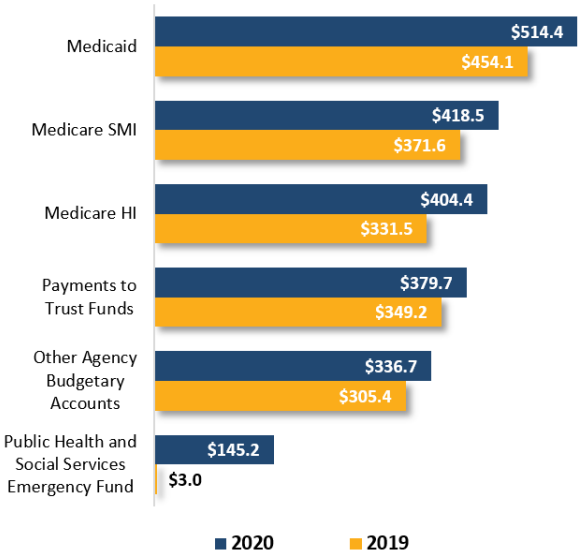
Schedule of Spending

HHS has elected to present the trends in spending in the audited notes to the principal financial statements titled, Combined Schedule of Spending. The "Spending by Treasury Symbol" chart illustrates spending as of September 30, 2020 and 2019 for the top five HHS Treasury Account Symbols (TAS). The remaining TAS are presented in Other Agency Budgetary Accounts.

The New Obligations and Upward Adjustments line on the Combined Statement of Budgetary Resources is the same as Total Amounts Agreed to be Spent line on the Combined Schedule of Spending. Total obligations for FY 2020 were approximately $2.2 trillion with a 21 percent increase over FY 2019.

The HHS's total spending is once again significantly represented by four of CMS's TAS (Medicaid, Medicare SMI, Medicare HI, and PTF) at 78 percent of HHS total obligations.

Spending by Treasury Symbol
(in Billions)

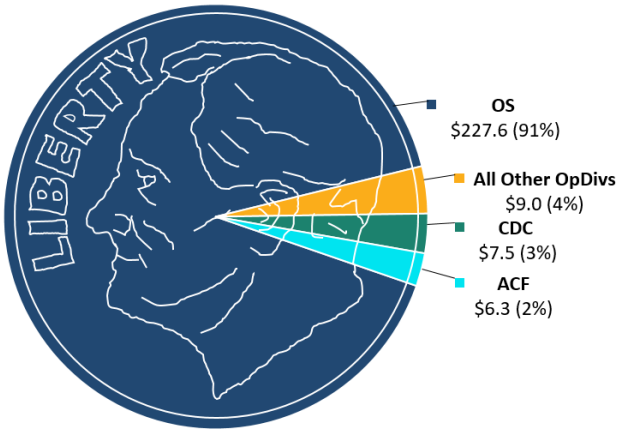


As the American public will see more clearly on the USAspending.gov website, the majority of HHS spending was made through Grants, Subsidies, and Contributions at $1 trillion or 45 percent. Additionally, HHS has incurred obligations for Insurance Claims and Indemnities totaling $918.3 billion or 42 percent. HHS classifies obligations by items or services provided into categories known as object classes. For more information refer to Note 21, Combined Schedule of Spending in the "Financial Section" of this report.

COVID-19 Activities

The CARES Act and three additional supplemental appropriations provided HHS with COVID-19 budgetary resources of $250.7 billion for response and recovery. Of this amount, $0.3 billion was transferred to the Department of Homeland Security, resulting in net budgetary resources of $250.4 billion, which includes $0.3 billion precluded from obligation. The "COVID-19 Budgetary Resources by OpDiv" chart to the right shows the amount of funding received by the OpDivs. OS received $227.6 billion or 91 percent through the PHSSEF, with the majority supporting the Provider Relief Fund, Strategic National Stockpile, and vaccine, therapeutic and diagnostic research and development and advance purchase through Biomedical Advanced Research and Development Authority.

COVID-19 Budgetary Resources by OpDiv
(in Billions)



As of September 30, 2020 HHS has obligated $158.1 billion to support efforts, of which $113.5 billion has been outlayed, and $92.2 billion remains available for future fiscal years in order to continue providing relief, testing, research, and other COVID-19 related activities. For more information refer to Note 22, COVID-19 Activities in the "Financial Section" of this report.

Stewardship Information

Investment in Research and Development

HHS has Investments in Research and Development of $41.7 billion of which $40.8 billion is for NIH programs. NIH supports research that seeks fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. NIH supports extramural and intramural activities that span the spectra of medical research, including fundamental, disease-oriented, pre-clinical laboratory animal, observational, population-based, behavioral, social science, and translational research. Moreover, NIH's clinical research activities aim to understand healthy and disease states, move laboratory findings into medical applications, as well as assess new treatments or compare different treatment approaches. NIH also regards the expeditious transfer of the results of its medical research for further development and commercialization of biomedical products as an important component to improve public health.

Investment in Human Capital

Investments in Human Capital are expenses incurred by federal education and training programs for the public, intended to maintain or increase national productive capacity. HHS has Investments in Human Capital of $2.1 billion of which NIH and HRSA activities represent the majority.

NIH has long recognized the importance of a sustainable and diverse workforce is key to achieving its mission. To this end, NIH remains committed to the development, support, and retention of our next generation of investigators. The NIH Research Training and Career Development Programs address the need for trained scientists to conduct biomedical and behavioral research. The primary goal of the support that NIH provides for research training and career development is to produce new, highly trained investigators who are likely to conduct research that will benefit public health.

HRSA's Bureau of Health Workforce (BHW) improves the health of the nation's underserved communities and vulnerable populations by developing, implementing, evaluating, and refining programs that strengthen the nation's health care workforce. BHW programs support a diverse, culturally competent workforce by addressing components including education, training, and financial support for students, faculty, practitioners, and supporting institutions.

Statement of Social Insurance

The Statement of Social Insurance (SOSI) presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected to arise for current and future program participants. This projection is considered important information in evaluating the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheets, Statements of Net Cost, Statements of Changes in Net Position, or Combined Statements of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Trustees Report). The projections and analysis in this report do not reflect the potential effects of the COVID-19 pandemic, or the legislation enacted in response to it, on the Medicare program. However, given the uncertainty associated with these impacts, the Trustees stated that it was not possible to adjust the estimates accurately at the time the report was released. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $5.5 trillion, determined as of January 1, 2019, to $(4.8) trillion, determined as of January 1, 2020.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2020, the future cash flow for all current and future participants was $(4.5) trillion for the 75-year valuation period. The comparable cash flow for the closed group of participants, including the combined HI and SMI trust fund assets, is $(12.8) trillion.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program; thus, the HI trust fund assets have been declining. The table to the right shows the HI trust fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio steadily dropped from 67 percent at the beginning of FY 2016 to 57 percent at the beginning of FY 2020.

Trust Fund Ratio Beginning of Fiscal Year[6]	
FY	HI
2020	57%
2019	62%
2018	66%
2017	66%
2016	67%

Short-Term Financing

The HI trust fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2020 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2020 Trustees Report, the HI trust fund ratio is estimated to decline steadily until the fund is depleted in calendar year 2026. Assets at the end of calendar year 2019 were $194.6 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

[6] Assets at the beginning of the year to expenditures during the year.

The short-range outlook for the HI trust fund is similar to what was projected last year. The trust fund ratio declines until the fund is depleted in 2026, the same date as projected last year. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 90 percent in 2026 to 78 percent in 2044, and then to increase to about 90 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 3.0 in 2019 to about 2.1 by 2094. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $4.6 trillion, which is 0.8 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information: Social Insurance disclosures required by the Federal Accounting Standards Advisory Board.

SMI Trust Fund Solvency

The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement, the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government-wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(40.9) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2019, SMI expenditures were 2.2 percent of GDP. By 2094, SMI expenditures are projected to grow to 4.5 percent of the GDP.

The following table presents key amounts from CMS's basic financial statements for fiscal year 2018 through 2020.

Table of Key Measures[7]

(in Billions)

	2020	2019	2018
Net Position (end of fiscal year)			
Assets	$ 590.1	$ 502.0	$ 467.3
Less Total Liabilities	133.4	134.2	123.5
Net Position (assets net of liabilities)	**$ 456.7**	**$ 367.8**	**$ 343.8**
Costs (end of fiscal year)			
Net Costs	$ 1,157.0	$ 1,087.3	$ 1,009.1
Total Financing Sources	1,189.5	1,079.0	1,017.7
Net Change in Cumulative Results of Operations	**$ 32.5**	**$ (8.3)**	**$ 8.6**
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation (as of 1/1/2020)	$ (4,800)	$ (5,484)	$ (4,708)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation (as of 1/1/2019)	$ (5,484)	$ (4,708)	$ (3,532)
Change in Present Value	**$ 683**	**$ (776)**	**$ (1,176)**

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2020, decreased by $235 billion due to advancing the valuation date by 1 year and including the additional year 2094, by $1,715 billion due to changes in economic and health care assumptions, and by $453 billion due to changes in the law. However, changes in the projection base and demographic assumptions increased the present value by $399 and $2,687 billion, respectively. The net overall impact of these changes is an increase in the present value of $683 billion.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, *Accounting for Social Insurance* (as amended by SFFAS 37*, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), HHS has included information about the Medicare trust funds – HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to individuals with Medicare (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and*

[7] The table or other singular presentation showing the measures described above. Totals do not necessarily equal the sums of rounded components.

Federal Supplementary Medical Insurance Trust Funds, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitation of the Principal Financial Statements

The principal financial statements in the "Financial Section" have been prepared to report HHS's financial position and results of operations, pursuant to the requirements of 31 U.S.C. §3515(b). Although the statements have been prepared from HHS's books and records in accordance with generally accepted accounting principles for federal entities and the formats prescribed by the OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources, which are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing HHS with resources and budget authority.

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SECTION 2

FINANCIAL SECTION

IN THIS SECTION

- Message from the Principal Deputy Assistant Secretary
- Report of the Independent Auditors
- Department's Response to the Report of the Independent Auditors
- Principal Financial Statements
- Notes to the Principal Financial Statements
- Required Supplementary Information

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Message from the Principal Deputy Assistant Secretary

It is a privilege to present the Fiscal Year (FY) 2020 Agency Financial Report (AFR) on behalf of the Department of Health and Human Services (HHS). The FY 2020 AFR demonstrates HHS's stewardship of the resources entrusted to us by publishing our financial statements and disclosures for the President, Congress, and the American people. HHS is responsible for approximately a quarter of all federal outlays and administers more grant dollars than all other agencies combined. HHS's Chief Financial Officer Community works diligently to enhance and sustain a financial management environment that ensures accountability and manages risks related to our significant budgetary resources.

The emergence of the COVID-19 pandemic created unprecedented challenges, and HHS is executing a whole-of-America response to the COVID-19 pandemic to protect the health and safety of the American people. In FY 2020, HHS received approximately $250 billion in emergency supplemental appropriations to prevent, prepare for, and respond to the COVID-19 pandemic. As noted in the Message from the Secretary, we are building on lessons learned to ensure HHS and its Operating Divisions are more prepared than ever to enhance and protect the health and well-being of all citizens.

To proactively address the increased financial and performance risks associated with the significant COVID-19 supplemental funding, we established the COVID-19 Accountability and Risk Assessment Team (CARAT) in the Assistant Secretary for Financial Resources. The CARAT will continue to mitigate risks and implement a Department-wide financial accountability and oversight approach for COVID-19 funds.

For the 22nd consecutive year, HHS obtained an unmodified or "clean" opinion on the Consolidated Balance Sheets, Statement of Net Cost, Statement of Changes in Net Position, and the Combined Statement of Budgetary Resources. The auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, primarily due to the uncertainties surrounding provisions of the *Patient Protection and Affordable Care Act* and the impact of potential changes in law that would influence underlying assumptions of financial projections. The AFR's "Financial Section" provides detailed information about HHS's financial statements and activities.

Finally, I am pleased to report that, in recognition of the exceptional quality of our FY 2019 AFR, the Association of Government Accountants awarded HHS the prestigious *Certificate of Excellence in Accountability Reporting*, our seventh consecutive award. Additionally, the Department was recognized with a Best-in-Class award for its Presentation of the Agency's Strategic Framework.

While we are pleased with our accomplishments this year, we recognize there are several matters referenced in the Report of the Independent Auditors that will require our continued attention and focus. I want to thank our employees and partners for their remarkable efforts and dedication, especially in combatting the COVID-19 pandemic. Their everyday hard work ensures the success of our stewardship efforts and helps advance our mission.

/Jen Moughalian/

Jen Moughalian
Principal Deputy Assistant Secretary for Financial Resources
November 13, 2020

Report of the Independent Auditors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 13, 2020

TO: The Secretary

FROM: Amy J. Frontz
Deputy Inspector General for Audit Services

Amy Frontz
Digitally signed by AMY FRONTZ
Date: 2020.11.13 07:44:52 -05'00'

SUBJECT: *Financial Statement Audit of the Department of Health and Human Services for Fiscal Year 2020*, A-17-20-00001

This memorandum transmits the independent auditors' reports on the Department of Health and Human Services (HHS) fiscal year (FY) 2020 financial statements, internal control over financial reporting, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the HHS financial statements in accordance with applicable standards.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the HHS: (1) consolidated balance sheets as of September 30, 2020 and 2019, and the related consolidated statements of net cost and changes in net position; (2) the combined statements of budgetary resources for the years then ended; and (3) the sustainability statements that comprise the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 19-03, *Audit Requirements for Federal Financial Statements.*

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2020 HHS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statements of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2020, 2019, 2018, 2017, and 2016, and the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019. As a result, Ernst & Young was not able to, and did not, express an opinion on the financial condition of the HHS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young did not identify any deficiencies in internal control that it considered a material weakness. Ernst & Young noted improvements over internal controls but continued to identify two significant deficiencies related to HHS's Financial Information Systems and HHS's Financial Reporting Systems, Analyses, and Oversight, as described below:

- *Financial Information Systems*—Ernst & Young noted that HHS had continued to make strides to improve information technology (IT) controls within its financial systems. HHS management continued to establish a governance model and was consistent in focusing on strengthening the maturity over HHS's IT controls. In FY 2020, HHS management continued to take a leadership role in monitoring remediation activities across all IT systems within the scope of Ernst & Young's review, with a focus on general ledger systems and control deficiencies that contributed to the significant IT deficiency noted in the consolidated Financial Statement Audit. These efforts led to a reduction in the number of internal control deficiencies that contributed to the significant IT deficiency reported in FY 2019. Specifically, the resolved internal control deficiencies related to information systems and applications within the scope of the audit. Additional improvements included the remediation of control deficiencies identified in non-General Ledger feeder systems that provide significant information to HHS Financial Systems.

  Even with these improvements and as in previous fiscal years, Ernst & Young identified control deficiencies related to segregation of duties, configuration management, and access to HHS systems that could affect HHS's financial statements. These deficiencies collectively constitute a significant deficiency in internal control.

- *Financial Reporting, Analysis, and Reporting*—During the FY 2020 audit, Ernst & Young noted that HHS made progress in addressing certain issues. However, the FY 2020 audit still identified a series of deficiencies in financial systems and processes for producing financial statements. These deficiencies included a lack of integrated financial management systems, antiquated processes that impacted journal entries about its financial and budgetary amounts, and insufficient analysis and oversight of certain significant accounts and programs. Ernst & Young specifically described concerns about the number and dollar amount of nonstandard journal entries, controls over the Strategic National Stockpile inventory, HHS acquisition processes, Grant Monitoring and Closeout, Medicaid oversight, Statement of Social Insurance and Improper Payments. Ernst & Young noted that a significant number of nonstandard journal vouchers are needed to record entries that cannot be recorded through routine processing in HHS Financial Systems. These entries are needed to ensure accurate account balances, but Ernst & Young noted that their volume and dollar values comprise a significant portion of HHS's overall financial activity.

  HHS incurred a substantial increase in activity surrounding its Strategic National Stockpile inventory due to the impacts of COVID-19 and the increased funding of

$11.1 billion through the Coronavirus Aid, Relief, and Economic Security Act and other legislation. Through the audit, Ernst & Young identified weaknesses related to the timely posting of both receiving and issuance activity in HHS's inventory and financial systems. Although the differences were not material and the volume of transactions was significantly higher than previous years due to COVID-19, discrepancies and unreconciled amounts were also found between the warehouse counts and the inventory management system.

Ernst & Young also noted that HHS management and HHS OIG, over the past several years, have identified a series of: (1) concerns related to internal control and (2) violations of laws and regulations related to acquisition processes at both the HHS Department and Operating Division levels. Ernst & Young identified concerns related to accounting and reporting of procurement activity within financial systems, noting for example that the National Institutes of Health (NIH) maintains two separate acquisition systems. These two acquisition systems are: (1) the NIH Business System (NBS) Purchase Request Information System Management (PRISM)system, which supports 26 NIH Institutes and Centers, and (2) the Contract Award & Management System (CAMS), which is a standalone system within the National Heart, Lung, and Blood Institute (NHLBI). NBS PRISM is fully integrated with NBS and provides stringent controls across acquisition and financial management. CAMS is not integrated and requires alternative methods and tools to transfer acquisitions data into NBS PRISM to interface with the NBS financial system This setup contributed to an accounting error in which a contract was fully executed in CAMS for $413,863.20 but was subsequently recorded in NBS PRISM as $0. Ernst & Young noted that the use of two systems poses significant financial management risks and additional costs that would not exist if NHLBI operated within the NBS PRISM system.

For grant closeout and monitoring, Ernst & Young noted that HHS should strengthen its control to ensure that grants that had expired were closed out in a timely fashion. Ernst & Young's analysis showed that grants awaiting closeout increased 23 percent from 16,150 grants in FY 2019 to 19,935 grants in FY 2020. Ernst & Young also identified untimely corrections of discrepancies in grant activity and a series of abnormal grant balances that required either followup with the grantees or adjustments or both followup and adjustments to ensure financial systems contain accurate information. Although the impact to the financial statements was not significant, Ernst & Young noted that enhanced grant monitoring and closeout would provide for more timely identification and resolution of discrepancies to ensure grant activity is accounted for accurately.

For Medicaid oversight, Ernst & Young noted that although the Centers for Medicare & Medicaid Services' (CMS's) Transformed-Medicaid Statistical Information System was fully operational, CMS still needed to work with the States to assess and improve data quality to support national and State-level program analysis with timely, accurate, and complete data for policymaking and research. Given that CMS still did not have reliable historical claims-level data, data analysis using this information has been limited. CMS also still had not performed a claims-level detailed look-back analysis for the Medicaid Benefits Due and Payable line item reported in both the FY 2020 CMS and HHS

financial statements to determine the reasonableness of various State calculations of unpaid claims that have not yet been reported as liabilities.

For the Statement of Social Insurance, Ernst & Young identified formula errors in the spreadsheets used in the preparation of the statement, which were not detected by the organization's monitoring and review function. Ernst & Young concluded that the control over the formula was not functioning as designed. These deficiencies collectively constitute a significant deficiency in internal control.

Ernst & Young noted that the nature and volume of CMS's expenditures presented a substantial challenge to CMS in the quantification, evaluation, and remediation of improper payments. CMS has developed sophisticated sampling processes for estimating improper payment rates in these high-risk CMS programs: Medicare fee-for-service, Medicare Advantage, Medicare prescription drugs, Medicaid, and the Children's Health Insurance Program (CHIP). As a result of CMS efforts, improper payment rates have declined for the Medicare fee-for-service and Medicare Advantage programs. The Medicare prescription drug program had a slight increase in its improper payment rate from the previous year's estimate; however, the improper payment rate remained low. For the Medicaid program and CHIP, there was a significant increase in the improper payment rates; however, this was due to CMS reintegrating the eligibility component of the measurement in 2019. As a result, the 2020 rates are not comparable to error rates from the previous year. Rates between years will not be comparable until a baseline is established in 2021, when all States have been measured under the new eligibility requirements. CMS has specific initiatives underway to address these new results

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2020, HHS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (PIIA) (P.L. No. 116-117) and section 6411 of the Affordable Care Act[1] related to the implementation of recovery activities for the Medicare Advantage program. HHS reported improper payment error rates for its high-risk programs, except for Temporary Assistance for Needy Families (TANF). HHS believes it does not have the authority under the Social Security Act to compel the States to report error rates for TANF. HHS reported two high priority programs, Medicaid and the CHIP, with error rates in excess of 10 percent. These are also violations of the PIIA. We will report further on agency compliance with improper payment reporting, as required by the PIIA, later in FY 2021. HHS's management determined that it may have potential violations of the Antideficiency Act (P.L. No. 101-508) related to: (1) an obligation of funds for conference spending at the Food and Drug Administration, (2) certain contract obligations at CMS that occurred in FYs 2014 and 2015 and at HHS's Program Support Center that occurred between FY 2006 and FY 2011, and (3) certain transfers and administrative costs within the Biomedical Advanced Research and Development Authority within the Office of the Secretary. HHS's management also determined that the agency's Medicare appeals process did not adjudicate appeals within the statutory timeframes required by the Social Security Act (P.L. No. 74-271). As discussed above, HHS identified potential violations with laws and

[1] The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act.

regulations related to its acquisition processes. In FY 2020, CMS management was also notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters.

Evaluation and Monitoring of Audit Performance

We reviewed Ernst & Young's audit of the HHS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and HHS officials;
- monitoring the progress of the audit;
- examining audit documentation, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the HHS *FY 2020 Agency Financial Report*.

Ernst & Young is responsible for the attached reports and the conclusions expressed in those reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on HHS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996, or HHS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carla J. Lewis, Acting Assistant Inspector General for Audit Services, at (202) 205-9125 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-20-00001.

Attachment

Page 6—The Secretary

cc:
Jennifer Moughalian
Acting Assistant Secretary for Financial Resources
and Acting Chief Financial Officer

Sheila Conley
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Report of Independent Auditors

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the U.S. Department of Health and Human Services (HHS) as of September 30, 2020 and 2019, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements. We were also engaged to audit the sustainability financial statements, which comprise the statements of social insurance as of January 1, 2020, 2019, 2018, 2017, and 2016, the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019, and the related notes to the sustainability financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2020, 2019, 2018, 2017, and 2016, the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States, and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 19-03 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control

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relevant to HHS's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2020 and 2019, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal years then ended, and the related notes to the principal financial statements.

Basis for Disclaimer of Opinion on the Statement of Social Insurance and the Related Changes in the Social Insurance Program

As discussed in Note 24 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statements of social insurance and changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

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As further described in Note 25 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2020, 2019, 2018, 2017, and 2016, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 25, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent a change in the health care delivery system or level of update by subsequent legislation, access to Medicare-participating providers may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2020, 2019, 2018, 2017, and 2016, and the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019.

Disclaimer of Opinion on the Statements of Social Insurance and the Related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the HHS social insurance program as of January 1, 2020, 2019, 2018, 2017, and 2016, and the related changes in the social insurance program for the periods ended January 1, 2020 and 2019.

Opinion

In our opinion, the consolidated balance sheets, consolidated statements of net cost and changes in net position, and combined statement of budgetary resources referred to above present fairly, in all material respects, the consolidated financial position of HHS as of September 30, 2020 and 2019, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

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Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the Management's Discussion and Analysis and Required Supplementary Information, as identified on HHS's Agency Financial Report Table of Contents, be presented to supplement the financial statements. Such information, although not a part of the financial statements, is required by the Federal Accounting Standards Advisory Board, which considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the financial statements, and other knowledge we obtained during our audits of the financial statements. We do not express an opinion or provide any assurance on the information, because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Financial Information and Other Information

Our audits were conducted for the purpose of forming opinions on the financial statements that collectively comprise HHS's financial statements. The Other Financial Information, as identified on HHS's Agency Financial Report Table of Contents, is presented for purposes of additional analysis and is not a required part of the financial statements.

The Other Financial Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. Such information has been subjected to the auditing procedures applied in the audits of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Other Financial Information is fairly stated, in all material respects, in relation to the financial statements as a whole.

Except for the Other Financial Information described above, the Other Information has not been subjected to the auditing procedures applied in the audits of the financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

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Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 13, 2020 on our consideration of HHS's internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations, contracts and grant agreements, and other matters. The purpose of those reports is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of HHS's internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control over financial reporting and compliance.

Ernst & Young LLP

November 13, 2020

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Report of Independent Auditors on Internal Control over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the U.S. Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2020, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year (FY) then ended, and the related notes to the principal financial statements, and we were also engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts for the period ended January 1, 2020, and have issued our report thereon dated November 13, 2020. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts for the period ended January 1, 2020.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered HHS's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of HHS's internal control. Accordingly, we do not express an opinion on the effectiveness of HHS's internal control. We did not consider all internal controls relevant to operating objectives as broadly defined by the *Federal Managers' Financial Integrity Act of 1982*, such as those controls relevant to preparing performance information and ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that have not been identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control related to Financial Information Systems and Financial Systems, Analysis and Reporting, as described below, to be significant deficiencies.

Significant Deficiencies

Financial Information Systems

As a part of our procedures for the FY 2020 HHS financial statement audit, we noted that the Department continues to make strides to improve the controls within its supporting information technology (IT) financial systems. In particular, HHS management has continued to establish a governance model and consistent tone at the top focused on strengthening the maturity of the Department's IT controls. Specifically, management has taken a leadership role in monitoring remediation activities across all IT systems in scope, with a focus on general ledger systems and control deficiencies that contributed to the IT significant deficiency of the consolidated Financial Statement Audit. These efforts have led to a reduction of the number of internal control deficiencies that contributed to the FY 2019 IT significant deficiency related to in-scope information systems and applications. The following summarizes additional improvements achieved that resulted from this increased attention:

- Management has continued their enterprise-wide focus on corrective actions which has led to the remediation of a number of prior year control deficiencies.

- Management has made improvements in the remediation of control deficiencies identified on feeder systems (non-GL) that are financially significant

We have performed a separate financial statement audit of CMS for FY 2020 and in conjunction with our reports on that audit have provided recommendations specific to CMS on our IT internal control findings. Those findings and recommendations were considered in our overall HHS conclusions and are summarized below.

The following is a summary of the deficiencies that we considered most critical at the application layer. When assessed in aggregate, our conclusion of IT's significant deficiency is based on the following:

- **Access controls –** We identified four (4) access control exceptions across two (2) of the applications in-scope of our review, which spanned non-Centers for Medicare & Medicaid Services' (CMS) systems, in aggregate contributed to the IT significant deficiency.

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Specifically, the four exceptions are: (1) all auditable events required are not being logged and monitored and the procedures required to be performed in the event that the logging and monitoring tool is down or unavailable were not consistently performed by management, (2) users were granted additional access than what was requested and approved on the user access forms, (3) users had their access approved and provisioned by an individual who is not a part of the group of users who are authorized to approve new users, and (4) management has not consistently adhered to Department and system-level logging and monitoring requirements. We identified similar exceptions at CMS: (1) procedures for the removal of users who no longer required access were not consistently followed, and (2) monitoring of privileged access for key applications and underlying IT infrastructure was not performed or evidence of such monitoring activity was not retained.

- **Configuration management** – We identified two (2) configuration management exceptions across two (2) applications in-scope of our review which spanned non-CMS systems. Specifically, the two exceptions are: (1) management was not able to delineate how configuration management approvals are captured for all changes, and (2) management was not able to provide a system generated listing/population of changes deployed into production during the audit period. In addition, CMS continues to experience deficiencies in the implementation and monitoring of compliance with its information systems control standards and processes. Specifically, (1) system configuration settings were not compliant with CMS requirements, (2) security baseline scans were not performed for part of the fiscal year, and (3) an expedited change to the general ledger system was implemented without obtaining all appropriate approvals.

- **Segregation of duties** – We identified two (2) segregation of duties exceptions across two (2) applications in scope of our review which spanned non-CMS systems. Specifically, the two exceptions are: (1) management has not implemented a process for validating the completeness and accuracy of supporting its segregation of duties (SOD) monitoring controls and sufficient evidence was not provided to support all SOD rules/colliding transactions in accordance with the documented OpDiv-level process, and (2) management was unable to provide evidence to demonstrate that appropriate monitoring procedures were performed for users with a segregation of duties waiver.

Recommendations

HHS should continue the progress achieved in FY2020 to remediate the remaining deficiencies contributing to the significant deficiency and focus on continuous improvement. The following are some specific considerations:

- Continue to prioritize high impact remediation activities ultimately strengthening the IT controls maturity, with specific attention on the remaining high-risk control deficiencies identified as a part of the FY2020 Financial Statement Audit centered on access controls, configuration management, and segregation of duties;

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- Work to strengthen overarching governance/oversight to improve sustainability of remediation activities limiting the identification of new internal control deficiencies that could contribute to the IT significant deficiency during the audit; and

- Continue to build on the maturity of the IT controls enterprise and strengthen all layers of the IT enterprise, to include operating system, data tier, and application layer, while being cognizant of the identification of new internal control deficiencies in material systems that could contribute to the IT significant deficiency.

Financial Systems, Analysis and Reporting

Although progress in certain areas has been identified, our review of internal control disclosed a series of deficiencies in financial systems and processes for producing financial statements, including the need for a number of non-standard journal entries to significantly adjust financial and budgetary amounts, and/or insufficient analysis and oversight of certain significant accounts, balances, or programs. We identified the following items in the current year's audit that indicate additional improvements in the financial reporting systems and processes are required.

Non-Standard Journal Voucher Processes

HHS posts a significant number of non-standard journal vouchers to record entries that are unable to be recorded through routine systematic processing. The majority of these entries are generated by National Institutes of Health (NIH); however, in comparison to their budgetary resources, many of the other operating divisions also have a significant number of non-standard entries recorded to ensure consolidated financial statement amounts are accurate. During FY 2020, although HHS's annual total budgetary resources were $2.4 trillion, HHS was required to process 7,943 manual entries totaling an absolute value of more than $480.6 billion to its NIH Business System (NBS) or Unified Financial Management Systems (UFMS). Although the number and absolute dollar value of manual entries decreased compared to FY 2019 where 9,498 manual entries totaling an absolute value of more than $623.3 billion were posted, the number and absolute dollar value of manual entries remain substantial. These entries consist of non-standard postings to record both the proprietary and budgetary effects of certain financial activities for which either the financial system is not configured properly to post automatically or to post differences identified during the various reconciliations or analyses performed by HHS personnel. Additionally, we noted that certain manual entries related to undelivered orders, grant close out, and budgetary entries were either not reported on a timely basis or were recorded improperly and then required further adjustment. Although necessary to ensure balances are accurate, the volume and dollar value of manual entries is significant compared to HHS's overall activity.

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National Stockpile Inventory

During FY 2020 HHS incurred a significant amount of activity surrounding the Strategic National Stockpile (SNS) inventories due to the impacts of the COVID-19 response and the increased funding of $11.1 billion through the CARES Act and other legislation. Through the audit, we identified weaknesses related to the timely posting of both receiving and issuance activities in the inventory management system. Although the differences were not material, and the volume of transactions was significantly higher than previous years due to COVID-19, discrepancies and unreconciled amounts were found between the warehouse counts and the inventory management system. Due to COVID-19 restrictions on travel, HHS was not able to perform certain annual inventory counts and related reconciliation processes. Further, we also noted certain transactions with interagency partners were not supported by sufficient documentation to support what was purchased and when it was received. HHS is currently reviewing its processes to identify lessons learned so that new processes are developed to address potential future crisis situations similar to the current pandemic.

Grant Monitoring and Close Out

During FY 2020, nearly 45 percent or $1.01 trillion of HHS spending was made through grants. Although we found HHS's internal controls for grants were properly designed, we noted that HHS should strengthen its controls to ensure grants with expired project periods were closed out in a timely manner. Open grant awards represent obligations for goods and/or services that have not been delivered or are awards for which proper expenditure reporting from the grantee has not been received, recorded and/or reconciled. HHS grant managers are required to closely monitor outstanding grant balances and ensure grant recipients follow proper expenditure reporting guidance/timelines. HHS utilizes Grant Closeout reports to aid managers in the closeout process. Based on our analysis, the grants with expired project periods awaiting closeout increased by 23% from 16,150 grants in FY 2019 to 19,935 grants in FY 2020, which is not evenly distributed across HHS grants awarding OpDivs. Recent legislation and guidance, including OMB Circular A-136 and the Code of Federal Regulations (2 CFR 200), has placed an emphasis on timely and efficient closing of grant awards, especially with a focus on older awards. HHS has shown consistent improvement in recent years in the effort to close out grants timely. However, in FY 2020, management indicated that efforts to close out grants timely were slowed due to competing priorities within grant offices. Additionally, we noted certain untimely corrections of discrepancies in grant activity and a series of abnormal grant balances which required follow up with the grantees and/or adjustments to financial systems to ensure accurate information. Although the impact to the financial statements was not significant, enhanced grant monitoring and close out would provide for more timely identification and resolution of discrepancies to ensure grant activity is accounted for accurately.

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HHS Procurement Processes

Over the past several years, HHS and our audit have identified several concerns related to internal control and potential violations of laws and regulations related to its procurement processes at both the HHS department and Operating Division Levels. We have reported that HHS identified a series of potential violations to the Anti-deficiency Act within our accompanying Report on Compliance and Other Matters.

From an internal control standpoint, HHS and our audit identified certain concerns related to accounting and reporting of procurement activities within its financial systems. For example:

The National Institutes of Health (NIH) leverages the Procurement Request Information System (PRISM) for their acquisition information management. NIH currently maintains two separate PRISM systems: (1) the NIH Business System (NBS) PRISM (NBS PRISM) that supports 26 NIH Institutes and Centers (IC), and (2) the Contract Award & Management System (CAMS), which is a standalone PRISM system within the National Heart, Lung, and Blood Institute (NHLBI). NBS PRISM is fully integrated with the NBS financial system and provides stringent controls across acquisition and financial management. CAMS is not integrated and requires alternative methods and tools to transfer acquisitions data into NBS PRISM to interface with the NBS financial system. This setup contributed to an accounting error late in September as a contract was fully executed in CAMS for $413,863, and subsequently recorded in NBS PRISM as $0. The Office of Financial Management (OFM) made correcting entries in NBS to record the proper obligation amount for fiscal year 2020 reporting. The dependency on non-integrated third-party applications to transfer acquisitions data poses significant financial management and information security risks and increases the level of effort required to reconcile data between the two acquisition systems. There are also significant costs associated with procuring and maintaining two PRISM systems. These increased risks and additional costs would be non-existent if NHLBI operated within the NBS PRISM system. Additionally, there appear to be no functional, operational or cost benefits to maintaining a separate PRISM system that supports only one Institute. Further, we noted certain concerns related to the accounting and documentation supporting its interagency activity. As noted above, certain interagency agreements did not have adequate requirements surrounding documentation to support the receiving and accounting for its Strategic National Stockpile inventories.

CMS Oversight Processes

We performed a separate audit of the financial statements of CMS and reported on the results of our audit, including a report on its internal controls, dated November 6, 2020. In that report, we outlined details of deficiencies noted and made recommendations for improvement in its financial management controls. Consistent with our findings in the previous year, we concluded that the aggregation of these deficiencies to be a significant deficiency for the CMS internal control over financial reporting.

The most significant of those deficiencies fell within the oversight of the CMS Medicaid program and the Statements of Social Insurance.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters.

CMS previously completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. Although operational data is currently available, information contained within T-MSIS requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for Medicaid. CMS should evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures. Given the claims level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2020 financial statements and is subject to volatility based on the complexity and judgment required in establishing this estimate. From time to time, claim processing cycle changes, such as a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence.

Despite the implementation of T-MSIS, CMS must continue to evaluate and improve the quality and completeness of data reported by the states in T-MSIS before a claims level detailed look-back analysis for Medicaid EBDP can be suitably relied upon. Until further analysis is developed and performed to verify the reliability of T-MSIS data, there remains a risk that potential updates to CMS's analysis will not be reflected in CMS's financial statements in a timely manner.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS present a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS's policies and procedures.

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As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. In the current year, CMS incorporated changes to key assumptions and certain aspects of its methodology in the SOSI projection, resulting in changes to the inputs, formulas and macros, and outputs of certain spreadsheets. The extent of those changes was significant and the majority of those changes were implemented without issue; however, during our procedures, formula errors associated with certain of the changes were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

Improper Payments

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates in the high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage, Medicare Prescription Drugs, Medicaid and CHIP.

CMS builds time into its processes to allow all payments sampled for review sufficient time to allow for appeals of the errors and submission of additional documentation by the claimant. CMS believes that expediting the improper payment rate calculations would result in less time for sampled payments to complete the measurement process, allowing errors to be cited solely due to the fact that not enough time was given for things such as appeals or documentation submission. Allowing the maximum amount of time for this development causes the processes to be completed very near the required annual reporting deadline. CMS remains committed to achieving reductions in improper payment rates. As a result, improper payment rates declined for Medicare FFS and Medicare Part C. Part D saw a slight increase from the prior year's estimate; however, the improper payment rate remains low. For Medicaid and CHIP, CMS reintegrated the eligibility component of the measurement in 2019, resulting in a significant increase in the improper payment rates; however, the 2020 rates are not comparable to the prior year as a result of this reintegration of the new eligibility component which contributed to a further increase in the Medicaid and CHIP error rates in 2020. Rates between years will not be comparable until a baseline is established in 2021, when all states have been measured under the new eligibility requirements. CMS has specific initiatives underway to address these new results.

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Recommendations

We recommend that HHS continue to develop and refine its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. This will require focused efforts and continued prioritization of issues related to controls within and surrounding its financial information management systems. Specifically, we recommend the following:

- For non-standard journal processes, we recommend that HHS continue to focus on automating and reducing the number of non-standard journal vouchers by determining the cause and the ability to upgrade systems to allow for automated posting of high-volume routine transactions and to ensure financial data is accurate. Additionally, we recommend that HHS strengthen its controls around its manual journal entry process or reinforce its controls through training of personnel to ensure that control processes are operating effectively.

- HHS should continue to analyze its current processes to identify ways to strengthen controls surrounding its Strategic National Stockpile inventories and related processes to ensure activity is recorded properly in a timely fashion in both its inventory and financial systems.

- HHS should continue to strengthen its processes and accounting related to acquisition activities. As potential internal control and law and regulation concerns are identified, we strongly recommend that policies and procedures are updated with training provided to the acquisition personnel to provide assurances that processes are executed properly. Further, we recommend that the ongoing monitoring process be enhanced to provide stronger internal controls so that anomalies can be prevented or identified timely. Finally, we recommend NIH consider transitioning to a single PRISM instance. Operating a standalone non-integrated PRISM system poses significant risks and does not provide cost benefit. In addition, maintaining a fully integrated acquisition system for 26 NIH ICs, and then procuring and maintaining a second acquisition system for only one component of NIH raises questions about responsible stewardship of resources to administer acquisition activities at NIH. .

- HHS should continue to strengthen its processes related to grant activities by continuing to closely monitor outstanding grant balances, especially grants with abnormal balances, and ensuring timely closeout of grants.

- We recommend that CMS continue to develop, refine and enhance e its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. This would include having CMS:

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- Continue to enhance the data analyses on Medicaid claims level data to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the financial accounting and reporting of the Medicaid program.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the approximately $45.9 billion liability.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision and when significant changes are made, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

- Consider additional opportunities to further reduce improper payments which are consistent with the organization's objectives of improving payment accuracy levels.

More detailed recommendations related to our specific findings on these topics are included in our CMS Report on Internal Control.

HHS's Response to Findings

HHS's response to the findings identified in our audit are included in the accompanying letter dated November 13, 2020. HHS's response was not subjected to the auditing procedures applied in the audit of the consolidated financial statements, and, accordingly, we express no opinion on it.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the effectiveness of HHS's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's internal control. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 13, 2020

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Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

The Secretary and the Inspector General of the
U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and the Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*, the consolidated financial statements of the Department of Health and Human Services (HHS or the Department), which comprise the consolidated balance sheet as of September 30, 2020, and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources for the fiscal year (FY) then ended, and the related notes to the principal financial statements, and we were engaged to audit the sustainability financial statements, which comprise the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts for the period ended January 1, 2020, and have issued our report thereon dated November 13, 2020. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts for the period ended January 1, 2020.

Compliance and Other Matters

In connection with our audit of the financial statements of HHS, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements, as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to HHS. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 19-03, as described below.

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During FY 2020, HHS's management determined that it may have potential violations of the Anti-Deficiency Act (P.L. 101-508 and OMB Circular A-11) related to (1) an obligation of funds for conference spending at Food and Drug Administration, (2) certain contract obligations serviced by the Program Support Center between FY 2006 and FY 2011 and Centers for Medicare & Medicaid Services occurring between FY 2014 and FY 2015, and (3) certain transfers and administrative costs within the Biomedical Advanced Research and Development Authority within the Office of the Secretary. Additionally, during FY 2020, Centers for Medicare & Medicaid Services' management was notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters. Finally, HHS's management determined that its Medicare appeals process did not adjudicate appeals within the statutory decisional time frames required by the *Social Security Act*.

The *Payment Integrity Information Act of 2019 (*P.L.116-117) (hereinafter, the "Act") (1) requires federal agencies to identify the program and activities that may be susceptible to significant improper payments, and estimate the amount of the improper payments, and (2) establish certain reporting requirements surrounding such programs and their related estimates. While the Department continues to make progress, HHS currently is not in full compliance with the requirements of the Act. For example, HHS has reported improper payment error rates for each of its high-risk programs, or components of such programs, except for the Temporary Assistance for Needy Families (TANF). HHS indicated that it is unable to compel states to collect the necessary information required to conduct an improper payment measurement for TANF due to Section 411 of the *Social Security Act*, which specifies the data elements that HHS may require states to report, and Section 417 of the same *Social Security Act*, which dictates that the federal government may only regulate the conduct of states where Congress has given them the express authority. Accordingly, HHS states that it does not have the authority to collect data pertaining to case and payment accuracy for TANF since the information is not included under the *Social Security Act.* Additionally, the Medicaid and CHIP improper payment rates exceeded the statutorily required maximum of 10%. Finally, HHS is not in full compliance with Section 6411 of the *Patient Protection and Affordable Care Act*, as HHS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

Under FFMIA, we are required to report whether HHS's financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA Section 803(a) requirements. The results of our tests disclosed no instances in which HHS's financial management systems did not substantially comply with requirements as discussed above.

* * * * *

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HHS's Response to Findings

HHS's response to the findings identified in our audit are described in its letter dated November 13, 2020. HHS's response was not subjected to the auditing procedures applied in the audit of the financial statements, and, accordingly, we express no opinion on it. Additionally, HHS is updating its Department-wide corrective action plan to address the financial management issues discussed above.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on HHS's compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering HHS's compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 13, 2020

Department's Response to the Report of the Independent Auditors

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Office of the Assistant Secretary for Financial Resources
Washington, D.C. 20201

To: Christi A. Grimm, Principal Deputy Inspector General

From: Jen Moughalian, Principal Deputy Assistant Secretary for Financial Resources

Subject: Fiscal Year (FY) 2020 Independent Auditors' Financial Statement Audit Report

Thank you for the opportunity to comment on the FY 2020 Independent Auditors' Report. We appreciate the diligent work of the Office of Inspector General (OIG) and independent auditors, Ernst & Young LLP (EY), throughout the audit of the Department of Health and Human Services' financial statements.

We are pleased to receive an unmodified opinion on our financial statements. We acknowledge that the auditors disclaimed providing an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts, and the three identified material noncompliances with laws and regulations. We generally concur with the auditors' findings. We will continue to actively identify root causes, implement corrective actions, and monitor remediation efforts. The Department has diligently worked to improve the effectiveness of our internal control environment.

Overall, we have made strong progress in enhancing our internal control environment. We are very proud of our progress and remain committed to ensuring high standards of integrity and transparency in reporting our financial performance.

/Jen Moughalian/

Jen Moughalian
Principal Deputy Assistant Secretary for Financial Resources
November 13, 2020

Principal Financial Statements

U.S. Department of Health and Human Services
Consolidated Balance Sheets

As of September 30, 2020 and 2019
(in Millions)

	2020	2019
Assets (Note 2)		
Intragovernmental Assets		
Fund Balance with Treasury (Note 3)	$ 514,042	$ 296,257
Investments, Net (Note 4)	226,215	309,349
Accounts Receivable, Net (Note 5)	715	812
Advances (Note 8)	1,993	180
Total Intragovernmental Assets	**742,965**	**606,598**
Accounts Receivable, Net (Note 5)	21,712	24,156
Inventory and Related Property, Net (Note 6)	13,430	10,781
General Property, Plant and Equipment, Net (Note 7)	6,904	6,544
Advances (Note 8)	106,082	2,452
Other Assets	533	197
Total Assets	**$ 891,626**	**$ 650,728**
Stewardship Land (Note 19)		
Liabilities (Note 9)		
Intragovernmental Liabilities		
Accounts Payable	$ 2,389	$ 1,153
Other Liabilities (Note 13)	3,653	5,573
Total Intragovernmental Liabilities	**6,042**	**6,726**
Accounts Payable	2,583	1,221
Entitlement Benefits Due and Payable (Note 10)	116,935	110,100
Accrued Liabilities (Note 12)	15,798	15,543
Federal Employee and Veterans' Benefits (Note 11)	15,319	14,826
Contingencies and Commitments (Note 14)	11,267	17,083
Other Liabilities (Note 13)	3,920	3,695
Total Liabilities	**171,864**	**169,194**
Net Position		
Unexpended Appropriations - Funds from Dedicated Collections (Note 18)	98,117	57,968
Unexpended Appropriations - All Other Funds	333,140	170,438
Cumulative Results of Operations - Funds from Dedicated Collections (Note 18)	285,692	258,392
Cumulative Results of Operations - All Other Funds	2,813	(5,264)
Total Net Position - Funds from Dedicated Collections	**383,809**	**316,360**
Total Net Position - All Other Funds	**335,953**	**165,174**
Total Net Position	**719,762**	**481,534**
Total Liabilities and Net Position	**$ 891,626**	**$ 650,728**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statements of Net Cost
For the Years Ended September 30, 2020 and 2019
(in Millions)

	2020	2019
Responsibility Segments		
Centers for Medicare & Medicaid Services (CMS)		
Gross Costs	$ 1,281,918	$ 1,201,630
Exchange Revenue	(125,288)	(114,723)
CMS Net Cost of Operations	1,156,630	1,086,907
Other Segments:		
Administration for Children and Families (ACF)	61,159	56,087
Administration for Community Living (ACL)	2,444	2,176
Agency for Healthcare Research and Quality (AHRQ)	334	335
Centers for Disease Control and Prevention (CDC)	11,980	12,285
Food and Drug Administration (FDA)	5,687	5,339
Health Resources and Services Administration (HRSA)	12,241	11,655
Indian Health Service (IHS)	8,429	7,550
National Institutes of Health (NIH)	36,819	35,822
Office of the Secretary (OS)	110,043	3,439
Program Support Center (PSC)	2,218	2,771
Substance Abuse and Mental Health Services Administration (SAMHSA)	5,339	4,525
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	$ 256,693	$ 141,984
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes (Note 11)	71	(27)
Other Segments Gross Costs of Operations after Actuarial Gains and Losses	$ 256,764	$ 141,957
Exchange Revenue	(5,657)	(6,015)
Other Segments Net Cost of Operations	251,107	135,942
Net Cost of Operations (Note 20)	**$ 1,407,737**	**$ 1,222,849**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2020
(in Millions)

	Funds from Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 57,968	$ 170,438	$ -	$ 228,406
Budgetary Financing Sources:				
Appropriations Received	438,810	921,741	-	1,360,551
Appropriations Transferred in/out (+/-)	-	(285)	-	(285)
Other Adjustments (+/-)	(6,460)	(25,153)	-	(31,613)
Appropriations Used	(392,201)	(733,601)	-	(1,125,802)
Total Budgetary Financing Sources	40,149	162,702	-	202,851
Total Unexpended Appropriations	**$ 98,117**	**$ 333,140**	**$ -**	**$ 431,257**
Cumulative Results of Operations:				
Beginning Balances	$ 258,392	$ (5,264)	$ -	$ 253,128
Budgetary Financing Sources:				
Other Adjustments (+/-)	-	(9)	-	(9)
Appropriations Used	392,201	733,601	-	1,125,802
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	295,913	-	-	295,913
Nonexchange Revenue - Investment Revenue	6,406	242	-	6,648
Nonexchange Revenue - Other	3,971	310	-	4,281
Donations and Forfeitures of Cash and Cash Equivalents	61	-	-	61
Transfers-in/out without Reimbursement (+/-)	(4,134)	1,895	-	(2,239)
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	127	-	127
Imputed Financing	12,358	825	(309)	12,874
Other (+/-)	6	(350)	-	(344)
Total Financing Sources	706,782	736,641	(309)	1,443,114
Net Cost of Operations	679,482	728,564	(309)	1,407,737
Net Change	27,300	8,077	-	35,377
Cumulative Results of Operations	**$ 285,692**	**$ 2,813**	**$ -**	**$ 288,505**
Net Position	**$ 383,809**	**$ 335,953**	**$ -**	**$ 719,762**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Consolidated Statement of Changes in Net Position
For the Year Ended September 30, 2019
(in Millions)

	Funds from Dedicated Collections	All Other Funds	Eliminations	Consolidated Total
Unexpended Appropriations:				
Beginning Balance	$ 22,934	$ 163,667	$ -	$ 186,601
Budgetary Financing Sources:				
Appropriations Received	402,356	657,034	-	1,059,390
Appropriations Transferred in/out (+/-)	-	3	-	3
Other Adjustments (+/-)	(5,861)	(89,481)	-	(95,342)
Appropriations Used	(361,461)	(560,785)	-	(922,246)
Total Budgetary Financing Sources	35,034	6,771	-	41,805
Total Unexpended Appropriations	**$ 57,968**	**$ 170,438**	**$ -**	**$ 228,406**
Cumulative Results of Operations:				
Beginning Balances	$ 262,972	$ (2,378)	$ -	$ 260,594
Budgetary Financing Sources:				
Other Adjustments (+/-)	(3)	(5)		(8)
Appropriations Used	361,461	560,785	-	922,246
Nonexchange Revenue				
Nonexchange Revenue - Tax Revenue	281,441	-	-	281,441
Nonexchange Revenue - Investment Revenue	9,519	252	-	9,771
Nonexchange Revenue - Other	3,533	-	-	3,533
Donations and Forfeitures of Cash and Cash Equivalents	69	-	-	69
Transfers-in/out without Reimbursement (+/-)	(3,230)	1,010	-	(2,220)
Other Financing Sources (Nonexchange):				
Donations and Forfeitures of Property	-	7	-	7
Transfers-in/out without Reimbursement (+/-)	(2)	2	-	-
Imputed Financing	56	813	(321)	548
Other (+/-)	3	(7)	-	(4)
Total Financing Sources	652,847	562,857	(321)	1,215,383
Net Cost of Operations	657,427	565,743	(321)	1,222,849
Net Change	(4,580)	(2,886)	-	(7,466)
Cumulative Results of Operations	**$ 258,392**	**$ (5,264)**	**$ -**	**$ 253,128**
Net Position	**$ 316,360**	**$ 165,174**	**$ -**	**$ 481,534**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Combined Statement of Budgetary Resources
For the Years Ended September 30, 2020 and 2019
(in Millions)

	2020	2019
Budgetary Resources		
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 157,422	$ 120,849
Appropriations (Discretionary and Mandatory)	2,255,613	1,777,690
Borrowing Authority (Discretionary and Mandatory)	2	5
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	26,710	25,621
Total Budgetary Resources (Note 21)	**$ 2,439,747**	**$ 1,924,165**
Status of Budgetary Resources		
New Obligations and Upward Adjustments (Note 21)	$ 2,198,886	$ 1,814,780
Unobligated Balance, End of Year:		
Apportioned, Unexpired Accounts	158,596	50,356
Exempt from Apportionment, Unexpired Accounts	188	172
Unapportioned, Unexpired Accounts	12,288	30,976
Unexpired Unobligated Balance, End of Year	171,072	81,504
Expired Unobligated Balance, End of Year	69,789	27,881
Unobligated Balance, End of Year	240,861	109,385
Total Budgetary Resources (Note 21)	**$ 2,439,747**	**$ 1,924,165**
Outlays, Net		
Outlays, Net (Discretionary and Mandatory) (Note 20)	$ 2,037,911	$ 1,706,314
Distributed Offsetting Receipts (Note 20)	(533,915)	(492,692)
Agency Outlays, Net (Discretionary and Mandatory) (Note 20)	**$ 1,503,996**	**$ 1,213,622**

The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Social Insurance (Unaudited)

75-Year Projection as of January 1, 2020 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	2020	2019	2018	2017	2016
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 12,454	$ 11,995	$ 11,323	$ 10,679	$ 10,294
SMI Part B	32,165	27,556	24,143	21,641	19,386
SMI Part D	6,975	7,181	7,176	6,929	7,659
Have attained eligibility age (age 65 or over)					
HI	637	559	525	492	455
SMI Part B	5,864	5,232	4,725	4,122	3,660
SMI Part D	1,016	1,052	1,015	958	952
Those expected to become participants					
HI	12,464	11,805	10,959	10,567	9,952
SMI Part B	8,567	6,864	5,586	5,019	4,437
SMI Part D	3,043	3,000	2,932	2,869	3,602
All current and future participants					
HI	25,554	24,359	22,807	21,738	20,701
SMI Part B	46,596	39,652	34,453	30,783	27,484
SMI Part D	11,035	11,232	11,124	10,756	12,213
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 24 and 25)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$ 20,103	$ 20,028	$ 18,604	$ 17,193	$ 16,800
SMI Part B	31,819	27,270	23,832	21,392	19,178
SMI Part D	6,975	7,181	7,176	6,929	7,659
Have attained eligibility age (age 65 and over)					
HI	6,073	5,348	5,027	4,539	4,285
SMI Part B	6,194	5,741	5,180	4,531	4,026
SMI Part D	1,016	1,052	1,015	958	952
Those expected to become participants					
HI	4,179	4,467	3,884	3,539	3,437
SMI Part B	8,583	6,641	5,442	4,860	4,281
SMI Part D	3,043	3,000	2,932	2,869	3,602
All current and future participants:					
HI	30,355	29,843	27,515	25,270	24,523
SMI Part B	46,596	39,652	34,453	30,783	27,484
SMI Part D	11,035	11,232	11,124	10,756	12,213
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (4,800)	$ (5,484)	$ (4,708)	$ (3,532)	$ (3,822)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 24 and 25)					
HI	$ (4,800)	$ (5,484)	$ (4,708)	$ (3,532)	$ (3,822)
SMI Part B	-	-	-	-	-
SMI Part D	-	-	-	-	-
Trust Fund assets at start of period					
HI	195	200	202	199	194
SMI Part B	100	96	80	88	68
SMI Part D	9	8	8	8	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 24 and 25)					
HI	$ (4,606)	$ (5,283)	$ (4,506)	$ (3,333)	$ (3,628)
SMI Part B	100	96	80	88	68
SMI Part D	9	8	8	8	1

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Social Insurance (Continued) (Unaudited)
75-Year Projection as of January 1, 2020 and Prior Base Years
(in Billions)

		Estimates from Prior Years			
	2020	2019	2018	2017	2016
Medicare Social Insurance Summary					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$ 7,517	$ 6,843	$ 6,266	$ 5,572	$ 5,067
Expenditures	13,284	12,140	11,222	10,027	9,263
Income less expenditures	(5,766)	(5,297)	(4,957)	(4,455)	(4,196)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	51,594	46,731	42,643	39,250	37,339
Expenditures	58,897	54,479	49,612	45,514	43,637
Income less expenditures	(7,303)	(7,748)	(6,970)	(6,264)	(6,298)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,069)	(13,045)	(11,926)	(10,719)	(10,493)
Combined Medicare Trust Fund assets at start of period	303	305	290	295	263
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(12,766)	(12,740)	(11,637)	(10,425)	(10,230)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	24,074	21,669	19,477	18,456	17,992
Expenditures	15,805	14,108	12,258	11,268	11,320
Income less expenditures	8,269	7,561	7,219	7,187	6,672
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,800)	(5,484)	(4,708)	(3,532)	(3,822)
Combined Medicare Trust Fund assets at start of period	303	305	290	295	263
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$ (4,497)	$ (5,179)	$ (4,418)	$ (3,237)	$ (3,559)

Please note for the entirety of the Statement of Social Insurance:
Totals do not necessarily equal the sum of the rounded components.
Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Unaudited)

January 1, 2019 to January 1, 2020

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 26)					
As of January 1, 2019	$ 75,243	$ 80,727	$ (5,484)	$ 305	$ (5,179)
Reasons for change					
Change in the valuation period	2,691	2,926	(235)	(3)	(238)
Change in projection base	444	45	399	2	401
Changes in the demographic assumptions	(1,871)	(4,558)	2,687	-	2,687
Changes in economic and health care assumptions	7,455	9,170	(1,715)	-	(1,715)
Changes in law	(778)	(325)	(453)	-	(453)
Net changes	7,942	7,259	683	(1)	682
As of January 1, 2020	$ 83,185	$ 87,986	$ (4,800)	$ 303	$ (4,497)
HI - Part A (Note 26)					
As of January 1, 2019	$ 24,359	$ 29,843	$ (5,484)	$ 200	$ (5,283)
Reasons for change					
Change in the valuation period	799	1,034	(235)	(7)	(242)
Change in projection base	(17)	(415)	399	1	400
Changes in the demographic assumptions	(426)	(3,114)	2,687	-	2,687
Changes in economic and health care assumptions	1,386	3,101	(1,715)	-	(1,715)
Changes in law	(547)	(94)	(453)	-	(453)
Net changes	1,195	512	683	(6)	677
As of January 1, 2020	$ 25,554	$ 30,355	$ (4,800)	$ 195	$ (4,606)
SMI - Part B (Note 26)					
As of January 1, 2019	$ 39,652	$ 39,652	$ -	$ 96	$ 96
Reasons for change					
Change in the valuation period	1,449	1,449	-	3	3
Change in projection base	285	285	-	-	-
Changes in the demographic assumptions	(1,049)	(1,049)	-	-	-
Changes in economic and health care assumptions	6,414	6,414	-	-	-
Changes in law	(154)	(154)	-	-	-
Net changes	6,944	6,944	-	3	3
As of January 1, 2020	$ 46,596	$ 46,596	$ -	$ 100	$ 100
SMI - Part D (Note 26)					
As of January 1, 2019	$ 11,232	$ 11,232	$ -	$ 8	$ 8
Reasons for change					
Change in the valuation period	444	444	-	-	-
Change in projection base	176	176	-	1	1
Changes in the demographic assumptions	(395)	(395)	-	-	-
Changes in economic and health care assumptions	(345)	(345)	-	-	-
Changes in law	(77)	(77)	-	-	-
Net changes	(198)	(198)	-	1	1
As of January 1, 2020	$ 11,035	$ 11,035	$ -	$ 9	$ 9

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

U.S. Department of Health and Human Services
Statement of Changes in Social Insurance Amounts (Continued) (Unaudited)

January 1, 2018 to January 1, 2019

Medicare Hospital and Supplementary Medical Insurance

(in Billions)

	Actuarial present value over the next 75 years (open group measure)				
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures	Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
Total Medicare (Note 26)					
As of January 1, 2018	$ 68,385	$ 73,092	$ (4,708)	$ 290	$ (4,418)
Reasons for change					
Change in the valuation period	2,427	2,628	(201)	7	(193)
Change in projection base	251	451	(200)	8	(193)
Changes in the demographic assumptions	(852)	(879)	27	-	27
Changes in economic and health care assumptions	5,032	5,435	(402)	-	(402)
Changes in law	-	-	-	-	-
Net changes	6,858	7,634	(776)	15	(761)
As of January 1, 2019	$ 75,243	$ 80,727	$ (5,484)	$ 305	$ (5,179)
HI - Part A (Note 26)					
As of January 1, 2018	$ 22,807	$ 27,515	$ (4,708)	$ 202	$ (4,506)
Reasons for change					
Change in the valuation period	748	949	(201)	(5)	(206)
Change in projection base	(100)	100	(200)	4	(197)
Changes in the demographic assumptions	(243)	(270)	27	-	27
Changes in economic and health care assumptions	1,146	1,548	(402)	-	(402)
Changes in law	-	-	-	-	-
Net changes	1,552	2,328	(776)	(2)	(778)
As of January 1, 2019	$ 24,359	$ 29,843	$ (5,484)	$ 200	$ (5,283)
SMI - Part B (Note 26)					
As of January 1, 2018	$ 34,453	$ 34,453	$ -	$ 80	$ 80
Reasons for change					
Change in the valuation period	1,232	1,232	-	13	13
Change in projection base	70	70	-	3	3
Changes in the demographic assumptions	(507)	(507)	-	-	-
Changes in economic and health care assumptions	4,404	4,404	-	-	-
Changes in law	-	-	-	-	-
Net changes	5,199	5,199	-	16	16
As of January 1, 2019	$ 39,652	$ 39,652	$ -	$ 96	$ 96
SMI - Part D (Note 26)					
As of January 1, 2018	$ 11,124	$ 11,124	$ -	$ 8	$ 8
Reasons for change					
Change in the valuation period	447	447	-	(1)	(1)
Change in projection base	281	281	-	1	1
Changes in the demographic assumptions	(103)	(103)	-	-	-
Changes in economic and health care assumptions	(517)	(517)	-	-	-
Changes in law	-	-	-	-	-
Net changes	108	108	-	-	-
As of January 1, 2019	$ 11,232	$ 11,232	$ -	$ 8	$ 8

Totals do not necessarily equal the sum of the rounded components.
The accompanying "Notes to the Principal Financial Statements" are an integral part of these statements.

Notes to the Principal Financial Statements

Note 1. Summary of Significant Accounting Policies

A. Reporting Entity

HHS is a Cabinet-level agency within the executive branch of the federal government. Its predecessor, the Department of Health, Education and Welfare (HEW), was officially established on April 11, 1953. In 1979, the *Department of Education Organization Act* was signed into law. The law established a new federal entity, the Department of Education. The HEW officially became HHS on May 4, 1980. HHS is responsible for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

The accompanying financial statements include activities and operations of the United States (U.S.) Department of Health and Human Services (HHS or the Department). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, HHS has included all consolidation entities for which it is accountable in this general purpose federal financial report. The Office of the Secretary (OS) and 11 Operating Divisions (OpDivs) listed below, and all of their federal funding are consolidated into the HHS financial statements. HHS conducted a systematic and thorough review of all organizations and found two Federally Funded Research and Development Centers (FFRDC) that are contract-based. The Department analyzed its existing relationship with the FFRDCs and determined they do not require a separate disclosure, as they are immaterial and part of the Department's consolidated financial statements.

Organization and Structure of HHS

Each HHS OpDiv is responsible for carrying out a mission, conducting a major line of activity, or producing one or a group of related products and/or services. Although organizationally located within OS, the Program Support Center (PSC) is a responsibility segment and reports separately due to the business activities conducted on behalf of other federal agencies and HHS OpDivs. The Agency for Toxic Substances and Disease Registry (ATSDR) is combined with the Centers for Disease Control and Prevention (CDC) for financial reporting purposes. Therefore, references to the CDC responsibility segment include ATSDR. Responsibility segment management report directly to the Department's top management, and the resources and results of operations can be clearly distinguished from those of other responsibility segments. The 12 responsibility segments are:

- Administration for Children and Families (ACF)
- Administration for Community Living (ACL)
- Agency for Healthcare Research and Quality (AHRQ)
- Centers for Disease Control and Prevention (CDC)
- Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of the Secretary (OS) – excluding the Program Support Center
- Program Support Center (PSC)
- Substance Abuse and Mental Health Services Administration (SAMHSA)

CMS, the largest HHS OpDiv, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and other health related programs. CMS is also a separate reporting entity. The CMS annual financial report can be found at CMS.gov.

B. Basis of Accounting and Presentation

HHS financial statements have been prepared to report the financial position and results of operations of the Department, pursuant to the requirements of 31 U.S. Code (U.S.C.) §3515(b), the *Chief Financial Officers Act of 1990* (CFO Act), as amended by the *Government Management Reform Act of 1994*, and presented in accordance with the requirements in the Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements* (OMB Circular A-136). These financial statements have been prepared from HHS's financial records in conformity with accounting principles generally accepted in the U.S. The generally accepted accounting principles (GAAP) for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB) and recognized by the American Institute of Certified Public Accountants as federal GAAP. Therefore, these statements are different from financial reports prepared pursuant to other OMB directives that are primarily used to monitor and control the use of budgetary resources.

Transactions are recorded on accrual and budgetary basis of accounting. Under the accrual method of accounting, revenues are recognized when earned, and expenses are recognized when resources are consumed without regard to the payment of cash. Budgetary accounting principles are designed to recognize the obligation of funds according to legal requirements, which, in many cases, is prior to the occurrence of an accrual-based transaction. The recognition of budgetary accounting transactions is essential for compliance with legal constraints and controls over the use of federal funds.

The financial statements consolidate the balances of approximately 213 appropriation accounts. These accounts are used for general government functions, collection of receipts, and suspense. Transactions and balances within HHS have been eliminated in the presentation of the Consolidated Balance Sheets, Statements of Net Cost, and Statement of Changes in Net Position. The Statement of Budgetary Resources is represented on a combined basis. Therefore, transactions and balances within HHS have not been eliminated from that statement. Supplemental information is accumulated from the OpDivs, regulatory reports, and other sources within HHS. These statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation providing resources and budget authority for HHS.

Accounting standards require all reporting entities to disclose that accounting standards allow certain presentations and disclosures to be modified, if needed, to prevent the disclosure of classified information.

C. Use of Estimates in Preparing Financial Statements

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist the reader in understanding the effect of changes in assumptions on the related information.

D. *Patient Protection and Affordable Care Act*

In FY 2010, President Barack Obama signed the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Act*, collectively referred to as the PPACA. Further information is available at Healthcare.gov.

The PPACA contains the most significant changes to health care coverage since the *Social Security Act*. The PPACA provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). One of the main programs under CCIIO is the Health Insurance Exchanges (the "Exchanges"). A brief description of the remaining programs is presented below. There were two additional programs – Transitional Reinsurance and Risk Corridors – that are no longer in operation.

Health Insurance Exchanges

Grants have been provided to the states to establish Health Insurance Exchanges. The initial grants were made by HHS to the states "not later than 1 year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Exchanges were launched on October 1, 2013.

Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual and small group plans inside and outside the Exchanges. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower-risk enrollees to plans with relatively higher-risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a Risk Adjustment program. States operating a Risk Adjustment program may have an entity other than the Exchange perform this function. CMS operates a Risk Adjustment program for each state that does not operate its own Risk Adjustment program.

E. *Coronavirus Aid, Relief, and Economic Security Act*

The *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), was signed on March 27, 2020 to provide emergency assistance and health care response for individuals, families, and businesses affected by the COVID-19 pandemic. In addition to the CARES Act, HHS received additional supplemental appropriations through the *Coronavirus Preparedness and Response Supplemental Appropriations Act*, *Families First Coronavirus Response Act*, and the *Paycheck Protection Program and Health Care Enhancement Act*.

HHS received funding to support the new Provider Relief Fund which was created to prevent, prepare for, and respond to COVID-19, both domestically and internationally. The Provider Relief Fund provides necessary expense reimbursements to assist eligible health care providers for health care related expenses or lost revenues attributed to COVID-19. HHS also received funding to support Biomedical Advanced Research and Development Authority (BARDA) efforts to advance research, development, manufacturing, production, and purchase of COVID-19 vaccines, therapeutics, and testing and related supplies; rebuild the Strategic National Stockpile (SNS); and support other COVID-19 related activities.

F. Parent/Child Reporting

Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. HHS has allocation transfers with other federal entities as both a transferring (parent) entity and a receiving (child) entity. All financial activity related to these allocation transfers is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations, and budget apportionments are derived.

HHS received an exception to the parent/child reporting requirements of OMB Circular A−136, as it pertains to the allocation transfer from the Department of Homeland Security to HHS for the Biodefense Countermeasures Fund

for FY 2008 and beyond. Under this exception, HHS, as the child, assumed the financial statement reporting responsibilities of this fund.

Under the PPACA, HHS has established a child relationship with the Internal Revenue Service (IRS) of the U.S. Department of the Treasury (Treasury) for the payment of the advance premium tax credits to insurance providers. No financial activity is included in HHS's financial statements.

HHS also receives allocation transfers, as the child, from the Departments of Agriculture, Justice, and State. HHS allocates funds, as the parent, to the Bureau of Indian Affairs of the Department of the Interior (DOI), Treasury, and Social Security Administration (SSA).

G. Changes, Reclassifications and Adjustments

Certain FY 2019 balances have been reclassified to conform to FY 2020 financial statement presentations. The effects are immaterial.

H. Funds from Dedicated Collections

Funds from dedicated collections are generally financed by specifically identified revenues and provided to the government by non-federal sources. The sources are often supplemented by other financing sources, which remain available over time. Dedicated collections must meet the following criteria:

1. A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government from a non-federal source only for designated activities, benefits, or purposes;
2. Explicit authority for the fund to retain revenues and/or other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
3. A requirement to account for and report on the receipt, use, and retention of the revenues and/or other financing sources that distinguishes the dedicated collections from the federal government's general revenues.

HHS's major funds from dedicated collections are described in the sections below.

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust fund activities administered by Treasury. The HI trust fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contribution Act* (FICA) and the *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as the method to fully compensate the trust fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003* (MMA), established the Medicare Prescription Drug Benefit – Part D. Medicare also helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy. In addition, the Low Income Subsidy helps those with limited income and resources.

The PPACA provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs by 7 percentage points per year until coinsurance is 25 percent by 2020. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program at Section 1893 of the *Social Security Act*. HIPAA Section 201 also established the Health Care Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the *Deficit Reduction Act of 2005* (DRA), and codified at Section 1936 of the *Social Security Act*. The Medicaid Integrity Program represents the federal government's first national strategy to detect and prevent Medicaid fraud and abuse.

I. Revenue and Financing Sources

HHS receives the majority of funding needed to support its discretionary programs through Congressional appropriations and user fees. The U.S. Constitution prescribes that no money may be expended by an agency unless the funds have been made available by Congressional appropriation. Appropriations are recognized as financing sources when related expenses are incurred, or assets are purchased. Revenues from reimbursable agreements are recognized when the goods or services are provided by HHS. Other financing sources, such as donations and transfers of assets without reimbursements, are also recognized on the Consolidated Statement of Changes in Net Position.

Appropriations

HHS receives annual, multi-year, and no-year appropriations that may be used within statutory limits. For example, funds for general operations are normally made available for one fiscal year. Funds for long-term projects such as major construction will be available for the expected life of the project, and funds used to establish revolving fund operations are generally available indefinitely (i.e., no-year funds).

Permanent Indefinite Appropriations

HHS permanent indefinite appropriations are open-ended; the dollar amount is unknown at the time the authority is granted. These appropriations are available for specific purposes without current year action by Congress.

Exchange Revenue

Exchange revenue results when HHS provides goods or services to another entity for a price and is recognized when earned (i.e., when goods have been delivered or services have been rendered). These revenues reduce the cost of operations.

HHS pricing policy for reimbursable agreements is to recover full cost and should result in no profit or loss for HHS. In addition to revenues related to reimbursable agreements, HHS collects various user fees to offset the cost of its services. Certain fees charged by HHS are based on an amount set by law or regulation and may not represent full cost.

With minor exceptions, all revenue receipts by federal agencies are processed through the Treasury Central Accounting Reporting System. Regardless if they are derived from exchange or non-exchange transactions, all receipts not earmarked by Congressional appropriation for immediate HHS use are deposited in the General Fund or HHS designated Special Funds. Amounts not retained for use by HHS are reported as Transfers-in/out Without Reimbursement to other government agencies on the HHS Consolidated Statement of Changes in Net Position.

Non-Exchange Revenue

Non-exchange revenue results from donations to the government and from the government's sovereign right to demand payment, including taxes. Non-exchange revenues are recognized when a specifically identifiable, legally-enforceable claim to resources arises, but only to the extent that collection is probable, and the amount is reasonably estimable.

Non-exchange revenue is not considered to reduce the cost of the Department's operations and is separately reported on the Consolidated Statement of Changes in Net Position. Employment tax revenue collected under FICA and SECA is considered non-exchange revenue.

Imputed Financing Sources

In certain instances, HHS's operating costs are paid out of funds appropriated to other federal entities. For example, by law, certain costs of retirement programs are paid by the Office of Personnel Management (OPM), and certain legal judgments against HHS are paid from the Judgment Fund maintained by Bureau of Fiscal Service (Fiscal Service), Treasury. When costs are identifiable to HHS, directly attributable to HHS's operations, and paid by other agencies, HHS recognizes these amounts as imputed costs within the Consolidated Statements of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

J. Intragovernmental Transactions and Relationships

Intragovernmental transactions are business activities conducted between two different federal entities. Transactions with the public are transactions in which either the buyer or seller of the goods or services is a non-federal entity.

If a federal entity purchases goods or services from another federal entity and sells them to the public, the exchange revenue is classified as with the public, but the related costs would be classified as intragovernmental. The purpose of the classifications is to enable the federal government to provide consolidated financial statements and not to match public and intragovernmental revenue with costs incurred to produce public and intragovernmental revenue.

In the course of operations, HHS has relationships and financial transactions with numerous federal agencies, including SSA and Treasury. SSA determines eligibility for Medicare programs and also deducts Medicare Part B premiums from Social Security benefit payments for beneficiaries who elect to enroll in the Medicare Part B program and elect to deduct their premiums from their benefit checks. SSA then transfers those funds to the Medicare Part B trust fund. Treasury receives the cumulative excess of Medicare receipts and other financing over outlays and issues interest-bearing securities in exchange for the use of those monies. Medicare Part D is primarily financed by the General Fund as well as beneficiary premiums and payments from states.

K. Entity and Non-Entity Assets

Entity assets are assets the reporting entity has authority to use in its operations (i.e., management has the authority to decide how the funds are used), or management is legally obligated to use the funds to meet entity obligations.

Non-entity assets are assets held by the reporting entity, but not available for use. HHS non-entity assets are related to delinquent child support payments withheld from federal tax refunds for the Child Support Enforcement program, interest accrued on over-payments, and cost settlements reported by the Medicare contractors.

L. Fund Balance with Treasury (FBwT)

The FBwT is the aggregate amount of funds in the Department's accounts with Treasury. FBwT is available to pay current liabilities and finance authorized purchases. Treasury processes cash receipts and disbursements for the Department's operations. HHS reconciles FBwT accounts with Treasury on a regular basis.

M. Custodial Activity

HHS reports custodial activities on its Consolidated Balance Sheets in accordance with OMB Circular A-136. However, HHS does not prepare a separate Statement of Custodial Activity since custodial activities are incidental to its operations and the amounts collected are immaterial.

ACF receives funding from the IRS for outlay to the states for child support. This funding represents delinquent child support payments withheld from federal tax refunds. FDA custodial activity involves collections of Civil Monetary Penalties that are assessed by the Department of Justice on behalf of the FDA. FDA is charged with assessing penalties for violations in areas such as illegally manufactured, marketed, and distributed animal food and drug products. CDC's custodial activity consists of the collection of interest on outstanding receivables and funds received from debts in collection status.

N. Investments, Net

HHS invests entity Medicare trust fund balances in excess of current needs in U.S. securities. The Treasury acts as the fiscal agent for the U.S. Government's investments in securities. Sections 1817 and 1841 of the *Social Security Act* require that funds in the HI and SMI trust funds not needed to meet current expenditures be invested in interest-bearing obligations or in obligations guaranteed as to both principal and interest by the U.S. Government. The cash receipts, collected from the public as dedicated collections, are deposited with the Treasury, which uses the cash for general governmental purposes. Treasury securities are issued by the Fiscal Service to the HI and SMI trust funds as evidence of their receipt and are reported as an asset of the trust funds and a corresponding liability of the Treasury. The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI or SMI trust funds.

The Treasury securities provide the HI and SMI trust funds with authority to draw upon the Fiscal Service to make future benefit payments or other expenditures. When the trust funds require redemption of these securities to make expenditures, the government finances the expenditures by raising taxes, raising other receipts, borrowing

from the public or repaying less debt, or curtailing other expenditures. This is the same way that the government finances all expenditures.

The Treasury securities issued and redeemed to the HI and SMI trust funds are Non-marketable (Par Value) securities. These investments are carried at face value as determined by the Fiscal Service. Interest income is compounded semi-annually (i.e., June and December) by the Fiscal Service, and at fiscal year-end, interest income is adjusted to include an accrual for interest earned from July 1 to September 30.

The Vaccine Injury Compensation trust fund, a dedicated collections fund similar to the HI and SMI trust funds, invests in Non-Marketable, Market-Based securities issued by the Fiscal Service in the form of One Day Certificates and Market-Based Bills, Notes, and Bonds.

The NIH Gift Funds are invested in Non-Marketable, Market-Based Securities issued by the Fiscal Service. Funds are invested for either a 90 or 180-day period based on the need for funds. No provision is made for unrealized gains or losses on these securities since it is HHS's intent to hold investments to maturity.

O. Accounts Receivable, Net

Accounts Receivable, Net consists of the amounts owed to HHS by other federal agencies and the public for the provision of goods and services, less an allowance for uncollectible accounts. Intragovernmental accounts receivable consists of the amounts owed to HHS by other federal agencies for reimbursable work. Accounts Receivable, Net from the public are primarily composed of provider and beneficiary over-payments: Medicare Prescription Drug over-payments, Medicare premiums, civil monetary penalties, criminal restitution, state phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, and Medicare Secondary Payer accounts receivable.

Accounts Receivable, Net from the public is net of an allowance for uncollectible accounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past 5 years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable have been recorded to account for amounts due related to collections for Exchange activities.

P. Advances and Accrued Grant Liability

HHS awards grants and provides advance payments to meet grantees' cash needs in carrying out HHS programs. Advance payments are liquidated upon grantees reporting expenditures on the quarterly *Federal Financial Report*. In some instances, grantees incur expenditures before drawing down funds that, when claimed, would reduce the Advances account to a negative balance. An Accrued Grant Liability is shown on the Consolidated Balance Sheets when the accrued grant expenses exceed the outstanding advances to grantees.

Formula grants and block grants are funded when grantees provide services or payments to individuals and local agencies from a fixed amount of money. These grants are funded based on allocations determined by budgets and agreements approved by the sponsoring OpDiv. The expenses are recorded as the grantees draw funds; no year-end accrual is required.

All other grants are funded when the grantees draw funds based on their estimated cash needs. As grantees report their actual disbursements quarterly, the amounts are recorded as expenses, and their advance balances are

reduced. At year-end, the OpDivs report both actual payments made through the fourth quarter and an amount accrued for unreported grant expenditures estimated for the fourth quarter based on the grantees' historical spending patterns.

The Accelerated and Advance Payment (AAP) program was established to help providers and suppliers who had cash flow concerns due to system issues causing delays in submissions or processing claims or local emergencies. On March 30, 2020, the AAP program was expanded based on the language included in the CARES Act for specific providers.

Q. Inventory and Related Property, Net

Inventory and Related Property, Net primarily consists of Inventory Held for Sale and Use, Operating Materials and Supplies, and Stockpile Materials Held for Emergency and Contingency.

Inventory Held for Sale and Use consists of small equipment and supplies held by the Service and Supply Funds (SSF) for sale to HHS components and other federal entities. Inventories Held for Sale and Use are valued at historical cost using the weighted average valuation method for the PSC's SSF inventories and using the moving average valuation method for the NIH's SSF inventories.

Operating Materials and Supplies include pharmaceuticals, biological products, and other medical supplies used to provide medical services and conduct medical research. They are recorded as assets when purchased and are expensed when consumed. Operating Materials and Supplies are valued at historical cost using the first-in/first-out (FIFO) cost flow assumption.

Stockpile Materials are Held in Reserve to respond to local and national emergencies. HHS maintains several stockpiles for emergency response purposes, which include the SNS and Vaccines for Children (VFC). The stockpile contains several million doses of vaccine in bulk, which are stored and maintained for possible use.

Project BioShield has increased the preparedness of the nation by procuring medical countermeasures that include anthrax vaccine, anthrax antitoxins, botulin antitoxins, and blocking and decorporation agents for a radiological event. All stockpiles are valued at historical cost, using various cost flow assumptions, including the FIFO for SNS and specific identification for VFC.

R. General Property, Plant and Equipment, Net

General Property, Plant and Equipment, Net consists of buildings, structures, and facilities used for general operations, land acquired for general operating purposes, equipment, assets under capital lease, leasehold improvements, construction-in-progress, and internal-use software. The basis for recording purchased Property, Plant and Equipment is full cost, including all costs incurred to bring the Property, Plant and Equipment to a form and location suitable for its intended use and is presented net of accumulated depreciation.

The cost of General Property, Plant and Equipment acquired under a capital lease is the amount recognized as a liability for the capital lease at its inception. When property is acquired through a donation, the cost recognized is the estimated fair market value on the date of acquisition. The cost of General Property, Plant and Equipment transferred from other federal entities is the transferring entity's net book value. Except for internal-use software, HHS capitalizes all General Property, Plant and Equipment with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or more.

HHS has commitments under various operating leases with private entities as well as the General Services Administration (GSA) for offices, laboratory space, and land. Leases with private entities have initial or remaining

noncancelable lease terms from 1 to 50 years; however, some GSA leases are cancelable with 120 days notice. Under an operating lease, the cost of the lease is expensed as incurred.

General Property, Plant and Equipment is depreciated using the straight-line method over the estimated useful life of the asset. Land and land rights, including permanent improvements, are not depreciated. Normal maintenance and repair costs are expensed as incurred.

In accordance with SFFAS 10, *Accounting for Internal Use Software*, capitalization of internally developed, contractor-developed/commercial off-the-shelf software begins in the software development phase. HHS's capitalization threshold for internal-use software costs for appropriated fund accounts is $1 million, and the threshold for revolving fund accounts is $500,000. Costs below the threshold levels are expensed. Software is amortized using the straight-line method over a period of 5 to 10 years consistent with the estimated life used for planning and acquisition purposes. Capitalized costs include all direct and indirect costs.

S. Stewardship Land

HHS Stewardship Land (i.e., land not acquired for or in connection with General Property, Plant and Equipment) is Indian Trust land used to support the IHS day-to-day operations of providing health care to American Indians and Alaska Natives in remote areas of the country where no other facilities exist. In accordance with SFFAS 29*, Heritage Assets and Stewardship Land,* HHS does not report a related amount on the Consolidated Balance Sheets.

HHS asset accountability reports differentiate Indian Trust land parcels from General Property, Plant and Equipment situated thereon.

T. Liabilities

Liabilities are recognized for amounts of probable and measurable future outflows or other sacrifices of resources as a result of past transactions or events. Since HHS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. Payments of all liabilities other than contracts can be abrogated by the sovereign entity. In accordance with public law and existing federal accounting standards, no liability is recognized for future payments to be made on behalf of current workers contributing to the Medicare HI trust fund, since liabilities are only those items that are present obligations of the government. HHS's liabilities are classified as covered by budgetary resources, not covered by budgetary resources, or not requiring budgetary resources.

Liabilities Covered by Budgetary Resources

Available budgetary resources include new budget authority, spending authority from offsetting collections, recoveries of expired budget authority, unobligated balances of budgetary resources at the beginning of the year, permanent indefinite appropriation, and borrowing authority.

Liabilities Not Covered by Budgetary Resources

Sometimes funding has not yet been made available through Congressional appropriation or current earnings. The major liabilities in this category include contingencies, employee annual leave earned, but not taken, and amounts billed by the Department of Labor (DOL) for disability payments. The actuarial *Federal Employee Compensation Act* (FECA) liability determined by the DOL but not yet billed is also included in this category.

Liabilities Not Requiring Budgetary Resources

Clearing accounts, non-fiduciary deposit funds, custodial collections, and unearned revenue and liabilities that have not in the past required and will not in the future require use of budgetary resources.

U. Accounts Payable

Accounts Payable primarily consist of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

V. Accrued Payroll and Benefits

Accrued Payroll and Benefits consist of salaries, wages, leave, and benefits earned by employees but not disbursed at the end of the reporting period. A liability for annual and other vested compensatory leave is accrued as earned and reduced when taken. At the end of each fiscal year, the balance in the accrued annual leave liability account is adjusted to reflect current pay rates. Annual leave earned but not taken is considered an unfunded liability, since it will be funded from future appropriations when it is actually taken by employees. Sick leave and other types of leave are not accrued and are expensed when taken. Intragovernmental Accrued Payroll and Benefits consist primarily of HHS's current FECA liability to DOL.

W. Entitlement Benefits Due and Payable

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims incurred but not reported (IBNR) as of the end of the reporting period.

X. Federal Employee and Veterans' Benefits

HHS administers the Public Health Service (PHS) Commissioned Corps Retirement System (authorized by the *Public Health Service Act*), a defined non-contributory benefit plan, for its active-duty officers, retiree annuitants, and survivors. The plan does not have accumulated assets, and funding is provided entirely on a pay-as-you-go basis by Congressional appropriation. HHS records the present value of the Commissioned Corps pension and post-retirement health benefits on the Consolidated Balance Sheets. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end on the Statements of Net Cost.

The liability for Federal Employee and Veterans' Benefits also includes an actuarial liability for estimated future payments for workers' compensation pursuant to the FECA. FECA provides income and medical cost protection to federal employees who are injured on the job or who sustained a work-related occupational disease. It also covers beneficiaries of employees whose deaths are attributable to job-related injury or occupational disease. The FECA program is administered by DOL, which pays valid claims and subsequently bills the employing federal agency. The FECA liability consists of two components: (1) actual claims billed by the DOL to agencies but not yet paid; and (2) an estimated liability for future benefit payments as a result of past events such as death, disability, and medical costs. The claims that have been billed by DOL are included in Accrued Payroll and Benefits.

Most HHS employees participate in the Civil Service Retirement System (CSRS), a defined benefit plan, or the Federal Employees Retirement System (FERS), a defined benefit and contribution plan. For employees covered under CSRS, the Department contributes a fixed percentage of pay. Most employees hired after December 31, 1983, are automatically covered by the FERS. The FERS plan has three parts: a defined benefit payment, Social Security benefits, and the Thrift Savings Plan. For employees covered under FERS, HHS contributes a fixed percentage of pay for the defined benefit portion and the employer's matching share for Social Security and Medicare Insurance. HHS automatically contributes one percent of each employee's pay to the Thrift Savings Plan and matches the first three percent of employee contributions dollar for dollar. Each additional dollar of the employee's next 2 percent of basic pay is matched at 50 cents on the dollar.

OPM is the administering agency for both of these benefit plans and, thus, reports CSRS and FERS assets, accumulated plan benefits, and unfunded liabilities applicable to federal employees. Therefore, HHS does not

recognize any liability on its Consolidated Balance Sheets for pensions, other retirement benefits, or other post-employment benefits of its federal employees with the exception of the PHS Commissioned Corps. However, HHS does recognize an expense in the Consolidated Statements of Net Cost and an imputed financing source for the annualized unfunded portion of pension and post-retirement benefits in the Consolidated Statement of Changes in Net Position. Gains or losses from changes in assumptions in the PHS Commissioned Corps retirement benefits are recognized at year-end.

Y. Contingencies

A loss contingency is an existing condition, situation, or set of circumstances involving uncertainty as to possible loss to HHS. The uncertainty ultimately should be resolved when one or more future events occur or fail to occur. The likelihood that the future event or events will confirm the loss or the incurrence of a liability can range from probable to remote. SFFAS 5, *Accounting for Liabilities of the Federal Government*, as amended by SFFAS 12, *Recognition of Contingent Liabilities from Litigation*, contains the criteria for recognition and disclosure of contingent liabilities.

HHS and its components could be parties to various administrative proceedings, legal actions, and claims brought by or against it. With the exception of pending, threatened or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is more likely than not to occur, and the related future outflow or sacrifice of resources is measurable. For pending, threatened, or potential litigation, a contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is likely to occur and the related future outflow or sacrifice of resources is measurable.

Treaties and other international agreements are written agreements between the U.S. and other sovereign states, or between the U.S. and international organizations, governed by international law. The Department of State developed and continues to manage the Circular 175 procedure, which outlines the approval process for the negotiation and conclusion of international agreements which HHS will become a party. For reporting purposes HHS has no present or contingency obligation related to treaties and international agreements when entered into force.

HHS has no material obligations related to cancelled appropriations for which there is a contractual commitment for payment or for contractual arrangements which may require future financial obligations.

Z. Statement of Social Insurance (unaudited)

The Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the HI and SMI trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2020 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

Note 2. Entity and Non-Entity Assets (in Millions)

	2020	2019
Non-Entity Intragovernmental Assets	$ 8	$ 1
Non-Entity With the Public Assets	41	46
Total Non-Entity Assets	49	47
Total Entity Assets	891,577	650,681
Total Assets	**$ 891,626**	**$ 650,728**

HHS reported an increase of $240.9 billion in Total Entity Assets primarily due to COVID-19, affecting FBwT, Investments, and Advances.

Note 3. Fund Balance with Treasury (in Millions)

	2020	2019
Status of Fund Balance with Treasury		
Unobligated Balance		
Available	$ 158,784	$ 50,528
Unavailable	82,077	58,857
Obligated Balance not yet Disbursed	339,457	258,872
Non-Budgetary Fund Balance with Treasury	(66,276)	(72,000)
Total Fund Balance with Treasury	**$ 514,042**	**$ 296,257**

The Unobligated Balance, Available increase of $108.3 billion is mostly due to increased apportionments in the Public Health and Social Services Emergency Fund (PHSSEF) for COVID-19.

The Unobligated Balance includes funds that are restricted for future use and not apportioned for current use of $29.8 billion as of September 30, 2020 ($16.6 billion as of September 30, 2019). The restricted amount is primarily for PPACA, CHIP, CMS Program Management, and State Grants and Demonstrations.

Note 4. Investments, Net (in Millions)

	2020				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 221,212	$ -	$ 922	$ 222,134	$ 222,134
Non-Marketable: Market-Based	4,095	(25)	11	4,081	4,081
Total, Intragovernmental	**$ 225,307**	**$ (25)**	**$ 933**	**$ 226,215**	**$ 226,215**

	2019				
	Cost	Amortized (Premium)	Interest Receivable	Investments, Net	Market Value Disclosure
Intragovernmental Securities					
Non-Marketable: Par Value	$ 303,341	$ -	$ 2,037	$ 305,378	$ 305,378
Non-Marketable: Market-Based	3,968	(7)	10	3,971	3,971
Total, Intragovernmental	**$ 307,309**	**$ (7)**	**$ 2,047**	**$ 309,349**	**$ 309,349**

HHS investments consist primarily of Medicare Trust Fund investments. Medicare Non-Marketable: Par Value Bonds are carried at face value and have maturity dates ranging from June 30, 2022, through June 30, 2034, with interest rates ranging from 0.750 percent to 2.875 percent. Medicare Non-Marketable: Par Value Certificates of Indebtedness mature on June 30, 2021, with interest rates ranging from 0.625 percent to 0.750 percent.

Securities held by the Vaccine Injury Compensation Trust Fund will mature in FY 2020 through FY 2025. The Market-Based Notes paid from 0.375 percent to 2.375 percent during October 1, 2019, to September 30, 2020 (1.0 percent to 2.375 percent during October 1, 2018, to September 30, 2019). The Market-Based Bonds pay 6.875 percent through FY 2025.

The Market-Based Securities held in the NIH gift funds during 12 months of FY 2020, yielded from 0.0950 percent to 1.6468 percent depending on date purchased and length of time to maturity.

HHS reported investments of $226.2 billion as of September 30, 2020 ($309.3 billion as of September 30, 2019) representing a decrease of $83.1 billion due to the issuance of the COVID-19 AAP program.

Note 5. Accounts Receivable, Net (in Millions)

	2020				
	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivable, Net
Intragovernmental					
Entity	$ 715	$ -	$ 715	$ -	$ 715
Total, Intragovernmental	**$ 715**	**$ -**	**$ 715**	**$ -**	**$ 715**
With the Public					
Entity					
Medicare	$ 15,931	$ -	$ 15,931	$ (3,631)	$ 12,300
Medicaid	5,359	-	5,359	(1,038)	4,321
Other	5,700	344	6,044	(994)	5,050
Non-Entity	25	72	97	(56)	41
Total, With the Public	**$ 27,015**	**$ 416**	**$ 27,431**	**$ (5,719)**	**$ 21,712**

	2019				
	Accounts Receivable Principal	Interest Receivable	Accounts Receivable, Gross	Allowance	Accounts Receivables, Net
Intragovernmental					
Entity	$ 812	$ -	$ 812	$ -	$ 812
Total, Intragovernmental	**$ 812**	**$ -**	**$ 812**	**$ -**	**$ 812**
With the Public					
Entity					
Medicare	$ 18,515	$ -	$ 18,515	$ (3,507)	$ 15,008
Medicaid	4,943	-	4,943	(785)	4,158
Other	5,576	325	5,901	(957)	4,944
Non-Entity	18	72	90	(44)	46
Total, With the Public	**$ 29,052**	**$ 397**	**$ 29,449**	**$ (5,293)**	**$ 24,156**

As of September 30, 2020, the other accounts receivable with the public is primarily related to collections for Exchange activities and restitution. The restitution gross balances are approximately $2.4 billion with a net balance of $74 million as of September 30, 2020 ($2.2 billion with a net balance of $67 million as of September 30, 2019).

Note 6. Inventory and Related Property, Net (in Millions)

	2020	2019
Inventory Held for Sale or Use	$ 218	$ 91
Stockpile Materials Held for Emergency or Contingency	13,212	10,690
Inventory and Related Property, Net	**$ 13,430**	**$ 10,781**

Inventory and Related Property, Net increase of $2.6 billion is mostly due to an increase in the PHSSEF for COVID-19 personal protective equipment and SNS inventory.

Note 7. General Property, Plant and Equipment, Net (in Millions)

			2020		
	Depreciation Method	Estimated Useful Lives	Acquisition Cost	Accumulated Depreciation	Net Book Value
Land & Land Rights	N/A	N/A	$ 61	$ (1)	$ 60
Construction in Progress	N/A	N/A	1,131	-	1,131
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,398	(3,591)	2,807
Equipment	Straight-Line	3-20 Yrs	2,356	(1,383)	973
Internal Use Software	Straight-Line	5-10 Yrs	4,761	(2,885)	1,876
Assets Under Capital Lease	Straight-Line	1-30 Yrs	119	(80)	39
Leasehold Improvements	Straight-Line	*Life of Lease	71	(53)	18
Totals			**$ 14,897**	**$ (7,993)**	**$ 6,904**

	Depreciation Method	Estimated Useful Lives	2019 Acquisition Cost	2019 Accumulated Depreciation	2019 Net Book Value
Land & Land Rights	N/A	N/A	$ 54	$ -	$ 54
Construction in Progress	N/A	N/A	969	-	969
Buildings, Facilities & Other Structures	Straight-Line	5-50 Yrs	6,232	(3,415)	2,817
Equipment	Straight-Line	3-20 Yrs	2,259	(1,288)	971
Internal Use Software	Straight-Line	5-10 Yrs	3,965	(2,288)	1,677
Assets Under Capital Lease	Straight-Line	1-30 Yrs	119	(75)	44
Leasehold Improvements	Straight-Line	*Life of Lease	60	(48)	12
Totals			**$ 13,658**	**$ (7,114)**	**$ 6,544**

*7 to 15 years or the life of the lease, whichever is shorter.

	2020 Acquisition Cost	2020 Accumulated Depreciation	2020 PP&E, Net
Balance Beginning of Year	$ 13,658	$ (7,114)	$ 6,544
Capitalized Acquisitions from the Public	1,481	-	1,481
Capitalized Acquisitions from Government Agencies	2	-	2
Dispositions	(287)	65	(222)
Depreciation Expense	43	(944)	(901)
Balance End of Year	**$ 14,897**	**$ (7,993)**	**$ 6,904**

Note 8. Advances (in Millions)

	2020	2019
Intragovernmental		
Advances to Other Federal Entities	$ 1,993	$ 180
Total Intragovernmental	**$ 1,993**	**$ 180**
With the Public		
COVID-19 Accelerated and Advance Payment Program	$ 103,638	$ -
Grant Advances	2,318	2,395
Other	126	57
Total with the Public	**$ 106,082**	**$ 2,452**

As of September 30, 2020, advances with the public primarily represent payments made for the COVID-19 AAP program. On March 30, 2020, the AAP program was expanded based on the language included in the CARES Act. Collections of these items will begin in March 2021.

Note 9. Liabilities Not Covered by Budgetary Resources (in Millions)

	2020	2019
Intragovernmental		
Accrued Payroll and Benefits	$ 51	$ 53
Other	1,809	1,533
Total Intragovernmental	**$ 1,860**	**$ 1,586**
Federal Employee and Veterans' Benefits (Note 11)	$ 15,319	$ 14,826
Accrued Payroll and Benefits	902	722
Contingencies and Commitments (Note 14)	11,267	17,083
Accrued Liabilities	4,547	5,057
Other	221	229
Total Liabilities Not Covered by Budgetary Resources	$ 34,116	$ 39,503
Total Liabilities Covered by Budgetary Resources	135,551	127,437
Total Liabilities Not Requiring Budgetary Resources	2,197	2,254
Total Liabilities	**$ 171,864**	**$ 169,194**

Note 10. Entitlement Benefits Due and Payable (in Millions)

	2020	2019
Medicare Fee-For-Service	$ 49,262	$ 54,752
Medicare Advantage/Prescription Drug Program	20,890	16,839
Medicaid	45,850	37,147
CHIP	933	1,360
Other	-	2
Totals	**$ 116,935**	**$ 110,100**

Entitlement Benefits Due and Payable represents a liability for Medicare fee-for-service, Medicare Advantage and Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims IBNR as of the end of the reporting period.

The Medicare fee-for-service liability is primarily an actuarial liability which represents: (1) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment; (2) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued; (3) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees; (4) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year; and (5) an estimate of retroactive settlements of cost reports. The September 30, 2020 and 2019 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represent amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment-related adjustments including the estimate for the first nine months of the calendar year 2020. In addition, it includes an

estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2020.

The Medicaid and CHIP estimates represent the net federal share of expenses that have been incurred by the states but not yet reported to CMS based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded at September 30, 2020 and 2019.

Note 11. Federal Employee and Veterans' Benefits (in Millions)

	2020	2019
With the Public		
Liabilities Not Covered by Budgetary Resources		
PHS Commissioned Corp Pension Liability	$ 14,318	$ 13,758
PHS Commissioned Corp Post-Retirement Health Benefits	718	792
Workers' Compensation Benefits (Actuarial FECA Liability)	283	276
Total, Federal Employee and Veterans' Benefits	**$ 15,319**	**$ 14,826**

Public Health Service Commissioned Corps

HHS administers the PHS Commissioned Corps Retirement System for 5,985 active duty officers and 7,461 retiree annuitants and survivors. As of September 30, 2020, the actuarial accrued liability for the retirement benefit plan was $14.3 and $0.7 billion for non-Medicare coverage of the Post-Retirement Medical Plan.

The Commissioned Corps Retirement System and the Post-Retirement Medical Plan are not funded. Therefore, in accordance with SFFAS 33, *Pensions, Other Retirement Benefits and Other Postemployment Benefits: Reporting the Gains and Losses from Changes in Assumptions and Selecting Discount Rates and Valuation Dates*, the discount rate should be based on long-term assumptions, for marketable securities (i.e., Treasury marketable securities) of similar maturity to the period over which the payments are to be made. The discount rates should be matched with the expected timing of the associated expected cash flow. A single discount rate may be used for all the projected cash flow, as long as the resulting present value is not materially different than the resulting present value using multiple rates.

The significant assumptions used in the calculation of the pension and medical program liability, as of September 30, 2020 and September 30, 2019, were:

	2020	2019
Discount Rate	3.56 percent	3.76 percent
Annual Basic Pay Scale Increase	2.28 percent	2.31 percent
Annual Inflation	1.87 percent	2.01 percent

The table on the next page shows key valuation results as of September 30, 2020 and 2019, in conformance with the actuarial reporting standards set forth in the SFFAS 5, *Accounting for Liabilities of the Federal Government* and SFFAS 33. The valuation is based upon the current plan provisions, membership data collected as of September 30, 2020 and actuarial assumptions. The September 30, 2020 valuation includes an increase in liabilities of $486 million resulting from changes in the assumed annual inflation rate, the assumed salary scale, and in the assumed discount

rate. These changes in combination with the actual plan experience over the past year (based upon new census data) and a law change (pursuant to the *National Defense Authorization Act of 2020*), resulted in an overall net increase in the actuarial accrued liability as compared to the prior valuation. The annual expense for the Retirement Benefit Plan for FY 2020 has increased relative to the prior year expense.

	2020	2019
Beginning Liability Balance	$ 14,550	$ 14,110
Expense		
Normal Cost	400	397
Interest on the Liability Balance	535	542
Actuarial (Gain)/Loss		
From Experience	55	77
From Assumption Changes		
Change in Discount Rate Assumption	398	307
Change in Inflation/Salary Increase Assumption	(237)	(213)
Change in New Medical Trends Assumption	(105)	-
Change from Experience Study	-	(105)
Change in Mortality Rate/Others	15	(16)
Total From Assumption Changes	$ 71	$ (27)
Net Actuarial (Gain)/Loss	126	50
Total Expense	$ 1,061	$ 989
Less Amounts Paid	(575)	(549)
Ending Liability Balance	**$ 15,036**	**$ 14,550**

Workers' Compensation Benefits

The actuarial liability for future workers' compensation benefits includes the expected liability for death, disability, medical and miscellaneous costs for approved compensation cases, plus a component for incurred but not reported claims. The liability utilizes historical benefit payment patterns to predict the ultimate payment related to that period. For FYs 2020 and 2019, discount rates were based on averaging the Treasury's Yield Curve for Treasury Nominal Coupon Issues for the current and prior 4 years. Interest rate assumptions utilized for discounting as of September 30, 2020 and September 30, 2019, were:

	2020	2019
Wage Benefits	2.414% in Year 1 and years thereafter	2.610% in Year 1 and years thereafter
Medical Benefits	2.303% in Year 1 and years thereafter	2.350% in Year 1 and years thereafter

To provide specifically for the effects of inflation on the liability for future workers' compensation benefits, wage inflation factors (i.e., cost of living adjustments [COLA]) and medical inflation factors (i.e., consumer price index-medical [CPIM]) are applied to the calculations of projected future benefits. The actual rates for these factors are also used to adjust the methodology's historical payments to current year constant dollars. The compensation COLAs and CPIMs used in the projections are:

FY	COLA	CPIM
2020	N/A	N/A
2021	1.87%	3.21%
2022	2.14%	3.23%
2023	2.19%	3.60%
2024	2.23%	4.01%
2025	2.30%	3.94%

Note 12. Accrued Liabilities (in Millions)

	2020	2019
Grant Liability	$ 7,972	$ 7,582
Other Accrued Liabilities	7,826	7,961
Accrued Liabilities	**$ 15,798**	**$ 15,543**

Note 13. Other Liabilities (in Millions)

	2020		2019	
	Intragovernmental	With the Public	Intragovernmental	With the Public
Accrued Payroll & Benefits	$ 183	$ 1,488	$ 151	$ 1,197
Advances from Others	282	107	520	842
Deferred Revenue	-	1,900	-	1,250
Custodial Liabilities	237	20	332	8
Legal Liabilities	1,208	-	1,172	-
Other	1,743	405	3,398	398
Total Other Liabilities	**$ 3,653**	**$ 3,920**	**$ 5,573**	**$ 3,695**

The *Bipartisan Budget Act of 2015* (Section 601) authorized a transfer from the General Fund to SMI, to temporarily replace the reduction in Medicare Part B premiums. Section 601 created an "additional premium" charged alongside the normal Medicare Part B monthly premiums, for calendar years 2016 and 2017, which will be used to pay back the General Fund transfer without interest. These repayments are transferred quarterly. As of September 30, 2020, $1.2 billion ($3.2 billion as of September 30, 2019) is still owed and is reported as Other. Legal Liabilities of $1.2 billion as of September 30, 2020 ($1.2 billion as of September 30, 2019) consist of reimbursable claims due to the Judgment Fund, which is administered by Fiscal Service.

Note 14. Contingencies and Commitments

HHS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. HHS has accrued contingent liabilities where a loss is determined to be probable and the amount can be estimated. The liabilities are primarily related to the Medicaid audit and program disallowances. Other contingencies exist where losses are reasonably possible and an estimate can be determined or an estimate of the range of possible liability has been determined. Selected contingencies and commitments are described below.

Medicaid Audit and Program Disallowances

The Medicaid amount of $3.7 billion as of September 30, 2020 ($9.9 billion as of September 30, 2019) consists of Medicaid audit and program disallowances and reimbursement of State Plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or HHS can decrease the state's authority. HHS will be required to pay these amounts if the appeals are decided in favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made.

Other Accrued Contingent Liabilities

The U.S. Supreme Court decision in *Salazar v Ramah Navajo Chapter*, dated June 18, 2012, and subsequent cases related to contract support costs have resulted in increased claims against IHS. As a result of this decision, many tribes have filed claims. Some claims have been paid and others have been asserted but not yet settled. It is expected that some tribes will file additional claims for prior years. The estimated amount recorded for contract support costs is $5.5 billion as of September 30, 2020 ($5.2 billion as of September 30, 2019).

Other contingent liabilities against HHS have been accrued in the financial statements for the Vaccine Injury Compensation program and the Health Center Program malpractice claims through the *Federal Tort Claims Act*.

Note 15. Legal Arrangements Affecting Use of Unobligated Balances

The unobligated balances on the Combined Statement of Budgetary Resources consist of trust funds, appropriated funds, revolving funds, management funds, gift funds, cooperative research and development agreement funds, and royalty funds. Annual appropriations are available for new obligations in the year of appropriation and for adjustments to valid obligations for 5 subsequent years. Other appropriations are available for obligation for multiple years or until expended based on Congressional authority.

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Combined Statement of Budgetary Resources; therefore, it is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and become available for obligation, as needed. The entire trust fund balances in the amount of $146.5 billion, as of September 30, 2020 ($223.6 billion as of September 30, 2019) are included in Investments on the Consolidated Balance Sheets.

Note 16. Explanation of Differences between the Combined Statement of Budgetary Resources and the Budget of the United States Government (in Millions)

	2019			
	Budgetary Resources	New Obligations and Upward Adjustments	Distributed Offsetting Receipts	Outlays, net (discretionary and mandatory)
Combined Statement of Budgetary Resources	$ 1,924,165	$ 1,814,780	$ 492,692	$ 1,706,314
Expired Accounts	(28,006)	-	-	-
Other	(1,520)	(512)	83	(10)
Budget of the U.S. Government	**$ 1,894,639**	**$ 1,814,268**	**$ 492,775**	**$ 1,706,304**

The *Budget of the United States Government* (also known as the *President's Budget*), with the actual amounts for FY 2020, has not been published; therefore, no comparisons can be made between FY 2020 amounts presented in the Combined Statement of Budgetary Resources with amounts reported in the Actual column of the *President's Budget*. The *FY 2022 President's Budget* is expected to be released in February 2021 and may be obtained from OMB or from the Government Publishing Office.

HHS reconciled the amounts of the FY 2019 column on the Combined Statement of Budgetary Resources to the actual amounts for FY 2019 from the Appendix in the *FY 2021 President's Budget* for budgetary resources, new obligations and upward adjustments, distributed offsetting receipts, and net outlays.

For the budgetary resources reconciliation, the amount used from the *President's Budget* was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the *President's Budget* is the budgetary resources that were not available. The Expired Accounts line in the above schedule includes expired authority, recoveries, and other amounts included in the Combined Statement of Budgetary Resources that are not included in the *President's Budget*.

The Other differences in the budgetary resources are mainly due to adjustments made to recoveries of prior year obligations.

Note 17. Undelivered Orders (in Millions)

	2020			2019		
	Federal	Non-Federal	Total	Federal	Non-Federal	Total
Undelivered Orders, Paid	$ 2,683	$ 106,250	$ 108,933	$ 323	$ 2,527	$ 2,850
Undelivered Orders, Unpaid	20,640	187,189	207,829	7,052	131,458	138,510
Total Undelivered Orders	**$ 23,323**	**$ 293,439**	**$ 316,762**	**$ 7,375**	**$ 133,985**	**$ 141,360**

Undelivered Orders include obligations that have been issued but not yet drawn down, as well as goods and services ordered that have not been received. HHS reported $316.8 billion of budgetary resources obligated for undelivered orders as of September 30, 2020 ($141.4 billion as of September 30, 2019). The Undelivered Orders, Paid increase of $106.1 billion is primarily due to the COVID-19 AAP program. The Undelivered Orders, Unpaid increase of $69.3 billion is primarily due to COVID-19 activity.

Note 18. Funds from Dedicated Collections (in Millions)

Medicare is the largest dedicated collections program managed by HHS and is presented in a separate column in the table below. The Medicare program includes the HI Trust Fund; the SMI Trust Fund which includes both Part B medical insurance, and the Medicare Prescription Drug Benefit – Part D; and the Medicare and Medicaid Integrity Programs. Portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. See Note 1 for a description of each fund's purpose and how HHS accounts for and reports the funds.

	2020			
Balance Sheet as of September 30	**Medicare**	**Other**	**Eliminations**	**Total**
Fund Balance with Treasury	$ 107,525	$ 11,975	$ -	$ 119,500
Investments	222,134	3,967	-	226,101
Other Assets	191,183	12,668	(81,414)	122,437
Total Assets	**$ 520,842**	**$ 28,610**	**$ (81,414)**	**$ 468,038**
Entitlement Benefits Due and Payable	$ 70,152	$ -	$ -	$ 70,152
Other Liabilities	85,839	9,652	(81,414)	14,077
Total Liabilities	**$ 155,991**	**$ 9,652**	**$ (81,414)**	**$ 84,229**
Unexpended Appropriations	97,863	254	-	98,117
Cumulative Results of Operations	266,988	18,704	-	285,692
Total Liabilities and Net Position	**$ 520,842**	**$ 28,610**	**$ (81,414)**	**$ 468,038**
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 779,800	$ 26,065	$ 1,659	$ 807,524
Less: Exchange Revenues	(117,317)	(9,066)	(1,663)	(128,046)
Net Cost of Operations	**$ 662,483**	**$ 16,999**	**$ (4)**	**$ 679,478**
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 297,880	$ 18,480	$ -	$ 316,360
Nonexchange Revenue	306,288	2	-	306,290
Other Financing Sources	423,166	17,475	(4)	440,637
Net Cost of Operations	(662,483)	(16,999)	4	(679,478)
Change in Net Position	$ 66,971	$ 478	$ -	$ 67,449
Net Position End of Period	**$ 364,851**	**$ 18,958**	**$ -**	**$ 383,809**

Balance Sheet as of September 30	2019 Medicare	Other	Eliminations	Total
Fund Balance with Treasury	$ 63,442	$ 11,155	$ -	$ 74,597
Investments	305,378	3,971	-	309,349
Other Assets	93,327	13,880	(86,036)	21,171
Total Assets	**$ 462,147**	**$ 29,006**	**$ (86,036)**	**$ 405,117**
Entitlement Benefits Due and Payable	$ 71,591	$ 3	$ -	$ 71,594
Other Liabilities	92,676	10,523	(86,036)	17,163
Total Liabilities	**$ 164,267**	**$ 10,526**	**$ (86,036)**	**$ 88,757**
Unexpended Appropriations	57,895	73	-	57,968
Cumulative Results of Operations	239,985	18,407	-	258,392
Total Liabilities and Net Position	**$ 462,147**	**$ 29,006**	**$ (86,036)**	**$ 405,117**
Statement of Net Cost for the Period Ended September 30				
Gross Program Costs	$ 759,898	$ 15,304	$ (308)	$ 774,894
Less: Exchange Revenues	(106,755)	(11,020)	294	(117,481)
Net Cost of Operations	**$ 653,143**	**$ 4,284**	**$ (14)**	**$ 657,413**
Statement of Changes in Net Position for the Period Ended September 30				
Net Position Beginning of Period	$ 275,348	$ 10,558	$ -	$ 285,906
Nonexchange Revenue	294,129	364	-	294,493
Other Financing Sources	381,546	11,842	(14)	393,374
Net Cost of Operations	(653,143)	(4,284)	14	(657,413)
Change in Net Position	$ 22,532	$ 7,922	$ -	$ 30,454
Net Position End of Period	**$ 297,880**	**$ 18,480**	**$ -**	**$ 316,360**

Note 19. Stewardship Land

IHS provides federal health services to American Indians and Alaska Natives to help raise their health status to the highest possible level. IHS provides health care to approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states. Health services are provided on tribal/reservation trust land that DOI transferred to IHS for this purpose. Although the structures on this land are operational in nature, the land on which these structures reside is managed in a stewardship manner. All trust land, when no longer needed by IHS, must be returned to the DOI's Bureau of Indian Affairs for continuing trust responsibilities and oversight.

The table below presents stewardship land held by HHS:

Indian Trust Land by Locations and Number of Sites

IHS Area	2020	2019
Albuquerque	4	4
Bemidji	2	2
Billings	7	7
Great Plains	9	9
Navajo	36	36
Oklahoma City	1	1
Phoenix	10	10
Portland	3	3
Tucson	5	5
Total	**77**	**77**

Note 20. Budget and Accrual Reconciliation (in Millions)

	2020		
	Intragovernmental	With the Public	Total
Net Cost of Operations	**$ 18,830**	**$ 1,388,907**	**$ 1,407,737**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation	-	(942)	(942)
Property, Plant, and Equipment Disposal & Reevaluation	-	(3)	(3)
Other	-	804	804
	-	**(141)**	**(141)**
Increase/(Decrease) in Assets:			
Accounts Receivables	16	(2,436)	(2,420)
Investments	(5)	-	(5)
Advances and Other Assets	1,812	103,966	105,778
	1,823	**101,530**	**103,353**
(Increase)/Decrease in Liabilities:			
Accounts Payable	(892)	(7,461)	(8,353)
Other Liabilities (Unfunded leave, Unfunded FECA, Actuarial FECA)	(425)	4,128	3,703
	(1,317)	**(3,333)**	**(4,650)**
Other Financing Sources:			
Federal Employee Retirement Benefit Costs Paid by OPM and Imputed to the Agency	(12,874)	-	(12,874)
Transfers out (in) Without Reimbursement	2,756	-	2,756
	(10,118)	**-**	**(10,118)**
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	7	488	495
Acquisition of Inventory	5	2,957	2,962
Acquisition of Other Assets	116	-	116
Other	793	5,016	5,809
	921	**8,461**	**9,382**
Net Outlays	**$ 10,139**	**$ 1,495,424**	**$ 1,505,563**
Federal Share of Child Support Collections and Other[8]			(1,567)
Net Outlays, Net			**$ 1,503,996**
Related Amounts on Combined Statement of Budgetary Resources			
Outlays, Net			2,037,911
Distributed Offsetting Receipts			(533,915)
Agency Outlays, Net			**$ 1,503,996**

[8] This amount is included in the HHS SBR, Distributed Offsetting Receipts but does not have an impact on Net Cost.

	2019		
	Intragovernmental	With the Public	Total
Net Cost of Operations	**$ 3,599**	**$ 1,219,250**	**$ 1,222,849**
Components of Net Cost Not Part of the Budget Outlays			
Property, Plant, and Equipment Depreciation	-	(809)	(809)
Property, Plant, and Equipment Disposal & Reevaluation	-	(2)	(2)
Other	-	580	580
	-	**(231)**	**(231)**
Increase/(Decrease) in Assets:			
Accounts Receivables	(339)	(2,652)	(2,991)
Investments	17	-	17
Advances and Other Assets	(76)	(249)	(325)
	(398)	**(2,901)**	**(3,299)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	301	(11,168)	(10,867)
Other Liabilities (Unfunded leave, Unfunded FECA, Actuarial FECA)	(51)	(3,051)	(3,102)
	250	**(14,219)**	**(13,969)**
Other Financing Sources:			
Federal Employee Retirement Benefit Costs Paid by OPM and Imputed to the Agency	(548)	-	(548)
Transfers out (in) Without Reimbursement	2,802	-	2,802
	2,254	**-**	**2,254**
Components of Budget Outlays Not Part of Net Cost:			
Acquisition of Capital Assets	7	407	414
Acquisition of Inventory	1	1,001	1,002
Acquisition of Other Assets	140	-	140
Other	8	5,346	5,354
	156	**6,754**	**6,910**
Net Outlays	**$ 5,861**	**$ 1,208,653**	**$ 1,214,514**
Federal Share of Child Support Collections and Other[9]			(892)
Net Outlays, Net			**$ 1,213,622**
Related Amounts on Combined Statement of Budgetary Resources			
Outlays, Net			$ 1,706,314
Distributed Offsetting Receipts			(492,692)
Agency Outlays, Net			**$ 1,213,622**

[9] This amount is included in the HHS SBR, Distributed Offsetting Receipts but does not have an impact on Net Cost.

Note 21. Combined Schedule of Spending (in Millions)

The Combined Schedule of Spending presents an overview of how departments or agencies spend (i.e., obligate) money. The data used to populate this schedule are the same underlying data used to populate the Combined Statement of Budgetary Resources. Simplified terms are used to improve the public's understanding of the budgetary accounting terminology used in the Combined Statement of Budgetary Resources.

Additional efforts to improve the transparency of spending activity in the federal government have recently come to fruition in the implementation of the *Digital Accountability and Transparency Act of 2014* (DATA Act). This legislation makes available to the public, at no cost, a searchable website that provides award and financial information on contracts and financial assistance awards (including grants). While the underlying obligation data used to generate both the Combined Schedule of Spending and the DATA Act submission are the same, there is a fundamentally different purpose behind each, which should be taken into account when comparing the two. The Combined Schedule of Spending presents total budgetary resources, total new obligations, and upward adjustments for the reporting entity. The website displaying the DATA Act submission, USAspending.gov,[10] collects the same data as well as recoveries. Additional differences include the definition of key attributes in each. Programs for the Combined Schedule of Spending are defined by the Treasury Account Symbol, whereas the DATA Act uses the Program and Financing lines from the *President's Budget*. The Combined Schedule of Spending and DATA Act both report spending activity by object class. However, the DATA Act requires granular-level object class assignments, while the Combined Schedule of Spending groups object classes at a higher level for presentation purposes. Additionally, the DATA Act submission at the award-level data does not include certain obligations, such as personnel compensation, travel, utilities, leases, intra-departmental and interagency spending, and various other categories of financial awards. The Combined Schedule of Spending has no such exclusions and is similar to the program activity reporting file for DATA Act. Lastly, the DATA Act reporting responsibility for award-level activity in allocation accounts is always assigned to the child entity. This is not entirely consistent with allocation account reporting for the financial statements for which either the parent or child will report.

What Money is Available to Spend? This section presents resources that were available to spend, as reported in the Combined Statement of Budgetary Resources. Total Resources refers to Total Budgetary Resources as described in the Combined Statement of Budgetary Resources and represents amounts approved for spending by law. Amount Available but Not Agreed to be Spent represents amounts that HHS was allowed to spend but did not take action to spend by the end of the fiscal year. Amount Not Available to be Spent represents amounts that HHS was not approved to spend during the current fiscal year. Total Amounts Agreed to be Spent represents spending actions taken by HHS – including contracts, purchase orders, grants, or other legally binding agreements of the federal government – to pay for goods or services. This line total agrees to the New Obligations and Upward Adjustments line in the Combined Statement of Budgetary Resources.

Who did the Money Go To? This section identifies the recipient of the money by federal and non-federal entities. Amounts in this section reflect amounts agreed to be spent and agree to the New Obligations and Upward Adjustments line on the Statement of Budgetary Resources.

[10] The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

How was the Money Spent/Issued? This section presents services or items that were purchased, categorized by program with spending greater than $2.0 billion in the current fiscal year. Programs with spending greater than $1.0 billion in the prior fiscal year are presented separately. Grants, Subsidies, & Contributions, Insurance Claims and Indemnities, Other Contractual Services and Personnel Compensation & Benefits are the object classes that have a material impact on HHS reporting. HHS Medicare payments are reported under Insurance Claims and Indemnities based on the OMB A-11, *Preparation, Submission, and Execution of the Budget*, object class definition.

Combined Schedule of Spending

For the Years Ended September 30, 2020 and 2019
(in Millions)

What Money is Available to Spend	2020	2019
Total Resources	$ 2,439,747	$ 1,924,165
Less Amount Available but Not Agreed to be Spent	158,784	50,528
Less Amount Not Available to be Spent	82,077	58,857
Total Amounts Agreed to be Spent	**$ 2,198,886**	**$ 1,814,780**

Who Did the Money Go To	2020	2019
Federal	$ 27,009	$ 10,522
Non-Federal	2,171,877	1,804,258
Total Amounts Agreed to be Spent	**$ 2,198,886**	**$ 1,814,780**

Total Amounts Agreed to be Spent increased by $384.1 billion, mostly due to additional appropriations for COVID-19 and the COVID-19 AAP program.

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2020

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 514,429	$ -	$ -	$ -	$ -	$ 514,429
Federal Supplementary Medical Insurance Trust Fund	-	416,066	125	1	2,287	418,479
Federal Hospital Insurance Trust Fund	-	403,401	13	-	979	404,393
Payments to Trust Funds	294,573	-	-	-	85,143	379,716
Public Health and Social Services Emergency Fund	12,434	-	125,518	226	7,046	145,224
Medicare Prescription Drug Account	-	91,901	-	1	1,506	93,408
Taxation on OASDI Benefits, HI	26,941	-	-	-	-	26,941
State Children's Health Insurance Fund	18,553	-	6	-	-	18,559
Temporary Assistance for Needy Families	16,622	-	83	13	1	16,719
Children and Families Services Programs	14,358	-	354	163	17	14,892
Payment to States for the Child Care and Development Block Grant	9,173	-	171	2	1	9,347
Payments for Foster Care and Permanency	9,206	-	39	-	1	9,246
Primary Health Care	7,211	-	253	88	9	7,561
Indian Health Services	3,266	-	1,076	1,645	1,056	7,043
National Institute of Allergy and Infectious Diseases	4,042	-	2,113	385	133	6,673
National Cancer Institute	4,012	-	1,810	600	117	6,539
Risk Adjustment Program Payments	-	6,251	-	-	-	6,251
FDA Salaries and Expenses	318	1	2,314	2,826	707	6,166
CMS Program Management	32	-	5,045	732	156	5,965
Payments to States for Child Support Enforcement and Family Support Programs	4,009	-	983	-	-	4,992
Low Income Home Energy Assistance	4,639	-	3	-	-	4,642
CDC-Wide Activities and Program Support	2,834	-	1,401	144	206	4,585
Vaccines for Children Program	115	-	81	21	4,361	4,578
Substance Abuse Treatment	3,746	-	101	5	1	3,853
National Heart, Lung, and Blood Institute	2,954	-	559	165	31	3,709
National Institute on Aging	3,135	-	304	89	70	3,598
Aging and Disability Services Programs	3,399	-	57	30	4	3,490
Child Care Entitlement to States	2,933	-	33	-	-	2,966
National Institute of General Medical Sciences	2,805	-	110	33	-	2,948
NIH Office of the Director	1,933	-	609	149	10	2,701
Refugee and Entrant Assistance	2,350	1	319	23	3	2,696
Ryan White HIV/AIDS Program	2,377	-	94	30	3	2,504
NIH Service and Supply Fund	-	-	1,809	310	382	2,501
National Institute of Neurological Disorders and Stroke	1,989	-	346	105	34	2,474
National Institute of Diabetes and Digestive and Kidney Diseases	1,823	-	253	132	32	2,240
Health Care Fraud and Abuse Control Program	-	-	1,477	89	661	2,227
National Institute of Mental Health	1,663	-	259	114	33	2,069
Other Agency Budgetary Accounts	23,245	691	10,378	5,352	2,896	42,562
Total Amounts Agreed to be Spent	**$ 1,001,119**	**$ 918,312**	**$ 158,096**	**$ 13,473**	**$ 107,886**	**$ 2,198,886**

Combined Schedule of Spending By Object Class

For the Year Ended September 30, 2019

(in Millions)

How was the Money Spent/Issued?	Grants, Subsidies, & Contributions	Insurance Claims & Indemnities	Other Contractual Services	Personnel Compensation & Benefits	Other	Total
Medicaid	$ 454,050	$ 1	$ 1	$ -	$ -	$ 454,052
Federal Supplementary Medical Insurance Trust Fund	-	366,285	115	1	5,152	371,553
Payments to Trust Funds	272,784	-	-	-	76,403	349,187
Federal Hospital Insurance Trust Fund	-	326,789	12	-	4,686	331,487
Medicare Prescription Drug Account	-	87,548	-	1	654	88,203
Taxation on OASDI Benefits, HI	23,781	-	-	-	-	23,781
State Children's Health Insurance Fund	17,598	-	7	-	-	17,605
Temporary Assistance for Needy Families	16,609	-	93	10	2	16,714
Children and Families Services Programs	12,137	-	355	152	11	12,655
Payments for Foster Care and Permanency	8,886	-	29	1	2	8,918
Risk Adjustment Program Payments	-	7,397	-	-	-	7,397
National Cancer Institute	3,718	-	1,645	569	114	6,046
CMS Program Management	34	-	5,074	679	156	5,943
Indian Health Services	2,570	16	968	1,484	899	5,937
National Institute of Allergy and Infectious Diseases	3,502	-	1,690	355	109	5,656
FDA Salaries and Expenses	303	3	2,277	2,606	460	5,649
Primary Health Care	5,203	-	251	76	9	5,539
Payment to States for the Child Care and Development Block Grant	5,151	-	106	2	1	5,260
Payments to States for Child Support Enforcement and Family Support Programs	4,064	-	543	-	-	4,607
Vaccines for Children Program	102	-	106	19	3,934	4,161
Substance Abuse Treatment	3,735	-	99	8	1	3,843
Low Income Home Energy Assistance	3,653	-	3	-	-	3,656
National Heart, Lung, and Blood Institute	2,815	-	516	159	33	3,523
Refugee and Entrant Assistance	2,380	-	764	16	11	3,171
National Institute on Aging	2,778	-	260	80	32	3,150
Public Health and Social Services Emergency Fund	299	-	1,202	180	1,347	3,028
Child Care Entitlement to States	2,951	-	31	-	-	2,982
National Institute of General Medical Sciences	2,696	-	104	32	3	2,835
National Institute of Neurological Disorders and Stroke	2,038	-	286	98	31	2,453
Ryan White HIV/AIDS Program	2,216	-	91	29	4	2,340
Aging and Disability Services Programs	2,158	-	49	30	5	2,242
National Institute of Diabetes and Digestive and Kidney Diseases	1,728	-	242	124	29	2,123
NIH Office of the Director	1,487	-	411	133	11	2,042
Health Care Fraud and Abuse Control Program	-	-	1,324	94	612	2,030
NIH Service and Supply Fund	-	-	1,333	291	378	2,002
National Institute of Mental Health	1,509	-	250	107	19	1,885
National Institute on Drug Abuse	1,362	-	272	70	10	1,714
Social Services Block Grant	1,666	-	10	1	-	1,677
Mental Health	1,502	-	77	4	2	1,585
National Institute of Child Health and Human Development	1,082	-	338	105	24	1,549
PSC Service and Supply Fund	-	-	1,247	161	94	1,502
Chronic Disease Prevention and Health Promotion	768	1	292	129	8	1,198
HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases and Tuberculosis Prevention	744	1	195	180	15	1,135
Health Workforce	1,026	-	74	25	9	1,134
Other Agency Budgetary Accounts	13,076	1,099	8,278	4,460	2,718	29,631
Total Amounts Agreed to be Spent	**$ 884,161**	**$ 789,140**	**$ 31,020**	**$ 12,471**	**$ 97,988**	**$ 1,814,780**

Note 22. COVID-19 Activities (in Millions)

	Budgetary Resources	Unobligated Balance	Obligations Incurred	Outlays
Coronavirus Preparedness and Response Supplemental Appropriations Act				
CDC	$ 2,200	$ 392	$ 1,808	$ 604
FDA	61	28	33	7
HRSA	100	0	100	79
NIH	836	320	516	109
OS**	3,300*	513	2,787	593
Total *Coronavirus Preparedness and Response Supplemental Appropriations Act*	**$ 6,497**	**$ 1,253**	**$ 5,244**	**$ 1,392**
Families First Coronavirus Response Act				
ACL	$ 250	$ -	$ 250	$ 172
IHS	64	11	53	48
OS**	1,000	500	500	499
Total *Families First Coronavirus Response Act*	**$ 1,314**	**$ 511**	**$ 803**	**$ 719**
Coronavirus Aid, Relief, and Economic Security Act				
ACF	$ 6,274	$ 76	$ 6,198	$ 2,068
ACL	955	-	955	277
CDC	4,313	2,403	1,910	222
CMS	200	116	84	12
FDA	80	71	9	3
HRSA	1,595	3	1,592	684
IHS	1,032	372	660	592
NIH	945	631	314	16
OS**	126,725	76,947	49,778	29,921
SAMHSA	425	2	423	18
Total *Coronavirus Aid, Relief, and Economic Security Act*	**$ 142,544**	**$ 80,621**	**$ 61,923**	**$ 33,813**
Paycheck Protection Program and Health Care Enhancement Act				
CDC	$ 1,000	$ 751	$ 249	$ 157
FDA	22	22	-	-
HRSA	600	1	599	133
NIH	1,806	1,101	705	129
OS**	96,572	7,962	88,610	77,114
Total *Paycheck Protection Program and Health Care Enhancement Act*	**$ 100,000**	**$ 9,837**	**$ 90,163**	**$ 77,533**
Total COVID-19	**$ 250,355**	**$ 92,222**	**$ 158,133**	**$ 113,457**

*The HHS budgetary resources amounts includes $300 million in *Coronavirus Preparedness and Response Supplemental Appropriations Act* funds precluded from obligation and is reduced by $289 million in *Coronavirus Aid, Relief, and Economic Security Act* funds transferred to the Department of Homeland Security.

** OS received COVID-19 funding through the PHSSEF.

The *Coronavirus Preparedness and Response Supplemental Appropriations Act* provides funding for HHS to reimburse costs incurred for COVID-19 preparedness and response activities. Funds could be used for contract support services to support the prevention of, preparation for, or response to COVID-19. HHS received $6.5 billion to support programs including: BARDA; SNS; grants for state, local, and tribal governments; Institute of Allergy and Infectious Diseases; and Institute of Environmental Health Sciences.

The *Families First Coronavirus Response Act* provides funding for paid leave, free COVID-19 testing, unemployment benefits, food assistance for vulnerable children and families, and states for economic consequences due to the pandemic. HHS received $1.3 billion primarily for the PHSSEF, with $1.0 billion for provider reimbursement.

The CARES Act provides emergency assistance and health care for individuals, families, and businesses that are impacted by COVID-19. HHS received $142.5 billion primarily for the PHSSEF with $126.7 billion. Through the PHSSEF, the Provider Relief Fund received $100.0 billion to prevent, prepare for, and respond to COVID-19, both domestically and internationally. The Provider Relief Fund provides payments to assist eligible health care providers for health care related expenses or lost revenues attributed to the COVID-19 pandemic. BARDA received funding to advance research, development, manufacturing, production, purchases, and other activities related to COVID-19 testing.

The *Paycheck Protection Program and Health Care Enhancement Act* provides additional funding to key programs under the CARES Act, including the Paycheck Protection Program, loans and grants to small businesses, health care providers and hospitals, and COVID-19 testing. HHS received $100.0 billion for the PHSSEF, of which $75.0 billion was for the Provider Relief Fund, and the remaining $25.0 billion to provide relief to state, local, and tribal governments and other COVID-19 response activities.

Refer to the following notes for additional information on COVID-19 activities: Entity and Non-Entity Assets (Note 2), Fund Balance with Treasury (Note 3), Investments, Net (Note 4), Inventory and Related Property, Net (Note 6), Advances (Note 8), Undelivered Orders (Note 17), and Combined Schedule of Spending (Note 21).

Note 23: Reclassification of Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position for FR Compilation Process

Reclassification of Balance Sheet to Line Items Used for the Government-wide Balance Sheet as of September 30, 2020 (in Millions)							
FY 2020 HHS Balance Sheet		Line Items Used to Prepare FY 2020 Government-wide Balance Sheet					
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Eliminations Between Dedicated and All Other	Total	Reclassified Financial Statement Line
ASSETS							**ASSETS**
Intra-Governmental Assets							**Intra-Governmental Assets**
Fund Balance with Treasury	$ 514,042	$ 119,500	$ -	$ 394,542	$	$ 514,042	Fund Balance with Treasury
		225,169	-	113	-	225,282	*Federal Investments*
		932	-	1	-	933	*Interest Receivable - Investments*
Investments, Net	226,215	226,101	-	114	-	226,215	Total Reclassified Investments, Net
		444	(444)	283	(45)	238	*Accounts Receivable*
		81,447	(82,434)	-	1,464	477	*Transfers Receivable*
Accounts Receivable, Net	715	81,891	(82,878)	283	1,419	715	Total Reclassified Accounts Receivable
Advances	1,993	21	19	1,972	(19)	1,993	Other
Total Intra-Governmental Assets	**$ 742,965**	**$ 427,513**	**$ (82,859)**	**$ 396,911**	**$ 1,400**	**$ 742,965**	**Total Intra-Governmental Assets**
Accounts Receivable, Net	$ 21,712	$ 16,771	$ -	$ 4,941	$ -	$ 21,712	Accounts Receivable, Net
Inventory and Related Property, Net	13,430	-	-	13,430	-	13,430	Inventory and Related Property, Net
General PP&E, Net	6,904	1,412	-	5,492	-	6,904	General PP&E, Net
Advances	106,082	103,756	-	2,326	-	106,082	Other Assets
		-	-	524	-	524	*Loans Receivable, Net*
		-	-	9	-	9	*Other Assets*
Other Assets	533	-	-	533	-	533	Other Assets
Total Assets	**$ 891,626**	**$ 549,452**	**$ (82,859)**	**$ 423,633**	**$ 1,400**	**$ 891,626**	**Total Assets**
LIABILITIES							**LIABILITIES**
Intra-Governmental Liabilities							**Intra-Governmental Liabilities**
		$ 521	$ (444)	$ 1,260	$ (45)	$ 1,292	*Accounts Payable*
		83,528	(82,434)	(1,461)	1,464	1,097	*Transfers Payable*
Accounts Payable	$ 2,389	84,049	(82,878)	(201)	1,419	2,389	Total Accounts Payable
		1,153	-	208	-	1,361	*Loans Payable*
		20	-	129	-	149	Benefit Program Contributions Payable
		-	-	1,237	-	1,237	*Accounts Payable*
		-	19	282	(19)	282	*Advances from Others and Deferred Credits*
		6	-	40	-	46	*Other Liabilities (without reciprocals)*
		-	-	579	-	579	*Other Liabilities*
Other Liabilities	3,653	1,179	19	2,475	(19)	3,654	Total Other Liabilities
Total Intra-Governmental Liabilities	**$ 6,042**	**$ 85,228**	**$ (82,859)**	**$ 2,274**	**$ 1,400**	**$ 6,043**	**Total Intra-Governmental Liabilities**
Accounts Payable	$ 2,583	$ 347	$ -	$ 2,236	$ -	$ 2,583	Accounts Payable
Federal Employee and Veteran Benefits	15,319	14	-	15,304	-	15,318	Federal Employee and Veteran Benefits Payable
Benefits Due and Payable	116,935	70,152	-	46,783	-	116,935	Benefits Due and Payable
Contingent Liabilities	11,267						Total: Debt Held by the Public; Environmental and Disposal Liabilities, Loan Guarantee Liability; Federal Employee and Veteran Benefits Payable; and Other Liabilities
Accrued Liabilities	15,798						
Other Liabilities	3,920						
Total	30,985	9,902	-	21,083	-	30,985	
Total Liabilities	**$ 171,864**	**$ 165,643**	**$ (82,859)**	**$ 87,680**	**$ 1,400**	**$ 171,864**	**Total Liabilities**

Note: Table continued on the next page.

Reclassification of Balance Sheet to Line Items Used for the Government-wide Balance Sheet as of September 30, 2020 (in Millions)							
FY 2020 HHS Balance Sheet		Line Items Used to Prepare FY 2020 Government-wide Balance Sheet					
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Eliminations Between Dedicated and All Other	Total	Reclassified Financial Statement Line
NET POSITION							**NET POSITION**
Unexpended Appropriations – Funds from Dedicated Collections	$ 98,117	$ 98,117	$ -	$ -	$ -	$ 98,117	Net Position – Funds from Dedicated Collections
Unexpended Appropriations – All Other Funds	333,140	-	-	333,140	-	333,140	Net Position – Funds Other than those from Dedicated Collections
Cumulative Results of Operations – Funds from Dedicated Collections	285,692	285,692	-	-	-	285,692	Net Position – Funds from Dedicated Collections
Cumulative Results of Operations – All Other Funds	2,813	-	-	2,813	-	2,813	Net Position – Funds Other than those from Dedicated Collections
Total Net Position	**$ 719,762**	**$ 383,809**	**$ -**	**$ 335,953**	**$ -**	**$ 719,762**	**Total Net Position**
Total Liabilities & Net Position	**$ 891,626**	**$ 549,452**	**$ (82,859)**	**$ 423,633**	**$ 1,400**	**$ 891,626**	**Total Liabilities & Net Position**

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Net Cost to Line Items Used for the Government-wide Statement of Net Cost For the Year Ending September 30, 2020 (in Millions)							
FY 2020 HHS Statement of Net Cost		**Line Items Used to Prepare FY 2020 Government-wide Statement of Net Cost**					
Financial Statement Line	**Amounts**	**Dedicated Collections Combined**	**Dedicated Collections Eliminations**	**All Other Amounts (with Eliminations)**	**Eliminations Between Dedicated and All Other**	**Total**	**Reclassified Financial Statement Line**
		$ 793,561	**$ -**	**$ 725,189**	**$ -**	**$ 1,518,750**	***Non-Federal Costs***
							Intragovernmental Costs
		341	-	1,627	-	1,968	*Benefit Program Costs*
		12,358	(4)	520	-	12,874	*Imputed Costs*
		(509)	975	3,911	-	4,377	*Buy/Sell Costs*
		10	-	118	-	128	*Purchase of Assets*
		-	-	5	-	5	*Borrowing and Other Interest Expense*
		114	-	523	-	637	*Other Expenses (w/o Reciprocals)*
		$ 12,314	**$ 971**	**$ 6,704**	**$ -**	**$ 19,988**	**Total Intragovernmental Costs**
CMS: Gross Cost	$ 1,281,918						
Other Segments Gross Costs of Operations before Actuarial Gains and Losses	256,693						
Total Gross Costs	**$ 1,538,611**	**$ 805,875**	**$ 971**	**$ 731,893**	**$ -**	**$ 1,538,738**	***Total Reclassified Gross Costs***
		$ (128,039)	**$ -**	**$ (1,865)**	**$ -**	**$ (129,904)**	**Non-Federal Earned Revenue**
							Intragovernmental Earned Revenue
		1,656	(1,284)	(1,404)	-	(1,031)	*Buy/Sell Revenue*
		(10)	-	(118)	-	(128)	*Purchase of Assets Offset*
		$ 1,647	**$ (1,284)**	**$ (1,522)**	**$ -**	**$ (1,159)**	**Total Intragovernmental Earned Revenue**
CMS: Exchange Revenue	$ (125,288)						
Other Segments: Exchange Revenue	(5,657)						
Total Exchange Revenue	**$ (130,945)**	**$ (126,392)**	**$ (1,284)**	**$ (3,387)**	**$ -**	**$ (131,063)**	***Total Reclassified Earned Revenue***
Actuarial (Gains) and Losses Commissioned Corp Retirement and Medical Plan Assumption Changes	71	-	-	71	-	71	Gain/Loss on Changes in Actuarial Assumptions (Non-Federal)
Net Cost	**$ 1,407,737**	**$ 679,482**	**$ (313)**	**$ 728,577**	**$ -**	**$ 1,407,746**	**Net Cost**

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Changes in Net Position to Line Items Used for Government-wide Statement of Operations and Changes in Net Position For the Year Ending September 30, 2020 (in Millions)							
FY 2020 HHS Statement of Change in Net Position		Line Items Used to Prepare FY 2020 Government-wide Statement of Changes in Net Position					
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Eliminations Between Dedicated and All Other	Total	Reclassified Financial Statement Line
UNEXPENDED APPROPRIATIONS							
Unexpended Appropriations, Beginning Balance	$ 228,406	$ 57,966	$ -	$ 170,440	$ -	$ 228,406	Net Position, Beginning of Period
Appropriations Received	1,360,551	438,810	-	921,741	-	1,360,551	Appropriations Received as Adjusted
Other Adjustments	(31,613)	(6,460)	-	(25,154)	-	(31,614)	
		-	-	10	-	10	*Non-Expenditure Transfers-In of Unexpended Appropriations and Financing Sources (Federal)*
		-	-	(295)	-	(295)	*Non-Expenditure Transfers-Out of Unexpended*
Appropriations Transferred In/Out	(285)	-	-	(285)	-	(285)	Total Reclassified Appropriations Transferred In/Out
Appropriations Used	(1,125,802)	(392,201)	-	(733,601)	-	(1,125,802)	Appropriations Used (Federal)
Total Unexpended Appropriations	**$ 431,257**	**$ 98,115**	**$ -**	**$ 333,141**	**$ -**	**$ 431,256**	
CUMULATIVE RESULTS OF OPERATIONS							
Cumulative Results, Beginning Balance	$ 253,128	$ 258,394	$ -	$ (5,266)	$ -	$ 253,128	Net Position, Beginning of Period
Other Adjustments	(9)	-	-	(9)	-	(9)	Revenue and Other Financing Sources – Cancellations
Appropriations Used	1,125,802	392,201	-	733,601	-	1,125,802	Appropriations Expended
							Intragovernmental Non-Exchange Revenues
Nonexchange Revenue – Tax Revenue	295,913	299,080	-	311	-	299,391	Other Taxes and Receipts (RC 45)
Nonexchange Revenue – Investment Revenue	6,648	6,404	-	244	-	6,648	Federal Securities Interest Revenue, including Associated Gains/Losses (Non-Exchange)
		2,101	-	-	-	2,101	*Collections Transferred into a TAS Other Than the General Fund of the U.S. Government*
		(1,295)	-	-	-	(1,295)	*Other Taxes and Receipts*
Nonexchange Revenue – Other	4,281	806		-		806	Total Other Taxes and Receipts
		$ 306,290	**$ -**	**$ 555**	**$ -**	**$ 306,845**	***Total Intragovernmental Non-Exchange Revenues***
Donations and Forfeitures of Cash and Cash Equivalents	$ 61	$ 61	$ -	$ -	$ -	$ 61	Other Taxes and Receipts
		(905,003)	904,549	-	454	-	*Non-Expenditure Transfers-In of Unexpended Appropriations and Financing Sources*
		905,007	(905,007)	454	(454)	-	*Non-Expenditure Transfers-Out of Unexpended Appropriations and Financing Sources*
		397,541	(397,042)	1,906	(1,721)	684	*Expenditure Transfers-In of Financing Sources*
		(401,670)	397,049	(23)	1,721	(2,923)	*Expenditure Transfers-Out of Financing Sources*
Transfers-In/Out Without Reimbursement (+/-) – Budgetary	(2,239)	(4,125)	(451)	2,337	-	(2,239)	Total Reclassified Transfers-In/Out w/o Reimbursement – Budgetary
Total Budgetary Financing Sources	**$ 1,430,457**	**$ 694,427**	**$ (451)**	**$ 736,484**	**$ -**	**$ 1,430,460**	**Total Budgetary Financing Sources**

Note: Table continued on the next page.

*Subtotals and totals may not equal due to rounding.

Reclassification of Statement of Changes in Net Position to Line Items Used for Government-wide Statement of Operations and Changes in Net Position For the Year Ending September 30, 2020 (in Millions)							
FY 2020 HHS Statement of Change in Net Position		Line Items Used to Prepare FY 2020 Government-wide Statement of Changes in Net Position					
Financial Statement Line	Amounts	Dedicated Collections Combined	Dedicated Collections Eliminations	All Other Amounts (with Eliminations)	Eliminations Between Dedicated and All Other	Total	Reclassified Financial Statement Line
Other Financing Sources							
Donations and Forfeitures of Property	$ 127	$ -	$ -	$ 127	$ -	$ 127	Other Taxes and Receipts
Imputed Financing	12,874	12,358	(4)	520	-	12,874	Imputed Financing Sources (Federal)
		3	-	(8)	-	(5)	*Other Taxes and Receipts*
		-	-	(342)	-	(342)	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund*
		(1)	1	-	-	-	*Transfers-In Without Reimbursement*
		2	(1)	-	-	1	*Transfers-Out Without Reimbursement*
		1	-	-	-	1	*Other Non-Budgetary Financing Sources*
Other (+/-)	(344)	5	-	(350)	-	(345)	*Total Other*
Total Other Financing Sources	**$ 12,657**	**$ 12,363**	**$ (4)**	**$ 297**	**$ -**	**$ 12,656**	Total Reclassified Other
Total Financing Sources	**$ 1,443,114**	**$ 706,790**	**$ (455)**	**$ 736,781**	**$ -**	**$ 1,443,116**	**Total Financing Sources**
		$ -	$ -	$ 1,350	$ -	$ 1,350	*Non-Entity Collections Transferred to the General Fund*
		-	-	(1,268)	-	(1,268)	*Other Taxes and Receipts*
		-	-	(90)	-	(90)	*Accrual for Non-Entity Amounts to be Collected and Transferred to the General Fund*
		-	-	**(8)**	-	**(8)**	
Net Cost of Operations	**$ 1,407,737**	**$ 679,482**	**$ (313)**	**$ 728,577**	**$ -**	**$ 1,407,746**	**Net Cost of Operations**
Ending Balance – Cumulative Results of Operations	**$ 288,505**	**$ 285,702**	**$ (142)**	**$ 2,946**	**$ -**	**$ 288,506**	**Net Position – Ending Balance**
Total Net Position	**$ 719,762**	**$ 383,817**	**$ (142)**	**$ 336,087**	**$ -**	**$ 719,762**	**Total Net Position**

*Subtotals and totals may not equal due to rounding.

To prepare the Financial Report of the U.S. Government (FR), Treasury requires agencies to submit an adjusted trial balance, which is a listing of amounts by U.S. Standard General Ledger account that appears in the financial statements. Treasury uses the trial balance information reported in Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) to develop a Reclassified Balance Sheet, Reclassified Statement of Net Cost, and a Reclassified Statement of Changes in Net Position for each agency, which are accessed using GTAS. Treasury eliminates all intragovernmental balances from the reclassified statements and aggregates lines with the same title to develop the FR statements. This note shows the HHS financial statements and the HHS reclassified statements prior to elimination of intragovernmental balances and prior to aggregation of repeated FR line items. A copy of the 2019 FR can be found at Fiscal Service's website and the 2020 FR will be posted to the site as soon as it is released.

The Statement of Net Cost and Statement of Changes in Net Position have immaterial differences primarily due to the presentations between HHS's financial statements and the reclassified financial statements. There is a difference of $9 million for the Statements of Net Cost and $8 million for the Statement of Changes in Net Position due to custodial activities. The remainder of the differences are due to rounding.

Note 24. Statement of Social Insurance (Unaudited)

Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the *2020 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on January 1, 2020 and do not reflect any changes in law or regulation subsequent to that date in accordance with SFFAS 39. They do not reflect the potential effects of the COVID-19 pandemic, which occurred subsequent to January 1, or the legislation enacted in response to it, including i) the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* (Public Law 116-123); ii) the *Families First Coronavirus Response Act* (Public Law 116-127); and iii) the *Coronavirus, Aid, Relief, and Economic Security Act* (Public Law 116-136). However, given the uncertainty associated with these impacts, the Trustees stated that it was not possible to adjust the estimates accurately at the time the report was released. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

In addition, the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on April 22, 2020, excluding the impact of the legislation enacted in response to the COVID-19 pandemic and disregarding the payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, wages, and the consumer price index (CPI); fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2020 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2020. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website.[11]

[11] The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2020

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[10]
2020	1.69	1,418,000	790.4	1.23	3.50	2.27	2.1	5.2	6.5	-0.7[9]	[11]
2030	1.95	1,326,000	729.4	1.25	3.65	2.40	2.0	6.5	8.3	4.5	2.3
2040	1.95	1,277,000	669.5	1.14	3.54	2.40	1.9	4.4	4.4	4.2	2.3
2050	1.95	1,249,000	616.6	1.12	3.52	2.40	2.0	3.4	3.8	4.4	2.3
2060	1.95	1,236,000	570.1	1.16	3.56	2.40	2.0	3.1	3.7	4.2	2.3
2070	1.95	1,227,000	529.1	1.12	3.52	2.40	1.9	3.4	3.6	4.1	2.3
2080	1.95	1,221,000	492.8	1.11	3.51	2.40	2.0	3.5	3.7	4.2	2.3
2090	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3

[1] Average number of children per woman.

[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4] Difference between percentage increases in wages and the CPI.

[5] Average annual wage in covered employment.

[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

[9] Part D cost growth is projected to be negative in 2020 mainly due to higher assumed direct and indirect remuneration.

[10] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

[11] The assumption for 2020 is greater than -0.05 and less than 0.05 percent.

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance FY 2020-2016

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2020	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3
2019	2.0	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5
2018	2.0	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7
2017	2.0	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2027.

[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. (Beginning with FY 2018 legal immigration is referred to as lawful permanent resident (LPR) immigration, and other, non-legal, immigration is referred to as other-than-LPR immigration.) The ultimate level of net legal immigration is 788,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

[4] Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in Table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

[5] Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2090.

[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

Note 25. Alternative Statement of Social Insurance Projections (Unaudited)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

Certain features of current law may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide

private nonfarm business multifactor productivity although these health providers have historically achieved lower levels of productivity growth. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The Trustees previously estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048 and will be about 30 percent lower by the end of the projection period. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028 to 2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the 5-percent bonuses for qualified physicians in advanced alternative models (advanced APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2025.[12] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

[12] The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the enactment of MACRA in 2015 replaced the SGR with specified physician updates.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

Medicare Present Values

(in Billions)

	Current law (Unaudited)	Alternative scenario[1, 2] (Unaudited)
Income		
Part A	$ 25,554	$ 25,619
Part B	46,596	52,522
Part D	11,035	11,035
Expenditures		
Part A	30,355	35,543
Part B	46,596	52,522
Part D	11,035	11,035
Income less expenditures		
Part A	(4,800)	(9,924)
Part B	-	-
Part D	-	-

[1] These amounts are not presented in the 2020 Trustees Report.

[2] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the 5-percent bonuses paid to qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 17 percent and Part B expenditures would be higher than the current-law projections by roughly 13 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 13 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are the same under each projection because the services are not affected by the productivity adjustments or the physician updates.

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments and physician updates depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

Note 26. Statement of Changes in Social Insurance Amounts (Unaudited)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2019 to the period beginning on January 1, 2020, and the reconciliation from the period beginning on January 1, 2018 to the period beginning on January 1, 2019. The reconciliation identifies several significant components of the change and provides reasons for the change.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the SCSIA are, in order, as follows:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the SCSIA represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the SCSIA are for the current and prior years and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 24 summarizes these assumptions for the current year.

Period beginning on January 1, 2019 and ending January 1, 2020

Present values as of January 1, 2019 are calculated using interest rates from the intermediate assumptions of the 2019 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2020. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2019 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2020 Trustees Report.

Period beginning on January 1, 2018 and ending January 1, 2019

Present values as of January 1, 2018 are calculated using interest rates from the intermediate assumptions of the 2018 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2019. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2018 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2019 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2019-93) to the current valuation period (2020-94) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2019, replaces it with a much larger negative net cash flow for 2094, and measures the present values as of January 1, 2020, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2019-93 to 2020-94. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2019 are realized. The change in valuation period resulted in a slight decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $238 billion.

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2018-92) to the current valuation period (2019-93) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2018, replaces it with a much larger negative net cash flow for 2093, and measures the present values as of January 1, 2019, 1 year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2018-92 to 2019-93. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2018 are realized. The change in valuation period resulted in a slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $193 billion.

Change in Projection Base

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

Actual income and expenditures in 2019 were different from what was anticipated when the 2019 Trustees Report projections were prepared. Part A income and expenditures in 2019 were lower than anticipated based on actual experience. For both Part B and Part D, total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $401 billion in the

present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2019 and January 1, 2020 is incorporated in the current valuation and is more than projected in the prior valuation.

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

Actual income and expenditures in 2018 were different from what was anticipated when the 2018 Trustees Report projections were prepared. Part A income in 2018 was lower and expenditures were higher than anticipated based on actual experience. For both Part B and Part D, total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is a decrease of $193 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2018 and January 1, 2019 is incorporated in the current valuation and is more than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2020), there were two changes to the ultimate demographic assumptions.

- The ultimate total fertility rate was lowered from 2.00 to 1.95 children per woman, reflecting a continued decline in fertility rates since 2007.
- The ultimate disability incidence rate was lowered from 5.2 per thousand exposed in the prior valuation to 5.0 in the current valuation. In addition, near-term assumed disability incidence rates, in the period of transition from recent historical values to the ultimate rates, are somewhat lower in the current valuation than in the prior valuation.

In addition to these ultimate demographic assumption changes, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2018 and the first quarter of 2019 indicated somewhat lower birth rates than were assumed in the prior valuation.
- Incorporating 2017 mortality data obtained from the National Center for Health Statistics (NCHS) for ages under 65 in addition to final 2016, preliminary 2017, and preliminary 2018 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- The latest valuation included the impact of time to death on Medicare expenditures. Previously, the valuation included only the impact of age and sex on the expenditures.

These changes, especially the time to death assumption lowered Medicare expenditures for the current valuation period, particularly for Part A, and resulted in a large increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $2,687 billion.

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2019) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- The numbers of new lawful permanent residents (LPR) for calendar years 2018 and 2019 were assumed to be slightly lower than projected in the prior valuation period, due to recent lower annual refugee ceilings set by the Administration.
- The current valuation incorporated a gradual rise in 2017 and 2018 of other-than-LPR immigrants, reaching the ultimate assumed level in 2019. In contrast, the prior valuation incorporated a surge in the number of other-than-LPR immigrants for years 2016 through 2021.
- Final birth rate data for 2017 indicated slightly lower birth rates than were assumed in the prior valuation.
- Incorporating 2016 mortality data obtained from the NCHS for ages under 65 and 2016 and preliminary 2017 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.

There were two notable changes in demographic methodology:

- Improved the method for projecting fertility rates by better incorporating detailed provisional birth rate data available from NCHS.
- Incorporated more comprehensive Medicare mortality data from CMS.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in a slight increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $27 billion.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2019 to the period beginning on January 1, 2020

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2020), there were four changes to the ultimate economic assumptions.

- The ultimate rate of price inflation (CPI-W) was lowered by 0.2 percentage point, from 2.6 percent in the prior valuation to 2.4 percent in the current valuation.
- The ultimate average real-wage differential was decreased from 1.21 percentage points in the prior valuation to 1.14 percentage points in the current valuation. Most of this decrease is due to the repeal of the PPACA excise tax, the effect of which is accounted for in the “Changes in Law or Policy” section. However, a small portion is due to faster assumed growth in employer-sponsored group health insurance premiums separate from this repeal.
- The ultimate age-sex-adjusted unemployment rate was reduced from 5.5 percent for the prior valuation to 5.0 percent in the current valuation. At the same time, long-term labor force participation rates were

reduced by age and sex for the current valuation, such that projected employment rates remained essentially unchanged from the prior valuation to the current valuation.
- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.5 percent in the prior valuation to 2.3 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include a 0.7 percent decrease in the estimated level of potential GDP for the fourth quarter of 2019 and thereafter. This and other smaller changes in starting values and near-term growth assumptions combined to decrease the present value of estimated future net cash flows.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Higher projected spending growth for Medicare Advantage beneficiaries.
- Faster projected spending growth for Part B drugs.
- Slower overall drug price increases and higher direct and indirect remuneration.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $1,715 billion.

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2019), there were four changes to the ultimate economic assumptions.

- The ultimate annual rate of change in total-economy labor productivity was lowered from 1.68 percent in the prior valuation to 1.63 percent in the current valuation, reflecting an expected slower rate of productivity growth in the long term.
- The difference between the ultimate growth rates for the Consumer Price Index for Urban Wage Earners and Clerical Workers and the GDP implicit price deflator (the "price differential"), was decreased from 0.40 percentage point in the prior valuation to 0.35 percentage point in the current valuation.
- The ultimate average real-wage differential was increased from 1.20 percentage points in the prior valuation to 1.21 percentage points in the current valuation.
- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.7 percent in the prior valuation to 2.5 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include the July 2018 revisions in historical GDP estimated by the Bureau of Economic Analysis of the Department of Commerce. This and other smaller changes in starting values and near-term growth assumptions combined to increase the present value of estimated future net cash flows.

There was one notable change in economic methodology.

- Incorporated more recent projections of disability prevalence in the labor force participation model.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Lower assumed growth in economy-wide productivity, which results in higher payment updates for certain providers.
- Faster projected spending growth for physician-administered drugs under Part B.
- Higher projected drug manufacturer rebates and slower overall drug price increases assumed in the short-range period.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $402 billion.

Changes in Law

For the period beginning on January 1, 2019 to the period beginning on January 1, 2020

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019) included one provision that affects HI and SMI programs.
    - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by two years, through fiscal years 2028 and 2029.
- The *Further Consolidated Appropriations Act, 2020* (Public Law 116-94, enacted on December 20, 2019) included provisions that affect HI and SMI programs.
    - The annual fee imposed on certain large health insurer providers, including those furnishing coverage under Medicare Advantage and Medicare Part D, is repealed for calendar years beginning after December 31, 2020.
    - The excise tax on employer-sponsored group health insurance premiums above a specified level (commonly referred to as the “Cadillac Tax” and provided for by legislation in 2010) is repealed. This excise tax was expected to decrease the average cost of health insurance, thereby increasing the portion of employee compensation subject to the HI payroll tax, over both the short- and long-range projection periods. Although the implementation of this provision has been repeatedly delayed since inception, the 2010-2019 annual reports reflected the assumption that the excise tax would eventually be applied. Therefore, the repeal of this provision decreases the share of employee compensation that will be subject to the HI payroll tax.
    - The 1.00 floor on the geographic index for physician work is extended through May 22, 2020 (from December 31, 2019).
    - The clinical laboratory commercial payer data reporting requirement is delayed for 1 year (that is, until calendar year 2021).

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. The present values of estimated income and expenditures are lower for Part A, Part B, and Part D. Overall, these changes decreased the present value of the estimated future net cash flow by $453 billion.

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The provisions enacted as part of Medicare legislation since the prior valuation date had no measurable impact on program expenditures. For more information on the legislation please see section V.A of the 2019 Medicare Trustees Report.

Required Supplementary Information

Combining Statement of Budgetary Resources (in Millions)

For the Year Ended September 30, 2020

	CMS					
	Medicare HI	Medicare SMI	Payments to Trust Funds	Medicaid	Other Agency Accounts	Agency Combined Totals
Budgetary Resources						
Unobligated Balance from Prior Year Budget Authority, Net (Discretionary and Mandatory)	$ 693	$ 1,130	$ 56,217	$ 50,457	$ 48,925	$ 157,422
Appropriations (Discretionary and Mandatory)	403,700	417,349	438,608	462,991	532,965	2,255,613
Borrowing Authority (Discretionary and Mandatory)	-	-	-	-	2	2
Spending Authority from Offsetting Collections (Discretionary and Mandatory)	-	-	-	1,292	25,418	26,710
Total Budgetary Resources	**$ 404,393**	**$ 418,479**	**$ 494,825**	**$ 514,740**	**$ 607,310**	**$ 2,439,747**
Status of Budgetary Resources						
New Obligations and Upward Adjustments	$ 404,393	$ 418,479	$ 407,385	$ 514,429	$ 454,200	$ 2,198,886
Unobligated Balance, End of Year:						
Apportioned, Unexpired Accounts	-	-	31,223	-	127,373	158,596
Exempt from Apportionment, Unexpired Accounts	-	-	-	-	188	188
Unapportioned, Unexpired Accounts	-	-	-	311	11,977	12,288
Unexpired Unobligated Balance, End of Year	-	-	31,223	311	139,538	171,072
Expired Unobligated Balance, End of Year	-	-	56,217	-	13,572	69,789
Unobligated Balance, End of Year	-	-	87,440	311	153,110	240,861
Total Status of Budgetary Resources	**$ 404,393**	**$ 418,479**	**$ 494,825**	**$ 514,740**	**$ 607,310**	**$ 2,439,747**
Outlays, Net						
Outlays, Net (Discretionary and Mandatory)	$ 407,738	$ 419,999	$ 388,522	$ 455,176	$ 366,476	$ 2,037,911
Distributed Offsetting Receipts	(42,602)	(489,119)	-	-	(2,194)	(533,915)
Agency Outlays, Net (Discretionary and Mandatory)	**$ 365,136**	**$ (69,120)**	**$ 388,522**	**$ 455,176**	**$ 364,282**	**$ 1,503,996**

Summary of Other Agency Accounts

	Budgetary Resources	Outlays, Net
ACF	$ 72,393	$ 59,835
ACL	3,513	2,418
AHRQ	396	334
CDC	23,568	12,007
CMS	174,892	114,884
FDA	8,281	2,906
HRSA	15,386	12,080
IHS	11,905	6,181
NIH	52,024	35,818
OS	236,166	111,945
PSC	1,950	667
SAMHSA	6,836	5,207
Totals	**$ 607,310**	**$ 364,282**

Deferred Maintenance and Repairs

For the Years Ended September 30, 2020 and 2019

The FASAB issued SFFAS 42, *Deferred Maintenance and Repairs*: *Amending Statement of Federal Financial Accounting Standards 6, 14, 29, and 32* effective for periods after September 30, 2014. This standard clarifies that repair activities should be included to better reflect asset management practices and improve reporting on deferred maintenance and repairs. Deferred maintenance and repairs are maintenance and repair activities not performed when they should have been or were scheduled to be, and then put off or delayed for a future period. Maintenance and repairs are the activities directed toward keeping fixed capital assets in acceptable condition, including preventive maintenance, normal repairs, replacement of parts and structural components, and other activities needed to preserve the asset so that it continues to provide acceptable service. Other factors under consideration are whether the asset meets applicable building codes and achieves its expected life. Maintenance and repairs do not include activities aimed at expanding the capacity of an asset or otherwise upgrading it to serve needs different from, or significantly greater than, those originally intended. Maintenance and repair expenses are recognized as incurred.

CDC, NIH, and FDA use the condition assessment survey for all classes of property. IHS uses two methods to assess installations – annual general inspections and facility condition surveys. The landholding OpDivs prioritize their maintenance activities based on urgency and the best use of their limited resources, with life safety the top priority. Deferred maintenance and repairs have been reported for all active and inactive assets; excess buildings and structures that are slated for disposal or demolition are not included. For buildings, equipment, and other structures, acceptable condition is defined in accordance with standards comparable to those used in private industry. For example, factors can include Property, Plant and Equipment location, age, design etc. Equipment affixed to real property should be appropriately reflected in building and other structures.

Estimated Cost to Return to Acceptable Condition (in Millions)

Category of Asset	2020	2019
General PP&E		
Buildings	$ 2,780	$ 2,533
Other Structures	18	17
Total	**$ 2,798**	**$ 2,550**

In a condition assessment survey, asset condition is assessed on a scale of 1-5 as follows: Excellent-1; Good-2; Fair-3; Poor-4; Very Poor-5. A "fair" or 3 rating is considered acceptable operating condition. Although Property, Plant and Equipment categories may be rated as acceptable, individual assets within a category may require maintenance work to return them to acceptable operating condition. Therefore, asset categories with an overall rating of "fair" or above may still report necessary costs to return them to acceptable condition.

Social Insurance

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on January 1, 2020 and do not reflect any changes in law or regulation subsequent to that date in accordance with SFFAS 39. They do not reflect the potential effects of the COVID-19 pandemic, which occurred subsequent to January 1, or the legislation enacted in response to it. However, given the uncertainty associated with these impacts, the Trustees stated that it was not possible to adjust the estimates accurately at the time the report was released. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

The projections presented here are based on current law, certain features of which may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity[13] although these health providers have historically achieved lower levels of productivity growth. If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013); the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014); the *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015); the *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018); and the *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019). The sequestration reduces benefit payments by 2 percent

[13] For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

from April 1, 2013 through March 31, 2029 and by 4 percent from April 1, 2029 through September 30, 2029. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2029.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most categories of health care providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting health care cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[14] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; (ii) the average physician payment updates would transition from current law[15] to payment updates that reflect the Medicare Economic Index; and (iii) the 5-percent bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and the $500-million payments for physicians in the merit-based incentive payment system (MIPS) would continue indefinitely rather than expire in 2025. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 25 in these financial statements, in section V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from the CMS website.

[14] Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth of economy-wide productivity (1.0 percent over the long range).

[15] The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models (advanced APMs) or the merit-based incentive payment system (MIPS), respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.

Actuarial Projections

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[16] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[17]

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Technical Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Medicare payment rates for most non-physician provider categories are updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care provider services:

(i) ***All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity***

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year cost growth rates for these provider services start at 3.8 percent in 2044, or GDP plus 0.1 percent, declining gradually to 3.3 percent in 2094, or GDP minus 0.3 percent.

(ii) ***Physician services***

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to be 3.3 percent in 2044, or GDP minus 0.4 percent, declining to 2.8 percent in 2094, or GDP minus 0.8 percent.

[16] This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the gender composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

[17] The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel (final report available here) and with Finding 3-2 of the 2016-2017 Medicare Technical Review Panel (final report available here).

(iii) ***Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity***

Such services include durable medical equipment that is not subject to competitive bidding,[18] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the year-by-year cost growth rates for these services to be 3.0 percent in 2044, or GDP minus 0.7 percent, declining to 2.6 percent in 2094, or GDP minus 1.0 percent.

(iv) ***All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services***

These Part B outlays constitute an estimated 33 percent of total Part B expenditures in 2029 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[19] The long-range cost growth rates for Part D and these Part B services are assumed to equal the growth rates as determined from the factors model. The corresponding year-by-year cost growth rates for these services are 4.4 percent in 2044, or GDP plus 0.7 percent, declining to 4.1 percent by 2094, or GDP plus 0.5 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. In the 2019 report and prior reports, these impacts reflected the changing distribution of Medicare enrollment by age and sex. For the 2020 report, these effects are being modified to estimate not only the changing distribution of Medicare enrollment by age and sex but also the beneficiary's proximity to death, which is referred to as a time-to-death (TTD) adjustment. The TTD adjustment reflects the fact that the closer an individual is to death, the higher his or her health care spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on health care is offset somewhat. For the 2020 report, inclusion of the TTD adjustment results in demographic impacts that are smaller than those in the 2019 report.[20] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing, and home health services—for which the distribution of spending is more concentrated in the period right before death.[21] For Part B services that are less acute, the incorporation of the TTD adjustment has a smaller effect. Finally, this demographic adjustment has significantly less of an impact on Part D costs because the incidence of prescription drug use is more evenly distributed by age and TTD.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent in 2044, or GDP plus 0.2 percent, declining to 3.7 percent by 2094, or GDP plus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 4.0 percent, or GDP plus 0.3 percent in 2044, declining to 3.7 percent, or GDP plus 0.1 percent by 2094.

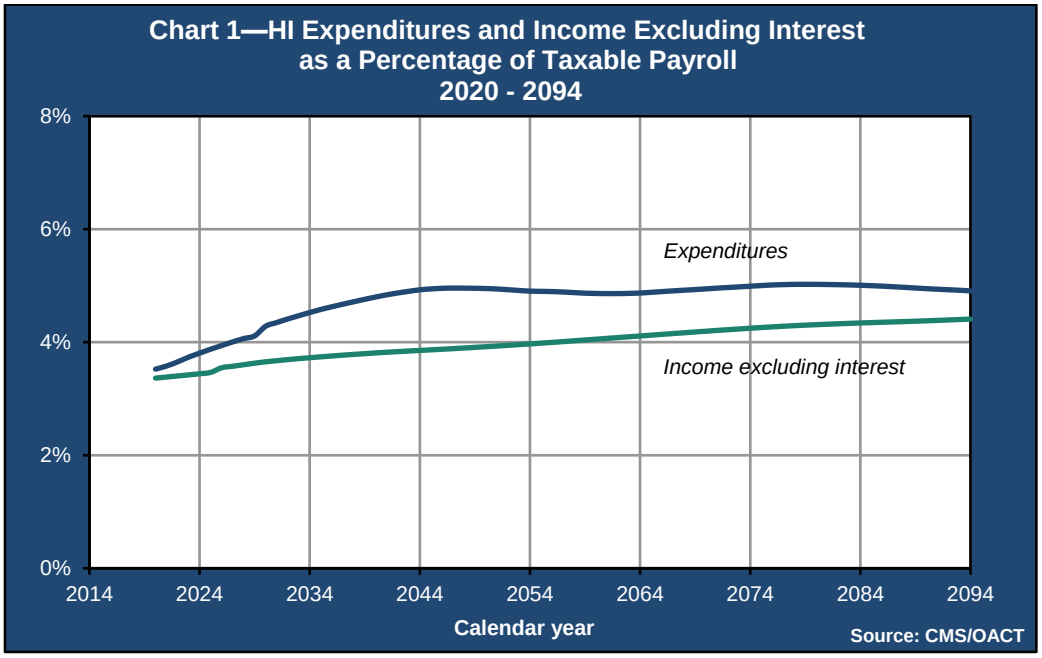
HI Cash Flow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore,

[18] The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see section IV.B of the 2020 Medicare Trustees Report.
[19] For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.
[20] More information on the TTD adjustment is available at the CMS website.
[21] The one exception is for hospice services, which previously did not reflect changing demographics. The inclusion of an age and sex adjustment in the 2020 report has a larger impact in raising hospice spending—particularly during the period when the baby boom generation reaches older ages—than does the TTD adjustment in lowering such spending.

income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2020 report are lower than those from the 2019 report for nearly all years largely because of lower expenditures attributable to lower-than-projected 2019 spending and the incorporation of time-to-death into the demographic factors used in the projection model.



Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation; this result will occur because the income thresholds determining taxable benefits are not indexed for price inflation and because the income tax brackets are indexed to the chained CPI (C-CPI-U), which increases at a slower rate than average wages.[22] Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

In 2020 and beyond, as indicated in Chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to an acceleration of health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.7 percent through 2029

[22] After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as, rather than significantly faster than, taxable payroll. See section V.C7 of the 2020 Old-Age, Survivors, and Disability Insurance Trustees Report for more detailed information on the projection of income from taxation of Social Security benefits.

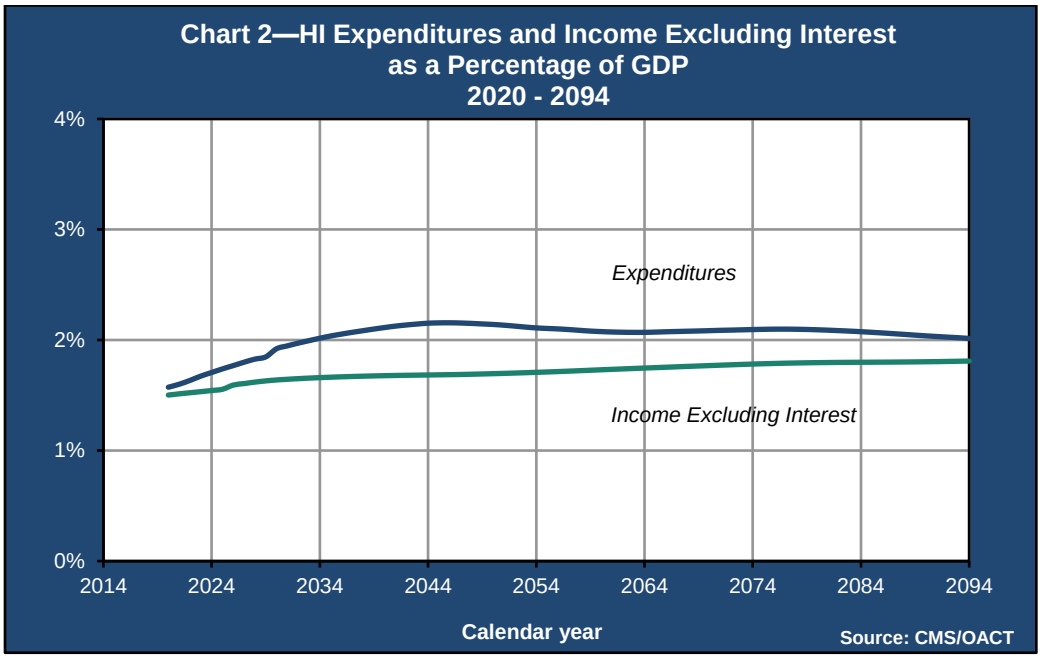
and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2045 and 7.3 percent in 2094.

HI and SMI Cash Flow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

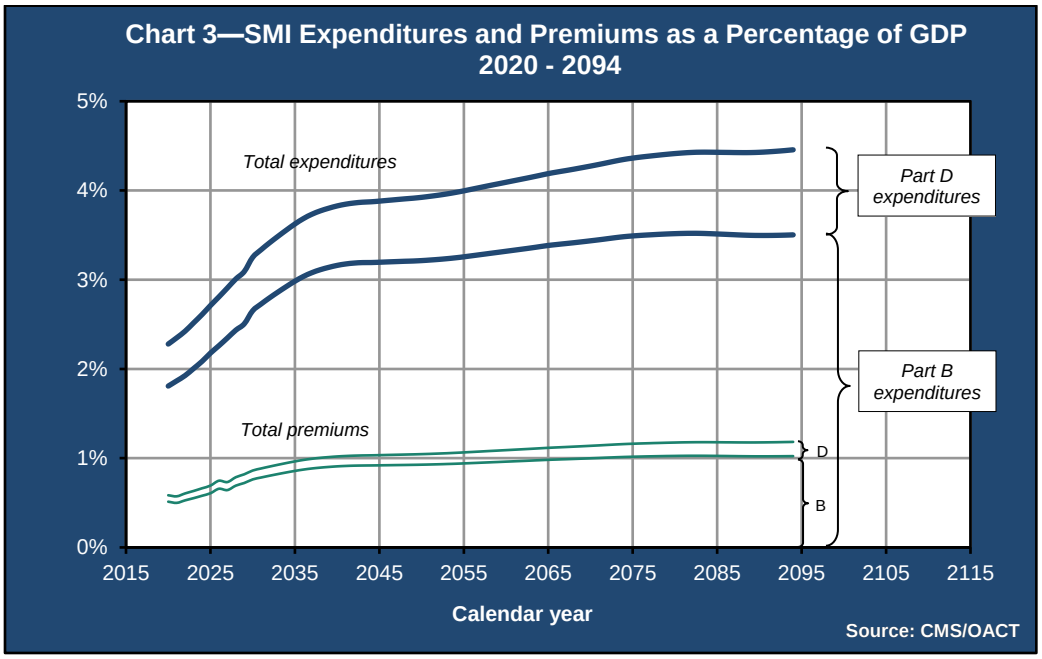
Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2019, the expenditures were $328.3 billion, which was 1.5 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.0 percent in 2094.



SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.



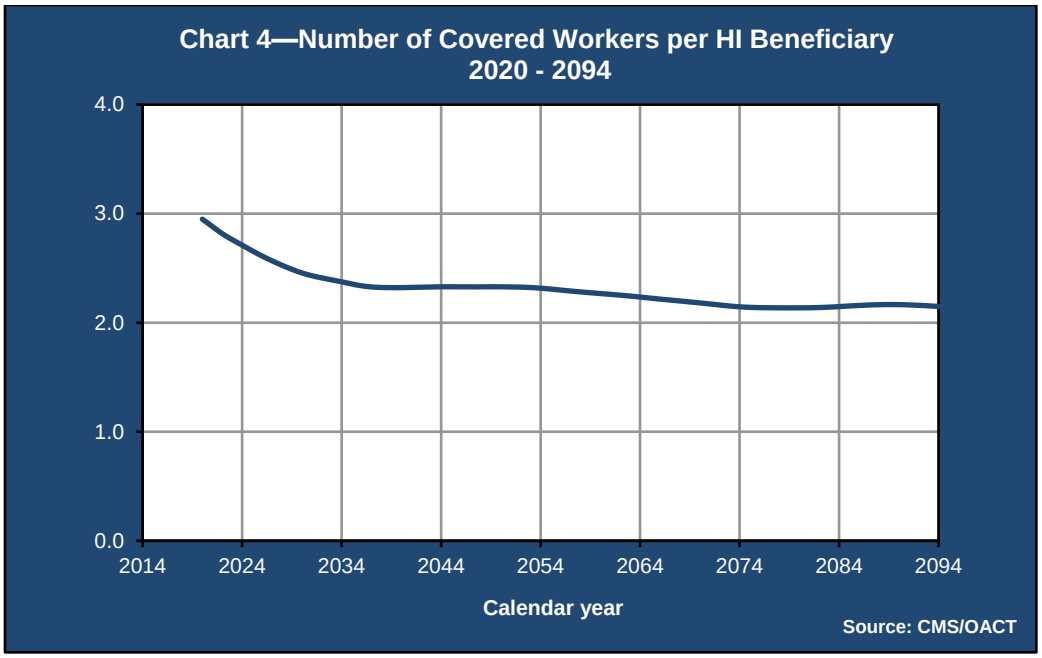
In 2019, SMI expenditures were $467.9 billion, or about 2.2 percent of GDP. Under current law, they would grow to about 3.9 percent of GDP within 25 years and to 4.5 percent by the end of the projection period, as demonstrated in Chart 3. Under the illustrative alternative, total SMI expenditures in 2094 would be 5.5 percent of GDP.

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2019 by about 4.2 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation.



In 2019, every beneficiary had about 3.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in Chart 4. The projected ratio continues to decline until there are only 2.1 workers per beneficiary by 2094.

Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under current law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[23] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[24]

For this analysis, the intermediate economic and demographic assumptions in the *2020 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2020 and are based on estimates of income and expenditures during the 75-year projection period.

[23] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.
[24] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

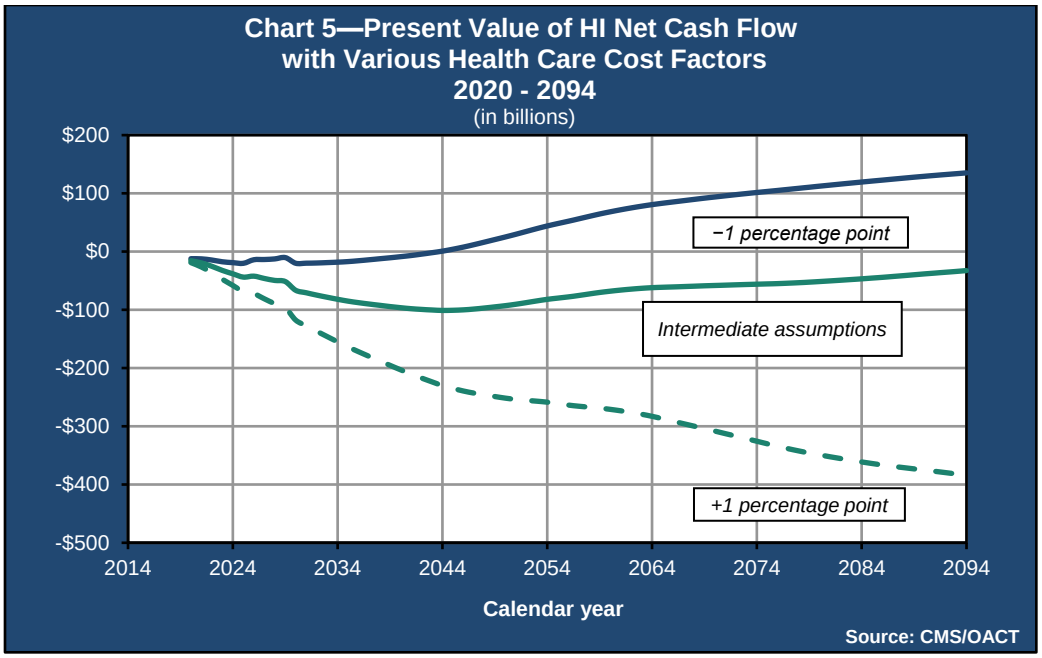
Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate projections.

Table 1—Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$3,879	-$4,800	-$18,727

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,680 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $13,927 billion.

Chart 5 below shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.



This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus due to the improved financial outlook for the HI trust fund as a result of the cost-reduction provisions required under current law. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.52, 1.14, and 1.76 percentage points.[25] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 2.92, 3.54, and 4.16 percent, respectively.

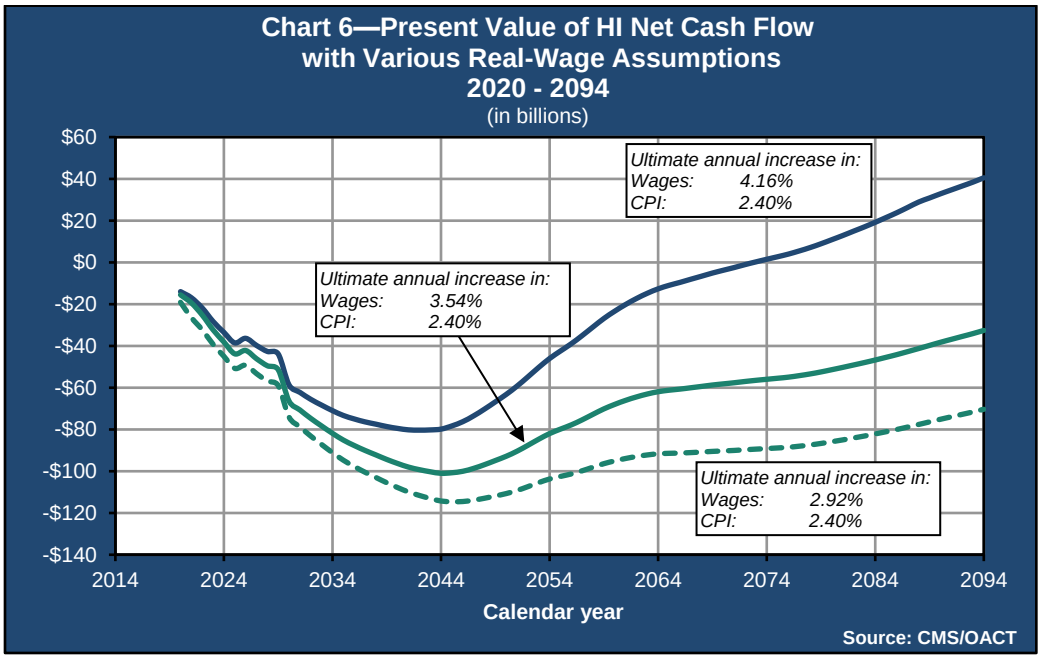
Table 2—Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages - CPI	2.92 – 2.40	3.54 – 2.40	4.16 – 2.40
Ultimate percentage increase in real-wage differential	0.52	1.14	1.76
Income minus expenditures (in billions)	−$6,493	−$4,800	−$1,952

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,297 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,365 billion.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real-wage differential assumptions presented in Table 2.

[25] The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.



Faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars, as demonstrated in Chart 6. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

Consumer Price Index

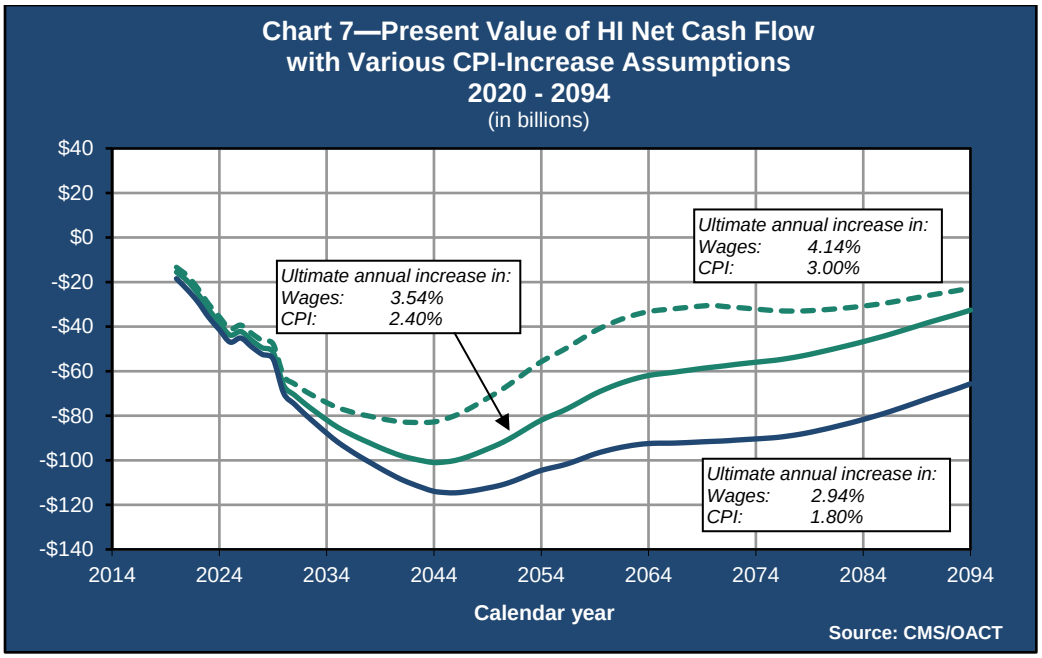
Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the assumed ultimate real-wage differential is 1.14 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.14, 3.54, and 2.94 percent, respectively.

Table 3—Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	4.14 – 3.00	3.54 – 2.40	2.94 – 1.80
Income minus expenditures (in billions)	−$3,507	−$4,800	−$6,426

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,293 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,625 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in Table 3.



This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

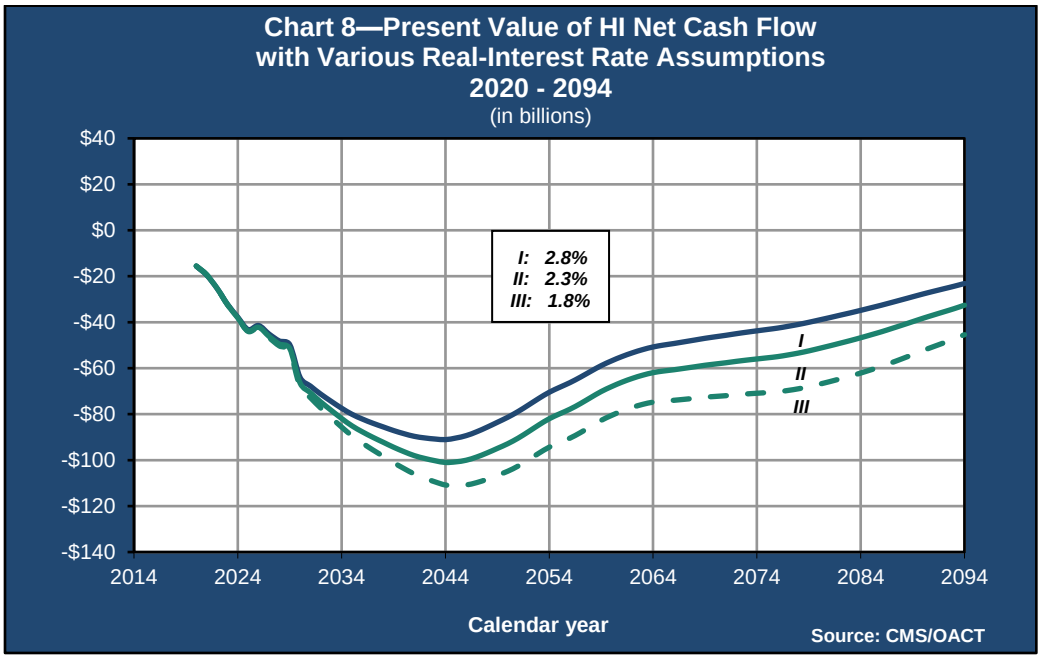
Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 4.2, 4.7, and 5.2 percent, respectively.

Table 4—Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	-$5,566	-$4,800	-$4,130

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $145 billion.

Chart 8, on the following page, illustrates projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in Table 4.



The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in Chart 8. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.75, 1.95, and 2.15 children per woman.

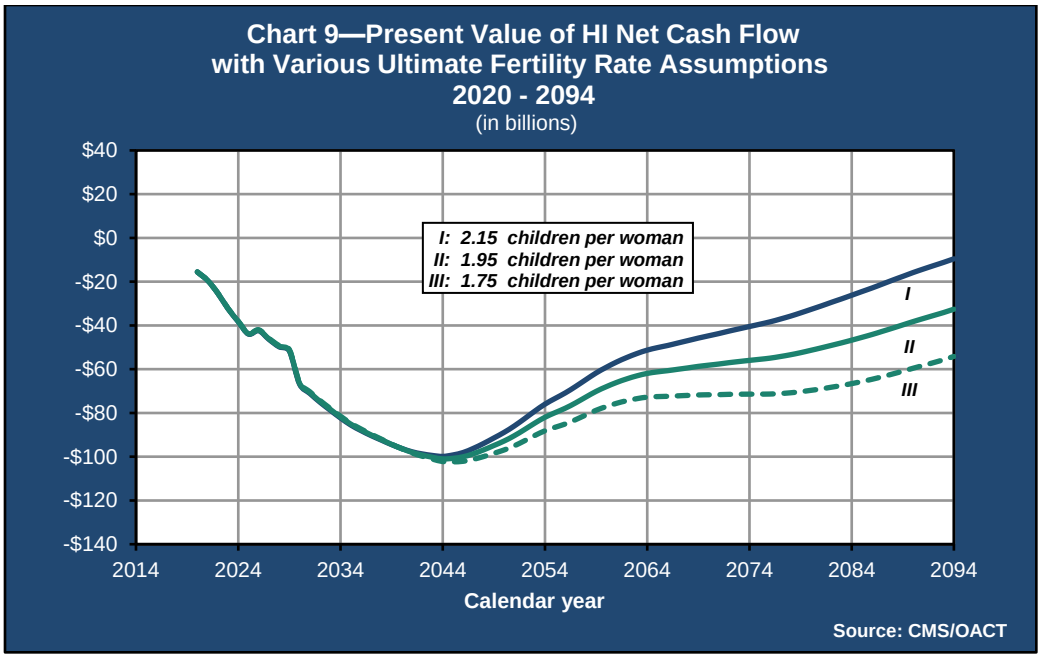
Table 5—Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.75	1.95	2.15
Income minus expenditures (in billions)	−$5,449	−$4,800	−$4,142

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $655 billion.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.



The fertility rate assumption has a substantial impact on projected HI cash flows, as Chart 9 indicates. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Net Immigration

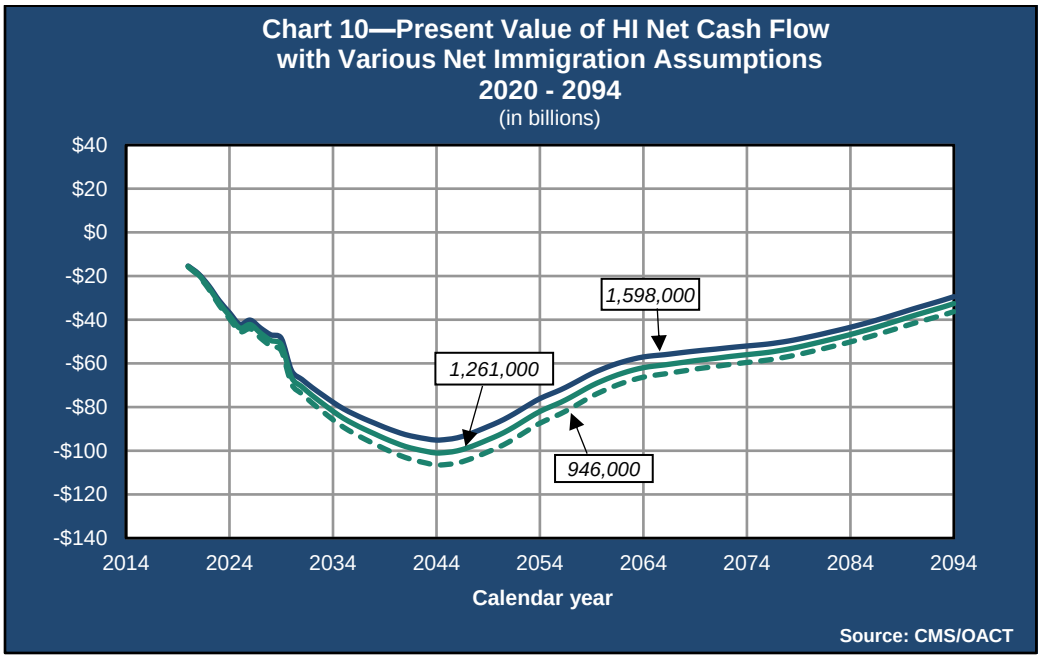
Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 946,000 persons, 1,261,000 persons, and 1,598,000 persons per year.

Table 6—Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	946,000	1,261,000	1,598,000
Income minus expenditures (in billions)	−$5,093	−$4,800	−$4,490

As indicated in Table 6, if the average annual net immigration assumption is 946,000 persons, the deficit—expressed in present-value dollars—increases by $292 billion. Conversely, if the assumption is 1,598,000 persons, the deficit decreases by $310 billion.

Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in Table 6.



Higher net immigration results in smaller HI cash flow deficits, as demonstrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is similar to the projections in last year's annual report. The estimated depletion date for the HI trust fund is 2026, the same as in the 2019 report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI income is projected to be lower than last year's estimates due to lower payroll taxes. HI expenditures are projected to be lower than last year's estimates because of lower-than-projected 2019 spending, lower projected provider payment updates, and incorporation of time-to-death into the demographic factors used in the projection model. Partially offsetting this decrease in expenditures is higher projected spending growth for Medicare Advantage beneficiaries.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018 and 2019, expenditures again exceeded income, with trust fund deficits of $1.6 billion and $5.8 billion, respectively. The Trustees project deficits in all future years until the trust fund becomes depleted in 2026. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in

the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general revenue transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[26] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2020-2026). For the 2020 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2021, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2022 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 and 2019 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2020 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges."

[26] Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

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SECTION 3

OTHER INFORMATION

IN THIS SECTION

- Other Financial Information
- Real Property
- Summary of Financial Statement Audit and Management Assurances
- Civil Monetary Penalty Adjustment for Inflation
- Grants Closeout Reporting
- Payment Integrity Report
- FY 2020 Top Management and Performance Challenges Identified by the Office of Inspector General
- Department's Response to the Office of Inspector General

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Other Financial Information

Consolidating Balance Sheet by Budget Function

As of September 30, 2020

(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)	$ 17,346	$ 361,299	$ 107,525	$ 27,872	$ 514,042	$ -	$ 514,042
Investments, Net (Note 4)	-	4,081	222,134	-	226,215	-	226,215
Accounts Receivable, Net (Note 5)	182	8,849	75,070	-	84,101	(83,386)	715
Advances (Note 8)	91	2,665	-	95	2,851	(858)	1,993
Total Intragovernmental Assets	**17,619**	**376,894**	**404,729**	**27,967**	**827,209**	**(84,244)**	**742,965**
Accounts Receivable, Net (Note 5)	-	9,324	12,300	88	21,712	-	21,712
Inventory and Related Property, Net (Note 6)	-	13,430	-	-	13,430	-	13,430
General Property, Plant and Equipment, Net (Note 7)	-	6,731	173	-	6,904	-	6,904
Advances (Note 8)	345	725	103,640	1,372	106,082	-	106,082
Other Assets	-	532	-	1	533	-	533
Total Assets	**$ 17,964**	**$ 407,636**	**$ 520,842**	**$ 29,428**	**$ 975,870**	**$ (84,244)**	**$ 891,626**
Stewardship Land (Note 19)							
Liabilities (Note 9)							
Intragovernmental Liabilities							
Accounts Payable	$ 23	$ 1,400	$ 84,008	$ 2	$ 85,433	$ (83,044)	$ 2,389
Other Liabilities (Note 13)	27	3,597	1,155	74	4,853	(1,200)	3,653
Total Intragovernmental Liabilities	**50**	**4,997**	**85,163**	**76**	**90,286**	**(84,244)**	**6,042**
Accounts Payable	23	2,411	144	5	2,583	-	2,583
Entitlement Benefits Due and Payable (Note 10)	-	46,783	70,152	-	116,935	-	116,935
Accrued Liabilities (Note 12)	1,247	12,127	-	2,424	15,798	-	15,798
Federal Employee and Veterans Benefits (Note 11)	3	15,316	-	-	15,319	-	15,319
Contingencies and Commitments (Note 14)	-	11,255	12	-	11,267	-	11,267
Other Liabilities (Note 13)	24	3,351	520	25	3,920	-	3,920
Total Liabilities	**1,347**	**96,240**	**155,991**	**2,530**	**256,108**	**(84,244)**	**171,864**
Net Position							
Unexpended Appropriations - Funds from Dedicated Collections (Note 18)	-	254	97,863	-	98,117	-	98,117
Unexpended Appropriations – All Other Funds	16,526	289,744	-	26,870	333,140	-	333,140
Cumulative Results of Operations - Funds from Dedicated Collections (Note 18)	-	18,704	266,988	-	285,692	-	285,692
Cumulative Results of Operations – All Other Funds	91	2,694	-	28	2,813	-	2,813
Total Net Position - Funds from Dedicated Collections	**-**	**18,958**	**364,851**	**-**	**383,809**	**-**	**383,809**
Total Net Position – All Other Funds	**16,617**	**292,438**	**-**	**26,898**	**335,953**	**-**	**335,953**
Total Net Position	**16,617**	**311,396**	**364,851**	**26,898**	**719,762**	**-**	**719,762**
Total Liabilities and Net Position	**$ 17,964**	**$ 407,636**	**$ 520,842**	**$ 29,428**	**$ 975,870**	**$ (84,244)**	**$ 891,626**

Consolidating Statement of Net Cost by Budget Function

For the Year Ended September 30, 2020
(in Millions)

Responsibility Segments	Education, Training, & Social Services	Health	Medicare	Income Security	Agency Combined Totals	Intra HHS Eliminations		Consolidated Totals
						Cost (-)	Revenue	
ACF	$ 14,591	$ -	$ -	$ 46,512	$ 61,103	$ (146)	$ 176	$ 61,133
ACL	2,453	-	-	-	2,453	(11)	2	2,444
AHRQ	-	333	-	-	333	(25)	18	326
CDC	-	12,005	-	-	12,005	(331)	112	11,786
CMS	-	494,471	662,483	-	1,156,954	(341)	17	1,156,630
FDA	-	3,350	-	-	3,350	(300)	16	3,066
HRSA	-	12,386	-	-	12,386	(248)	11	12,149
IHS	-	6,673	-	-	6,673	(187)	224	6,710
NIH	-	36,407	-	-	36,407	(249)	331	36,489
OS	-	110,000	-	-	110,000	(661)	501	109,840
PSC	-	1,122	-	-	1,122	(46)	779	1,855
SAMHSA	-	5,259	-	-	5,259	(66)	116	5,309
Totals	**$ 17,044**	**$ 682,006**	**$ 662,483**	**$ 46,512**	**$ 1,408,045**	**$ (2,611)**	**$ 2,303**	**$ 1,407,737**

Gross Cost and Exchange Revenue

For the Year Ended September 30, 2020
(in Millions)

Responsibility Segments	Intragovernmental						With the Public		Consolidated Net Cost of Operations
	Gross Cost			Less: Exchange Revenue			Gross Cost	Less: Exchange Revenue	
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated			
ACF	$ 293	$ (146)	$ 147	$ (185)	$ 176	$ (9)	$ 61,012	$ (17)	$ 61,133
ACL	23	(11)	12	(2)	2	-	2,432	-	2,444
AHRQ	50	(25)	25	(19)	18	(1)	309	(7)	326
CDC	1,054	(331)	723	(241)	112	(129)	11,257	(65)	11,786
CMS	13,321	(341)	12,980	(24)	17	(7)	1,268,938	(125,281)	1,156,630
FDA	1,494	(300)	1,194	(24)	16	(8)	4,493	(2,613)	3,066
HRSA	368	(248)	120	(11)	11	-	12,121	(92)	12,149
IHS	779	(187)	592	(261)	224	(37)	7,837	(1,682)	6,710
NIH	1,584	(249)	1,335	(535)	331	(204)	35,484	(126)	36,489
OS	3,079	(661)	2,418	(672)	501	(171)	107,625	(32)	109,840
PSC	324	(46)	278	(1,212)	779	(433)	2,011	(1)	1,855
SAMHSA	103	(66)	37	(148)	116	(32)	5,302	2	5,309
Totals	**$ 22,472**	**$ (2,611)**	**$ 19,861**	**$ (3,334)**	**$ 2,303**	**$ (1,031)**	**$ 1,518,821**	**$ (129,914)**	**$ 1,407,737**

Real Property

Office of Management and Budget (OMB) Memorandum 12-12, *Promoting Efficient Spending to Support Agency Operations*, and OMB Management Procedures Memorandum 2015-01, *Implementation of OMB Memorandum M-12-12 Section 3: Reduce the Footprint*, requires *Chief Financial Officer Act of 1990* (CFO Act) agencies to set annual targets for reducing the total square footage of their domestic office and warehouse space compared to the FY 2015 baseline. With the issuance of OMB Memorandum M-20-03, *Implementation of Agency-wide Real Property Capital Planning*, the CFO Act agencies are no longer required to submit annual plans; however, they are still required to set annual reduction targets. The HHS results for the Reduce the Footprint initiative can be found on Performance.gov.

HHS's real property portfolio is divided into four major categories: HHS owned, HHS directly leased, GSA owned, and GSA leased property. HHS owned assets are primarily held by the Department's four land-holding Operating Divisions (OpDiv): Food and Drug Administration (FDA), Indian Health Service (IHS), National Institutes of Health (NIH), and Centers for Disease Control and Prevention (CDC).

Summary of Financial Statement Audit and Management Assurances

As described in the "Management's Discussion and Analysis" section, management annually presents an assurance statement on the effectiveness of internal control. The following two tables present summary information related to any material weakness identified during the audit, as well as conformance with the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) and compliance with the *Federal Financial Management Improvement Act of 1996* (FFMIA).

Table 1: Summary of Financial Statement Audit

Audit Opinion			Unmodified for Five Financial Statements Disclaimed Opinion on Statement of Social Insurance and Statement of Changes in Social Insurance Amounts		
Restatement			**No**		
Material Weaknesses	**Beginning Balance**	**New**	**Resolved**	**Consolidated**	**Ending Balance**
No Material Weaknesses Noted	0	-	-	-	0
Total Material Weaknesses	***0***	***-***	***-***	***-***	***0***

Definition of Terms – Tables 1 And 2

(Reference: OMB Circular A-136, *Financial Reporting Requirements*, August 27, 2020, pages 108 – 109)

Beginning Balance: The beginning balance must agree with the ending balance from the prior year.

New: The total number of material weaknesses/non-conformances identified during the current year.

Resolved: The total number of material weaknesses/non-conformances that dropped below the level of materiality in the current year.

Consolidated: The combining of two or more findings.

Reassessed: The removal of any finding not attributable to corrective actions (e.g., management has re-evaluated and determined a finding does not meet the criteria for materiality or is redefined as more correctly classified under another heading).

Ending Balance: The year-end balance that will be the beginning balance next year.

Table 2: Summary of Management Assurances

Effectiveness of Internal Control over Reporting (FMFIA Section 2)

Statement of Assurance	Unmodified					
Material Weaknesses	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Material Weaknesses Noted	0	-	-	-	-	0
Total Material Weaknesses	***0***	***-***	***-***	***-***	***-***	***0***

Effectiveness of Internal Control over Operations and Compliance with Laws and Regulations (FMFIA Section 2)

Statement of Assurance	Modified					
Material Weaknesses/ Noncompliances	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
Error Rate Measurement	2	-	-	-	2	2
Medicare Appeals Process	1	-	-	-	1	1
Contracting	1	-	1	-	-	0
Total Material Weaknesses/ Noncompliances	***4***	***-***	***1***	***-***	***3***	***3***

Conformance with Federal Financial Management System Requirements (FMFIA Section 4)

Statement of Assurance	Federal Systems conform to financial management system requirements					
Noncompliance	Beginning Balance	New	Resolved	Consolidated	Reassessed	Ending Balance
No Noncompliance Noted	0	-	-	-	-	0
Total Noncompliance	***0***	***-***	***-***	***-***	***-***	***0***

Compliance with Section 803(a) of the FFMIA

	Agency	Auditor
1. Federal Financial Management System Requirements	No lack of compliance noted	No lack of compliance noted
2. Applicable Federal Accounting Standards	No lack of compliance noted	No lack of compliance noted
3. U.S. Standard General Ledger at Transaction Level	No lack of compliance noted	No lack of compliance noted

Civil Monetary Penalty Adjustment for Inflation

The *Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015* (the 2015 Act), as amended, requires agencies to make regular and consistent inflationary adjustments of civil monetary penalties to maintain their deterrent effect. To improve compliance with the 2015 Act, agencies are required to publish annual inflation adjustments in the Federal Register and should report annually in their agency financial report.

The 2015 Act applies to eight OpDivs and Staff Divisions (StaffDivs): Administration for Children and Families; Agency for Healthcare Research and Quality; Health Resources and Service Administration; FDA; Centers for Medicare & Medicaid Services; Office for Civil Rights; Office of the General Counsel; and Office of Inspector General. The tables below illustrate HHS's Civil Monetary Penalties by OpDivs and StaffDivs. Refer to the Federal Register for the Annual Civil Monetary Penalties Inflation Adjustment.

Administration for Children and Families

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for Misuse of Information in the National Directory of New Hires.	42 U.S.C. 653(l)(2)	2019	2020	$ 1,569

Agency for Healthcare Research and Quality

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for an establishment or person supplying information obtained in the course of activities for any purpose other than the purpose for which it was supplied.	42 U.S.C. 299c—(3)(d)	2019	2020	$ 15,299

Health Resources and Services Administration

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each instance of overcharging a 340B covered entity.	42 U.S.C. 256b(d)(1)(B)(vi)	2019	2020	$ 5,883

Office for Civil Rights

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violation of confidentiality provision of the *Patient Safety and Quality Improvement Act*.	42 U.S.C. 299b-22(f)(1)	2019	2020	$ 12,919
Penalty for each pre-February 18, 2009, violation of the *Health Insurance Portability and Accountability Act* (HIPAA) administrative simplification provisions.	42 U.S.C. 299b-22(f)(1)	2019	2020	162
Calendar Year Cap	42 U.S.C. 299b-22(f)(1)	2019	2020	40,640
Penalty for each February 18, 2009, or later violation of a HIPAA administrative simplification provision in which it is established that the covered entity or business associate did not know and by exercising reasonable diligence, would not have known that the covered entity or business associate violated such a provision:	42 U.S.C. 1320(d)-5(a)			
Minimum	42 U.S.C. 1320(d)-5(a)	2019	2020	119

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Minimum	42 U.S.C. 1320(d)-5(a)	2019	2020	119
Maximum	42 U.S.C. 1320(d)-5(a)	2019	2020	59,522
Calendar Year Cap	42 U.S.C. 1320(d)-5(a)	2019	2020	1,785,651

Office of the General Counsel

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for the first time an individual makes an expenditure prohibited by regulations regarding lobbying disclosure, absent aggravating circumstances.	31 U.S.C. 1352	2019	2020	$ 20,489
Penalty for second and subsequent offenses by individuals who make an expenditure prohibited by regulations regarding lobbying disclosure:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2019	2020	20,489
Maximum	31 U.S.C. 1352	2019	2020	204,892
Penalty for the first time an individual fails to file or amend a lobbying disclosure form, absent aggravating circumstances.	31 U.S.C. 1352	2019	2020	20,489
Penalty for second and subsequent offenses by individuals who fail to file or amend a lobbying disclosure form, absent aggravating circumstances:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2019	2020	20,489
Maximum	31 U.S.C. 1352	2019	2020	204,892
Penalty for failure to provide certification regarding lobbying in the award documents for all sub-awards of all tiers:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2019	2020	20,489
Maximum	31 U.S.C. 1352	2019	2020	204,892
Penalty for failure to provide statement regarding lobbying for loan guarantee and loan insurance transactions:	31 U.S.C. 1352			
Minimum	31 U.S.C. 1352	2019	2020	20,489
Maximum	31 U.S.C. 1352	2019	2020	204,892
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department.	31 U.S.C. 3801-3812	2019	2020	10,706
Penalty against any individual who - with knowledge or reason to know - makes, presents or submits a false, fictitious or fraudulent claim to the Department.	31 U.S.C. 3801-3812	2019	2020	10,706

Office of Inspector General

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for each individual who violates safety and security procedures related to handling dangerous biological agents and toxins.	42 U.S.C. 262a(i)(1)	2019	2020	$ 354,859
Penalty for any other person who violates safety and security procedures related to handling dangerous biological agents and toxins.	42 U.S.C. 262a(i)(1)	2019	2020	709,720

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty per violation for committing information blocking.	42 U.S.C. 300jj-51	2019	2020	1,082,016
Penalty for knowingly presenting or causing to be presented to an officer, employee, or agent of the United States a false claim.	42 U.S.C. 1320a-7a(a)	2019	2020	20,866
Penalty for knowingly presenting or causing to be presented a request for payment which violates the terms of an assignment, agreement, or PPS agreement.	42 U.S.C. 1320a-7a(a)	2019	2020	20,866
Penalty for knowingly giving or causing to be presented to a participating provider or supplier false or misleading information that could reasonably be expected to influence a discharge decision.	42 U.S.C. 1320a-7a(a)	2019	2020	31,300
Penalty for an excluded party retaining ownership or control interest in a participating entity.	42 U.S.C. 1320a-7a(a)	2019	2020	20,866
Penalty for remuneration offered to induce program beneficiaries to use particular providers, practitioners, or suppliers.	42 U.S.C. 1320a-7a(a)	2019	2020	20,886
Penalty for employing or contracting with an excluded individual.	42 U.S.C. 1320a-7a(a)	2019	2020	20,866
Penalty for knowing and willful solicitation, receipt, offer, or payment of remuneration for referring an individual for a service or for purchasing, leasing, or ordering an item to be paid for by a Federal health care program.	42 U.S.C. 1320a-7a(a)	2019	2020	104,330
Penalty for ordering or prescribing medical or other item or service during a period in which the person was excluded.	42 U.S.C. 1320a-7a(a)	2019	2020	20,866
Penalty for knowingly making or causing to be made a false statement, omission or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider or supplier.	42 U.S.C. 1320a-7a(a)	2019	2020	104,330
Penalty for knowing of an overpayment and failing to report and return.	42 U.S.C. 1320a-7a(a)	2019	2020	20,866
Penalty for making or using a false record or statement that is material to a false or fraudulent claim	42 U.S.C. 1320a-7a(a)	2019	2020	58,832
Penalty for failure to grant timely access to HHS OIG for audits, investigations, evaluations, and other statutory functions of HHS OIG.	42 U.S.C. 1320a-7a(a)	2019	2020	31,300
Penalty for payments by a hospital or critical access hospital to induce a physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.	42 U.S.C. 1320a-7a(b)	2019	2020	5,216
Penalty for physicians who knowingly receive payments from a hospital or critical access hospital to induce such physician to reduce or limit services to individuals under direct care of physician or who are entitled to certain medical assistance benefits.	42 U.S.C. 1320a-7a(b)	2019	2020	5,216
Penalty for a physician who executes a document that falsely certifies home health needs for Medicare beneficiaries.	42 U.S.C. 1320a-7a(b)	2019	2020	10,433
Penalty for knowingly presenting or causing to be presented a false or fraudulent specified claim under a grant, contract, or other agreement for which the Secretary provides funding.	42 U.S.C. 1320a-7a(o)	2016	2020	10,176
Penalty for knowingly making, using, or causing to be made or used any false statement, omission, or misrepresentation of a material fact in any application, proposal, bid, progress report, or other document required to directly or indirectly receive or retain funds provided pursuant to grant, contract, or other agreement.	42 U.S.C. 1320a-7a(o)	2016	2020	50,882
Penalty for knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent specified claim under grant, contract, or other agreement.	42 U.S.C. 1320a-7a(o)	2016	2020	50,882

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit funds or property with respect to grant, contract, or other agreement, or knowingly conceals or improperly avoids or decreases any such obligation.	42 U.S.C. 1320a-7a(o)	2016	2020	53,231 for each false record statement, 10,646 per day
Penalty for failure to grant timely access, upon reasonable request, to the I.G. for purposes of audits, investigations, evaluations, or other statutory functions of I.G. in matters involving grants, contracts, or other agreements.	42 U.S.C. 1320a-7a(o)	2016	2020	15,265
Penalty for failure to report any final adverse action taken against a health care provider, supplier, or practitioner.	42 U.S.C. 1320a-7e(b)(6)(A)	2019	2020	39,811
Penalty for the misuse of words, symbols, or emblems in communications in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(1)	2019	2020	10,705
Penalty for the misuse of words, symbols, or emblems in a broadcast or telecast in a manner in which a person could falsely construe that such item is approved, endorsed, or authorized by HHS.	42 U.S.C. 1320b-10(b)(2)	2019	2020	53,524
Penalty for certification of a false statement in assessment of functional capacity of a Skilled Nursing Facility resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(1)	2019	2020	2,233
Penalty for causing another to certify or make a false statement in assessment of functional capacity of a Skilled Nursing Facility resident assessment.	42 U.S.C. 1395i-3(b)(3)(B)(ii)(2)	2019	2020	11,160
Penalty for any individual who notifies or causes to be notified a Skilled Nursing Facility of the time or date on which a survey is to be conducted.	42 U.S.C. 1395i-3(g)(2)(A)	2019	2020	4,465
Penalty for a Medicare Advantage organization that substantially fails to provide medically necessary, required items and services.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	40,640
Penalty for a Medicare Advantage organization that charges excessive premiums.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a Medicare Advantage organization that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a Medicare Advantage organization that engages in practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	159,248
Penalty per individual who does not enroll as a result of a Medicare Advantage organization's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	23,887
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to Secretary.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	159,248
Penalty for a Medicare Advantage organization misrepresenting or falsifying information to individual or other entity.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for Medicare Advantage organization interfering with provider's advice to enrollee and non-MCO affiliated providers that balance bill enrollees.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a Medicare Advantage organization that employs or contracts with excluded individual or entity.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a Medicare Advantage organization enrolling an individual in without prior written consent.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a Medicare Advantage organization transferring an enrollee to another plan without consent or solely for the purpose of earning a commission.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a Medicare Advantage organization failing to comply with marketing restrictions or applicable implementing regulations or guidance.	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a Medicare Advantage organization employing or contracting with an individual or entity who violates 1395w-27(g)(1)(A)-(J).	42 U.S.C. 1395w-27(g)(2)(A)	2019	2020	39,811
Penalty for a prescription drug card sponsor that falsifies or misrepresents marketing materials, overcharges program enrollees, or misuse transitional assistance funds.	42 U.S.C. 1395w-141(i)(3)	2019	2020	13,910
Penalty for improper billing by Hospitals, Critical Access Hospitals, or Skilled Nursing Facilities.	42 U.S.C. 1395cc(g)	2019	2020	5,411
Penalty for a hospital or responsible physician dumping patients needing emergency medical care, if the hospital has 100 beds or more.	42 U.S.C. 1395dd(d)(1)	2019	2020	111,597
Penalty for a hospital or responsible physician dumping patients needing emergency care, if the hospital has less than 100 beds.	42 U.S.C. 1395dd(d)(1)	2019	2020	55,800
Penalty for a HMO or competitive plan is such plan substantially fails to provide medically necessary, required items or services	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	55,800
Penalty for HMOs/competitive medical plans that charge premiums in excess of permitted amounts	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	55,800
Penalty for a HMO or competitive medical plan that expels or refuses to reenroll an individual per prescribed conditions	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	55,800
Penalty for a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in future.	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	223,196
Penalty per individual not enrolled in a plan as a result of a HMO or competitive medical plan that implements practices to discourage enrollment of individuals needing services in the future.	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	32,115
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to the Secretary.	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	223,196
Penalty for a HMO or competitive medical plan that misrepresents or falsifies information to an individual or any other entity.	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	55,800
Penalty for failure by HMO or competitive medical plan to assure prompt payment of Medicare risk sharing contracts or incentive plan provisions.	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	55,800
Penalty for HMO that employs or contracts with excluded individual or entity.	42 U.S.C. 1395mm(i)(6)(B)(i)	2019	2020	51,222
Penalty for submitting or causing to be submitted claims in violation of the Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(3)	2019	2020	25,820
Penalty for circumventing Stark Law's restrictions on physician self-referrals.	42 U.S.C. 1395nn(g)(4)	2019	2020	172,137
Penalty for a material misrepresentation regarding Medigap compliance policies.	42 U.S.C. 1395ss(d)(1)	2019	2020	10,705
Penalty for selling Medigap policy under false pretense.	42 U.S.C. 1395ss(d)(2)	2019	2020	10,705
Penalty for an issuer that sells health insurance policy that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2019	2020	48,192
Penalty for someone other than issuer that sells health insurance that duplicates benefits.	42 U.S.C. 1395ss(d)(3)(A)(ii)	2019	2020	28,914
Penalty for using mail to sell a non-approved Medigap insurance policy.	42 U.S.C. 1395ss(d)(4)(A)	2019	2020	10,705
Penalty for a Medicaid MCO that substantially fails to provide medically necessary, required items or services.	42 U.S.C. 1396b(m)(5)(B)(i)	2019	2020	53,524
Penalty for a Medicaid MCO that charges excessive premiums.	42 U.S.C. 1395mm(i)(5)(B)(i)	2019	2020	53,524
Penalty for a Medicaid MCO that improperly expels or refuses to reenroll a beneficiary.	42 U.S.C. 1395mm(i)(5)(B)(i)	2019	2020	214,097

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty per individual who does not enroll as a result of a Medicaid MCO's practice that would reasonably be expected to have the effect of denying or discouraging enrollment.	42 U.S.C. 1396b(m)(5)(B)(i)	2019	2020	32,115
Penalty for a Medicaid MCO misrepresenting or falsifying information to the Secretary.	42 U.S.C. 1396b(m)(5)(B)(i)	2019	2020	214,097
Penalty for a Medicaid MCO misrepresenting or falsifying information to an individual or another entity.	42 U.S.C. 1396b(m)(5)(B)(i)	2019	2020	53,524
Penalty for a Medicaid MCO that fails to comply with contract requirements with respect to physician incentive plans.	42 U.S.C. 1396b(m)(5)(B)(i)	2019	2020	48,192
Penalty for willfully and knowingly certifying a material and false statement in a Skilled Nursing Facility resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(I)	2019	2020	2,233
Penalty for willfully and knowingly causing another individual to certify a material and false statement in a Skilled Nursing Facility resident assessment.	42 U.S.C. 1396r(b)(3)(B)(ii)(II)	2019	2020	11,160
Penalty for notifying or causing to be notified a Skilled Nursing Facility of the time or date on which a survey is to be conducted.	42 U.S.C. 1396r(g)(2)(A)(i)	2019	2020	4,465
Penalty for the knowing provision of false information or refusing to provide information about charges or prices of a covered outpatient drug.	42 U.S.C. 1396r-8(b)(3)(B)	2019	2020	192,768
Penalty per day for failure to timely provide information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(i)	2019	2020	19,277
Penalty for knowing provision of false information by drug manufacturer with rebate agreement.	42 U.S.C. 1396r-8(b)(3)(C)(ii)	2019	2020	192,768
Penalty for notifying home and community-based providers or settings of survey.	42 U.S.C. 1396t(i)(3)(A)	2019	2020	3,855
Penalty for failing to report a medical malpractice claim to National Practitioner Data Bank.	42 U.S.C. 11131(c)	2019	2020	23,331
Penalty for breaching confidentiality of information reported to National Practitioner Data Bank.	42 U.S.C. 11137(b)(2)	2019	2020	23,331

Food and Drug Administration

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for violations related to drug samples resulting in a conviction of any representative of manufacturer or distributor in any 10-year period.	21 U.S.C. 333 (b)(2)(A)	2019	2020	$ 107,050
Penalty for violation related to drug samples resulting in a conviction of any representative of manufacturer or distributor after the second conviction in any 10-year period.	21 U.S.C. 333 (b)(2)(B)	2019	2020	2,184,670
Penalty for failure to make a report required by 21 U.S.C. 353(d)(3)(E) relating to drug samples.	21 U.S.C. 333 (b)(3)	2019	2020	214,097
Penalty for any person who violates a requirement related to devices for each such violation.	21 U.S.C. 333 (f)(1)(A)	2019	2020	28,914
Penalty for aggregate of all violations related to devices in a single proceeding.	21 U.S.C. 333 (f)(1)(A)	2019	2020	1,927,676
Penalty for any individual who introduces or delivers for introduction into interstate commerce food that is adulterated per 21 U.S.C. 342(a)(2)(B) or any individual who does not comply with a recall order under 21 U.S.C. 350l.	21 U.S.C. 333 (f)(2)(A)	2019	2020	81,284
Penalty in the case of any other person other than an individual) for such introduction or delivery of adulterated food.	21 U.S.C. 333 (f)(2)(A)	2019	2020	406,419
Penalty for aggregate of all such violations related to adulterated food adjudicated in a single proceeding.	21 U.S.C. 333 (f)(2)(A)	2019	2020	812,837

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for all violations adjudicated in a single proceeding for any person who violates 21 U.S.C. 331(jj) by failing to submit the certification required by 42 U.S.C. 282(j)(5)(B) or knowingly submitting a false certification; by failing to submit clinical trial information under 42 U.S.C. 282(j); or by submitting clinical trial information under 42 U.S.C. 282(j) that is false or misleading in any particular under 42 U.S.C. 282(j)(5)(D).	21 U.S.C. 333 (f)(3)(A)	2019	2020	12,316
Penalty for each day any above violation is not corrected after a 30-day period following notification until the violation is corrected.	21 U.S.C. 333 (f)(3)(B)	2019	2020	12,316
Penalty for any responsible person that violates a requirement of 21 U.S.C. 355(o) (post-marketing studies, clinical trials, labeling), 21 U.S.C. 355(p) (risk evaluation and mitigation (REMS)), or 21 U.S.C. 355–1 (REMS).	21 U.S.C. 333 (f)(4)(A)(i)	2019	2020	307,923
Penalty for aggregate of all such above violations in a single proceeding.	21 U.S.C. 333 (f)(4)(A)(i)	2019	2020	1,231,690
Penalty for REMS violation that continues after written notice to the responsible person for the first 30-day period (or any portion thereof) the responsible person continues to be in violation.	21 U.S.C. 333 (f)(4)(A)(ii)	2019	2020	307,923
Penalty for REMS violation that continues after written notice to responsible person doubles for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333 (f)(4)(A)(ii)	2019	2020	1,231,690
Penalty for aggregate of all such above violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(4)(A)(ii)	2019	2020	12,316,908
Penalty for any person who violates a requirement which relates to tobacco products for each such violation.	21 U.S.C. 333 (f)(9)(A)	2019	2020	17,857
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(A)	2019	2020	1,190,433
Penalty per violation related to violations of tobacco requirements.	21 U.S.C. 333 (f)(9)(B)(i)(I)	2019	2020	297,609
Penalty for aggregate of all such violations of tobacco product requirements adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(i)(I)	2019	2020	1,190,433
Penalty in the case of a violation of tobacco product requirements that continues after written notice to such person, for the first 30-day period (or any portion thereof) the person continues to be in violation.	21 U.S.C. 333 (f)(9)(B)(i)(II)	2019	2020	297,609
Penalty for violation of tobacco product requirements that continues after written notice to such person shall double for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333 (f)(9)(B)(i)(II)	2019	2020	1,190,433
Penalty for aggregate of all such violations related to tobacco product requirements adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(i)(II)	2019	2020	11,904,335
Penalty for any person who either does not conduct post-market surveillance and studies to determine impact of a modified risk tobacco product for which the HHS Secretary has provided them an order to sell, or who does not submit a protocol to the HHS Secretary after being notified of a requirement to conduct post-market surveillance of such tobacco products.	21 U.S.C. 333 (f)(9)(B)(ii)(I)	2019	2020	297,609
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(ii)(I)	2019	2020	1,190,433
Penalty for violation of modified risk tobacco product post-market surveillance that continues after written notice to such person for the first 30-day period (or any portion thereof) that the person continues to be in violation.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2019	2020	297,609
Penalty for post-notice violation of modified risk tobacco product post-market surveillance shall double for every 30-day period thereafter that the tobacco product requirement violation continues for any 30-day period, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2019	2020	1,190,433

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2019	2020	11,904,335
Penalty for any person who disseminates or causes another party to disseminate a direct-to-consumer advertisement that is false or misleading for the first such violation in any 3-year period.	21 U.S.C. 333 (g)(1)	2019	2020	307,923
Penalty for each subsequent above violation in any 3-year period.	21 U.S.C. 333 (g)(1)	2019	2020	615,846
Penalty for any responsible person that violates a requirement of 21 U.S.C. 355(o) (post-marketing studies, clinical trials, labeling), 21 U.S.C. 355(p) (risk evaluation and mitigation (REMS)), or 21 U.S.C. 355–1 (REMS).	21 U.S.C. 333 (f)(4)(A)(i)	2019	2020	307,923
Penalty for aggregate of all such above violations in a single proceeding.	21 U.S.C. 333 (f)(4)(A)(i)	2019	2020	1,231,690
Penalty for REMS violation that continues after written notice to the responsible person for the first 30-day period (or any portion thereof) the responsible person continues to be in violation.	21 U.S.C. 333 (f)(4)(A)(ii)	2019	2020	307,923
Penalty for REMS violation that continues after written notice to responsible person doubles for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333 (f)(4)(A)(ii)	2019	2020	1,231,690
Penalty for aggregate of all such above violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(4)(A)(ii)	2019	2020	12,316,908
Penalty for any person who violates a requirement which relates to tobacco products for each such violation.	21 U.S.C. 333 (f)(9)(A)	2019	2020	17,857
Penalty for aggregate of all such violations of tobacco product requirement adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(A)	2019	2020	1,190,433
Penalty per violation related to violations of tobacco requirements.	21 U.S.C. 333 (f)(9)(B)(i)(I)	2019	2020	297,609
Penalty for aggregate of all such violations of tobacco product requirements adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(i)(I)	2019	2020	1,190,433
Penalty in the case of a violation of tobacco product requirements that continues after written notice to such person, for the first 30-day period (or any portion thereof) the person continues to be in violation.	21 U.S.C. 333 (f)(9)(B)(i)(II)	2019	2020	297,609
Penalty for violation of tobacco product requirements that continues after written notice to such person shall double for every 30-day period thereafter the violation continues, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333 (f)(9)(B)(i)(II)	2019	2020	1,190,433
Penalty for aggregate of all such violations related to tobacco product requirements adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(i)(II)	2019	2020	11,904,335
Penalty for any person who either does not conduct post-market surveillance and studies to determine impact of a modified risk tobacco product for which the HHS Secretary has provided them an order to sell, or who does not submit a protocol to the HHS Secretary after being notified of a requirement to conduct post-market surveillance of such tobacco products.	21 U.S.C. 333 (f)(9)(B)(ii)(I)	2019	2020	297,609
Penalty for aggregate of for all such above violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(ii)(I)	2019	2020	1,190,433
Penalty for violation of modified risk tobacco product post-market surveillance that continues after written notice to such person for the first 30-day period (or any portion thereof) that the person continues to be in violation.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2019	2020	297,609
Penalty for post-notice violation of modified risk tobacco product post-market surveillance shall double for every 30-day period thereafter that the tobacco product requirement violation continues for any 30-day period, but may not exceed penalty amount for any 30-day period.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2019	2020	1,190,433
Penalty for aggregate above tobacco product requirement violations adjudicated in a single proceeding.	21 U.S.C. 333 (f)(9)(B)(ii)(II)	2019	2020	11,904,335

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for any person who disseminates or causes another party to disseminate a direct-to-consumer advertisement that is false or misleading for the first such violation in any 3-year period.	21 U.S.C. 333 (g)(1)	2019	2020	307,923
Penalty for each subsequent above violation in any 3-year period.	21 U.S.C. 333 (g)(1)	2019	2020	615,846
Penalty to be applied for violations of 21 U.S.C. 387f(d)(5) or of violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR part 1140) with respect to a retailer with an approved training program in the case of a second regulation violation within a 12-month period.	21 U.S.C. 333 note	2019	2020	297
Penalty in the case of a third violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2019	2020	594
Penalty in the case of a fourth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2019	2020	2,381
Penalty in the case of a fifth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 36-month period.	21 U.S.C. 333 note	2019	2020	5,952
Penalty in the case of a sixth or subsequent violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 48-month period as determined on a case-by-case basis.	21 U.S.C. 333 note	2019	2020	11,904
Penalty to be applied for violations of 21 U.S.C. 387f(d)(5) or of violations of restrictions on the sale or distribution of tobacco products promulgated under 21 U.S.C. 387f(d) (e.g., violations of regulations in 21 CFR part 1140) with respect to a retailer that does not have an approved training program in the case of the first regulation violation.	21 U.S.C. 333 note	2019	2020	297
Penalty in the case of a second violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 12-month period.	21 U.S.C. 333 note	2019	2020	594
Penalty in the case of a third violation of 21 U.S.C. 387f(d)(5) tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2019	2020	1,191
Penalty in the case of a fourth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 24-month period.	21 U.S.C. 333 note	2019	2020	2,381
Penalty in the case of a fifth violation of 21 U.S.C. 387f(d)(5) or of the tobacco product regulations within a 36-month period.	21 U.S.C. 333 note	2019	2020	5,952
Penalty in the case of a sixth or subsequent violation of 21 U.S.C. 387f(d)(5) tobacco product regulations within a 48-month period as determined on a case-by-case basis.	21 U.S.C. 333 note	2019	2020	11,904
Penalty for each violation for any individual who made a false statement or misrepresentation of a material fact, bribed, destroyed, altered, removed, or secreted, or procured the destruction, alteration, removal, or secretion of, any material document, failed to disclose a material fact, obstructed an investigation, employed a consultant who was debarred, debarred individual provided consultant services.	21 U.S.C. 335b(a)	2019	2020	453,711
Penalty in the case of any other person (other than an individual) per above violation.	21 U.S.C. 335b(a)	2019	2020	1,814,843
Penalty for any person who violates any such requirements for electronic products, with each unlawful act or omission constituting a separate violation.	21 U.S.C. 360pp(b)(1)	2019	2020	2,976
Penalty imposed for any related series of violations of requirements relating to electronic products.	21 U.S.C. 360pp(b)(1)	2019	2020	1,014,390
Penalty per day for violation of order of recall of biological product presenting imminent or substantial hazard.	42 U.S.C. 262(d)	2019	2020	233,313
Penalty for failure to obtain a mammography certificate as required.	42 U.S.C. 263b(h)(3)	2019	2020	18,149
Penalty per occurrence for any vaccine manufacturer that intentionally destroys, alters, falsifies, or conceals any record or report required.	42 U.S.C. 300aa-28(b)(1)	2019	2020	233,313

Centers for Medicare & Medicaid Services

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a clinical laboratory's failure to meet participation and certification requirements and poses immediate jeopardy:	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)			
Minimum	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)	2019	2020	6,530
Maximum	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)	2019	2020	21,410
Penalty for a clinical laboratory's failure to meet participation and certification requirements and the failure does not pose immediate jeopardy:	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)			
Minimum	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)	2019	2020	108
Maximum	42 U.S.C. 263a(h)(2)(B) & 42 U.S.C. 1395w-2(b)(2)(A)(ii)	2019	2020	6,422
Failure to provide the Summary of Benefits and Coverage.	42 U.S.C. 300gg-15(f)	2019	2020	1,176
Penalty for violations of regulations related to the medical loss ratio reporting and rebating.	42 U.S.C. 300gg-18	2019	2020	118
Penalty for manufacturer or group purchasing organization failing to report information required under 42 U.S.C. 1320a-7h(a), relating to physician ownership or investment interests:	42 U.S.C. 1320a-7h(b)(1)			
Minimum	42 U.S.C. 1320a-7h(b)(1)	2019	2020	1,176
Maximum	42 U.S.C. 1320a-7h(b)(1)	2019	2020	11,766
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(1)	2019	2020	176,495
Penalty for manufacturer or group purchasing organization knowingly failing to report information required under 42 U.S.C. 1320a-7h(a), relating to physician ownership or investment interests:	42 U.S.C. 1320a-7h(b)(2)			
Minimum	42 U.S.C. 1320a-7h(b)(2)	2019	2020	11,766
Maximum	42 U.S.C. 1320a-7h(b)(2)	2019	2020	117,644
Calendar Year Cap	42 U.S.C. 1320a-7h(b)(2)	2019	2020	1,176,638
Penalty for an administrator of a facility that fails to comply with notice requirements for the closure of a facility.	42 U.S.C. 1320a-7h(b)(2)	2019	2020	117,644
Minimum penalty for the first offense of an administrator who fails to provide notice of facility closure.	42 U.S.C. 1320a-7j(h)(3)(A)	2019	2020	588
Minimum penalty for the second offense of an administrator who fails to provide notice of facility closure.	42 U.S.C. 1320a-7j(h)(3)(A)	2019	2020	1,766
Minimum penalty for the third and subsequent offenses of an administrator who fails to provide notice of facility closure.	42 U.S.C. 1320a-7j(h)(3)(A)	2019	2020	3,529

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for an entity knowingly making a false statement or representation of material fact in the determination of the amount of benefits or payments related to old-age, survivors, and disability insurance benefits, special benefits for certain World War II veterans, or supplemental security income for the aged, blind, and disabled.	42 U.S.C. 1320a-8(a)(1)	2019	2020	8,606
Penalty for the violation of 42 U.S.C. 1320a-8a(1) if the violator is a person who receives a fee or other income for services performed in connection with determination of the benefit amount or the person is a physician or other health care provider who submits evidence in connection with such a determination.	42 U.S.C. 1320a-8(a)(1)	2019	2020	8,116
Penalty for a representative payee (under 42 U.S.C. 405(j), 1007, or 1383(a)(2)) converting any part of a received payment from the benefit programs described in the previous civil monetary penalty to a use other than for the benefit of the beneficiary.	42 U.S.C. 1320a-8(a)(3)	2019	2020	6,740
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility.	42 U.S.C. 1320b-25(c)(1)(A)	2019	2020	235,328
Penalty for failure of covered individuals to report to the Secretary and 1 or more law enforcement officials any reasonable suspicion of a crime against a resident, or individual receiving care, from a long-term care facility if such failure exacerbates the harm to the victim of the crime or results in the harm to another individual.	42 U.S.C. 1320b-25(c)(2)(A)	2019	2020	352,991
Penalty for a long-term care facility that retaliates against any employee because of lawful acts done by the employee, or files a complaint or report with the State professional disciplinary agency against an employee or nurse for lawful acts done by the employee or nurse.	42 U.S.C. 1320b-25(d)(2)	2019	2020	235,328
Penalty for any person who knowingly and willfully fails to furnish a beneficiary with an itemized statement of items or services within 30 days of the beneficiary's request.	42 U.S.C. 1395b-7(b)(2)(B)	2019	2020	159
Penalty per day for a Skilled Nursing Facility that has a Category 2 violation of certification requirements:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	112
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	6,695
Penalty per instance of Category 2 noncompliance by a Skilled Nursing Facility:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	2,233
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320
Penalty per day for a Skilled Nursing Facility that has a Category 3 violation of certification requirements:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	6,808
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty per instance of Category 3 noncompliance by a Skilled Nursing Facility:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	2,233
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320
Penalty per day and per instance for a Skilled Nursing Facility that has Category 3 noncompliance with Immediate Jeopardy:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Per Day (Minimum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	6,808
Per Day (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320
Per Instance (Minimum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	2,233
Per Instance (Maximum)	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320
Penalty per day of a Skilled Nursing Facility that fails to meet certification requirements. These amounts represent the upper range per day:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	6,808
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320
Penalty per day of a Skilled Nursing Facility that fails to meet certification requirements. These amounts represent the lower range per day:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	112
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	6,695
Penalty per instance of a Skilled Nursing Facility that fails to meet certification requirements:	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)			
Minimum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	2,233
Maximum	42 U.S.C. 1395i-3(h)(2)(B)(ii)(I)	2019	2020	22,320
Penalty for knowingly, willfully, and repeatedly billing for a clinical diagnostic laboratory test other than on an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395l(h)(5)(D)	2019	2020	16,257
Penalty for knowingly and willfully presenting or causing to be presented a bill or request for payment for an intraocular lens inserted during or after cataract surgery for which the Medicare payment rate includes the cost of acquiring the class of lens involved.	42 U.S.C. 1395l(i)(6)	2019	2020	4,282

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for knowingly and willfully failing to provide information about a referring physician when seeking payment on an unassigned basis.	42 U.S.C. 1395l(q)(2)(B)(i)	2019	2020	4,098
Penalty for any durable medical equipment supplier that knowingly and willfully charges for a covered service that is furnished on a rental basis after the rental payments may no longer be made. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(11)(A)	2019	2020	16,257
Penalty for any nonparticipating durable medical equipment supplier that knowingly and willfully fails to make a refund to Medicare beneficiaries for a covered service for which payment is precluded due to an unsolicited telephone contact from the supplier. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(a)(18)(B)	2019	2020	16,257
Penalty for any nonparticipating physician or supplier that knowingly and willfully charges a Medicare beneficiary more than the limiting charge for radiologist services. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(b)(5)(C)	2019	2020	16,257
Penalty for any supplier of prosthetic devices, orthotics, and prosthetics that knowing and willfully charges for a covered prosthetic device, orthotic, or prosthetic that is furnished on a rental basis after the rental payment may no longer be made. (Penalties are assessed in the same manner as 42 U.S.C. 1395m(a)(11)(A), that is in the same manner as 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(h)(3)	2019	2020	16,257
Penalty for any supplier of durable medical equipment including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully distributes a certificate of medical necessity in violation of Section 1834(j)(2)(A)(i) of the Act or fails to provide the information required under Section 1834(j)(2)(A)(ii) of the Act.	42 U.S.C. 1395m(j)(2)(A)(iii)	2019	2020	1,722
Penalty for any supplier of durable medical equipment, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries for series billed other than on as assignment-related basis under certain conditions. (Penalties are assessed in the same manner as 42 U.S.C. 1395m(j)(4) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(j)(4)	2019	2020	16,257
Penalty for any person or entity who knowingly and willfully bills or collects for any outpatient therapy services or comprehensive outpatient rehabilitation services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395m(k)(6) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(k)(6)	2019	2020	16,257
Penalty for any supplier of ambulance services who knowingly and willfully fills or collects for any services on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(b)(18)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395m(l)(6)	2019	2020	16,257
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(b)(18)(B)	2019	2020	16,257
Penalty for any physician who charges more than 125% for a non-participating referral. (Penalties are assessed in the same manner as 42 U.S.C. 1320a-7a(a)).	42 U.S.C. 1395u(j)(2)(B)	2019	2020	16,257

Civil Monetary Penalty Adjustment for Inflation

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for any physician who knowingly and willfully presents or causes to be presented a claim for bill for an assistant at a cataract surgery performed on or after March 1, 1987, for which payment may not be made because of section 1862(a)(15). (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(k)	2019	2020	16,257
Penalty for any nonparticipating physician who does not accept payment on an assignment-related basis and who knowingly and willfully fails to refund on a timely basis any amounts collected for services that are not reasonable or medically necessary or are of poor quality under 1842(l)(1)(A). (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(l)(3)	2019	2020	16,257
Penalty for any nonparticipating physician charging more than $500 who does not accept payment for an elective surgical procedure on an assignment related basis and who knowingly and willfully fails to disclose the required information regarding charges and coinsurance amounts and fails to refund on a timely basis any amount collected for the procedure in excess of the charges recognized and approved by the Medicare program. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(m)(3)	2019	2020	16,257
Penalty for any physician who knowingly, willfully, and repeatedly bills one or more beneficiaries for purchased diagnostic tests any amount other than the payment amount specified by the Act. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(n)(3)	2019	2020	16,257
Penalty for any practitioner specified in Section 1842(b)(18)(C) of the Act or other person that knowingly and willfully bills or collects for any services pertaining to drugs or biologics by the practitioners on other than an assignment-related basis. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(b)(18)(B) and 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395u(o)(3)(B)	2019	2020	16,257
Penalty for any physician or practitioner who knowingly and willfully fails promptly to provide the appropriate diagnosis codes upon CMS or Medicare administrative contractor request for payment or bill not submitted on an assignment-related basis.	42 U.S.C. 1395u(p)(3)(A)	2019	2020	4,282
Penalty for a pharmaceutical manufacturer's misrepresentation of average sales price of a drug, or biologic.	42 U.S.C. 1395w-3a(d)(4)(A)	2019	2020	13,910
Penalty for any nonparticipating physician, supplier, or other person that furnishes physician services not on an assignment-related basis who either knowingly and willfully bills or collects in excess of the statutorily-defined limiting charge or fails to make a timely refund or adjustment. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(1)(B)	2019	2020	16,257
Penalty for any person that knowingly and willfully bills for statutorily defined State-plan approved physicians' services on any other basis than an assignment-related basis for a Medicare/Medicaid dual eligible beneficiary. (Penalties are assessed in the same manner as 42 U.S.C. 1395u(j)(2)(B), which is assessed according to 1320a-7a(a)).	42 U.S.C. 1395w-4(g)(3)(B)	2019	2020	16,257
Penalty for each termination determination the Secretary makes that is the result of actions by a Medicare Advantage organization or Part D sponsor that has adversely affected an individual covered under the organization's contract.	42 U.S.C. 1395w-27(g)(3)(A); 1857(g)(3)	2019	2020	39,811
Penalty for each week beginning after the initiation of civil money penalty procedures by the Secretary because a Medicare Advantage organization or Part D sponsor has failed to carry out a contract, or has carried out a contract inconsistently with regulations.	42 U.S.C. 1395w-27(g)(3)(B); 1857(g)(3)	2019	2020	15,925

Penalty	Statutory Authority	Date of Previous Adjustment	Date of Current Adjustment	Current Penalty Level ($ Amount)
Penalty for a Medicare Advantage organization's or Part D sponsor's early termination of its contract.	42 U.S.C. 1395w-27(g)(3)(D); 1857(g)(3)	2019	2020	147,899
Penalty for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits not to enroll under a group health plan or large group health plan which would be a primary plan.	42 U.S.C. 1395y(b)(3)(C)	2019	2020	9,639
Penalty for any non-governmental employer that, before October 1, 1998, willfully or repeatedly failed to provide timely and accurate information requested relating to an employee's group health insurance coverage.	42 U.S.C. 1395y(b)(5)(C)(ii)	2019	2020	1,569
Penalty for any entity that knowingly, willfully, and repeatedly fails to complete a claim form relating to the availability of other health benefits in accordance with statute or provides inaccurate information relating to such on the claim form.	42 U.S.C. 1395y(b)(6)(B)	2019	2020	3,443
Penalty for any entity serving as insurer, third party administrator, or fiduciary for a group health plan that fails to provide information that identifies situations where the group health plan is or was a primary plan to Medicare to the HHS Secretary.	42 U.S.C. 1395y(b)(7)(B)(i)	2019	2020	1,232
Penalty for any non-group health plan that fails to identify claimants who are Medicare beneficiaries and provide information to the HHS Secretary to coordinate benefits and pursue any applicable recovery claim.	42 U.S.C. 1395y(b)(8)(E)	2019	2020	1,232
Penalty for any person that fails to report information required by HHS under Section 1877(f) concerning ownership, investment, and compensation arrangements.	42 U.S.C. 1395nn(g)(5)	2019	2020	20,489
Penalty for any durable medical equipment supplier, including a supplier of prosthetic devices, prosthetics, orthotics, or supplies, that knowingly and willfully fails to make refunds in a timely manner to Medicare beneficiaries under certain conditions. (42 U.S.C. 1395(m)(18) sanctions apply here in the same manner, which is under 1395u(j)(2) and 1320a–7a(a)).	42 U.S.C. 1395pp(h)	2019	2020	16,257
Penalty for any person that issues a Medicare supplemental policy that has not been approved by the State regulatory program or does not meet Federal standards after a statutorily defined effective date.	42 U.S.C. 1395ss(a)(2)	2019	2020	55,799
Penalty for someone other than issuer that sells or issues a Medicare supplemental policy to beneficiary without a disclosure Statement.	42 U.S.C. 1395ss(d)(3)(A)(vi)(II)	2019	2020	28,914
Penalty for an issuer that sells or issues a Medicare supplemental policy without disclosure statement.	42 U.S.C. 1395ss(d)(3)(A)(vi)(II)	2019	2020	48,192
Penalty for someone other than issuer that sells or issues a Medicare supplemental policy without acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	2019	2020	28,914
Penalty for issuer that sells or issues a Medicare supplemental policy without an acknowledgement form.	42 U.S.C. 1395ss(d)(3)(B)(iv)	2019	2020	48,192
Penalty for any person that sells or issues Medicare supplemental polices after a given date that fail to conform to the National Association of Insurance Commissioners (NAIC) or Federal standards established by statute.	42 U.S.C. 1395ss(p)(8)	2019	2020	28,914
Penalty for any person that sells or issues Medicare supplemental polices after a given date that fail to conform to the NAIC or Federal standards established by statute.	42 U.S.C. 1395ss(p)(8)	2019	2020	48,192
Penalty for any person that sells a Medicare supplemental policy and fails to make available for sale the core group of basic benefits when selling other Medicare supplemental policies with additional benefits or fails to provide the individual, before selling the policy, an outline of coverage describing benefits.	42 U.S.C. 1395ss(p)(9)(C)	2019	2020	28,914

Grants Closeout Reporting

HHS continues to make grants closeout a priority by closing out *Grants Oversight and New Efficiency Act* (GONE Act) reportable awards, and effecting organizational change to improve processes to prevent future grant closeout backlogs. HHS's Grants Closeout Remediation Integrated Project Team (Closeout IPT) has made significant progress closing out grant awards to address documents reported in the original GONE Act submission with a period of performance (POP) end date over 5 years old.

As required by OMB Circular A-136, *Financial Reporting Requirements*, the following table presents the population of awards for which the POP has elapsed by 2 years or more, along with related undisbursed balances. When the number of grants/cooperative agreements reported in **Table 1** below are totaled, HHS has 25,129 grants with a POP end date of September 30, 2018, or earlier that are expired, but not yet closed.

Table 1: HHS Expired-but-not-Closed Awards with a POP End Date Exceeding 2 Years

Category	2-3 Years	3-5 Years	More than 5 Years
Number of Grants/Cooperative Agreements with Zero Dollar Balances	4,316	794	1,546
Number of Grants/Cooperative Agreements with Undisbursed Balances	10,885	4,193	3,395
Total Amount of Undisbursed Balances	**$2,079,032,221**	**$857,750,424**	**$644,261,152**

Despite the challenges discussed below, in FY 2020, the Closeout IPT successfully closed over 12,981 grant awards originally reported in the FY 2018 HHS Agency Financial Report (AFR) GONE Act Report. Table 1 above is not comparable to previous HHS AFR GONE Act reporting as the OMB Circular A-136 reporting parameters were modified from before September 30, 2015, to the current requirement of September 30, 2018.

Challenges

HHS remains committed to addressing and resolving the complexities that prevent the closeout of open-but-expired accounts. The greatest challenge to successful and sustained closeout performance relates to change management, getting OpDivs to prioritize the grant closeout process. Additionally, grant closeout timeliness remains a challenge to OpDivs as awards are not being closed out in accordance with deadlines. To address these challenges, HHS identified closeout business process improvements, policy enhancements, and training initiatives to shift priority and resources to post-award management.

Further, HHS recognized additional complex factors affecting the closeout of other grant programs. For example, HHS has a number of programs authorized in the *Social Security Act* that make certain grant funds "available until expended." This means that even though the grant performance period has ended, the funds must remain available to the recipient for use and the grant award cannot be closed. HHS intends to also address these programmatic issues through grant management policy enhancements and training initiatives.

Remaining Actions

In an effort to further reduce the existing backlog, all open grant documents with POP end dates prior to September 30, 2017, have been grouped into like categories and will be closed in batches, to the maximum extent possible, as permitted by appropriation law. HHS leadership will continue to prioritize these alternative closeout

methods and improve grants management policy and procedures to prevent future closeout backlogs. In FY 2021, the Closeout IPT plans to close remaining open grant documents with POP end dates prior to September 30, 2017.

HHS will also utilize its Business Process Re-Engineering IPT to improve the effectiveness and efficiency of the closeout process. The Business Process Re-Engineering IPT is focusing on solutions in the areas of closeout policy, systems improvements, and enhanced on-demand training to support timely and accurate closeout of awards. To address more urgent needs, the IPT has already prioritized policy development in the areas of fund deobligation and debt collection. This IPT, in coordination with the Department's Office of Grants Division of Workforce Development, will also pilot web-based, on-demand training modules for recipients and HHS awarding agencies. This effort will focus on the new federal-wide closeout regulations and appropriation law.

Did You Know?

This spring, HHS announced $250 million in grants from the Administration for Community Living (ACL) to help communities provide meals for older adults. The *Families First Coronavirus Response Act* provided the additional funding for the nutrition services programs authorized by the *Older Americans Act of 1965*, and reauthorized by the *Supporting Older Americans Act of 2020*. These programs provide meals to more than 2.4 million older adults each year, both through home delivery and in places like community centers. To learn more, visit the HHS or ACL websites.

Payment Integrity Report

OVERVIEW

HHS is advancing a transparent, accountable, and collaborative financial management environment to fulfill its federal requirements and provide stakeholders with accessible and actionable financial information. An important part of this effort is the continuous improvement of payment accuracy in all HHS programs. The Department implemented various innovative solutions to prevent, detect, and reduce improper payments, while reducing unnecessary administrative burden on its stakeholders and protecting beneficiaries' access to important programs.

In accordance with the *Payment Integrity Information Act of 2019* (PIIA),[27] OMB Circular A-136; and Appendix C of OMB Circular A-123, *Requirements for Payment Integrity Improvement*, HHS's Fiscal Year (FY) 2020 Payment Integrity Report includes a discussion of the following topics:

Section	Topic
1.0	Program Descriptions
2.0	Risk Assessments
3.0	Statistical Sampling Process:
3.1	• Improper Payment Measurement Estimates
3.2	• Improper Payment Root Causes and Drivers
4.0	Corrective Action Plans
5.0	Accountability in Reducing and Recovering Improper Payments
6.0	Information Systems and Other Infrastructure
7.0	Mitigation Efforts Related to Statutory or Regulatory Barriers
8.0	FY 2020 Achievements
9.0	Improper Payment Performance FY 2020 through FY 2021:
9.1	• Accompanying Notes for Table 1
9.2	• Proper and Improper Payments
10.0	Improper Payment Root Cause Categories and Types
11.0	Program-Specific Reporting Information:
11.1	• Medicare Fee-for-Service (FFS) (Parts A and B)
11.2	• Medicare Advantage (Part C)
11.3	• Medicare Prescription Drug Benefit (Part D)
11.4	• Medicaid
11.5	• Children's Health Insurance Program (CHIP)
11.6	• Temporary Assistance for Needy Families (TANF)
11.7	• Foster Care
11.8	• Child Care and Development Fund (CCDF)
12.0	Disaster Relief Funding Reporting Information:
12.1	• Office of the Assistant Secretary for Preparedness and Response (ASPR)
12.2	• Health Resources and Services Administration (HRSA)
13.0	Recovery Auditing Reporting
14.0	Fraud Reduction Report

Refer to PaymentAccuracy.gov for additional detailed information on HHS's payment integrity efforts.

[27] The President signed PIIA (Pub. L. No. 116-117) into law on March 2, 2020, and PIIA contains substantially similar provisions as the *Improper Payments Information Act of 2002*, as amended by the *Improper Payments Elimination and Recovery Act of 2010,* and the *Improper Payments Elimination and Recovery Improvement Act of 2012*.

1.0 PROGRAM DESCRIPTIONS

HHS utilizes annual improper payment risk assessments to identify new risk-susceptible programs, which are required to estimate improper payments and report other information, such as reduction targets and corrective actions. **Figure 1** provides a brief description of the programs that HHS or OMB identified as risk-susceptible and are discussed in this report.

Figure 1: Risk-Susceptible Programs

Medicare FFS	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 (ESRD).
Medicare Part C	A federal health insurance program that allows beneficiaries to receive their Medicare benefits through a private health plan.
Medicare Part D	A federal prescription drug benefit program for Medicare beneficiaries.
Medicaid	A joint federal/state program, administered by the states, that provides health insurance to qualifying low-income individuals.
CHIP	A joint federal/state program, administered by the states, that provides health insurance for qualifying children.
APTC	A federal insurance affordability program, administered by HHS and/or the states, to support enrollees in purchasing Qualified Health Plan (QHP) coverage from state and federal insurance exchanges.
TANF	A joint federal/state program, administered by the states, that provides time-limited cash assistance as well as job preparation, work support, and other services to needy families with children to promote work, responsibility, and self-sufficiency.
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.
CCDF	A joint federal/state program, administered by the states, that provides child care financial assistance to low-income working families.
ASPR Disaster Relief	ASPR's mission is to save lives and protect Americans from 21st century health security threats. This program includes expenses related to the consequences of Hurricanes Harvey, Irma, and Maria.
CDC Disaster Relief	Supplemental appropriation for the response, recovery, preparation, mitigation, and other expenses directly related to the consequences of Hurricanes Harvey, Irma, and Maria.
HRSA Disaster Relief	A federal opportunity that provides one-time capital funding to eligible Health Center Program award recipients for expenses related to the consequences of Hurricanes Harvey, Irma, and Maria.

Program-specific information on each risk-susceptible program is located throughout the Payment Integrity Report. However, because HHS is not reporting an Advance Premium Tax Credit (APTC) improper payment estimate for FY 2020, the program is not included in Section 11.0: *Program-Specific Reporting Information*. For additional

information on the Department's efforts to develop an APTC improper payment measurement program, see Note 6 of Section 9.1: *Accompanying Notes for Table 1*. In addition, under the *Bipartisan Budget Act of 2018* and the *Additional Supplemental Appropriations for Disaster Relief Requirements Act of 2017,* HHS received approximately $1 billion to respond to and recover from hurricanes, wildfires, and other disasters. Department programs that received funding and expended more than $10 million during an annual reporting period are reporting improper payment estimates in the FY 2020 Payment Integrity Report, as appropriate. Two programs established methodologies and are reporting improper payment estimates for disaster funding in FY 2020, including ASPR and HRSA. Section 12.0: *Disaster Relief Funding Reporting Information* provides program-specific information on each disaster relief program. However, because HHS is not reporting a Centers for Disease Control and Prevention (CDC) disaster funding improper payment estimate for FY 2020, the program is not included in Section 12.0. See Note 10 of Section 9.1 for more detailed information on the Department's efforts to develop a CDC disaster funding improper payment measurement program.

2.0 RISK ASSESSMENTS

As required by the PIIA and OMB implementing guidance, HHS reviews its non-risk-susceptible programs (including payment streams and activities) using the HHS PIIA Risk Assessment Tool to determine susceptibility to significant improper payments.

The HHS PIIA Risk Assessment Tool provides for a comprehensive review and analysis of selected program operations to determine potential payment risks and risk severity. HHS follows guidance contained in OMB Circular A-123, Appendix C, when determining how to group programs or activities for risk assessments, if applicable. In FY 2020, HHS revamped its risk assessment methodology and platform. HHS revised the improper payment risk assessment questionnaire and scoring process to generate a more effective, efficient, and systematic way of determining susceptibility to improper payments. Drawing from Appendix C guidance and risk assessments developed by other federal agencies, HHS developed a robust set of questions to assess programs for a broader range of risk factors, while also developing a new methodology for quantifying these risk factors. HHS also created an automated platform for collecting risk assessments, allowing for more efficient data collection and risk factor calculation. HHS continues to review Government Accountability Office (GAO) reports and resources, capture best practices from other agencies, and solicit feedback from HHS's Operating Divisions (OpDiv) to further improve its processes. HHS will continue to develop policies, procedures, and supporting tools throughout 2021.

For FY 2020, HHS conducted 23 improper payment risk assessments. Out of these, none was found to be potentially susceptible to significant improper payments. However, because FY 2020 was a pilot year for the revised scoring methodology, it is necessary for HHS to perform additional analysis in order to ensure the pilot scoring methodology provided an accurate representation of susceptibility. Additional analyses of the new questionnaire and scoring methodology will continue to provide HHS with a systematic approach to conducting a reliable assessment of whether its programs are potentially susceptible to significant improper payments. For additional information on HHS programs assessed for risk of improper payments during the FY 2020 risk assessment cycle, refer to PaymentAccuracy.gov.

3.0 STATISTICAL SAMPLING PROCESS

All programs that reported improper payment estimates complied with OMB-approved statistical sampling plans and confidence intervals per OMB's previously issued guidance[28] on sampling and estimation plans. OMB updated its guidance in June 2018,[29] and, effective for FY 2020 reporting, six programs (Medicare FFS, Medicare Part C, Medicare Part D, ASPR disaster funding, and HRSA disaster funding) complied with the OMB requirements for statistical sampling plans and confidence intervals. OMB approved four other programs' (Medicaid, CHIP, Foster Care, and CCDF) use of non-statistical plans due to the rolling nature of the improper payment methodologies. Generally, these programs' improper payment estimates are based on a system of reviews, wherein each state is reviewed triennially and each year's improper payment estimate incorporates new review data for approximately one-third of states. As a result, the improper payment estimate is based not on a statistical sample drawn from the full population of payments for any one-time period, but, rather, on a combination of statistical samples drawn from several different time periods. HHS will continue to work with its risk-susceptible programs and OMB to modify, to the extent possible, its sampling and estimation plans to comply with OMB's prescribed statistical requirements. Due to the impact of the Public Health Emergency (PHE) for COVID-19 pandemic, ACF modified its reviews; while CMS exercised its enforcement discretion and implemented a temporary policy to stop documentation requests, and other improper payment-related communications and engagement with providers, suppliers, health plans, and states between March 2020 and August 2020. HHS resumed improper payment activities for future measurement periods in August 2020. It should be noted that all claims reviewed for this reporting period are dated prior to the COVID-19 PHE. Because of these pauses, ACF and HHS implemented temporary adjustments to estimate the improper payment rates for its programs in FY 2020. HHS still complied with PIIA and OMB requirements for meeting statutory national-level precision requirements that the rates are +/- 3 percentage points at a 95 percent confidence interval.

The statistical sampling and estimation processes for Medicare FFS, Medicare Part C, Medicare Part D, Foster Care, and CCDF are detailed in Section 11.0: *Program-Specific Reporting Information*. The statistical sampling and estimation processes for disaster funding is detailed in Section 12.0: *Disaster Relief Funding Reporting Information*.

3.1 IMPROPER PAYMENT MEASUREMENT ESTIMATES

HHS prioritizes protecting taxpayer resources and strives to prevent, and reduce, future improper payments. While the vast majority of the Department's payments are proper, unfortunately, some payments are improper.

Most improper payments are either unintentional payment errors or instances where the reviewer cannot determine if a payment is proper due to insufficient payment documentation. While fraud and abuse are improper payments, it is important to note that not all improper payments constitute fraud, and improper payment estimates are not fraud rate estimates.

HHS leverages improper payment methodologies to identify estimates of monetary loss (a subset of improper payments where the wrong recipient was paid or the correct recipient was paid the wrong amount). Not all improper payments are expenses that should not have occurred; they do not all represent funds the federal government should not have spent. For example, a significant amount of HHS's improper payments are due to documentation errors; that is, either lack of documentation or errors in the documentation that limited HHS's ability to verify

[28] On October 20, 2014, OMB issued M-15-02, "Appendix C to Circular No. A-123, *Requirements for Effective Estimation and Remediation of Improper Payments.*"
[29] On June 26, 2018, OMB issued M-18-20, "Transmittal of Appendix C to OMB Circular A-123, *Requirements for Payment Integrity Improvement*," which replaces M-15-02.

information. Some improper payment estimation methodologies are able to discern if the insufficient documentation payment error was for an item or service that should have been paid but the documentation did not comply with all the rules and requirements per policy, therefore representing a non-monetary loss to the federal government. Lastly, a smaller proportion of improper payments are payments that either should not have been made or should have been made in a different amount and represent monetary losses to the government.

3.2 IMPROPER PAYMENT ROOT CAUSES AND DRIVERS

A key component of the improper payment sampling, estimation, and reporting process is the identification of improper payment root causes. Once a program identifies improper payment root causes, the program personnel work with stakeholders to implement corrective actions to address those root causes. Section 11.0*: Program-Specific Reporting Information* and Section 12.0: *Disaster Relief Funding Reporting Information* include program-specific root cause information and corrective actions that align with OMB Circular A-123, Appendix C's root cause categories. In addition, some HHS risk-susceptible programs have also identified improper payment drivers that are more detailed or program-specific than OMB's root cause categories. Section 11.0 and Section 12.0 provide more information on these improper payment drivers and the related corrective actions.

4.0 CORRECTIVE ACTION PLANS

Generally, each program develops a multi-faceted corrective action plan with various remediation efforts taking place concurrently. Corrective actions vary by stage — from development, to piloting, to steady-state implementation, to completion. Corrective action plans help set aggressive but realistic targets for reducing improper payments with a timetable to achieve scheduled targets. Under OMB's implementing guidance, OMB approves all corrective action plans and reduction targets published in the AFR. The Department reviews corrective action plans annually to confirm remediation plans focus on the root causes of the improper payments, thus increasing the likelihood that targets are successfully met. If targets are not met, HHS develops new strategies, adjusts staffing and other resources, and/or revises targets.

See Section 11.0: *Program-Specific Reporting Information* and Section 12.0: *Disaster Relief Funding Reporting Information* for each program's corrective action plan for reducing the estimated rate of improper payments. Due to the impact of COVID-19, HHS paused and/or altered some corrective actions in FY 2020; these changes are denoted in the program-specific sections, if applicable.

5.0 ACCOUNTABILITY IN REDUCING AND RECOVERING IMPROPER PAYMENTS

Strengthening program integrity throughout the organization is a top departmental priority, extending to all HHS senior executives and program officials. As evidence of this focus, beginning with senior leadership and cascading down, performance plans contain strategic goals related to enhancing program integrity, protecting taxpayer resources, and reducing improper payments. As part of the semi-annual and annual performance evaluations, senior executives and program officials are evaluated on progress toward achieving these goals.

6.0 INFORMATION SYSTEMS AND OTHER INFRASTRUCTURE

Section 11.0: *Program-Specific Reporting Information* and Section 12.0: *Disaster Relief Funding Reporting Information* details each program's information system(s) and other infrastructure. Unless otherwise stated in Section 11.0 or Section 12.0, HHS has the appropriate information systems and other necessary infrastructure to reduce improper payments to the targeted levels in applicable risk-susceptible programs.

7.0 MITIGATION EFFORTS RELATED TO STATUTORY OR REGULATORY BARRIERS

Section 11.0: *Program-Specific Reporting Information* and Section 12.0: *Disaster Relief Funding Reporting Information* details each program's statutory or regulatory barriers to reducing improper payments. Unless otherwise stated in Section 11.0 or Section 12.0, HHS has no current statutory or regulatory barriers to reducing improper payments.

8.0 FY 2020 ACHIEVEMENTS

In FY 2020, HHS strengthened its efforts to reduce and recover improper payments in its programs. Results of the efforts are outlined here, as well as in Section 11.0: *Program-Specific Reporting Information* and Section 12.0: *Disaster Relief Funding Reporting Information*. Three of the nine risk-susceptible programs that report improper payment estimates reported lower estimated improper payment rates in FY 2020 than in FY 2019. The more notable efforts are highlighted in the following subsections and detailed information on program performance and corrective actions can be found in Section 11.0 and Section 12.0.

President's Management Agenda and Cross-Agency Priority Goal

In March 2018, the Administration announced the President's Management Agenda (PMA), which is designed to improve how the federal government operates, provides customer service, and oversees taxpayer resources. As part of the PMA, the Administration also announced a series of Cross-Agency Priority (CAP) Goals, where multiple agencies collaborate to achieve success and meet the PMA's vision. CAP Goal 9, "Getting Payments Right," focuses on improving and streamlining improper payment regulations and reducing monetary loss.

Since its inception, HHS assumed a key role in the "Getting Payments Right" CAP Goal – serving as an agency lead and contributor on multiple workgroups created under the CAP Goal. HHS's role carried into the CAP Goal's efforts in FY 2020, as HHS supported multiple workgroups helping to reduce improper payments by re-aligning improper payment root cause categories, improving agency and programmatic access to data, and examining resources programs use to verify recipient identity. HHS will continue to support this CAP Goal and other efforts to reduce improper payments in FY 2021.

Head Start

As of FY 2013, the Head Start program no longer reports annual improper payment estimates due to the strong internal controls, monitoring systems, and low reported improper payment rates from FYs 2009 through 2012. In lieu of an annual improper payment rate measurement, HHS monitors Head Start's existing internal controls and monitoring systems and annually reports to OMB on the status and results of the internal controls and monitoring systems. HHS also performs periodic risk assessments of the Head Start program. An improper payment risk assessment of the program in FY 2018 indicated that Head Start continues not to be susceptible to significant improper payments.

For FY 2020, HHS conducted an assessment of eligibility practices as part of the review process, focusing on grantee compliance with Eligibility, Recruitment, Selection, Enrollment, and Attendance Head Start Performance Standards. In FY 2020, HHS assessed 112 grantees, which exceeds the number of grantees (50) that were assessed each year as part of the previously required improper payment rate reporting efforts. Of the grantees assessed, only 10 were identified as having erroneous payments related to eligibility, providing reasonable assurance that the Department's control and monitoring systems are still working as intended. On August 27, 2020, HHS issued Final Rule ACF-PI-HS-20-05, Designation Renewal System Changes. The new Designation Renewal System rule holds Head Start and Early Head Start agencies accountable for delivering high-quality and comprehensive services by ensuring the best

grantees are providing services to Head Start children and families in each local area. The final rule enhances the fiscal health of Head Start grantees by requiring competition for agencies with two or more audit findings of material weakness or questioned costs associated with Head Start funds during the project period. It also expands the requirement to compete if a going concern is identified at any time during the project period.

Vulnerability Collaboration Council (VCC)

To detect and combat fraud, waste, and abuse, HHS utilizes a centralized, vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the VCC, is comprised of Centers for Medicare & Medicaid Services (CMS) leadership and subject matter experts that work collaboratively to identify vulnerabilities that lead to fraud, waste, and abuse and develop comprehensive risk strategies to mitigate these vulnerabilities. HHS aligned the VCC's risk-based approach with GAO's fraud risk framework (GAO-15-593SP). By aligning with the GAO framework, HHS standardized the vulnerability management process by focusing on the identification and mitigation of key risk factors through the design and implementation of specific mitigation activities that are regularly evaluated and adapted to adjust to changing circumstances.

Major Case Coordination (MCC)

In FY 2018, HHS began the MCC initiative that includes representation from the HHS Office of Inspector General (OIG), United States Department of Justice (DOJ), and HHS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate before, during, and after the development of fraud leads. This level of collaboration contributed to several successful coordinated law enforcement actions and helped HHS to better identify national trends and program vulnerabilities that can lead to fraud and improper payments. Since implementation of the MCC, there have been over 2,198 MCC reviews and 1,416 law enforcement referrals.

In FY 2020, HHS established the Medicaid MCC process, which brings together the HHS-OIG, DOJ, State Medicaid Fraud Control Units (MFCU), state program integrity units, and representatives from HHS in a forum to discuss Medicaid-related law enforcement referrals. As of July 1, 2020, HHS has participated in four Medicaid MCCs, which resulted in approximately 15 law enforcement referrals. The information gained from the Medicaid MCC process can also be used to identify Medicaid and CHIP vulnerabilities that can lead to improper payments. The level of collaboration resulting from the Medicaid MCC has contributed to several successful coordinated law enforcement actions and helped HHS better identify national trends and program vulnerabilities that can lead to fraud and other improper payments.

Fraud Prevention System (FPS)

The FPS analyzes Medicare FFS claims using sophisticated algorithms to:

- Target investigative resources;
- Generate alerts for suspect claims or providers and suppliers; and
- Provide information to facilitate and support investigations of the most egregious, suspect, or aberrant activity.

HHS uses the FPS information to prevent and address improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, Medicare billing privilege revocations, and law enforcement referrals. In FY 2020, HHS continued to add and refine models in FPS.

During FY 2020, the FPS generated alerts that resulted in 1,032 new leads for program integrity contractors (PIC) and augmented information for 413 existing PIC leads or investigations. The PICs reported initiating FPS-attributable actions against 599 providers in FY 2020.

National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) and Investigations MEDIC (I-MEDIC)
As part of HHS's ongoing efforts to continue to improve and strengthen oversight of the Medicare Part C and Part D programs, HHS divided the previous Medicare Drug Integrity Contractor (MEDIC) into two contracts in FY 2019. The two MEDICs are known as the National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) and the Investigations Medicare Drug Integrity Contractor (I-MEDIC). The NBI MEDIC primarily assists CPI with outreach and education support, audits, and data analysis. The I-MEDIC conducts investigations, makes administrative action recommendations, and submits case referrals to law enforcement.

Based on the NBI MEDIC's data analysis, the NBI MEDIC completed Part D plan sponsor self-audits, which led to HHS recovering $6.54 million from Part D sponsors during the first three quarters of FY 2020. In June 2020, HHS awarded the new Plan Program Integrity (PPI) MEDIC contract, which encompasses the NBI MEDIC's work in Parts C and D. With the award of the PPI MEDIC, the NBI MEDIC ended in late September 2020.

The I-MEDIC continues to focus on activities in order to detect, prevent, and proactively deter fraud, waste, and abuse for high-risk prescribers or pharmacies in Medicare Part C and Part D by focusing primarily on complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support.

Medicaid Integrity Program
Under Section 1936 of the *Social Security Act*, as amended by the *Deficit Reduction Act of 2005* (DRA), HHS's Medicaid Integrity Program is responsible for:

- Reviewing Medicaid provider activities, auditing claims, identifying overpayments, and educating providers and others on Medicaid program integrity issues; and
- Supporting and assisting state efforts to combat Medicaid provider fraud, waste, and abuse.

Increased Medicaid recoveries demonstrate HHS's continued commitment to Medicaid program integrity. For example, the Medicaid Integrity Program includes federal personnel specialized in program integrity and contractor support to states to bolster program integrity activities and collections. Since enactment of the DRA, total state Medicaid program integrity collections (federal and state shares) have grown from $265 million in FY 2006 to $525.10 million in FY 2020.[30] In addition, HHS uses DRA funding to support critical Medicaid financial management oversight activities, including reviewing quarterly state expenditure requests to ensure appropriate use of federal funds, conducting targeted state financial management reviews based on questionable claims identified through claims review processes, and working with states to recover the federal share of unallowable Medicaid expenditures.

The DRA also requires HHS to establish a 5-year Comprehensive Medicaid Integrity Plan (CMIP) that sets forth HHS's strategy to safeguard the integrity of the Medicaid program. HHS has released CMIPs since 2006. The current 5-year CMIP covers FYs 2019 through 2023 and focuses on protecting taxpayer dollars in the Medicaid program and CHIP by combatting fraud, waste, and abuse. In June 2018, HHS issued a Medicaid Program Integrity Strategy with new and enhanced initiatives to improve state oversight and accountability. These initiatives – including conducting audits of state beneficiary eligibility determinations and audits of Medicaid managed care plans' Medical Loss Ratio

[30] This amount may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.

calculations – have formed the foundation for the current CMIP. Noteworthy outcomes from the previous CMIP (FYs 2014 through 2018) have been referenced in the Medicaid section of the HHS AFR Payment Integrity Report for recent years, and Section 11.4: *Medicaid* of this year's Payment Integrity Report describes early outcomes from the current CMIP.

Public Assistance Reporting Information System (PARIS)

PARIS provides state public assistance agencies in all 50 states, the District of Columbia, and Puerto Rico, with matching data to verify public assistance eligibility and to detect and deter improper payments in TANF, Medicaid, Workers' Compensation, child care related programs, and the Supplemental Nutrition Assistance Program across state lines. Provided to states at no cost, PARIS data helps states strengthen program administration by allowing states to compare public assistance data between non-interoperable systems. Over the course of four quarterly matches (August 2019 to May 2020), states submitted over 256 million records for matching, and PARIS provided states with match records for an average of over half a million unique social security numbers in each quarter.

State public assistance agencies realize cost savings in a variety of manners using PARIS data. For example:

- The Michigan Department of Health and Human Services reports its usage of the PARIS Interstate match resulted in $24.7 million in annualized cost avoidance in FY 2019.
- New York's Office of Temporary and Disability Assistance reports it used PARIS to close or remove active clients from 6,493 public assistance cases for projected cost savings of $39.01 million between April 2019 and March 2020.
- Pennsylvania's Department of Human Services reports it reduced or closed 14,892 cases using PARIS match data for an estimated savings of $33.51 million in 2019.
- Washington State Health Care Authority's Veterans Program reports it had approximately $16.98 million in cost savings from fee-for-service claims and cessation of managed care premium payments between July 2019 and June 2020.

For more information, refer to PARIS.

Results of the Do Not Pay (DNP) Initiative in Preventing Improper Payments

In June 2010, the President issued a Memorandum on Enhancing Payment Accuracy Through a "Do Not Pay List" where agencies can access and analyze relevant information before determining eligibility for funding. Since 2010, HHS worked diligently to implement the DNP initiative. Several of HHS's OpDivs are using DNP to check for recipients' or potential recipients' eligibility for payment and to prevent improper payments. Further, U.S. Department of the Treasury (Treasury)-disbursed payments are matched against the Social Security Administration's (SSA) Death Master File (DMF) in the DNP portal on a daily basis to identify improper payments. In FY 2020, the Department screened 1.06 million payments against PIIA-listed databases, representing $655.73 billion. While the Department identified 46 potential improper payments over the past year through these daily matches, there were zero confirmed matches in FY 2020. Lastly, CMS also checks certain payments against PIIA-listed databases outside of the DNP portal. In FY 2020, CMS screened 1.1 billion payments against PIIA-listed databases, representing $394.1 billion in payments. Through these checks, CMS stopped 378,135 payments, representing a savings of $2.0 billion.

HHS was one of the first agencies to establish a Computer Matching Agreement (CMA) with Treasury in FY 2014 and has been utilizing these data sources successfully since then to verify eligibility and stop improper payments. In FY 2020, CMS began working towards renewing the CMA with Treasury to allow for continued use of these essential data sources. HHS completed the new CMA in October 2020.

9.0 IMPROPER PAYMENT PERFORMANCE FY 2020 THROUGH FY 2021

Each year, HHS reports updated improper payment estimates in the Payment Integrity Report. Table 1 displays HHS's proper and improper payment estimates for current year (CY) (FY 2020) and improper payment targets for FY 2021 (CY+1). The table includes the following information by year and program, as applicable:

- FY outlays;
- Estimated amount and percent paid or projected to be paid properly (PP) and improperly (IP); and
- Estimated improper payment rate or future target rate (IP%).

In addition, for the CY, Table 1 on the next page includes:

- Estimated dollar amount of overpayments (CY Overpayments);
- Estimated dollar amount of underpayments (CY Underpayments); and
- Estimated dollar amount of unknown payments (CY Unknown), when available.

HHS utilizes statistical sampling to calculate each program's estimated gross improper payment rate and a projected dollar amount of improper payments.

$$\text{Gross Improper Payment Rate} = \frac{(\text{Overpayments} + \text{Underpayments} + \text{Unknown})}{\text{Total Payments Actually Made}}$$

The gross improper payment rate is the official program improper payment rate and is included in Table 1.

Table 1
Estimated Proper and Improper Payments for HHS's Risk-Susceptible Programs
FY 2020 – FY 2021 (in Millions)

Program or Activity	CY Outlays $	CY PP %	CY PP $	CY IP %	CY IP $	CY Over Payment $	CY Under Payment $	CY Unknown $	CY+1 Est. Outlays $	CY+1 IP %	CY+1 IP $
Medicare FFS	$410,812.72 [a]	93.73	$385,074.41	6.27% [1]	$25,738.31	$9,315.60	$710.63	$15,712.09	$466,229.20 [b]	6.17	$28,766.34
Medicare Part C	$240,082.81 [c]	93.22	$223,811.15	6.78	$16,271.66	$8,448.12	$7,471.72	$351.82	$336,311.00 [d]	N/A [2]	N/A
Medicare Part D	$80,738.40 [e]	98.85	$79,810.89	1.15	$927.50	$158.25	$89.70	$679.55 [3]	$102,844.00 [f]	1.14	$1,172.42
Medicaid	$404,899.18 [g]	78.64	$318,411.79 [b]	21.36 [4, 7]	$86,487.38	$12,300.44	$368.64	$73,818.30	$442,823.28 [g]	N/A [6]	N/A [6]
CHIP	$17,691.53 [h]	73.00	$12,914.27 [b]	27.00 [5, 7]	$4,777.27	$1,241.82	$11.32	$3,524.12	$17,667.00 [h]	N/A [6]	N/A [6]
APTC	$48,795.88 [i]	N/A	N/A	N/A [8]	N/A	N/A	N/A	N/A	$42,737.23 [i]	N/A	N/A
TANF	$16,218.87 [j]	N/A	N/A	N/A [9]	N/A	N/A	N/A	N/A	$15,944.82 [j]	N/A	N/A
Foster Care	$1,226.00 [k]	96.64	$1,184.77	3.36	$41.23	$39.11	$2.12	$0.00 [10]	$1,542.00 [k]	N/A [11]	N/A [11]
CCDF	$7,938.96 [l]	94.84	$7,529.51	5.16	$409.45	$130.89	$25.34	$253.22	$8,837.27 [l]	N/A [12]	N/A [12]
ASPR Disaster Relief	$31.91 [m]	98.65	$31.48	1.35	$0.43	$0.43	$0.00	$0.00	$9.40 [m]	0.00	$0.00
CDC Disaster Relief	$145.59 [n]	N/A	N/A	N/A [13]	N/A	N/A	N/A	N/A	$194.54 [n]	N/A	N/A
HRSA Disaster Relief	$18.69 [o]	99.60	$18.61	0.40	$0.08	$0.08	$0.00	$0.00	$26.51 [o]	0.40	$0.11

Note: Totals do not necessarily equal the sum of the rounded components.

9.1 Accompanying Notes for Table 1: Estimated Proper and Improper Payments for HHS's Risk-Susceptible Programs

a) Medicare FFS CY outlays are from the FY 2020 Medicare FFS Improper Payments Report (based on claims from July 2018 – June 2019).
b) Medicare FFS CY+1 outlays are based on the *FY 2021 President's Budget*.
c) Medicare Part C CY outlays reflect 2018 Part C payments, as reported in the FY 2020 Medicare Part C Payment Error Final Report.
d) Medicare Part C CY+1 outlays are based on the *FY 2021 President's Budget*.
e) Medicare Part D CY outlays reflect 2018 Part D payments, as reported in the FY 2020 Medicare Part D Payment Error Final Report.
f) Medicare Part D CY+1 outlays are based on the *FY 2021 President's Budget*.
g) Medicaid CY are based on FY 2019 expenditures and CY+1 outlays (Medicaid - Outlays current law exclude CDC Vaccine for Children program funding) are based on the *FY 2021 President's Budget*.
h) CHIP CY are based on FY 2019 expenditures and CY+1 outlays are based on the *FY 2021 President's Budget*.
i) APTC CY and CY+1 outlays are based on the *FY 2021 President's Budget*.
j) TANF CY and CY+1 outlays are based on the *FY 2021 President's Budget* baseline (TANF total outlays including the Healthy Marriage Promotion and Responsible Fatherhood Grants programs and excluding the TANF Contingency Fund).
k) Foster Care CY and CY+1 outlays are based on the *FY 2021 President's Budget* baseline, and reflect the federal share of maintenance payments.
l) CCDF CY and CY+1 outlays are based on the *FY 2021 President's Budget* baseline.
m) ASPR Disaster Relief CY and CY+1 outlays are based on the FY 2020 HHS Disaster Emergency Funding: Obligations and Outlays Summary Report, for Emergency PL 115-123 (as of September 30, 2020).
n) CDC Disaster Relief CY (based on FY 2018, FY 2019, and FY 2020 expenditures, advances, and adjustments) and CY+1 outlays are based on an estimated Outlay Rate = Outlays (single year) divide by Total Obligations (For first year plus adjustments in subsequent years).
o) HRSA Disaster Relief CY and CY+1 outlays are based on one-time capital funding to Health Center Program award recipients for expenses related to Hurricanes Harvey, Irma, and Maria during FY 2019.

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1. Beginning in FY 2012, HHS consulted with OMB and refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital 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 (i.e., improper payments due to inpatient status reviews). HHS used this methodology from FY 2013 through FY 2020. This approach is consistent with: (1) Administrative Law Judge and Departmental Appeals Board decisions that directed HHS to pay hospitals under Part B for all 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.

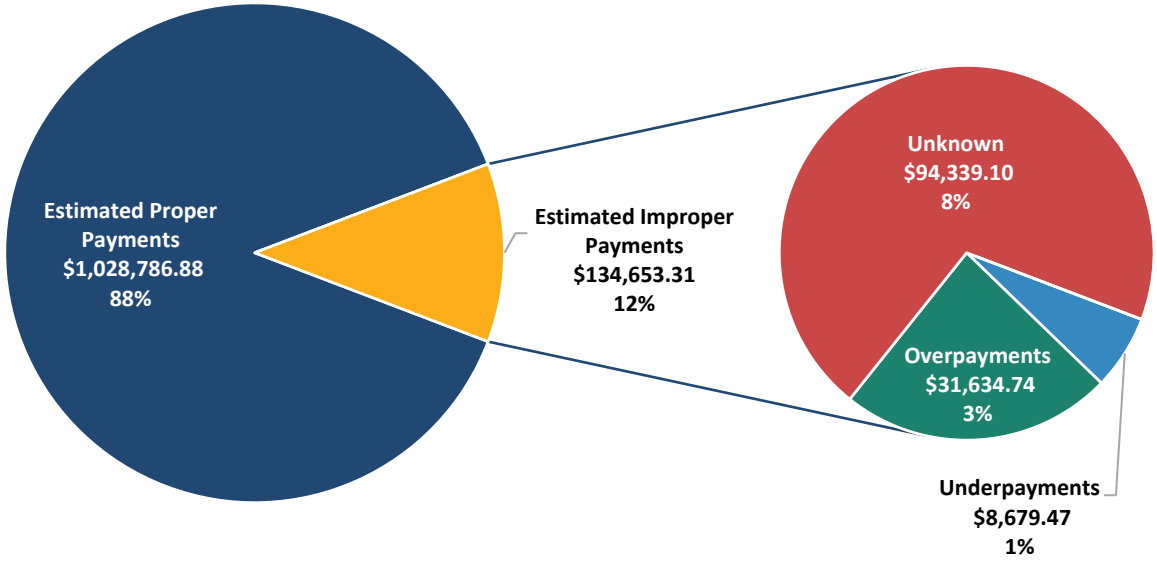
   HHS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services provided should have been outpatient services. This adjustment factor reflects the difference between the inpatient hospital claims paid under Medicare Part A and what the payment would have been had the hospital claim been properly submitted as a Medicare Part B outpatient claim. Application of the adjustment factor decreased the overall improper payment rate by 0.29 percentage points to 6.27 percent or $25.74 billion in projected improper payments. Additional adjustment factor information is on pages 166-167 of HHS's FY 2012 AFR.
2. Due HHS's temporary policy to stop documentation requests to providers as a result of the PHE for COVID-19 pandemic, the Medicare Part C Improper Payment Measurement medical record submission did not follow the same pattern as in previous years. As a result, HHS had to make significant changes to the sampling and estimation plan for FY 2020 Medicare Part C improper payment reporting. This impacted HHS's ability to set an aggressive yet realistic out-year target given the situation with the current year data as compared to prior year's data. OMB allows for this exception for not reporting out-year targets in the OMB Circular A-123, Appendix C.
3. HHS's changes to the Medicare Part D sampling and estimation plan for the 2020 reporting impacted the calculation for the unknown improper payments. As such, HHS calculated the FY 2020 unknown improper payments, which are mostly comprised of nonresponse errors, based on the FY 2019 improper payments data.
4. HHS calculated and is reporting the national Medicaid improper payment rate based on measurements conducted in FYs 2018, 2019, and 2020. The national Medicaid component improper payment rates are: Medicaid FFS: 16.84 percent, Medicaid managed care: 0.06 percent, and Medicaid eligibility: 14.94 percent.
5. HHS calculated and is reporting the national CHIP improper payment rate based on measurements conducted in FYs 2018, 2019, and 2020. The national CHIP component improper payment rates are: CHIP FFS: 14.15 percent, CHIP managed care: 0.49 percent, and CHIP eligibility: 23.53 percent.

6. Medicaid and CHIP are not reporting CY+1 improper payment targets. As described in Sections 11.4: *Medicaid* and 11.5: *CHIP*, HHS resumed the Medicaid and CHIP eligibility component measurements in 2019 and is reporting the second updated national eligibility improper payment estimates in FY 2020. Since HHS uses a 17-state, 3-year rotation for measuring Medicaid and CHIP improper payments, the publication of reduction targets will occur in FY 2021 once HHS establishes and reports a full baseline, including eligibility.
7. In FY 2018, HHS identified some concerns with the FY 2018 estimate due to issues with a portion of the Medicaid and CHIP reviews for PERM Cycle 3 states. Prior to reporting in the AFR, HHS calculated scenarios for what the national improper payment rate would be if all reviews in question were considered errors or all were considered proper. In these extreme scenarios, the FY 2018 national rate would be adjusted by +/- 0.33 percent, well within the estimate's confidence interval. Due to the PERM methodology, which utilizes three cycles to combine to the overall Medicaid and CHIP rates, these concerns also have an impact on the FY 2019 and FY 2020 rates, until the same cycle of states is measured again and reported in FY 2021. The FY 2020 rate would adjust by up to +/- 0.22 percent based on these concerns, again well within the estimate's confidence interval.
8. While a FY 2016 risk assessment concluded that the APTC program is susceptible to significant improper payments, the program is not yet reporting improper payment estimates for FY 2020. The Department is committed to implementing an improper payment measurement program as required by PIIA. As with similar HHS programs, developing an effective and efficient improper payment measurement program requires multiple, time-intensive steps including contractor procurement, developing measurement policies, procedures, and tools, and extensive pilot testing to ensure an accurate improper payment estimate. HHS will continue to monitor and assess the program for changes and adapt accordingly. In FYs 2017 through 2020, HHS conducted development and piloting activities for the APTC improper payment measurement program and will continue these activities in FY 2021. The Department will continue to update its annual AFRs with the measurement program development status until the reporting of the improper payment estimate.
9. The TANF program is not reporting an error rate for FY 2020. As discussed in Section 11.6: *TANF*, statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement.
10. Foster Care does not have Unknown Monetary Losses because the data reflect whether the state met federal requirements in claiming Title IV-E funding, as is typical of federally-funded, state-administered programs. Federal requirements include that the state must provide appropriate documentation for a claim when requested. Thus, while a payment from an agency to an individual beneficiary may qualify as an "Unknown Monetary Loss" due to lack of appropriate documentation, states must demonstrate that they can access the correct supporting documentation for Title IV-E claims. Without evidence of such documentation, the funds are considered "known" improper payments.
11. Foster Care is not reporting a CY+1 improper payment target. Given the ongoing COVID-19 PHE, HHS is uncertain when it will be safe to resume conducting onsite Title IV-E Reviews and how many states will be newly reviewed in time for the FY 2021 improper payment reporting cycle. In light of this uncertainty, as well as the unknown impact of the recent programmatic changes on the improper payment rate, HHS has chosen not to set an improper payment reduction target for FY 2021.
12. CCDF is not reporting a CY+1 improper payment target. The *Child Care and Development Block Grant Act of 2014* (CCDBG) and CCDF regulations (2016) require states to create and put in place new policies and procedures. For this reason, a full baseline has yet to be established. Rolling implementation of the new requirements will continue to affect the improper payment rate in the FY 2021 measurement, making it challenging to determine a target rate. HHS anticipates that the improper payment rate may continue to rise as states work to meet the new requirements. CCDF state grantees are implementing large-scale changes to their child care programs. Further, as a result of uncertainties due to the COVID-19 PHE, states' abilities to complete planned actions is impacted.
13. The COVID-19 PHE delayed HHS's efforts to test the CDC disaster relief funds in FY 2020. However, for FY 2020, HHS will leverage the results of the special emphasis review that focuses on the internal controls related to the funding of Hurricanes Harvey, Irma, and Maria to ensure the improper payment requirement is satisfied for the CDC disaster funding. Hence, the outcome will help inform and identify next year's testing work plan under OMB Circular A-123, Appendix C. The results of the special emphasis review will not be available until FY 2021, at which time HHS will commence testing at the transactional level.

9.2 PROPER AND IMPROPER PAYMENTS FOR HHS'S RISK-SUSCEPTIBLE PROGRAMS

Overall, the vast majority of the Department's payments are proper and represent payments made to the right recipient for the right amount. Unfortunately, some payments are improper and represent payments that either should not have been made or should have been made in a different amount. Improper payments are broken down into three categories: overpayments, underpayments, and unknown payments. **Figure 2** below illustrates the proportion of overpayments, underpayments, and unknown payments that represent HHS's FY 2020 improper payments for all of HHS's risk-susceptible programs. While overpayments and underpayments represent payments that are more or less, respectively, than what is due, unknown payments could be either proper or improper, but HHS is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation. Of HHS's improper payments, unknown makes up the largest category.

Figure 2: FY 2020 Estimated Proper Payments and Improper Payments[1] (Dollar Amounts in Millions)

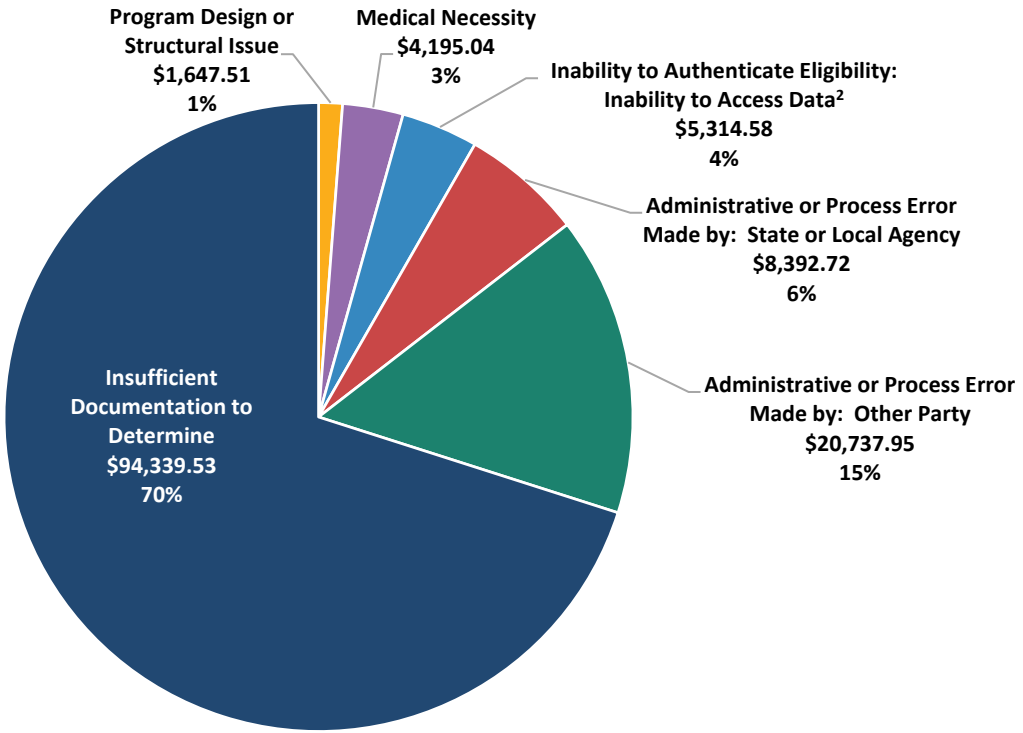


[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

10.0 IMPROPER PAYMENT ROOT CAUSE CATEGORIES AND TYPES

OMB guidance requires agencies to report the improper payment root causes for risk-susceptible programs with reported improper payment estimates. **Figure 3** below displays HHS's FY 2020 improper payment root causes for all of HHS's risk-susceptible programs. For reporting purposes, Administrative or Process Errors Made by Other Party may include health care providers, contractors, or other organization administering federal dollars. Section 11: *Program-Specific Reporting Information* provides additional information on the root causes and corrective actions.

Figure 3: FY 2020 Improper Payment Root Cause Categories for HHS's Risk-Susceptible Programs[1] (Dollar Amounts in Millions)



[1] Failure to Verify: Death Data and Failure to Verify: Other Eligibility Data each accounted for less than 1 percent of HHS's improper payments ($12.90 million and $0.08 million, respectively) and, thus, were not included in Figure 3. In addition, due to rounding, amounts in this figure may not add up precisely to other tables in this document.

[2] As described in Sections 11.4: *Medicaid* and 11.5: *CHIP*, HHS resumed the eligibility component measurement for the second cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2020. The national eligibility improper payment rate still includes a proxy estimate for the remaining 17 states that have not yet been measured since the reintegration of the PERM eligibility component. Therefore, eligibility improper payments reported under Inability to Authenticate Eligibility: Inability to Access Data represent the proxy eligibility improper payment rates, which include multiple types of historical eligibility improper payments. All eligibility improper payments from the FY 2020 and FY 2019 measurements are included in the appropriate category.

OMB Circular A-136 directs agencies to report, by program, the estimated amount of improper payments attributed to monetary loss, non-monetary loss, and unknown monetary loss. Monetary Loss means that the payment should not have occurred or should have been paid in a different, lower amount. The documentation is sufficient to confirm that the payment should not have been made at all or should have been made in a lesser amount. Examples include medical necessity, incorrect coding, and other errors in Medicare FFS.

For the second year, agencies are required to categorize the total monetary loss estimate as either (1) monetary loss within agency control or (2) monetary loss outside agency control. Monetary loss within agency control is an overpayment that resulted in a monetary loss to the government due to errors in the agency's program processing or billing, excluding payments authorized by law; while monetary loss outside agency control is an overpayment that resulted in a monetary loss to the government due to factors beyond the agency's control.

Non-Monetary Loss means that the payment is either an underpayment or a payment to the right recipient for the correct amount, where the payment process fails to follow applicable regulations and/or statutes.

Unknown Monetary Loss describes a payment where more information is needed to determine if the payment should have been issued or if the amount of the payment should have been different. When a payment lacks appropriate supporting documentation, it cannot be determined whether the payment would have been confirmed proper or confirmed improper, and resulted in a monetary loss to the government. These unknown monetary loss payments are typically the majority of the payments counted as improper, and could be overpayments, underpayments, or proper payments, if more documentation was available.

HHS's FY 2020 estimated improper payments are distributed between monetary loss, non-monetary loss, and unknown monetary loss for each program, as displayed in Table 2 below. In addition, Table 2 below identifies the estimated amounts of monetary loss within agency control and outside agency control. See Section 11.0: *Program-Specific Reporting Information* for the factors contributing toward the programs' estimated monetary loss outside agency control and additional information regarding the distribution of improper payments between monetary loss, non-monetary loss, and unknown.

Table 2
Estimated Proper and Improper Payments (across Monetary Loss [ML], Non-Monetary Loss [NML], and Unknown Monetary Loss) by Program
FY 2020 (in Millions)

			Monetary Loss				Non-Monetary Loss		Unknown Monetary Loss	
Program or Activity	CY PP Amount	CY IP Amount	ML Amount	Percent of IP	Within Agency Control	Outside Agency Control	NML Amount	Percent of IP	Unknown Amount	Percent of IP
Medicare FFS	$385,074.41	$25,738.31	$7,668.09 [1]	30%	$7,668.09		$2,358.14	9%	$15,712.09	61%
Medicare Part C	$223,811.15	$16,271.66	$8,448.12	52%		$8,448.12	$7471.72	46%	$351.82	2%
Medicare Part D	$79,810.89	$927.50	$158.25	17%		$158.25	$89.70	10%	$679.55	73%
Medicaid	$318,411.79	$86,487.38	$12,300.44 [2]	14%		$12,300.44	$368.64	< 1%	$73,818.30	85%
CHIP	$12,914.27	$4,777.27	$1,241.82 [2]	26%		$1,241.82	$11.32	< 1%	$3,524.12	74%
Foster Care	$1,184.77	$41.23	$39.11	95%		$39.11 [3]	$2.12	5%		
CCDF	$7,529.51	$409.45	$130.89	32%		$130.89 [4]	$25.34	6%	$253.22	62%
ASPR	$28.30	$0.43	$0.43	100%	$0.43					
HRSA	$18.61	$0.08	$0.08	100%	$0.08	$0.00				
Total [5]	$1,028,783.70	$134,653.31	$29,987.23	22%	$7,668.60	$22,318.63	$10,326.98	8%	$94,339.10	70%

Notes:

1. The majority of monetary loss for the Medicare FFS program is due to medical necessity improper payments for Inpatient Rehabilitation Facility (IRF) claims.
2. The majority of monetary loss for the Medicaid program and CHIP is due to errors resulting from noncompliance with provider enrollment requirements and cases where the beneficiary was ineligible for the program or service.
3. Title IV-E Foster Care is a state-administered program and therefore eligibility is determined by staff at the state and local levels.
4. Since CCDF is a block grant, HHS has limited authority to require specific actions of state grantees given that states determine the specifics of their program.
5. Totals do not necessarily equal the sum of the rounded components.

11.0 PROGRAM-SPECIFIC REPORTING INFORMATION

11.1 MEDICARE FFS (PARTS A AND B)

Medicare FFS Statistical Sampling Process

HHS uses the Comprehensive Error Rate Testing (CERT) program to estimate the Medicare FFS improper payments. The CERT program reviews a stratified random sample of Medicare FFS claims to determine if HHS properly paid claims under Medicare coverage, coding, and billing rules. The Medicare FFS improper payment estimate also includes improper payments due to insufficient or no documentation. **Figure 4** below depicts the CERT process.

The CERT program considers improper payments to be:

- Any claim payment that should have been denied or was made in the wrong amount, including overpayments and underpayments. The claim counts as either a total or partial improper payment, depending on the error;
- Improper payments of all dollar amounts (i.e., there is no dollar threshold under which errors will not be cited); and
- Improper payments caused by policy changes as of the new policy's effective date (i.e., there is no grace period permitted).

Figure 4: CERT Process

The CERT program ensures statistically valid random sampling across four claim types:

- Part A claims excluding hospital Inpatient Prospective Payment System (IPPS) (including but not limited to home health, Inpatient Rehabilitation Facility [IRF], Skilled Nursing Facility [SNF], and hospice);
- Part A hospital IPPS claims;
- Part B claims (e.g., physician, laboratory, and ambulance services); and
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

In response to the COVID-19 PHE, HHS exercised its enforcement discretion to provide temporary administrative relief to all providers and suppliers. Effective March 27, 2020, the CERT program stopped sending documentation request letters to or conducting phone calls with providers or suppliers to request medical documentation or other data for claims in the 2020 report period (claims submitted July 1, 2018, through June 30, 2019).

HHS had sufficient data to estimate the FY 2020 Medicare FFS program improper payment rate based on the data that HHS had or that providers or suppliers voluntarily submitted and still complied with the OMB requirements for a statistical sample plan and confidence interval.

HHS sampled approximately 50,000 claims during the FY 2020 report period. The improper payment rate estimated from this sample reflects all claims processed by the Medicare FFS program during the report period. All Medicare FFS estimated improper payments were made by the federal government or its representatives. Additional information on Medicare FFS improper payment methodology is on pages 166-167 of HHS's FY 2012 AFR.

Service Areas Driving Improper Payments

The Medicare FFS improper payment estimate for FY 2020 is 6.27 percent of total outlays or $25.74 billion. This year's estimate decreased from the prior year's reported 7.25 percent improper payment estimate due to a reduction in improper payments for home health, and SNF claims. Although the improper payment rate for these services and the gross Medicare FFS improper payment rate decreased, improper payments for hospital outpatient, IRF, SNF, and home health claims were major contributing factors to the FY 2020 Medicare FFS improper payment rate, comprising 34.22 percent of the overall estimated improper payment rate. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors as described in the following four driver service areas:

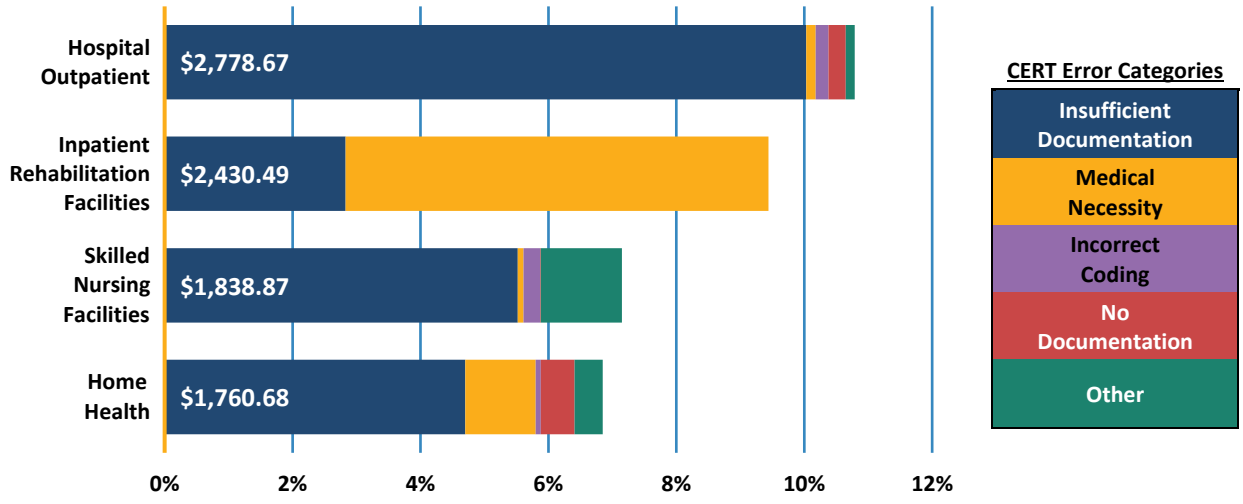
- Insufficient documentation continues to be the major error reason for hospital outpatient claims. The improper payment rate for hospital outpatient claims decreased from 4.37 percent in FY 2019 to 4.02 percent in FY 2020. The primary reason for the errors was that the order (or the intent to order for certain services) or medical necessity documentation was missing or insufficient (42 United States Code [U.S.C.] §1395y, 42 Code of Federal Regulations [CFR] §410.32).
- Medical necessity (i.e., services billed were not medically necessary) continues to be the major error contributor for IRF claims. The IRF claims improper payment rate decreased from 34.87 percent in FY 2019 to 30.81 percent in FY 2020. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires a reasonable expectation that the patient meets all coverage criteria at the time of IRF admission (42 CFR §412.622(a)(3)).
- Insufficient documentation continues to be the major error reason for SNF claims. The SNF claims improper payment rate decreased from 8.54 percent in FY 2019 to 5.43 percent in FY 2020. The primary reason for these errors was missing or insufficient certification/recertification statements and the medical record did not contain the required missing elements. Medicare coverage of SNF services requires certification and recertification for these services (42 CFR §424.20).
- Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 12.15 percent in FY 2019 to 9.30 percent in FY 2020. The primary reason for the errors was missing or insufficient documentation to support the certification of home health eligibility requirements. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR §424.22).

Most CERT error categories are more detailed than OMB root cause categories in an effort to help generate useful root cause information regarding HHS improper payments. **Figure 5** describes the CERT error categories, while **Figure 6** shows the FY 2020 Medicare FFS drivers for hospital outpatient, IRF, SNF, and home health claims by CERT error category.

Figure 5: CERT Error Categories and Percentage of Improper Payments

CERT Error Category	Error Category Description	Share of Improper Payments
Insufficient Documentation	These errors occur when submitted medical records are inadequate to determine if billed services were provided, provided at the level billed, and/or were medically necessary; or when specific documentation required as a condition of payment is missing.	63.11%
Medical Necessity	These errors occur when submitted medical records contain adequate documentation to make an informed decision that services billed were not medically necessary based upon Medicare coverage and payment policies.	16.17%
Incorrect Coding	These errors occur when submitted medical records support a different code than what was billed; the service was performed by someone other than the billing provider or supplier; the billed service was unbundled; or the beneficiary was discharged to a site other than the one coded on the claim.	10.92%
No Documentation	These errors occur when the provider or supplier fails to respond to repeated requests for medical records or responds that they do not have the requested documentation.	4.42%
Other	These errors do not fit into the previous categories (e.g., duplicate payment error, non-covered or unallowable service, ineligible Medicare beneficiary, etc.).	5.37%

Figure 6: FY 2020 Medicare FFS Service Areas with the Largest Estimated Improper Payment Dollar Amounts: Percentage Share of Medicare FFS Improper Payments, by CERT Error Category (Dollar Amounts in Millions)



Unknown versus Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Instances where there is insufficient or no documentation to support the payment as proper are cited as improper payments. The majority of Medicare FFS improper payments are due to documentation errors where HHS could not determine if billed services were provided, provided at the level billed, and/or were medically necessary. In other words, when payments lack the appropriate supporting documentation, validity cannot be determined. These are payments

where more documentation is necessary to determine if the claims were payable or if they should be considered monetary losses to the program. In **Figure 7** below, "unknown" represents payments where there was insufficient or no documentation to support the payment as proper or as a known monetary loss.

To provide additional information for unknown payments, HHS reviewed insufficient documentation errors to determine if the errors were "documentation noncompliance errors" which includes services or items:

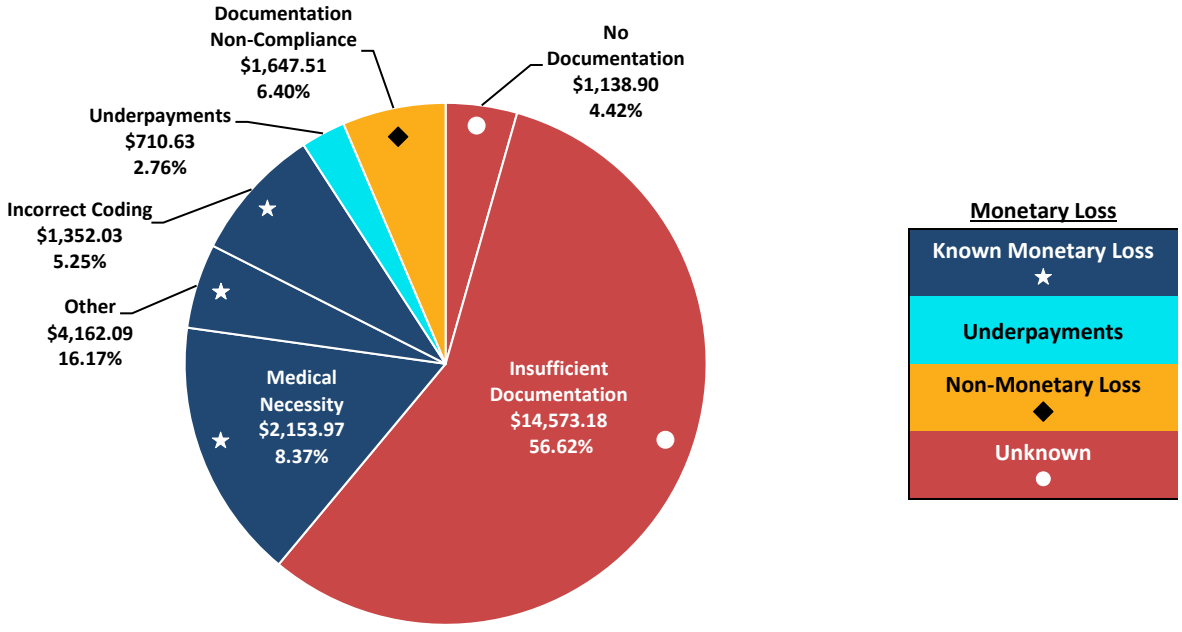
- That were covered and necessary;
- Provided/delivered to an eligible beneficiary;
- Paid in the correct amount; and
- The medical record documentation did not comply with rules and requirements per Medicare policy.

HHS determined that 6.40 percent of the total improper payments were documentation noncompliance errors. If the documentation noncompliance errors were corrected, the government would have made the payment in the assigned amount, and therefore, it represents a "non-monetary loss" to the government. If the documentation noncompliance errors counted as proper payments, the FY 2020 Medicare FFS improper payment rate would have been 5.86 percent, representing $24.10 billion in projected improper payments.

Another proportion of improper payments is claims where HHS determined that the Medicare FFS payment should not have occurred or should have been paid in a different amount. For this reason, medical necessity, incorrect coding, and other errors are improper and known monetary losses to the program.

In addition, **Figure 7** below provides information on Medicare FFS improper payments that are known monetary losses, underpayments, unknown, and non-monetary losses to the program.

Figure 7: FY 2020 Medicare FFS Estimated Improper Payments, by Monetary Loss Category and Type of CERT Error[1] (Dollar Amounts in Millions)



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Medicare FFS Corrective Action Plan

HHS addresses improper payments in Medicare FFS through various corrective actions. HHS's aggressive corrective actions have led to consistent reductions in the Medicare FFS improper payment rate since 2014. This reduction in improper payments was achieved as a result of HHS's commitment and steadfast efforts to identify the root causes of improper payments, implement action plans to reduce and prevent improper payments, and extend our capacity to address emerging areas of risk through workgroups and interagency collaborations. The following sections discuss key HHS corrective actions to address driver service area errors and OMB root cause categories. Corrective actions denoted with an asterisk (*) indicate that HHS temporarily paused and/or altered the corrective action due to the COVID-19 PHE. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

Corrective Actions to Address Driver Service Areas

HHS developed multiple preventive and detective measures for specific service areas with high improper payment rates, such as hospital outpatient, IRF, SNF, and home health claims. HHS believes implementing targeted corrective actions will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Service Area: Hospital Outpatient

HHS implemented corrective actions for payment errors related to hospital outpatient services resulting from missing or insufficient medical record documentation and medical necessity issues. Key hospital outpatient corrective actions include:

Key Hospital Outpatient Corrective Actions	
Corrective Action	**Description**
TPE for Hospital Outpatient Reviews*	During FY 2020, Medicare Administrative Contractors (MAC) continued performing medical review following the TPE process by conducting up to three rounds of hospital outpatient claims review of 20 to 40 claims per round, with one-on-one education provided at the end of each round. In FY 2020, MACs reviewed approximately 1,124 Hospital Outpatient providers under the TPE program.
Supplemental Medical Review Contractor (SMRC) Hospital Outpatient Reviews*	In FY 2020, the SMRC performed medical reviews on a post-payment basis for hospital outpatient claims, such as outpatient dental services, electrodiagnostic testing, spinal cord stimulator, outpatient hyperbaric oxygen services, polysomnography services, intravenous immunoglobulin, and transforaminal epidural injections. The SMRC shares the results of its medical review with the MACs for claim adjustments upon the review's completion. The providers receive detailed review result letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers regarding what was incorrect in the original billing of the claim.
Recovery Audit Contractors (RAC) Outpatient Reviews*	During FY 2020, Medicare FFS RACs continued to identify and collect improper payments related to outpatient claims for several factors, including insufficient documentation. Approximately 43.2 percent of Medicare FFS RAC collections were from overpayments identified during hospital outpatient claim reviews.

Key Hospital Outpatient Corrective Actions	
Corrective Action	**Description**
Outpatient Prior Authorization	In FY 2020, HHS finalized a regulation through the Calendar Year 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC) establishing a nationwide prior authorization process and requirements for certain hospital outpatient services. Beginning July 1, 2020, HHS now requires prior authorization for the following services: Blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation.[31] This process serves as a method for controlling unnecessary increases in the volume of these services. In FY 2020, HHS provisionally affirmed (approved) 20,178 services through this process.

Service Area: Inpatient Rehabilitation Facilities

HHS also continues to focus on addressing IRF payment errors, including errors resulting from medical necessity. Key IRF corrective actions include:

Key IRF Corrective Actions	
Corrective Action	**Description**
TPE for IRF Reviews*	During FY 2020, MACs continued performing medical review following the TPE process by conducting up to three rounds of IRF claims review of 20 to 40 claims per round, with one-on-one education provided at the end of each round. In FY 2020, MACs reviewed approximately 92 IRF providers under the TPE program.
SMRC IRF Reviews*	In FY 2020, the SMRC continued medical review on a post-payment basis of IRF claims. The SMRC shares the results with the MACs for claim adjustment. The providers receive detailed review result letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers regarding what was incorrect in the original billing of the claim.
RAC IRF Reviews*	In FY 2020, HHS approved the Medicare FFS RACs to review IRF claims for several factors, including medical necessity and insufficient documentation. In FY 2020, 4.1 percent of Medicare FFS RAC collections were from overpayments identified during IRF claim reviews.
Removal of the Post-Admission Physician Evaluation	In the FY 2021 IRF Prospective Payment System (CMS-1729-F) final rule, HHS finalized the removal of the post-admission physician evaluation required to be completed within the first 24 hours of the IRF patient's admission to the IRF by the rehabilitation physician. This finalized change became effective for all IRF discharges beginning on or after October 1, 2020.

Service Area: Skilled Nursing Facilities

HHS implemented corrective actions for payment errors related to SNF services resulting from missing or insufficient medical record documentation. Key SNF corrective actions include:

Key SNF Corrective Actions	
Corrective Action	**Description**
TPE for SNF Reviews*	During FY 2020, HHS continued performing medical review of SNF claims with high improper payment rates under the TPE program. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the end of each round. In FY 2020, MACs reviewed approximately 22 SNF providers under the TPE program.

[31] Refer to the CMS website for additional information on Prior Authorization for Certain Hospital Outpatient Department Services.

Key SNF Corrective Actions	
Corrective Action	**Description**
SMRC SNF Reviews*	In FY 2020, the SMRC continued performing medical review activities related to post-payment review of SNF claims. The SMRC shares the results with the MACs for claim adjustment. The providers receive detailed review result letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers regarding what was incorrect in the original billing of the claim.
RAC SNF Reviews*	During FY 2020, Medicare FFS RACs continued to conduct rapid post pay reviews of SNF services. Medicare FFS RACs continued to identify and collect improper payments related to SNF claims for several factors, including medical necessity and insufficient documentation. In FY 2020, 7.4 percent of Medicare FFS RAC collections were from overpayments identified during SNF claim reviews.

Service Area: Home Health

HHS continues to implement corrective actions to address program payment vulnerabilities related to home health services, including errors resulting from missing or insufficient documentation to support beneficiary eligibility for home health services and/or for skilled services. Key Home Health corrective actions include:

Key Home Health Corrective Actions	
Corrective Action	**Description**
TPE for Home Health Agencies (HHA)*	During FY 2020, MACs continued performing medical reviews following the TPE process by reviewing home health agencies with high error rates. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the end of each round. HHAs with high error rates at the end of round two of the previous Home Health Probe and Educate program and those identified by MAC data analysis as statistical outliers are included in the TPE process. In FY 2020, MACs reviewed approximately 582 HHA providers under the TPE program.
Review Choice Demonstration for Home Health Services*	The review Choice Demonstration for Home Health Services gives Jurisdiction M (Palmetto) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas an initial choice of three options (i.e., pre-claim review, post-payment review, or minimal post-payment review with a 25 percent payment reduction for all home health services). A provider's compliance with Medicare billing, coding, and coverage requirements would determine the provider's next steps under the demonstration. HHS received OMB *Paperwork Reduction Act* approval on February 26, 2019. The demonstration began for Illinois providers on June 1, 2019, for Ohio providers on September 30, 2019, and for Texas providers on March 2, 2020. The demonstration began voluntarily for North Carolina and Florida providers on August 31, 2020.[32] In FY 2020, HHS affirmed provisionally (or approved) 786,586 billing periods for home health services.
RAC Home Health Reviews*	In FY 2020, the national HHA RAC conducted comprehensive documentation and medical necessity review of home health claims. HHS approved the Medicare FFS Home Health and Hospice RAC to review home health claims for several factors, including lack of documentation to support medical necessity of provided home health services, insufficient documentation to support billed home health claims, and if home health services were rendered as billed.

[32] Refer to the August 21, 2020 update for Review Choice Demonstration for Home Health Services on the CMS website for additional information.

Key Home Health Corrective Actions	
Corrective Action	**Description**
Elimination of Home Health Requests for Anticipated Payment	As part of the Calendar Year 2020 Payment and Policy Changes for Home Health Agencies and Calendar Year 2021 Home Infusion Therapy Benefit (CMS-1711-FC), HHS issued a final rule with comment period that finalized a policy to decrease the upfront, split-percentage payment for 30-day home health periods of care beginning on January 1, 2020 to 20 percent for existing HHAs, and to lower the split-percentage payments to zero for all 30-day periods of care beginning on or after January 1, 2021. Newly enrolled HHAs already were not receiving split-percentage payments for periods of care beginning on or after January 1, 2020.

Other Service Areas

HHS leverages prior corrective action successes in other service areas (such as DMEPOS) and other non-emergent services by working with providers to improve understanding of HHS policies and explore new opportunities for corrective actions. Key Other Service Area corrective actions include:

Key Other Service Area Corrective Actions	
Corrective Action	**Description**
DMEPOS Prior Authorization*	In FY 2020, HHS provisionally affirmed (or approved) over 53,130 DMEPOS items through the prior authorization process. On October 21, 2019, HHS expanded nationwide a requirement for prior authorization for five Pressure Reducing Support Surface codes. HHS initially required prior authorization for these codes beginning July 22, 2019 in California, Indiana, New Jersey, and North Carolina. On February 11, 2020, HHS published a Federal Register Notice requiring prior authorization for six Lower Limb Prosthetic codes effective May 11, 2020 in California, Michigan, Pennsylvania, and Texas, and nationwide effective October 8, 2020. Due to the PHE, HHS delayed implementation of these additional codes until September 1, 2020 for California, Michigan, Pennsylvania, and Texas, and nationwide effective December 1, 2020.
Ambulance Transport Prior Authorization*	In FY 2020, HHS continued a prior authorization model for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, South Carolina, North Carolina, Virginia, West Virginia, Maryland, the District of Columbia, and Delaware. Consistent with Section 515(b) of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA), the model continues to reduce Medicare spending while maintaining overall levels of quality of and access to care. Based on expenditure data, spending decreased in the initial model states from an average of $18.9 million to an average of $6.0 million per month. Based on data from the additional MACRA states, spending decreased from an average of $5.7 million to an average of $2.7 million per month. On September 22, 2020, HHS announced that it will expand the model nationwide, as the model has met all expansion criteria under section 1834(l)16 of the Act (as added by section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10) (MACRA).
TPE for DMEPOS Reviews*	During FY 2020, HHS conducted medical review of DMEPOS claims with high improper payment rates under the TPE program. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the end of each round. In FY 2020, MACs reviewed approximately 2,463 DMEPOS suppliers under the TPE program.

Key Other Service Area Corrective Actions	
Corrective Action	**Description**
SMRC DMEPOS Reviews*	In FY 2020, the SMRC performed medical reviews on a post-payment basis for DMEPOS claims, such as Replacement Positive Airway Pressure supplies, Transcutaneous Electrical Nerve Stimulation Units, Therapeutic Shoes for Diabetics, and Diabetic Test Strips. After the SMRC completes its medical review, the results are shared with the MACs for claim adjustment. The providers receive detailed review result letters from the SMRC and demand letters for overpayment recovery from the MAC. These letters include educational information to providers regarding what was incorrect in the original billing of the claim.
RAC DMEPOS Reviews*	During FY 2020, the national Durable Medical Equipment (DME) RAC continues to conduct complex DMEPOS reviews for medical necessity of DMEPOS items billed, insufficient documentation to support DMEPOS items billed, missing valid orders for DME items billed, and if items/services billed were rendered. The DME RAC is also conducting automated DMEPOS reviews for inappropriate unbundling and if the DME items billed were medically necessary.
TPE for Hospice Reviews*	In FY 2020, HHS conducted medical review of hospice claims with high improper payment rates under the TPE program. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per hospice selected, with one-on-one education provided at the end of each round. In FY 2020, MACs reviewed approximately 754 hospice providers under the TPE program.
DMEPOS Supplier Education*	In FY 2020, HHS educated providers and DMEPOS suppliers through Medicare Learning Network (MLN) articles called Provider Compliance Tips. HHS posted 20 articles, each on a different DMEPOS related service area, to the MLN website in FY 2020. These Provider Compliance Tips are added to and updated regularly as a result of improper payment findings, as well as regulatory and other policy changes, including the Calendar Year 2020 ESRD and DMEPOS Final Rule (CMS-1713-F).

In addition to these initiatives, HHS has implemented further efforts to reduce improper payments in Medicare FFS, spanning multiple service areas and addressing the OMB root causes of improper payments as outlined below.

Corrective Actions to Address OMB Root Causes:

Root Cause: Administrative or Process Errors Made by Other Party

Administrative or process errors made by other party (22.78 percent or $5,864.14 million; $5,153.51 million Overpayments and $710.63 million Underpayments) mainly consists of coding errors. Key corrective actions include:

Corrective Actions for Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
Automated Edits	Due to the high volume of Medicare claims processed by HHS daily and the significant cost associated with conducting medical reviews of an individual claim, HHS relies on automated edits to identify inappropriate claims. HHS designed its systems to detect anomalies on the face of the claims and prevent payment for many erroneous claims through these efforts. HHS uses the National Correct Coding Initiative (NCCI) to prevent inappropriate payments of Medicare Part B claims and Medicaid claims. For example, this program prevents payments for services such as the repair of an organ by two different methods. HHS will report FY 2020 savings from the NCCI edits in the forthcoming *Annual Report to Congress on the Medicare and Medicaid Integrity Programs*.

Corrective Actions for Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
Provider and Supplier Screening*	Existing Medicare Providers and Suppliers: HHS revalidates all existing Medicare providers and suppliers on an ongoing basis to ensure that only qualified and legitimate providers and suppliers deliver health care items and services to Medicare beneficiaries. HHS's provider screening and enrollment initiatives have had a significant impact on removing ineligible providers and suppliers from the Medicare program. HHS manages 2,561,285 million distinct Medicare enrollments through the Provider Enrollment, Chain, and Ownership System (PECOS). In FY 2020, HHS performed approximately 225,988 initial enrollment screenings, completed 182,538 revalidations, deactivated 111,884 enrollments, and revoked 2,827 enrollments.
	New Medicare Providers and Suppliers: HHS uses three levels of provider and supplier enrollment risk-based screening: "limited," "moderate," and "high." Providers and suppliers designated in the "limited" risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider- or supplier-specific requirements. Providers and suppliers designated in the "moderate" risk category are subject to unannounced site visits in addition to all the requirements in the "limited" screening level. Providers and suppliers in the "high" risk category are subject to fingerprint-based criminal background checks (FCBC) in addition to all of the requirements in the "limited" and "moderate" screening levels. In FY 2020, the initiative resulted in 23,652 site visits conducted by the National Site Visit Contractor, which conducts site visits for most Medicare FFS providers and suppliers, and 23,269 conducted by the National Supplier Clearinghouse, which conducts site visits for Medicare DME suppliers. This work resulted in 217 revocations due to non-operational site visit determinations for all providers and suppliers. In FY 2020, HHS denied 471 enrollments and revoked 11 enrollments as a result of the FCBCs or a failure to respond.
Healthcare Fraud Prevention Partnership (HFPP)	HHS continues to engage with the HFPP, a public-private partnership to improve detection and prevention of health care fraud, waste, and abuse by exchanging data, information, and anti-fraud practices. During FY 2020, HFPP membership grew from 144 to 172 partner organizations, including federal and state partners, private payers, associations, and law enforcement organizations.
Medical Review Strategies	HHS and its contractors develop medical review strategies using improper payment data to target the areas of highest risk and exposure. HHS requires its Medicare review contractors to identify and prevent improper payments due to documentation errors in certain error-prone claim types, such as SNF, hospital outpatient claims, IRF, and home health.
Overpayment Recoveries Related to Regulatory Provisions	In the Medicare Reporting and Returning of Self-Identified Overpayments (CMS-6037-F) final rule, HHS codified a rule requiring providers and suppliers to identify, report, and return self-identified Medicare Part A or Part B overpayments. This rule incentivizes providers and suppliers to maintain documentation and submit accurate claims, reducing potential improper payments.

Root Cause: Insufficient Documentation to Determine and Medical Necessity

The primary cause of Medicare FFS improper payments is insufficient documentation (61.05 percent or $15,712.09 million). For these claims, the submitted medical records are inadequate to conclude that the billed services were actually provided, provided at the level billed, and/or were medically necessary; or a specific documentation element, required as a condition of payment, is missing. Medicare FFS claims are also included in this category when the provider or supplier fails to respond to repeated requests for medical records or responds

that they do not have the documentation. If the provider submitted documentation or the provider had complete and sufficient documentation, then the claim may have been payable.

Another improper payment cause is medical necessity errors (16.17 percent or $4,162.09 million Overpayments). For these claims, the submitted medical records contain adequate documentation to make an informed decision that services billed were not medically necessary based upon Medicare coverage and payment policies. Key corrective actions include:

Corrective Actions for Insufficient Documentation and Medical Necessity	
Corrective Action	**Description**
SMRC Strategy	HHS contracts with the SMRC to perform medical reviews focused on vulnerabilities identified by HHS data analysis, the CERT program, professional organizations, and federal oversight entities. The SMRC evaluates medical records and related documents to determine if billed claims comply with Medicare coverage, coding, payment, and billing rules. In FY 2020, HHS tasked the SMRC with performing post-payment reviews on multiple areas: Replacement Positive Airway Pressure Devices; DMEPOS in SNF; Emergency Ambulance Services; Hospice Services; Non-Emergency Ambulance Services; Spinal Cord Stimulator; DMEPOS and No Response Providers; IRF services; Specimen Validity II; Botulinum Toxin; Intravenous Immunoglobulin; and Transforaminal Epidural Injections. HHS uses the reviewers' results to improve billing accuracy. Results are shared with providers through detailed review results letters and possible overpayment determinations. These letters include educational information regarding what was incorrect in the original claim billing.
TPE / Medical Review Strategies	HHS uses the TPE process, which is a targeted approach where MACs focus on specific providers and suppliers within a service type, rather than all providers and suppliers billing the service. This eliminates the burden to providers and suppliers who, based on data analysis, are already submitting claims that are compliant with Medicare policy. In FY 2020, MACs reviewed 3,217 DMEPOS and Hospice providers and suppliers under the TPE program for several factors, including lack of documentation to support medical necessity of provided items or services. In an attempt to create additional efficiencies to the TPE process, HHS continued the TPE 10-Claim Preview Pilot for DMEPOS suppliers, which reduces burden to compliant and/or large suppliers that demonstrate full compliance with CMS requirements.
Medical Review Accuracy Award Fee Metric	Beginning in FY 2014, HHS included the Medical Review Accuracy Award Fee Metric in the Award Fee Plan for MACs that process Part A, Part B, and DME claims. The Medical Review Accuracy Award Fee Metric measures the accuracy of the MAC's complex medical review decisions. This project assists with consistent medical review decisions across MACs, leading to uniform education to providers on all improper payments, including medical necessity and the impact of insufficient documentation errors. Additional goals of this project in FY 2020 included identifying unclear and/or burdensome policy requirements that can be clarified or simplified to prevent unnecessary denials. HHS continues to work on implementing an accuracy review initiative for the MAC redetermination appeal units to ensure consistent medical review decisions are made at that level.
Provider Billing Review Evaluation	In FY 2020, HHS issued Comparative Billing Reports (CBR) for the following topics: Atherectomy; Drugs billed in excess of Medically Unlikely Edits (MUE); Mohs Microsurgery; Shoulder Arthroscopy; Anesthesia; Lower Extremity Joint Replacement without prior conservative treatment; Peripheral Vascular Intervention for Claudication; Subsequent Nursing Facility Evaluation and Management Services; Breast Re-Excision; Therapeutic Injections and Infusions; and Office Visits, New & Established Patients by Nurse Practitioners.

Medicare FFS Information Systems and Other Infrastructure

HHS's systems can identify developing and continuing aberrant billing patterns through comparison of local payment rates to national rates. A secure high-speed network rapidly transmits large data sets between systems at both the Medicare contractor and HHS levels. In addition, to prevent improper payments on a prepayment basis, HHS continuously reviews opportunities for centralizing the development and implementation of automated edits based on national coverage determinations, medically unlikely units billed, and other relevant parameters.

11.2 Medicare Advantage (Part C)

Medicare Advantage Statistical Sampling Process

The Part C methodology estimates improper payments resulting from errors in beneficiary risk scores. The primary component of most beneficiary risk scores is clinical diagnoses submitted by the plan. If medical records do not support the diagnoses submitted to HHS, the risk scores may be inaccurate and resulting in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual Part C Improper Payment Measurement process, where HHS identifies unsupported diagnoses and calculates corrected risk scores. The Part C Improper Payment Measurement (see **Figure 8** below) calculates the beneficiary-level payment error for the sample and extrapolates the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount. In FY 2020, HHS selected a stratified random sample of beneficiaries with a risk adjusted payment in calendar year 2018 (where the strata are high, medium, and low risk scores) and reviewed medical records of the diagnoses submitted by plans for the sample beneficiaries.

Figure 8: Part C Improper Payment Measurement Process

Due to the COVID-19 PHE, HHS exercised its enforcement discretion and directed Medicare Advantage organizations to temporarily cease requests for documentation from providers regarding improper payment measures. However, plans were allowed to continue submitting documentation already obtained from providers. In order to account for the significant disruption caused by COVID-19 and the directive to cease contact with providers, HHS conducted analyses to determine the impact of this directive on medical record submission and adjusted the methodology accordingly.

The Medicare Part C gross improper payment estimate for FY 2020 is 6.78 percent or $16.27 billion.[33] This is a decrease from the prior year's estimate of 7.87 percent. All Medicare Part C estimated improper payments were made by the federal government or its representatives.

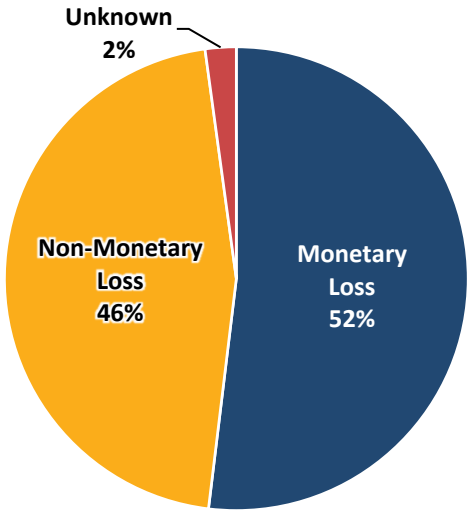
Unknown versus Monetary Loss Findings

The root causes of FY 2020 Medicare Part C improper payments consist of administrative or process errors made by another party (51.92 percent in Overpayments and 45.92 percent in Underpayments), with a smaller portion of overpayments resulting from missing documentation (2.16 percent). Monetary loss results from administrative or process errors by other party, specifically, when medical record documentation submitted by the MA organization does not substantiate a condition for which it received payment. The non-monetary loss component is comprised

[33] Medicare Part C 2018 (FY 2020) Improper Payment rate and amount listed are the preliminary results after applying a COVID-19 bias adjustment to the results from the reduced sample cohort of 627 enrollees.

of conditions identified during the medical review process that the MA organization did not submit for payment, while unknown is comprised of situations in which sufficient information was not available to make a determination. Monetary versus non-monetary loss is displayed in **Figure 9** below.

Figure 9: FY 2020 Medicare Part C Estimated Improper Payments, by Monetary, Non-Monetary Loss, and Unknown (i.e., Missing or Insufficient Documentation) Categories[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Medicare Advantage Corrective Action Plan

HHS addresses improper payments in Medicare Part C through various corrective actions. The following sections discuss key HHS corrective actions to address root cause categories. Corrective actions denoted with an asterisk (*) indicate that HHS temporarily paused and/or altered the corrective action due to the COVID-19 PHE. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

Corrective Actions to Address OMB Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

HHS implemented two key corrective actions to address the Part C improper payment estimate:

Corrective Actions for Insufficient Documentation and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
Contract-Level Audits*	Contract-level Risk Adjustment Data Validation (RADV) audits are HHS's primary corrective action to recoup overpayments. RADV uses medical record review to verify the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. HHS expects payment recovery will have a sentinel effect on risk adjustment data quality submitted by plans for payment because contract-level RADV audits increase the incentive for MA organizations to submit valid and accurate diagnosis information. Contract-level RADV audits also encourage MA organizations to self-identify, report, and return overpayments. In September 2019, HHS launched the payment year 2015 RADV audit. On January 9, 2020 HHS held a contract-level RADV training session for the 2015 payment year audit that included an overview of RADV enrollee data, guidance on preparing and submitting medical records and demonstration of the Central Data Abstraction Tool (CDAT). Due to the COVID-19 PHE, HHS suspended the 2015 audit in March 2020 and resumed it in September 2020. On September 10, 2020, HHS provided

Corrective Actions for Insufficient Documentation and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
	a refresher training regarding the payment year 2015 RADV audit that also included updates on enrollee data and how to access systems to submit medical records. The payment year 2014 RADV audit medical record submission phase is complete and the audit is expected to conclude in FY 2021. HHS expects to start contract-level RADV audits for payment years 2016 and 2017 by fall 2021.
Training	HHS conducted training sessions for Medicare Part C and Part D sponsors on program integrity initiatives, investigations, data analyses, and potential fraud schemes. In FY 2020, HHS conducted two Medicare Advantage Organization and Prescription Drug Plan fraud, waste, and abuse training webinars in January 2020 and July 2020; a Fraud, Waste, and Abuse Training in April 2020; and two Opioid Education Missions in October 2019 and March 2020. The missions included multi-disciplinary teams of experts and decision makers from HHS and its partners, and allowed them to undertake collaborative efforts to protect the Medicare Part C and D programs.

Medicare Advantage Information Systems and Other Infrastructure

HHS uses the following internal Medicare systems to make and validate Medicare Part C payments:

- Medicare Beneficiary Database;
- Risk Adjustment Processing System;
- Encounter Data Processing System;
- Health Plan Management System; and
- Medicare Advantage Prescription Drug (MARx) payment system.

11.3 Medicare Prescription Drug Benefit (Part D)

Medicare Prescription Drug Benefit Statistical Sampling Process

The Part D improper payment estimate measures the payment error related to prescription drug event (PDE) data, where most errors for the program exist. HHS measures inconsistencies between information reported on PDEs and supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error. A representative sample of beneficiaries undergoes a simulation to determine the Part D improper payment estimate.

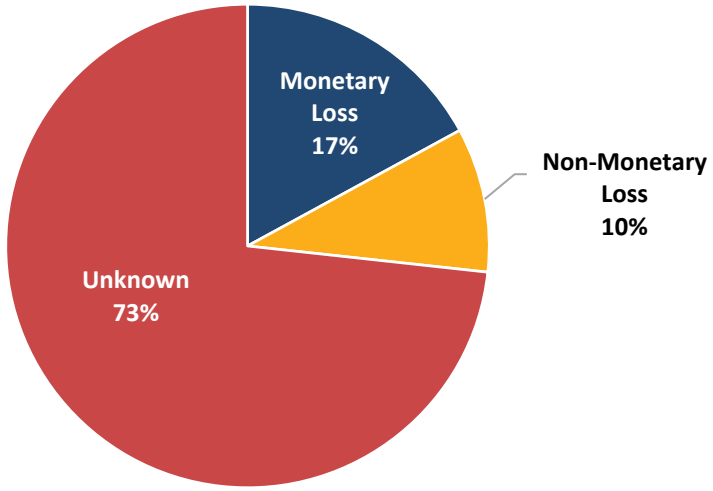
In order to reduce burden on providers due to the COVID-19 PHE, HHS exercised its enforcement discretion and directed Part D Sponsors to cease requests for documentation from providers and pharmacies regarding the improper payment measures. Without further contact with providers and pharmacies, plans were unable to obtain necessary documentation to support the measures; plans were, however, allowed to continue submitting documentation already on hand or that had been previously requested. In order to report accurate improper payment measures, HHS calculated the Medicare Part D improper payment measure excluding the small portion of the sample that was not submitted at the time of HHS's enforcement discretion. HHS then conducted analysis to compare with prior years' results to determine if additional adjustment was needed.

The FY 2020 Medicare Part D gross improper payment estimate is 1.15 percent or $927.50 million. The increase from the prior year's estimate of 0.75 percent is due to year-over-year variability. As the rate is already low, any variation can cause shifts that are relatively (but not absolutely) large. All Medicare Part D estimated improper payments were made by the federal government or its representatives.

Unknown versus Monetary Loss Findings

The FY 2020 Medicare Part D improper payments root causes are administrative or process errors made by other party (17.06 percent in Overpayments and 9.67 percent in Underpayments) and missing documentation (73.27 percent). Monetary loss results when the prescription documentation submitted indicates that an overpayment occurred. Non-monetary loss results when the documentation submitted indicates that an underpayment occurred, while unknown is comprised of a situation in which insufficient documentation was submitted to make a determination. Monetary versus non-monetary loss is displayed in **Figure 10** below.

Figure 10: FY 2020 Medicare Part D Estimated Improper Payments, by Monetary Loss, Non-Monetary Loss, and Unknown (i.e., Missing or Insufficient Documentation) Categories[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

Medicare Prescription Drug Benefit Corrective Action Plan

HHS addresses improper payments in Medicare Part D through various corrective actions. The following section discuss key HHS corrective actions to address root cause categories. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

Corrective Actions to Address OMB Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

HHS conducted the following corrective actions to address Part D payment errors:

Corrective Actions for Insufficient Documentation and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
Outreach	HHS continued formal outreach to plan sponsors for invalid or incomplete documentation. HHS distributed Final Findings Reports to all Part D sponsors participating in the PDE review process. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.
Training	HHS continued national training sessions on payment and data submission with detailed instructions as part of the improper payment estimation process for Part D sponsors. HHS also conducted in-person training sessions for Medicare Part C and Part D sponsors on program integrity initiatives, investigations, data analysis, and potential fraud schemes. In FY 2020, HHS conducted two Medicare Advantage Organization and Prescription Drug Plan fraud, waste, and

Corrective Actions for Insufficient Documentation and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
	abuse training webinars in January 2020 and July 2020; a Fraud, Waste, and Abuse COVID-19 webinar in April 2020; and two Opioid Education Missions in October 2019 and March 2020. The missions included multi-disciplinary teams of experts and decision makers from HHS and its partners, and supported collaborative efforts to protect Medicare Part C and D.

Medicare Prescription Drug Benefit Information Systems and Other Infrastructure

HHS uses the following internal Medicare systems to make and validate Medicare Part D payments:

- Medicare Beneficiary Database;
- Risk Adjustment Processing System;
- Health Plan Management System;
- MARx payment system; and
- Integrated Data Repository.

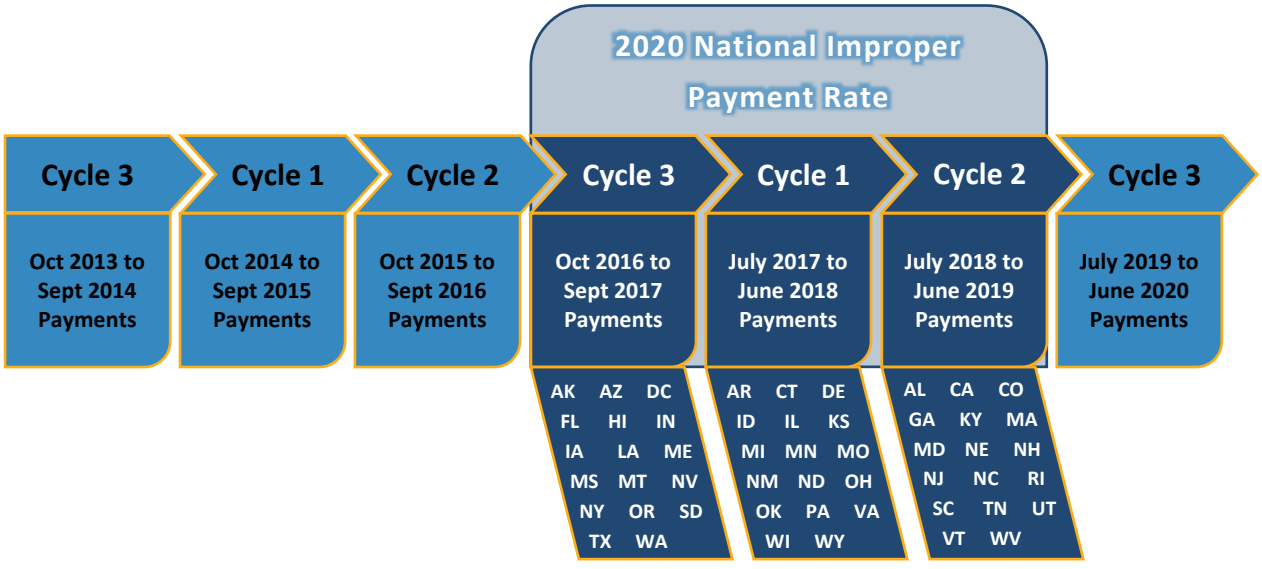
11.4 MEDICAID

Medicaid Statistical Sampling Process

Through the Payment Error Rate Measurement (PERM) program, HHS estimates Medicaid improper payments on an annual basis, utilizing federal contractors to measure three components: FFS, managed care, and eligibility.

HHS's PERM program uses a 17-states-per-year, 3-year rotation for measuring Medicaid improper payments. All 50 states and the District of Columbia are reflected in the national Medicaid improper payment rate reported here, as that rate includes findings from the most recent 3 years of measurements. Each time a group of 17 states is measured under the PERM program, HHS removes that group's previous findings from the calculation and includes its newest findings. The national FY 2020 Medicaid improper payment rate is based on FYs 2018, 2019, and 2020 measurements (see **Figure 11** below).

Figure 11: FY 2020 Medicaid Cycle Measurements



To learn how HHS grouped states into three cycles, refer to pages 177-179 of HHS's FY 2012 AFR.

Due to the COVID-19 PHE, HHS exercised its enforcement discretion by temporarily suspending all improper payment related engagement/communications and data requests to providers and state agencies from HHS. In order to complete reviews for FY 2020 national reporting and maintain a consistent review of all states, HHS only reviewed claims that had been fully completed review before implementation of the COVID-19 response measures and that HHS could complete without additional outreach to states or providers. HHS incorporated documentation voluntarily submitted by states and/or providers during the period of enforcement discretion into the reviews.

FFS and Managed Care Components

FFS includes the traditional method of paying for medical services under which a state pays providers for each service rendered to individual beneficiaries. Managed care is a delivery system where a state makes a monthly payment to a managed care plan, which is responsible for managing beneficiary care and rendering payments to providers. Quarterly, states submit adjudicated claims data and HHS randomly selects a sample of FFS claims and managed care capitated payments. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to only a data processing review. Reviewing either the medical records associated with historical payments to providers or the medical records associated with payments to providers that occurred during the month sampled does not have a direct link to the established capitated payment sampled and, thus, is not included in the improper payment review.

Additionally, HHS selects a combination of FFS claims and managed care payments for eligibility review. Based on each state's expenditures and historical FFS and managed care improper payment data, the FFS sample size was between 49 and 1717 claims per state, the managed care sample size was between 38 and 240 payments per state, the eligibility FFS sample size was between 102 and 477 per state, and the eligibility managed care sample size was between 100 and 574 per state. When a state's FFS or managed care component accounted for less than two percent of the state's total Medicaid expenditures, HHS combined the state's FFS and managed care claims into one component for sampling and measurement purposes.

Eligibility Component

Through the eligibility component, a federal contractor assesses states' application of federal rules and the state's documented policies and procedures related to beneficiary eligibility. States must produce records and documentation to support the eligibility determination. Examples of noncompliance with eligibility requirements include a state: enrolling a beneficiary when he or she is ineligible for Medicaid; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible service or incorrect federal reimbursement amount being provided; not conducting a timely beneficiary redetermination; or not performing, completing, or providing sufficient documentation to support a required element of the eligibility determination process, such as income verification. As described in the PERM final rule (82 Federal Register 31158, July 5, 2017), HHS resumed the eligibility component measurement for the 17 Cycle 2 states and reported an updated national eligibility improper payment estimate for FY 2020. Between FY 2015 and FY 2018, HHS did not conduct the eligibility measurement component of PERM; refer to pages 211-214 of HHS's 2018 AFR for more information. Note that the national eligibility improper payment rate still includes a proxy estimate for the remaining 17 states in Cycle 3 that have not yet been measured since the reintegration of the PERM eligibility component.

Calculations and Findings

The national Medicaid program's improper payment estimate combines each state's Medicaid FFS, managed care, and eligibility improper payment estimate. In addition, HHS combines individual state component improper payment estimates to calculate the national component improper payment estimates. National component

improper payment rates and the Medicaid program improper payment rate are weighted by state size, such that a state with a $10 billion program is weighted more in the national rate than a state with a $1 billion program. A correction factor in the methodology ensures that each Medicaid improper payment is counted only once in the combined national rate. All Medicaid estimated improper payments were made by recipients of federal money.

The national Medicaid improper payment estimate for FY 2020 is 21.36 percent or $86.49 billion.

The FY 2020 national Medicaid improper payment rate for each component is:

- *Medicaid FFS*: 16.84 percent
- *Medicaid managed care*: 0.06 percent
- *Medicaid eligibility*: 14.94 percent

Supplemental information related to the FY 2020 Medicaid improper payment results will be published on the PERM page of the CMS website in early 2021.

One area driving the FY 2020 Medicaid improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the *Patient Protection and Affordable Care Act* (PPACA) requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with federal eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is an indication that eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

Additionally, since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. Most improper payments cited on claims were a newly enrolled provider not appropriately screened by the state; a provider without the required NPI on the claim; or a provider not enrolled.

While the screening errors described above are for newly enrolled providers, states also must revalidate enrollment and rescreen all providers at least every 5 years. States were required to complete the revalidation process of all existing providers by September 25, 2016. In FY 2020, HHS measured the third cycle of states for compliance with requirements for provider screening at revalidation. Improper payments cited on claims where a provider had not been appropriately screened at revalidation is a new major error source in the Medicaid improper payment rate. HHS completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, HHS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

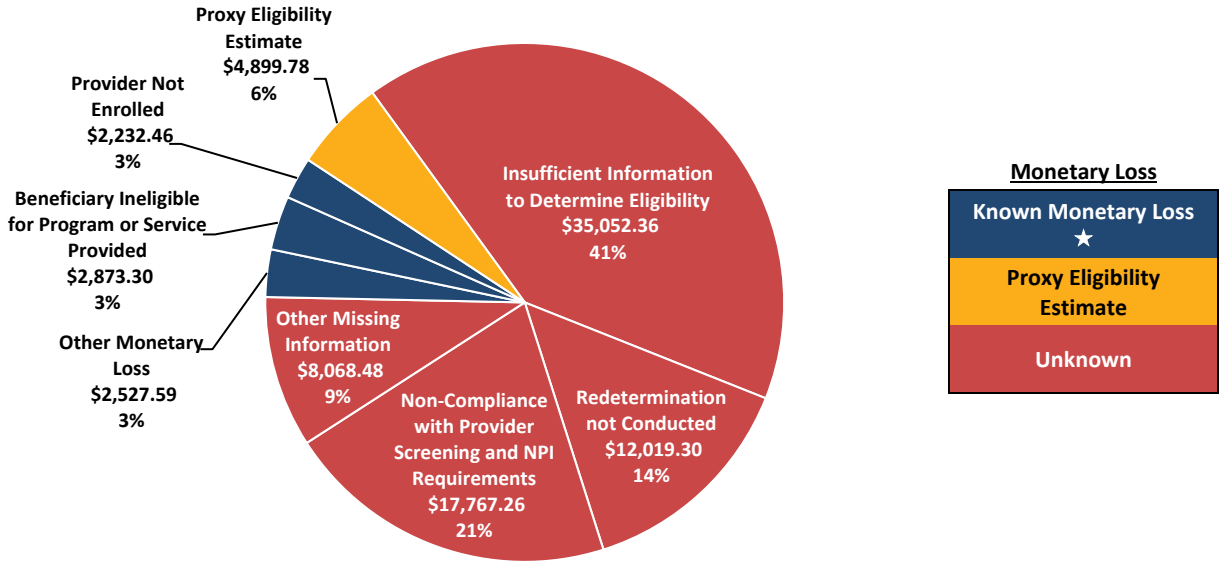
Unknown versus Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Improper payments also include instances of insufficient or no documentation to support the payment as proper. A majority of Medicaid improper payments were due to instances where information required for payment was missing, an eligibility determination was missing from the claim or state systems, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or on behalf of

ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, then the claims may have been payable. Conversely, if the missing documentation had been available, it could have affirmatively indicated whether a provider or beneficiary was ineligible for Medicaid reimbursement, which could be considered known monetary loss. Known monetary losses to the program are claims where HHS determines the Medicaid payment should have either not occurred or been made in a different amount.

Figure 12 below provides information on Medicaid improper payments that are a known monetary loss to the program (i.e., provider not enrolled, beneficiary ineligible for program or service, incorrect coding, and other errors like claims processing errors, duplicate claims, or pricing mistakes). "Unknown" represents payments where there was insufficient or no documentation to support the payment as proper or as a known monetary loss (e.g., claims where information was missing or states did not follow appropriate processes).

Figure 12: FY 2020 Medicaid Estimated Improper Payments, by Monetary Loss versus Unknown Categories and Type of PERM Error[1] (Dollar Amounts in Millions)



[1] The Proxy Eligibility Estimate is used to represent the eligibility component for the 17 states not yet measured since the reintegration of the PERM eligibility component. All eligibility improper payments from the FY 2020 measurement are included in the appropriate category (Known Monetary Loss or Unknown). The Proxy Eligibility Estimate includes both overpayments and underpayments, whereas Known Monetary Loss and Unknown only include overpayments. The value of underpayments outside the Proxy Eligibility Estimate ($137.64 million) was too small to report in Figure 12. In addition, due to rounding, amounts in this figure may not add up precisely to other tables in this document.

Medicaid Corrective Action Plan

HHS addresses improper payments in Medicaid through various corrective actions. While HHS takes broad steps to reduce Medicaid improper payments at the federal level, the Medicaid program is a federal-state partnership, and states are equally responsible for addressing improper payments at the state level by developing and implementing state-specific corrective action plans. HHS works closely with all states through enhanced technical assistance (including liaisons that are assigned to each state to assist with identifying and overcoming barriers to corrective action implementation) and guidance to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the corrective action plan's effectiveness, with assistance and oversight from HHS. When developing corrective action plans, states focus on the major causes of improper payments.

Several important ongoing activities inform the development of HHS's corrective actions by providing data and information directly from state experiences with implementing the Medicaid program:

- Reviewing improper payment rate data for each component of the PERM program;
- Conducting outreach during off-cycle PERM years to identify issues states are experiencing with the state-specific corrective action plans;
- Reviewing state data submitted through the Medicaid Eligibility Quality Control (MEQC) program;
- Facilitating national best practice calls that identify state promising practices;
- Offering ongoing technical assistance;
- Providing additional guidance, as needed; and
- Providing training to state partners through the Medicaid Integrity Institute.

The following sections discuss key HHS corrective actions to address root cause categories. Corrective actions denoted with an asterisk (*) indicate that HHS temporarily paused and/or altered the corrective action due to the COVID-19 PHE. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

Corrective Actions to Address OMB Root Causes:

Root Causes: Administrative or Process Errors Made by State or Local Agency and Failure to Verify

Administrative or process errors made by states or local agencies (8.53 percent or $7,379.68 million; $7,269.22 million Overpayments and $110.46 million Underpayments) and failure to verify (0.03 percent or $25.90 million; all Overpayments) errors mainly consist of errors resulting from noncompliance with the requirement to screen and enroll providers and from cases where the beneficiary was ineligible for the program or service. State corrective action plans focus on system or process changes to reduce these errors. HHS corrective actions include providing additional guidance and oversight to states' enrollment processes for providers and beneficiaries, described in the table below.

Corrective Actions for Administrative or Process Errors Made by State or Local Agency and Failure to Verify	
Corrective Action	**Description**
Enhanced State PERM Corrective Action Plan Process*	In FY 2020, HHS implemented a more robust state-specific corrective action plan process that provides enhanced technical assistance and guidance to states. HHS continued working with the states to coordinate state development of corrective action plans to address each error and deficiency identified during the PERM cycle. After the corrective action plan submissions, HHS monitored and followed up with all states on their progress in implementing effective corrective actions to address the errors and deficiencies. HHS continued using lessons learned from this process to inform areas to evaluate for future guidance and education.
Enhanced Assistance on State Medicaid Provider Screening and Enrollment	HHS provides ongoing guidance, education, and outreach to states on federal requirements for Medicaid provider screening and enrollment. In addition, HHS updated the Medicaid Provider Enrollment Compendium in July 2018 to provide additional sub-regulatory guidance to assist states in applying the regulatory requirements, and is planning further updates in FY 2021. HHS also continued state site visits during FY 2020 to assess provider screening and enrollment compliance, provide technical assistance, and offer states the opportunity to leverage Medicare screening and enrollment activities. HHS provided screening and enrollment assistance through visits to Colorado, Oklahoma, and Wyoming in FY 2020.
MEQC Program*	Under the MEQC program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. States have flexibility in designing pilots to focus on vulnerable or error-prone areas identified by the PERM program

Corrective Actions for Administrative or Process Errors Made by State or Local Agency and Failure to Verify	
Corrective Action	**Description**
	and state. The MEQC program also reviews eligibility determinations that are not reviewed under the PERM program, such as denials and terminations. MEQC pilots are conducted during the 2-year intervals that occur between states' triennial PERM review years ("off-years"), allowing states to implement prospective improvements in eligibility determination processes prior to their next PERM review. In FY 2020, HHS worked with the Cycle 1 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission; the Cycle 2 states to restart their MEQC reviews; and the Cycle 3 states to submit the required MEQC pilot planning documents.
Conduct Audits of State Beneficiary Eligibility Determinations*	As part of HHS's CMIP for FYs 2019-2023, in FY 2020, HHS continued conducting audits of beneficiary eligibility determinations in states with eligibility errors in previous OIG and State Auditor reports. These audits included assessments of state eligibility policies, processes, and systems. For example, HHS reviewed if beneficiaries were found properly eligible for the adult expansion group in New York, Kentucky, and Louisiana. Future audits may focus on states that may be at higher risk of errors, such as those with higher eligibility improper payment rates under the PERM program, eligibility errors based on GAO or OIG reports, issues identified by states through the MEQC program, and issues identified through HHS's various corrective action plan oversight processes.
Medicaid Integrity Institute (MII)*	HHS offers training, technical assistance, and support to state Medicaid program integrity officials through the MII. In FY 2020, HHS continued a robust training program, which included both residential and virtual training opportunities. For example, FY 2020 offerings included coding courses, investigative skills courses, and a session to discuss the future of the MII in an ever-changing program integrity landscape. HHS cancelled all residential courses after the start of the COVID-19 PHE, and established virtual courses to continue educational offerings. Despite this change, state interest and participation was strong, consistent with previous years. More information is located at the Medicaid Integrity Institute website.
Technical Assistance and Education on Beneficiary Eligibility and Enrollment	In June 2019, HHS released an Informational Bulletin to states reiterating and clarifying existing federal requirements for eligibility and enrollment processes, including information specific to the Medicaid adult expansion group. Specifically, the Informational Bulletin provided states technical guidance on requirements related to eligibility and enrollment systems, including system requirements to ensure accurate eligibility determinations, processes to distinguish newly eligible adults from non-newly eligible adults, and capacities to conduct trend analysis for eligibility-related fraud, waste and abuse. In addition, the Informational Bulletin described state responsibilities related to eligibility policies and procedures, included eligibility verification plans, and staff training. In FY 2020, HHS continued to promote the Informational Bulletin through training webinars and other educational venues to educate states on the importance of the guidance requirements. HHS also conducted a project under the Medicaid and CHIP Learning Collaborative to identify state best practices in program integrity and to draw from the Informational Bulletin, MEQC program, PERM reviews, eligibility audits, state verification plans, OIG audits, and relevant materials from the MII to develop a training to further state efforts in this area. As part of this project, HHS conducted an all-state webinar for Medicaid and CHIP eligibility officials and program integrity officials, which emphasized the important connection between program integrity and conducting accurate eligibility determinations and redeterminations. HHS personnel also continued important ongoing technical assistance efforts, such as: • Providing one-on-one technical assistance to states regarding application processing, eligibility determinations, enrollment, retention, and verification policies;

Corrective Actions for Administrative or Process Errors Made by State or Local Agency and Failure to Verify	
Corrective Action	**Description**
	• Working closely with states when regulatory compliance issues are identified regarding eligibility, enrollment, verification, or renewal policies to diagnose root causes and then develop mitigation and/or corrective action plans; and • Working collaboratively across HHS components and with states to ensure eligibility and enrollment rules are appropriately programmed into states' Medicaid/CHIP eligibility and enrollment systems, the Federally Facilitated Exchange, and State Based Exchanges.

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

Insufficient documentation to determine (85.35 percent or $73,818.30 million) errors primarily result from noncompliance with provider screening, revalidation, or NPI requirements; insufficient documentation to determine eligibility; noncompliance with eligibility redetermination requirements; insufficient or no medical documentation submitted by providers; or other missing information from the state. Administrative or process errors made by other party (0.38 percent or $331.05 million; $305.55 million Overpayments and $25.49 million Underpayments) primarily consist of other provider errors identified through medical review. State corrective action plans include implementing new claims processing edits, converting to a more sophisticated claims processing system, implementing provider enrollment process improvements, implementing beneficiary enrollment and redetermination process improvements, and conducting provider communication and education to reduce errors related to documentation requirements. HHS corrective actions include additional guidance and technical assistance, as well as greater state oversight. While several of the corrective actions also apply to the above Administrative or Process Errors Made by State or Local Agency and Failure to Verify root causes, additional corrective actions applicable to these root causes are included in the table below.

Corrective Actions for Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
Enhanced State PERM Corrective Action Plan Process*	For description, see related corrective action above for the Administration or Process Errors Made by State or Local Agency and Failure to Verify root causes.
Education	In FY 2020, HHS launched a newly designed Medicaid Integrity Program web page for state officials, providers, and beneficiaries that include a collection of resources, including toolkits for providers, fact sheets for state Medicaid agencies, infographics, and more. These resources help educate providers, beneficiaries, and other stakeholders in promoting promising practices and raising awareness of Medicaid fraud, waste, and abuse. Lastly, HHS oversees multiple state technical assistance group (TAG) calls that focus on preventing fraud, waste, abuse, and other improper payments. TAG calls offer a forum for sharing issues, solutions, resources, and experiences among the states to develop promising practices, provide technical assistance, and advise on policies, procedures, and program development.
State Medicaid Provider Screening and Enrollment Data and Tools	HHS shares Medicare data to assist states and territories with meeting Medicaid screening and enrollment requirements. Specifically, HHS shares the Medicare provider enrollment record via the PECOS administrative interface and via data extracts from the PECOS system and OIG exclusion data. Since May 2016, HHS has offered a data compare service that allows a state or territory to rely on Medicare's screening in lieu of conducting a state screening, particularly

Corrective Actions for Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party	
Corrective Action	**Description**
	during revalidation. This allows states territories to remove dual-enrolled providers from the revalidation workload. Using the data compare service, a state or territory provides a Medicaid provider enrollment data extract to HHS, and then HHS returns information indicating which providers have undergone a Medicare screening on which the state can rely (thus reducing the state's or territory's work load). The following states participated in the data compare service in FY 2020: Idaho, Nebraska, Nevada, New York, Oklahoma, and Pennsylvania. HHS is working to expand the data compare service to additional states. In addition to the data compare service, HHS piloted a process to screen Medicaid-only providers on behalf of states. HHS recruited two states, Iowa and Missouri, to participate in this pilot in FY 2019. In FY 2020, HHS screened these two states' Medicaid-only providers and produced a report of providers with licensure issues, criminal activity, and Do Not Pay activity. Iowa and Missouri are currently evaluating the screening results. HHS evaluated the pilot impact and results and expanded the service to additional states. Looking forward, Oklahoma and Nevada have agreed to participate in the pilot and HHS continues to contact other states to gauge interest.
Enhanced Technical Assistance and Site Visits Relating to Medicaid Provider Screening and Enrollment	For description, see related corrective action above for the Administration or Process Errors Made by State or Local Agency and Failure to Verify root causes.
DMF	To help alleviate state concerns with the cost of completing the SSA DMF check as part of provider screening, HHS worked with the SSA to provide states the DMF. In May 2017, HHS made DMF data available to pilot states via the same file server where states currently access PECOS provider file extracts, Medicare revocations, Medicaid terminations, and OIG exclusions. HHS expanded access to DMF data to additional states via the Data Exchange which is a system for sharing data among HHS and the separate Medicaid programs of every state. In FY 2020, all 50 states, the District of Columbia, and Puerto Rico have access to DMF data through the Data Exchange.
MEQC Program*	For description, see related corrective action above for the Administration or Process Errors Made by State or Local Agency and Failure to Verify root causes.
Conduct Audits of State Beneficiary Eligibility Determinations*	For description, see related corrective action above for the Administration or Process Errors Made by State or Local Agency and Failure to Verify root causes.
MII*	For description, see related corrective action above for the Administration or Process Errors Made by State or Local Agency and Failure to Verify root causes.
Technical Assistance and Education on Beneficiary Eligibility and Enrollment	For description, see related corrective action above for the Administration or Process Errors Made by State or Local Agency and Failure to Verify root causes.

Medicaid Information Systems and Other Infrastructure

Because Medicaid payments occur at the state level, information systems and other infrastructure need to be implemented at the state level to reduce Medicaid improper payments. HHS encouraged and supported state efforts to modernize and improve state Medicaid Enterprise Systems, which will produce greater efficiencies in areas reflected in the PERM measurement and strengthen program integrity. Lastly, the state systems workgroup (composed of HHS and state staff representatives) meets regularly to identify and discuss system vulnerabilities and the impact on the measurement of improper payments.

HHS developed a comprehensive plan to modernize the federal Medicaid and CHIP data systems. The plan's primary goal is to leverage technologies to create an authoritative and comprehensive Medicaid and CHIP data structure so HHS can provide more effective program oversight. The plan will also reduce state burden and provide more robust data for the PERM program.

HHS also developed the Transformed Medicaid Statistical Information System (T-MSIS) to 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 submissions in real-time. Through the use of T-MSIS, HHS will acquire higher quality data and reduce state data requests. As of August 30, 2020, 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands are submitting T-MSIS data. More information on states' overall data submission progress is available on the T-MSIS website. HHS closely monitors monthly T-MSIS data submissions, with a focus on assessing and improving data quality. HHS has developed analytics files, tools, and reports aimed at enabling data use by various stakeholders. As such, on August 10, 2018, HHS released a State Health Official (SHO) letter 18-008 prioritizing T-MSIS data quality with state leadership. Then, on March 18, 2019, HHS released a Center for Medicaid and CHIP Services Informational Bulletin (CIB) providing more specific direction to states on improving their T-MSIS data, followed by individual notices to each State Medicaid Director describing the state's compliance with the CIB requirements. HHS expects states to continue to improve the quality of T-MSIS data and to ensure changes to state systems or operations will not degrade T-MSIS data submission quality, completeness, and/or timeliness.

11.5 CHIP

CHIP Statistical Sampling Process

Through the PERM program, HHS estimates CHIP improper payments on an annual basis, utilizing federal contractors to measure three components: FFS, managed care, and eligibility.

CHIP utilizes the same state sampling process as Medicaid through the PERM program. HHS determined that the same states selected for Medicaid review each year can also measure CHIP, with a high probability that the CHIP improper payment rate estimates will meet the PIIA required confidence and precision levels. For information on how HHS grouped states into three cycles for CHIP, refer to pages 183-185 of HHS's FY 2012 AFR.

Due to the COVID-19 PHE, HHS exercised its enforcement discretion by temporarily suspending all improper payment related engagement/communications and data requests to providers and state agencies from HHS. In order to complete reviews for FY 2020 national reporting and maintain a consistent review of all states, HHS only reviewed claims that had been fully completed review before implementation of the COVID-19 response measures and that HHS could complete without additional outreach to states or providers. HHS incorporated documentation voluntarily submitted by states and/or providers during the period of enforcement discretion into the reviews.

FFS and Managed Care Components

FFS includes the traditional method of paying for medical services under which a state pays providers for each service rendered to individual beneficiaries. Managed care is a delivery system where a state makes a monthly payment to a managed care organization, which is responsible for managing beneficiary care and rendering payments to providers. Quarterly, states submit adjudicated claims data, and HHS randomly selects a sample of FFS claims and managed care payments. Each FFS claim selected undergoes a medical and data processing review, while managed care payments are subjected to only a data processing review. Reviewing either the medical records associated with historical payments to providers or the medical records associated with payments to providers that occurred during the month sampled does not have a direct link to the established capitated payment sampled and, thus, is not included in the improper payment review.

Additionally, HHS selects a combination of FFS claims and managed care payments for eligibility review. Based on each state's expenditures and historical FFS and managed care improper payment data, the FFS sample size was between 32 and 974 claims per state, the managed care sample size was between 22 and 270 payments per state, the eligibility FFS sample size was between 65 and 324 per state, and the eligibility managed care sample size was between 36 and 396 per state. When a state's FFS or managed care component for a state accounted for less than two percent of the state's total CHIP expenditures, HHS combined the state's FFS and managed care claims into one component for sampling and measurement purposes.

Eligibility Component

Through the eligibility component, a federal contractor assesses states' application of federal rules and the state's documented policies and procedures related to beneficiary eligibility. States must produce records and documentation to support the eligibility determination. Examples of noncompliance with eligibility requirements include a state: enrolling a beneficiary when he or she is ineligible for CHIP; determining a beneficiary to be eligible for the incorrect eligibility category, resulting in an ineligible service or incorrect federal reimbursement amount being provided; not conducting a timely beneficiary redetermination; or not performing, completing, or providing sufficient documentation to support a required element of the eligibility determination process, such as income verification. As described in the PERM final rule (82 Federal Register 31158, July 5, 2017), HHS resumed the eligibility component measurement for the 17 Cycle 2 states and reported an updated national eligibility improper payment estimate for FY 2020. Between FY 2015 and FY 2018, HHS did not conduct the eligibility measurement component of PERM; refer to pages 211-214 of HHS's 2018 AFR for more information. Note that the national eligibility improper payment rate still includes a proxy estimate for the remaining 17 in Cycle 3 states that have not yet been measured since the reintegration of the PERM eligibility component.

Calculations and Findings

The national CHIP improper payment estimate combines each state's FFS, managed care, and eligibility improper payment estimate. In addition, HHS combines individual state component improper payment estimates to calculate the national component improper payment estimates. National component improper payment rates and the CHIP improper payment rate are weighted by state size, such that a state with a $1 billion program is appropriately weighted more in the national rate than a state with a $200 million program. A correction factor in the methodology ensures that each CHIP improper payment is counted only once in the combined national rate. All CHIP estimated improper payments were made by recipients of federal money.

The national CHIP gross improper payment estimate for FY 2020 is 27.00 percent or $4.78 billion.

The FY 2020 national CHIP improper payment rate for each component is:

- *CHIP FFS:* 14.15 percent
- *CHIP managed care:* 0.49 percent
- *CHIP eligibility*: 23.53 percent

Supplemental information related to the FY 2020 CHIP improper payment results will be published on the PERM page of the CMS website in early 2021.

One area driving the FY 2020 CHIP improper payment estimate is the continued reintegration of the PERM eligibility component, which was revamped to incorporate the PPACA requirements in the PERM eligibility reviews. A federal contractor conducts the eligibility measurement, allowing for consistent insight into the accuracy of CHIP eligibility determinations, and increases the oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify the eligibility determination or noncompliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification of eligibility data, such as income, was not done at all and where there is indication that the eligibility verification was initiated but the state provided no documentation to validate the verification process was completed. The CHIP improper payment rate was also driven by claims where the beneficiary was ineligible for CHIP, but was eligible for Medicaid, mostly related to beneficiary income, third party insurance, or household composition/tax filer status. HHS will complete the measurement of all states under the new eligibility component and establish a baseline in FY 2021.

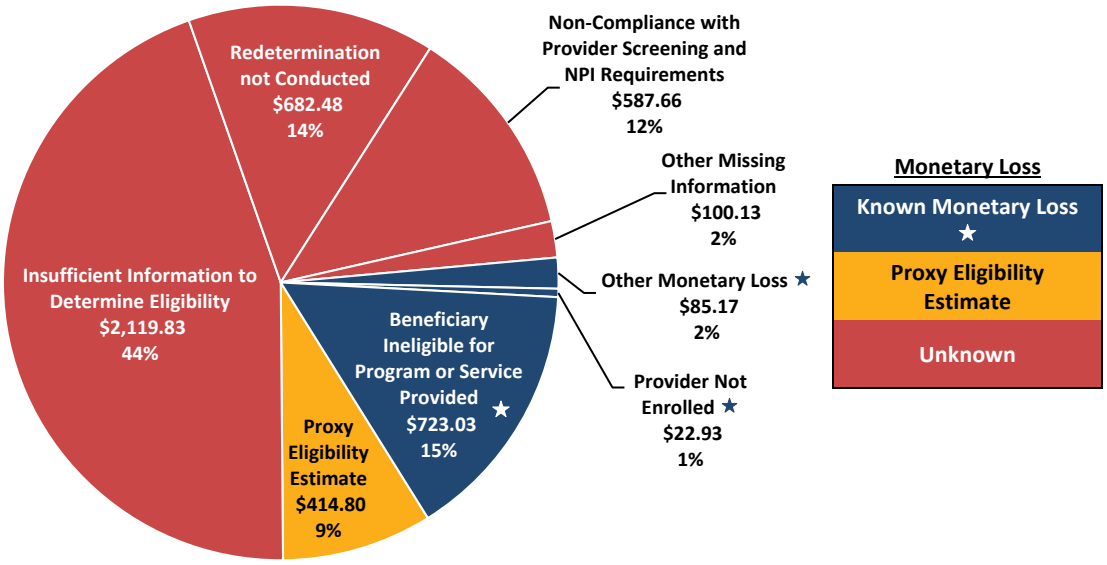
Additionally, since FY 2014, improper payments cited on claims where a newly enrolled provider or a provider due for revalidation had not been appropriately enrolled and screened by the state or a provider did not have the required NPI on the claim have also driven the CHIP rate (see Section 11.4 for further description of HHS's review of these errors). HHS has completed the measurement of all states for compliance with provider revalidation requirements in FY 2020 in order to establish a baseline. Moving forward, HHS will be able to track improvement in compliance with revalidation requirements as each cycle of states is measured a second time.

Unknown versus Monetary Loss Findings

Improper payments do not necessarily represent expenses that should not have occurred. Improper payments also include instances of insufficient or no documentation to support the payment as proper are cited as improper payments. A majority of CHIP improper payments were due to instances where information required for payment was missing, an eligibility determination was missing from the claim or state systems, states did not follow the appropriate process for enrolling providers, and/or states did not follow the appropriate process for determining beneficiary eligibility. However, these improper payments do not necessarily represent payments to illegitimate providers or on behalf of ineligible beneficiaries. If the missing information had been on the claim and/or the state had complied with the enrollment or redetermination requirements, then the claims may have been payable in whole or in part. Conversely, if the missing documentation had been available, it could have affirmatively indicated whether a provider or beneficiary was ineligible for CHIP reimbursement, which could be considered known monetary loss. Known monetary losses to the program are claims where HHS determines the CHIP payment should have either not occurred or been made in a different amount.

Figure 13 provides information on CHIP improper payments that are a known monetary loss to the program (i.e., provider not enrolled, beneficiary ineligible for program or service, incorrect coding, and other errors like claims processing errors, duplicate claims, or pricing mistakes). "Unknown" represents payments where there was insufficient or no documentation to support the payment as a proper payment or a known monetary loss (e.g., claims where information was missing or states did not follow appropriate processes).

Figure 13: FY 2020 CHIP Estimated Improper Payments, by Monetary Loss versus Unknown Categories and Type of PERM Error[1] (Dollar Amounts in Millions)



[1] The Proxy Eligibility Estimate is used to represent the eligibility component for the 17 states not yet measured since the reintegration of the PERM eligibility component. All eligibility improper payments from the FY 2020 measurement are included in the appropriate category (Known Monetary Loss or Unknown). The Proxy Eligibility Estimate includes both overpayments and underpayments, whereas Known Monetary Loss and Unknown only include overpayments. The value of underpayments outside the Proxy Eligibility Estimate ($7.21 million) was too small to report in Figure 13. In addition, due to rounding, amounts in this figure may not add up precisely to other tables in this document.

CHIP Corrective Action Plan

HHS addresses improper payments in CHIP through various corrective actions. While HHS takes broad steps to reduce CHIP improper payments at the federal level, CHIP is a federal-state partnership, and states are equally responsible for addressing improper payments at the state level by developing and implementing state-specific corrective action plans. HHS works closely with all states through enhanced technical assistance (including liaisons that are assigned to each state to assist states with identifying and overcoming barriers to corrective action implementation) and guidance to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the corrective action plan's effectiveness, with assistance and oversight from HHS. When developing corrective action plans, states focus on the major causes of improper payments.

Several important ongoing activities inform the development of HHS's corrective actions by providing data and information directly from state experiences with implementing CHIP:

- Reviewing improper payment rate data for each component of the PERM program;
- Conducting outreach during off-cycle PERM years to identify issues states are experiencing with the state-specific corrective action plans;
- Reviewing state data submitted through the MEQC program;
- Facilitating national best practice calls that identify state promising practices;
- Offering ongoing technical assistance;
- Providing additional guidance, as needed; and
- Providing training to state partners through the Medicaid Integrity Institute.

The following sections discuss key HHS corrective actions to address root cause categories. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

Corrective Actions to Address OMB Root Causes:

Root Causes: Administrative or Process Errors Made by State or Local Agency

Administrative or process errors made by states or local agencies (17.31 percent or $826.84 million; $821.87 million Overpayments and $4.96 million Underpayments) mainly consist of errors resulting from noncompliance with the requirement to screen and enroll providers and from cases where the beneficiary was ineligible for the program or service.

State corrective action plans focus on system or process changes to reduce these errors. HHS corrective actions include providing additional guidance and oversight of states' enrollment processes for providers and beneficiaries. Section 11.4 provides more detailed information on these activities and the impact of the COVID-19 PHE, if any.

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by Other Party

Insufficient documentation to determine (73.77 percent or $3,524.12 million) errors primarily result from noncompliance with provider screening, revalidation, or NPI requirements; insufficient documentation to determine eligibility; noncompliance with eligibility redetermination requirements; insufficient or no medical documentation submitted by providers; or other missing information from the state. Administrative or process errors made by other parties (0.23 percent or $11.22 million; $8.97 million Overpayments and $2.25 million Underpayments) primarily consist of other provider errors identified through medical review. State corrective action plans include implementing new claims processing edits, converting to a more sophisticated claims processing system, implementing provider enrollment process improvements, implementing beneficiary enrollment and redetermination process improvements, and conducting provider communication and education to reduce errors related to documentation requirements. Section 11.4 provides more detailed information on these activities.

CHIP Information Systems and Other Infrastructure

Since CHIP payments occur at the state level, information systems and other infrastructure need to be implemented at the state level to reduce CHIP improper payments. Refer to Section 11.4 for information on HHS and state-led efforts to modernize information and data systems at the national and state levels.

11.6 TANF

TANF Statistical Sampling Process

Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement. As a result, the TANF program is not reporting an improper payment estimate for FY 2020.

TANF Corrective Action Plan

Since TANF is a state-administered program, corrective actions would be implemented at the state level to reduce improper payments. Since HHS cannot require states to participate in a TANF improper payment measurement, the Department is also unable to compel states to collect the required information to implement and report on corrective actions.

Despite these limitations, HHS uses a multi-faceted approach to support states in improving TANF program integrity and preventing improper payments:

Corrective Actions for TANF Program Integrity	
Corrective Action	**Description**
Risk Assessment	In FY 2019, HHS performed a detailed risk assessment of the TANF program to determine susceptibility to significant improper payments. HHS identified potential payment risks at the federal level and will continue to work to mitigate these risks.
Promoting and Supporting Innovation in TANF Data	In FY 2017, HHS awarded a 5-year contract for Promoting and Supporting Innovation in TANF Data. A component of the contract includes engaging TANF stakeholders to better understand how states assess improper payments and ensure program integrity in TANF. Through this contract, in FY 2019, HHS conducted a comprehensive needs assessment of all TANF states, territories, and the District of Columbia, including information about payment integrity efforts, and HHS will build off this assessment with a detailed look at payment integrity efforts in a select group of states. This assessment is helping HHS understand existing state approaches and alternative methods for measuring TANF improper payments, including the feasibility and cost-benefit analysis of different approaches.
Final Regulation on Reporting of Electronic Benefit Transfer Policies and Practices	In FY 2016, HHS issued final regulations regarding State Reporting on Policies and Practices to Prevent the Use of TANF Funds in Electronic Benefit Transfer Transactions in Specified Locations (81 Federal Register 2092, January 15, 2016). Thus far, HHS has not assessed any penalties for noncompliance with this regulation, and the Department continues to monitor compliance.

TANF Information Systems and Other Infrastructure

Information systems and other infrastructure at the state level are needed to reduce TANF improper payments. States utilize PARIS, the National Directory of New Hires, and the Income and Eligibility Verification System to minimize improper payments.

TANF Statutory or Regulatory Barriers that Could Limit Corrective Actions

Statutory limitations preclude HHS from requiring states to participate in a TANF improper payment measurement. The *FY 2021 President's Budget* included a proposal that, if enacted, would help address the challenge HHS faces in reporting an improper payment estimate for TANF. The Budget proposes giving HHS authority to collect quantitative and qualitative program integrity information from TANF programs, which will lay the ground work for the data collection efforts needed to provide information on states' improper payments.

11.7 Foster Care

Foster Care Statistical Sampling Process

There were no changes to the statistical sampling process for Title IV-E Foster Care in FY 2020. This program uses the review cycle already in place (in compliance with 45 CFR §1356.71, *Foster Care Eligibility Reviews*) and, with OMB approval, leverages the existing review cycle to provide a rolling, 3-year weighted average improper payment estimate. Since each state is reviewed every 3 years, each year's improper payments estimate incorporates new review data for approximately one-third of the states. Each state's triennial review covers a recent 6-month period. For a more detailed description of the Foster Care improper payment methodology, refer to pages 189-190 of HHS's FY 2012 AFR.

While HHS made no changes to the statistical sampling process, the COVID-19 PHE affected the number of states that HHS reviewed this cycle. Originally, the program anticipated reviewing and updating data for 11 states.

However, in response to the COVID-19 PHE, HHS decided to postpone Title IV-E reviews until it is safe to travel again. Foster care reviews occur onsite in each state, so HHS decided to protect the health and safety of state and federal reviewers and to ensure that state child welfare officials could remain focused on mission-critical activities serving children and families during the public health crisis. The decision resulted in postponing five of the 11 reviews that HHS expected to provide updated data for as part of this year's estimate. Therefore, in calculating FY 2020 improper payment estimates, HHS had updated data for only six states; for the rest of the states included in the estimate, prior year performance was used. While the FY 2020 improper payment rate includes updated data from fewer states than anticipated, the approach used to calculate the improper payment rate follows previous practice regarding 1) the handling of review delays, 2) the year-to-year variation in the number of new reviews, and 3) incorporating new data in a timely manner.

As stated in the FY 2015 AFR, implementation of time-limited child welfare waiver demonstration projects (which all terminated as of September 30, 2019) temporarily reduced the number of jurisdictions subject to review and inclusion in the program improper payment estimate during the demonstration projects. More information on these demonstration projects and the impact on the Foster Care improper payment rate calculation can be found on pages 202-203 of HHS's FY 2015 AFR.

The program's improper payment estimate includes data from the most recent review for states that operated non-state-wide waivers, including reviews conducted on the non-waiver populations in those states following waiver implementation. This approach (approved by OMB) maintains continuity while also permitting consistent treatment of states with state-wide and non-state-wide waivers. Following this approach, the FY 2020 estimate is based on review data for 33 states or territories operating traditional Title IV-E programs, including states that operated non-state-wide waivers. The FY 2020 estimate excludes data for 19 states operating state-wide waiver demonstrations: one state due for a review during this review cycle (Arizona) and 18 states or territories due for a review in prior years (Arkansas, Colorado, the District of Columbia, Florida, Hawaii, Illinois, Indiana, Kentucky, Maine, Maryland, Nebraska, Oklahoma, Oregon, Tennessee, Utah, Washington, West Virginia, and Wisconsin). HHS will incorporate data for these former waiver states into the improper payment rate calculation again in future years, once they are newly reviewed for a time period following termination of the waiver demonstration.

The Foster Care gross improper payment estimate for FY 2020 is 3.36 percent or $41.23 million. The improper payment rate decreased from 4.85 percent in FY 2019 to 3.36 percent in FY 2020 because five out of the six states that were newly reviewed had decreases in improper payment rates. In particular, two states with large programs (and thus more impact) had substantial decreases of more than 13 percent in their state-level improper payment rates. Three states that already had low rates decreased their improper payment rates by more than 1 percent. One state had a moderate increase of just over 3 percent in its state-level improper payment rate. Overall, all six states had improper payment rates of less than 6 percent. All Foster Care estimated improper payments were made by the states which receive federal funds.

Foster Care Corrective Action Plan

All improper payments (100 percent) in the Title IV-E Foster Care program are administrative or process errors due to incorrect case classification and payment processing by state agencies. The Foster Care program designs corrective action plans to help states address the improper payments that contribute most to Title IV-E improper payments.

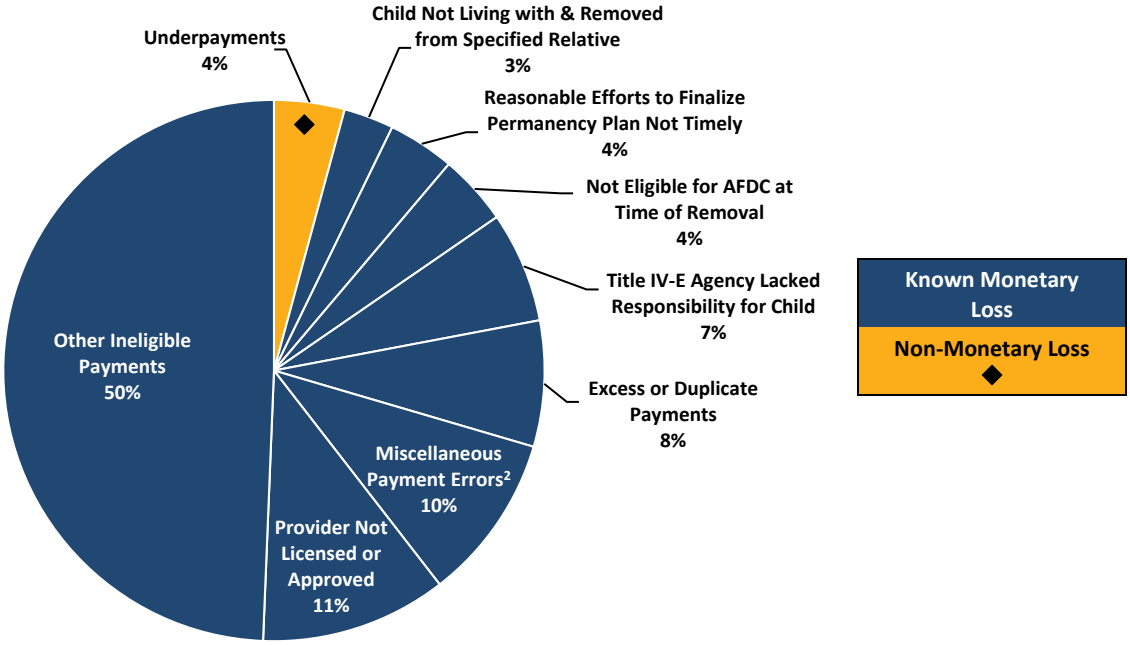
Corrective Actions to Address OMB Root Cause:

Root Cause: Administrative or Process Error Made by State or Local Agency

Foster Care improper payments are caused by administrative or process errors made by state or local agencies ($41.23 million; $39.11 million Overpayments and $2.12 million Underpayments). Corrective actions over the years helped reduce the frequency of some error types. For example, following years of work with State Court Improvement Programs and outreach to raise awareness, errors related to judicial determinations (once the most prevalent error type) are now among the least common error types.

Monitoring and Analysis: HHS continues to monitor, review results, and analyze the types of payment errors in the Foster Care program to target corrective action planning. **Figure 14** below presents the most common administrative or process payment errors in FY 2020.

Figure 14: Root Causes, by Monetary and Non-Monetary Loss Categories, for FY 2020 Title IV-E Foster Care Improper Payments across All States[1]



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

[2] Miscellaneous Payment Errors include error types below 3 percent of total: Criminal record check not completed; No safety documentation for institutional caregiver staff; Child not living with specified relative within 6 months of removal – Aid to Families with Dependent Children (AFDC) eligibility; Reasonable efforts to prevent removal not met; No valid removal of child from home; Contrary to welfare determination not met; Child not in a Title IV-E allowable foster care placement; Payment made prior to eligibility; Child over 18 and AFDC school attendance requirement not met; Voluntary placement agreement not signed; Voluntary placement - no judicial determination of best interest in 180 days.

As shown in **Figure 14**, the eight most frequent error types (except for miscellaneous payment errors) account for about 90 percent of Foster Care's improper payments.[34] "Other ineligible payments" continues to constitute the largest number of errors, accounting for 50 percent of errors. Two states reviewed in earlier years account for 73 percent of "Other ineligible payments," which are payments for services such as child health support that are not allowable expenditures as a Title IV-E Foster Care maintenance payment. Because these states have taken corrective action to address the accounting issues that resulted in systemic incorrect claiming of certain costs not allowable as

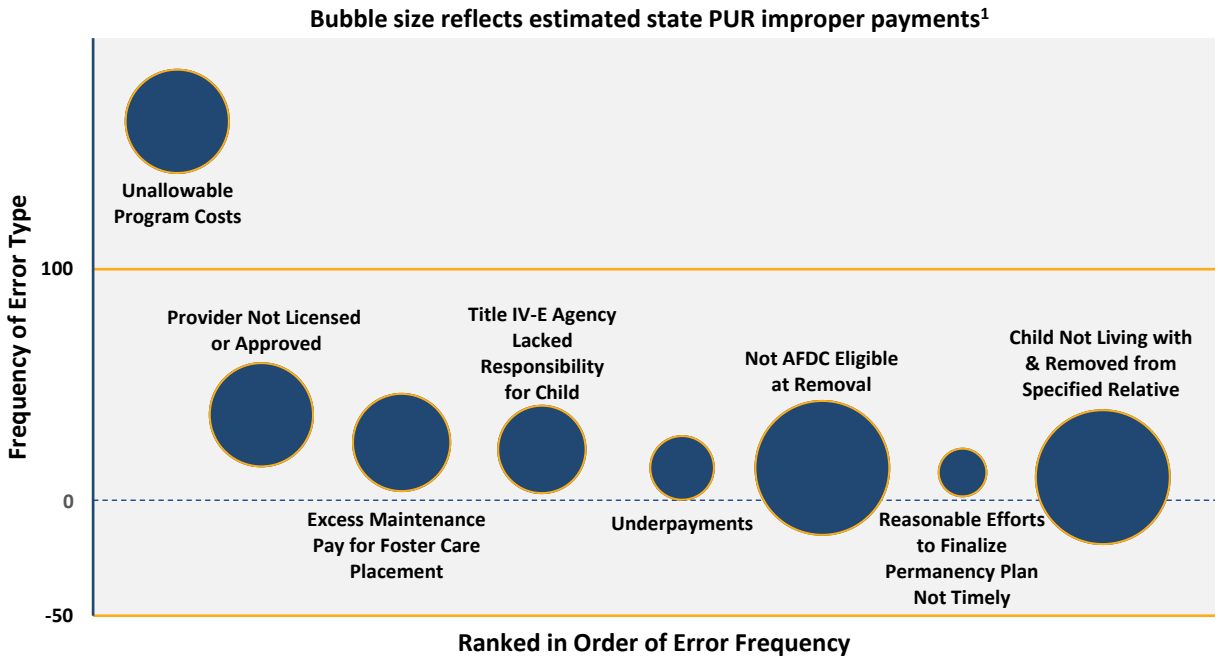
[34] Because cases may have more than one type of overpayment error, the rate for any specific type of overpayment may involve some duplication and therefore slight overestimation.

Title IV-E Foster Care maintenance payments, HHS expects this number of this type of error to decline when the states are next reviewed.

Although "Other ineligible payment" errors constitute 50 percent of the total improper payments, they are still less costly than other errors that were much lower in frequency. "Not AFDC eligible at time of removal" and "Child not living with and removed from specified relative" account for 4 percent and 3 percent of the total errors, respectively. These errors are more costly due to the errors occurring at the beginning of a child's episode in foster care and reflecting months of foster care maintenance payments improperly claimed, while "Other ineligible payment" refers to what is often a time-limited payment for a service that is not Title IV-E eligible.

In previous years, the total cases with "No safety documentation for institutional caregiver staff" errors have been the most expensive due to the high cost of institutional care compared to family foster care placements. This year, however, none of the states with new reviews had these errors and the error type constitutes only 2 percent of the total errors. This reflects significant improvement in two states whose previous reviews had a total of 19 of these errors but whose FY 2020 reviews showed none. **Figure 15** below provides more information on the relative contribution of the top eight payment error types.

Figure 15: Reasons for Title IV-E Foster Care Program Improper Payments across All States – FY 2020 Frequency and Dollar Amount across Error Types



[1] Improper payments for cases with more than one error type (N=34) are counted under all applicable error types during the period under review (PUR).

In FY 2020, HHS undertook the following key actions to reduce Foster Care improper payments in the future:

Corrective Actions to Address Administrative or Process Errors Made by State or Local Agency	
Corrective Action	**Description**
Emphasizing Quality Improvement	HHS engaged with state Title IV-E Foster Care agencies to enhance the understanding of program compliance requirements and to share successful strategies among states. Based on discussions with individual states on review preparation and compliance results, HHS worked with states to emphasize and develop strategies for continuous program improvement. HHS emphasized viewing the quality assurance process as ongoing and developing sound program improvements that support systemic change and sustain improvement efforts.
Enhancing Targeted Outreach Strategies	Pre-Review Engagement of States: Since certain types of improper payments (such as those pertaining to foster care provider requirements) occur in a small number of states, HHS implemented pre-review outreach strategies (e.g., calls and site visits) tailored to each state child welfare agency to provide feedback about specific program performance areas needing improvement and to facilitate correction efforts. HHS also reviewed safety documentation of background checks for staff of child care institutions prior to the onsite Title IV-E Review to assess and provide feedback on the adequacy of the documentation, given the comparatively high-dollar impact of errors pertaining to institutional care. The pre-review of state documentation focused on the federal requirements to increase state agency staff and foster care providers' knowledge of the requirements, help the state identify missing or insufficient documentation, and help the state eliminate improper payments involving inadequate or missing documentation of safety checks. HHS will continue these successful measures. Due to the steady increase in the frequency of payment errors attributable to "Other ineligible payments" which consist of expenditures unallowable as Title IV-E Foster Care maintenance payments, HHS will work closely with states to further clarify allowable costs under the program. HHS will also examine state payment records prior to and during the on-site review to help evaluate areas of over- and under claiming and incorrect expenditure categories to improve the accuracy of state claims.
	Outreach Regarding Changes in Federal Requirements: The *Family First Prevention Services Act*, enacted as Title VII of the *Bipartisan Budget Act of 2018*, changed the federal statutory requirements for staff safety checks at child care institutions. The new requirements became effective October 1, 2018, although some states needing to enact new state legislation are allowed additional time to implement the provisions. In response to this legislation, HHS conducted a series of webinars in FY 2018 and issued written guidance to federal and state staff throughout FY 2019 and FY 2020 to instruct all staff on the updated federal safety check requirements and other provisions of the 2018 federal law. Additional guidance and instructional tools are planned for early FY 2021 to deepen federal and state staff knowledge on the federal requirements for state implementation and maintenance of required policies and practices.
	Communications and Monitoring: HHS also worked with states to encourage effective communication between state child welfare agencies and licensing agencies to further promote adequate documentation of licensing and safety check compliance. Assisting states with developing and applying techniques to effectively engage foster care providers in a partnership to reduce or eliminate improper payments is integral to success. HHS also will encourage states to regularly and systematically monitor foster care providers to document and promote compliance with the Title IV-E requirements and require non-compliant providers to undergo corrective action.

In addition, HHS continued the following ongoing corrective actions:

Corrective Actions to Address Administrative or Process Errors Made by State or Local Agency	
Corrective Action	**Description**
Conducting Eligibility Reviews and Providing Feedback to State Agencies	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 pre-site and on-site to the state agency to bring about proper and efficient program administration and implementation. Furthermore, HHS issues a comprehensive final report that presents review findings to the state agency including if the state exceeded the error threshold in a review and must develop a performance improvement plan (PIP).
Developing PIPs	HHS requires states that exceed the error threshold in a primary review to develop and execute state-specific PIPs that identify specific action steps to correct error root causes. A PIP is an effective tool with a successful track record at HHS with improper payments reporting; since FY 2004, only one state has not been found in compliance on a Title IV-E Review conducted following PIP completion. States must complete each action strategy within 1 year from the date HHS approved the plan. In FY 2020, all six states reviewed were determined in substantial compliance and, therefore, are not required to complete a PIP.
Providing Training and Technical Assistance	HHS trains and assists states in developing and implementing program improvements, even when states are not required to develop a PIP. This assistance helps states expand organizational capacity and promote more effective program operations. In FY 2020, HHS trained all six states reviewed on the federal eligibility and payment requirements and provided technical assistance prior to, during, and after the Title IV-E Reviews.
Conducting Secondary Reviews and Disallowances	HHS conducts secondary reviews for non-compliant states and establishes appropriate disallowances (e.g., to recover improper payments) consistent with the review findings (HHS establishes disallowances for error findings in both primary and secondary reviews). A secondary review was conducted for one state in the FY 2020 review cycle. On a secondary review, if a state is not in substantial compliance, HHS establishes an extrapolated disallowance. Additional disallowances, in conjunction with PIP development and implementation, incentivize states to improve compliance.

Foster Care Information Systems and Other Infrastructure

HHS uses the Adoption and Foster Care Analysis and Reporting System (AFCARS) to draw samples for the regulatory reviews. This reduces the burden on states to draw their own samples, promotes uniformity in sample selection, and employs AFCARS in a practical and beneficial manner. Since Foster Care payments occur at the state level, the state must implement the information systems and other infrastructure needed to reduce Foster Care improper payments. States have the option to receive federal financial participation to develop and implement a Comprehensive Child Welfare Information System (CCWIS) in accordance with federal regulations at 45 CFR §1355.50 through §1355.59. CCWIS project requirements include the performance of automated program eligibility determinations and bi-directional data exchanges with systems generating the financial payments and claims to ensure the availability of needed supporting documentation.

Foster Care Statutory or Regulatory Barriers that Could Limit Corrective Actions

While HHS and states have implemented many corrective actions, the Department recognizes that several factors may contribute to increased improper payments over the next several years. It is likely that changes in Title IV-E Foster Care eligibility requirements made by the *Family First Prevention Services Act* (FFPSA) may contribute to increased improper payments as states adjust to changes in law affecting eligibility, particularly for children placed in child care institutions. Among the changes made in the law are revised safety check requirements applicable to

all adults working in child care institutions, which became effective on October 1, 2018. The FY 2020 estimate of improper payments for the Foster Care program was originally expected to include review data from states subject to the new child care institution safety check requirements. However, due to the postponement of reviews during the COVID-19 PHE, HHS has not yet conducted reviews covering time periods in which the new requirements were in effect in states. Given the historically high level of improper payments under prior safety check eligibility requirements, it is likely that the change in federal requirements may again drive higher improper payment rates in some states in future years.

New limitations in the availability of Title IV-E Foster Care maintenance payments for children placed in certain non-family based foster care settings will begin to take effect in some states beginning October 1, 2019, and will become applicable in all states by October 1, 2021. These limitations on funding availability may also contribute to increases in improper payment estimates in FY 2021 and beyond. Another factor that may increase the rate of improper payments is that all states previously operating child welfare waiver demonstrations were required to conclude these demonstrations by September 30, 2019, and will be subject to review over the next several years. As previously noted, HHS temporarily suspended conducting Title IV-E Reviews in some states during the operation of their time-limited projects, since the projects allowed the states to use funds more flexibly than under the traditional program. As these states return to operating under traditional program rules, as well as adapting to recent changes in federal law, it is possible that they may experience higher state-level improper payment rates.

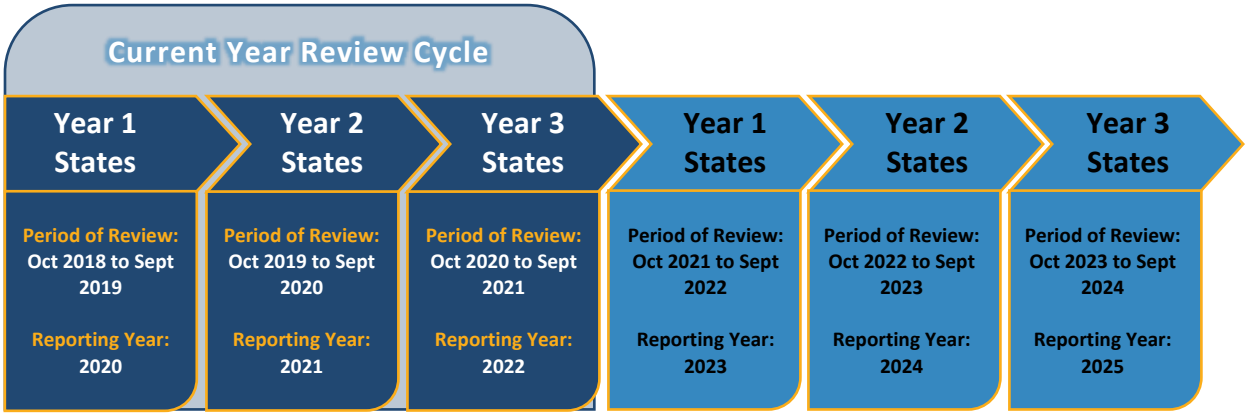
While cognizant of the challenges ahead, HHS remains committed to working with all states to ensure that they have a clear understanding of changes in federal eligibility requirements and are prepared to successfully manage Title IV-E eligibility determinations for their Foster Care programs. Given the ongoing COVID-19 PHE, however, HHS is uncertain when it will be safe to resume conducting onsite Title IV-E Reviews and how many states will be newly reviewed in time for the FY 2021 improper payment reporting cycle. In light of this uncertainty, as well as the unknown impact of the programmatic changes made by FFPSA on the improper payment rate, HHS has chosen not to set an improper payment reduction target for FY 2021.

11.8 CCDF

CCDF Statistical Sampling Process

The CCDF improper payments methodology uses a case-record review process to determine if child care subsidies were paid properly for services provided to eligible families. All states, the District of Columbia, and Puerto Rico (from here on referred to as “states”) are split into three cohorts and conduct the improper payment rate review once every 3 years (as shown in **Figure 16**).

Figure 16: CCDF Improper Payment Rate Review Cycle and Reporting Year



In addition to federal rules, states have varying requirements for establishing and verifying eligibility. The methodology enables states to determine types of errors and their sources to reflect policies and procedures unique to each state. For CCDF's improper payments methodology, see Improper Payments Error Rate Review Process.

The current methodology incorporates the following: (1) drawing a statistical sample from a universe of paid cases; (2) measuring improper payments; and (3) requiring states with improper payment estimates exceeding 10 percent to submit a corrective action plan. The improper payment methodology and reporting requirements focus on payment and non-payment errors associated with client eligibility. Effective October 31, 2018, HHS revised the CCDF Data Collection Instructions (DCI) to states regarding implementation of the Error Rate Review. The DCI now instructs states to consider if making additional inquiries might mitigate potential improper payments that are due to missing or insufficient documentation. Additional DCI revisions such as clarifying language and requirements to provide more information about error causes and action steps are aimed at increasing accuracy and streamlining data collection. In FY 2020, the Year One states implemented the revised methodology for review for the first time. The Year Three states implemented the revised methodology in FY 2019. In FY 2021, HHS will gather data from the remaining state grantee cohort (Year Two) to determine the impact of the revisions.

FY 2020 brought on many challenges. In March 2020, Puerto Rico requested and HHS granted a waiver for Extraordinary Circumstances under 45 CFR 98.19 (b)(2), temporarily relieving them of the fifth cycle improper payment rate reporting requirements. Puerto Rico had been severely affected by an earthquake and its aftershocks, which impacted the territory's ability to conduct the review.

In addition, in FY 2020, many Year One states experienced challenges conducting and completing the improper payment rate review due to the ongoing COVID-19 PHE. Challenges include staffing, accessing files, and conducting reviews remotely. As the State Improper Payments Report (ACF-404) submission deadline neared, it became evident that some Year One states would be unable to complete all 276 case reviews. HHS determined that a state's data would still be statistically representative, and thus could be included in the national improper payment measure calculations, as long as the state completed and reported on 203 case reviews.[35]

[35] To determine the threshold, HHS assumed (1) an error rate estimate of 5 percent, (2) a 95 percent confidence level, and (3) a margin of error of +/- 3 percent. The parameters for confidence level and margin of error meet OMB recommendations for a statistically rigorous plan, and the error rate estimate is reflective of actual results. This estimate was determined by computing the average national error rate for the past five years. The result was 4.55 percent, which was rounded to 5 percent for a slightly more conservative estimate. The sample size, n, is computed as n=[Z2*p*(1-p)]/E2, where Z is the critical value from a standard normal distribution corresponding to the 95 percent confidence level, p is the error rate estimate, and E is the margin of error. Thus, n=(3.8416*.05*.95)/.0009=202.8, for a final sample size of 203.

The following is a breakdown of the Year One states' reporting statuses for the fifth cycle of reviews:

- Fourteen states completed all 276 reviews (Alaska, California, Colorado, Georgia, Illinois, Indiana, Kansas, New Hampshire, North Dakota, Oklahoma, Pennsylvania, Texas, Vermont, and Washington)
- Two states did not complete all 276 reviews, but were above the threshold of 203 reviews (Alabama, with 246 reviews completed; and Nevada, with 210 reviews completed)
- One state did not complete all 276 reviews and was below the threshold of 203 reviews (West Virginia, with 82 reviews completed)
- One state did not complete any reviews (Puerto Rico)

For those states that did not meet the threshold (Puerto Rico and West Virginia), HHS substituted results from the previous cycle of reviews (FY 2017).

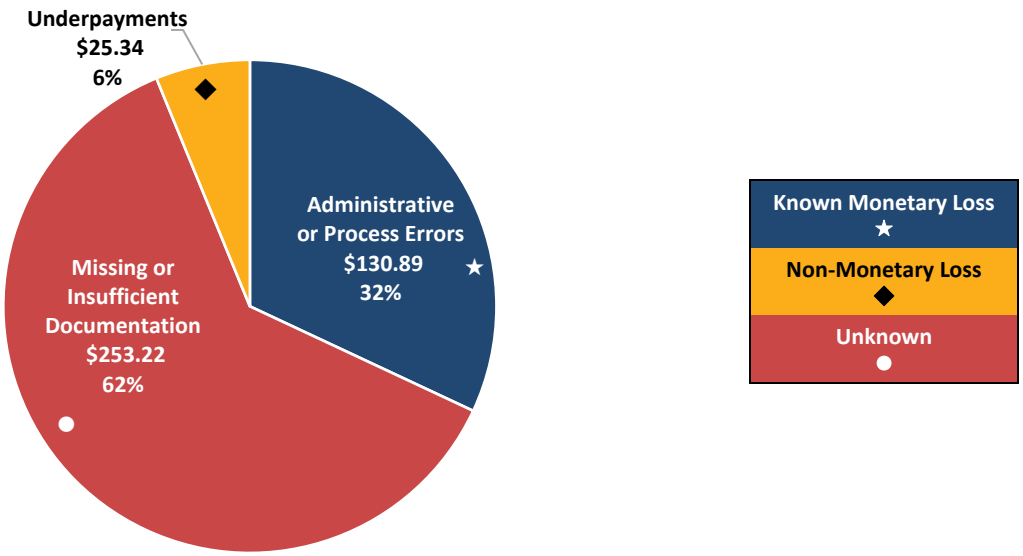
The CCDF gross improper payment estimate for FY 2020 is 5.16 percent or $409.45 million. All CCDF estimated improper payments were made by recipients of federal funds. HHS attributes the improper payment estimate increase, from 4.53 percent in FY 2019 to 5.16 percent in FY 2020, to the challenges that state grantees continue to experience as part of their efforts to comply with the CCDF reauthorization and related regulations. All states had multi-faceted challenges attempting to meet the CCDBG and CCDF regulation requirements and many are required to submit corrective action plans for not meeting implementation deadlines. States have had to make information technology (IT) systems changes, including purchasing new IT infrastructure, passing new legislation, promulgating new regulations and policies, drafting new procedures, and adding new personnel.

CCDF Corrective Action Plan

CCDF program errors can be categorized as (1) non-payment errors and (2) payment errors. The HHS Payment Integrity Report data only reflects improper payments. An error is any violation or misapplication of law, regulation, or policy governing the administration of CCDF grant funds, regardless of whether such a violation results in an improper payment. An improper payment is a monetary discrepancy between the subsidy amount as determined by the reviewer and the sample month payment amount, resulting from error. If an error does not result in monetary discrepancy, it is a non-payment error. A non-payment error example may include an incomplete application. The worker may have made an error by not requiring the family to fully complete the form, but if the incomplete application form did not result in a monetary discrepancy, it is considered a non-payment error. A payment error example may include a missing paystub. If non-receipt of a paystub results in a monetary discrepancy, the error is considered a payment error. These errors are further defined as (1) administrative or process errors and (2) errors caused by missing or insufficient documentation. Errors can be a misapplication of policy or procedure and can cause both a payment and a non-payment error. States have flexibility in the administration of Child Care programs and state-level policies and procedures reflect this variety.

Historically, CCDF improper payments have been divided evenly between administrative or process errors (including both overpayments and underpayments) and missing or insufficient documentation errors. **Figure 17** shows that for Year One reviews, missing or insufficient documentation errors caused more improper payments (about 61.84 percent or $253.22 million) than administrative or process errors, which includes overpayments (about 31.97 percent or $130.89 million), and underpayments (about 6.19 percent or $25.34 million).

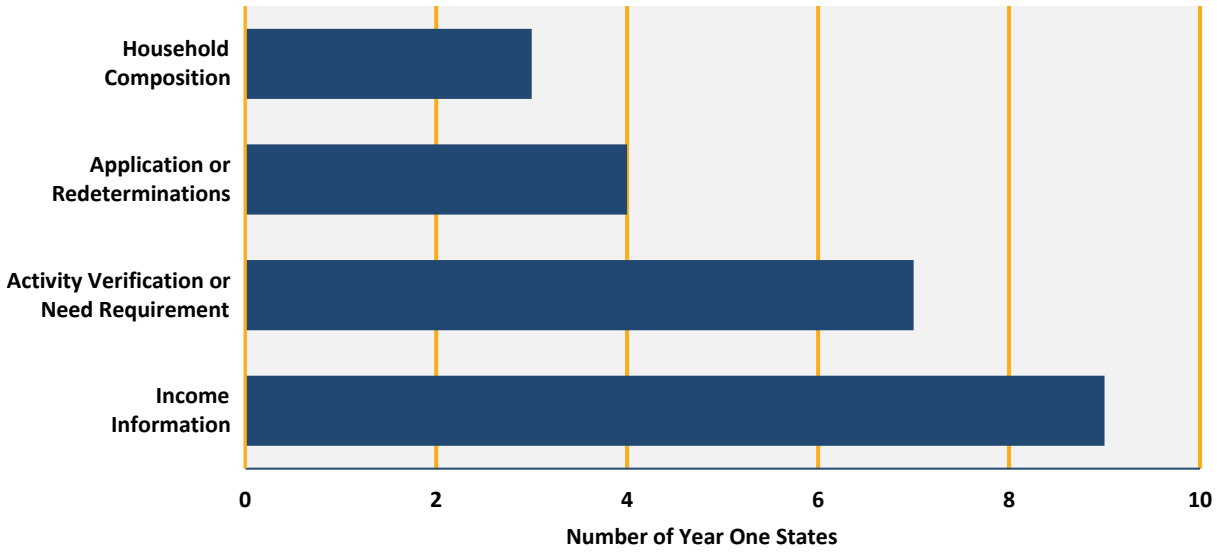
Figure 17: Root Causes for FY 2020 CCDF Improper Payments[1] (Dollar Amounts in Millions)



[1] Values in this figure may not add up precisely to other tables in this document due to rounding.

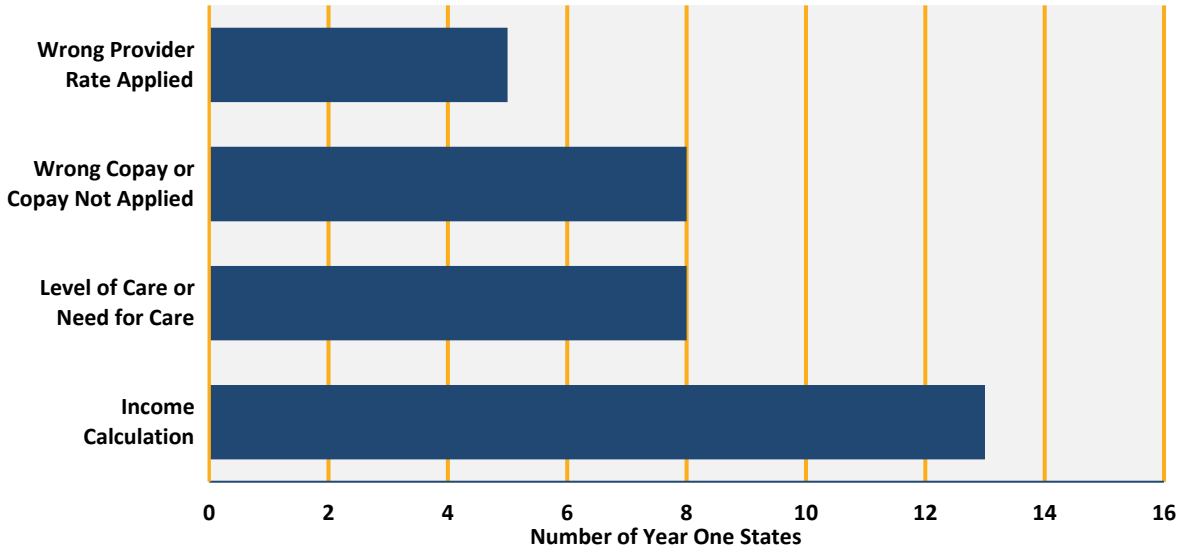
Missing or insufficient documentation errors accounted for an estimated 26.54 percent of errors identified in the CCDF improper payment review process. Errors were primarily due to missing or insufficient documentation in the case record. **Figure 18** presents the most frequently cited errors.

Figure 18: Most Frequently Cited Errors Due to Missing or Insufficient Documentation for CCDF



Administrative or process errors represent approximately 73.46 percent of errors noted in the Year One reviews. These errors consist of the failure to apply policy correctly, as shown in **Figure 19**.

Figure 19: Most Frequently Cited Errors Due to Administrative or Process Errors for CCDF



Corrective Actions to Address OMB Root Causes:

Root Causes: Insufficient Documentation to Determine and Administrative or Process Errors Made by State or Local Agency

Insufficient documentation to determine (61.84 percent or $253.22 million) and administrative or process errors made by a state or local agency (35.41 percent or $144.97 million; $123.83 million Overpayments and $21.14 million Underpayments) drive CCDF improper payments. HHS and states establish corrective actions targeting both error types. States must report on the root causes of errors once every 3 years. Each report also allows states to report on actions taken on errors from the prior review. HHS offers targeted technical assistance to specifically support each state's efforts to reduce errors. States reporting in FY 2020 plan the following corrective actions:

State Corrective Actions for Missing or Insufficient Documentation and Administrative or Process Errors Made by State or Local Agency	
Corrective Action	**Description**
Training	Eleven states plan to conduct training with eligibility staff on CCDF policies and procedures.
Oversight	Reviews: Eleven states plan to conduct ongoing case reviews or audits.
	Monitoring: Four states plan to conduct targeted monitoring of local eligibility agencies.
State Policies and Procedures	Policy Review: Five states plan to review and possibly update state eligibility policies.
	Eligibility Procedures: Three states plan to make changes to the eligibility determination procedures.
Information Systems	Four states plan to upgrade or implement new IT systems.
Technical Assistance	Four states plan to provide technical assistance to eligibility agencies.

HHS has limited authority to require specific actions of state grantees given that states determine the specifics of their CCDF programs. As resources allow, HHS provides additional onsite and remote oversight of policy and procedure implementation to assist in lowering the improper payment rate. HHS began monitoring states for

compliance with the CCDF regulations in FY 2019. Beginning in the spring of FY 2020, the COVID-19 PHE impacted some monitoring and onsite visit processes and procedures, however, HHS conducted these visits virtually with some adjustments. In addition, HHS implemented other corrective actions to assist all states in the review process and error reduction efforts, including:

HHS Corrective Actions for Insufficient Documentation and Administrative or Process Errors Made by State or Local Agency	
Corrective Action	**Description**
Oversight	All reporting states participate in Joint Case Reviews that include state and federal representatives. Through these reviews, HHS gains insight into the error methodology implementation and provides additional technical assistance to states to ensure consistent reviews.
Technical Assistance	Site Visits: HHS visits states needing assistance to address root causes as resources allow. Due to the COVID-19 PHE, HHS conducted some of these visits virtually.
	Regulations: HHS provides states with technical assistance on policy and procedure changes to meet new CCDBG requirements. HHS funds the Office of Child Care's National Center on Subsidy Innovation and Accountability to provide technical assistance to states and territories on program integrity and accountability, including targeting technical assistance to states to support reauthorization requirements.
	IT: HHS delivers technical assistance to states regarding updating or developing IT systems that will improve practices and reduce errors.
Methodology Training	HHS provides improper payments methodology training on how to conduct error rate reviews, which also allow states to share best practices on conducting the reviews with each other.

CCDF Information Systems and Other Infrastructure

Information systems and other infrastructure needed to reduce CCDF improper payments need implementation at the state level where CCDF payments occur. In addition to the efforts outlined in prior HHS AFRs, states have taken many steps to improve IT systems and infrastructure. Because states were not asked to report on specific information systems or infrastructure, other states may have certain capabilities not reported. The following categories include the information systems and infrastructure capabilities some states chose to report for FY 2020:

- Capabilities to improve eligibility determination and authorization;
- Capabilities to improve information on providers or provider payments;
- Capabilities to improve information on active cases to assist in case management; and
- Other capabilities to improve information systems and infrastructure.

Figure 20 below identifies the Year One states and the capabilities applied for FY 2020 to improve information systems and infrastructure.

Figure 20: FY 2020 CCDF Capabilities to Improve Information Systems and Infrastructure

Capabilities and Improvements to:		CCDF Year One States																Total
		AL	AK	CA	CO	GA	IL	IN	KS	NV	NH	ND	OK	PA	TX	VT	WA	
Eligibility Determination and Authorization	Part or All of Eligibility Automated	✓			✓				✓		✓		✓	✓		✓		7
	Flags/Blocks for Avoiding Eligibility Errors		✓			✓			✓	✓	✓	✓				✓		7
	Integrated with Other Agency/State Systems	✓			✓		✓		✓	✓	✓	✓	✓		✓		✓	10
Information on Providers or Provider Payments	Issues Payments	✓			✓								✓			✓		4
	Flags/Blocks for Avoiding Erroneous Payments										✓				✓			2
	Time and Attendance	✓											✓					2
Information on Active Cases to Assist in Case Management	Fraud Detection and Investigation					✓			✓						✓			3
	Monitoring/Case Audits					✓		✓	✓					✓	✓	✓		6
Other Capabilities and Improvements to Information Systems and Infrastructure	Upgrades, Enhancements, or New Systems					✓					✓							2
	Planned Updates/System Replacements		✓	✓				✓					✓		✓			5
	Systems Limitations			✓											✓			2

CCDF Statutory or Regulatory Barriers that Could Limit Corrective Actions

The CCDBG Act, signed into law in November 2014, reauthorized CCDF for the first time since 1996. The statute improves the quality and access to care for children across the country by requiring states to:

- Change eligibility to a minimum of 12 months;
- Revise redetermination policies;
- Update provider payment rates and payment practices; and
- Increase health and safety standards for providers.

CCDF regulations (issued in September 2016) also required comprehensive changes for state programs. To enact the law and regulations, states are developing and implementing new policies and procedures, which increased errors as the changes were put in place. Many states needed to pass legislation to enact the requirements under the regulations. Other states needed to update policy and procedure manuals, develop personnel training and program oversight methods, and enhance IT resources and infrastructure to monitor and oversee the new requirements. These sweeping changes to the states' child care programs have created many challenges and will likely increase errors in the near future (despite states efforts to implement the requirements). HHS will continue providing support and technical assistance to help reduce errors.

States also struggled with the challenges brought on by the COVID-19 PHE. HHS continues to engage with states to anticipate needed technical assistance and oversight.

12.0 DISASTER RELIEF FUNDING REPORTING INFORMATION

In 2017, several hurricanes, wildfires, and other disasters devastated portions of the United States, causing extensive damage across the country. In response to these disasters, Congress passed the *Additional Supplemental Appropriations for Disaster Relief Requirements Act of 2017* (Disaster Relief Act), which provided HHS with approximately $1 billion in emergency supplemental appropriations to respond to and recover from the disasters. Because funding of this type and magnitude often carries additional risk, the *Bipartisan Budget Act of 2018* created an amendment to apply improper payment reporting and grant expenditure requirements to these funds. Under the legislation and OMB guidance, disaster programs or activities that are deemed susceptible to significant improper payments—those with annual outlays exceeding $10 million—shall produce and report an improper payment estimate. Three HHS programs or Divisions met this criteria for FY 2020 reporting: ASPR, CDC, and HRSA. Information on ASPR and HRSA's Disaster Relief Act programs' improper payment methodologies, results, and corrective actions are provided in the following sections. HHS will also report CDC's disaster related improper payment information—in addition to ACF's Head Start—in the FY 2021 AFR.

12.1 ASPR DISASTER RELIEF

ASPR Statistical Sampling Process

The Disaster Relief Act allocated $162 million to the Public Health and Social Services Emergency Fund (PHSSEF), out of which ASPR received $80 million. This portion of the PHSSEF appropriation was directed to support recovery and response activities within ASPR.

To determine an improper payment rate, HHS generated a report to identify all activities that used supplemental funding. Program personnel conducted an initial check of transactions for funds usage and subsequently conducted

a review to identify any improper payments related to disaster relief funding. HHS then used a statistically valid formula to calculate an error rate of improper payments made against total disaster relief funding.

The ASPR gross improper payment estimate for FY 2020 is 1.35 percent or $0.43 million.

ASPR Corrective Action Plan

The single payment error in the ASPR Disaster Relief program is due to insufficient documentation to determine whether the activity was ineligible and found to have been paid with supplemental funding. HHS designs corrective action plans to prevent similar errors from occurring in the future.

Corrective Actions to Address OMB Root Causes:

Root Cause: Insufficient Documentation to Determine

The root cause may be an internal control deficiency. The initial step for a corrective action plan will be to conduct a key control review to obtain results on this deficiency in FY 2021. Depending on the review outcome, the deficiency will be addressed accordingly. In addition, ASPR plans to determine if any improper payment can be recovered. In the interim, appropriations law training is being supplied as a mitigation strategy and the Procure-to-Pay transactional cycle memo is planned for updates in FY 2021. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

12.2 HRSA Disaster Relief

HRSA Statistical Sampling Process

HRSA received $60 million in Capital Assistance for Hurricane Response and Recovery Efforts (CARE) funding to address necessary expenses resulting from Hurricanes Harvey, Irma, and Maria. These expenses include one-capital funding (minor alteration and renovation [A/R] and/or equipment costs) to health centers for expenses related to the consequences of the hurricanes. The HRSA CARE funds were allocated to 160 health centers affected by Hurricanes Harvey, Irma, and Maria. HRSA performed a 100 percent validation of the eligibility of the CARE grant recipients to identify any disallowed costs and generate an improper payment rate calculation. Data sources used for reviewing eligibility and payment accuracy include:

- Any site visits of CARE grant recipients conducted by the HRSA Bureau of Primary Health Care (BPHC) during FY 2019;
- Semi-Annual Progress Reports received by the BPHC during FY 2019;
- Any Single Audit resolutions received by Office of Federal Assistance Management (OFAM)/Division of Financial Integrity (DFI) (FY 2019) pertaining to CARE grant funding;
- Any OFM/DFI grant review audit resolutions (FY 2019) pertaining to CARE grant funding; and
- Any DFI non-audit collections (FY 2019) pertaining to CARE grant funding.

Amounts identified in these data sources were aggregated and compared to the total amount of CARE grant funding outlays during FY 2019 to calculate an improper payment rate estimate.

The HRSA gross improper payment estimate for FY 2020 is 0.40 percent or $0.08 million.

HRSA Corrective Action Plan

The single payment error in the HRSA Disaster Relief program is due to failure to verify other eligibility data. HHS designs corrective action plans to prevent similar errors from occurring in the future.

Corrective Actions to Address OMB Root Causes:

Root Cause: Failure to Verify Other Eligibility Data

HHS has improved the internal cross-collaboration to the processing of funding actions in order to mitigate any future failure to verify eligibility occurrences. A process has been employed where supplemental funding actions do not proceed from the Program Office to the Grants Office if an active Health Center Program awardee is on the verge of losing their active grant status. A definitive determination must be made by HHS that the Health Center program awardee will be active at the time of the planned supplemental award release. To ensure a cross-check, a preliminary list of eligible awardees is released between the Program Office and the Grants Office prior to the processing of funding actions through the formal funding memo process. The corrective action processes have proved to be effective after a subsequent request for funds was intercepted and rejected. HHS will report information about statutory and/or regulatory barriers to corrective actions at a later time, if available.

13.0 RECOVERY AUDITING REPORTING

HHS developed a risk-based strategy to implement PIIA's recovery auditing provisions that expanded payment recapture audits to programs or activities that expend $1 million or more annually, if cost effective. Specifically, HHS focuses on implementing recovery audit programs in Medicare, or providing a framework for states to implement recovery audit programs in Medicaid, which accounted for approximately 86 percent of HHS's outlays in FY 2020. HHS is progressing in recovering improper payments in Medicare and Medicaid and, most importantly, implementing corrective actions to prevent improper payments, as described in Section 11.0*: Program-Specific Reporting Information* and the following subsections. HHS will consider lessons learned from these experiences as it implements this requirement.

Medicare FFS RACs

Section 1893(h)(3) of the *Social Security Act* requires HHS to implement the Medicare FFS RAC program in all 50 states by January 1, 2010. RACs can review a variety of claim types, with restrictions on inpatient hospital patient status reviews (limited only to providers referred by the Quality Improvement Organizations for exhibiting persistent noncompliance with Medicare policies). On October 31, 2016, HHS awarded five new Medicare FFS RAC contracts that incorporated several program enhancements developed in response to industry feedback discussed on page 219 of HHS's FY 2017 AFR.

In FY 2020, the Medicare FFS RAC program identified approximately $265.90 million in overpayments and recovered $220.25 million. During FY 2020, the majority of Medicare FFS RAC collections were from outpatient claim reviews. In FY 2020, the Medicare FFS RACs made recommendations to HHS to improve program operations and prevent improper payments. The recommendations resulted in the submission of New Issue proposals for RAC review areas.

HHS also uses Medicare FFS RAC findings to prevent future improper payments. For example, in FY 2020, HHS released quarterly Provider Compliance Newsletters with detailed information on five findings identified by the Medicare FFS RACs. HHS used these findings to implement local and/or national system edits to prevent improper payments. More information can be found at the Medicare FFS RAC program website.

Medicare Secondary Payer (MSP) RACs

The MSP RAC, also known as the MSP Commercial Repayment Center (CRC), reviews HHS collected information regarding beneficiaries that had or have primary coverage through an employer-sponsored Group Health Plan (GHP) and situations where a Non-Group Health Plan (NGHP) (e.g., Workers' Compensation entity or No-Fault insurer) has or had primary payment responsibility. When GHP information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers these mistaken payments from the entity that had primary payment

responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). At the end of FY 2016, the CRC workload expanded to include the recovery of certain conditional payments made by Medicare FFS until HHS identifies an NGHP with primary payment responsibility. The CRC is a single contractor with national jurisdiction.

In FY 2020, the CRC identified approximately $539.87 million and collected $260.20 million in mistaken payments. The MSP RAC recommended to HHS the following to improve program operations:

- Procedural changes to improve the accuracy of the inclusion of recoverable conditional claim payments, thereby reducing the number of appeals for MSP debts.
- Improvements to the MSP recovery portals to implement self-service functionalities for debtors, which allowed for more timely resolution of outstanding debts.

Medicare Part C and Part D RACs

Section 1893(h) of the *Social Security Act* expanded the RAC program to Medicare Parts C and D.

The primary corrective action on Part C payment error is the contract-level RADV audits. RADV verifies that diagnoses submitted by MA organizations for risk-adjusted payment corroborate with medical record documentation. The RADV program is currently operational with the support of contractors. To effectively implement a successful Part C RAC program, in 2015, HHS issued a Request for Information on the proposal to place RADV under the purview of a Part C RAC. In response, the MA industry expressed concerns of burden related to the high overturn appeal rate in the early experience of the FFS RAC program. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to timeframes for appeal decisions in the MA appeal process remaining unestablished (42 CFR §423.2600).

Despite their success in Medicare FFS, RACs have found Medicare Part C to be an unattractive business model because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes. To more efficiently use program integrity resources, the *FY 2021 President's Budget* proposed to remove the requirement for HHS to expand the RAC program to Medicare Part C. The proposal also requires plan sponsors to report Part C fraud, abuse incidents, and corrective actions. Given that Part C RAC program functions are being performed through other program integrity mechanisms, the proposal creates programmatic and administrative efficiencies while strengthening fraud and abuse reporting.

To more efficiently use program integrity resources, the *FY 2021 President's Budget* included a proposal to remove the requirement for HHS to expand the RAC program to Medicare Part D. The proposal also requires Part D plan sponsors to report Part D fraud and abuse incidents and corrective actions. In a similar circumstance to the Part C RAC, HHS believes that Part D RAC functions are currently being performed by the PPI-MEDIC. The PPI MEDIC's workload is substantially like that of the Part D RAC, and the PPI MEDIC has a robust program to identify improper payments. After the PPI MEDIC identifies improper payments, HHS requests that plan sponsors delete PDE records that are associated with potential overpayments. Subsequently, HHS validates whether plan sponsors delete the PDEs and do not resubmit such PDEs for payment. As noted previously, the PPI MEDIC's responsibilities relate to plan oversight and pertain to specific initiatives like data analysis, health plan audits, outreach and education, and law enforcement support. In FY 2020, the NBI-MEDIC continued audits that identified potentially improper payments- and conducted education and outreach for Part D plan sponsors.

The Medicare Part D RAC contract has ended, but an administrative and appeals option period allowed the RAC to complete work on outstanding audit issues. Because the Part D RAC program option period does not permit new audit work, there were no new improper payments identified by the Part D RAC in FY 2020. In FY 2020, HHS recouped

$1.17 million in overpayments identified in previous years. See the Medicare Part C and Part D RAC programs website for more information.

State Medicaid RACs

Section 1902(a)(42)(B) of the *Social Security Act* required states to submit by December 31, 2010, assurances that programs meet statutory requirements to establish State Medicaid RAC programs. States were required to implement RAC programs by January 1, 2012. However, federal law provides authority for states to request an exception from the Medicaid RAC requirement(s), and in FY 2020, several states operated under an exception granted, for example, because of the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS. FY 2020 is the eighth full federal FY of reporting State Medicaid RAC recoveries. In FY 2020, State Medicaid RAC federal-share recoveries totaled $75.07 million and include overpayments collected, adjusted, or refunded to HHS, as reported by states on the Form CMS-64, Medicaid Statement of Expenditures.[36]

Recovery Auditing Reporting Tables

PIIA and OMB guidance requires agencies to provide detailed information on agency recovery auditing programs, and other efforts to recapture improper payments. If HHS excluded a program from a table, the program does not have results in that area.

[36] This amount may differ from `the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.

Table 3
Overpayments Recaptured with and without Payment Recapture Audit Programs
FY 2020 (in Millions)

Program or Activity	Overpayments Recaptured through Payment Recapture Audits			Overpayments Recaptured Outside of Payment Recapture Audits	
	Amount Identified	Amount Recaptured [1]	CY Recapture Rate	Amount Identified	Amount Recaptured [1]
CMS Error Rate Measurements [2]				$22.99	$15.06
Medicare FFS Recovery Auditors	$265.90	$220.25	83%		
Medicare Secondary Payer Recovery Auditor	$539.87	$260.20	48%		
Medicare Contractors [3]				$13,876.89	$12,033.85
Medicare Part D Recovery Auditors	N/A	$1.17	N/A		
Medicaid Integrity Contractors - Federal Share [4]				$14.91	$2.60
State Medicaid Recovery Auditors - Federal Share [5]	N/A	$75.07	N/A		
ACF IP Rate Measurements and Eligibility Reviews [6]				$39.77	$6.18
ACF OIG Reviews [7]				$2.02	$0.365
ACF Single Audits [8]				$26.65	$5.23
HRSA National Health Service Corps				$11.47	$4.61
HRSA Disaster Relief [9]				$0.08	$0.00
TOTAL [10]	**$805.77**	**$556.69**	**69%**	**$13,994.78**	**$12,067.90**

Notes:

1. The amount reported in the Amount Recaptured column is the amount recovered in FY 2020, regardless of the year HHS identified the overpayment.
2. The CMS Error Rate Measurements row includes recoveries from Medicare FFS (via the CERT program), as well as Medicaid and CHIP (via the PERM program). The actual overpayments identified by the CERT program during the FY 2020 report period were $21,266,220.32. The MACs recovered the identified overpayments via standard payment recovery methods. As of the report publication date, MACs reported collecting $14,353,794.35 or 67.50 percent of the actual overpayment dollars. For Medicaid and CHIP, HHS works closely with states to recover overpayments identified from the FFS and managed care claims sampled and reviewed. The *Social Security Act* and related regulations governs the recoveries of Medicaid and CHIP improper payments (under which states must return the federal share of overpayments). States reimburse HHS for the federal share of overpayments. Section 1903(d)(d) of the *Social Security Act* allows states up to 1 year from the date of discovery of an overpayment for Medicaid and CHIP services to recover, or to attempt to recover, such overpayment before making an adjustment to refund the federal share of the overpayment. The actual overpayments identified by the PERM program during the FY 2020 report period were $1,442,193.32 for Medicaid and $284,214.66 for CHIP. The amounts recovered were $493,734.00 for Medicaid and $209,162.00 for CHIP. The amounts recovered were for overpayments identified in prior report periods and, therefore, do not represent a proportion recovered from the identified overpayment amount for this report period.
3. Total reflects amounts reported by Medicare FFS Contractors excluding amounts reported for the Medicare FFS Recovery Auditors program and Medicare FFS Error Rate Measurement program, which HHS reports separately in this table.
4. Medicaid Integrity Contractors identified total overpayments that include both federal and state shares. However, HHS reports only the federal share across audits. The amount recaptured may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.
5. For the State Medicaid Recovery Auditors - Federal Share row, only the amount recaptured is available. The amount recaptured may differ from that which is reported in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs because the Agency Financial Report is prepared prior to the finalization of state reporting.
6. The ACF Improper Payment Rate Measurements and Eligibility Reviews row contains Amount Identified information for the Foster Care and CCDF programs for which the amounts were identified during the current reporting year. As a result of conducting Foster Care eligibility reviews in six states between July 2019 and June 2020, HHS recovered $0.45 million in Title IV-E improper payments (comprised of $0.32 million in disallowed maintenance payments and $0.13 million in disallowed administrative payments). For CCDF, states must recover child care payments resulting from 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 identified in the improper payments review. For the CCDF portion of the Amount Recaptured information, data reported in FY 2020 represent improper payments recovered in FYs 2018 through 2020 by the Year One states based on improper payments identified in FY 2017. States reported identifying $39.32 million and recovering $5.73 million.
7. The ACF OIG row includes Amount Identified information for all ACF programs for which the amounts from an OIG Report were sustained in FY 2020.
8. The ACF Single Audits row includes Amount Identified information for all ACF programs subject to federal audit requirements for which the audit report amounts were sustained in the FY 2020 reporting period.

9. For HRSA Disaster Relief, a single improper payment of $75,000.00 ($0.08 million) was identified during the FY 2020 report period. The amount of $124.05 ($0.0001 million) was recovered from this single improper payment during the FY 2020 report period.
10. Totals do not necessarily equal the sum of the rounded components.

14.0 FRAUD REDUCTION REPORT

The Department continues to engage in various fraud reduction efforts, including activities to meet the PIIA requirements. Since 2016, HHS has participated in the required OMB-led interagency fraud working group. HHS will continue working with OMB and other agencies to implement PIIA and to further advance fraud risk management activities.

HHS continues to take steps, at both the Department and OpDiv/StaffDiv levels, to implement fraud requirements under PIIA, and to adopt leading practices in fraud risk management, as presented in GAO's fraud risk management framework and selected leading practices published in July 2015. Select fraud risk management activities at the Department include:

- Drafting a Fraud Risk Management Implementation Plan that outlines actions taken or planned in order to enhance financial and administrative controls relating to fraud;
- Conducting internal control assessments to include the consideration of fraud and financial management risks, in accordance with the law and OMB Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, as well as designing control activities to mitigate these risks; and
- Beginning in FY 2018, HHS's improper payment risk assessments included consideration of fraud risk in individual programs or payment activities, and HHS is analyzing the FY 2018, FY 2019, and FY 2020 data.

HHS OpDivs and StaffDivs also generally manage fraud risk within other scopes of responsibility (e.g., yearly internal control reviews and audits; reviews of allegations involving misuse of grant or contractor funds, conflicts of interest, misconduct or misuse cases; continuous monitoring of grant recipients [audit resolution, special conditions/drawdown restrictions, site visits, performance reports, etc.]; the use of SAM.gov [e.g., Suspension and Debarment]); and other activities.

FY 2020 Top Management and Performance Challenges Identified By the Office of Inspector General

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

DATE: November 2, 2020

TO: Alex M. Azar II
Secretary

THROUGH: Ann C. Agnew
Executive Secretary

FROM: Christi A. Grimm
Principal Deputy Inspector General

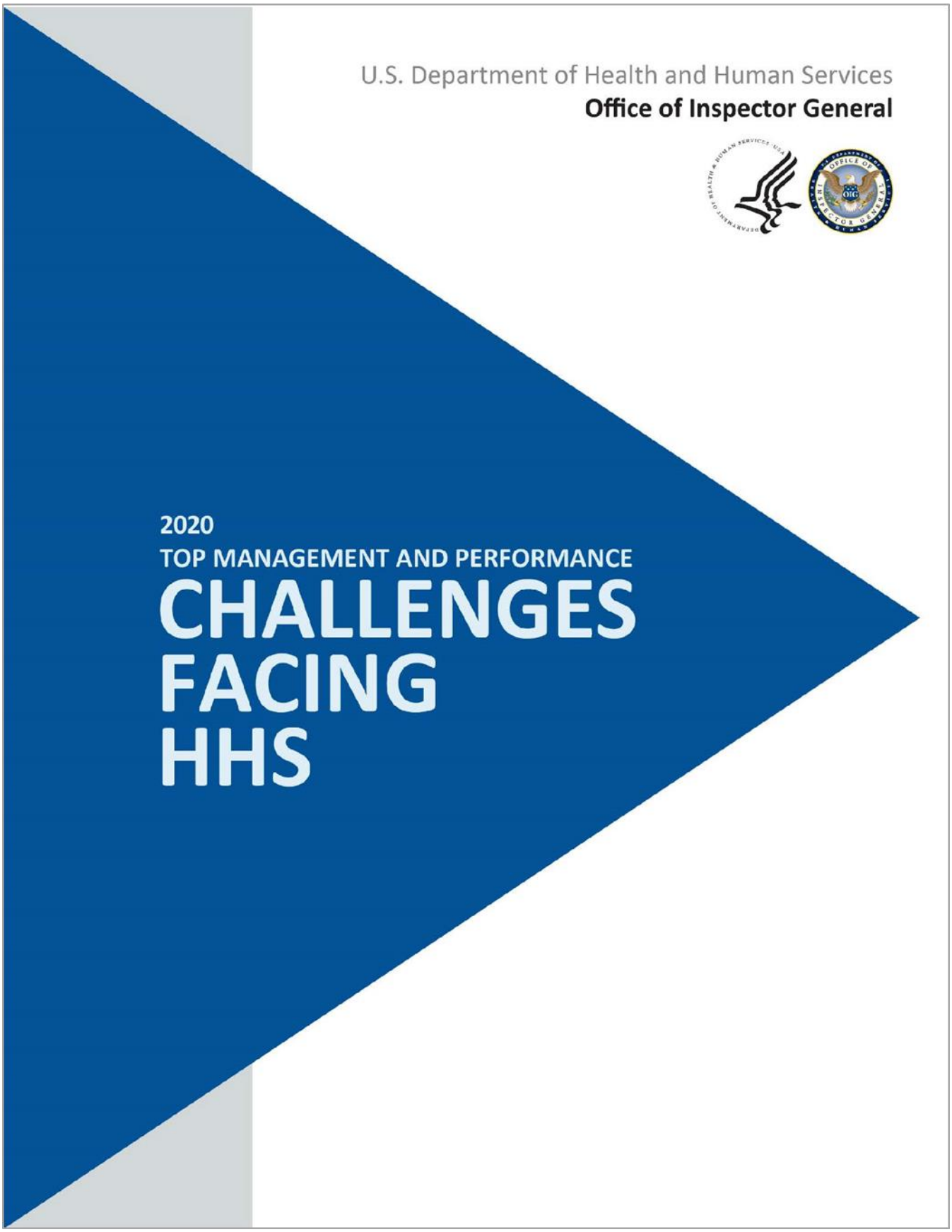
SUBJECT: Top Management and Performance Challenges Facing the Department of Health and Human Services in Fiscal Year 2020

This memorandum transmits the Office of Inspector General's (OIG's) list of top management and performance challenges facing the Department of Health and Human Services (HHS or the Department). The Reports Consolidation Act of 2000, P.L. No. 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.

HHS's top management and performance challenges for fiscal year 2020 are:

1. Safeguarding Public Health
2. Ensuring the Financial Integrity of HHS Programs
3. Delivering Value, Quality, and Improved Outcomes in Medicare and Medicaid
4. Protecting the Health and Safety of HHS Beneficiaries
5. Harnessing Data To Improve Health and Well-Being of Individuals
6. Improving Collaboration To Better Serve Our Nation

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 Juliet Hodgkins, Deputy Chief of Staff, at (202) 708-9797 or Juliet.Hodgkins@oig.hhs.gov.


U.S. Department of Health and Human Services
Office of Inspector General
2020
TOP MANAGEMENT AND PERFORMANCE
CHALLENGES
FACING
HHS

INTRODUCTION

The 2020 Top Management and Performance Challenges Facing HHS is an annual publication of the Department of Health and Human Services (HHS or the Department) Office of Inspector General (OIG). In this edition, OIG has identified six top management and performance challenges (TMCs) the Department faces as it strives to fulfill its mission "to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services." These top six challenges reflect overarching issues that affect multiple HHS programs and responsibilities. These are not the only challenges that confront HHS, and OIG reports are a key resource that highlight specific opportunities to improve HHS programs and operations.

HHS is responsible for a $2.4 trillion portfolio, and its programs impact the lives of virtually all Americans. To identify the six TMCs, we integrated OIG's oversight, enforcement, data analytics, and risk analysis work. For each TMC, we describe the dimensions of the challenge, highlight the progress the Department has made in addressing the challenge, and identify what remains to be done.

Throughout this document, we highlight the unprecedented challenges the Department faces because of the emergence of novel coronavirus disease 2019 (COVID-19). As the lead Federal agency for medical support and coordination during public health emergencies, HHS has numerous significant responsibilities to assist communities throughout the United States (U.S.) to prepare for, respond to, and recover from the fast-moving COVID-19 pandemic. HHS's responsibilities include working with Federal, State, Tribal, and local and international governments to effectively respond; supporting the development of vaccines, treatments, and other research on COVID-19; assisting the health care system by providing flexibility, resources, and funding; ensuring the safety of the health care workforce and protecting the health and well-being of the public. Challenges related to the Department's COVID-19 response are primarily addressed in TMC 1 for public health. However, the COVID-19 response affects nearly every aspect of Department operations, and challenges related to it are also addressed in other TMCs.

COVID-19 Challenges
Throughout the TMCs, we highlight the unprecedented challenges the Department faces in its response to the COVID-19 pandemic.

- TMC 1: Mitigating the loss of life and negative health consequences associated with COVID-19, while promoting the operation of essential programs and services.
- TMC 2: Ensuring responsible stewardship, transparency, and accountability of COVID-19 funds.
- TMC 3: Ensuring telehealth and other flexibilities implemented during the public health emergency work as intended.
- TMC 4: Protecting the health and safety of people especially vulnerable to COVID-19 and ensuring access to, safety, and efficacy of COVID-19 immunizations and treatments.
- TMC 5: Ensuring that public and private stakeholders have access to timely, accurate, and secure data related to the COVID-19 response and recovery.
- TMC 6: Fostering effective coordination among Federal, State, Tribal, and private sector stakeholders to combat COVID-19.

Management and performance challenges are inherently cross-cutting. The TMCs reflect how multiple HHS Staff Divisions (StaffDivs) and Operating Divisions (OpDivs) are addressing these pressing issues. For example, the challenge of financial integrity highlighted in TMC 2 has natural intersections with the challenge of delivering value, quality, and improved outcomes in Medicare and Medicaid, the subject of TMC 3. Given that challenges cross both internal HHS boundaries and externally with Federal and State agencies, coordination among HHS agencies and across government is integral to addressing these challenges.

In addition to this annual publication, OIG maintains a list of significant unimplemented OIG recommendations, including legislative recommendations, to address vulnerabilities. These recommendations are drawn from OIG's audits and evaluations. OIG identifies the top unimplemented recommendations that if implemented would, in OIG's view, most positively affect HHS programs in terms of cost savings, program effectiveness and efficiency, and public health and safety.

More information on OIG's work, including the reports mentioned in this publication, is on our website at https://oig.hhs.gov.

2020
TOP MANAGEMENT AND PERFORMANCE

CHALLENGES FACING HHS

1 Safeguarding Public Health

2 Ensuring the Financial Integrity of HHS Programs

3 Delivering Value, Quality, and Improved Outcomes in Medicare and Medicaid

4 Protecting the Health and Safety of HHS Beneficiaries

5 Harnessing Data To Improve Health and Well-Being of Individuals

6 Improving Collaboration To Better Serve Our Nation

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Acronyms

ACF	Administration for Children and Families
ACO	Accountable Care Organization
ADHD	Attention Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AI	Artificial Intelligence
AI/AN	American Indian/Alaska Native
API	Application Programming Interface
ASPR	Office of the Assistant Secretary for Preparedness and Response
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CTO	Office of Chief Technology Officer
DHS	Department of Homeland Security
DME	Durable Medical Equipment
DOJ	U.S. Department of Justice
EHR	Electronic Health Record
EID	Emerging Infectious Diseases
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FFS	Fee-For-Service
FPS	Fraud Prevention System
FY	Fiscal Year
GAO	U.S. Government Accountability Office
HC3	Health Sector Cybersecurity Coordination Center
HEAL	Helping to End Addiction Long-term Initiative
HIPAA	*Health Insurance Portability and Accountability Act of 1996*
HRSA	Health Resources and Services Administration
HHS	U.S. Department of Health and Human Services
IHS	Indian Health Service
IT	Information Technology
MA	Medicare Advantage
MAO	Medicare Advantage Organization
MAT	Medication Assisted Treatment
MCO	Medicaid Managed Care Organization
NIH	National Institutes of Health
OCR	Office for Civil Rights
OGA	Office of Global Affairs
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of National Coordinator for Health Information Technology
ORR	Office of Refugee Resettlement
OUD	Opioid Use Disorder
PCS	Personal Care Services
PERM	Payment Error Rate Measurement
PPE	Personal Protective Equipment
PSO	Patient Safety Organizations
SAMHSA	Substance Abuse and Mental Health Services Administration
SNF	Skilled Nursing Facility
TANF	Temporary Assistance for Needy Families
TEFCA	Trusted Exchange Framework and Common Agreement
T-MSIS	Transformed Medicaid Statistical Information System
UAC	Unaccompanied Alien Children

CHALLENGE 1

1: Safeguarding Public Health

HHS's core mission is to enhance the health and well-being of all Americans. The emergence and spread of COVID-19 has greatly exacerbated the Department's challenge to ensure public health and safety. HHS must act vigilantly to mitigate the loss of life and negative health consequences associated with COVID-19, while continuing to operate a range of programs and services that are essential to protecting individuals and communities. This includes facilitating the safe delivery of necessary medical care unrelated to COVID-19 (e.g., routine screenings, vaccinations, and mental health and substance use disorder services), ensuring that medical products regulated by the Food and Drug Administration (FDA) are safe and effective, and working to identify and combat health disparities. To operate effective public health programs, the Department must ensure that its agencies coordinate with each other, as well as with partners at all levels of government. (See TMC 6 for more information on the Department's challenge of coordinating with internal and external partners.)

KEY TAKEAWAYS

I. Relevant Agencies: All HHS
II. Elements of the Challenge:
- Strengthening emergency preparedness and response capabilities
- Providing adequate oversight of FDA-regulated products
- Tackling the opioid epidemic and ensuring access to treatment

Strengthening emergency preparedness and response capabilities

Public health emergencies can severely strain public health and medical infrastructure and lead to serious illness and loss of life. HHS has a lead role in preparing for, responding to, and recovering from the adverse health effects of public health emergencies, including infectious disease outbreaks, natural disasters, and chemical, biological, and radiological nuclear events. HHS is uniquely positioned to provide guidance, funding, and support to assist communities throughout the U.S. so that they can respond to and deliver health services in response to emergencies, as well as to support sustained recovery efforts.

A key challenge is having adequate planning prior to a public health emergency and mechanisms in place to efficiently and rapidly deploy assets and provide relief to those in need of HHS resources and assistance during a public health emergency. HHS plays a critical role in identifying, acquiring, developing, distributing, and administering medical countermeasures (e.g., vaccines, therapeutics, and diagnostics) to effectively prevent and treat infectious diseases. Among HHS's offices, the Centers for Disease Control and Prevention (CDC) is responsible for responding to health threats and providing critical scientific information to protect Americans, the Biomedical Advanced Research and Development Authority (BARDA) within the Office of the Assistant Secretary for Preparedness and Response (ASPR) promotes the development and acquisition of medical countermeasures, including supporting the transition of medical countermeasures from research through advanced development towards consideration for approval by the FDA and inclusion into the Strategic National Stockpile. The National Institutes of Health (NIH) is responsible for research related to the development of medical countermeasures. FDA is responsible for regulating the safety and effectiveness of such medical countermeasures and ensuring the safety and availability of the U.S. blood supply and tissue donations. And, the Office of Global Affairs (OGA) is responsible for leading international engagements to support both preparedness and response for public health emergencies.

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In addition to coordinating emergency planning and response efforts effectively with its program offices, HHS works with States and localities to facilitate planning and preparedness to address a wide range of health and human service needs, including management and distribution of medical supplies, establishment of alternative care sites, and distribution of vaccines and antiviral drugs. (See TMC 6) HHS should support health care coalitions and other entities in their efforts to plan for and coordinate emergency response among diverse entities (such as hospitals, public health agencies, emergency medical services, and emergency management).[1] Community planning is essential to managing and distributing medical equipment and supplies. Past OIG work highlighted the importance of identifying sufficient storage space, maintaining and replacing equipment, and determining the logistics of transporting the equipment when needed.[2]

OIG is conducting work examining HHS's response to the current COVID-19 pandemic. Existing OIG work on prior outbreaks of communicable diseases illustrates the importance of ongoing HHS readiness to detect, assess, and respond to new disease outbreaks and other emergencies. For instance, a 2019 OIG report about HHS's response to the 2014 Ebola outbreak recommended that HHS develop departmentwide objectives and a strategic framework for responding to international public health emergencies.[3] HHS concurred with the recommendations in the report and indicated that it continues to coordinate on these efforts and will provide additional updates.

In addition, health care facilities must have emergency plans in place to keep individuals and staff safe from harm. Prior OIG work has identified opportunities for health care facilities to improve emergency preparedness and response planning during infectious disease outbreaks and disasters.[4] For example, during Hurricane Sandy, OIG identified gaps in nursing home emergency preparedness and response.[5] Similarly, during the Ebola outbreak in 2014, many hospitals reported that they were unprepared to receive cases and experienced challenges, such as difficulty using Federal guidance, to sustain preparedness.[6] More recently, OIG's March 2020 survey of hospitals caring for patients known or suspected to have COVID-19 identified challenges with testing and caring for patients, keeping staff safe, and maintaining or expanding their facilities' capacity to treat patients with COVID-19.[7] ASPR, CDC, and the Centers for Medicare & Medicaid Services (CMS) recently took steps to provide practical advice to hospitals and coordinate guidance, and these efforts should continue.

As the COVID-19 emergency continues to evolve and scientific studies provide a deeper understanding of transmission risk, long-term health effects, and other impacts, HHS faces the challenge of ensuring it is a continuous learning organization that uses up-to-date information to sustain and strengthen its emergency response. This includes addressing the availability of timely testing, providing guidance to reduce the risk of transmission, and identifying, developing, and deploying medical countermeasures (such as safe and effective therapeutics or vaccines). HHS has the significant challenge of adapting as the pandemic evolves to minimize negative health impacts on all Americans. As part of addressing this challenge, HHS must account for racial, socioeconomic, geographic, and other disparities and the effects that such disparities have on public health. Additionally, HHS must continue to plan for other emergencies, such as hurricanes, wildfires, and other natural disasters, which have and may continue to occur simultaneously with the COVID-19 pandemic.

Providing adequate oversight of FDA-regulated products

FDA is charged with ensuring the safety, effectiveness, and security of human and animal drugs, biological products, and medical devices; ensuring the safety of the nation's food supply, cosmetics and products that emit radiation; and regulating tobacco products. These functions are critical to ensuring that Americans can trust the expansive array of products in FDA's purview.[8] FDA has the added challenge of facilitating emergency response efforts related to the current COVID-19 emergency. The American public relies on FDA to expeditiously assess new medical

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products or new uses of legally marketed medical products (such as drugs or vaccines) that treat or offer protection from negative health effects associated with COVID-19, without sacrificing assurances of safety and efficacy. This challenge also encompasses approving and facilitating the widespread availability of COVID-19 tests.

Drug, biologic, and medical device safety

FDA's responsibility to ensure the safety and effectiveness of medical products begins before approval and continues after the product is marketed. This includes overseeing manufacturing facilities; reviewing drugs, devices, and biologics for safety and effectiveness; authorizing the use of investigational medical products; and conducting postmarket surveillance. The public relies on FDA to be expeditious in evaluating products and thoughtful in its decisions regarding approval for marketing in the U.S.

FDA's task of assessing products becomes more difficult as manufacturing processes and products become more intricate. The drug, biologic, and medical device supply chain is becoming increasingly complex, and many drugs used in the U.S. are manufactured overseas. In 2019, FDA reported that approximately 53 percent of the finished dosage from manufacturing facilities and 72 percent of active pharmaceutical ingredient manufacturing facilities of human drugs for the U.S. market were located outside of the U.S.[9] OIG has identified vulnerabilities with FDA's oversight of manufacturing and distributing drugs, including high-risk drugs such as compounded drugs.[10] This presents FDA with many challenges as medical products move through the supply chain and are at risk of diversion, theft, counterfeiting, and adulteration. When problematic products are identified, it is imperative for FDA to be able to trace the path drugs follow from manufacturer to patient.

The rapid speed at which science and technology are evolving presents new concerns for FDA to address via its oversight role. Further, managing the cybersecurity risks associated with networked devices is increasingly difficult as more medical devices use internet connectivity. Networked medical devices approved by FDA can be susceptible to cybersecurity threats, such as ransomware and unauthorized remote access, if the devices lack adequate security controls.[11] These networked devices include hospital-room infusion pumps, diagnostic imaging, and pacemakers.

In 2018, OIG released two reports assessing FDA's oversight of premarket and postmarket cybersecurity risks to medical devices.[12] An underlying issue identified in both reports was the opportunity for FDA to take further action in addressing cybersecurity threats to reduce risk to patients and the health care industry. FDA has made administrative changes to improve its premarket and postmarket processes, but FDA should continue to take steps to enhance its ability to receive relevant information as well as securely share it with key stakeholders. (See TMC 5 on data for additional actions FDA has taken related to cybersecurity.)

Food safety

FDA has the complex responsibility of keeping the foods that it regulates safe. An estimated 1 in 6 Americans get sick from contaminated foods each year, and 3,000 die.[13] Foodborne illnesses are largely preventable, and the American public relies on FDA, working with partners including CDC, to ensure the safety of both human and animal food.[14] The Department must ensure that FDA continues to modernize the food safety system and responds effectively when issues are identified. FDA should conduct risk-based inspections of domestic and foreign food facilities within the timeframes required by the *Food Safety*

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Modernization Act, identify instances of failure to comply with good manufacturing practices, and take necessary steps when health risks are identified, including administrative and enforcement actions when warranted.[15] FDA has made organizational changes with the goal of improving incident response through, for example, instituting its Coordinated Outbreak Response and Evaluation Network, and should continue to improve the timeliness and effectiveness of its processes, such as food recalls, to optimize its ability to protect the public from outbreaks of foodborne illnesses.

Tobacco

FDA is also in charge of regulating tobacco products and has made a commitment to reduce harm from tobacco products, particularly among youth. FDA must undertake this effort amid increasing concerns surrounding the growing use and detrimental health effects of electronic nicotine delivery systems, such as vape pens and e-cigarettes. Working with CDC, FDA faces the challenge of better understanding the science of tobacco products and the most effective use of its authorities to regulate their manufacturing, marketing, and sale. It remains a priority for FDA to address the public health crisis of youth e-cigarette use by, among other things, focusing product review and enforcement on youth-appealing products and investing in campaigns to educate youth about the dangers of e-cigarette use.

Tackling the opioid epidemic and ensuring access to treatment

In 2017, the President declared the opioid crisis a public health emergency. While the Nation has made progress with addressing the opioid crisis, significant challenges remain. In 2018, approximately 2 million people had an opioid use disorder (OUD),[16] and an estimated 69.5 percent of all drug overdose deaths involved an opioid.[17] Although the overall rate of drug overdose deaths involving opioids decreased from 2017 to 2018, it increased in five states. Additionally, in 2018 the overall rate of overdose deaths from synthetic opioids increased by 10 percent and two-thirds of opioid overdose deaths involved synthetic opioids (excluding methadone).[18] There are also new and highly dangerous patterns of use, including polysubstance use of both methamphetamines and illicit fentanyl or fentanyl analogs.[19]

HHS developed a five-point strategy in 2017 to combat the opioid crisis and must continue working toward addressing the problem and adjusting its approach as appropriate. HHS's OpDivs have an essential role to play in preventing substance use disorders and facilitating the delivery of safe and effective treatment, including continuity of care during the coronavirus outbreak. The Department should continue to use the tools available across its programs to address the opioid epidemic while being mindful of patients' needs to access appropriate pain management, which may include the use of opioid analgesics.

Moreover, the impacts of COVID-19 on people's daily lives present new, complicating obstacles to effectively providing care related to mental health and substance use disorders. The pandemic and related stressors are thought to put people at risk for developing substance use disorders or relapsing, and those with OUD may experience negative respiratory and pulmonary health effects that make them particularly vulnerable to COVID-19.[20] Of additional concern, chronic respiratory disease is known to increase the risk of fatal overdose among people taking opioids, and COVID-19 could similarly increase the risk of overdose for people who have OUD.[21] Ensuring access to effective treatment remains crucial to combating the opioid epidemic, and the COVID-19 pandemic may create additional obstacles to effectively running opioid treatment programs and providing care.

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The opioid crisis is partially fueled by opioids prescribed by licensed medical professionals, dispensed by licensed pharmacies, and paid for by Federal funds. OIG identified 71,260 Medicare Part D beneficiaries who, in 2017, were prescribed opioids in quantities, or from sources, suggesting that they were at serious risk of misuse or overdose. In 2018, most of this same beneficiary population received high quantities of opioids, 11 percent had an overdose or adverse effect, and only a small subset received naloxone or medication-assisted treatment (MAT) through Medicare.[22] Ensuring access to appropriate pain management therapies and combating opioid abuse remains a high priority, and CMS should continue to expand its role in ensuring that beneficiaries receive treatment for opioid use disorder. In particular, CMS should educate beneficiaries and providers about access to MAT drugs and naloxone.

The Indian Health Service (IHS) also has an important role in preventing and detecting opioid misuse or abuse. A 2019 OIG report found that IHS hospitals did not fully use the States' prescription drug monitoring programs when prescribing or dispensing opioids at certain IHS hospitals.[23] In addition, the hospitals did not use available data to identify risks in their prescribing and dispensing practices, such as giving patients opioid doses as high as 500 daily morphine milligram equivalents; and giving opioids and benzodiazepines at the same time, which puts patients at greater risk of a potentially fatal overdose. IHS could improve the quality of care for prescribing and dispensing opioids to the American Indian/Alaska Native (AI/AN) population by fully utilizing States' prescription drug monitoring programs.

Additionally, FDA has an important role to ensure the safe use of opioids. FDA approves new drugs before they are marketed in the U.S., assessing the benefits and risks that a drug can be taken safely and effectively.[24] FDA also monitors the safety of marketed drugs as new information becomes available. Through this framework, FDA has a range tools and authorities: encourage the development of abuse-deterrent formulations of opioids to reduce the risk that such products may be abused; employ tools to mitigate risks associated with approved drugs, including the Risk Evaluation and Mitigation Strategy program; pursue measures that include withdrawing drugs from the market when there are serious safety concerns; and support the treatment of OUDs with FDA-approved drugs—buprenorphine, methadone, or naltrexone—as well as the development of additional therapies to treat OUD.[25]

Ensuring access to treatment

HHS must work diligently across all of its programs to ensure access to effective, specialized OUD treatment. HHS continues to manage and oversee investments to address OUDs. From 2016 to 2019, HHS awarded more than $9 billion in grant funding to States, Tribes, and local communities to increase access to prevention, treatment, and recovery services. For example, in FY 2019, NIH awarded $945 million for grants, contracts, and cooperative agreements across 41 States through the Helping to End Addiction Long-term Initiative (NIH HEAL Initiative), which aims to improve treatments for chronic pain, curb the rates of OUD and overdose, and achieve long-term recovery from opioid addiction.[26] To address OUD and mortality, it is vital for the public to be able to access specialized and effective, quality substance use disorder treatments, including MAT. People suffering from an OUD are at risk for withdrawal and relapse and without effective treatment, may seek out illicit opioids, such as heroin. However, only a fraction of the 2.1 million people with OUDs received treatment in 2018 (19.7 percent).[27] MAT combines the use of medications with counseling and behavioral therapies, which can be an effective treatment for OUDs. A 2020 OIG review found access to buprenorphine services remains challenging in many localities and recommended Substance Abuse and Mental Health Services Administration (SAMHSA) geographically target its efforts to increase providers who can treat patients in need of buprenorphine services in high-need counties.[28]

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There is a great need for treatment, especially in areas disproportionately affected by the opioid epidemic, including the AI/AN population and rural communities. HHS must ensure that money to address the opioid epidemic is efficiently and effectively spent for its intended purpose. OIG found that States have been slow to spend their awards under the State Targeted Response to the Opioid Crisis; of the total $1 billion in the grant program, $304 million remains unspent after 2 years.[29] Additionally, OIG's audit of the Health Resources and Services Administration's (HRSA) Access Increases in Mental Health and Substance Abuse Services (AIMS) grant found that HRSA followed its policies and procedures for awarding AIMS grants but did not always follow its policies and procedures when monitoring health centers' compliance with supplemental funding requirements.[30] It is paramount that HHS's OpDivs, including SAMHSA and HRSA, work with grantees and subgrantees to ensure grant dollars are used effectively for their intended purposes. Additionally, HHS must continue to implement the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act*, which, among other things, requires Medicare to cover certain treatment services provided by opioid treatment programs, including methadone.

CHALLENGE 2

2: Ensuring the Financial Integrity of HHS Programs

KEY TAKEAWAYS

I. Relevant Agency: All HHS
II. Elements of the Challenge:
- Controlling costs by ensuring prudent pricing for goods and services
- Reducing improper payments
- Combating fraud, waste, and abuse
- Monitoring and reporting on the integrity of HHS programs

HHS is the largest civilian agency in the Federal government, with a $2.4 trillion budget, representing one-third of the total Federal budget.[31] HHS's Medicare program is the Nation's largest health insurer by expenditures, handling more than 1 billion claims per year. Medicaid is the largest health insurer in terms of lives covered, with 76.5 million beneficiaries in Medicaid and the Children's Health Insurance Program (CHIP) enrolled individuals.[32] Medicare and Medicaid are the Department's largest programs; funding for these programs (including State funding) represents 37 cents of every dollar spent on health care.[33] Almost 140 million beneficiaries, or more than 40 percent of Americans, rely on these programs for their health insurance, including senior citizens, individuals with disabilities, low-income families and individuals, and patients with end-stage renal disease.[34] CMS bears the responsibility at HHS for administering these programs. Medicare expenditures totaled $796 billion in 2019.[35] The Federal Medicaid budget totaled $411.3 billion in FY 2019 (with an additional $17.5 billion for CHIP).[36] As many providers faced fiscal uncertainty due to COVID-19, CMS took steps to provide increased flexibility and advance payments to mitigate the financial effects of the pandemic.

HHS is also the largest grant-making and second-largest contracting agency in the Federal government. In FY 2020, HHS awarded $244.7 billion in grants (excluding CMS)[37] and $160.7 billion in contracts.[38] Responsible stewardship that ensures the transparency and accountability of HHS funds is paramount to making sure that HHS beneficiaries and the American public get the true benefit of this substantial financial investment.

The Department must protect the fiscal integrity of HHS funds and ensure that beneficiaries have access to the services they need, especially in light of looming financial shortfalls in the Medicare program,[39, 40] the expansion of Medicaid services to a larger population, and the increased dollar amounts that HHS is responsible for distributing and overseeing via grants and other mechanisms. HHS must not only manage the efficient and effective use of funds internally, but also oversee the thousands of external funding recipients' use of Federal funds to fulfill the Department's mission. Further, responsible stewardship, transparency, and accountability of the significant amount of funds provided to HHS for the COVID-19 response are needed to ensure that HHS beneficiaries and the American taxpayers receive the biggest return on their financial investment.

Controlling costs by ensuring prudent payment for goods and services

Whether HHS is paying for medical services, prescription drugs, or human service programs, managing what the Department pays and recognizing and remedying payment policies that inadvertently incentivize improper billing or inflate prices are critical to controlling costs.

Medicare

Medicare should act as a prudent payer on behalf of taxpayers and beneficiaries, including instituting

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payment policies delivering greater value. (See TMC 3 for more information on value-based payment models.) In certain contexts, Medicare payment policies, which are generally set by statute by Congress, may result in Medicare and beneficiaries paying more for care provided in certain settings than for the same care provided in other settings. For example, Medicare could have potentially saved $4.1 billion over a 6-year period if swing-bed services at critical access hospitals had been paid for at the same rates as at skilled nursing facilities (SNFs).[41] Likewise, Medicare pays hospitals different amounts for the same care depending on whether the hospital admits beneficiaries as inpatients or treats them as outpatients.

Prescription drug programs

Vulnerabilities exist in HHS's payment strategies for prescription drugs and biologicals. HHS programs accounted for 43 percent ($143 billion) of the total U.S. prescription drug expenditures in 2018.[42] Increased costs may limit patients' ability to afford needed prescription drugs, in some cases causing patients to skip or split doses of medication or forgo purchasing medications altogether. The way that Medicare and Medicaid pay for drugs can result in additional costs for programs and their beneficiaries. In the Part D program, for example, OIG found that although there was a 17-percent decrease in Medicare Part D prescriptions for brand-name drugs from 2011 to 2015, there was a 77-percent increase in total reimbursement for these drugs, leading to greater overall Part D spending and higher beneficiary out-of-pocket costs.[43] In the Part B program, OIG found that Medicare would have saved millions of dollars if dispensing fees for several drugs had been aligned with the rates that Part D and State Medicaid programs paid.[44] In addition, CMS includes prices for higher-cost versions of drugs that are not covered under Medicare Part B when setting Part B payment amounts. OIG found that, because CMS included non-covered versions when setting payment for two Part B drugs, Medicare and beneficiaries paid an extra $366 million from 2014 through 2016.[45] HHS must endeavor to limit the impact of high prices on programs and beneficiaries while protecting access to medically necessary drugs. Additionally, the Department should be prepared to address coverage and reimbursement challenges of emerging technologies.

Preventing and reducing improper payments

An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.[46] Reducing improper payments—such as payments to ineligible recipients or duplicate payments—is critical to safeguarding Federal funds. Due to their size, HHS programs account for some of the largest estimated improper payments in the Federal government. Medicare and Medicaid accounted for 59 percent, or $103.6 billion, of all governmentwide estimated improper payments reported in FY 2019.[47] Furthermore, insufficient HHS oversight of grant programs and contracts poses risks of significant improper payments.

Medicare

Original Medicare fee-for-service (FFS), Medicare Part C (also known as Medicare Advantage (MA)), and Medicare Part D accounted for $46.2 billion, or 43 percent, of the estimated improper payments that HHS reported in FY 2019.[48] Notably, the Medicare FFS improper payment rate estimate decreased from 8.1 percent ($31.6 billion) in FY 2018 to 7.3 percent ($28.9 billion) in FY 2019.[49] This represents positive momentum upon which the Department and CMS can build. However, some types of providers and suppliers pose heightened risk to the financial security of Medicare. For instance, OIG and CMS have identified especially high rates of improper payments for home health, hospice, and SNF care; durable

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medical equipment (DME); chiropractic services; and certain hospital services.[50] HHS and CMS have taken corrective actions for the Medicare FFS program focusing on specific service areas with high improper payment rates. This year's reduction in the improper payment rate was driven by a reduction in improper payments for home health, Part B, and DME claims. However, CMS should take further action to reduce improper payments among certain provider and supplier types and in geographic locations that present a high risk to the financial security of Medicare. Further, CMS should ensure that it is prepared to detect and prevent improper payments in burgeoning areas, such as telemedicine and genetic testing.

Moreover, improper payments to MA plans pose a significant vulnerability for CMS and cost taxpayers billions of dollars. In FY 2019, the improper payment rate for MA was 7.9 percent, for a total of $16.7 billion in improper payments. Unlike in FFS, where CMS pays providers directly for each covered service received by a beneficiary, under managed care, CMS makes a capitated payment to a managed care plan for each person enrolled in the plan. In turn, the plan pays providers for services a beneficiary may require that are included in the plan's contract with CMS. CMS risk-adjusts payments to pay MA Organizations (MAOs) different amounts for beneficiaries with different expected health care costs. This helps to ensure that beneficiaries with greater health care needs have continued access to MA plans. However, OIG has found that improper payments in MA are largely driven by improper risk adjustment payments (See below for more information about risk adjustment vulnerabilities.)[51, 52]

Medicaid

Medicaid is a Federal-State financing partnership with the 50 States, 5 territories, and the District of Columbia, each offering its own program variations reflecting State and local needs and preferences. CMS's Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid and CHIP in all 50 States and the District of Columbia and produces a national improper payment rate for each program. The estimated improper payment rate increased significantly, from 9.8 percent in FY 2018 to 14.9 percent in FY 2019 (CHIP increased from 8.6 percent to 15.8 percent), largely due to changes in how CMS measured and reported beneficiary eligibility errors.[53] Medicaid accounted for approximately $57.4 billion in estimated improper payments in FY 2019. CMS attributes these increases to high levels of observed eligibility errors, including States maintaining insufficient documentation to substantiate that income and other information was appropriately verified, failures to conduct timely and appropriate annual redeterminations, and claiming beneficiaries under incorrect eligibility categories that provide a higher Federal matching rate than was appropriate.[54]

OIG work has found that States are not always correctly determining eligibility of individuals to receive Medicaid benefits, resulting in potential improper payments. OIG audits have also identified substantial improper payments to providers across a variety of Medicaid services, including school-based, non-emergency medical transportation, targeted case management, and personal care services (PCS).[55] CMS has engaged with State Medicaid and CHIP agencies to develop corrective action plans that address State-specific reasons for improper payments identified through the PERM program and as part of other Medicaid fiscal oversight efforts. Given that CMS continues to use the updated Medicaid eligibility measurements for additional states in FY 2020, the improper payment rate is likely to see similar, significant increases for this fiscal year and in the near future. As such, it will be imperative that CMS focus its efforts to examine and reduce the Medicaid and CHIP improper payment rates.

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Grants and contracts

Administering grant programs and contracts requires HHS to implement internal controls to ensure program goals are met and funds are used appropriately. For grant programs, this includes oversight and guidance to award recipients. HHS is responsible for providing up-to-date policies to grant recipients and helping States and other grantees address their own financial management and internal control issues. Without proper internal controls, funds may be misspent, duplication of services may occur, and sub-recipients may not be adequately monitored. OIG has identified grantee-level concerns in several HHS programs, including some Office of Refugee Resettlement (ORR) Unaccompanied Alien Children (UAC) Program grantees reporting unallowable costs and lacking effective systems for administering program funds.[56] Additionally, OIG found that HHS has taken minimal action to improve policies and procedures for ensuring Small Business Innovation Research Program awardee eligibility and has taken no action to improve policies and procedures for preventing duplicative funding.[57]

As a critical element of ensuring that grant funds are used appropriately, HHS must track and report improper payment rates for its risk-susceptible grant programs, in keeping with the *Payment Integrity Information Act of 2019*.[58] However, since the inception of these reporting requirements, HHS has not reported an improper payment estimate for the Temporary Assistance for Needy Families (TANF) program.[59] States receive block grants ($16.5 billion annually) to design and operate TANF programs.[60] HHS has stated that it does not believe it has the statutory authority to collect from States the data necessary for calculating an improper payment rate for the TANF program. The Office of Management and Budget (OMB) has identified TANF as a risk-susceptible program that must report estimated rates and amounts of improper payments. HHS must continue to pursue legislative remedies to develop an appropriate methodology for measuring TANF payment accuracy and report an improper payment estimate for TANF.

In terms of the Department's oversight of contracts, HHS has taken steps to enhance its acquisition systems and better monitor contract closeouts and contract payments. Moreover, CMS has increased its efforts in examining workload statistics for benefit integrity contractors and improving performance outcomes. Although CMS has taken steps to improve its contract management and closeout processes, the Department needs to take additional actions to ensure that it is meeting other Federal requirements. For example, OIG found that CMS did not identify and report potential *Antideficiency Act* violations for 12 contracts used to establish the Federal Marketplace under the *Affordable Care Act*.[61] Additionally, OIG found that CMS did not administer and manage strategic communications services contracts in accordance with Federal requirements and made recommendations to both HHS and CMS to address the significant deficiencies we identified.[62]

COVID-19 funding

As of October 2020, the total HHS COVID-19 appropriation was $251 billion, including $175 billion in Provider Relief Funds. Provider Relief Fund monies are for hospitals and other health care providers on the front lines of the coronavirus response. This funding is intended to support health-care-related expenses or lost revenue attributable to COVID-19 and to ensure that uninsured Americans can receive testing and treatment for COVID-19. By October 2020, HHS had allocated approximately $145 billion for Provider Relief Fund payments, including $50 billion for Medicare providers; $15 billion for Medicaid, CHIP, and dental providers; $59.8 billion in targeted allocations to high impact areas, safety net hospitals, rural providers, Tribal facilities, clinics and urban health centers, skilled nursing facilities, and nursing homes; and $20 billion

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for general distribution, including providers previously ineligible for payment, such as those who began practicing in 2020.[63] HHS has developed financial assistance policy guidance and tracking mechanisms to support the COVID-19 supplemental funding appropriations.[64] Efficient and effective management and administration will be essential to ensuring that COVID-19 response programs achieve their intended purposes and provide relief to intended individuals and entities.

Combating fraud, waste, and abuse in HHS programs

Fraud, waste, and abuse divert needed program resources to inappropriate, unauthorized, or illegal purposes. Effectively fighting fraud, waste, and abuse requires vigilance and sustained focus on preventing problems from occurring in the first place, detecting problems promptly when they occur, and rapidly remediating detected problems through investigations, enforcement, and corrective actions. To accomplish this, HHS must have controls to ensure the proper use of resources to detect and prevent fraud. The Department should also apply a robust variety of program integrity strategies to protect HHS programs. These strategies must include systems and processes to detect and prevent fraud, as well as plans for addressing fraud when it occurs.

Fraud involving COVID-19 funds

As noted above, HHS has been appropriated $251 billion in COVID-19 funding. Moreover, as of October 2020, CMS had made accelerated and advanced payments to Medicare providers totaling $108 billion and is paying providers for certain services at enhanced rates applicable during the public health emergency. CMS also temporarily suspended or reduced the scope of many program integrity safeguards, such as provider enrollment screening. While these steps may be appropriate to ensure access to care, they also raise the risks of fraud by those seeking to exploit the emergency. Regardless of the source of funds, HHS must effectively and efficiently manage the use of funds internally, award and manage contracts related to COVID-19 funding in accordance with contracting requirements, and appropriately oversee thousands of external funding recipients' use and accounting of Federal funds. HHS should ensure that funds are paid only to eligible recipients in correct amounts and used in accordance with program requirements. Additionally, the Department must identify and fight fraud that would divert funds intended for COVID-19 response and recovery. This includes taking action to protect individuals from being defrauded under the guise of the public health emergency. Effective internal controls and the collection, maintenance, and analysis of relevant data are key to ensuring that funds are used for their intended purposes.

Further, as with all HHS grant programs, it will be critical that the Department provide up-to-date policies to COVID-19 related grant recipients and help States and other grantees address their own financial management and internal control issues. Without proper internal controls, funds may be misspent, duplication of services may occur, and sub-recipients may lack adequate monitoring.

Medicare and Medicaid

CMS must be vigilant in identifying and addressing fraud in its programs. Schemes to steal money from Medicare and Medicaid take many forms and vary depending on setting and services provided. These fraud schemes can be as simple as billing for services not provided and identity theft, or as complex as kickbacks, improper prescribing, deceptive marketing, and money laundering. The perpetrators of fraud schemes range, from highly respected physicians to organized criminal enterprises with no legitimate role in health care.

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Managed Care

HHS faces a significant challenge in protecting managed care programs and other non-traditional models against fraud, waste, and abuse. Managed care is the primary delivery system for Medicaid, covering at least some services for more than 80 percent of all enrollees.[65] In Medicare, one-third of beneficiaries are currently enrolled in MAOs. OIG has found weaknesses in MAOs' and Medicaid managed care organizations' (MCOs') efforts to identify and address fraud and abuse by their providers.[66] CMS requires MAOs and Medicaid MCOs, prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) (hereinafter referred to as managed care plans) to implement compliance plans that include measures to prevent, detect, and correct instances of fraud, waste, and abuse and non-compliance with CMS's program requirements. However, these plans vary widely among the MAOs, as does the detection of suspected fraud. In Medicaid managed care, program integrity responsibilities are even more dispersed, as they are shared among CMS, States, and managed care plans. This makes effective oversight by CMS more complex and challenging.

Further, the MA program is vulnerable to fraud, waste, or abuse perpetrated by MAOs to inappropriately inflate the payments that they receive from Medicare or to inappropriately deny care that they are obligated to provide. OIG found that billions of dollars in estimated MA risk-adjusted payments supported solely through chart reviews or diagnoses reported only on health risk assessments raise concerns about the completeness of payment data submitted to CMS, the validity of diagnoses on chart reviews and health risk assessments, and the quality of care provided to beneficiaries.[67, 68] OIG has made recommendations to CMS to improve its oversight of MA plans so that plans will ensure practices drive better care and not just higher profits and enact policies and procedures to improve the integrity and usefulness of payment data.

Additionally, significant concerns have been raised that the capitated payment model used in MA may provide a potential incentive for MAOs to inappropriately deny access to services and payment in an attempt to increase their profits. An MAO that inappropriately denies authorization of services for beneficiaries or payments to health care providers may contribute to physical or financial harm and also misuses Medicare program dollars that CMS paid for beneficiaries' health care. OIG found that high numbers of overturned denials upon appeal and persistent performance problems identified by CMS audits raise concerns that some beneficiaries and providers may not be getting services and payment that MAOs are required to provide.[69]

To strengthen CMS's oversight of the MA program, OIG has recommended that CMS make improvements to MA encounter data.[70] CMS has taken action to address potential errors in the data and ensure that billing provider identifiers are active and valid on all records. However, CMS must also provide targeted oversight of MAOs that have submitted a higher percentage of records with potential errors, track how MAOs respond to edits that reject data, and establish and monitor performance thresholds related to MAOs' submission of records with complete and valid data.[71] Additionally, CMS is working to validate the completeness and accuracy of Medicare and Medicaid managed care plan encounter data and release best practices guidance for MAOs to improve encounter data submission.

In addition, to improve Medicaid managed care plan identification and referral of cases of suspected fraud or abuse, CMS is working with States to provide technical assistance and education on best practices. CMS should take further actions to ensure the completeness, validity, and timeliness of Medicaid encounter

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data. Further, the agency should work with its contractors and with States to improve efforts to identify and address fraud and abuse. Additionally, CMS should work to ensure that appropriate information and referrals are sent to law enforcement.

Grants and contracts

Without adequate oversight and internal controls, HHS grants and contracts are vulnerable to fraud schemes, including embezzlement.[72] HHS has worked to strengthen some of its program integrity efforts focused on grant programs. For instance, it issued guidance and developed tools to help HHS awarding OpDivs examine prospective grantee risk prior to awarding grants.[73] This information enhances awarding OpDivs' assessment of prospective grant recipients' integrity and potential performance.

Fraud involving prescription opioids

Opioid-related fraud encompasses a broad range of criminal activity, from prescription drug diversion to addiction treatment schemes. OIG investigations show that opioid drug diversion (the redirection of legitimate drugs for illegitimate purposes) is on the rise. Diverted opioid drugs are at high risk to be used inappropriately and create significant harm, including increased risk of overdose. Also at high risk for diversion are potentiator drugs (drugs that exaggerate euphoria and escalate the potential for misuse when combined with opioids) and drugs indicated to treat OUDs (particularly buprenorphine).

OpDivs should improve efforts to identify and investigate potential fraud and abuse in prescription drug programs. For instance, CMS should collect comprehensive data from Medicare Part D plan sponsors. CMS should also require pharmacies that bill Medicare Part D to enroll in the Medicare program. Currently, CMS's three key tools for safeguarding against fraud—enrollment, revocation, and preclusion—apply to pharmacies only when they bill Medicare Parts B or C, not when they bill Medicare Part D.[74] Further, CMS should ensure that national Medicaid data are adequate to detect suspected fraud or abuse. The lack of reliable national Medicaid data hampers enforcement efforts. (See TMC 5.) CMS and States should follow up on prescribers with questionable prescribing patterns to ensure that Medicare Part D and Medicaid are not paying for unnecessary drugs that are being diverted for resale or recreational use. OIG has also recommended that IHS improve its internal controls against opioid-related fraud, including controls at entry points to sensitive areas of its hospitals to protect its pharmacy inventory from unauthorized access.[75] In addition, the Department must guard against fraud in OUD treatment programs, including the submission of fraudulent insurance claims for purported OUD treatment and testing services.[76]

Systems and processes for detecting and preventing fraud

With respect to detecting and preventing fraud and improper payments, CMS's Fraud Prevention System (FPS) serves as an important tool that should be improved to increase its effectiveness. Since 2011, the FPS has continuously run predictive algorithms and other sophisticated analytics nation-wide against Medicare FFS claims prior to payment to identify, prevent, and stop fraudulent claims. However, OIG found that the FPS is not as effective in preventing fraud, waste, and abuse in Medicare as it could be and recommended that CMS should make better use of the performance results within its FPS to refine and enhance its predictive analytic models.[77]

An effective provider enrollment screening process is an important tool for preventing Medicaid and Medicare fraud. It plays a vital role in identifying unscrupulous providers and preventing them from enrolling in Medicaid and Medicare. OIG work has found that Medicaid is vulnerable to being defrauded

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by high-risk providers that were not properly screened. Specifically, OIG found 13 States had not implemented fingerprint-based criminal background checks for their high-risk Medicaid providers as of January 2019. We also found that unscrupulous providers could exploit loopholes in the provider enrollment process to enroll in Medicaid without undergoing these checks.[78] In addition, OIG found 23 States had not enrolled all providers serving Medicaid beneficiaries in their respective Medicaid programs, exposing them to potentially harmful providers that had not been screened for fraud, waste, and abuse.[79] Furthermore, OIG work found that nearly 1,000 terminated providers—or 11 percent of all terminated providers—were inappropriately enrolled in State Medicaid programs.[80] Despite legislative requirements in the *21st Century Cures Act* designed to strengthen Medicaid program integrity, terminated providers continue to serve Medicaid beneficiaries. CMS should: (1) ensure that all States fully implement fingerprint-based criminal background checks for high-risk Medicaid providers, (2) work with States to ensure that they have the controls required to prevent unenrolled providers from participating in Medicaid, and (3) follow up with States to remove terminated providers that OIG identified as inappropriately enrolled in Medicaid.

Monitoring and reporting on the integrity of HHS programs

HHS must ensure the completeness, accuracy, and timeliness of financial and program information provided to other entities, both internal and external to the Federal government. Responsible stewardship of HHS programs is vital to operating a financial management and administrative infrastructure that employs appropriate safeguards to minimize risk and provide oversight for the protection of resources. Although HHS continues to maintain a clean opinion on their basic financial statements addressing weaknesses in financial management systems and resolving issues related to reporting requirements of the *Digital Accountability and Transparency Act of 2014*[81] remain challenges for HHS. OIG has recommended that HHS continue to focus its efforts on resolving issues related to its IT system controls and completing data cleanup activities.

In addition, financial management systems help OpDivs ensure operational effectiveness and efficiency, financial reporting reliability, and compliance with applicable laws and regulations. OIG continues to find significant deficiencies in internal controls over segregation of duties, configuration management for approved changes to HHS financial systems, and access to HHS financial systems.[82] HHS must take additional actions to address and resolve these issues, including continuing to work to control user access, ensuring proper approval of and documentation supporting system changes, and ensuring appropriate segregation of duties so that no one employee can both enter and approve information entered into HHS financial management systems.[83]

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3: Delivering Value, Quality, and Improved Outcomes in Medicare and Medicaid

HHS continues to reform Medicare and Medicaid to promote quality, efficiency, and value of care. Changes affect virtually every type of health care service and come with an array of operational and program integrity challenges. The changes also offer opportunities for better health outcomes, better quality of care, lower costs, improved transparency and choices for consumers, and reduced administrative burden on providers.[84]

KEY TAKEAWAYS

I. Relevant Agency: CMS
II. Elements of the Challenge:
- Aligning program incentives with health outcomes
- Strengthening program integrity
- Delivering on the promise of innovative technology to improve health outcomes

Medicare and Medicaid are the two largest and most complex programs at HHS. Both programs offer benefits in multiple formats (FFS, managed care, and newer payment models); cover a broad array of health conditions, providers, services, and settings; and operate pursuant to intricate statutory directives and regulatory schemes. To reduce disease spread and expedite the delivery of medically needed care during the COVID-19 public health emergency, CMS and OIG have implemented targeted flexibilities addressing coverage and payment for items and services, as well as application of fraud and abuse authorities to specified types of business arrangements.[85] These flexibilities introduce additional regulatory risks and compliance challenges for stakeholders implementing them and the Department overseeing their effectiveness.

An increasing number of Medicare and Medicaid beneficiaries are enrolling in managed care options, and an increasing number of providers are participating in value-based health care models. The Health Care Payment Learning & Action Network, an HHS-sponsored public-private partnership, estimated that for calendar year 2018, 90 percent of providers in Medicare FFS were paid based, at least in part, on quality and value, with 41 percent being paid under an alternate payment model or a population-based payment. The comparable figures for Medicaid were 34 percent and 23 percent, respectively.[86] Continued growth in value-based care is expected. CMS's Innovation Center continues to test and introduce new models across the health care spectrum, from hospitals to hospices, from integrated delivery systems to small primary care practices, and from urban areas to sparsely populated rural areas. Examples of models designed to accelerate development and testing of new payment and delivery service models include the Accountable Health Communities Model focused on unmet social needs; an Artificial Intelligence (AI) Health Outcomes Challenge to demonstrate how AI tools can be used to predict unplanned hospital and SNF admissions and adverse events; and the Direct Provider Contracting Models to test direct contracting between payers and physician practices. Recently announced models focus on patients needing insulin and patients with OUD, among others. Some models involve partnerships with states; some are all-payer models designed to align with private sector initiatives. Among its permanent value-based programs, CMS administers the Quality Payment Program for physician reimbursement and the Medicare Shared Savings Program for accountable care organizations (ACOs). CMS paused timelines and modified some model and program requirements because of the COVID-19 public health emergency.

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Both Medicare (FFS, Part C, and Part D) and Medicaid have proven susceptible to fraud, waste, and abuse, with FY 2019 estimates of improper payments ranging from 7.3 percent (Medicare FFS) to 14.9 percent (Medicaid) of total expenditures. Improper payments for Medicare and Medicaid totaled approximately $103.6 billion.[87, 88] Both programs have been on the U.S. Government Accountability Office's (GAO's) list of high-risk government programs for years. OIG's enforcement work shows that wrongdoers defraud Medicare and Medicaid through schemes ranging from false billings to kickbacks. OIG's oversight work demonstrates a range of vulnerabilities, including:

- Flawed program design and administration (e.g., improper payments) (see TMC 2),
- Misaligned program incentives and confusing or insufficient program guidance,
- Deficient delivery of care to beneficiaries (e.g., poor quality and unsafe care (see TMC 4) or inappropriate utilization),
- Gaps in provider enrollment systems and available data needed for proper oversight (see TMCs 2 and 5), and
- Challenges with adequate access for beneficiaries to covered services in both FFS and managed care.

To ensure effectiveness of Medicare and Medicaid in delivering value, the Department should focus on three facets of the challenge: (1) aligning program incentives with quality and health outcomes, (2) strengthening program integrity, and (3) delivering on the promise of innovative technology.

Aligning program incentives with quality and health outcomes

Developing effective incentives and policies to drive better health outcomes is difficult given the complexities of medicine, the programs themselves, and the varying needs of the populations served by these programs. HHS faces obstacles in correctly measuring the value of care. Designing measures that effectively incentivize high-quality care and improved outcomes without being overly prescriptive or burdensome to providers is challenging, and the science of quality measurement continues to evolve.

The Department is undertaking initiatives to streamline, improve, and target quality measures more precisely and to move from process measures to outcome measures. Through its *Meaningful Measures* initiative, CMS reports it rolled back 20 percent of measures because they were topped out, duplicative, or overly burdensome.[89] Pursuant to Executive Order 13877 on Health Care Price Transparency and Quality, in May 2020, HHS published a National Health Quality Roadmap, in consultation with the Secretaries of Defense and Veterans Affairs, to improve patient outcomes through enhanced effectiveness and efficiency in the health care quality system supported by Federal investments. The roadmap identifies specific strategies and planned actions to drive change through establishment of coordinated governance and oversight; modernized data collection, reporting, and sharing; and reforming how measures are used in Federal quality programs.[90]

Moving forward, HHS should ensure that its programs use effective, evidence-based measures to improve quality of care and beneficiary outcomes. CMS must clearly define actionable and meaningful quality and outcomes measures for its programs and ensure their reliability, accuracy, and utility. CMS should continue, where appropriate, to align its efforts with other OpDivs using quality measurements to reduce unnecessary provider burden and strengthen quality measurement. Accuracy and completeness of reported quality and performance information is also critical for payment purposes.

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CMS should take steps to support and develop high-performing ACOs.

OIG work examining ACOs' strategies for transitioning to value-based care identified lessons learned from the Medicare Shared Savings Program. These lessons addressed engaging beneficiaries in improving their health outcomes, managing beneficiaries with costly or complex care needs, reducing avoidable hospitalizations, controlling costs and improving quality in skilled nursing and home health care, addressing behavioral health needs and social determinants of health, and using technology to increase information sharing among providers.[91] Based on this work, OIG recommended—and CMS concurred—that CMS support and share successful ACO strategies. These strategies may be adaptable in other value-based models.

The Department has been engaged in the Regulatory Sprint to Coordinated Care led by the Deputy Secretary to reform regulations administered by CMS, OIG, SAMHSA, and the Office for Civil Rights (OCR) to promote value and quality through better coordinated care for patients and broader sharing of patient information for patient care. To date, CMS and OIG have issued proposed regulations, SAMHSA has issued final regulations, and OCR has issued a request for information.[92] Once final rules are issued, HHS should monitor results to ensure that the regulations operate as intended to promote beneficial arrangements and practices, and are not subject to abuse.

New payment structures, care delivery methods, business arrangements among providers, and incentives all give rise to risk-management challenges in Medicare and Medicaid. Notwithstanding identified successes, CMS must maintain a steady focus on quality of care and health outcomes. This is particularly true during the COVID-19 public health emergency when normal guardrails and conditions have been adjusted to address exigent public health circumstances and when providers may temporarily be unable to meet optimal care guidelines. (See TMC 4 for further discussion of quality-of-care challenges.)

Strengthening program integrity

HHS must be attentive across FFS and managed care programs to assess, identify, and mitigate program integrity risks. The nature of fraud and abuse risk differs depending on how Medicare and Medicaid pay for services. Traditional FFS risks, arising from volume-sensitive payments, include inappropriate utilization, increased program costs, and improper patient steering. In managed care, a capitated payment system leads to risks such as: stinting on care to reduce costs, discriminating against expensive patients, or manipulating or falsifying data used to measure performance, outcomes, or acuity, as well as to receive improper payments. In nontraditional health care models that marry FFS payments with value-based payments, such as shared savings or partial capitation payments, elements of both FFS and managed care risks may be present. In evaluating and managing risks for a specific model, CMS must consider the range of incentives in the model. Managed care is not immune from risks created by mixed incentives. OIG's oversight and enforcement work has revealed opportunities for "downstream" fraud and abuse in managed care by providers paid by plans on an FFS basis. (See TMC 2 for further discussion of program integrity in managed care.)

In testing and implementing value-based care models, CMS must continue to focus on program integrity risks, incorporating safeguards to reduce them and strategies to correct them. Focusing on program integrity risk is especially important for models that introduce new payment incentives, which could lead to new fraud schemes, and for models for which waivers of customary payment, coverage, or fraud and abuse laws have been issued. Additional risks may arise from novel flexibilities granted because of the COVID-19 public health emergency. HHS should mitigate risks when designing flexibilities, monitor implementation of flexibilities for any abuse, and take prompt action to correct problems and hold wrongdoers accountable.

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Value-based care models increasingly promote care in home and community settings through in-person home visits, remote monitoring, and other technologies. These services can be less costly and are often preferred by patients. OIG work in areas such as hospice care, home health, and PCS consistently demonstrates that patients and the programs may be vulnerable to fraud and abuse in home- and community-based settings. Moreover, home-based services may not meet quality of care requirements. For example, recent OIG work showed that hospices lacked oversight of their registered nurses, resulting in nurses failing to meet requirements to visit beneficiaries' homes to assess quality of care provided by hospice aides.[93]

During the COVID-19 public health emergency, HHS determined that virtual services could be safer for patients and issued broad flexibilities for providers to furnish telehealth and other virtual care in settings and under conditions not typically allowed. HHS should monitor and assess services furnished and billed under these flexibilities for compliance with requirements, payment accuracy, and quality of care to ensure the flexibilities work as intended. As it considers how and whether to incorporate such services into the regular programs before or after the public health emergency abates, HHS should be attuned to program integrity risks such as unknown or unqualified providers furnishing virtual services, providers offering and billing for services not suitable for virtual care, substandard services, unsecured technology or data transmission, and improper incentives to beneficiaries to receive virtual care or provide their Medicare billing number to those purporting to furnish virtual services.

Additional risks to program integrity across Medicare and Medicaid, including improper payments, compliance with program requirements, provider eligibility and qualifications, data integrity and availability, transparency and accuracy of information available to consumers, patient safety, substandard care, and access to care, are covered in more detail in TMCs 2, 4, and 5.

Delivering on the promise of innovative technology to improve health outcomes

Leveraging digital and health technology to foster efficient, high-quality, safe care is critical to a value-driven health care system, as is ensuring the appropriate flow of complete, accurate, timely, and secure information. For example, OIG's work examining how ACOs use health information technology (IT) showed that, although ACOs have used health IT to aid in care coordination, the full potential of health IT has not been realized.[94]

HHS faces challenges in achieving a connected health care system to support better coordinated and value-based care in which patients' data—including conventional health care data and newer types of data related to social determinants, demographics, and personal trackers—flow freely across provider settings, with appropriate privacy and security protections. As health-related apps and technologies proliferate with the delivery of care, beneficiaries will need access to new and integrated information. This information should enable beneficiaries to choose reliable apps and technologies and to assure themselves that providers they engage with via an app or technology are trustworthy. (See TMC 5.) HHS will need to ensure that rural beneficiaries and underserved populations are not left out of a technology-enriched, value-driven health system.

The Department also faces challenges in ensuring that evolving technologies are effective, enhance patient access to quality care, and support providers' ability to furnish such care. The law enforcement action known as Operation Brace Yourself illustrated how telephone-based remote physician consultations can make a familiar fraud scheme—charging Medicare for DME that patients do not need—bigger with less effort. HHS must provide appropriate oversight of rapidly evolving technologies, such as telehealth, networked medical devices, robotics, genomic testing, and remote monitoring. In many cases, new technologies and apps are being developed by individuals and entities—often engineers or scientists—unschooled in the complex regulations governing health care and unaware of the

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range of program integrity risks their inventions may face. These new participants in the health care system will need education, guidance, and appropriate oversight.

HHS faces a growing challenge in understanding and, as appropriate, overseeing providers' use of AI and machine learning in the delivery of health care, such as in diagnostics, as well as for administrative functions, such as coding and claims submission. AI and machine learning are introducing new paradigms that likely require fresh thinking about quality of care, compliance, and fraud prevention. Relatedly, HHS will need to assess how it can use AI, machine learning, and other technologies to foster program integrity, value, and quality of care in Medicare, Medicaid, and other HHS programs. (See TMC 1 for further information about FDA's role in emerging technology.)

In sum: realizing the promise of value-based care and payment structures

To achieve better care at lower cost, HHS must maintain a steady focus on developing and refining effective, innovative, evidence-driven models while being proactive in preventing and detecting fraud, waste, and abuse. HHS must pay special attention to effectiveness and program integrity in nascent areas such as the intersection of health care with social determinants of health and new uses of digital technology. This is vitally important given the current and anticipated growth in the cost and number of beneficiaries in Medicare and Medicaid. Meeting this challenge will enable the Department to expand the reach of dollars devoted to these programs, thereby abating some of the anticipated rise in cost of these programs over the next decades and improving the lives and health outcomes of the beneficiaries they serve.

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4: Protecting the Health and Safety of HHS Beneficiaries

HHS programs provide critical services to diverse populations across a broad range of settings, including hospitals, child care facilities, and beneficiaries' own homes. Some services are directly provided by HHS personnel, some delivered via HHS grant programs, and others rendered by professionals of the beneficiary's choosing, who then claim reimbursement from Federal programs. Services include health care, education, child care, and even physical custody for select populations. Ensuring that intended beneficiaries receive appropriate services that meet standards for quality, are free from abuse or neglect, and are not exposed to infectious agents represents a major challenge for the Department. As the Department supports the current race to develop treatments for and immunizations to protect against COVID-19, there will be challenges to ensure equitable distribution of risks and benefits of participation in clinical trials, as well as access to and safety and efficacy of immunizations and treatments.

KEY TAKEAWAYS

I. Relevant Agencies: ACF, CMS, IHS, HRSA, SAMHSA
II. Elements of the Challenge:
- Ensuring safety and quality of care for beneficiaries of Federal health care programs
- Protecting the health and safety of children served by HHS programs
- Preventing abuse and neglect

Ensuring safety and quality of care for beneficiaries of Federal health care programs

HHS operates the Medicare program to serve about 62 million elderly or disabled Americans. In partnership with the States, the Medicaid program serves almost 68 million beneficiaries, and the CHIP program serves 6.7 million beneficiaries. IHS provides direct services for about 2.6 million members of 574 Federally recognized Tribes. These programs cover specific health care services, which may include hospital care, physician services, prescription drugs, hospice care, home- and community-based care, DME, and skilled nursing care.

Delivering covered services

Ensuring access to care that meets quality and safety standards remains a challenge. Even when Federal health care programs cover care, many beneficiaries do not actually receive the care they need. For example, OIG found that over 500,000 children with attention deficit hyperactivity disorder (ADHD) who were Medicaid-enrolled did not receive timely follow-up care, and that over 50,000 such children did not receive behavioral therapy as recommended by professional guidelines.[95] At the other end of the life cycle, OIG found that more than 80 percent of hospice providers, a growing sector of health care serving beneficiaries and their families at an extremely vulnerable time near end-of-life, had quality-of-care deficiencies.[96] Additionally, fixed daily payment structures may incentivize hospices to enroll beneficiaries for longer time periods but scrimp on care.

Quality of care

Oversight work revealed that patients experience significant rates of adverse events (patient harm as a result of medical care) in health care facilities. Specifically, OIG found that 27 percent of Medicare beneficiaries were harmed during their stays in acute care hospitals, 29 percent in rehabilitation hospitals,

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33 percent in SNF, and 46 percent in long-term-care hospitals.[97] OIG also found that hospitals did not identify when harm occurred in their facilities, in part due to confusion over HHS and other government guidance regarding how to define and report adverse events.[98] OIG is currently conducting a study to update the harm rate for Medicare beneficiaries in hospitals. The review will assess progress made in reducing harm in the decade since the prior study was released in 2010.[99] OIG also has work underway to measure the rate of adverse events for patients at IHS Hospitals and work looking at substandard care in labor and delivery services at IHS Hospitals. (See TMC 6 for more information on cross-government efforts to keep patients safe.)

The Department continues efforts to improve the quality of covered services as well the information available to beneficiaries and their families when selecting a care provider. One example is CMS's efforts to improve nursing home care. CMS's Five-Star Quality Rating System facilitates informed comparison of nursing homes. Besides selecting appropriate nursing homes, beneficiaries and families need access to better information about other types of providers, such as hospices.[100] CMS has announced plans to revamp its Hospital Quality Star Rating System to enable better informed decision-making for beneficiaries seeking hospital care. Especially given some curtailment of visitation during the COVID-19 pandemic, accurate information about nursing home quality is critically important to inform patients' and families' choices. Given the important role friends and families usually play in identifying and reporting quality issues, as this information source may be diminished during the pandemic, OIG launched an education and outreach campaign to promote nursing homes' attention to quality and inform patients, staff, and others how to report quality of care concerns.

As the COVID-19 pandemic has taken a heavy toll on beneficiaries in nursing homes, longstanding staffing and quality of care concerns remain pressing, as well as new infection control imperatives. OIG continues its series of audits to assess nursing homes' compliance with health and safety regulations. CMS enforcement actions have stopped some poor-performing nursing homes from rendering deficient services. One nursing home chain charged with rendering grossly substandard care to Medicare and Medicaid beneficiaries agreed to repay $18 million and abide by the terms of a Corporate Integrity Agreement to ensure that it delivers appropriate care going forward.[101] Further, after a series of OIG reports about quality of care problems in IHS-operated hospitals,[102] IHS created a new Quality Framework and Office of Quality to provide better guidance and oversight to its facilities and clinical staff.[103] IHS is also working to establish a nationwide compliance program to address several OIG recommendations and improve care for beneficiaries. However, some longstanding challenges, such as recruiting and retaining qualified staff, persist. As discussed below, there is also a pressing need to protect patients, especially children, from predators within the ranks of health care and other service providers.

Although the Department has made progress, more work remains to improve access to, and quality of, all types of care. Among the top priorities, as identified by OIG work, are improving hospice care, including strengthening the survey process and better educating beneficiaries and their families and caregivers,[104] and improving the health and safety of nursing home residents by ensuring facility correction of deficiencies.[105] To continue improvements at IHS, OIG has recommended that IHS prioritize developing and implementing a staffing program to ensure there is sufficient qualified staff, including those at remote facilities; enhance training for staff and hospital leaders; intervene quickly and effectively when quality problems are identified; and establish better procedures, including improved external communication.[106]

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Protecting the health and safety of children served by HHS programs

HHS operates or funds many programs that provide child care, education, and residential care, in addition to health care for children, including some especially vulnerable children, such as children living in foster care and children in the UAC Program. The Head Start program promotes school readiness for nearly 1 million children from low-income families, and the Child Care and Development Fund (CCDF) provides child care for about 1.3 million children from low-income families. The importance of properly vetting program staff to ensure children's safety is discussed below.

Operating the UAC Program

Through the UAC Program, ORR assumes custody of children who enter the U.S. without immigration status and have no parent or guardian in the U.S. able to provide for their physical and mental well-being. The child may have arrived in the U.S. alone, or in certain circumstances, may have been separated from their parents or legal guardians at the border. The UAC Program merits specific discussion, as it uniquely tasks the Department with assuming physical and legal custody for children, and the comprehensive responsibility for their welfare thus entailed. Through the UAC Program, ORR places unaccompanied or separated children in State-licensed shelters and other facilities operated by grantees or contractors. These facilities provide food and shelter, as well as medical and mental health care and other services. Children remain in these placements until a sponsor (usually a parent or family member) is found to whom the child may be safely released, the child's immigration status is resolved, or the child turns 18 years old and ages out of the program. Since ORR began operating the UAC Program in 2002, it has served more than 400,000 children.

In recent years, ORR has been called upon to care for more children, including children who did not come to the U.S. alone but were separated from their parent or guardian at or after arrival. HHS reported to a court as part of a lawsuit that 2,737 children had been separated by the Department of Homeland Security (DHS) and remained in ORR care as of June 2018. Following OIG's January 2019 report finding that significantly more children had been separated from their parents than had previously been reported, the government identified an additional 1,556 children who had been separated. Neither ORR nor DHS had kept adequate records about separated families, impeding efforts to identify and reunite them. As of October 2020, a court-appointed steering committee reported that it was unable to locate parents of 545 children; efforts to do so are continuing. OIG also reported, and subsequent court filings confirmed, that children continued to be separated by DHS from their parents for reasons such as the parents' criminal history; however, ORR did not always receive adequate information about parents of separated children.[107] Lack of complete and accurate data about separated children complicates HHS's ability to ensure appropriate placement. These factors may cause children to spend more time in HHS custody. Issues related to identifying and vetting appropriate sponsors may also prolong children's time in HHS care facilities. OIG also found failures in conducting required staff background checks and insufficient clinical staff to serve children's mental health needs,[108] lack of oversight over facilities' use of inspection checklists to ensure security measures,[109] and shortcomings in incident reporting systems to protect children's safety.[110]

The Department must work to ensure that UAC Program-funded facilities meet all safety requirements, including new infection control priorities related to the current COVID-19 pandemic, and provide adequate

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medical and mental health care. As discussed further below, HHS must also enhance efforts to ensure that all staff with access to children have passed required background checks.

Preventing abuse and neglect

HHS funds and oversees many types of services for a broad range of beneficiaries. Countless HHS-funded providers hold positions of trust that bring them into close contact with beneficiaries, often behind closed doors and at especially vulnerable times in the beneficiaries' lives. The vast majority of providers seek to serve beneficiaries' best interests. However, some providers may cause beneficiaries harm, and HHS must protect its beneficiaries from abuse and neglect. For example, a former IHS pediatrician is currently serving a prison sentence for sexually assaulting boys he treated as patients. This disturbing case commanded extensive attention, and the Department has committed to collaborating with a Presidential Task Force on Protecting Native American Children in the IHS system established in March 2019.[111] The Task Force released a report in July 2020 detailing its investigation of institutional and systemic breakdowns that failed to protect children from abuse.[112] Better attention to protecting vulnerable beneficiaries of all ages in all HHS care settings is also needed.[113]

Vetting providers and staff

Although even the most thorough vetting cannot completely prevent all potential predators from abusing Federal programs to gain access to victims, background checks are a useful tool. OIG identified failure to conduct required background checks for UAC facility staff whose jobs entail access to children.[114] Failure to conduct adequate background checks has been a problem in other HHS child care programs as well. OIG found that some States have not fully implemented CCDF requirements to conduct comprehensive criminal background checks on current and prospective staff.[115] Additionally, some IHS-funded tribally run health centers failed to conduct required background checks on employees working with American Indian children.[116] Implementation of background checks for long-term-care providers remains a challenge as well.[117] Along with demonstrating job-specific competency and qualifications, ensuring that staff pass all required background checks is an important safety measure.

The Department should improve efforts to ensure staff pass required background checks before they have access to patients in various health care settings and to children in the UAC Program, Head Start, and CCDF funded programs. The Department is also working to support States' implementation of the CCDF background check requirements. The Department should continue to work with States to ensure that implementation of the *Child Care and Development Block Grant Act of 2014* background check requirements align with the statutorily required effective dates and the allowable timelines described in the CCDF Final Rule.

Identifying and reporting abuse and neglect

Beneficiaries in all care settings are at risk of abuse and neglect. About 1.8 million Medicare beneficiaries receive care in SNFs each year.[118] Home and community-based services allow many Medicaid beneficiaries the opportunity to avoid undesired facility care. However, some beneficiaries have been abused or neglected by individuals, including some family members that Federal health care programs paid to care for the beneficiary at home. Group homes provide care to many especially vulnerable people, including adults with developmental disabilities. OIG's work found extensive failures to properly handle critical incidents, including suspected abuse and neglect of group home residents.[119] OIG has also identified substantial failures to report incidents of potential abuse or neglect of Medicare beneficiaries living in SNFs

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who require treatment in hospital emergency departments.[120] All States have enacted mandatory reporting laws that require certain individuals, like school teachers or nursing home staff, to report suspected abuse or neglect of vulnerable individuals. However, many instances of abuse and neglect go unreported, making it harder to help victims and hold wrongdoers accountable.[121] During the ongoing COVID-19 pandemic, with many students not going to school and many patients not able to receive visitors, ensuring well-functioning processes to identify and report abuse is particularly important. Continued oversight and contact with family and friends can be particularly important to ensure quality of care in nursing homes. OIG is reviewing continuity of on-site oversight by CMS and State Survey Agencies during the pandemic. Also, CMS issued guidance to help nursing homes resume in-person visitation while minimizing the risk of COVID-19 transmission.

The Department has created several resources to better address abuse and neglect of residents of group homes. These resources include model practices for: (1) State incident management and investigation, (2) State incident management audits, (3) State mortality reviews, and (4) State quality assurance.[122] The model practices offer strategies designed to better protect group home residents and several States have adopted these model practices.

It is important to prevent ongoing harm by identifying providers and facilities subjecting beneficiaries to abuse or neglect. States and other partners should use claims data to better identify unreported abuse and neglect. OIG created a resource guide to help accomplish this goal.[123] OIG has also explored Medicaid claims data as an additional way to identity potential child abuse and neglect.[124] Additional efforts would help to improve reporting. For example, CMS should compile a list of diagnosis codes that indicate potential abuse or neglect, conduct periodic data extracts, and encourage States to better use data to facilitate compliance with mandatory reporting laws.

CMS should also work to ensure that Federal mandatory reporting laws suffice to protect beneficiaries in all care settings and are adequately enforced. Protecting beneficiaries from abuse and neglect is a critical responsibility requiring attention and cooperation from all stakeholders.

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5: Harnessing Data To Improve Health and Well-Being of Individuals

Improving how the Federal government manages, shares, and secures its data is a priority for both Congress and the Administration.[125] The COVID-19 pandemic has underscored the need for significant and sustained efforts to modernize data practices across the Department. The response to COVID-19 is directly dependent on data that HHS collects or generates. Ensuring that government officials, researchers, the public, and other stakeholders can access timely, accurate data is critical. Data that HHS generates or collects are used to support nearly all COVID-19 response efforts, including tracking spread within nursing facilities, allocating health care resources across the country, and distributing health care Provider Relief Funds.

KEY TAKEAWAYS

I. Relevant Agency: All HHS
II. Elements of the Challenge:
- Expanding HHS's capacity to use and share data to support evidence-based policymaking, program management and program improvement
- Providing data to HHS partners and promoting the public data access and sharing
- Protecting data from misuse or unlawful disclosure

HHS's capabilities to operationalize and change how it internally uses and shares data for the COVID-19 response was in part aligned with the focus HHS has placed on "Leveraging the Power of Data" as one of its six strategic shifts for its *ReImagine HHS* effort.[126] Under this initiative and other associated Federal government action actions, HHS recognized the need to transform "the way HHS internally shares, analyzes, and derives new insights by leveraging data across HHS agencies...."[127] The pandemic accelerated that need, and the Department built new systems to improve and centralize some data functions in support of the COVID-19 response, including "HHS Protect."[128] The implementation of "HHS Protect" faces significant challenges including standardized and consistent reporting to HHS Protect by hospitals,[129] potential data accuracy, and the public use of data,[130] all of which highlight many longstanding issues associated with collecting, managing, and sharing data across HHS OpDivs. Continued modernization of HHS data practices is needed for HHS and its OpDivs to fulfill their missions, especially in support of the COVID-19 response.

HHS's authorities shape how an individual's data are used and protected by other private and public entities. These authorities are increasingly important in a technology-enriched health and human service delivery system. HHS made progress on this front, but COVID-19 has presented a new challenge by amplifying demand for easier access to data. As many health care providers, State and local governments, and others switched to remote and virtual interactions to slow the spread of COVID-19, the need to continue to improve data interoperability and security was evident. Data access needs to follow where people are, not where data happens to be. HHS will need to sustain efforts to ensure early progress turns into lasting structural improvement across the health and human service systems.

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Expanding HHS's capacity to use and share data to support evidence-based policy making, management, and program improvement

Data play a central role in every HHS program or policy mission.[131] The COVID-19 pandemic has highlighted how data are essential in the success of HHS programs and stakeholder engagement. HHS operations depend on the effective collection and use of a large amount of sensitive and important data about individuals, health care providers, key public health assets, and other entities and actors. These data are vital to improving the health and welfare of individuals in the Nation. The Department and its programs are increasingly able to collect, store, and analyze data from disparate sources and able to provide new pathways within HHS to improve access to data.

However, having large amounts of data does not mean that the data can be used efficiently and effectively. HHS faces challenges in how it manages and leverages that data across its programs. Although most OpDivs primarily collect data to administer their own programs, the use of data across programs and OpDivs remains a challenge. Data are often housed within a single OpDiv ("data silo") and not easily shared with other parts of HHS, even though OpDiv missions often overlap.[132] These restrictions potentially impair the Federal government's response to COVID-19 by limiting how HHS and its partners gain insight about COVID-19.[133] As part of the pandemic response, HHS, other Federal agencies, State, local, and Tribal officials must work together on a nearly constant basis. Through OGA, the Department also engages with international stakeholders during a public health emergency. These collaborations require timely access to data that can flow across data silos within HHS, to different levels of government, and key stakeholders. HHS has stated that it built HHS Protect to centralize and report out data on COVID-19 quickly and improve the sharing, parsing, housing, and accessing of relevant COVID-19 data.[134] The Department continues to work on HHS Protect to address implementation difficulties that led to confusion among hospitals and public health officials.[135] Although HHS Protect was established in exigent circumstances during a pandemic under short timelines, the challenges it faces are likely indicative of future challenges that HHS may encounter as it continues to modernize its data practices.

Data silos may also impede deployment of emerging technologies, such as machine learning, that have enormous potential to improve the efficiency and effectiveness of the Department. These technologies are often dependent on large, standardized data sets and will require collaboration across the Department. Eliminating or reducing data silos within the Department and increasing appropriate access across programs will be an essential step to improving program management and evidence-based decision-making, as well as seeding the ground for HHS to benefit from emerging technologies.

Improving data governance to enhance program management

One critical step to improving HHS's capacity to utilize its data is the adoption of a better data governance approach. Effective data governance can improve communication and transparency by making data more available and useable. However, data governance practices are not consistent across HHS. The need to improve data governance is not unique to the Department and is a priority and a requirement for Federal agencies.[136] It is also part of HHS Strategic Plan and the Digital Strategy at HHS.[137] The Department is taking steps to improve its data governance and more effectively use its data. In 2019, the Office of Chief Technology Officer (CTO) released a report detailing a vision of how to improve internal sharing and data analysis.[138] Additionally, under the Reimagine Data Insights Initiative, HHS launched a proof of concept data-sharing platform called "Unifi." The platform is designed to address a number of internal data-sharing issues, including automating workflow for data access requests, making open source data analytic toolkits

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available, and providing dashboards and other reports to allow for more transparency about HHS data. Although progress has been promising, the Department's challenge will be to operationalize its plans notwithstanding: the continued effect of data silos, restrictions related to the privacy and use of certain data, and legacy technology and data systems that do not easily support data sharing. HHS must ensure any progress it makes on improving governance of its internally generated data must also apply to data that are generated by external entities but received and managed by the Department. This challenge will play a significant role as CDC moves forward with the Public Health Data Modernization Initiative to update antiquated systems and support improvement of State and local health departments' data capacities.[139] As HHS, CMS, CDC, and other OpDivs moved quickly to implement additional COVID-19 reporting requirements for health care providers and other entities, some of these efforts encountered challenges that are consistent with data collection and reporting issues in other HHS programs.

For example, OIG has raised concerns about the completeness and quality of data submissions by States for the national Medicaid data set named the Transformed Medicaid Statistical Information System (T-MSIS).[140] CMS's recent progress related to T-MSIS may be helpful in providing lessons learned. Nearly all State Medicaid programs now report data directly to T-MSIS, and CMS has worked with States to improve the quality of data submissions and to release T-MSIS data to researchers. However, concerns still exist about the completeness and reliability of the T-MSIS data. CMS has issued guidance to States to improve T-MSIS reporting of certain variables, but additional guidance and testing is needed.[141] Similar data quality and governance challenges will be important to proactively address as HHS modernizes how it collects and uses external data from grantees or other organizations.[142]

Building advanced capacity to use data to improve programs

Improving how HHS, its programs, and its employees use data is a critical component of the 2018 HHS's Data Strategy and the 2019 CTO report on internal data sharing. Better use of data may improve evidence-based policy making, improve internal administrative functions, and support the deployment of emerging technologies, all of which are part of the larger Federal and Departmental strategies to promote efficient and appropriate data use.[143]

HHS's ability to use new technologies that can make the Department more effective and efficient is dependent on how well data can be gathered and curated from multiple OpDivs. For example, the CDC Data Modernization Initiative includes plans to deploy next-generation tools to improve public health surveillance.[144] Technologies such as machine learning and AI must function on top of large data sets. To effectively deploy those tools, HHS will have to rely on data from across its programs, which will require complex technical coordination among diverse types of data, some of which have technical limitations.[145] The Department is making progress by exploring solutions through Unifi, pilots, initiatives, limited scope projects, and internal training focused on improving data science skills within HHS.[146]

The challenge for HHS will be to go from strategic pilot tests and training to fully incorporating advanced data capabilities into the Department's operations. There are significant barriers—legal, cultural, and resource limitations—that strategic pilots and training alone will not resolve. To overcome these barriers and fully harness data to improve the health and welfare of the Nation, the Department will need to continue multiyear efforts and implement sustained change management across its OpDivs.

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Increasing data access and sharing with HHS partners and the public

There is an increasing recognition that Federal agency stakeholders[147] and the public can also use Federal data assets for the public good.[148] That value continues to be demonstrated throughout the response to COVID-19 as data collected or generated by HHS provides necessary information to the public. Much of HHS's data are publicly available but may not be easy to use or may have other barriers, such as a lack of standardization, that limit stakeholders' and the public's access or use.[149] Those barriers present a challenge to providing increased access to HHS data that are vital for public health and welfare and that could lead to innovation and improvement in health and human service systems. HHS also has significant authority, incentives, and influence to change the way data are shared in the health care system, public health, emergency preparedness and response, medical research, and other sectors that are vital to the Nation. Despite that significant influence, many of these sectors do not easily or regularly share data, to the detriment of patients, individuals, and the public.

Expanding and improving access to HHS data

Many HHS external stakeholders rely on effective dissemination of data collected by Departmental programs. Most importantly for the COVID-19 response, many State and local public health departments utilize HHS data to track the spread of COVID-19. However, the complex public health surveillance system and the underlying data infrastructure overseen by HHS faces challenges in providing COVID-19 data to the public and other external stakeholders. For example, in July 2020, HHS changed COVID-19 reporting processes for hospitals from the CDC National Healthcare Safety Network to HHS Protect to streamline data for the COVID-19 response.[150] The change caused confusion on how the public and other stakeholders could obtain hospital COVID-19 data previously made public by CDC and there were delays in HHS Protect making updated data publicly available. HHS also had successes. CMS, through the Data.CMS.gov platform, made COVID-19 nursing home data available after it updated reporting requirements.[151] Both examples demonstrate potential challenges and the value of HHS using modern approaches to make data publicly available.

Currently, most public access to HHS data does use contemporary approaches, such as the use of application programming interfaces (APIs). Although data might be available, they may not be well understood or in easily accessed formats. OpDivs are planning and have made some progress to expand access to these important assets. In May 2020, NIH made beta access available to its *All of Us* Researcher Workbench.[152] NIH utilized a modern, iterative approach providing researchers access to the *All of Us* data earlier in the data collection process to facilitate continued development of the research platform based on feedback from researchers. In September 2019, FDA released a Technology Modernization Action Plan.[153] Among other goals, FDA aims to improve how it uses data to carry out its mission and improve communication and collaboration with other government and external stakeholders. These approaches and plans must be replicated across HHS to remove barriers to other HHS program data and allow HHS partners to more effectively use that data.

Making data sharing between health care providers, patients, and payers commonplace

Several OpDivs have authority or influence to shape how data are shared within the industries they regulate, among HHS partners, and with individuals and patients. Most notable is HHS's potential to improve the availability and interoperability of electronic health information. Yet, the health care system

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and patients have not fully realized and benefited from modern approaches to improve the appropriate flow of electronic health information. Promoting interoperability is part of the four Secretarial priorities and HHS will need to continue utilizing its significant leverage to expedite progress.[154]

Routine and robust health information exchange between providers remains a challenge, although there are signs of recent progress. In 2018, 46 percent of acute care hospitals electronically performed all four interoperability functions: find patient health information, send, receive, and integrate patient summary of care records from sources outside their health system.[155] This is up from 23 percent of hospitals in 2014. Among the interoperability functions, the largest increase was in hospitals that can integrate data rising from 40 percent to 62 percent over the same timeframe.[156] Interoperability of electronic health records (EHR) also plays a crucial role in providing data for the response to COVID-19. Many agencies in HHS, including CDC, FDA, the Office of National Coordinator for Health Information Technology (ONC); external standards organizations; and individual developers moved quickly to develop and issue interoperability standards related to COVID-19 data.[157] The level of effort and engagement needed to issue these COVID-19 standards highlights that the factors limiting increased interoperability and exchange more broadly are numerous and complicated. Several Departmental initiatives depend on improving the interoperability of electronic health information, including the transition to value-based care and payment (See TMC 3). Making real progress so that the health care system and patients can benefit from the improved flow of data will take sustained engagement within HHS, with HHS partners, and with external stakeholders such as organizations that set data standards.

Recently, HHS has taken significant steps using regulatory authorities and its influence to improve and potentially standardize the way in which health information can be accessed, used, and exchanged. In 2020, ONC finalized rules directly related to improving interoperability and helping cement data standards and data exchange mechanisms.[158] In a coordinated effort, CMS finalized rules to improve the interoperability of health information at many entities it regulates through the use of standard, open APIs.[159] Additionally, the CMS pilot to provide Medicare claims data to providers via API in the *Data at the Point of Care* pilot involved provider organizations that included over 100,000 providers.[160] ONC also moved to the next stage of implementing the Trusted Exchange Framework and Common Agreement (TEFCA) by selecting a recognized coordinating entity to develop, update, implement, and maintain TEFCA.[161] While TEFCA holds promise for improving how health information is exchanged, many hurdles remain. Overcoming themwill require close coordination between government, the recognized coordinating entity, and industry. The challenge for HHS will be translating these new authorities into more widespread improvements across the health care industry. This will require further engagement to ensure progress is not limited to those health care entities with resources to implement modern technologies and data practices.

Protecting data from misuse or unlawful disclosure

Managing, using, and sharing data must be complemented by appropriately securing data. External threats to the confidentiality, integrity, and availability of HHS-held data are persistent and growing. Similar to data governance and sharing challenges, several aspects of cybersecurity within the Department are siloed within its OpDivs and programs. As a result, deployment of effective cybersecurity can be highly variable across the Department's OpDivs. Further increasing the challenge is the vital nature of many of the Department's programs, operations, and data. Interruption of these programs caused by a cyberattack may have significant negative effects on the health and welfare of the Nation. This is especially true given HHS's central role in the COVID-19 response. Cyber threats to

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HHS increased due to adversaries attempting to take advantage of the public health emergency to infiltrate HHS systems or impede their performance, which included a large distributed denial-of-service attack that persisted for weeks.[162] Outside of the Department's systems, many of HHS's partners and grantees, and the health care system at large, are subject to an increasing amount of cyber threats. For example, in October 2020, HHS, CISA, and the Federal Bureau of Investigation (FBI) issued a cybersecurity advisory warning of the potential for increased and imminent cybercrime threat in the form of ransomware to hospitals and other health care providers.[163] Public confidence in HHS's ability to protect crucial public health data or sensitive, personal health data is important for the success of Federal initiatives that seek to leverage technology to create medical treatments of the future.

Improving HHS's cybersecurity posture

The Department has made progress in improving its overall cybersecurity posture, but certain weaknesses persist and pose challenges. Recent OIG work found that HHS continues to implement changes to strengthen the maturity of its enterprise-wide cybersecurity program but the program still has some weaknesses and deficiencies.[164] Other OIG work that examined eight Departmental OpDivs identified vulnerabilities in configuration management, access control, data input control, and software patching.[165] This work highlights the challenge the Department faces to simultaneously improve the security across OpDivs while also helping provide resources and support so that OpDivs can take action to improve their own cybersecurity. (See TMC 1 for more information about FDA's role regarding cybersecurity of medical devices.)

HHS also faces data security challenges outside of cyberthreats. For example, HHS has recognized the threat of foreign government action aimed at unduly influencing and capitalizing on medical research programs funded and overseen by the Department. HHS's challenge in responding to these threats is the need to protect these programs while also supporting an open, collaborative research approach that is critical to scientific advances.[166] The Department has made progress recognizing threats, working with law enforcement as appropriate, studying the potential impact on its programs, and working with grantees to mitigate risks.[167]

Promoting the security and privacy of the health care system

HHS's responsibilities for ensuring cybersecurity also extend to the health care system. The strength of the health care system's cybersecurity defenses continues to be tested as cyberthreats continue to increase during the COVID-19 pandemic. Additionally, many health care providers rapidly shifted care to telehealth and other remote technology. If telehealth and remote care utilization remain at levels seen during the pandemic, health care cybersecurity may also depend on where and how patients access care. This may pose a significant challenge because health care entities remain prime targets for cyberattacks, and health care data are reported to be among the most valuable data for cybercriminals. In addition to data and identity theft, cyberthreats can also pose safety risks by causing system outages needed for patient care or exploiting vulnerabilities in the growing number of connected medical devices and other medical equipment involved in direct patient care.

The Department made some progress to bolster cybersecurity in the health care industry. Since 2019, the HHS Health Sector Cybersecurity Coordination Center (HC3) has issued a number of products aimed at educating the health care industry on specific threats, mitigation efforts, and other educational materials. The products describe trends and new cybersecurity threats designed to take advantage of the COVID-19 pandemic.[168] FDA has continued to issue safety communications on medical device cyber vulnerabilities working in partnership with the Cybersecurity

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Infrastructure Security Agency of DHS (CISA).[169] The Department also proposed rules to protect donations of cybersecurity technology within the health care industry to promote increased adoption of cybersecurity.[170] These developments demonstrate HHS's commitment to working across the health care sector to better prepare for and remediate continuously evolving cyber threats.

The Department also plays a significant role in ensuring the privacy of sensitive individual data, such as personal health information, genetic information, and more. Most OpDivs are stewards of sensitive personal information and are required to protect such information from improper disclosure, including by external entities. Given the size, complexity, and constant use of this data, OpDivs face challenges in ensuring that third parties access this information for legitimate purposes. Most recently, OIG found that pharmacies were accessing a CMS Medicare beneficiary eligibility system for inappropriate purposes, including to evaluate marketing leads or by allowing marketing companies to use the pharmacies' information to access to the CMS system. This put the privacy of beneficiaries' personal health information at risk. As HHS and OpDivs continue to collect more data, ensuring that external entities access and use this information for authorized purposes will be vital to protect the privacy and security of millions of individuals.

Most notably, OCR established and enforces the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) Privacy Rule's requirements. However, the bulk of the Privacy Rule's requirements were established nearly 20 years ago and may not adequately address modern issues related to privacy concerns associated with the use and disclosure of protected health information. Some of the limitations associated with HIPAA were highlighted as the health care industry responded to COVID-19. In response, OCR took several actions, including exercising its enforcement discretion to support greater flexibilities for the types of technology used for telehealth and issuing guidance about sharing patient health information on COVID-19 to emergency first responders.[171] OCR's response to COVID-19 foreshadows the need for potential future actions to address privacy issues as the health care industry continues to modernize. As health care providers and patients shift to using more telehealth, remote-based care, and emerging technologies, new challenges related to the privacy and security of patient health information will arise. The Department's challenge is to keep up with changes in the health care industry and with nontraditional health care entities that may impact patient privacy. The Department has made progress by issuing guidance and frequently asked questions related to mobile apps, use of APIs, and working with the Federal Trade Commission to build a web-based tool for developers of health-related mobile apps.[172]

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6: Improving Collaboration To Better Serve Our Nation

HHS faces some of the largest and most complex issues that challenge our government and the Nation. These problems commonly transcend a single HHS program. Often, HHS's mission is only one piece in a larger puzzle of overlapping and coordinating responsibilities. For HHS to achieve its mission, it needs to collaborate effectively, including across HHS programs and other Federal agencies, as well as outside the Federal government, including with Tribal, State and local governments, international entities, industry, and other stakeholders.

KEY TAKEAWAYS

I. Relevant Agency: All HHS
II. Elements of the Challenge:
- Combating COVID-19
- Turning the tide on the opioid crisis
- Protecting children
- Keeping patients safe

Improving HHS's collaboration can help Americans receive more efficient, higher-quality health and human services and benefit from greater advances in the sciences underlying them. Cross-agency efforts led by the Department, such as the Rural Health Task Force and the Secretary's Intradepartmental Council on Native American Affairs, along with those related to Department management and data, provide opportunities for HHS programs to work more efficiently and in greater alignment. Effective partnerships with other Federal agencies help ensure critical initiatives and resources are working in concert, such as those for emergency preparedness and response and law enforcement investigations. Established networks of information exchange with other governments, such as through the Secretary's Tribal Advisory Committee, can better allow HHS programs to reflect community needs. Collaboration with HHS's vast array of non-governmental stakeholders—from health care providers, to food and drug manufacturers, health systems, nursing homes, hospices, professional associations, scientists, and community nonprofits, just to name a few—is essential to delivering the best services and care to the American people, and supporting HHS programs in achieving their intended outcomes.

Effective collaboration is vital to success at HHS. This need for effective collaboration crosses many of the programs and challenges discussed in the other TMCs, highlighting the broad and complex nature of HHS's work. For example, the importance of data access and sharing across stakeholders is discussed in TMC 5. To run effective and efficient programs, HHS must consider issues and impacts outside of a single program or mission of any one of its agencies.

Barriers to HHS collaboration include navigating a breadth of stakeholders with different goals and authorities, the scope and complexity of the problems that HHS needs partnerships to solve, and the ever-changing landscape of the health and human services sectors. Overcoming these barriers requires the Department to engage in intentional and sustained efforts toward building effective partnerships both domestically and internationally, communicating effectively, managing collaborative work, and maintaining accountability. Recent OIG work reveals the importance of effective and collaborative management within HHS and with HHS's partners, and areas for improvement.

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Combating COVID-19

The COVID-19 pandemic underscores the critical importance of effective coordination in emergency preparedness and response. The unprecedented nature of the pandemic quickly increased the need for collaboration among stakeholders, including related to temporary emergency expansions, Federal funds distribution, managing health care programs, nursing home safety, vaccine development, testing, personal protective equipment (PPE) and respirator availability from the national stockpile, and public health guidance.

An OIG survey of hospitals responding to COVID-19, conducted in late March 2020, found that changing and sometimes inconsistent guidance from Federal, State, and local authorities on issues such as testing, use of PPE, and obtaining supplies from the national stockpile, posed challenges and confused hospitals and the public.[173] Reports from OIG related to coordination in past emergencies have found that by consolidating outgoing communication and requests for data or information, Federal agencies can reduce burden on States and other stakeholders and that clearly defined roles can ensure that staff are not working at cross-purposes.

The Department has taken steps to address challenges to emergency coordination efforts. Related to cross-agency coordination, ASPR, CDC, and CMS implemented a joint OIG recommendation in May 2020 to continue to help hospitals sustain preparedness for emerging infectious diseases (EID) by coordinating guidance and providing practical advice for all hospitals.[174] These agencies have taken actions to update EID preparedness guidance to ensure that it is clear and concise, develop strategies for updating information about EID threats, and provide practical advice that hospitals can easily employ. These efforts have continued during the COVID-19 response.

Turning the Tide on the Opioid Crisis

The COVID-19 pandemic has further challenged HHS in achieving its goal of reducing opioid morbidity and mortality. The pandemic may be exacerbating the nation's opioid epidemic and individuals with an opioid use disorder may be at greater risk for COVID-19 (see TMC 1).[175] A number of OpDivs within HHS and other Federal agencies play a role in addressing opioid abuse and misuse, and coordination among them and other partners is vital to turn the tide on this crisis. State sharing of prescription drug monitoring program data, for example, may help to improve safe prescribing practices and prevent prescription drug abuse and misuse.[176]

Part of the framework of HHS's strategy to combat opioid abuse, misuse, and overdose is supporting stakeholder efforts to make MAT available to all individuals with OUD who meet the eligibility criteria. To do so, HHS has a goal to increase the number of MAT providers.[177] Aligned with this goal, OIG recommended that SAMHSA work with its State partners and grantees to determine the best strategies to expand access to buprenorphine services, particularly targeted to high-need counties with low-to-no patient capacity, and to partner with HRSA in ongoing efforts to address health professional shortage areas.[178] Better collaboration is a key step in helping to reduce geographic disparities in access to MAT. Improved stakeholder communication may also help make MAT more available. In another recent report, OIG recommended that CMS educate Medicare Part D beneficiaries and providers about access to drugs for MAT and naloxone and partner with SAMHSA when developing these educational strategies.[179]

Protecting Children

In 2017 and 2018, the Department of Justice (DOJ) and DHS took steps to increase enforcement of immigration laws, culminating in the spring 2018 implementation of a "zero-tolerance" policy for certain immigration offenses. Under that policy, large numbers of families entering the United States without authorization were separated by DHS.

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Typically, adults were held in Federal detention while their children were transferred to the care ORR within HHS. A June 20, 2018, Executive Order curtailed the policy but did not address reunification of families already separated. On June 26, 2018, a Federal district court issued a preliminary injunction prohibiting family separations (subject to some exceptions) and ordered the Federal government to quickly reunify separated families who met certain criteria.

In a review of challenges that HHS faced in responding to the zero-tolerance policy and with reunifying separated children with their parents,[180] OIG identified shortfalls in internal HHS communication, collaboration across Federal agencies, and outreach to critical stakeholders. These challenges impeded HHS in protecting children in its custody. In the Department, key senior HHS officials did not act on OpDiv staff's repeated warnings that family separations were occurring and might increase, which impeded the Department's ability to provide prompt and appropriate care for separated children when the zero-tolerance policy was implemented. For example, HHS could not always place separated children in HHS-funded care provider facilities in a timely manner due to the lack of sufficient bed capacity.

Problems with inter-agency coordination also limited the Department's ability to plan for the care of children in its custody. For instance, Federal agencies involved in immigration did not effectively share information in advance of the zero-tolerance policy, despite existing channels to facilitate high-level interagency coordination and engagement on important immigration issues. Furthermore, HHS and DHS did not collaborate on systems to track separated families across agencies for later reunification, leaving HHS to struggle to identify separated children and reunite them with their parents. Additionally, poorly communicated guidance from HHS complicated care provider facilities' ability to care for children separated from their parents.

An audit of facilities serving children who arrive in the United States unaccompanied, as well as children who are separated from their parents or legal guardians by immigration authorities, found shortfalls in operations that could put children at risk, including related to required FBI fingerprint and out-of-State Child Protective Services background checks for employees.[181] OIG recommendations emphasized the importance of the Administration for Children and Families' (ACF's) monitoring of, and communication with, these facilities to help ensure children's safety.

HHS oversees numerous other programs that provide direct services to children. Program funding may pass from the Federal government, to States, and then to local implementing entities that are providing such services as foster care and child care. OIG audits of State compliance with employee background check and other health and safety requirements in HHS programs found lapses that can put children at risk,[182, 183] supporting the need for better coordination between HHS and States to keep children safe (see TMC 4 for more information on keeping children safe).

Keeping patients safe

Health care and mental health care providers, OUD treatment, and hospice and nursing home services are among those on the front-line of ensuring safety for beneficiaries receiving care through HHS programs and at HHS facilities. Reports from OIG have identified issues with HHS coordination with, and outreach to, external partners that may leave patients at risk of harm, including a series of reports finding deficiencies in State Agency oversight of nursing homes' compliance with life safety and emergency preparedness requirements.[184]

Recent cases of patient abuse by IHS employees have raised concerns about protecting the AI/AN population. The convictions of a former IHS pediatrician in September 2018 and 2019 brought attention to the issue and shed light

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on areas requiring improvement within IHS.[185, 186] An OIG report examining IHS's patient protection policies emphasized, among other recommendations, the need for the agency to reach out to Tribal communities to inform them of patient rights, solicit community concerns, and address barriers that may deter patients and their families from reporting abuse.[187] A memorandum to IHS on past and ongoing OIG audits reported that Tribal health programs that received Indian Self-Determination and Education Assistance Act funds from the IHS were not conducting required FBI fingerprint background checks for all employees, contractors, and volunteers who have regular contact with Indian children.[188] This creates an increased risk that an individual with a disqualifying criminal history in a different State could be hired into a position with regular contact with Indian children.

In response to OIG's memorandum, IHS issued a letter to Tribal leaders identifying the need for immediate action and steps toward a collaborative response to address this vulnerability that may compromise the safety and well-being of Indian children who receive treatment at IHS-funded Tribal health programs.[189]

Patient Safety Organizations (PSOs) are designed to reduce the risk associated with patient care by establishing an environment where clinicians and health care organizations can voluntarily report and analyze data. The Agency for Healthcare Research and Quality's (AHRQ's) voluntary PSO program is the first and only nationwide program that offers legal protections for providers to disclose and learn from patient safety events. Many hospitals that participate in the PSO program find that it has improved patient safety. However, challenges to progress remain, including with AHRQ communication with stakeholders, such as provider associations, professional societies, and risk management organizations.[190]

By building and sustaining effective partnerships, HHS can better safeguard and improve the programs so crucial to the health and well-being of the Nation.

ENDNOTES

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Department's Response to the Office of Inspector General

THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

To: Christi A. Grimm, Principal Deputy Inspector General

From: Eric D. Hargan, Deputy Secretary

Subject: FY 2020 Top Management and Performance Challenges Facing HHS

The Office of Inspector General (OIG) identified six top management and performance challenges facing the Department as it strives to fulfill its mission. These top six challenges reflect overarching issues that affect multiple HHS programs and responsibilities. We appreciate the OIG's dedication to helping us improve operations through its audit and investigative work throughout the years.

The OIG highlighted the unparalleled challenges the Department faces because of the emergence of COVID-19. As the lead federal agency, HHS has numerous significant responsibilities to assist communities to prepare and respond to the pandemic. We are committed to building on our progress and recognize that there is more to be done that will require our organization's sustained attention, action, and improvement. Our management is committed to resolving these challenges to help us achieve our mission of improving the health and well-being of the American people.

The suggestions you offer to address our challenges will help us inform and improve decisions related to budgeting, strategic planning and other critical mission functions. We look forward to cooperating with you and our stakeholders on the continuous improvement of our activities.

/Eric D. Hargan/

Eric D. Hargan
Deputy Secretary
November 13, 2020

SECTION 4

APPENDICES

IN THIS SECTION

- Acronyms
- Connect with HHS

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Appendix A: Acronyms

AAP	Accelerated and Advance Payment
ACF	Administration for Children and Families
ACO	Accountable Care Organization
ACL	Administration for Community Living
ADA	*Antideficiency Act*
ADHD	Attention Deficit Hyperactivity Disorder
AFCARS	Adoption and Foster Care Analysis and Reporting System
AFR	Agency Financial Report
AGA	Association of Government Accountants
AHRQ	Agency for Healthcare Research and Quality
AI	Artificial Intelligence
AI/AN	America Indian and Alaska Native
API	Application Programming Interface
APG	Agency Priority Goal
APM	Alternative Payment Model
APTC	Advance Premium Tax Credit
ASA	Office of the Assistant Secretary for Administration
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
BARDA	Biomedical Advanced Research and Development Authority
BHW	Bureau of Health Workforce
BPHC	Bureau of Primary Health Care
CAP	Cross-Agency Priority
CARE	Capital Assistance for Hurricane Response and Recovery Efforts
CARES Act	*Coronavirus Aid, Relief, and Economic Security Act*
CBR	Comparative Billing Reports
CCDBG	*Child Care and Development Block Grant Act of 2014*
CCDF	Child Care and Development Fund
CCIIO	Center for Consumer Information and Insurance Oversight
CCWIS	Comprehensive Child Welfare Information System
CDAT	Central Data Abstraction Tool
CDC	Centers for Disease Control and Prevention
CEAR	Certificate of Excellence in Accountability Reporting
CERT	Comprehensive Error Rate Testing
CFO	Chief Financial Officer
CFO Act	*Chief Financial Officers Act of 1990*
CFRS	Consolidated Financial Reporting System
CHIP	Children's Health Insurance Program
CIB	CMCS Informational Bulletin
CIO	Chief Information Officer
CMA	Computer Matching Agreement
CMCS	Center for Medicaid and CHIP Services
CMIP	Comprehensive Medicaid Integrity Plan
CMS	Centers for Medicare & Medicaid Services
COLA	Cost of Living Adjustment
CPI	Consumer Price Index
CPIM	Consumer Price Index-Medical
CRC	Commercial Repayment Center
CSRS	Civil Service Retirement System
CTO	Office of Chief Technology Officer
CY	Current Year
DHS	Department of Homeland Security
DAB	Departmental Appeals Board
DATA Act	*Digital Accountability and Transparency Act of 2014*
DCI	Data Collection Instructions
DFI	Division of Financial Integrity
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMF	Death Master File
DNP	Do Not Pay
DOI	Department of the Interior
DOJ	Department of Justice
DOL	Department of Labor
DRA	*Deficit Reduction Act of 2005*
E-Invoicing	Electronic Invoicing
EHE	Ending the HIV Epidemic
EHR	Electronic Health Record
EID	Emerging Infectious Diseases
ERM	Enterprise Risk Management
ESRD	End-stage Renal Disease
FASAB	Federal Accounting Standards Advisory Board
FBI	Federal Bureau of Investigation
FBIS	Financial Business Intelligence System
FBwT	Fund Balance with Treasury
FCBC	Fingerprint-based Criminal Background Checks

FDA	Food and Drug Administration
FECA	*Federal Employees' Compensation Act*
FERS	Federal Employees Retirement System
FFATA	*Federal Funding Accountability and Transparency Act of 2006*
FFMIA	*Federal Financial Management Improvement Act of 1996*
FFPSA	*Family First Prevention Services Act*
FFRDC	Federally Funded Research and Development Centers
FFS	Fee-For-Service
FGB	Financial Management Governance Board
FICA	*Federal Insurance Contributions Act*
FISCAM	Federal Information System Controls Audit Manual
FIFO	First-In/First-Out
FITARA	*Federal Information Technology Acquisition Reform Act*
FMFIA	*Federal Managers' Financial Integrity Act of 1982*
FPS	Fraud Prevention System
FR	Financial Report of the United States Government
FSC	Financial Systems Consortium
FSIP	Financial Systems Improvement Program
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	U.S. Government Accountability Office
GDP	Gross Domestic Product
GHP	Group Health Plan
GONE Act	*Grants Oversight and New Efficiency Act*
GPRAMA	*Government Performance and Results Act Modernization Act of 2010*
GSA	General Services Administration
GTAS	Governmentwide Treasury Account Symbol Adjusted Trial Balance System
HC3	Health Sector Cyber Security Coordination Center
HEAL	Helping to End Addiction Long-Term
HEW	Department of Health, Education, and Welfare
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency
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*
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HRSA	Health Resources and Services Administration
I-MEDIC	Investigations Medicare Drug Integrity Contractor
IBNR	Incurred But Not Reported
IEA	Office of Intergovernmental and External Affairs
IHS	Indian Health Service
IOS	Immediate Office of the Secretary
IP	Improper Payment
IPPS	Inpatient Prospective Payment System
IPT	Integrated Project Team
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IT	Information Technology
LPR	Lawful Permanent Resident
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACRA	*Medicare Access and CHIP Reauthorization Act of 2015*
MAO	Medicare Advantage Organization
MARx	Medicare Advantage Prescription Drug
MAT	Medication Assisted Treatment
MCC	Major Case Coordination
MCO	Medicaid Managed Care Organization
MEDIC	Medicare Drug Integrity Contractor
MEQC	Medicaid Eligibility Quality Control
MFCU	Medicaid Fraud Controls Units
MII	Medicaid Integrity Institute
MIPS	Merit-based Incentive Payment System
MMA	*Medicare Modernization Act of 2003*
MLN	Medicare Learning Network
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edit
NBI	National Benefit Integrity
NBS	NIH Business System
NCCI	National Correct Coding Initiative
NCHS	National Center for Health Statistics
NGHP	Non-Group Health Plan
NIH	National Institutes of Health
NML	Non-Monetary Loss
NPI	National Provider Identifier
OASDI	Old-Age, Survivors, and Disability Insurance
OASH	Office of the Assistant Secretary for Health
OCR	Office for Civil Rights
OFAM	Office of Federal Assistance Management
OGA	Office of Global Affairs
OGC	Office of the General Counsel
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals

Acronyms

ONC	Office of the National Coordinator for Health Information Technology
ONS	Office of National Security
OpDiv	Operating Division
OPM	Office of Personnel Management
ORR	Office of Refugee Resettlement
OS	Office of the Secretary
PARIS	Public Assistance Reporting Information System
Part A	Hospital Insurance
Part B	Medical Insurance
Part C	Medicare Advantage
Part D	Medicare Prescription Drug Benefit
PCS	Personal Care Services
PDE	Prescription Drug Event
PECOS	Provider Enrollment, Chain and Ownership System
PERM	Payment Error Rate Measurement
PHE	Public Health Emergency
PHS	Public Health Service
PIIA	*Payment Integrity Information Act of 2019*
PIP	Performance Improvement Plan
PMA	President's Management Agenda
PP	Proper Payment
PPACA	*Patient Protection and Affordable Care Act*
PPE	Personal Protective Equipment
PPI	Plan Program Integrity
PRAC	Pandemic Response Accountability Committee
PrEP	Pre-Exposure Prophylaxis
PSC	Program Support Center
PSO	Patient Safety Organizations
PTF	Payments to the Trust Funds
PUR	Period Under Review
QHP	Qualified Health Plan
RAC	Recovery Auditor Contractor
RADV	Risk Adjustment Data Validation
RSI	Required Supplementary Information
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSIA	Statement of Changes in Social Insurance Amounts
SECA	*Self Employment Contributions Act of 1954*
Section 601	*Bipartisan Budget Act of 2015*
SFFAS	Statement of Federal Financial Accounting Standards
SGR	Sustainable Growth Rate
SHO	State Health Official
SMI	Supplementary Medical Insurance
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SOD	Segregation of Duties
SOSI	Statement of Social Insurance
SSA	Social Security Administration
SSF	Service and Supply Funds
StaffDiv	Staff Division
STI	Sexually Transmitted Infections
T-MSIS	Transformed Medicaid Statistical Information System
TAG	Technical Assistance Group
TANF	Temporary Assistance for Needy Families
TAS	Treasury Account Symbol
TEFCA	Trusted Exchange Framework and Common Agreement
Treasury	U.S. Department of the Treasury
UAC	Unaccompanied Alien Children
UFMS	Unified Financial Management System
U.S.	United States
U.S.C.	United States Code
VFC	Vaccines for Children
VCC	Vulnerability Collaboration Council

Appendix B: Connect with HHS

On behalf of the Department, we would like to sincerely thank and acknowledge all the individuals that provided support, either through content contribution or review feedback, to produce the FY 2020 AFR. We could not have prepared the FY 2020 AFR without the talent, time, and dedication of the employees across the Department of Health and Human Services.

The Hubert H. Humphrey Building, headquarters of the U.S. Department of Health and Human Services, was the first federal building dedicated to a living person.

Thank you for your interest in HHS's FY 2020 AFR. We welcome your comments on how we can make this report more informative for our readers. Please send your comments to:

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